

# Migration, Mobility and HIV



A rapid assessment of risks and vulnerabilities in the Pacific



SPC  
Secretariat  
of the Pacific  
Community

## Acknowledgements

### Lead authors/researchers:

John Connell and Joel Negin  
The University of Sydney

### Reviewers & contributors:

UNDP: Caitlin Wiesen, Carol Flore-Smrecznia, Ferdinand Strobel, Marta Vellejo Mestres, Nashida Sattar, Pramod Kumar Kazuyuki Uji;  
UNAIDS: Steven Vete, Stuart Watson, Tracey Newbury;  
Secretariat of the Pacific Community: Dennie Inakwala and Linda Petersen  
UNFPA: Tim Sladden ;  
Pacific Islands Forum Secretariat: Helen Tavola;  
WHO: Dr. Aneley Getahun

### Production & editing:

Ferdinand Strobel assisted by Anna Laqeretabua, Shobhna Decloitre and Shadiyana Begum under the leadership of Caitlin Wiesen, David Abbott and Garry Wiseman.

### Photographs credits:

The Maritime Programme Secretariat of the Pacific Community  
Ferdinand Strobel (UNDP)  
Thomas Jensen (UNDP)  
Mike McCaffrey (UNDP)

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## List of Acronyms

ADB	Asian Development Bank
AIDS	Acquired Immunodeficiency Syndrome
ARV	Anti-Retroviral
AusAID	Australian Agency for International Development
CNMI	Commonwealth of Northern Mariana Islands
CPR	Contraceptive Prevalence Rate
CSW	Commercial Sex Workers
DPKO	United Nations Department of Peacekeeping Operations
ECREA	Ecumenical Centre for Research, Education and Advocacy
ESCAP	United Nations Economic and Social Commission for Asia and the Pacific
FSM	Federated States of Micronesia
GDP	Gross Domestic Product
GNP	Gross National Product
HIV	Human immunodeficiency virus
IEC	Information, education and communication
IMR	Infant Mortality Rate
IOM	International Organization for Migration
IT	Information Technology
KAP	Knowledge, Attitude and Practice
MDG	Millennium Development Goals
MIRAB	Migration, Remittances, Aid, and Bureaucracy
MMM	Mobile Men with Money
MSM	Men who have Sex with Men
NAC	National AIDS Council (PNG)
NACS	National AIDS Council Secretariat (PNG)
NCD	Non Communicable Disease
NDOH	National Department of Health (PNG)
NGO	Non-Governmental Organisation
NZ	New Zealand
NZAID	New Zealand Agency for International Development
PFL	Pacific Forum Line
PICTs	Pacific Island countries and territories
PLWHA	People Living with HIV or AIDS
PNG	Papua New Guinea
POC	Pacific Operations Centre
PRHP	Pacific Regional HIV/AIDS Project
RAMSI	Regional Assistance Mission to the Solomon Islands
RMI	Republic of the Marshall Islands
SPC	Secretariat of the Pacific Community
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections
TTPI	Trust Territory of the Pacific Islands
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNMIL	United Nations Mission in Liberia
UNSW	University of New South Wales
UPNG	University of Papua New Guinea
USA	United States of America
USP	University of the South Pacific
WHO	World Health Organization

## Executive Summary

The objective of this report is to provide a rapid assessment of migration and mobility as key influences on the distribution and spread of HIV in the Pacific. While this has been established globally with targeted and tailored prevention programmes on mobility and HIV in a number of countries, the Pacific has yet to develop appropriate responses that take migration and mobility into consideration and ensure that HIV interventions address the drivers of mobility and the specific vulnerabilities that mobility creates. It is expected that this report will contribute to the development of multi-sectoral responses required to address the HIV epidemic in the Pacific region and provide the impetus for the development of effective and targeted interventions for people on the move.

The report establishes migration, mobility and urbanisation as key facilitating factors in the transmission and spread of HIV and sexually transmitted infections (STIs) in the Pacific. Although HIV was first detected in the Commonwealth of Northern Mariana Islands (CNMI) in 1982, Papua New Guinea (PNG) has the highest recorded cases in the region today. Case numbers outside of Papua New Guinea remain low, however, the high prevalence of STIs and teenage pregnancies point to the possibility of possible higher HIV transmission in the future.

According to reported data in most Pacific Island Countries and Territories (PICTs), sexual activity, heterosexual predominantly, is by far the most common mode of HIV transmission. However, vertical transmission (from mother-to-child) and transmission through the sharing of infected needles amongst injecting drug user is also reported although the latter remains relatively uncommon in the Pacific compared to Asia and other regions.

This report reviews a number of different migration behaviours in the Pacific. Open island economies are fragile and many rely heavily on migration for economic opportunity to the point of being characterised by some as MIRAB economies (Migration, Remittances, Aid and Bureaucracy). There is a dichotomy between predominantly internal migration, notably urbanisation, and external migration – individuals leaving the Pacific and those entering the region. Within this broad pattern are vastly divergent mobile groups such as skilled workers, seafarers, students, traders, civil servants, military personnel and sex workers. These groups are mobile and characterised by different behaviours, access to services and risk exposure to HIV and STIs.

While the report covers all Pacific island states, some emphasis is given to Papua New Guinea where the prevalence and impact of HIV are greatest. According to country data collected by the Secretariat of the Pacific Community (SPC) from the end of 2008, there were about 29,631 cumulative reported cases of HIV and AIDs across all Pacific Island Countries and Territories, of which 28,294 in Papua New Guinea alone. The high prevalence of HIV in Papua New Guinea points to the significance of internal migration, rather than international migration. Most internal migration is to the larger urban centres and to some mining towns that are “hot spots” for HIV transmission. In the Pacific, the rationale for urbanisation is consistent throughout the region as employment opportunities and services such as education and health are concentrated in the urban areas. Within PNG, the contemporary incidence of HIV is seen as having much to do with “mobile men with money” MMM- who characterise larger urban areas and are even personified as a new kind of “sugar daddy” – the dakglas kar man (dark glass car man): businessmen, landowners and politicians with plenty of disposable income (Lepani 2008a). However, international migration is also on the increase with some migrant groups vulnerable.

Workers who engage in circular migration such as working in mines, construction, plantations/forestry and military personnel are at higher HIV risk exposure due to long periods away from home, relatively high salaries and a risk-taking ethos. Another group that also exhibits risky sexual behaviour is transport workers and seafarers. They tend to be younger males who leave their families for extended periods of time, have relatively well paid employment in distant locations and are more likely to turn to commercial sex. Sex workers, both commercial and transactional, are also at-risk communities, many of whom migrate domestically or internationally. Sex workers are often some of the most marginalised members of society, thus heightening their vulnerability to HIV.

High risk sexual behaviour and high levels of migration coincide in urban areas. Urban populations grow steadily alongside a growing “floating” urban population of informal squatter settlements. Commercial sex and the unprotected sex that is associated with it is a key source of HIV and STI transmission, and is mainly an urban phenomenon. Commercial sex tends to concentrate on locations where foreign visitors can be found such as in ports, development enclaves, military installations and tourism locations. In such situations, HIV risk is indirectly linked to poverty or

hardship. Many of the mobile groups such as soldiers, seafarers and guest workers have some degree of economic foundation compared to other members of the population. Persons providing sexual services to these groups (mostly women) are, however, often driven by poverty and lack of opportunity.

The lack of specific data on the sexual behaviour and risk factors of migrant groups in the Pacific makes the development of firm conclusions difficult. Additionally, information on the number and trends of migrant groups such as guest workers and students is not currently available. Given this, more research is needed to determine levels of risk and factors that drive decision-making of mobility and sexual behaviour.

While all countries have some degree of mobility-related HIV vulnerability, a few countries stand out. As Papua New

Guinea has a large number of higher risk mobile groups, the country should be a focal point for interventions focussed on mitigating HIV vulnerability driven by mobility. Additionally, Guam, Northern Marianas, Fiji, Solomon Islands, Kiribati, Palau, Marshall Islands, New Caledonia and French Polynesia have relatively significant sex worker populations, growing urbanisation and other high risk migrant groups such as soldiers and seafarers. Some specific urban centres such as Suva in Fiji, Honiara in Solomon Islands, Guam, Saipan in the Commonwealth of the Northern Mariana Islands (CNMI) and Tarawa in Kiribati are hotspots worthy of further/enhanced preventive interventions.

Greater recognition is needed over the present and potential significance of migration for the transmission of HIV in order to develop effective interventions specifically suited to the Pacific's social, epidemiological and behavioural context.










**Table 1. Summary of Most Significant HIV Vulnerability by Migration Group**

Migration Group <sup>1</sup>	Number of Pacific Islanders Involved <sup>2</sup>	Countries Most Affected <sup>3</sup>	Vulnerability to HIV <sup>4</sup>	How Much is Known <sup>5</sup>
Urbanisation	VL	PNG, Fiji, Solomon Islands, Marshall Islands, Kiribati, Guam, CNMI, New Caledonia		
Sex Work	L (little data on number of foreign CSWs)	Fiji, Solomon Islands, Kiribati, Marshall Islands, PNG, Guam, CNMI, Palau, New Caledonia, French Polynesia, FSM		
Plantation/ Forestry/ Logging	NA	PNG, Solomon Islands		
Mining	M (approx 8000)	PNG, New Caledonia		
Transport and Seafarers	L (approx 7000 PI seafarers and more than 10,000 foreign seafarers through region)	FSM, Kiribati, Marshall Islands, Tonga, Tuvalu, PNG, Fiji, French Polynesia		
Military	L (approx 8000 domestic soldiers and 4000 overseas soldiers)	Fiji, PNG, Samoa, Tonga, Guam, CNMI, New Caledonia, Marshall Islands		
Guest Workers	M (approx 7000)	Vanuatu, Tonga, Samoa		
Skilled Workers	NA			
Tourism	NA	Fiji, French Polynesia, New Caledonia, Palau, Guam, CNMI, Vanuatu, Cook Islands		
Refugees and Displaced People	L (10,000 refugees in PNG alone)	PNG		
Students	NA	PNG, Fiji		
Return Migration	NA	Tonga, Samoa, Marshall Islands, Fiji		

### Notes to Table 1:

- Each of these groups are analysed in more detail in the report.
- Using the information available, the number of Pacific Islanders involved in the migration group is assessed. VL represents very large, L large, M medium and S small. Where insufficient data is available, NA is noted for not available.
- This column is an assessment of the few countries **most** affected or involved with the particular migration group based on the analysis conducted for this report. While other countries are certainly affected, the inclusion of countries was based on a qualitative assessment of relative levels of impact.
- Acknowledging that all migrants have some vulnerability to HIV, the moons represent the following risk profile: full moon – high risk profile; half moon – medium risk profile; empty moon – limited risk profile. This is a **qualitative** assessment meant to be generally representative of overall vulnerability of the group. The assessments are done even where they are based on limited information.
- Based on the research conducted, this is a **qualitative** assessment of how much reliable data is available specifically about the migration group and its risk behaviour in the Pacific region. A full moon represents a significant amount of information is available, a half moon represents some limited information is available and an empty moon suggests that almost no specific information is currently available. This is necessarily a relative measure; even for those that have a full moon represented, more research would certainly be beneficial.

**Table 2. Summary of HIV Vulnerability by Country**

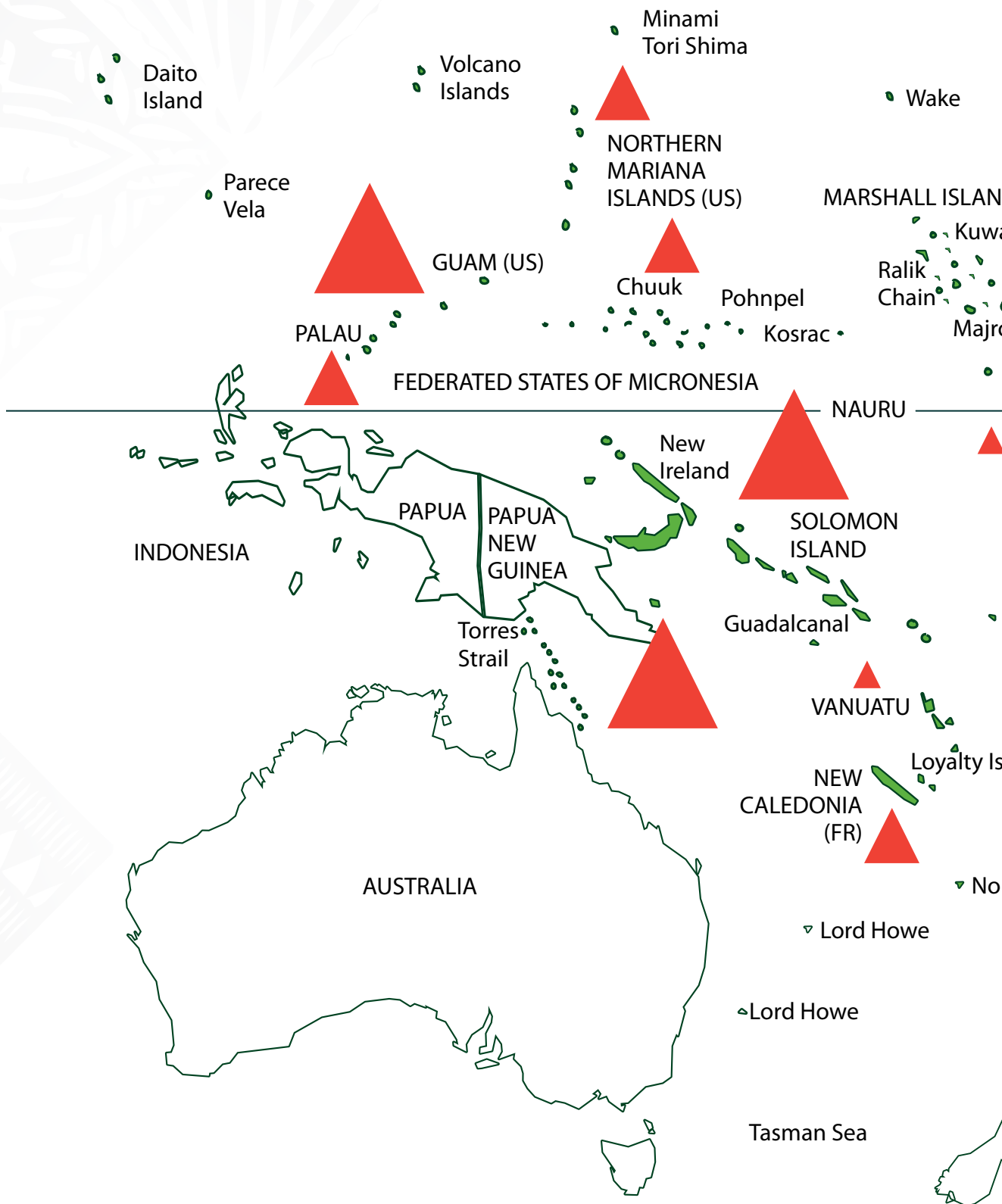
Country	Major Migration Groups	Country HIV Vulnerability <sup>1</sup>
PNG	Urbanisation, Sex Work, Plantation, Mining, Transport/Seafarers, Military, Refugees, Students	
Guam	Urbanisation, Sex Work, Military, Tourism	
Fiji	Urbanisation, Sex Work, Military, Tourism, Students, Transport/Seafarers, Return Migration	
Solomon Islands	Urbanisation, Sex Work, Plantation	
Kiribati	Urbanisation, Transport/Seafarers, Sex Work	
Northern Mariana Islands	Urbanisation, Sex Work, Tourism, Military	
Tonga	Transport/Seafarers, Military, Return Migration, Guest Workers	
Tuvalu	Transport/Seafarers	
Samoa	Return Migration, Guest Workers, Military	

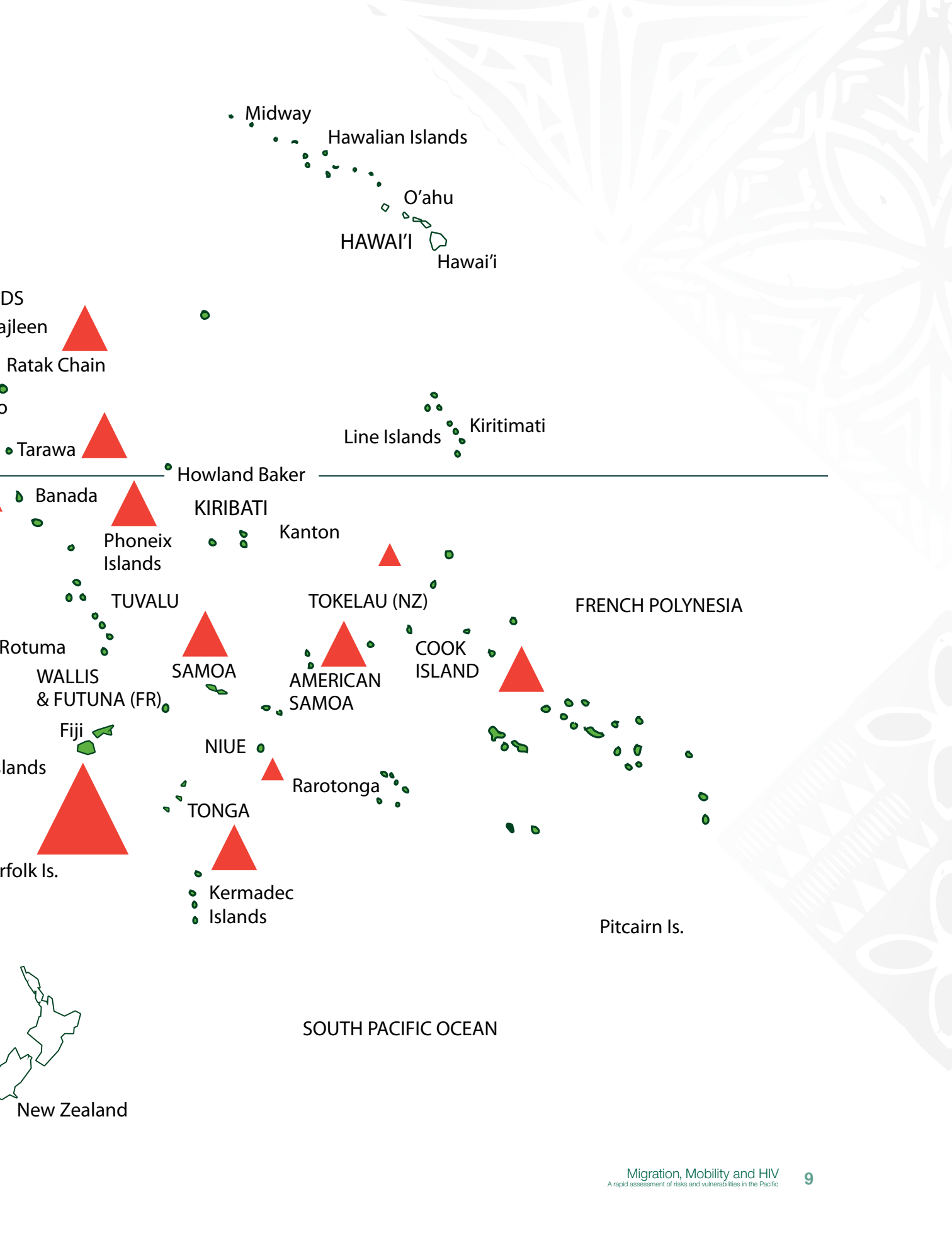
<sup>1</sup> Country HIV vulnerability is determined specifically with regard to migration and mobility issues. The moons represent the following risk profile: full moon – high risk profile; half moon – medium risk profile; empty moon – limited risk profile.





**Map 1. Visualisation Mobility related HIV vulnerability by country**





Midway  
Hawaiian Islands  
O'ahu  
HAWAI'I  
Hawai'i

DS  
ajleen  
Ratak Chain  
Tarawa

Line Islands  
Kiritimati

Howland Baker  
KIRIBATI

Banada  
Phoneix Islands  
TUVALU

Kanton  
TOKELAU (NZ)

FRENCH POLYNESIA

Rotuma  
WALLIS & FUTUNA (FR)

SAMOA  
AMERICAN SAMOA  
COOK ISLAND

Fiji  
lands  
rfolk Is.

NIUE  
Rarotonga  
TONGA

Kermadec Islands

Pitcairn Is.

SOUTH PACIFIC OCEAN

New Zealand

## Introduction

The Pacific region has a strong tradition of mobility. The current migration situation varies dramatically from country to country, and within each country. Urbanisation and internal migration are predominant in Melanesia while international migration is more significant in Micronesia and Polynesia, and is increasing. However, recent labour migration from Vanuatu and other Melanesian countries suggests some limited convergence between the regions. Australia has recently followed New Zealand's seasonal worker/fruit picking scheme, granting allocations of time-limited work visas to Pacific island nationals each year. In almost every context, migration occurs for economic reasons in response to uneven development, though there are social considerations. While economic development issues and the role of employment in migration are significant, migration and mobility and their link to HIV risk and transmission are not strictly just a question of poverty.

Despite increased concern over the prevalence of HIV in the Pacific region, there is still limited data available. The first case of HIV in the Pacific was reported in 1982 in Northern Marianas followed by French Polynesia in 1984 and Guam in 1985. HIV cases have since been reported in most countries except in small and isolated states like Niue and Tokelau (Sladden 2005).

While the numbers are low in most countries (although there is probably significant under-reporting), nowhere are they declining. Papua New Guinea stands out from the rest of the Pacific in terms of its HIV situation and, through its large population, distinct internal migration structure, economic and social diversity and urbanisation.

Given the definition of vulnerability to HIV as *"the lack of power of individual and communities to minimize or modulate their risk of exposure to HIV infection and, once infected, to receive adequate care and support"* (Gruskin et al 2002), it is not so much migration itself that is relevant for HIV vulnerability, but the social context that drives migrant behaviour.

As an International Organization for Migration (IOM) report from 2006 notes: *Potential risk factors for migrants include separation from families and partners, and separation from the socio-cultural norms that guide behaviours in more stable communities. Population mobility may also affect HIV vulnerability of people who do not migrate at all, such as people in communities along major transit corridors or*

*with major construction sites, or those whose partners are working abroad. Finally, migrants often have limited access to health services, including to health promotion, to HIV prevention, to voluntary counselling and testing, and to HIV care and support.*

In a broader sense, and in the Pacific context too, higher HIV risk exposure has therefore been associated with increased mobility (Herdt 1997). More specifically, in Papua New Guinea, it has been linked to the rise of a relatively new social group called "mobile men with money" (MMM). This is primarily an urban phenomenon but is significant in many social contexts of high population movement and economic disparity. This is especially so where men are involved in various forms of itinerant wage labour, often in resource enclaves such as mining and logging, and where limited educational and employment opportunities for women encourage commercial and transactional sex (Lepani 2008a: 152, Wardlow 2007, Koczbarski 2000, Wilde 2007). In several rural parts of Papua New Guinea and elsewhere in the region, HIV is seen as a "foreign disease" that can only be contracted by people moving away from their home areas (Wilde 2007), or is associated with tourists coming into the Pacific.

Based on the situation in other parts of the world, it is reasonable to argue that understanding the complex issues of migration, mobility and HIV is critical to addressing the HIV epidemic both regionally and globally. Mobility has been associated with higher HIV prevalence in southern Africa as far back as 1989 (Hunt 1989, Jochelson et al 1991, Zuma et al 2003), with one researcher noting that "mobility is associated with increased extramarital multi-partner sexual relations through which HIV is spread" (Mtika 2007).

In the Pacific, data on migration are highly fragmented. Despite the database developed by the Secretariat of the Pacific Community (SPC), statistics are not consistent across the region. Migration data are collected very differently within the Pacific (for example according to de facto or de jure populations) and in the main destinations (New Zealand, Australia and the United States of America). At this stage, therefore, clear conclusions on the basic geography of both HIV and migration are impossible.

Similarly, data on HIV incidence, awareness and sexual behaviours are highly uneven. There are large numbers of sources for information on HIV and AIDS in the Pacific, though consistency, quality and scope vary considerably. Reports



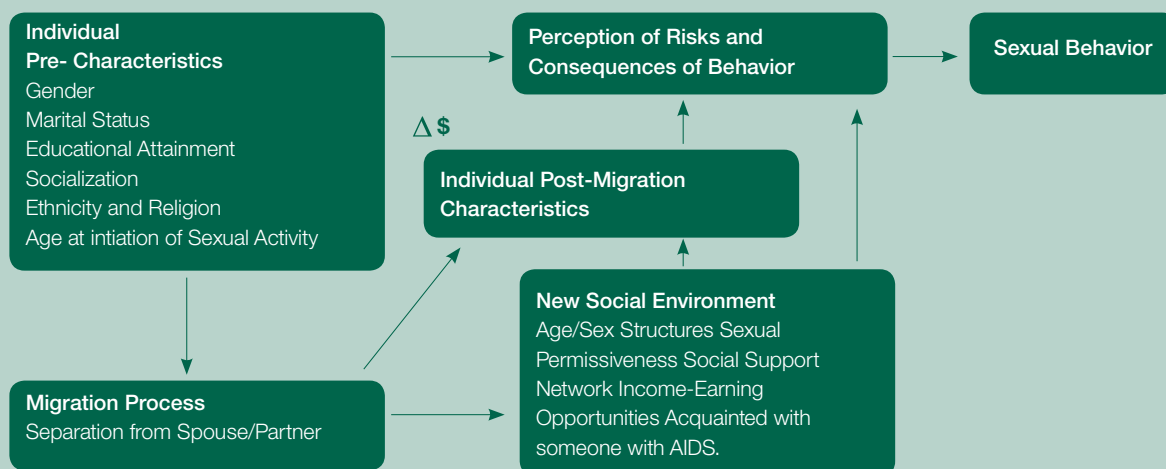
from the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) exist for 5 countries in the region while other prevalence and epidemiological data are available from various surveys and documents (Pacific Regional HIV/AIDS Project Country Updates 2007, Pacific Regional Strategy on HIV/AIDS 2004-2008 and 2009-2013, Jenkins 2005, WHO 2006, Report of the commission on AIDS in the Pacific 2009).

Mobile populations and migrant behaviour (other than seafarers) are not explicitly mentioned in the Pacific Regional Strategy on HIV and Other STIs 2004-2008 (Pacific Regional Strategy 2005). And while the Pacific Strategy 2009-2013 notes migrant and mobile populations as one of a number of key populations, the targeted and tailored prevention programmes for mobile populations still need to be further developed (SPC 2008). The International Organization for Migration, which has programmes on mobility and HIV in Latin America, Asia, Africa and Europe, does not have any programmes in the Pacific. While the issue of mobility and HIV is acknowledged in the Pacific and there have been some activities with specific groups, there has been no comprehensive focus on this area and further attention is needed.

Data on sexual behaviour and social aspects of sexual intercourse are more accessible in Papua New Guinea

than for some of the smaller island states (though the social diversity of Papua New Guinea means that what is valid in one cultural group may be invalid elsewhere in the country). However, speaking on sexual matters is socially inappropriate in most contexts (thus challenging the development of educational programmes) and some of the established churches (which hold considerable social importance) discourage the promotion of condoms (which are not easy to find on sale in many parts of the region). Approaches to sexually transmitted infections and HIV have not been consistent in education or health programmes (partly because of low prevalence) with the generally low status of women and the special health risks they face as well as sexual violence placing them at a higher risk of HIV. Women in PNG have low life expectancy largely because of the health risks posed by childbirth, malnutrition and malaria. Women also have a literacy rate about 10 per cent lower than men. While almost equal numbers of men and women are reported to have HIV, women are generally infected at a younger age. Women are particularly disadvantaged by limited employment opportunities and may lack information about medical services, counselling or support services. Because of the difficulties of economic survival, many women trade sex for money or other goods. In some circumstances, sexual transactions are brokered by male relatives [Hammar, 1998]. Non Governmental Organizations (NGOs) and churches have played a significant role in social change in

**Figure 1: An example of Conceptual Model of the Influence of Migration on Sexual Behaviour** (adapted from Brockhoff and Biddlecom, 1999 in Hugo, G (2001))



PNG reaching the remotest rural areas and providing almost 50 percent of health and educational services but have been unable to change entrenched gender relations (PNG National Strategic Plan on HIV/AIDS 2006 – 2010). NGOs continue to play a key role in some parts of the region (ADB 2007; Butt & Eves 2008).

How HIV spreads in a community is shaped by culture, economy and complex social interactions. “Vulnerability to HIV and AIDS has increasingly come to be understood as fundamentally linked to questions of social and economic equality and justice” (Parker 2000). In many parts of the world, the fragile political economy has encouraged labour migration which consequently impacts on decisions regarding the type, duration and vulnerability of sexual partnerships.

*“Migrants are not necessarily at higher risk of being infected with HIV than non-migrants. However, some will be more vulnerable as a group due to the selectivity of the migration process which means that people with higher HIV risk exposure are more mobile (i.e. sex workers, seamen, soldiers, miners...). The context of the migrant is determinant at destination and while migrating in particular and may predispose toward high risk behaviour”*

Vulnerability to HIV is not just an issue for migrants or mobile individuals only. It involves families and communities. Moreover, as Paul Farmer noted of rural Haitian women, “the chief risk factors seem to involve not number of partners but rather the professions of these partners” (Farmer 1999). Another reason for viewing HIV vulnerability as a family

issue is that migration decisions are often taken in the context of nuclear and extended family considerations and constraints.

*“Vulnerability to HIV is not just an issue for migrants or mobile individuals. It involves families and communities”*

The above contextualisation informs the present assessment. Though this document is organised by mobile groups, the interactions between the groups are significant and the organisation of the review is not meant to imply that these groups are static in their composition and that there are no links between them. Understanding the interaction and sexual networking between these groups is necessary to address vulnerability and develop appropriate responses.

A study in the Marshall Islands documented “high risk sexual networking links between foreign sex workers, seafarers, Marshallese young women involved in the informal exchange of sex, local women and men, and migrant and expatriate workers” (Buchanan-Aruwafu 2007). This complexity needs to serve as an underlying framework for the review, as similar and different complexities exist elsewhere.

This rapid assessment aims to contribute to current, broader efforts to understand the epidemiology and social-behavioural context of the disease in the region toward more Pacific-centred solutions rather than simply adopting models developed for other parts of the world. Such an approach depends on multi-disciplinary or integrated initiatives and research on critical areas such as mobility and migration.

### **Box 1. Why do people move?**

People move from one place to another temporarily, seasonally or permanently due to a host of push and pull factors. Pull factors include the search for professional or economic opportunities or to join family members living away from home. Examples of push factors include poverty, food insecurity, warfare or other violence, human rights abuses, political repression, ethnic tensions, and persecution. There is ample evidence to demonstrate a close association between increased vulnerability during mobility and the spread of HIV, and many people believe that migrants and mobile populations bring HIV with them when entering countries or communities. Evidence has established, however, that the opposite is more likely to be the case: rather than bringing diseases, migrants often become vulnerable to contracting HIV during transit and after they arrive at their destinations. The linkages between population mobility and HIV/AIDS are related to the conditions and structures of the migration process, including in communities of origin, during transit, at destinations, and on return. Factors linking population mobility and increased vulnerability to HIV include poverty, lack of legal protection and of power, discrimination, and exploitation.

*(International Organization for Migration 2005)*





## Methodology

The methodology undertaken in this desk review has been an exhaustive search for and analysis of existing documentation on migration and HIV. A mix of existing qualitative and quantitative data has been used to determine estimates of the number of people who migrate in the Pacific as well as a description of the populations. These sources include epidemiological data available from the Secretariat of the Pacific Community, the World Health Organisation and United Nations sources, programmatic data from the Pacific Regional HIV/AIDS Project (PRHP) and the Secretariat of the Pacific Community, newspaper articles and academic literature, and some online sources. Relevant experiences from other parts of the world have been included though it is acknowledged that those experiences may not be directly applicable to the Pacific.

The review is intended to be as comprehensive as possible, and therefore includes data that has been reliably verified but also anecdotes and assertions found in various reports. While it is acknowledged that some of these assertions might not be verified, given the lack of data and research in some areas, such information is needed to give a full picture of the complex world of mobility in the Pacific.

Migrant groups have been identified along a number of axes focusing on type of employment, reason for migration and characteristics. The document is organised in two broad sections: migration that is predominantly internal to the Pacific island countries and territories and migration

that is predominantly international. Acknowledging that these categories are too blunt, they nevertheless provide a useful frame for analysis. For each of the migration groups identified, discussion of HIV vulnerability behaviours and access to services are addressed using existing reports from comparable groups in other parts of the world where specific data are available.

Using the information collected, maps can be created to highlight areas where migration is significant and rate routes or destinations as high, medium or low risk for HIV transmission. Because of the complexity of this task and the difficulty in collecting adequate data, this has been done sparingly at this stage.

While this report covers all Pacific island states, it has given some emphasis to Papua New Guinea where the prevalence and impact of HIV are greatest. Papua New Guinea is also a country with particular challenges where more practical policies and solutions have been put in place, and where data on the social context is more readily available. Less emphasis has been placed on smaller states, where the prevalence of HIV is minimal and documentation is limited or non-existent. The report has not been able to comment adequately on the situation in the French territories of New Caledonia, Wallis and Futuna and French Polynesia due to the lack of sufficient data accessible to English speakers. While some data points are included, more evidence will be needed to strengthen assertions.



## Background

### Population

In the Pacific where data exists, they are generally adequate enough to enable gross estimates of the populations where migration/mobility is significant. Though a small number of countries have poor census data, good census data exists for most countries in the region. All Pacific states are still going through the demographic transition but population growth remains high in some places, including the larger Melanesian states (see Table 3). While the average population growth rate in the region is around 2%, in Vanuatu and Solomon Islands it is around 2.6% but it is decreasing. Only in Fiji has there been significant adoption of modern family planning techniques. Outside Melanesia, emigration has long been an important regulator of demographic change, especially as modern contraception has not been easily available. Hence migration has partly been a “safety valve” for both population growth and economic stagnation. In almost every state, population growth rates are as high as or higher than economic growth rates.

Life expectancies have risen over the past quarter of a century but remain lowest in Melanesia - less than 55 in PNG but over 70 in most Polynesian states. Longer life expectancies, aging and growing populations, the rise of non-communicable diseases (NCDs) and the migration of people in working age groups have increased the stress on all health care systems. Infant mortality rates are highest in Melanesia, with Vanuatu (at 67 per 1000) the worst of the region compared with most parts of Polynesia (less than 15 per 1000).

In PNG, infant mortality is increasing because of inadequate and declining provision of health services to rural areas. Total fertility rates (Table 3) remain very high, especially in parts of Melanesia and Micronesia because contraceptive rates are low compared with developing countries of similar income levels (Ahlburg 1996). Fertility control is a taboo topic in most Pacific countries and contraceptive prevalence rates (CPR) vary throughout the region but are rarely above 40% and may be as low as 3-4 % in Vanuatu and the Solomon Islands. Although recent surveys have shown increases in Vanuatu (37%) and Solomon Is (34%), most data are suspect or include significant reliance on “traditional” methods (Rallu and Ahlburg 2008).

Data on unmet contraceptive needs available from health surveys during 2006-7 in the Marshall Islands, Tuvalu, Solomon Islands and Nauru show that teenagers have higher unmet needs in the Marshall Islands. Many reasons

explain limited use of modern family planning techniques including the need for the work of children, conservative social and religious attitudes and the unavailability (and perhaps expense) of contraceptives.

A decade ago Port Vila had a fertility rate of 4.5 compared with a national average of 5.3. In 1994 more than half of urban women reported that they used contraception. Users were most likely to be better educated, employed (and/or have employed husbands) but also to have several children (Jayaraman 1995). This situation was and is probably true of other Melanesian towns and cities. The only independent state with relatively high access to family planning is Fiji, where in 1990 some 27% of women were reported to be using contraception.

### Health

Health status varies considerably within the Pacific. The large Melanesian states have the lowest levels of access to essential primary health services (Taylor, Bampton and Lopez 2005) while the less tropical states with substantial aid, notably Niue and the Cook Islands, have fewer health problems and better funded health services.

Variations are a function of local conditions, economic and social development, the isolation of many parts of Melanesian and Micronesian states, and the status of health care. Even greater variations exist in health services provision and financing. At the core of the uneven distribution of human resources, hospital beds and other physical resources are the significant variations in funding, in absolute terms, and in the proportion of national budgets spent on health care.

Health services are highly concentrated in urban areas. The reductions in spending on health care systems in the Pacific, that became evident from the 1980s, have had a damaging result in sustaining a skilled health labour force, meeting national health needs and developing preventative systems that are appropriate for dealing with HIV.

Small Pacific island countries and territories continue to face significant health challenges ranging from the spread of malaria in Melanesia to the rise of non-communicable diseases (NCDs) throughout the Pacific (Gani 2008). These health challenges also include “the unfinished agenda in achieving the MDGs, high fertility rates, continued prevalence of communicable diseases and emerging threat of HIV/AIDS, combined with a rising, and in many cases a crisis in, NCD prevalence” (World Bank 2007). This is compounded

**Table 3. Pacific Populations (based on Secretariat of the Pacific Community, 2008)**

	Population 2008 estimate	Population density persons	Population growth rate per sq km)	Urban population (%)	Migration Rate (%)	Total fertility rate	IMR	Life expectancy at birth	GDP per capita US\$
American Samoa	66,000	330	1.6	50	1.6	4.0	12	72	6,600
Cook Islands	15,500	65	-0.5	42	0.4	2.9	15	71	11,000
FSM	111,000	158	0.5	22	0.4	4.0	38	67	2,200
Fiji	832,000	46	0.5	46	-10.0	2.6	19	66	8,380
French Polynesia	263,000	75	1.2	53	1.2	2.2	7	74	17,500
Guam	179,000	330	2.8	93	2.8	2.7	10	72	
Kiribati	95,000	118	1.9	44	1.8	3.5	52	62	790
Marshall Islands	53,000	290	1.0	68	1.0	4.4	37	66	1,800
Nauru	9,900	473	2.3	100	2.3	4.0	42	55	..
New Caledonia	247,000	13	1.7	63	1.7	2.3	7	74	16,000
Niue	1,450	6	-2.5	36	-30.6	2.6	8	72	8,000
Northern Marianas	60,000	135	-1.8	90	-31.5	1.6	7	75	..
Palau	20,000	41	0.6	64	0.0	1.9	31	69	5,700
PNG	6,333,000	14	2.2	14	0.0	4.6	64	54	850
Samoa	179,000	61	0.1	24	-19.8	4.6	19	73	1,450
Solomon Islands	504,000	18	2.7	17	0.0	4.8	66	61	500
Tokelau	1,100	95	0.0	0	-16.7	4.5	18	72	..
Tonga	102,000	157	0.4	31	-17.2	4.2	19	70	1,780
Tuvalu	9,700	373	0.3	47	-9.4	3.7	35	64	2,100
Vanuatu	227,000	19	2.6	22	0.0	4.4	67	67	1,300
Wallis & Futuna	15,000	105	0.7	20	-6.0	2.6	6	75	5,000
									15,240

by the migration of skilled health workers and poses new problems for poorly staffed, managed and funded health sectors. Over 15% of Pacific island doctors and nurses have migrated to the United States, New Zealand, Australia, the United Kingdom and neighbouring island countries in the past two decades, and this trend is expected to continue (Connell 2009, Negin 2008).

Substance abuse is emerging as a problem and its prevalence is universally worsening. For example, in the Marshall Islands where there is substantial American influence and a significant proportion of the population is in the United States, substance abuse appears to be contributing to emerging and re-emerging infections like HIV, sexually transmitted infections and tuberculosis (RMI Epidemiological Working Group 2008). While injecting drug use is relatively rare, marijuana is now quite common in several parts of the region, especially Papua New Guinea (eg Halvaksz and Lipset 2006) and other parts of Melanesia. Heroin and crack cocaine are similarly becoming more common in a few areas such as Guam and Northern Marianas. In most contexts, high levels of alcohol consumption are the most likely factors to be associated with risky sexual activity.

In several parts of Polynesia and Micronesia, suicide rates are very high. The Pacific, particularly the Marshall Islands, has some of the highest rates of youth suicides in the world (Rubinstein 1992, Booth 1999, ADB 2006:118, Jenkins and McSwain 2005). In Samoa a couple of decades ago, this high suicide rate was associated with migration because of the breakdown of family structures by the absence of parents during migration (Hezel 1989) and the declining opportunities (Macpherson and Macpherson 1987).

## HIV

As of 2007, there were an estimated 33 million people living with HIV and AIDS globally (UNAIDS 2008). Most of these cases are in sub-Saharan Africa (67%) followed by south and south-east Asia (13%). The Pacific region accounts for just 0.2% of the global burden of HIV, with the majority of these cases occurring in Papua New Guinea, Australia and New Zealand. According to data from the Secretariat of the Pacific Community from the end of 2008, there were about 29,631 cumulative reported cases of HIV and AIDS across all Pacific island countries and territories, of which over 28,000 cases occurred in Papua New Guinea (Table 4). However, the 2007 Estimation Report on the HIV Epidemic in Papua New Guinea estimates that there are in fact 54,000 cases of HIV in Papua New Guinea, demonstrating the difficulties in obtaining reliable epidemiological data both nationally

(National AIDS Council PNG 2008) and in particular regions (Haley 2008).

While there are low numbers of HIV in the Pacific – barring Papua New Guinea in particular and New Caledonia, Guam and French Polynesia to a lesser degree – a number of social and behavioural factors common across the region present risk factors for transmission. The primary means of HIV transmission in the Pacific is via unprotected heterosexual intercourse. Levels of sexually transmitted infections are relatively high, in some islands even appearing in the leading five causes of morbidity (eg. WHO CNMI 2007, WHO New Caledonia 2007). Other significant risk factors include highly mobile populations, a large population of seafarers, attitudes of taboo toward sex and sex education, and high levels of stigma and fear surrounding HIV (Hammar 2007; Jenkins 2005).

Data collection and research on the extent of the sale of sexual services and male-to-male sex, and their effects on HIV, have been limited to Papua New Guinea. Additionally, there are relatively high levels of early sexual debut and unprotected sex among young people (Jenkins 2005; WHO 2006). While levels of awareness are increasing, the response to the epidemic in the region has not been sufficient to date. Papua New Guinea stands out as the Pacific nation most affected by HIV and AIDS. It is critically important to understand why this has been so, what policies and practices might reduce the extent and minimize the further spread of HIV and what the experiences of Papua New Guinea imply for the rest of the region. The factors driving the epidemic in Papua New Guinea are not universally agreed but low levels of condom use, concurrent sexual partnerships, unequal gender relations which restrict the ability of women to negotiate safe sexual practices, high prevalence of untreated sexually transmitted infections, low levels of literacy, a weak health system within patriarchal societies and a high prevalence of sexual violence against women are all posited as explanations (Hammar 2007, Wardlow 2007, Dundon and Wilde 2007).

Moreover, in many parts of Papua New Guinea, basic knowledge of HIV is largely absent (Wilde 2007, Haley 2008, Lepani 2008b). Both commercial sex and increased HIV transmission have followed increased urban poverty and greater rural poverty such as in the context of the Southern Highlands of Papua New Guinea (Wardlow 2007: 1008, Wardlow 2008). In some places where alternative incomes are particularly difficult to obtain, commercial sex has become “survival sex” (Beer 2008).

**Table 4. Pacific Population and Reported Cases of HIV and AIDS as of end 2008**

Country	Population (mid 2008)	Cumulative HIV Reported Cases (including AIDS)	Cumulative Incidence per 100,000
<b>MELANESIA</b>	<b>8,312,417</b>	<b>28,932</b>	<b>286.9</b>
Fiji Islands	843,888	290	34.4
New Caledonia	246,598	331	134.2
Papua New Guinea	6,468,405	28,294	437.4
Solomon Islands	520,617	12	2.3
Vanuatu	232,908	5	2.1
<b>MICRONESIA</b>	<b>531,802</b>	<b>343</b>	<b>64</b>
Federated States of Micronesia	110,445	36	32.6
Guam	177,290	192	108.3
Kiribati	97,201	52	53.5
Republic of Marshall Islands	53,889	19	35.7
Nauru	9,570	2	20.9
Northern Mariana Islands	63,130	33	52.3
Palau	20,278	9	44.4
<b>POLYNESIA</b>	<b>655,017</b>	<b>356</b>	<b>54.3</b>
American Samoa	64,337	3	4.7
Cook Islands	15,564	2	12.8
French Polynesia	262,497	302	115.0
Niue	1,550	0	-
Pitcairn Islands	66	0	-
Samoa	181,964	19	10.4
Tokelau Islands	1,168	0	-
Tonga	102,652	17	16.6
Tuvalu	11,035	11	99.6
Wallis and Futuna	14,183	2	14.1
<b>ALL PICTs</b>	<b>9,499,236</b>	<b>29,631</b>	<b>311.9</b>
<b>ALL PICTs excluding PNG</b>	<b>3,030,831</b>	<b>1,337</b>	<b>44.1</b>

Source: SPC last update 28/01/20010 (data subject to revision)

*Population mobility, however, is another factor that is not sufficiently understood, but the relatively recent emergence of mobile men with money is a significant factor in the rise of HIV, and a measure of the importance of mobility. The combination of mobility and extramarital relationships has meant that marriage tends to be a very significant risk factor in Papua New Guinea as it is in other parts of the world.*

HIV has been reported in all provinces of Papua New Guinea; however, over 50% of all HIV has been reported in the National Capital District followed by the Western Highlands with 20% and Morobe with 9%. This data does not represent the actual prevalence of HIV by province as many people

travel to urban centres to access testing and treatment, and to avoid possible stigma (National AIDS Council PNG 2008).

The Second Generation Surveillance studies conducted throughout the Pacific from 2000 to the present reveal high levels of sexually transmitted infections. A report published in 2006 on 6 countries revealed the prevalence of chlamydia amongst pregnant women - 6.4% in the Solomon Islands to 29% in Fiji - and among all women less than 25 years of age (WHO 2006). The prevalence of chlamydia in over 30% of women in Fiji and Samoa is considered to be among the highest in the world, and indicates widespread unprotected sex and high levels of untreated sexually transmitted infections among men. Additionally, trichomonas vaginalis

has been reported to be very high in Vanuatu (Fotinas et al 2008, Cummings 2008).

The increase in sexually transmitted infections coincides with a recent increase in teenage pregnancies. Rates of condom use at last high-risk sex with a non-commercial partner ranges from 12.5% in Fiji to 45.1% in the Solomon Islands (WHO 2006). In the Second Generation Surveillance conducted by the World Health Organization, Secretariat of the Pacific Community and University of New South Wales, the percentage of youths reporting 2 or more sexual partners in the last 12 months ranged from 43.3% in Vanuatu to 12.7% in Samoa (WHO 2006).

In Saipan, teenagers are sexually active and condom use is less than 20%. In Fiji and Vanuatu, survey respondents believed that a large majority of the population was sexually active before marriage (Ahlburg and Larson 1995). High teenage fertility is consistent with low contraceptive prevalence among teenagers. This is linked to the more general factors noted above, alongside the lack of information and reluctance of teenagers to visit health centres to discuss sexual and reproductive health as well as social disapproval of (illegitimate) births in some contexts. Extra-marital sex may also be increasing in significance.

In Papua New Guinea, data indicate that 23% of married men, 6% of married women, 33% of bachelors and 12% of spinsters aged 15 to 49 years reported having non-regular sex in the last 12 months (that is, sex with a person who is not a regular partner or a spouse). Individuals with a high prevalence of changing sex partners play a disproportionate role in the spread of HIV and other sexually transmitted infections.

Of Tonga's 9 HIV cases since 1998, four were believed to have become infected while in the United States and one other while travelling overseas (Viekune 1998). Similarly, New Caledonia's 2008 HIV report contains a table outlining the risk factors that led to the infection of 316 people living with HIV or AIDS (PLWHA) in the territory. The table also notes how many of those infected have never left the territory suggesting the importance with which the government of New Caledonia regards migration and mobility in the transmission of HIV. The response to HIV in the Pacific region is growing. More than US\$77 million was allocated for HIV activities in the Pacific in 2008 (Commission on AIDS in the Pacific), and the majority of the funds are for Papua New Guinea. But even for the other Pacific island countries and territories where

there are only 1000 people living with HIV or AIDS and very low HIV prevalence, more than US\$15 million has been made available for 2009 from donors, multilateral agencies and Pacific governments. There are a number of major donors and multilateral agencies involved in the regional HIV response including AusAID, the Global Fund, Asian Development Bank (ADB), NZAID, the USA government and United Nations agencies.

Nine countries in the Pacific region (Australia, Fiji, Marshall Islands, Micronesia, Papua New Guinea, Samoa and Tonga) currently impose HIV related restrictions on entry, stay and residence of people living with HIV or AIDS. A recent UNAIDS report on the Mapping of restrictions on the entry, stay and residence of people living with HIV or AIDS highlights these restrictions since the beginning of the HIV epidemic as governments have used these measures as an attempt to prevent the spread of HIV and avoid the possible cost of treatment and care related to HIV. However, there is growing international momentum to rescind HIV-related restrictions given the recognition by public health and human rights experts that there is no public health rationale for them and that they are discriminatory and could well impede effective HIV responses.

### **Economic Development, Income and Remittances**

The economies of Pacific island countries and territories are constrained by various factors linked to their size, remoteness and isolation, diseconomies of scale, scarce natural and human resources, and vulnerability to external shocks and natural hazards. Commercial agriculture has been hindered by world prices, access and attitudes, and key commodities such as sugar in Fiji which has been propped up by preferential trade systems. Similarly, fisheries failed to achieve broad economic success and licence fees from leasing exclusive economic zones to distant states have been an important income source. Mining is highly localised and has brought limited benefits to local landowners. Industrial development is largely absent but tourism has flourished locally despite its vulnerability to economic uncertainty and political instability.

Two consequences of limited economic development have been an increased push toward migration and a substantial dependence on overseas aid. The decline or stagnation of the productive sector, especially agriculture, and the growth of imports offset by aid, remittances and tourism revenues in a situation where much employment is concentrated in the

public sector has led to the conceptualisation of the smallest Pacific island states as MIRAB (Migration, Remittances, Aid, Bureaucracy) states (Bertram and Watters 1995). This analysis, first propounded for Kiribati, Tuvalu, Cook Islands, Niue and Tokelau, is applicable to a greater or lesser extent in most island states. Aid dependence emphasises vulnerability.

The combination of migration, growing urban permanence (see Section 9 below), few new urban employment opportunities and the lack of industrialisation has resulted in the growing significance of the informal sector as a source of livelihood – though governments have been slow to recognise its role in employment creation and poverty alleviation. In some of the larger cities – particularly Port Moresby and Suva – the most visible elements of the informal sector include marketing. Formal sector employment in Kiribati is estimated at only 21% of adults, and often these individuals have to support large households. Only around one-quarter of the 2000 annual school leavers can hope to find full employment (ADB 2002). Even formal sector employment does not guarantee escaping income poverty. In Fiji in the mid-1990s, about 47% of full-time employed people lived below the poverty line and two-thirds of these were women.

In the future, the informal sector is likely to be the most important and accessible entry point into business and income generation for the poor. A very significant proportion of female workers in the informal sector in Papua New Guinea are sex workers (Levantis 1997) and these proportions may be increasing elsewhere. Given the challenges of finding formal or informal sector employment there and elsewhere, it is likely that both numbers and proportions will grow in most urban areas (see Urbanisation section below).

*Urban poverty is more than just an insufficient income. It is also about lack of services, poor living conditions, difficulty in meeting basic needs and a lack of representation in the decision-making process. The growth in urban poverty is likely to become the most important development in the Pacific over the coming decade and threatens progress towards the Millennium Development Goals.*

Because of the prevalence of the informal sector, there are few adequate measures of employment in use in the region. In the early 1990s, a third of the population of Port Moresby was searching for work, with most of the unemployed being in the 15–19 age group and many of them with little or no education (Connell 1997: 196). The extent of urban unemployment has contributed to social disorganisation.

Insofar as they can be measured, youth unemployment rates are frequently above 30%, as they have been reported for Tonga, Tuvalu and Nauru, and as high as 60% for the Marshall Islands. In most other states, they are probably somewhere in between, though they may be between 10% and 15% in Fiji, Cook Islands, Palau and Samoa.

Poverty is resulting from, and manifested in, increasing urban populations, a lack of employment opportunities, the absence of effective safety nets, and limited access to land and quality housing. In squatter settlements, hunger and poverty are no longer unusual, nor is the sight of families picking through municipal garbage sites for food and other goods. A further consequence of difficult urban conditions is the growth of suicide and domestic violence, though neither are exclusively urban phenomena, and the increase in the number of female-headed households that follows on the heels of family breakdown and social disorganisation. Such female-headed households have significant problems of income generation and may result in some orientation towards commercial sex work.

Though based on small samples, a number of recent surveys from the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP), the Ecumenical Centre for Research, Education and Advocacy (ECEA) and academics in Fiji have pointed to the following trends. Firstly, about 80% of those living in informal settlements in Suva fall below the “poverty line” (although this is an estimated figure); secondly average incomes in settlements were \$90-100/week, even though at least one adult was working full time and most families had a second source of income; thirdly urban poverty is increasing with migration and growth. In 1997, urban poverty was estimated at 27.6% of the Fiji population, in 2002 29.3% of urban households fell below the poverty line and figures released in 2006 estimate that between one-quarter and one-third of urban populations continue to live below the poverty line.

Urban poverty in the region's smaller states is also related to low incomes and high rates of domestic migration, leading to overcrowding. In south Tarawa, for example, those living below the poverty line had a household average of 11.7 persons compared to families above the poverty line with 7.7 persons/household (ADB 2002: 68). As a reflection of the lack of space, knowledge and essential tools, I-Kiribati on Tarawa are increasingly dependent on the monetary economy and imported food.





In almost all Pacific island states, urban poverty is a growing problem. It is poorly measured and understood, and constitutes both an absolute poverty in terms of lack of adequate incomes and a poverty of opportunity. Urban poverty is more than just an insufficient income. It is also about lack of services, poor living conditions, difficulty in meeting basic needs and a lack of representation in the decision-making process. The growth in urban poverty is likely to become the most important development in the Pacific over the coming decade and threatens progress towards the Millennium Development Goals (MDGs).

### *Incomes and Remittances*

In some states, urbanisation and low incomes have resulted in a downward spiral where there is little hope of improvement, waiting for uncertain opportunities, securing multiple jobs, maintaining strict budgets and abandoning some 'traditional' obligations to get by. Urban and rural 'safety nets', where extended families support those with problems, are breaking down. Absolute poverty is increasing, but a poverty of opportunity and dignity is more critical.

Poverty data have been unavailable in the past partly because, amongst other reasons, poverty was considered non-existent by Pacific governments. Only three countries - Fiji, Samoa and Kiribati - have the most basic time series data. Poverty is more easily measurable in Fiji because of the greater extent of monetisation of the economy, even in rural areas where poverty is more prevalent than in urban areas (38% against 32%). By contrast Vanuatu and Solomon Islands have higher poverty in urban (33%) than in rural areas (between 15% and 20%) due to the lower cost of living and the large subsistence economy in rural areas. Tonga and Samoa are estimated to have about 20% of their population under national poverty lines, but percentages are probably higher in most parts of Micronesia (38% in FSM and around 50% in Kiribati and the Marshall Islands) and also in Papua New Guinea (30%).

*Weak national economies and low national incomes suggest that most island states are ill-prepared to tackle poverty, HIV and sexual and reproductive health issues which directly affect population growth and well-being.*

Moreover, income levels in the region are key influences on social and economic behaviour, and on migration. Income inequality has increased in recent years as has the extent of poverty and hardship (Abbott and Pollard 2004, ECREA 2006).

In such circumstances, remittances play an increasingly important role in national and household incomes, especially in the smaller island states. In many countries, remittances form a significant part of disposable income. In states such as Samoa and Tonga, they constitute some of the highest proportions of the Gross National Product (GNP) of any country in the world. In both countries remittances are well over 50% of GNP and in aggregate more than three times the total value of exports (Connell and Brown 2005).

Remittances are also steadily increasing in Micronesia and now notably in Fiji. On the coral atoll of Nanumea in Tuvalu, remittances grew from being about half of the island income in the 1970s and 1980s to some 75% in the 1990s, in large part because of the collapse of copra marketing as world prices slumped (Chambers and Chambers 2001: 156). In Kiribati, the 2000 census recorded that overseas remittances, primarily from seamen, were the primary source of income for as many as 30% of households in the urban centre of south Tarawa. And in 2002, some 35% of all households in Tuvalu received remittances.

Conventional wisdom suggests that remittances are overwhelmingly used for consumption and inadequate amounts are directed towards investment. After debt repayment and new forms of consumption (housing, community projects, air fares and education), remittances are used for various forms of investment in the agricultural sector but more frequently in the service sector such as stores and transport businesses.

### **Migration**

The movement of people within and between islands has intensified in volume, increased in distance and become more complex in pattern and purpose since the conclusion of the Second World War. The shift of Pacific islanders from rural to urban locales has also become more permanent. With the development of modern transportation, the continued stagnation of rural economic development and the increasing significance of urban economies in globalising spaces, the opportunity for and logic of migration has increased in a region that has historically been characterised by high mobility.

Throughout the Pacific there are a number of general trends in population movement, although not all are necessarily present. First, international migration extends beyond the region; second, small islands are being depopulated as people move to large islands; third, mountain populations are moving to lowlands, usually along the coast; and fourth, urban populations are continuing to grow.



Alongside migration, there is considerable short term mobility. Some of this, such as working as shipping crew, may extend over very long distances, and some work employment (for example in mines) takes workers for lengthy periods away from their home areas. There is also significant short-term mobility such as the movement of students to universities, colleges and boarding schools, and patterns of visiting that take people to stay with their kin for various periods of time.

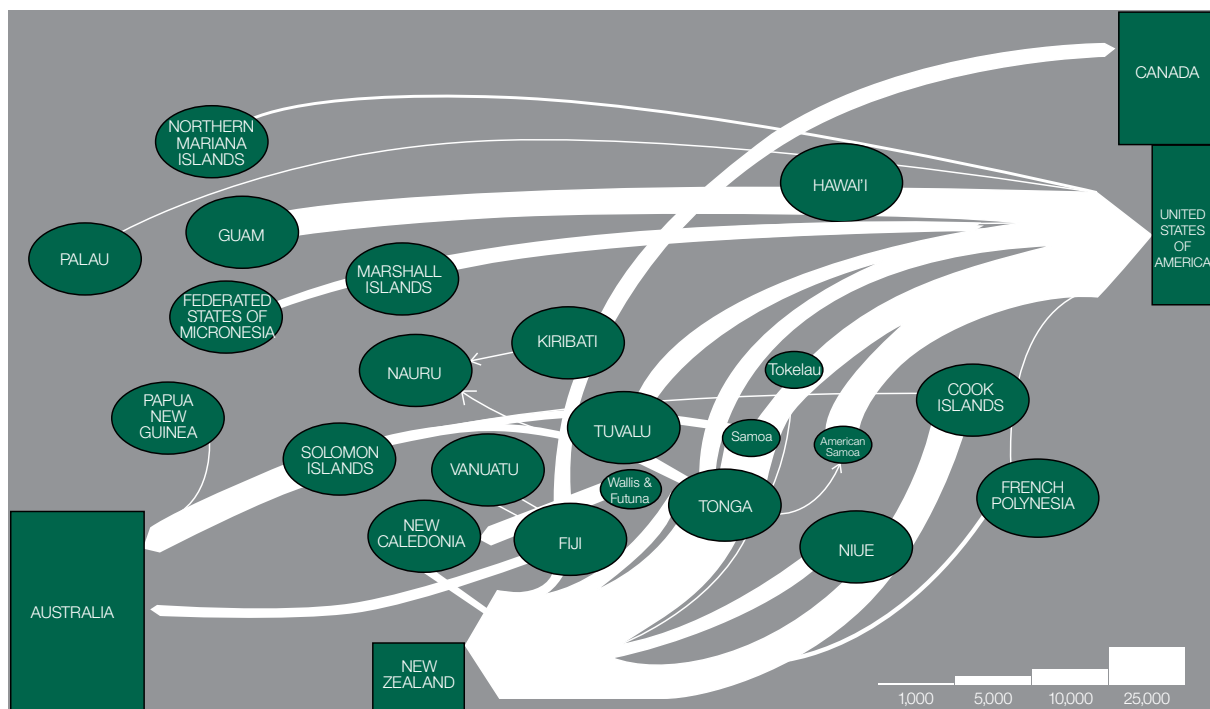
Over the past two decades, two themes have remained central to migration in the Pacific region. Firstly, there has been continued centralisation of populations on large islands and especially in urban centres as people have moved to take advantage of new employment opportunities and access to modern services. Secondly, international migration to the metropolitan states on the periphery of the region has continued. Both trends complement each other as Pacific populations increasingly become more urban. They have also intensified in the present century as economic circumstances in the region have worsened. Less numerically important trends, but with significant social consequences, have involved the movement of larger numbers of migrants, especially from Asia, into the region, and the movement of a

growing number of temporary migrants to the Middle East (Connell 2006).

Contemporary migration has continued to bring new migrants to the Pacific islands whether as miners, bureaucrats or commercial adventurers. While there have long been Chinatowns in most Pacific towns, Chinese migrants, most from southern China, have become established in several countries, including Tonga, Fiji and the Solomon Islands. Smaller numbers of Indians, Filipinos and others represent distinct population flows, and a regular flow of Europeans and others have come as miners, aid donors, missionaries, university lecturers and so on. The Pacific is now as cosmopolitan as it has ever been.

Migration has had important effects on age structure and dependency ratios. Emigration is concentrated among young adults of both sexes, and offsets natural increase in the more fertile age groups 20–24 and 25–29, so causing “hourglass” age pyramids in island groups with high outmigration such as Niue. Thus high fertility, low mortality and outmigration of young adults combine to produce very high dependency ratios in most Micronesian and Polynesian countries. Equally

**Map 2. Pacific Population Movements: Indicative Flows**



Connell J. 1987 Updated April 2010

**Table 5. Pacific Island born population overseas**

	NZ	Australia	USA
Fiji	35000	45000	35000
New Caledonia	100	2000	100
Papua New Guinea	1150	25000	1000
Solomon Islands	500	2000	100
Vanuatu	300	1200	
FSM			15000
Guam		100	40000
Kiribati	100	500	100
Marshall Is.			20000
N. Marianas			
Nauru		800	
Palau			12000
American Samoa	100	150	30000
Cook Islands	16125	6000	500
French Polynesia	100	600	1500
Niue	5280	600	
Samoa	58850	20000	20000
Tokelau	2200	400	100
Tonga	27000	18000	28000
Tuvalu	1700	300	200

these migrants are often the more educated and skilled within island populations.

International migration is primarily a Polynesian phenomenon, but more recently a Micronesian one (Map 2). Guamanians and Samoans are some of the most numerous Pacific Rim immigrants, followed by Fijians (mainly Indo-Fijians), Tongans, Cook Islanders and American Samoans. Perhaps more than any other group Samoans have something of a global distribution. In parts of Polynesia, more people are resident overseas than in the home islands. This applies almost as much to island states with large populations (Tonga and Samoa) as those with small populations (Niue, Tokelau, Wallis and Futuna, and the Cook Islands). A substantial majority of the ethnic population of the Cook Islands, American Samoa, Wallis and Futuna, Niue, Tokelau and Pitcairn live overseas. Four times as many Niue-born live in New Zealand than in Niue, and those of Niuean descent are even more numerous there. Much the same is true of Tokelau. By contrast, and very differently from the *blackbirding* era of a century ago, few Melanesians are now overseas.

Most international migration, such as that from Tonga and Samoa and the smaller Polynesian states, is to New

Zealand, the United States and Australia. Fiji has experienced significant outmigration since the two coups in 1987 and a third in 2000, and in this century has provided the largest flows in the region, both to the “traditional” destinations of North America (including Canada), Australia and New Zealand, but more recently to the Middle East.

After the Former Trust Territory states signed Compacts of Free Association with the United States, migration to the United States grew dramatically, especially from the Marshall Islands. Guam and the Northern Marianas have also received large numbers of Micronesians and Asian migrants, but most Micronesians now move to Hawai'i and the mainland United States (Hess et al 2001). Over time, the United States has become the preferred migration destination.

*The primary motive for migration in the Pacific, as elsewhere, is economic improvement for migrants and their families, although political, environmental and cultural considerations also affect flows. This is as true of internal migration as of international migration. Growing inequalities, uncertain economic futures, coupled with rising expectations are the concomitants of increased migration.*

Internationally, young adults find better-paying jobs overseas and their families benefit from their remittances. To some extent migrants from a single extended family may be distributed in different countries, in what has been described as a “transnational corporation of kin” (Marcus 1981), which strategically allocate family labour to local and overseas destinations (and also different employment sectors) to maximise income opportunities, minimize risk and benefit from resultant remittance flows. This “insures” the family against economic crises and unemployment, and enables the ease of possible return migration. The removal of many young, educated people from the population slows the pace of social change, partly because of limited return migration.

Migration decisions are usually shaped within a family context, as migrants leave to meet certain family expectations and financial support for kin. Migration is directed at improving both the living standards of those who remain at home and the lifestyle and income of the migrants. Consequently “families deliberate carefully about which members would be most likely to do well overseas and be reliable in sending remittances” (Gailey 1992: 465). International migration is more evidently an economic phenomenon, though other factors – such as access to high quality education and training – are necessarily involved.







MICRO SPIRIT

## Predominantly Internal Migration

*The following sections provide an overview of specific mobile groups and their sexual risk behaviour. The next six sections focus on mobile groups whose movements are predominantly internal to the Pacific – either within countries or within Pacific island countries and territories.*

### Urbanisation

In almost all Pacific island states, a significant demographic, economic and cultural transformation is taking place as urban populations are growing faster than total populations. If Papua New Guinea is excluded, more than half of all Pacific islanders live in urban areas, reflecting the global watershed heralded by the United Nations in 2007. In some countries - such as the atoll states of Kiribati, Tuvalu and the Marshall Islands - this growth has resulted in exceptionally high population densities, comparable with those in the most highly populated Asian cities, resulting in significant environmental and health problems.

In larger states, such as Fiji, the majority population now lives in cities and towns. Only a few mining towns do not have relatively balanced sex ratios. Where urban areas still account for a minority of people such as Papua New Guinea, the Solomon Islands and Vanuatu, urban growth rates are amongst the highest in the Asia-Pacific region, foreshadowing a late, though, inevitable urban revolution. Almost everywhere, urbanisation has been accompanied by rapid population growth (heightened through the limited impact of family planning), with the result that natural increase has become as important an influence on urban growth as rural-urban migration.

Most internal migration is to the larger urban centres, and to some mining towns that are “hot spots” for HIV risk exposure. Though migration still drives much urban growth, an increasing share is generated by birth rates of second and third-generation urban citizens, indicating the permanent shift of many Pacific islanders from “traditional” rural societies to urban centres and contradicting the still held view that migration is temporary and urban challenges can be met through rural development.

The rationale for urbanisation and increased population concentrations is consistent throughout the Pacific: employment opportunities and services (especially education and health) are concentrated in the urban centres. In small island states, where the labour force and capital are often limited, this urban concentration is inevitable to some extent.

Urbanisation is proportionally least in Melanesia, though towns and cities are larger, since modernisation has been belated. Greater Suva and Port Moresby are significant cities. Port Moresby (the National Capital District) had more than 250,00 people in 2000 and was growing at a rate of 3.6% per year, and, like some other rapidly growing urban centres, had a sex ratio of 121 males per 100 females. The more educated have tended to migrate first. Urbanisation characterizes contemporary migration within and beyond the Pacific.

The existence of kin in urban areas is a major influence and support. Early migrants are beach heads for those who follow. Not only do they provide demonstrations or create images of an impressive lifestyle, they may also provide remittances, fares and accommodation for new migrants to the city. Indeed migration is often best seen “as an almost inevitable decision that they [villagers] will have to make sooner or later and once this view is accepted a sort of migration momentum develops” (Walsh 1982: 7). Not only have the attractions of urban life, in terms of employment, access to services (notably education) and even the ‘bright lights’ drawn many people, and especially youth to urban areas on a semi-permanent basis, they have also resulted in considerable mobility in and out of towns and a relatively large “floating” population with uncertain allegiance to rural or urban areas. This particular fluctuating group, without permanent jobs or income, is at particular risk in urban areas. Moreover, they are also associated with a rise in urban crime rates most evident in Port Moresby and other urban centres in Papua New Guinea (Levantis 1997, Connell and Lea 2002, Buchanan-Aruwafu 2007).

Critical issues concern the growth of squatter settlements in the Pacific such as urban south Tarawa where the incidence of HIV tends to be greatest. Land tenure shapes the pattern and availability of affordable and secure housing. Housing is often a barometer of people’s income, their level of security and their access to resources (including land). Although informal settlements do not always house the very poor, the fact that Pacific middle classes have few alternatives but to live in poor quality housing areas is an indication of the low incomes and high relative cost of living in many Pacific towns and cities. A great majority of migrants to cities in the region now build their own houses outside formal legal regulations.

Burgeoning informal settlements in Fiji are the destination of Indo-Fijian cane farmers who have no rights to customary land but also Fijians moving to cities to further their opportunities,

even when they have access to rural land. This is also the case for the settlements around Port Moresby, Lae, and Honiara. Increasingly these settlements consist of makeshift shelter, with no water supply, sporadic access to electricity and are increasingly characterized by overcrowding, leading ESCAP to note that “there is a need for governments to take a more proactive approach with squatter settlements particularly in promoting a greater understanding of rights and services” (ESCAP/POC 2002: 30).

Inadequate finance for urban development has meant that Pacific urban centres are increasingly unhealthy and dangerous places to live, a trend noted almost two decades ago (Bryant 1993). Although progress has been made on health facilities, Pacific towns, particularly Majuro, Ebeye, Kolonia (Pohnpei, FSM) and south Tarawa (ADB 2002, Storey and Connell 2008), face periodic threats of cholera and other water-borne diseases.

*The Pacific faces an uncertain urban future. Social disorganisation and crime increasingly result from inequalities in the cities and have grown in concert with the increasing size of urban populations. In Nuku'alofa and Honiara there have been riots over inadequate urban employment and quality of life. Increases in poverty, crime and periodic unrest can be seen in towns and cities as diverse as Lae, Nuku'alofa and Suva.*

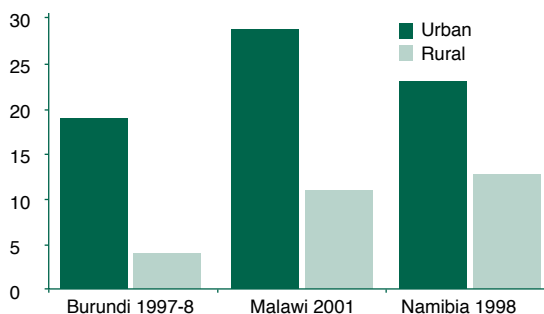
Law and order is a key area of urban concern in many countries, notably Papua New Guinea, and there has been a steady rise in the incidence of violent crime. In Papua New Guinea there has been a “pervasiveness of sexual assaults and gang rapes” and this impersonal and institutional violence against women, even among groups such as the police, has direct implications for the increased incidence of HIV (Lepani 2008a: 150, 156) and for the breakdown of family structures (Wardlow 2004). Outside Papua New Guinea it remains rare. In the failure to deal effectively with urban futures and in the absence of opportunities for growing

populations in both rural and urban areas, the Pacific is likely to encounter greater political instability and social insecurity in the decades to come.

### Sexual behaviour and risk factors

Across the world in general, infection rates have tended to be higher in urban areas (Dyson 2003; Figure 2). This holds for Papua New Guinea until 2006 (figure 3) however an apparent rapid increase of HIV prevalence in rural areas (figure 3) tends to lately inverse the trend. This is a particular cause for concern given that 83% of the total population of Papua New Guinea live in rural areas. However this apparent sharp increase in rural area needs to be treated with caution as it may only reflect the expansion of testing sites from 2006 (Commission on AIDS in the Pacific 2009).

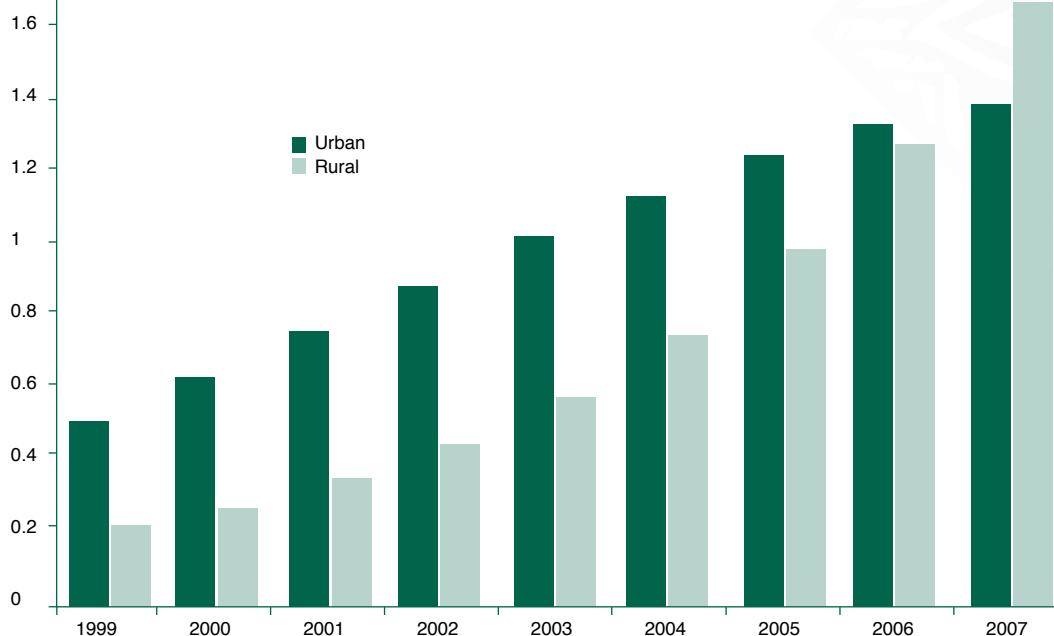
**Figure 2: HIV prevalence (%) among pregnant women in urban and rural areas (Dyson 2003)**



Urban areas are associated with certain HIV risk factors. Dyson, in his article on HIV and urbanisation, notes that “rates of social interaction are higher in urban areas, and fields of social interaction are wider too—phenomena that doubtless have implications for patterns of sexual interaction... And higher-risk behaviours (such as commercial sex activities) tend to be more prevalent in towns and cities. Surveys generally find that the proportions of people reporting non-regular sexual relationships are higher in urban areas” (2003: 429).



**Figure 3: HIV prevalence (%) in Papua New Guinea in urban and rural areas (PNG National AIDS Council 2007)**



**Box 2. Labor related migration and extramarital sex in the Southern Highland Province – Papua New Guinea**

*“After I was married, I left my wife and children and went to Goroka for work, and it was there that I had sex with another woman. That was the first time. I went with another man. It was his idea—he was my boss and I was the driver. He said, ‘Let’s go around and find some women. I’ll pay for some food and I’ll pay for the guest house.’ So I did this the first time because I was with him. We took a car and we went together. We impressed the women by riding around in a car. Lots of working men do this—they pressure each other to go drink and have sex with prostitutes.”*

Men’s narratives of the extramarital liaisons they had had during the course of labor-related migration typically emphasized both missing their families and feeling an exuberant sense of freedom from community scrutiny. The narratives also told of predominantly male work places where drinking and paying for sexual relations was the norm at the end of a long and arduous work week and of the fact that women tended to target employed men by gathering outside popular bars on men’s paydays. As one man said,

*“Sex is like money; they are temptations. If a man offers you money, you don’t say no. How can you make yourself say no when he is holding out his hand and giving it to you? The same is true when a woman offers to have sex with you. You just say yes.”*

Wardlow, H ( 2007)

It has been well documented in Papua New Guinea how the rise of HIV has been closely linked to the emergence of “mobile men with money”, –group found predominantly in larger urban areas and personified as a new kind of “sugar daddy” or the dakglas kar man (dark glass car man): businessmen, landowners and politicians with plenty of disposable income (Lepani 2008a).

Where poverty is relatively high and services are less available, there are greater risks of HIV vulnerability. This has been seen in slum areas of east and southern Africa where transactional sex, poor health indicators and inability to negotiate safe sex are more prevalent. Surveys conducted among students in Honiara found that around one fifth of respondents reported they had exchanged sex for money or goods in the previous year (Buchanan-Aruwafu, H. 2007). In Papua New Guinea, infection rates are particularly high in urban areas and amongst young girls and women, indicating that adolescent girls and young women are particularly vulnerable to cross-generational sexual relations (Lepani 2008a: 151). Their vulnerability to HIV is further compounded by unequal gender relations which often leave young girls and women at the mercy of men wielding power and dictating the terms of sexual relations.

### *Activities and interventions*

HIV activities are generally more prevalent in urban areas due to ease of access, proximity to decision makers and funders, and number of non-governmental organisations and other community groups. For example, the first HIV antibody tests and treatment were available in Port Moresby before it was gradually available in other larger cities. The extension of services to rural health centres has been slow. This holds true for other large islands and archipelago such as Solomon Islands, Vanuatu, Tonga and Fiji (to a lesser extent).

### **Commercial Sex Work**

The role, geographical distribution and social significance of sex work are important in the spread of HIV. Though most data are anecdotal, the selling of sex for cash is significant in many parts of the region, spearheaded by Papua New Guinea, Fiji and Solomon Islands. Commercial sex work is often informal, sporadic and largely transactional in nature rather than a full-time situation (PRHP 2007). Most commercial sex workers are women; men and transgendered sex workers are relatively rare. A relatively small number of studies provide some information on commercial sex, but much is dated and primarily refers to Papua New Guinea. Only fragmentary

data enable comparisons with other parts of the region, though commercial sex work is generally of less significance elsewhere (apart perhaps from Honiara, Suva, Guam and Saipan).

While most commercial sex workers are probably indigenous to the region, there is a growing number of migrant sex workers in the region mainly from China (see below). This section is thus divided into two sections dealing with a domestic commercial sex work context and an international migrant context, which are to some extent separate and distinct.

### *Domestic Sex Work*

With the exception of the Highlands Highway (in Papua New Guinea), almost all commercial sex is centred in the larger cities and towns. In Honiara and Tarawa, women tend to meet fishermen and sailors in port areas. In several port towns, including Suva, Majuro and port towns in Papua New Guinea, Chinese sex workers have been brought in for Asian seamen and fishermen (see below). Noumea and Papeete are similar but larger port towns, while New Caledonia's urban sex workers have been identified as a priority high-risk group (Agence Sanitaire 2007, Germain et al 1998). Asian sex workers in Fiji tend to be organised in brothels, and local sex workers are found in diverse locations, on particular streets and in certain clubs. Commercial sex workers are in many case migrants themselves and rarely practice their business in their home communities. There is a growing recognition, firstly, that the general age of sex workers is becoming younger (eg Save the Children Fiji 2005: 16, 25), and, secondly, that the principle influence on women becoming sex workers is poverty. In the case of Fiji, it has recently been reported by Save the Children that girls as young as 13 are engaged in commercial sex. In Papua New Guinea, there has been recent concern that growing urban poverty has increased the extent of commercial sex (The National, 28 October 2008) and some women who become pasindia meri (sex workers) exhibit a degree of rebellion and autonomy that gives them an ability to ‘move through the local and national landscape that other women do not exercise’ (Wardlow 2004: 1019). In most contexts there is relatively little information on how sex work is organised, or indeed whether it is organised (though massage parlours are becoming more common), who the sex workers are (their ethnic origin), their incomes, whether they are long-term or temporary workers (and whether they drop in and out of urban life), their health status and level/extent of safe sex practices.



### International Sex Work

Migration of sex workers into the region is of some significance. In Papua New Guinea, Northern Marianas, Marshall Islands, Palau and Fiji, there has been recent migration of Asian sex workers. Since this is illegal, data remain largely anecdotal but it is extremely important for the incidence of HIV. A further significant migration stream into the region is American military into Guam, and this is about to increase. Since both Saipan and Guam are significant tourist destinations and sites of a large, but sometimes itinerant, American military presence, they are critical hotspots.

In Saipan, commercial sex is centred in the urban area of Garapan where there are numerous massage parlours, clubs and karaoke bars, many of which are oriented at

an Asian tourist clientele. Commercial sex is reported to have increased in significance in recent years as Asian workers (mainly from China and the Philippines) have been displaced from the garment industry and tourist numbers declined. Some female factory workers who had not earned enough income to pay off their contracts may have been effectively forced to remain in Saipan in an unusual form of trafficking. Others were brought as 'waitresses' but forced into sex work. Court cases have been mounted against traffickers. Indicative of the kinds of statements and speculations made and issues raised were those expressed in July 2007 by the Deputy Assistant Secretary of Insular Affairs, David Cohen, testifying before the Senate Committee on Energy and Natural Resources.

#### Box 3. Challenges of International Human Trafficking in CNMI.

David Cohen, Deputy Assistant Secretary of Insular Affairs, CNMI, 19 July 2007  
(accessed online: <http://www.doi.gov/oia/press/2007/07192007.html>)

*Serious problems continue to plague the CNMI's administration of its immigration system, and we remain concerned that the CNMI's rapidly deteriorating fiscal situation may make it even more difficult for the CNMI government to devote the resources necessary to effectively administer its immigration system and to properly investigate and prosecute labor abuse. [...] While we congratulate the CNMI for its recent successful prosecution of a case in which foreign women were pressured into prostitution, human trafficking remains far more prevalent in the CNMI than it is in the rest of the U.S. During the twelve-month period ending on April 30, 2007, 36 female victims of human trafficking were admitted to or otherwise served by Guma' Esperansa, a women's shelter operated by a Catholic nonprofit organization. All of these victims were in the sex trade. Secretary Kempthorne personally visited the shelter and met with a number of women from the Philippines who were underage when they were trafficked into the CNMI for the sex industry. [...] It is clear that local control over CNMI immigration has resulted in a human trafficking problem that is proportionally much greater than the problem in the rest of the U.S. A number of foreign nationals have come to the Federal Ombudsman's office complaining that they were promised a job in the CNMI after paying a recruiter thousands of dollars to come there, only to find, upon arrival in the CNMI, that there was no job. Secretary Kempthorne met personally with a young lady from China who was the victim of such a scam and who was pressured to become a prostitute; she was able to report her situation and obtain help in the Federal Ombudsman's office. We believe that steps need to be taken to protect women from such terrible predicaments. We are also concerned about recent attempts to smuggle foreign nationals, in particular Chinese nationals, from the CNMI into Guam by boat. A woman was recently sentenced to five years in prison for attempting to smuggle over 30 Chinese nationals from the CNMI into Guam.*

The extent to which this remains the situation in Saipan is unknown, but there is little doubt that this is the main centre of any human trafficking for the sex trade purposes in the region. While Guam has a thriving commercial sex industry, with sex workers from Asia, trafficking may be generally absent. (Indeed Guam is the only place in the region where there have been government level discussions over whether to establish a "red light district" in order to group all "adult entertainment" outlets in one Tumon tourist district). However, in 2008 there was some consternation over the trafficking of a group of eight 18-22 year old women from Chuuk (FSM) who

had been promised work as waitresses and shop workers, had their airfares to Guam paid for them but were forced into commercial sex work upon arrival. Micronesians from Chuuk had acted as intermediaries for Chinese-owned business (Marianas Variety, 11 February 2008). Federated States of Micronesia migrants are free to go to Guam under the rules of the Compact of Free Association with the US government, but this appears to be the only documented example of trafficking for the sex trade of local people occurring within the Pacific region.

Illegal migration, which may amount to trafficking, also occurs elsewhere in the context of sex work. Information on this issue is by nature sketchy and hard to source and verify when existing. News paper reports such as the ones cited below in boxes provide however anecdotal information that needs to be taken with caution as to the extent of the phenomenon.

Broadly this situation appears to have remained unchanged since then. With the passing of the new Crime Decree in Fiji a number of police raids were conducted in massage parlour in Suva and resulted in the arrest of illegal immigrants allegedly engaged in sex work. Similar patterns are in place for Papua New Guinea as the Post Courier recorded earlier in the year (though once again such statements are largely anecdotal and must be treated with caution):

#### Box 4. Sex work and International Migration in Fiji

*(Asia Times September 16th 2002)*

In Fiji, a sudden rise in the number of Chinese in the island has coincided with a rise in prostitution, drugs, gambling and people smuggling, according to news reports. This month, joint raids by police, immigration and home affairs officers on nightspots throughout Suva led to arrest of 12 Chinese illegal immigrants. According to immigration officials, there are about 2,000 illegal immigrants in the Fiji Islands. Police and naval officers suspect that human-smuggling syndicates from China offload illegal immigrants from fishing boats in remote islands and bring them to Suva and other cities through domestic navigation routes. For most of this year, media have

reported about Chinese triad rings operating out of Fiji, as well as reports of gang fights breaking out on the streets of the capital Suva. Newspapers have also reported that Chinese are running exclusive prostitution rings in Suva, and barring access to brothels by non-Chinese visitors. In its latest issue, Pacific Monthly reported that Suva has at least 40 brothels. "A flood of mainland Chinese into Fiji is embroidering Suva's social scene with 'Chinese only' whorehouses," the magazine claimed, adding that these were serving an increasing number of Chinese fishermen and businessmen allowed to open shop in Suva. To try to cope with this

wave of immigration and its effects, Fiji has reduced its tourist visa from four months to just one month. Officials are also grappling with how to address illegal immigration while encouraging the investments that Fiji needs. Many Chinese, mostly women, come to work in garment factories set up by Chinese investors. But in March, the government found that it had issued eight work permits to a Chinese investor to bring in workers for a firm that has not been in operation for a year. But police believe this is an excuse to bring in women to work as prostitutes. "We must remember that these women are being brought to work

at a cheaper rate than the locals. They need money to live here. This is the reason they engage in prostitution," said Inspector Unaisi Vuniwaqa.

There are allegedly foreign teenage prostitutes as young as 17 years engaged in prostitution in Papua New Guinea. The prostitutes, reported to be mainly from Asian countries, are part of an illegal chain of businesses operated allegedly by the Chinese mafia gang members... These prostitutes were reportedly brought into the country illegally and are engaged in prostitution behind closed doors with arranged clients (20 March 2008)

*This brought an online response:*

Reports of Asian girls involved in prostitution highlights that PNG has now become a destination country for the global sex industry through the trafficking of women and girls. The global trafficking of women and girls for purposes of sexual exploitation and to serve the sexual demands of men is also another form of modern day slavery. In PNG, the buying of very young girls from rural or remote areas for the purposes of sexual exploitation and transporting them to other parts of the province amounts to domestic trafficking of humans and should not be tolerated. According to the 2006 UNICEF, UNESCAP, ECPAT Regional Report on Child Sexual Abuse and Commercial Sexual Exploitation of Children in the Pacific, trafficking in children for sexual abuse and exploitation is occurring both internally as well as across the Indonesia border. Very young girls from poor Central and Gulf villagers are handed over to men who offer large amounts of money. There are men negotiating these deals for payment. One report alleges that a doctor from Simbu province has bought a ten year old Waiori girl and has already slept with her. Uneven distribution of wealth, economic hardships and the increased demand for women as sex objects fuels the global problem. Organised criminal networks that abduct and illegally bring foreigners into PNG for their evil exploits are facilitated by their PUPPETS at strategic locations, such as immigration, air/sea port security or customs and government departments. Generally, the women and children are always the victims and the culprits who are the key players go unpunished, and continue to use the system as their pawn.

Similar movement of Chinese women has also been reported by the press in the Solomon Islands for Malaysian loggers and Asian crews of foreign vessels (Solomon Times, 19 April 2008). Comparable instances certainly occur in the Marshall Islands, and perhaps elsewhere in the region. It is not clear to what extent sex workers are coerced into working in the Pacific region, even in Saipan and Guam, but if they are coerced this is probably the only example of human trafficking in the region.

### *Sexual behaviour and risk factors*

Sex workers engage in sexual activity with a high number of partners. The transactional nature of the interactions limits the ability of sex workers to insist on condom use in the absence of strong legal or government engagement (as in Thailand where a 100% condom use in brothels policy has increased condom usage). Some clients will even pay extra for sex without a condom.

A 2002 study of 407 female sex workers in Port Moresby and Lae revealed an HIV prevalence of 10% and sexually transmitted infections ranging from 31% to 36% (Mgone et al 2002). The sex workers in Port Moresby had significantly higher HIV infection (17%) than those in Lae (3%). Condom use among the sex workers was very inconsistent; 85% reported that they did not use condoms at all times when having sex with their clients. Common reasons cited were dislike by clients, unavailability, alcohol use and familiarity with a client. Another Papua New Guinea study noted relatively high levels of condom use among sex workers,

with between two thirds and three quarters of female sex workers reported using a condom the last time they sold sex (National AIDS Council Secretariat Papua New Guinea & National HIV/AIDS Support Project, 2007). A further study in Eastern Highlands found that 74% of female sex workers were positive for at least one sexually transmitted infection and 43% had multiple infections (Gare 2005). Condom use was very low among these sex workers due to unavailability, dislike by clients, drunkenness or use of marijuana. A Vanuatu report noted that condom use among transactional sex workers was not consistent (Wan Smol Bag 2006).

Education is needed not only among sex workers but also among their clients – mobile groups are among the most frequent sex worker clients. In a study in Port Moresby published in 2000, 60% of married men acknowledged engaging in commercial sex (WHO 2000). Among males in Fiji, some 16% had engaged in commercial sex compared with 10% in Marshall Islands and 2% in Samoa (Jenkins 2005). By the age of 19, about 16% of Fijian men had visited sex workers (Kaitani 2004). A study in Thailand noted that condom usage differed significantly according to client region of origin with 76% of westerners, 52% of foreign Asians and only 27% of native Thai men using condoms (Buckingham et al 2005); hence similar variations in the Pacific may not be unexpected. Fiji's UNGASS report of 2006 notes that only 77% of men reported using a condom at last sex with a commercial female partner. In Port Moresby, sex work had increased significantly between 1998 and 2002 and condom use increased over the same time period, suggesting some





positive response to the HIV epidemic, though risky behaviour remained high (Yeka et al 2004). Sex workers are also more likely to engage in drug and alcohol abuse which may be a significant contributing factor to HIV risk. Though specific evidence of this is scant for the Pacific, studies in other small island states in the Caribbean confirm this risk behaviour (Surratt 2007). There is no specific data on the behaviours of Chinese and other Asian sex workers in the Pacific. Studies in Asia however have shown that girls who are trafficked into sex work have a higher risk to contract STIs and HIV, suffer qualitatively and quantitatively different levels of sexual risk as compared with non-trafficked sex workers, and are less likely to be reached by HIV prevention programme (Harvard School of Public Health and UNDP 2009 communication at International Congress on AIDS in Asia Pacific, 12 August 2009 Bali, Indonesia).

### *Interventions and Activities*

A few groups in the Pacific are working with sex workers on HIV awareness and activities. The Pacific Regional HIV/AIDS Project funded by Australia, New Zealand and France and managed through SPC has funded non-governmental organisations in Fiji, the Marshall Islands, Vanuatu and the Solomon Islands to conduct awareness and condom use activities with sex workers. The total funding allocated for these activities in 2004-2007 was about A\$665,000 (PRHP 2007). These projects include providing improved access to sexually transmitted infection diagnostic and treatment services for sex workers, peer education sessions, a project to distribute condoms to sex workers through taxi drivers in Honiara and the establishment of the Sex Workers Action Network in Fiji (PRHP 2007).

The Global Fund Round 2 Multi-Country Pacific HIV/AIDS funding application noted that "achievement of 70-80% of most at-risk populations (sex workers, seafarers) reporting consistent condom use with non regular partners is expected". This demonstrates that Pacific island country and territory governments and agencies are increasing their focus on sex worker interventions (Global Fund 2003). The Papua New Guinea Transex project began in 1996 and targeted transport and sex workers with specific prevention messages and tools. This has been claimed to be the first successful example of a targeted intervention for HIV in Papua New Guinea.

In general interventions targeting sex workers are rendered more difficult by legislation that criminalise sex work, which is the case in most Pacific Island Countries.

## **Plantation Employment**

Plantation work and other forms of short-term and seasonal migration for employment are less common than in the past but are of continued significance in some parts of Melanesia, primarily Papua New Guinea. Oil palm estates are still increasing and attracting some new migrant workers. Most plantations are on the north coast of New Guinea and in several parts of the island provinces. The cocoa/coconut plantation sector is declining partly because of low prices. Highland coffee plantations have also experienced decline and former migrants have tended to move on to urban areas such as Lae and Madang. There is some evidence that a growing proportion of workers on plantations are not short term migrant workers but established (a generation perhaps) migrants who are there as family groups. Rather like plantations, other sources of 'male' employment such as logging camps tend to have more local workforces. However, in Western Province (Papua New Guinea) sex workers live close to logging camps (Wilde 2007), and, at least in the Solomon Islands, young people were exchanging sex in logging areas (Buchanan-Aruwafu 2007: 23). There is every reason to suppose similar practices occur in Papua New Guinea. Indeed workers in logging camps are generally regarded as having a high incidence of HIV and STIs (Dundon and Wilde 2007).

### *Sexual behaviour and risk factors*

In the oil palm areas of West New Britain (Papua New Guinea), there is some evidence of sex workers being available on pay days for both smallholder and plantation workers. These are believed to be mainly 'local' women (that is descendants of established settlers, most of whom came to the area from Sepik and elsewhere in earlier decades). More detailed information on the risk behaviour of plantation workers and loggers is not available, though one can assume some similarities with mine workers (see section below).

### *Interventions and Activities*

No information was available on specific HIV relevant activities being made available to seasonal plantation workers though, at least one oil palm company provides condom information on HIV to migrant workers, and this may be a model for similar situations in rural Melanesia (Sales 2004, Hargy Oil Palms 2008).

## **Mining**

Increasingly more important than plantations for 'male migration' are mines, again now almost entirely in Papua New Guinea with some activity in New Caledonia. Mining centres

tend to be dominated by relatively young men and the most skewed urban sex ratios are in centres such as Tabubil (near Ok Tedi mine). Larger mines such as Ok Tedi and Lihir each employ about 2000 workers, most of whom are men from Papua New Guinea. Many overseas workers reside in northern Australia and are involved in fly-in fly-out schemes. In the past, sex workers moved to mining centres such as Mt Kare and Tabubil/Ok Tedi (eg Ryan 1991, Polier 1966) but there is ambiguity on contemporary practices, though sex work is certainly present in Tabubil (Hammar 2008b) and at Lihir. Much information remains anecdotal, but it is reasonable to assume that there is significant commercial sexual activity around most mining centres. Indeed, mines have been cited as a contributing factor to the growth of commercial sex in Papua New Guinea as early as 1900 (Jenkins and Massey 1998).

#### *Sexual behaviour and risk factors*

Information on sexual activity around mining sites in the Pacific is scarce, though the fastest growing HIV epidemic in the nearby province of West Papua (Indonesia) is at Timika, the mining town for the giant Freeport mine where poverty, poor health, migration and unemployment co-exist (Eves and Butt 2008; 12). Certain conclusions reached in some other parts of the world indicate similar possible parallel scenarios in the region. The mines of southern Africa have been seen by many as the epicentre of the HIV epidemic in the region with elevated prevalence among miners. Miners leave home for extended periods and live in intense, male-dominated and high-risk environments.

In general, miners are more likely to have unsafe sexual behaviours such as low levels of condom use, high number

of concurrent partnerships and visiting commercial sex workers. A study in China found that 61.2% of miners never used condoms with female sex workers and 84.1% never used condoms with their regular partners (Xu et al 2008). The risk factors are not only relevant for the miners themselves but also for the surrounding communities. A study in Tanzania revealed very high HIV prevalence for women in communities neighbouring the mines, suggesting high levels of interaction between not only sex workers and miners but between miners and community members (Clift et al 2003).

Quite recently, the mining boom in Western Australia has been cited as fuelling an increase in HIV infections due to the FIFO “two-weeks-on, two-weeks-off nature of work” which keeps men away from their wives or partners for extended periods (Williams 2008).

#### *Interventions and Activities*

Mining companies have been at the forefront of the response to HIV in southern Africa. For example, Botswana’s Debswana diamond mine has provided anti-retroviral (ARVs) to employees since 2001 after finding that 35% of miners were HIV positive. Anglo-American and other mines were some of the first organisations to provide testing, care and treatment services to its employees.

The PNG Business Coalition Against HIV and AIDS has been working with business organisations in a variety of sectors on developing HIV policies for the workplace and on developing appropriate responses. In 2003, Ok Tedi Mining, one of the largest mining groups in Papua New Guinea, developed its HIV policy and strategy.

#### **Box 5. Ok Tedi Mining HIV policy statements (2003)**

- Facilitate education and training initiatives within the workplace and community that will prevent or reduce the risk of infection
- Protect the rights of employees to work within a non-discriminatory environment with medical confidentiality.
- Understand the impact of the disease on our employees and our business and develop indicators to measure the success of our programmes
- Support community based research and management programmes through collaboration with government, industry, NGO’s and relevant institutions
- Ensure medical response procedures are available for any employee in the company who may be exposed to infection as a consequence of their work.





Similarly, Porgera mining Joint Venture has launched an HIV committee to work with employees through peer educators to improve their understanding of HIV and Lihir Gold has also finalised its HIV policy.

### Refugees and Internally Displaced People

There are few international refugees in the region, with the exception of West Papuans in Papua New Guinea. There are about 10,000 West Papuan refugees in Papua New Guinea, about 5000 in border areas, 2500 in the East Awin settlement and 2000 in other urban areas (United States Committee for Refugees 2008). Little is known about their social behaviour but refugee populations are at high risk of sexual exploitation and usually have limited health services (Spiegel and Nankoe, 2004).

In the past there has been resettlement of islanders from densely populated islands or from areas of mining or military activity, including the movement of Gilbertese to the Solomon Islands, Vaitupu (Tuvalu) islanders to Kioa in Fiji, Banabans to Rabi in Fiji, and Bikinians (and others) to more southern parts of the Marshall Islands. These movements took place in colonial times and have not been replicated subsequently though these groups largely remain away from their 'home' islands.

At various times there have been other displaced groups within countries. Between 1998 and 2000, 20,000 people were displaced in the Solomon Islands after violence in Honiara and Guadalcanal. Some Bougainvillean groups were similarly displaced in the violence that lasted during the first half of the 1990s. Most of these moved to new villages nearby or returned to the home areas they had previously migrated from.

Massive population movement after conflict has also been documented in Timor-Leste (Earnest and Finger 2006). There have also been significant localised movements following floods, cyclones and volcanic eruption, notably in Vanuatu (where Ambrym islanders have moved to Efate) and Papua New Guinea (where Manam islanders have moved to the mainland near Bogia, and some Carteret Islanders have moved to Bougainville).

### Sexual behaviour and risk factors

Conflict and displacement increase the vulnerability of individuals, especially women and children, to HIV. Women account for the vast majority of those adversely affected by conflict, and are often seen as targets by different factions

resulting in increased sexual and gender-based violence. Life as a refugee, whether within an established refugee camp or otherwise, often means struggling to meet basic needs which can lead women and girls into exchanging sexual services for resources. Beyond the increased vulnerability, refugees are often accused of bringing disease and HIV into an area.

In some ways, however, refugees are protected from the high levels of vulnerability encountered by other groups. Quesada has written that "whilst poverty and exploitation are common to many mobile populations, separation from families and partners is a potent vulnerability factor which does not necessarily apply to refugees, especially camp-based refugees, who often move as a family and maintain a strong sense of community" (Quesada 2007). Despite this, the vulnerability of refugees to HIV, particularly the vulnerability of women and girls, remains elevated.

In the Pacific, a 2006 study shows HIV prevalence in West Papua of 2.4% (15-49 age group) which is higher than that of Papua New Guinea (Statistics Indonesia 2006). This suggests that the refugees arriving in Papua New Guinea might have higher prevalence than those in the rural areas of Papua New Guinea. Where there have been localised violent conflicts in the region, notably in Bougainville and Guadalcanal, sexual violence has been reported. During the Solomon Islands conflict, there were a number of reports of sexual violence against women and girls by militants and police (Buchanan-Aruwafu 2007, Buchanan-Aruwafu and Maebiru 2008). Similarly in post-crisis Bougainville, there were a large number of recorded incidences of sexual violence and rape (Tonissen 2000).

### Interventions and Activities

The UN High Commission for Refugees (UNHCR) is generally the lead agency on providing HIV services to refugee populations. Along with UNAIDS, the UN High Commission for Refugees has developed a new policy brief that focuses specifically on actions required to prevent HIV and mitigate the effect of HIV on refugees and their host communities (UNAIDS and UNHCR 2007). The UN High Commission for Refugees advocates for the rights of refugees and works with non-governmental organisations and governments to ensure that HIV services are provided. Specific information on the UN High Commission for Refugees' activities on HIV in Papua New Guinea for West Papuan refugees is not available.



## Students

Throughout the region, universities, university centres, teaching and nursing colleges bring together a youthful population for extended periods in different ethnic or international contexts. In Suva, the University of the South Pacific (USP) alone has around 10,000 students. While most are from Fiji, a large number come from 12 other island states alongside a handful of international students from more distant metropolitan states. The Fiji Institute of Technology in Suva and the University of Fiji in Lautoka are destinations for a smaller scale and much more local migration. USP also has campuses in Samoa, Vanuatu and elsewhere. Similarly, in Papua New Guinea there are three different universities and various other tertiary training institutions where students migrate between provinces. The main university, UPNG, has 15,000 students mainly based at the Port Moresby campus. Other significant university campuses are in Lae and Goroka. The University of Guam, with over 3000 students, is a key destination for Micronesian students. Elsewhere the range of tertiary institutions is much smaller, but in almost every state, nursing schools and some other training institutions draw particular groups of people usually in urban centres. A substantial number of Pacific students are in Australia, New Zealand and other overseas destinations, often for several years but also for short term training courses.

## *Sexual behaviour and risk factors*

Students are generally young, sexually active and spend considerable time away from home and their support networks. Very little data is available on the sexual behaviour of students in the Pacific but evidence from other countries suggests that sexual risk taking is relatively high. In Madagascar, only 5.7% of university students reported consistent condom use in a survey (Rahamefy 2008). As mentioned above, surveys conducted in the capital of Solomon islands, Honiara, have shown that one fifth of students had exchanged sex for money or goods, few of them reporting consistent condom use, similarly behaviours are also reported for female students from boarding schools in the outer islands of the Marshall Islands (Buchanan-Aruwafu 2007: 22). Similarly in urban Fiji, school girls (usually from outer islands but resident in Suva) have been reported as becoming engaged in small scale commercial sex to pay their way through school (Save the Children Fiji 2005: 25). These situations may not be atypical and may be seen in other parts of the Pacific.

## *Interventions and Activities*

In general, HIV awareness services are available on university campuses as are basic health services. A number of HIV awareness activities are taking place at the USP campus in Fiji, including peer educators and counselling services, and HIV awareness through sport and arts. University campuses are usually in urban centres thus making access to services easier for students.

## Predominantly External Migration

*The next six sections focus on mobile groups whose movements are predominantly external to the Pacific – those groups that often travel outside of the region or who travel into the Pacific from outside the region.*

### Transport Routes and Seafarers

Transport hubs that are centres of HIV transmission in other parts of the world (IOM/UNAIDS 2005) are rare in the Pacific, although the Highlands Highway in Papua New Guinea is significant. Commercial work became significant on the Highlands Highway in the 1970s soon after its opening. More than 200 sex workers have been identified in surveys along the Highway (Gare et al 2005). This is the highest concentration of sex workers outside urban areas, so much so that the 700km route has sometimes been called “the AIDS highway.” The converse of this is the manner in which, at least in Tari (Southern Highlands), men who were drivers spoke freely about the extent of their sexual relations on the highway (Wardlow 2007: 1009). The Highlands Highway has provided a fast route for the virus to spread throughout the country, and the high level of HIV and AIDS in Western Highlands is a partial outcome of the presence of the road. Commercial sex on this road is a source of income for several hundred young women seeking a living.

Additionally, in several parts of the Highlands, traditional movements in association with exchange and ritual obligations have brought people together for significant periods of time. These social events can become high risk settings for the transmission of HIV. There are few parallels elsewhere in the region.

The seafaring industry is a significant source of employment for many men in most countries, but especially in Kiribati and Tuvalu (as a proportion of all employment). Kiribati, Papua New Guinea, Fiji, Tuvalu and, to a lesser extent, the Marshall Islands supply most of the region’s 6000-7000 seafarers, most of whom are men (Oriente 2006, Buchanan-Aruwafu 2007). Tuvalu has 1200 persons registered as seafarers or fishers, some 10% of the national population. In Kiribati and Tuvalu, at least each seafarer supports an average of seven people (Dennis 2003) and the contribution to Gross National Product in Kiribati and Tuvalu is significant (Clark 2003).

Beyond Pacific island seafarers, thousands of overseas sailors and fishers move through the region; about 10,000 move through Majuro each year (Oriente 2006). During the first six months of 2003, over 4000 seafarers – primarily from

China, Korea, Indonesia and Japan – docked in Majuro with an average nine-day stay (Blair 2005). Sex workers in Kiribati are characteristically referred to as Te Korekorea, those who have sex with Korean seafarers (Buchanan-Aruwafu 2007). Seafarers spend little time in port but when they do disembark, it may be for several days at a time. Seafarers make up the main clientele for the international sex work industry.

### Sexual behaviour and risk factors

Seafarers have been noted as one of the highest priority high-risk groups for HIV transmission in the Pacific. Documents assert that HIV was most likely brought to the Pacific region by seafarers. The first reported HIV infection in Fiji was in a seafarer as were the first two cases in Tuvalu. Of the 46 HIV and AIDS cases in Kiribati as of December 2004, 19 were seafarers and their wives (Oriente 2006). Of the nine HIV cases in Tuvalu, all were among seafarers, their wives and children (Global Fund 2007).

Sentinel surveillance studies conducted in Kiribati among 386 seafarers in 2003 revealed very high sexually transmitted infections with 28% having at least one infection although only one case of HIV was detected (WHO et al 2004). Despite these, less than 5% had ever been diagnosed suggesting a dangerous lack of awareness and action with regard to sexually transmitted infections. A later study among 304 seafarers in Kiribati reported that 23% of seafarers had sex with a sex worker in the past year and only 22% used condoms consistently with these commercial partners (WHO 2006). Around 6% had male to male sex and 66% had never been tested for HIV. Only 16.6% were deemed to have correct and comprehensive knowledge of HIV.

A study on HIV and seafarers from 2005 noted that the seafaring lifestyle “allows for very low condom use, excessive alcohol consumption, multiple sex partners, group sex, commercial sex and the development and circulation of lore and misinformation on HIV. Furthermore, Pacific island seafarers typically subscribe to the traditional gender roles and attitudes that remain dominant in the region, and are resistant to talking openly about sex and sexual health or negotiating safe sex with their partners” (Oriente 2006: 156). These behaviours and attitudes contribute significantly to a heightened HIV transmission risk.

About half of all seafarers literally seek “women in every port,” some remaining with the same woman for several





days. Despite educational programmes from a diversity of sources, less than a quarter of the seamen used condoms and less than half knew how HIV was spread. Seafarers tended to have high numbers of sex partners per year than other identifiable groups (Peteru 2002). 47% of seafarers aged between 17 and 35 had two or more sex partners in the past 12 months with 14% having more than five. Among seafarers older than 35, some 29% had more than five sexual partners over the past year with one respondent claiming 20 partners. Peteru's study suggests that those under 35 tended to have fewer partners and be more aware of HIV and the need for condom use (Peteru 2002). 25% of seafarers interviewed in Peteru's study had experienced at least one sexually transmitted infection in the past 12 months.

Seafarers themselves note that sex workers are easily accessible throughout Pacific ports with American Samoa, Fiji, French Polynesia, Guam, Nauru, New Caledonia, PNG, Samoa and Tonga explicitly mentioned. The use of sex workers by seafarers is often characterised by longer term relationships consisting of total time in port rather than just one night (Peteru 2002). This type of relationship has similarities with the concurrent partnerships of southern Africa that have been described as the major cause of high levels of transmission in that region (Halperin and Epstein 2007).

Alcohol use accompanies unsafe sex among seafarers, and is cited as the major barrier to increased use of condoms (Peteru 2002). In response to a question regarding reasons for unsafe sex, "drinking too much alcohol" was the response given by about 80% of seafarers from Tuvalu, Kiribati and Fiji (Dennis 2003). Time in port has been characterised as a time for heavy drinking, actively seeking entertainment and sexual activity. The 2003 Kiribati study noted that 85% of seafarers drink alcohol (WHO et al 2004).

Peteru's (2002) study of seafarers noted that 65% of seafarers interviewed could not describe HIV and AIDS or how it is transmitted, and 50% did not know what a sexually transmitted infection was. Most admitted to having had some HIV awareness training but could not remember the information. Seafarers under the age of 25, however, provided most of the correct responses suggesting that messaging has reached a younger generation. Knowledge about condoms and how to use them is also poor among seafarers (Peteru 2002; Armstrong 1998; Borovnik 2003). Additionally, cultural taboos exist against discussing sex and condom

use thus reducing opportunities for open discussion and learning (Borovnik 2003).

Truck drivers play a very significant role in the transmission of HIV in Africa and south Asia, and a number of reports have been written on this phenomenon (Alam 2006; Morris and Ferguson 2006, 2007). Data on truck drivers in Papua New Guinea support the characterisation of this group as most at risk. A survey revealed that 60-70% of truck drivers paid for sex in the previous 12 months (National AIDS Council Secretariat Papua New Guinea and National HIV/AIDS Support Project 2007). Only 1 in 3 (33%) of the truck drivers said they always used condoms with sex workers. Additionally, immediately after the construction of the Highlands Highway there was an epidemic of syphilis in the Highlands as a direct by-product of the increased access afforded by the highway (Hughes 1997).

#### *Interventions and Activities*

A significant number of organisations are involved in providing HIV information to seafarers including the Secretariat of the Pacific Community, shipping agencies, maritime training schools and non-governmental organisations. The Secretariat of the Pacific Community's HIV/AIDS and STI Project works closely with its Maritime Regional Program and Fisheries Division. In addition to providing information materials, the Secretariat has trained 35 peer educators from six islands who work on ships manned by Pacific islanders (SPC 2002). The Papua New Guinea Institute for Medical Research has also produced Information, Education and Communication (IEC) materials popular among seafarers. The TRANSEX project in Papua New Guinea trains sailors to become peer HIV educators and the ADB-funded Coastal Fisheries Management Development Project in PNG supports HIV education.

Seafarers generally have low levels of literacy, thus limiting their ability to access many information sources (Oriente 2006; Dennis 2003). So despite the availability of Information, Education, Communication materials, many do not appeal to seafarers nor are particularly accessible. More basic information packs are often required.

The Pacific Regional HIV/AIDS Project (PRHP) funded by AusAID, NZAID and France provided small grants to a number of organisations to conduct awareness building in the Pacific and a small number were conducted with seafarer groups. The Asian Development Bank's HIV/AIDS



Prevention and Capacity Development in the Pacific Project, which started in 2006, focuses on seafarers explicitly and on vulnerable groups generally. US\$1.092 million was targeted for vulnerable groups. Five drop-in centres were proposed for seafarers as well as funds for regional maritime schools to do training programmes on HIV. However, such education and awareness programmes are limited in extent and reach. In 2005 the National Fisheries College in Papua New Guinea offered no HIV courses and very little HIV awareness highlighting the need for such activities (Oriente 2006).

HIV education for seafarers is conducted at 14 training institutes in the region (Oriente 2006). Each year these programmes cover as many as 3000 Pacific islanders using the training manual "HIV/AIDS and STDs among seafarers in the Pacific region" (1999). Oriente notes that "in Samoa, the Solomon Islands, Federated States of Micronesia, Vanuatu, and Kiribati, graduates of the training institute must pass a test on basic HIV information" (2006: 166). No evidence on the efficacy of these various approaches is available but one can assume that HIV awareness will improve suggesting some improvement in risk behaviour.

Other groups involved in HIV activities among seafarers include the International Organization for Maritime. While it does not have any programmes specifically for Pacific island countries, they did develop a project in 2004 in the Philippines called *Seafarers Health Education Counselling* which focussed on a pre-departure orientation seminar for those seeking overseas employment. This workshop included HIV information. Additionally, Philippine law requires that HIV testing be administered and the International Organization for Maritime project supported training.

For truckers in Papua New Guinea, the Wagi Valley Transport Company is the first trucking company in the Western Highlands to have an AIDS education programme. The company sees HIV education as an economic necessity after two of their 22 drivers died from AIDS-related infection. AusAID funds the education programme and provides funding for condom distribution among drivers.

## Military

In the past decade, new and socially important migration streams have emerged in the region. Workers from Pacific island countries and territories have taken up overseas employment opportunities in the Middle East and elsewhere, mainly to work in the armies or in security. These individuals are mainly male, and from Fiji, Tonga, American Samoa and most of the formerly known Trust Territories of the Pacific Islands (Micronesia). Incomes are substantial and the impact of distance and high incomes has significant social consequences.

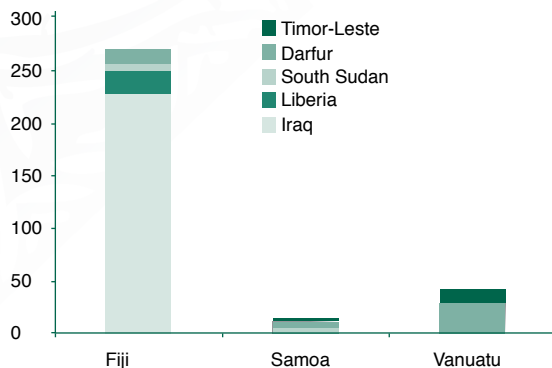
Pacific island soldiers and policemen are in UN peacekeeping missions and military conflicts overseas in Afghanistan and Iraq either through formal enlistment or as contract workers. Elevated HIV risk among military and police personnel is well known and well documented by such agencies as the UN's Department of Peacekeeping Operations (DPKO). This UN Department has written a number of reports on HIV among the military and has implemented control programmes including condom distribution and awareness building in peacekeeping missions around the world.

The Pacific's involvement in military migration globally has been increasing significantly over the past decade, and there are potentially important impacts on HIV transmission.

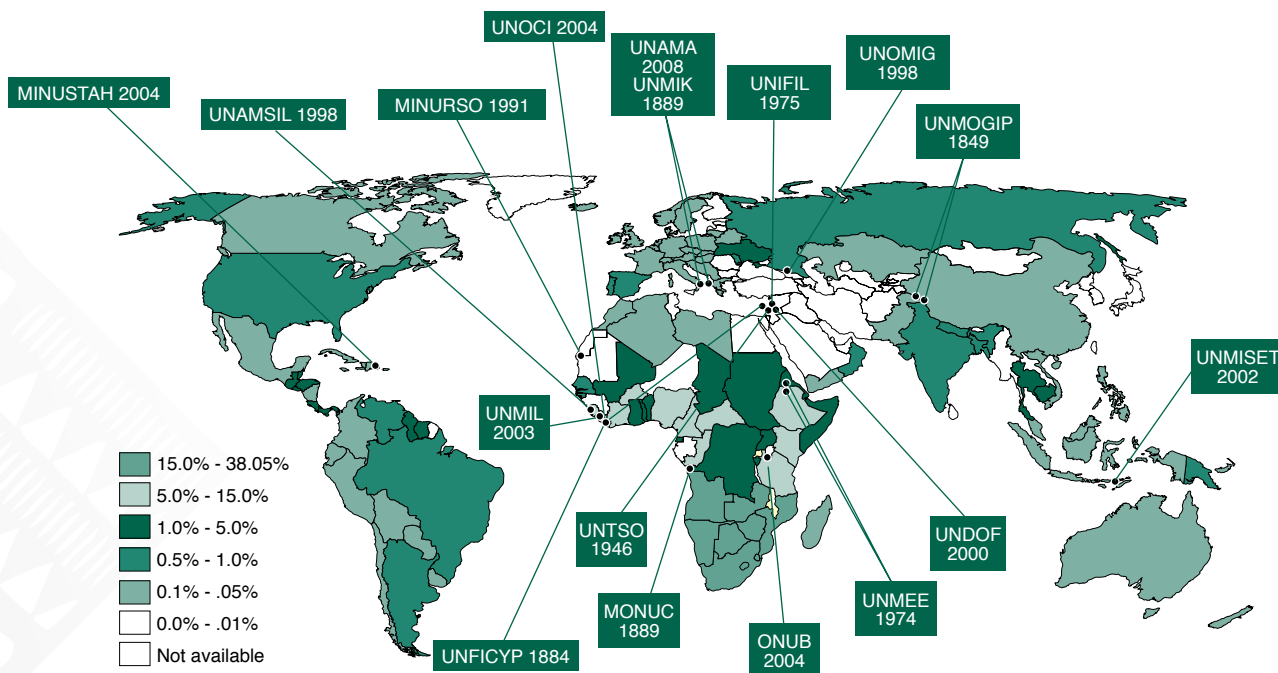
### *United Nations Peacekeeping Operations*

According to the UN's figures as of 31 January 2010, there are 268 Fijians, 15 Samoans and 34 Ni-Vanuatu serving as soldiers or policemen in UN Peacekeeping Operations (DPKO 2010). The majority of the Fijians are serving in Iraq, a country with very low HIV prevalence, but 46 Fijians and 29 Ni Vanuatu and 11 Samoans are serving in sub-Saharan African countries (Figure 4). While HIV prevalence in Sudan (1.4%) and Liberia (1.7%) is low relative to that of other African countries (UNAIDS 2008), there is elevated risk of HIV exposure when compared to the soldiers' home countries. Indeed, many of the locations of UN peacekeeping operations are high prevalence areas (Figure 5).

**Figure 4: Pacific Islanders in United Nations Peacekeeping Operations by Country, January 2010<sup>2</sup>**



**Figure 5: HIV Prevalence and United Nations Peacekeeping Missions, June 2004<sup>3</sup>**



<sup>2</sup> [http://www.un.org/en/peacekeepingcontributors/2010/jan10\\_5.pdf](http://www.un.org/en/peacekeepingcontributors/2010/jan10_5.pdf)

<sup>3</sup> UNAIDS Fact Sheet, "HIV/AIDS and Peacekeeping," UNAIDS Office on AIDS, Security and Humanitarian Response, June 2004.

### *Pacific islanders in the Middle East*

Tonga sent a force of 55 Royal Marines stationed to Iraq in 2004 as part of the Multinational Force in Iraq (separate from the UN). They have returned end of 2008. Citizens of the Pacific islands states under the Compact of Free Association with the United States (Marshall Islands, Federated States of Micronesia and Palau) are allowed to serve in the US military, and as of 2005, alongside 300 soldiers from American Samoa, 100 from Northern Marianas and 60 from Guam (as well as 150 from Hawaii) served in Company C, 100th Battalion, 442nd Infantry Division in Iraq (Boylan and Waite 2005, Hezel 2005). There are also over 2000 Fijians serving in the British Army, 60 of whom have been sent to Iraq as part of British Army deployments (Maclellan 2007).

Of the 182,000 contractors/mercenaries serving in Iraq, 43,000 are third-country nationals (ie. not Iraqi or American) from an estimated 30 countries. One estimate has over 1000 Fijians working in Iraq and Kuwait as soldiers, security guards, drivers and labourers (Maclellan 2006). These individuals are actively recruited by such organisations as the British-based Global Risk Strategies which went so far as to open a branch in Fiji to recruit ex-military personnel for contracts around the world. Such individuals have been lured by salaries of US\$1700 a month, substantially more than they were likely to receive at home.

### *American and French Military in the Pacific*

A third important component of military migration in the Pacific is the American military presence in Guam. There has been an American military presence in Guam for decades with about 10,000 military personnel and their family members on the island as of 1997 (Guam Military Overview 2008). Guam is set for a “peacetime invasion” over the coming years which “will balloon the island’s population by about 40,000 service people, contract workers and dependents” (Harden 2008). This represents an increase in the total island population of about 25%. More than 12,000 of these temporary migrants will be US Marines who are being relocated from bases in Okinawa, Japan (Casa 2008).

One journalist has already noted that “the newcomers will be mostly young, mostly single men trained as warriors - and periodically looking for a big night out on a small island” (Harden 2008). The presence of US servicemen has been associated with sexual violence in the Asia-Pacific region since the conviction of three US Marines for rape

of a Japanese schoolgirl on the island of Okinawa. While documentation of increased sexual violence rates with the presence of US military is difficult to gather empirically, the possibility of high-risk sexual activity and possibly HIV transmission is certainly elevated.

In the Marshall Islands, there is considerable interaction between Marshallese citizens living on the tiny, overcrowded island of Ebeye and the nearby US military base on Kwajalein. There are also French military bases in the Pacific, but in the middle of 2008 France took action to reduce significantly the numbers stationed in French Polynesia.

### *Regional Assistance Mission to the Solomon Islands*

Fifteen Pacific states contribute soldiers, policemen and advisers to the Regional Assistance Mission to the Solomon Islands (RAMSI). This ranges from two policemen from the Cook Islands, Federated States of Micronesia, Niue and Palau to larger groups of 93 from New Zealand and 379 from Australia.

### *Pacific Island Militaries Domestically*

Military forces in the Pacific (Fiji and Papua New Guinea each have about 4000 military personnel) also experience internal migration of soldiers travelling from base to base and relocating periodically depending on threats or location of exercises.

Throughout the world, military forces have been cited as high-risk groups due to the predominance of young men, lack of education and predisposition to risky behaviour. In 2004, there were 108 soldiers living with AIDS in Port Moresby barracks alone (Steven 2004).

A Papua New Guinea survey by the National AIDS Council revealed that as much as 60-70% of military personnel paid for sex in the previous 12 months (National AIDS Council Secretariat Papua New Guinea & National HIV/AIDS Support Project, 2007).

The senior Medical Adviser of Papua New Guinea’s National AIDS Council notes that “the defence force gets called upon to attend various crises around the country and the region which puts their exposure levels up” (quoted in Steven 2004). The movement of soldiers also increases the risk in the communities through which they pass and in which they are stationed.

### *Sexual behaviour and risk factors*

In general, soldiers and policemen earn significant incomes - certainly higher than most would earn at home and/or in other occupations - creating a situation where significant numbers of mostly young men are a long way from home, in a stressful environment, without any social safety net, with money in hand and sometimes with time on their hands. Militaries are also characterised by an ethos of risk-taking behaviour thus making soldiers a particularly dangerous mode of transmission of HIV (Bazergan 2004).

A behavioural surveillance survey conducted in Fiji in late 2004 among 257 male military personnel and policemen (WHO 2006) revealed that only 5.8% of respondents admitted having sex with a sex worker in the past 12 months and only 7.7% of them used a condom the last time. Overall, only 19.1% of the respondents exhibited comprehensive knowledge of HIV transmission. With regard to having sex with a male partner, 6.7% reported it with less than 2% in the past year.

The UN Department of Peace Keeping Operations has documented the risk behaviour of peacekeepers on overseas missions in an attempt to better understand how to intervene and protect peacekeepers. The Department has fielded Knowledge, Attitude and Practice (KAP) surveys in a few peacekeeping missions including in Liberia where 22 Pacific islanders are stationed. Though the survey was not specifically done amongst the Pacific islanders, it noted that the literacy rate was 98% and over 88% of respondents were married or had long-term partners at home. Despite this, 18% of peacekeepers reported having had sex while in Liberia and this is assumed to be underreporting (Bazergan 2006).

Additionally, some of the soldiers had just arrived in country. Of these, 40% had two or more partners. Though condoms were readily available, 21% did not use a condom every time they had sex in the mission area. While these figures are probably better than they would be among other groups in other situations, there remains significant potential risk for HIV transmission for both peacekeepers and the host community. A major reason for the relatively low rates of sexual activity and relatively high rates of condom usage is that few soldiers reported drinking or drug use. Similar surveys among peacekeepers in Eritrea and Haiti reveal generally comparable behaviour patterns. It is possible,

therefore, that such behaviours also exist for peacemakers in other contexts including within the Pacific region, and anecdotal evidence of RAMSI involvement (Christian Care Centre 2004).

### *Activities and interventions*

The United Nations Security Council Resolution 1308 of 2000 encouraged countries to develop HIV education strategies for uniformed services and obligates the Department of Peace Keeping Operations to provide HIV awareness and prevention programmes for UN peacekeepers. The UN General Assembly Special Session on HIV/AIDS Declaration of Commitment on HIV/AIDS of 2001 required the Department and countries to "ensure the inclusion of HIV/AIDS awareness and training, including a gender component, into guidelines designed for use by defence personnel and other personnel involved in international peacekeeping operations while also continuing with ongoing education and prevention efforts, including pre-deployment orientation, for these personnel."

HIV training is the responsibility of troop-contributing countries and, therefore, the Department of Peace Keeping Operations has developed a generic training module on HIV in order to assist countries with pre-deployment HIV education. It has also posted HIV advisers in its major missions to provide "ongoing sensitization and prevention programmes, including voluntary counselling and testing" (Bazergan 2006).

These various interventions are generally seen as successful as evidenced by the fact that 80% of the peacekeepers serving in Liberia in 2005 had undergone an HIV test as part of their pre-deployment preparation (Bazergan 2006). The Liberia survey also confirmed that in some battalions, 100% of soldiers received HIV and AIDS pre-deployment training. The lowest figure was 56%. The Department of Peace Keeping Operations also distributed 273,000 condoms in six months (December 2004 to May 2005) in Liberia, not including any stocks that forces brought with them. This helps to explain the relatively high condom usage among soldiers in the Liberia and Haiti surveys.

UNAIDS has developed an HIV and AIDS awareness card for peacekeepers in 12 languages. While the interventions conducted as part of the UN missions are laudable, the majority of work is conducted pre-departure and while on the field. Interventions and programmes on return are non-





existent. Therefore, when the soldiers return to their home communities, the support that they received in the field vanishes, thus increasing potential risk of engaging in risky behaviour.

Knowledge levels and behaviour among non-UN soldiers are more difficult to ascertain. While the Department of Peace Keeping Operations and UNAIDS focus on HIV among soldiers, evidence on activities by national Pacific island militaries and security contractors are limited. The US Department of Defense's HIV/AIDS Prevention Program was present at a workshop in Bangkok in 2005 that brought military medical officers from 22 countries together to discuss HIV/AIDS prevention, treatment and care in militaries. Representatives of Fiji, Papua New Guinea and Tonga participated (Department of Defense 2006).

UNAIDS provided US\$212,300 for activities among uniformed services in 2005-2007 (SPC 2008b). Fiji and Papua New Guinea are likely to have more developed HIV/AIDS activities among their military partly due to increasing prevalence among soldiers in Papua New Guinea, while UN deployment requirements that dictate that HIV and AIDS awareness must be provided to peacekeepers. Security contractors recruiting Fijian army soldiers are unlikely to emphasise HIV awareness and services, thus making that group potentially the most at-risk of all the mobile military workers included in this report.

### **Guest workers**

Another very new stream is the guest worker migration to New Zealand following increasing pressure from island governments on metropolitan countries as a response to domestic economic stagnation. In 2007, New Zealand implemented a new policy of allowing a quota of 5000 guest workers from several island states to work in the agricultural industry (Levick and Bedford 1988). Continued pressure from island states resulted in Australia introducing a scheme to begin at the end of 2008 for 2500 workers. Between 2007 and 2008, about 4500 seasonal workers travelled to New Zealand to be employed in various parts of the agricultural industry. Most were from Vanuatu with others from Kiribati, Tuvalu, Samoa and Tonga. Both male and female workers were selected from productive age groups (25-55) mainly from rural areas.

About two thirds of those who were recruited have been men. Preference was given to married men and women but only one of a married couple was recruited to avoid

substantial disruption to families who remained at home, hence individuals went alone (Hammond and Connell 2009). Most of the recruits stayed in shared accommodation, such as in caravan parks and, while employed, earned sums several times that available at home. Although it was intended that most workers stay in New Zealand for a maximum of seven months, some returned before that period was over. A roughly similar scheme will begin between Australia and four Pacific island states (Papua New Guinea, Vanuatu, Kiribati and Tonga) at the end of 2008 and is expected to take 2500 workers over the course of three years.

The social consequences of men and women travelling without their partners are important. Anecdotal evidence is suggesting that single workers in New Zealand are more likely to take advantage of "freedom" to engage in social activities less available or condoned at home.

### ***Sexual behaviour and risk factors***

While the rationale for having only one member of a married couple join the scheme makes sense from the perspective of social stability, it increases the likelihood of increased numbers of sexual partners. This trend has been seen in seasonal plantation and mining work where one member of a couple is away for an extended period. Therefore, the guest worker model might increase the number of sexual partnerships and put men and women at greater risk of HIV transmission. No data is available specifically for guest workers under this scheme.

### ***Interventions and Activities***

There has been no mention of a specific HIV component to the guest worker scheme to mitigate the potential impact of the migration, though at least in Vanuatu there are briefing sessions for guest workers that cover some issues related to sexual behaviour. How effective and general these may be is unknown.

### **Skilled Workers**

International migration flows have increasingly been of skilled workers. In recent years, general migration opportunities in metropolitan states have tended to decline, and migration has been increasingly targeted toward skilled migrants rather than family reunions. Structural changes within metropolitan states have meant that certain sectors, notably health, are short of skilled workers (Connell 2004) while there has also been a significant flow of teachers (Voigt-Graf 2003), engineers, IT workers, airline pilots and others. Pacific island

nurses, usually entering the bottom levels of the 'global health care chain', have migrated much greater distances, to the United Arab Emirates and beyond, as demand intensifies, and also to new destinations within the region, including the Marshall Islands and Palau (eg Rokoduru 2008, Connell 2004, 2009). Similarly, the globalisation of sport has meant rugby players going beyond the "traditional" destinations of New Zealand and Australia to Japan and Europe.

(Low remuneration, poor promotion opportunities, limited training and further educational opportunities, poor working and living conditions, particularly in remote regions, are push factors for skilled migrants (Connell 2006).

*The growing shortage of skilled workers has also contributed to increased inter-island migration, with workers migrating to countries offering better work conditions and salaries, such as Fijian teachers and nurses migrating to the Marshall Islands, and Fijian tourism workers moving to the Cook Islands.*

Several cities, notably Suva, host major regional institutions and UN agencies that are also important destinations for regional skilled migration. There is also considerable short-term mobility of skilled workers within and beyond the region. Bureaucrats and others move around the region, attending conferences and workshops. Sporting teams and dance groups similarly move around for such events as the South Pacific Games and the Festival of Pacific Arts.

In some smaller states, the brain drain has been equally excessive. The Cook Islands, for example, lost more than half its vocationally qualified population in a single decade (1966-76) and much the same happened again in the mid-1990s when the national economy collapsed (Connell 2005). Many islands and island states now also experience a shortage of airline pilots, accountants, engineers, IT workers and other skilled groups. Even tiny Niue has had to import refrigeration and other engineers from the Philippines because of its losses (Connell 2007a).

The shift to skilled migration, despite remittances, has been at some cost to service provision in many islands, rural and regional areas (especially in Papua New Guinea) and island states, and has resulted in reduced public health capacity in several states, and notably the rural areas of PNG.

As skilled migrants have moved away from the region they

have also been replaced by others moving into the region. Thus in the health sector there are doctors from a range of European and Asian countries, significant numbers of migrants from south Asia and the Philippines in many skilled occupations and international bureaucrats from a range of countries. Many of these migrants are well-paid individuals living apart from their families.

#### *Sexual behaviour and risk factors*

There is some limited data on increases in sexually transmitted infections and possibly HIV following the staging of large scale pan-Pacific events such as the Festival of Pacific Arts and the South Pacific Games. Specific commentary on the variety of skilled workers who are mobile is difficult due to the range of occupations, destinations and situations. In general, however, if one assumes that skilled workers have higher levels of education, they are more likely to have been exposed to HIV information than unskilled workers and might therefore be at less risk. This is less likely to be true of some groups moving into the region.

An additional consideration regarding vulnerability and migration is that the migration of health workers from the Pacific limits the health response to HIV in the region. Most Pacific island countries and territories have much lower rates of health workers per population than countries such as Australia and New Zealand. Further migration only limits the ability of Pacific countries to develop a comprehensive response to HIV and to provide treatment to those living with HIV. These factors can contribute significantly to the spread of the epidemic as it can spread unchecked. A vigorous public health response, often led by health workers, is necessary to prevent high rates of transmission.

#### *Interventions and Activities*

There are very few specific HIV interventions for skilled workers in the Pacific. UNAIDS does some limited work with sportsmen and women who travel for competition and there are opportunities to inform parliamentarians who travel on official business about HIV through the Asia-Pacific Leadership Forum and other bodies.

#### **Tourism**

Tourism is important in many parts of the region, but is of least importance in urban Papua New Guinea where HIV incidence is greatest. Guam and Saipan, being of great importance in Micronesia, receive tourism mainly from Asia (especially Japan, and emerging markets in Taiwan and

Korea and PR China). Fiji, and to a rather lesser extent, Tahiti, New Caledonia, Vanuatu and the Cook Islands are important elsewhere in the region. Fiji and Vanuatu benefit from tourism from the south, mainly from Australia and New Zealand, and Tahiti benefits from tourists from France and from the United States. Visitor numbers have been influenced by political instability, usually short-lived, and changes in airline routes.

Since the 1990s, cruise ship tourism has boomed, especially in the western Pacific (and particularly in Fiji, Vanuatu and New Caledonia). In some countries, notably Vanuatu, there are more cruise ship tourists than all other kinds. Passengers stay onshore for about eight hours. There is no indication that commercial sex has developed in response to cruise ship tourism, but this may merely be a matter of time. Ironically, in a number of parts of the region, including Vanuatu (Cummings 2008), HIV is seen as a “foreign disease” associated with and introduced by tourists, though there is little real evidence of such aetiology.

markets (eg ecotourism, honeymoons) so as to exploit their unique selling points, and Tonga and Samoa have had some limited success. Most tourists stay no more than a week or so, many are families and a large number spend a significant time close to the resorts.

Sex tourism from Papua New Guinea to neighbouring Jayapura in Indonesia has been reported in the Papua New Guinea press for 20 years and has been confirmed by a 2005 UNICEF-funded survey (HELP Resources Inc 2005). Some male tourists may also engage in sexually activities with other males, particularly in Fiji and some parts of Polynesia. Few specific reports or articles are available on risk factors for HIV in the tourism sector in the Pacific. Two reports that do contain some relevant information on the Fiji and Solomon Islands situation focus on the commercial sexual exploitation and sexual abuse of children (Save the Children Fiji 2005; Christian Care Centre 2004). While the Solomon Islands study cited a few instances, the Fiji study covered incidences

**Figure 6: Tourist Arrivals in selected Pacific Islands Countries, 2005 (Asia Pacific Human Development Report 2006)**

Country	Population (million)	Arrivals (millions)	Growth (%)	Tourism Earnings (% of GDP)
Vanuatu	0.2	0.0501	-0.8	17.2
Kiribati	0.1	0.004	-4.3	9.7
Fiji	0.8	0.361	-0.2	12
Papua New Guinea	5.4	0.043	-8.9	5.8
Marshall Islands	0.1	0.005	...	...
Samoa	0.2	0.096	2.7	...
Micronesia	0.1	0.021	5.5	...
Palau	0.02	0.054	-2.0	...
Solomon islands	0.4	...	...	3.1

Notes: Population data are for 2002; tourist arrivals are for 2004 and growth in arrivals in 2004 over the previous year; tourism as a percentage of GDP is based on estimates by WTTC for 2005.

Source: Aibara and Gopalani 2005 in UNDP Asia Pacific Human Development Report 2006.

With the exception of the Cook Islands and Palau, smaller countries have largely been unable to gain access to significant tourist markets because of their location, intervening opportunities and a lack of standard attractions. In both these countries, annual tourist numbers are significantly greater than the resident population hence the scope for tourism-initiated change is considerable. Within the region, some of the smaller destinations seek to find their own niche

of sex tourism and noted anecdotal evidence confirming that tourists travel to that part of the Pacific looking for anonymity and the availability of children in prostitution.

Child sex tourism is partly driven by poverty and weak law enforcement, but also by demands for greater access to cash, parental neglect and abuse at home (Save the Children Fiji 2005: 17-18, 23-25). The Save the Children study





noted a high correlation between child commercial sex work and tourists in areas where there are many hotels such as Savusavu.

While the most obvious temporary “in-migration” into the Pacific region is that of tourists, there are other short term visitors such as business workers (and even FIFO miners from northern Australia to Papua New Guinea). While the extent, duration and diversity of such visits are unknown, such visitors may be involved in the same risky behaviour as some tourists. In Cairns (Queensland), there has been a recent increase in HIV that can be linked to men travelling to Papua New Guinea on business or in some leisure areas.

### *Sexual behaviour and risk factors*

The Save the Children and Christian Care Centre studies noted above confirm high risk sexual encounters between tourists and young girls and boys in the Pacific, but primarily in Fiji, though they are unable to quantify the aspects of the interactions. The Christian Care Centre report on the Solomon Islands noted that child sex tourism is “relatively uncommon” whereas in Fiji it appeared to be becoming more common. In neither country was it easy to distinguish child sex tourism from more general commercial sex.

Studies from other parts of the world confirm that tourists can engage in significant high risk behaviour. A qualitative study in Brazil noted that “alcohol and other drug use by tourists increases their vulnerability to HIV transmission through favouring casual sexual intercourse without condoms” (Santos and Paiva 2007). Other studies note high rates of sex tourism in Costa Rica, Dominican Republic (Kelly 2005) and Kenya (Romero-Daza and Freidus 2008) and Asia. There is reason to believe that as governments crack down on sex tourism elsewhere, there is a better prospect of it becoming more important in the Pacific.

### *Interventions and Activities*

A number of the papers cited above include calls for greater HIV awareness to be made available in tourist areas. At present, however, there does not seem to be any specific activities targeted to tourists in the Pacific. The Fiji report notes that while the Ministry of Tourism is aware of the child sex tourism situation, “it did not believe the problem was grave enough to warrant the Ministry’s active involvement in preventative measures” (Save the Children Fiji 2005). The recent emergence of Business Coalitions Against HIV and AIDS in the Pacific (BAHA Fiji in the footsteps of BAHA PNG)

may however contribute to increases prevention activities as the private gets more involved.

### **Return Migration**

At no time during the past quarter of a century has there been substantial permanent return migration of international migrants to their home islands and island states, despite the centrality of an ideology of return. Return has been greatest where distances have been less and economic opportunities greater, and consequently least in more remote islands and regions. Limited return migration is partly due to the great differences in income levels with the metropolitan periphery, but also to a host of social factors. Hence it is greatest in the larger states where opportunities are greatest and least in the smallest island states.

The return migration of those with skills has tended to be limited in part because those skills cannot be practised locally and return migrants are poorly recompensed. Skilled migrants nonetheless do return often for family reasons or to establish businesses. Most island states, however, have been unable to benefit from contemporary strategies to benefit economically and socially from diaspora populations, since economic opportunities are limited in many island states.

Return migrants tend to be absorbed within the service sector, rather than directly in production, as in Tonga, where remittances have been used to set up market stalls which become the prelude to stores and business ventures. Disappointments discourage other returnees, and return migration may be the start of a new phase of circulation. Limited return is also function of a social context where the children of migrants are educated in the destination country, have lost some degree of contact with “home” societies and critical linguistic and other skills.

Importantly, however, there is a great deal of circular migration as migrants return temporarily or for holidays just as islanders visit their kin in metropolitan (and other destinations). This short term movement, a key means of transferring remittances to the region, is largely undocumented but highly important for the various forms of social and economic relations. It is particularly common throughout Polynesia and Micronesia.

While it is known that some Pacific migrants are employed as sex workers overseas (Federated States of Micronesians in Hawaii), the extent of this employment is largely unknown, and the extent to which workers who may have contracted

diseases overseas and then returned home is similarly unknown. The social and economic consequences of return migration are variable and the impact on public health is poorly understood but is likely to have some significance for the transmission of HIV.

#### *Sexual behaviour and risk factors*

Return migrants often come home with increased status and resources, thus potentially increasing the opportunities for sexual engagement and partnership. The Global Fund Round 7 multi-country Pacific application, for example, notes that “significant numbers of Federated States of Micronesia citizens reside in Guam and Hawai’i where HIV prevalence is considerably higher and there is ready movement of people between these populations. It is anticipated that this will be

the main source of future HIV infections diagnosed in the Federated States of Micronesia” (Global Fund 2007). Similarly, for the Marshall Islands, it is asserted that “citizens of the

Marshall Islands have the right of residence in Hawai’i and the mainland United States (where the HIV prevalence is higher) and there is considerable travel between the countries.” While these conclusions are certainly true, the extent of mobility between metropolitan states and “home states” is largely unknown.

#### *Interventions and Activities*

There are currently no HIV activities specifically targeted to return migrants in the Pacific.

## Conclusion

In reviewing the complex migration pathways in the Pacific and the behaviour of specific mobile groups, a number of key issues emerge.

Migration and mobility are powerful mechanisms in the Pacific. As long as urban employment appears more prestigious and city life is perceived as being of higher quality than rural life, population pressures in urban areas will increase. The social, economic and environmental future of the region depends to a great extent on how successfully these problems can be solved. As island economies have largely failed to grow in the present century, so dependence on migration (and on overseas aid) has increased significantly.

Economic growth in the region has been limited and, therefore, formal sector jobs are being created more slowly than school leavers are emerging from the education system. The consequence of this “youth bulge” is one of rising unemployment, the growth of the informal sector and visible signs of poverty within urban areas. Although poverty is not a welcome word in most parts of the region and few countries officially admit that it exists, there is now growing evidence that it is widespread, though disguised by words such as ‘hardship’ (Abbott and Pollard 2004), and is a critical factor in the rise of commercial sex work and HIV transmission.

A second consequence is sustained rural-urban migration. A major task for most states is to create employment and provide services, for outer islands and remote places, that would stimulate development, reduce migration and contribute to national growth. Island states, individuals and various international agencies have attached new and increased significance to migration, remittance flows, return migration and the role of the diaspora in contexts where “conventional” national development strategies have achieved limited success.

The high level of HIV in Papua New Guinea points to the significance of internal migration rather than international migration as the critical influence. This also indicates that an increasing prevalence may be more likely to occur in such urban areas as Honiara, Suva, and perhaps elsewhere in Fiji, where rural-urban migration is considerable, natural population increase remains relatively high, international migration opportunities are scarce and urban unemployment rates are very high.

Other countries and urban contexts where this conjuncture is emerging, notably Port Vila in Vanuatu and in other large towns in Fiji, may become of more critical concern. However, as the situation in Papua New Guinea indicates, rural areas are far from immune to HIV.

Beyond the general process of urbanisation, there are also a number of key migration groups that exist in large numbers in the Pacific including seafarers, military personnel and commercial sex workers. Urban areas where they tend to congregate, permanently or temporarily, are particular hot spots. Each of these groups is at particular risk of HIV transmission due to behaviours and attitudes. Mining centres and logging camps are lesser hot spots. Specific interventions and policies are needed to address the challenges that each group faces.

Migration and mobility are underestimated risk factors for HIV in the region. Greater recognition is needed among policy makers regarding the present and potential significance of migration for the spread of HIV. This recognition has come in Africa and Asia but is not sufficiently widespread in the Pacific. Although Asian Development Bank and AusAID-funded projects exist among seafarers, migration as a whole is not recognised as a driver of the epidemic in the region.

While the report has highlighted the sexual behaviour associated with a number of mobile groups from anecdotal evidence and the pockets of research conducted, the intervention and activities are limited reflecting the lack of appropriate responses when dealing with migration and mobility and the specific vulnerabilities to HIV and Sexually Transmitted Infections associated with mobility.

The report has drawn attention to the few groups in the Pacific working with sex workers on HIV awareness and activities and there are targeted interventions developed for seafarers and within some mining communities in Papua New Guinea. However, data collection and research on the extent of the sale of sexual services, male to male sex and their effects on HIV have been limited to areas within PNG. Further research is also needed to better understand the interaction and sexual networking between mobile groups as well as the specific vulnerabilities of women in the Pacific i.e. lack of legal protection and power, discrimination and exploitation manifesting in sexual and gender based violence.



Stigma and discrimination regarding HIV remains prevalent and the response to the epidemic has also been slowed by the conservatism of some Pacific leaders and institutions that have been reluctant to discuss issues of sex, marginalisation, men who have sex with men, sex work and access to condoms. It is significant that while there is no public health justification, out of 59 countries and territories that still have some form of HIV-specific restriction on entry, stay and residence that is based on HIV status, at least nine are in the Pacific (the information is not available for 5 additional Pacific Island Countries).

For these reasons, greater understanding of HIV risk factors and vulnerability is needed in the Pacific in order to reduce the spread of HIV in groups with high risk behaviours, and to reduce the unprotected sexual encounters which carry HIV infection between those groups and the wider population.

Further effort also needs to be made towards addressing the social context that drives migrant behaviour which is linked to the search for professional or economic opportunities and health and education services. Driving factors are also exacerbated in contexts of conflict, political tensions, repression and human rights abuses.

Because of the complexity of migration pathways (which are constantly evolving) and the diversity of countries within the region (in terms of social organisation, economic development migration and HIV status), any intervention will need to be equally diverse and involve “multisectoral approaches that bring together key actors from source, transit, and destination communities” (IOM 2006). It is the challenge facing the Pacific to integrate the twin challenges of HIV vulnerability and mobility decision-making in order to develop appropriate and targeted interventions.

### Suggested recommendations

On the basis of this rapid assessment and given both the complexity of the issues involved and the diversity of the region, it is inappropriate to make firm and very specific recommendations on the type of intervention or on the policies that need to be put in place to address mobility related HIV vulnerability.

The following suggestions are made based on these preliminary findings and are in line with principles and good practices internationally recognised:

### Improve the evidence base

In order to better inform the multi-sectoral approach necessary to deal with the challenges of HIV vulnerability and mobility, the lack of knowledge and specific data on the sexual behaviour and risk factors of migrant groups in the Pacific needs to be addressed.

A number of key areas of insufficient data emerge as priorities for future research. The most prominent of these include:

- Sufficient data on the increasing movement of people to urban areas and the development of informal settlements in the Pacific is not available. This movement is driven by poverty of opportunities and lack of available resources which can lead to sex work and poor health outcomes. Research on the drivers of urbanisation, types of settlements, and specific risk behaviours associated with the movement is needed to develop a further understanding of urban poverty as well as its link to HIV vulnerability;
- While quite a few studies have been conducted on commercial sex workers – in Papua New Guinea in particular – the issue of foreign sex workers migrating and some of them possibly being trafficked to the Pacific has not been understood sufficiently and might be an area of priority research given the high risk of HIV transmission;
- Migration of a predominantly male labour force for plantation and mining work has been linked to HIV transmission in Africa and elsewhere; more research needs to be done in the region on this. This might be an opportunity to partner with private sector organisations in Papua New Guinea to conduct relevant studies and develop response strategies;
- Specific studies on the behaviour and attitudes of Pacific military and security forces are not available. These intermittently risk-taking young men are increasingly globally mobile and receive substantial salaries. The potential for risky sexual behaviour is high as is the likelihood of returning with and spreading sexually transmitted infections if they do not practice safe sex and do not test themselves upon return;
- Whereas the UN High Commission for Refugees in Africa has done much work on HIV vulnerability of refugees, this does not seem to have been the case to date in Papua New Guinea among Papuan refugees. This might be an area of priority research as the epidemic escalates in Papua New Guinea and as climate change may result in more refugees in the region;

- French Polynesia and New Caledonia have some of the highest numbers of reported HIV cases in the Pacific. This might be linked to better surveillance systems, or the large tourism industry in those islands or to specific migration from metropolitan France but, at present, not enough information is available;
- Relatively little research has been done on the vulnerability of family members of migrants and mobile workers. Additional research on issues of economic and social vulnerability when an adult breadwinner travels would be appropriate to develop a more holistic understanding of relevant challenges.

### *Adopt a mobility system approach*

Targeted HIV intervention for migrant and mobile population groups need to adopt a mobility system wide approach. The mobility system encompasses origin, transit, destinations, return and what moves people around. A mobility system wide approach is necessary because migrants and mobile populations interact all along the mobility system and not only at their destination. In addition, migrants and mobile populations do not have a higher incidence of HIV per se; they are more vulnerable because the context of migration or mobility put them at increased exposure risk than people who do not move. Their degree of HIV vulnerability depend essentially on the conditions under which they move, interact, access or not services at different points of the mobility system. The most vulnerable amongst migrant groups are the undocumented ones.

Therefore interventions need to not only focus on the migrants themselves or at only one particular point of the system but also on:

- Host resident communities and workplaces
- Sending communities (i.e the home villages, families and communities of migrant workers)
- Communities at transit points as well as in the other areas where migrants are going
- Addressing/ improving the general condition under which people migrate, move and work or live within the mobility system, in particular in terms of access to adequate services ;
- Efforts to provide HIV and STI prevention care and treatment services for migrants and Mobile populations should be in proportion to their HIV risk vulnerability. In general this risk is greater for undocumented migrants;

### *Interventions should be grounded in human rights, promote and protect the human rights of both migrants and host residents;*

Migrants being foreigners in host communities are often stigmatised and see their rights violated. They have are often perceived has “vectors” of diseases and or associated with social problems such as crime, theft, drug use, etc... The reaction to this perception by host communities is often repressive, thus heightening migrants’ vulnerability to HIV.

To counteract this, all stakeholders must ensure that their responses are gender responsive promote and protect human rights and are culturally relevant. All mobile populations – nationals and non-nationals alike – should benefit from access to evidence-informed HIV programmes as part of efforts to achieve universal access to HIV prevention, treatment, care and support and to implement effective responses to HIV.

Legal barriers to HIV prevention, treatment and care services as well as to the free circulation of people living with HIV should be removed has they have no public health justification and are discriminatory. They restrict the participation of HIV positive people in major life activities and reduce their involvement in the response to HIV. They interfere with the rights to life, privacy, liberty, work, the highest attainable standard of health, the rights of women, the rights of the child, the rights of migrants, and the rights to seek asylum and to protect the unity of the family.

As recently highlighted by an International Task Team as well as the UN secretary General , there is no evidence that HIV-related restrictions on entry, stay and residence protect the public health and may in fact impede efforts to protect public health (UNAIDS 2008b).

### *Towards increased multi-sectoral international cooperation and improved HIV / STIs services for migrant and mobile populations*

- Both HIV and migration are impacted by a range of stakeholders, addressing mobility related HIV vulnerability requires a multi-stakeholder and multi-sectoral response;

- Cooperation should be developed with nations that have experience in developing programmes for migrant and mobile people (i.e the Philippines), for example to share good practice and lessons learned, IEC material, tools, etc...however it should be highlighted that good approaches from elsewhere will need to be specifically adapted to fit the Pacific situations;
- Use existing regional platforms/ fora for cooperation within the region (i.e SPC, PIFS) to identify issues, gaps, quantify needs and estimate costs, identify good practices from the region and develop a common approach as well as share and learn from the experience of other regions that have been proactive on HIV and mobility (i.e ASEAN) would be valuable;
- Similarly –in the case of internal migration- use national platforms for cooperation between different sectors (i.e transport, health, mining, entertainment, tourism, private sector, civil society, organisation representing migrants, etc..)
- National ownership is critical. It is the responsibility of governments working with their partners and civil society to lead and coordinate national action to provide HIV services for Migrants and mobile population;
- Empowering migrants and mobile populations is a crucial aspect of lowering their vulnerability to HIV infection. Strategies, programmes and services delivery should be informed by their active participation and contributions. Their efforts, experiences and insights are valuable in all aspects of the national response, from policy development to programme planning, implementation, monitoring and evaluation;
- Greater integration of HIV and STIs into the general health services and other types of services available for migrants and mobile population including should be promoted, similarly in sending communities, these should be strengthened;

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United Nations Development Programme Pacific Centre  
7th Floor, Kadavu House  
414 Victoria Parade, Suva, Fiji Islands  
Tel.: +679 330 0399 Fax: +679 330 1976  
Website: [www.undppc.org.fj](http://www.undppc.org.fj)