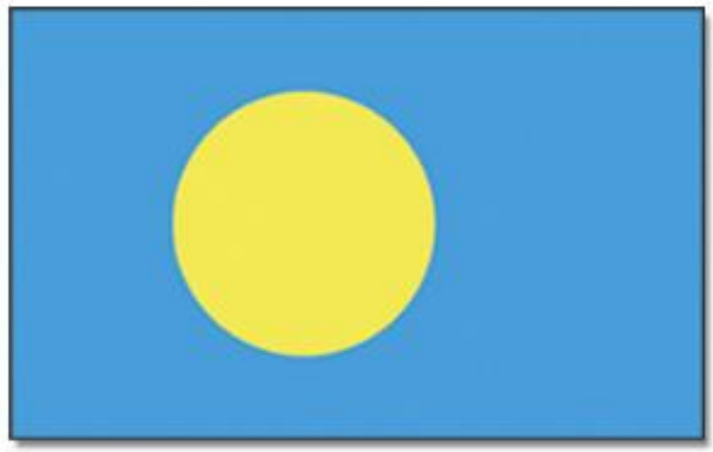
Pacific Multi-Country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations

Palau



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Definitions

Participant inclusion criteria

Female sex workers:

Any female aged 17 years and over who has exchanged sex (oral, anal and/or vaginal) for money or other items of value, over the past 12 months and is currently residing or working in the study area.

Transgender people and MSM:

Any male aged 17 years and over who has had any sexual contact (oral/anal sex, hand jobs, 'rimming', etc.) with a male or transgender person, regardless of his/her gender identity or sexual identity or orientation, over the past 12 months, and is currently residing in the study area.

Seafarers:

Any male aged 17 years and over who is engaged in working on a ship that is docked or based in the study area.

Definitions relevant to all participant groups

Regular partners:

Any sexual partner who the participant considers to be their main or regular non-paying partner. This person could be a spouse, boyfriend or girlfriend.

Casual partners:

Any sexual partner who is not a regular partner or a paying partner.

Commercial partner:

Any sexual partner who has paid the participant money or goods in exchange for sex.

Executive summary

- The incidence of HIV in Palau is low; there have been only 10 reported cases since 1989, of which three were men who have sex with men (MSM) or transgender (TG).
- We estimated that there are approximately 200 MSM and TG in Palau and around 40 sex workers (from the Philippines and China).

Transgender/Men who have sex with men

- Fourteen TG/MSM took part in a behavioural survey and three participated in in-depth interviews. Among these participants, there was a spread of sexual identity across gay/homosexual, bisexual, heterosexual and transgender. Transgender are proud of their identity, but the MSM population is very hidden and is not 'out' at all.
- Of the men and transgender in the survey, 93% had had sexual intercourse and the mean age at sexual debut was 16. Of these, 62% had receptive anal intercourse and 15% had insertive anal intercourse in the last 12 months. None reported sex with a female partner in the last 12 months.
- Overall knowledge about HIV was high in this group, and the participants knew that condoms are a barrier to HIV infection. Even so, condom use was inconsistent and the respondents gave a variety of reasons for not using a condom. In-depth interviews indicated that condom use was based on a judgement about the partner's risk. Condom use with regular sexual partners was low; with casual partners, only one in five had used a condom every time during sex in the last 12 months. Ten out of 13 had used a condom the last time they had anal sex.
- Stigma is common in Palau, especially towards transgender (who are easily identifiable), but physical violence was not reported. Forced sex was not common and only one participant reported forced sex in the past 12 months.
- Most participants knew how to access health services for HIV and STI testing and how to access condoms, but most did not know that they could access treatment and support. Feedback regarding services was positive in the survey, and only one participant said that they felt uncomfortable and embarrassed. However, two interviewees mentioned being unhappy with testing at the hospital clinic.
- Twelve of the 14 participants had ever been tested for HIV, with nine being tested in the past 12 months. None reported being HIV positive.

Female sex workers

- While nine women took part in the survey, only one indicated that she sold sex and so the survey data were not used. Five women were interviewed: three workers and two informants. Some of these interviews were informal and, because the participants declined, they were not tape recorded. Sex work in Palau is organised around entertainment venues and consists of Chinese and Filipina.
- There was a reported decline in the sex work trade as there were no longer military forces based in Palau and the tourist demographics had changed. Some venues where sex work occurred had closed.

- Sex work is undertaken from KTV (karaoke) bars (and some from massage parlours). Staff in bars work long hours. While none of the women interviewed had been trafficked, vulnerability to trafficking charges means that it is difficult to engage with sex workers in their workplaces.
- Chinese workers come from one province in China. Most stay at least a year and come to Palau to earn money for their families, although wages are not high.
- Most clients are either locals, foreign businessmen or Chinese men working in Palau. Condoms are provided by managers, who pick them up from the public health clinic. Condom use seems to be inconsistent and often dependent on the client.
- There are no established networks of female sex workers (FSW) outside the workplace and FSW are isolated from their families. KTV workers are considered by Palauans to be the lowest class of person and are highly stigmatised.
- The FSW do not use the health services and generally consider them to be very poor. They are reliant on their own resources and the medicines that they bring from their own country.

Capacity assessment

- The Palau Bureau of Health is the only identified agency providing HIV and STI-related services. No organisations specifically target MSM and TG, although the Health Information and Resource Centre is MSM and TG-friendly. There are no services provided for sex workers, since the Ladies in the Entertainment Business project ceased in 2013.
- HIV and STI testing is provided by the STD laboratory at the hospital. This deters some from testing and in-house clinic days at the Centre would be preferred.
- The major strengths of the HIV program are that it is integrated with HIV testing and treatment services; the program has in the past had good engagement with sex workers; the STI and HIV prevention staff have good connections with the TG community and, to a lesser extent, MSM; and the Resource Centre has a good selection of condoms and lubricant.
- Key needs are targeted programs and long-term funding for program staff, and record-keeping processes for HIV activities (condom pack distribution, condoms taken from clinics, etc).

1 Introduction

This research was carried out as a response to the need for greatly increased, contextualised information about the vulnerability to HIV of MSM/TG and sex workers and seafarers in many Pacific countries. The study provides:

1. An operational baseline for the implementation of the Integrated HIV/TB multi-country grant in the Pacific and for the Pacific Regional Sexual and Reproductive Health Programme.
2. Quantitative and qualitative data to inform relevant interventions aimed at reducing the HIV and STI risk vulnerability of key populations.
3. Specific evidence of barriers to prevention, in order to improve the effectiveness of prevention interventions and develop a strong advocacy case for legal and social transformation.

The key specific aims that the *Multi-country Mapping and Behavioural Study: HIV and STI Risk Vulnerability among Key Populations* must achieve in order to fulfil the objectives in each country are to:

- Estimate population sizes of vulnerable groups – sex workers, MSM/TG and, in some countries, seafarers – through a variety of methodologies.
- Identify demographic and behavioural factors (for example, sexual behaviours, mobility, drug use, history of STIs, and so on) that represent risk practices in each of these groups, as well as access to services and experiences of stigma, discrimination and violence, through a quantitative survey design. This survey must include baseline values for quantitative indicators for reporting obligations.
- Identify through in-depth interviews the social and structural determinants influencing these risk factors, including stigma, human rights violation, all forms of violence, discrimination, and socio-economic marginalisation and exclusion, as well as community norms, expectations and subcultures that can be facilitators or barriers for the uptake of HIV and STI prevention, care and support services.

2 Palau

Palau is an island nation located in the south-west portion of the North Pacific Ocean. The estimated mid-year population in 2010 was 20,879 persons, consisting of 73% Palauans and significant migrant populations from the Philippines, China, Taiwan and Japan (Office of Planning and Statistics, Republic of Palau 2010). Around 70% of the population of Palau resides in Koror, which is the economic centre and major port. The economy of Koror, which reflects that of the nation as a whole, is centred on tourism and fishing but is highly dependent on foreign aid (Asian Development Bank 2009).

The reported incidence of HIV is low in Palau. Since testing began in 1989, there have been 10 reported cases, all of which were of Palauan ethnicity and from Koror (Palau Ministry of Health 2015). It is difficult to fully ascertain the status of HIV in Palau, as no adequate information exists for many key indicators (ibid). Second-generation surveillance surveys conducted in 2006, aimed at investigating knowledge and behaviours surrounding HIV and other STIs, failed to gather data from crucial groups (AusAID 2009). There are specific vulnerabilities to HIV in the Palau context, including high rates of STIs; increasing travel and migration, especially to areas with higher HIV prevalence; the presence of many risk behaviours; stigma and discrimination, often associated with denial and misinformation – including refusal to take HIV seriously; and difficulties in discussing HIV issues. The uptake of 'walk-in' testing for HIV remains very low and reflects the stigmatisation of the disease and the perception that HIV is a foreign problem (Palau Ministry of Health 2012). Also, perceived issues of confidentiality present a significant barrier to higher rates of testing (ibid).

2.1 Men who have sex with men and transgender

While some sources report the contrary (Palau Ministry of Health 2014), MSM and TG populations have been identified in Palau. The 1991 Palau Health Survey reported that 4.3% of males identified as homosexual or bisexual (Gold et al 2007), and a 2006 second-generation surveillance survey of young people recruited 12 MSM to take part in the survey; however, due to the small sample size recruited, they were excluded from the results (SPC 2008). Voluntary HIV testing is uncommon among MSM and TG in Palau, with only three reported tests of known MSM or TG occurring in 2004 out of 1,084 tests overall (Gold et al 2007), although this may be due to MSM/TG being unlikely to self-identify in services. The MSM population is faced with stigma and discrimination, and their behaviour remains mostly hidden (McMillan et al 2015). There are currently no community groups or health initiatives aimed at this population. Transgender persons also experience stigmatisation and are a marginalised community, with no prior research having been carried out concerning their sexual health.

2.2 Female sex workers

There is one prior study of sex work in Palau (McMillan et al 2015). Results from this qualitative project indicated that sex work was most commonly undertaken by hostesses in the entertainment and hospitality industry. The majority of hostess workers in Koror came from China or the Philippines, and the workplaces typically differed by the country of origin of the workers. The circumstances, concerns and needs of Chinese hostess workers with regard to paid sex and HIV and STI prevention differed in many respects from those of Filipina hostess workers. The 2015 report indicates that Filipina hostesses in KTV bars served drinks, danced, sang and/or talked with customers. Kissing, cuddling and being physically handled by male patrons who pay for drinks was standard practice in most hostess establishments. VIP and other private rooms afforded in-house venues where sex could take place. Some establishments also provided call-out services. Clients frequently expected that hostesses and masseuses who were booked for callouts would also negotiate sexual services. Interviewees said that it was the worker's decision whether or not to provide sexual services.

Employment agents in the Philippines routinely misled prospective hostess workers over the nature of the role and the salary, and they charged high fees for placements. However, while some hostesses had been misled about the job that they were contracting to do, all the hostess workers had freely chosen to come to Palau, had entered the country legally, and had been granted valid work visas before entry. Similarly, while some hostesses were unhappy in their employment, financial considerations and visa conditions constituted a strong deterrent to terminating contracts. No hostesses were held against their will or prevented, by employers, from returning home. Few hostesses arrive in Palau intending to engage in sex work; however, a number of contextual factors create strong incentives to undertake paid sex. In addition to the hostess dress code, sexualised behaviours and employment practices positioned them as employers' chattels – available to be bought. While these factors, along with debt and low wages, created incentive and opportunity to undertake sex work, reportedly none of the hostesses had been coerced into selling sex. Due to stigma and fears of prosecution and deportation, hostesses are unwilling to identify as sex workers. HIV prevention programs for sex workers should be embedded first in hostess programs.

There are informal prevention interventions for sex workers that allow for interventions to take place without formally defining sex workers, as sex work is illegal in Palau (Palau Ministry of Health 2014). Outreach occurred through the Ladies in the Entertainment Business program, which is no longer funded.

3 Methodology

The research in Palau attempted a variety of methods of a cross-sectional (snapshot) design. Ethical approval for the project was obtained from the UNSW Human Research Ethics Committee and from the Palau Ministry of Health.

Fieldwork was undertaken between 10 and 29 February 2016 in Koror. Two local research assistants and one female Chinese research assistant were hired and trained to help in the collection of data.

3.1 Population size estimation

3.1.1 Men who have sex with men and transgender

A mapping exercise estimated the size of the MSM/TG population. Because there are no services for MSM and TG, there are no service data collected. Any data collected for HIV/STI testing are reliant on self-identification. Service providers say that self-identification is highly unlikely in a context where sex relationships between males are so covert. A roundtable meeting was not possible with this population, as members did not want to meet with other MSM/TG, and definitely not with service providers or other stakeholders.

Instead, TG and MSM were asked to estimate the size of the population, on the basis of people whom they know and their own various sexual partners, including heterosexual identified men who sometimes have sex with MSM or TG.

Palauan MSM and TG informants were asked individually and in groups of two where possible. All gave estimates of at least 200 and most thought that 200 was a conservative estimate.

TG from the Philippines could not offer any estimate, as they said that their social networks were very limited and they only knew their own friends.

3.1.2 Female sex workers

This estimate was based on a head count, plus enquiries as to the number of staff working in establishments that function predominantly as sex work venues/brothels. A venue was defined as being predominantly a sex work venue/brothel (that is, it might also be a bar) on the basis of three key criteria:

- assertions made by several key informants (such as an ex-brothel manager and clients)
- private rooms available at the venue
- an assertion made by at least one of the workers.

Additional evidence included:

- expressions of shock from management and a reluctance to offer service to women researchers entering the venue
- manager requests that we leave because if we (female researchers) sat in the bar area, it would discourage customers and hinder business
- bedrooms visible from the main bar area
- witnessing price negotiations with seafarers.

From this count, we estimated around 40 or more female sex workers in total. These figures are based on the number of establishments that could not be defined as brothels but where previous research has indicated that sex work is sometimes undertaken by at least a third of the staff, and there is likely to be a similar number of hostesses who undertake sex work occasionally as a supplement to their hostess earnings.

3.2 Behavioural survey and interviews

3.2.1 Behavioural survey of men who have sex with men and transgender

A behavioural survey captured quantitative information from MSM and TG about sexual behaviour, mobility, drugs and alcohol, STIs, and stigma and discrimination, as well as access to and assessment of services. In-depth interviews were conducted with members of key populations, collecting qualitatively rich data that described the circumstances and experiences of key populations over a range of issues.

A snowball method was the only viable option to recruit MSM and TG. Fourteen men took part in the survey. We initially recruited three potential research assistants, but only one participated in data collection. Others were helpful sources of information and key informant introductions, but were unable to recruit participants (because of either lack of time, lack of standing in the community, potential conflicts or other personal/interpersonal issues).

Recruitment was very slow, due to significant privacy concerns and trust issues among the population. Among the Palauan MSM and some TG, being identified to a third party is considered highly offensive. The recruitment slowed, but had not come to a halt by the time the data collection period was up.

3.2.2 Female sex workers

The behavioural survey was attempted for both Chinese and Filipino female sex workers. Invitations to participants were extended to hostess staff at known sex work venues, including during visits by a Mandarin-speaking researcher from mainland China. Researcher contact with the workers had to be approved by the *mamasan,* whose permission was necessary to access staff. Even where staff had told the researchers otherwise, these managers denied that any sexual behaviour occurred. This made it difficult to obtain reliable data collection from the staff. Asking hostesses to self-identify as sex workers was not feasible in a climate where all sex workers are at risk of being caught up in trafficking-in-persons cases, which are increasingly being laid in Palau. Managers are even more vulnerable and cannot risk permitting staff to self-identify as sex workers. A roundtable discussion group that included FSW was not possible due to confidentiality concerns and an inability to identify and gather a group of FSW outside of work premises. In addition, FSW are not networked in Palau and they only know the others who work at the same establishment.

3.3 Institutional capacity assessment

There is no data on health service utilisation by MSM and TG and by FSW. Due to the legislative environment, no FSW will willingly self-identify to health services. There are no HIV interventions or outreach programs targeting sex workers in Palau. The Palau Bureau of Health was the only identified agency providing HIV and STI-related services. There are no non-governmental organisations (NGOs) or community-based organisations (CBOs) that provide any sexual health (voluntary confidential counselling and testing, condoms, information or education) or social services to the identified population groups at risk of HIV (MSM/TG and FSW).

4 Results

4.1 Behavioural survey

4.1.1 Transgender and men who have sex with men

4.1.1.1 Description of the sample

Fourteen self-identifying transgender (TG) and men who have sex with men (MSM) provided survey data. In describing their gender, five participants described themselves as men while six described being transgender, one described being a woman, another described being transsexual, and one answered 'other' and then indicated their gender as 'gay'. Participants were also asked to describe their sexual identity (Table 1). There was a range of categories provided to participants in addition to the ones that participants chose; these are shown in Table 1. The majority of responses were for gay/homosexual or transgender. While two participants indicated being bisexual, none reported being 'straight' or heterosexual.

Table 1: Sexual identity

	Frequency	Percent (%)
Gay/Homosexual	6	42.9
MSM	1	7.1
Bisexual	2	14.3
Transgender/Fa'afafine/Fakaleiti/Akavaine	5	35.7
Total	**14**	**100.0**

The age of participants ranged from 20 to 54, with a mean age of 32 (SD=11.09) and a lower median age of 26. All participants had completed primary school and six had been educated to university or college level (Table 2).

Table 2: Highest level of education

Level of education	Frequency	Percent (%)
Pre-secondary	5	35.7
Secondary/Technical school	3	21.5
Polytechnic/Diploma	1	7.1
University/College	5	35.7
Total	**14**	**100.0**

In responding to the question about relationship status, a majority of participants reported being single (Table 3). The remainder all reported having a boyfriend.

Table 3: Relationship status

	Frequency	Percent (%)
Currently single	11	78.6
Have a boyfriend	3	21.4
Total	**14**	**100.0**

The majority of participants reported living alone or living with parents or a boyfriend/husband (Table 4).

Table 4: Whom participants were living with (n=14)*

	Frequency	Percent (%)
Parents	5	35.7
Live alone	5	35.7
Boyfriend/Husband	3	21.4
Siblings	2	14.3
Other relatives	1	7.1

* Multiple answers possible.

A majority were employed, mostly in full-time work. Two were unemployed (Table 5).

Table 5: Employment status

	Frequency	Percent (%)
Full-time employment	8	57.1
Part-time or casual employment	3	21.4
Not employed	2	14.3
Self-employed	1	7.1
Total	**14**	**100.0**

When asked to indicate their main job, the 12 who were employed indicated a range of different types of work, as shown in Table 6.

Table 6: Type of work (n=12)

	Frequency	Percent (%)
Community, social and personal services	5	40.4
Financial and business services	2	16.7
Wholesale and retail trade	2	16.7
Professional	3	26.2

4.1.1.2 Sexual history and practice

Thirteen of the 14 participants (92.9%) indicated that they had ever had sexual intercourse. Of these 13 people, their first occasion of sexual intercourse occurred between the ages of 11 and 20, with the mean age of sexual debut being 16 (SD=2.90). Four participants reported being in more than one sexual relationship concurrently in the previous six months.

Participants were asked to report on the types of sexual activity that they had engaged in during the last occasion on which they had sex with a male partner (Table 7). Of the 13 participants who answered this question, the majority had engaged in receptive anal intercourse with fewer having engaged in insertive anal intercourse.

Table 7: Types of sexual activity on last occasion of sex with a male partner (n=13)*

	Frequency	Percent (%)
Handshake (you masturbated him)	6	46.2
Handshake (he masturbated you)	6	46.2
Oral sex (you sucked his penis)	6	46.2
Oral sex (he sucked your penis)	8	61.5
Intercrural sex (his penis between your thighs)	3	23.1
Intercrural sex (your penis between his thighs)	2	15.4
Anal intercourse (your penis inside his anus)	2	15.4
Anal intercourse (his penis inside your anus)	8	61.5

* Multiple answers possible. Missing data n=1.

Types and numbers of male partners

Participants were asked how many male sex partners they had had in their lifetime and in the last 12 months. The most commonly reported number of male sex partners in the 12 months prior to the survey was between one and three, whereas over the lifetime almost 40% of participants indicated having had more than 10 male partners, with three participants having had more than 50 male partners (Table 8). One participant reported having no male partners in the previous 12 months.

Table 8: Number of male sexual partners

Number of male partners	Lifetime n (%)	Last 12 months n (%)
0	0	1 (7.1)
1 to 3	3 (23.1)	7 (49.7)
4 to 10	5 (38.4)	5 (35.5)
11 to 49	2 (15.4)	1 (7.1)
50+	3 (23.1)	0
Total*	**13 (100)[1]**	**14 (100.0)**

[1] Missing data n=1.

All 13 participants who reported having had sexual intercourse in the previous 12 months were asked how many of their male sex partners during that period were regular partners, casual partners and paying partners (Table 9). Five participants reported having had at least one regular male sexual partner during the previous 12 months with whom they had anal intercourse. Eight participants reported having had no regular male partners during that period. Seven participants reported having had anal intercourse with casual male partners during the previous 12 months, and three participants reported anal intercourse with male partners who paid them for sex.

Table 9: Number of regular, casual and paying male sexual partners with whom participants had anal intercourse in the 12 months prior to the survey

Number of partners	Regular partners frequency (%)	Casual partners frequency (%)	Paying partners frequency (%)
None	8 (61.5)	6 (46.2)	10 (76.9)
1 to 3	5 (38.5)	5 (38.4)	2 (15.4)
4 +	0	2 (15.4)	1 (7.7)
Total	**13 (100.0)**	**13 (100.0)**	**13 (100.0)**

Condom and lubrication use for anal intercourse with male partners

Condom use with the three different types of male partners in the last 12 months is shown in Table 10. Condom use with regular partners was understandably low. A majority of the seven participants who had anal intercourse with casual partners reported condom use with those partners almost every time or every time. None of the participants who earlier reported sex with paying partners chose to answer questions about condom use with those partners.

Although not reported in Table 10, two of the five participants who reported sex with a regular male partner reported using a condom on the last occasion with that partner. Five of the seven participants who had sex with casual male partners reported condom use on the last occasion of anal intercourse with a casual male partner.

The use of lubrication for anal intercourse was high. All five people who had sex with a regular male partner in the preceding 12 months reported using lubrication the last time they had anal intercourse with that partner. Also, all seven participants who had casual partners reported using lubricant on the last occasion of anal intercourse with a casual partner.

All participants were asked whether they used lubricant the last time they used a condom, to which 10 of the 13 answered the question in the affirmative. When asked which type of lubricant they used on that occasion, nine reported using water-based lubricant while one reported the use of coconut oil. Participants obtained lubricant on that occasion from various sources, including peer education worker (n=2), condom dispenser (n=1), NGO (n=1), pharmacy (n=2), friend (n=1), health clinic (n=1), hospital (n=1) and a store in Palau (n=1).

Table 10: Consistency of condom use with different types of male partners in the last 12 months

Regularity of condom use	Regular partners n (%)	Casual partners n (%)	Commercial partners n[1] (%)
Never	2 (40.0)	2 (28.6)	–
Sometimes	1 (20.0)	1 (14.3)	–
Almost every time	2 (40.0)	3 (42.9)	–
Every time	0	1 (14.3)	–
Total	**5 (100.0)**	**7 (100.0)**	**–**

* Missing data n=3.

Female partners

Four of the 13 participants who answered the question about ever having had sexual intercourse (vaginal or anal) with a female partner reported that they had. None of the four reported having sex with a female partner during the 12 months preceding the survey. The four participants reported having between two and four female partners in their lifetime. Since all condom use questions were asked in the context of the preceding 12 months, and given that no participants had sex with a woman during that period, there was no condom use data to report on for sex with female partners.

Obtaining condoms and reasons for not using them with male and female partners

All 13 participants who answered the question reported knowing what a condom was prior to the survey. Twelve of the 13 knew where to obtain condoms. Participants who had ever used condoms were asked where they had last obtained them (Table 11). A majority had last obtained condoms from peer educators/outreach workers or from a health clinic. The remainder of participants had last obtained condoms from a range of sources, including friends, hospital, NGO and condom dispenser.

Table 11: Where participants last obtained condoms for sex with male or female partners

	Frequency	**Percent (%)**
Peer educator/outreach worker	4	30.8
Health clinic	3	23.1
Friend	2	15.4
Hospital	2	15.4
NGO	1	7.7
Condom dispenser (bar/nightclub/restaurant/other venue)	1	7.7
Total	**13***	**(100.0)**

* Includes only participants who had ever used condoms.

The most commonly reported reasons for not using condoms with male or female partners included condoms taking away pleasure and not liking condoms (Table 12).

Table 12: Reasons for not using condoms with male and female partners*

	Male partners n=13 (%)	**Female partners n=2[1] (%)**
Condoms take away pleasure	4 (30.8)	0
Do not like condoms	1 (7.7)	0
Condoms were not available	6 (46.2)	1 (25.0)
Difficulty obtaining condoms	0	0
My partner(s) and I are faithful	3 (23.1)	0
Partner objected	2 (15.4)	0
Not necessary	2 (15.4)	0
Condoms are too expensive	0	0
Used other prevention methods	1 (7.7)	0
Other (‘too drunk’)	1 (7.7)	1 (25.0)

* Multiple answers possible. Includes only those who reported some occasions of not using condoms. [1] Missing data n=2.

4.1.1.3 Sexually transmissible infections, including HIV

Thirteen participants reported ever having heard of diseases that can be transmitted sexually. Among these participants, none reported having had symptoms of a sexually transmissible infection (STI). Two participants reported ever having been diagnosed with an STI, which included gonorrhoea (n=1) and syphilis (n=1). There were no data reported on how these two participants responded to having an STI symptom.

Thirteen participants reported having ever heard of HIV or the disease called AIDS prior to the survey. The most commonly reported sources of information about HIV and AIDS were school, television, posters/billboards and newspapers/magazines (Table 13). Four participants reported knowing someone who was infected with HIV.

Table 13: Sources of information about HIV and AIDS (n=13)*

	Frequency	Percent (%)
School	11	84.6
Television	10	77.0
Posters/Billboards	9	69.2
Newspapers/Magazines	9	69.2
Pamphlets/Leaflets	8	61.5
Workplace	8	61.5
Friends or family	8	61.5
NGO program	6	46.2
Radio	5	38.5

* Multiple answers possible. Includes only those men who reported having heard of HIV or AIDS.

The 13 participants who had previously heard of HIV or AIDS were asked a series of questions to assess their knowledge of HIV and its transmission. Correct responses are shaded in Table 14.

Table 14: Knowledge about HIV and AIDS (n=13)*

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Can a person get HIV from mosquito bites?	9 (69.2)	4 (30.8)	0	13 (100)
Do people get HIV because of something they have done wrong?	13 (100)	0	0	13 (100)
Can a person reduce the risk of getting HIV by using a condom every time they have sex?	2 (15.4)	11 (84.6)	0	13 (100)
Can a person get HIV by sharing food with someone who is infected?	13 (100)	0	0	13 (100)
Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	4 (30.8)	9 (69.2)	0	13 (100)
Can a healthy-looking person have HIV?	0	13 (100)	0	13 (100)
Can people be cured from HIV by a traditional healer?	13 (100)	0	0	13 (100)
Can a pregnant woman infected with HIV or AIDS transmit the virus to her unborn child?	0	13 (100)	0	13 (100)
Can a woman with HIV or AIDS transmit the virus to her newborn child through breastfeeding?	4 (30.8)	7 (53.8)	2 (15.4)	13 (100)
Can a pregnant woman take medicine to reduce the risk of transmission of HIV to her unborn child?	3 (25.0)	6 (50.0)	3 (25.0)	12[1] (100)

* Includes only those men who reported having heard of HIV or AIDS. [1] Missing data n=1.

Correct knowledge was high among this group. While only one of the 13 participants answered all 10 knowledge questions correctly, 11 participants answered eight or more questions correctly. The lowest score recorded was six of the 10 questions answered correctly.

4.1.1.4 Stigmatising attitudes towards people living with HIV

A majority of the 13 participants who had heard of HIV had non-stigmatising attitudes towards people living with HIV (Table 15). However, a majority indicated that if a family member had HIV they would want it to remain a secret.

Table 15: Attitudes towards people living with HIV among participants (n=9)*

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
If a relative of yours became ill with HIV, would you be willing to care for him or her in your household?	1 (7.7)	12 (92.3)	0	13 (100)
If a member of your family had HIV, would you want it to remain secret?	5 (45.5)	6 (54.5)	0	11[1] (100)
Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?	1 (7.7)	12 (92.3)	0	13 (100)

* Includes only those men who reported having heard of HIV or AIDS. [1] Missing data n=2.

Stigma and discrimination observed in the community

Participants were also asked questions about evidence of stigma that they had observed in the community (Table 16). Only one participant was aware of anyone being denied health services in the previous 12 months as a result of living with HIV or being suspected of living with HIV. One participant was also aware of someone being verbally abused because of HIV.

Table 16: Evidence of stigma and discrimination observed in the community (n=13)*

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Do you personally know someone who has been denied health services in the last 12 months because he or she is suspected to have HIV or has HIV?	11 (84.6)	1 (7.7)	1 (7.7)	13 (100)
Do you personally know someone who has been denied involvement in social events, religious services or community events in the last 12 months because he or she is suspected to have HIV or has HIV?	11 (91.7)	0	1 (8.3)	12[1] (100)
Do you personally know someone who has been verbally abused or teased in the last 12 months because he or she is suspected to have HIV or has HIV?	10 (83.3)	1 (8.3)	1 (8.3)	12[1] (100)

* Includes only those men who reported having heard of HIV or AIDS. [1] Missing data n=1.

Participants reported the reactions of their family, other people, and employers and co-workers to their sexual identity (Table 17). All three groups were reported to be relatively supportive of participants' sexual identity. Ignoring and gossiping about them was the most commonly reported reaction of other people. Employers and co-workers knew about participants' sexual identity and were reported to be supportive.

Table 17: Reactions of family members and other people to participants' sexual identity (n=13)*

	Reaction of family members n (%)	Reaction of other people n (%)	Reaction of employer or co-workers n (%)
They don't know at all	1 (7.7)	2 (15.4)	0
They support my identity	11 (84.6)	12 (92.3)	12 (92.3)
They ignore me/refuse to talk to me	0	3 (22.2)	0
They criticise/blame/verbally abuse me	1 (7.7)	0	0
They conduct violence/physical abuse on me	0	0	0
They lock/restrict me	0	NA	NA
They kicked me out of the family/group	0	0	NA
They force me to work more	0	NA	NA
They gossip about me	0	11 (84.6)	0
They fired me from work	NA	NA	0
Other ('they don't bother'; 'mother is cool with it but have not told father'; 'not out to them yet')	2 (15.4)	0	1 (7.7)

* Multiple answers possible. NA=not applicable.

Emotional and physical well-being

Participants were asked to indicate whether they had experienced any of a list of thoughts and feelings in the preceding 12 months. Only three participants chose to answer these questions, which is not surprising given the negative aspects of these issues. Of those who did respond, the highest response to any of the options was n=1 (Table 18). Due to the poor response rate to these questions, it is not possible to draw any conclusions about emotional and physical well-being.

Table 18: Participants' negative thoughts and feelings about their sexual identity in the last 12 months (n=3)*

	Frequency	Percent (%)
I feel ashamed	1	33.3
I feel guilty	1	33.3
I feel I should be punished	1	33.3
I have low self-esteem	0	
I blame myself	1	33.3
I blame others	1	33.3
I feel suicidal	0	0

* Multiple answers possible. Missing data n=11.

Participants were asked to indicate whether they had done or avoided certain events or activities because of their sexual identity (Table 19). Only four of the 14 participants chose to answer these questions, which is likely to reflect the negative aspects of these issues. Only two responses were confirmed in the affirmative and both were only applicable to one person. These included deciding not to get married and deciding not to have children.

Table 19: Participants' avoidance of events or activities because of their sexual identity in the last 12 months (n=4)*

	Frequency	Percent (%)
I chose not to attend social gathering	0	
I decided not to have children	1	25.0
I avoided going to a local clinic when I needed to	0	
I avoided going to a hospital when I needed to	0	
I withdrew from education/training	0	
I decided not to get married	1	25.0
I decided not to have sex	0	0
I have isolated myself from my family and/or friends	0	
I decided to stop working	0	
I decided not to apply for a job or for a promotion	0	

* Multiple answers possible. Missing data n=10.

Participants were asked whether they had been raped or forced to have sex in the preceding 12 months. One person confirmed that they had been sexually assaulted in that period. When asked who was responsible for the sexual assault, multiple answers were possible. The responses included boyfriend/husband (n=1) and casual partner (n=1), which tends to suggest that this participant was sexually assaulted on more than one occasion.

4.1.1.5 Access to health services

All participants were asked whether they knew where they could access a range of health services (Table 20). A majority (n=11) knew how to access health services for HIV and STI testing and how to obtain condoms, as well as how to access support or HIV and STI treatments.

Table 20: Knowledge about accessing health services (n=13)

	No n (%)	Yes n (%)	Don't know n (%)	Total n (%)
Support	3 (23.1)	10 (76.9)	0	13 (100)
Health-related information	2 (15.4)	11 (84.6)	0	13 (100)
HIV and STI testing	2 (15.4)	11 (84.6)	0	13 (100)
HIV and STI treatment	6 (46.2)	7 (53.8)	0	13 (100)
Condoms	2 (15.4)	11 (84.6)	0	13 (100)

Eleven participants knew of a local organisation providing information or services related to condoms, family planning, HIV and STIs. When asked what the names of any of these organisations were, the following names were reported: National Hospital, Family Health Unit and CDC and Resource Centre at PCC, Health Program and HIRC. Each of the services presented in Table 21 was utilised by almost a majority of participants.

Table 21: Connection with HIV-related and other health services

	No n (%)	Yes n (%)	Not applicable n (%)	Total n (%)
In the past 12 months, have you been contacted by a volunteer or outreach worker from a local organisation that provides information or services related to condoms, family planning, pregnancy, HIV and STIs or sexual assault?	5 (35.7)	6 (42.9)	3 (21.4)	14 (100)
In the past 12 months, have you visited a health service for information or services related to condoms, family planning, HIV and STIs or sexual assault?	8 (57.1)	5 (35.7)	1 (7.1)	14 (100)
In the past 12 months, have you been given condoms through an outreach service, health clinic or drop-in centre?	0	6 (42.9)	8 (57.1)	14 (100)
Have you ever participated in an HIV peer education program?	7 (50.0)	6 (42.9)	1 (7.1)	14 (100)

Five participants provided feedback about the various health services that they had utilised in relation to condoms, family planning, HIV and STIs, or sexual assault. These are reported on in Table 22. The majority of participants who used the service were generally satisfied and would use it again. None of the participants reported being dissatisfied with the service and all indicated that they would use it again. Eleven of the 14 participants reported that they would like to receive additional information about HIV, as well as contact details of any support services.

Table 22: Feedback about health service (n=5)*

	Strongly disagree n (%)	Disagree n (%)	Neither agree nor disagree n (%)	Agree n (%)	Strongly agree n (%)	Total n (%)
The service was easy to access or find	0	0	0	2 (40.0)	3 (60.0)	5 (100.0)
The health worker I saw was friendly and easy to talk to	0	0	0	2 (40.0)	3 (60.0)	5 (100.0)
I felt uncomfortable and embarrassed	1 (20.0)	3 (60.0)	0	1 (20.0)	0	5 (100.0)
The service was confidential and I felt my privacy was respected	0	0	0	2 (40.0)	3 (60.0)	5 (100.0)
I could get what I needed, eg contraceptives, condoms, HIV and STI test, etc	0	0	0	2 (40.0)	3 (60.0)	5 (100.0)
I would use the service again if I needed to	0	0	0	2 (40.0)	3 (60.0)	5 (100.0)

* Includes only those men who reported using the service.

HIV testing

Thirteen participants believed that it is possible for someone in their community to get a test to find out if they are infected with HIV and all knew where to go to receive the test. Twelve participants reported having ever had an HIV test and nine of these people had an HIV test in the 12 months prior to the survey. The most commonly reported place where they had an HIV test was at a government hospital health service (n=9) and private doctor (n=1). Eleven of the 12 people who had ever been tested for HIV reported receiving their HIV results. Of these 11 people, all reported that they were HIV-negative based on that result.

Alcohol and drug use

Ten of the 12 participants who responded to questions about alcohol use reported drinking alcohol in the preceding four weeks. While no-one reported drinking alcohol every day, the majority indicated that they drank alcohol at least once a week (Table 23) Those who drank alcohol were asked how many drinks they had the last time they drank alcohol, with the number ranging from one to 10 drinks, and the median number of drinks being 6.5.

Table 23: Alcohol use in the past four weeks*

	n (%)
I never drink alcohol	0
Never in the last 4 weeks	2 (16.7)
Less than once a week	4 (33.3)
At least once a week	6 (50.0)
Every day	0
Total	**12 (100.0)**

* Missing data n=2.

Participants were asked whether they had taken a range of drugs during the preceding 12 months. A range of drugs were reported to have been used in that period, including marijuana (n=10), heroin (n=1), amphetamine (speed) (n=1), crystal/ice (methamphetamine) (n=1), ecstasy (MDMA) (n=2), kava (n=1), freebase (n=1) and other (n=3), which included DMT, phentermine, tramadol and yellow jacket (Nembutal). When asked whether they had engaged in anal or vaginal intercourse in the previous four weeks after taking alcohol and/or drugs which left them feeling not in control, two participants indicated that that had happened to them.

4.1.2 Female sex workers

Nine women whom we strongly believe, and were advised, sold sex in exchange for money or goods provided survey data. However, when asked in the questionnaire whether they had exchanged sex for money, goods or services, only one of the nine women responded in the affirmative, which meant that the other eight women were not asked further questions. As such, no data for FSW will be reported here.

4.2 Interviews

4.2.1 Female sex workers

A formal interview was undertaken with one Chinese sex worker, informal discussions were held with three other Chinese sex workers in another venue, and two informant interviews were taken with previous workers known to the Team Leader (one Chinese and one Filipino).

4.2.1.1 Social and structural factors

The context of sex work in Palau has changed since the 2015 report *Risky Business Palau: Hostessing, Sex Work and HIV Prevention in Koror* (McMillan et al 2015). Tourist numbers in Koror have increased, but the demographics have changed. Tourism is now dominated by Chinese tour groups that cater primarily for families and couples on holiday. Much of the tourist activity is provided in-house (including the provision of bus and boat trips). A key Filipina informant said that the sex industry had declined: there were no more US military stationed there, tourist demographics had changed (dominated by Chinese families and couples, rather than Korean and Japanese men and male divers), and the numbers of Korean businessmen had decreased. The owners of one of the major sex work businesses in the area had recently moved offshore to the Marshall Islands, where there are fewer competitors.

To date, sex work is known to have been undertaken from KTV and massage venues. Several businesses run both a massage parlour and a KTV bar. Sex work is more commonly undertaken from KTV venues than from massage parlours. Staff in KTV bars work long hours and are only accessible (to researchers and outreach workers) in their workplaces, where they often also live in attached barracks. Female managers (*mamasans*) are gatekeepers who control access to workers at these sites.

It is far more difficult now than it was in 2014 to engage with FSW. This is due to a lack of trust, and a context of heightened vulnerability to trafficking charges: a number of KTV and massage businesses have been closed down and managers have been charged with trafficking-in-persons offences. More specifically, factors hindering engagement with FSW in Palau include:

- There have been no outreach activities or condom distributions since 2014.
- Staff and management turnover means that current staff and management have no memory of previous outreach activities and no reason to trust outsiders.
- Management no longer accept condoms, and insist that there is no need for them.
- There has been a history of health researchers visiting massage parlours and taking blood from staff for HIV and STI testing without informed consent. Workers resented this and feel that they are obliged to undergo blood tests as a condition of their visa. So, when our researchers first introduced themselves as wanting to conduct health research, all potential respondents refused. When our researchers introduced themselves as social researchers, the potential respondents were more inclined to hear us out. There was concern that we would want to take blood.

Other factors include the legal environment where, in keeping with the US State Department definition of trafficking in persons, any migrant FSW is defined as trafficked. This definition has attracted considerable worldwide criticism. Migrant women workers effectively have no rights or protections as KTV workers. When caught up in trafficking cases against their employers, FSW are forced to choose between being labelled a victim or a perpetrator of sex trafficking. As well, any claims or evidence of sex work are the basis for trafficking-in-persons charges. In some cases, condoms have been taken by police as evidence of sex work. Sex workers' fear of being entangled in trafficking charges renders them more isolated and marginalised. Management's fear of facing trafficking charges makes them resistant to outreach or research engagement.

4.2.1.2 Interview data

There are four venues where Chinese sex workers are employed. These women come from Liaoning province in Northern China and are brought to Palau on entertainment visas. Some come on short-term visas (three months) and others for longer (one year). The women are not young – both interviewees were in their 30s and were supporting children back in China.

Within some Palauan entertainment industry companies, workers may shift from KTV work to massage work, if they do not wish to undertake sex work. Earnings are much lower for massage work, as the pay is often commission based. Although massage work is higher status, as it is considered to be skilled, workers earn much less in the massage parlour than they can if they undertake sex work in a KTV bar. Not all female staff in all KTV venues are sex workers, however.

Before she came to Palau, Interviewee 1 was a masseuse in her home city. Her monthly income was 4,000 to 5,000 CNY. She was recruited by an acquaintance and introduced to an agent, whom she paid to arrange the job. She came to work in Koror as a masseuse and was offered work as a sex worker in the KTV bar. At first she declined and worked only in the massage parlour associated with the business. Working in the massage parlour, she soon realised that she couldn't earn any money because there were so few clients and her pay was commission based. So she transferred back to the KTV bar, where she now does sex work and can earn US$900 to US$1,000 per month. This is only slightly more than she earned in China but, because she has few overheads in Palau and living expenses are very low, she can save or send home nearly all of her income. She is saving for her son's future education in China. She will stay for a year before returning home.

Most clients are locals, foreign businessmen or seafarers. Interviewee 1 said that the clients at her KTV bar are typically Palauan men and Chinese men working in Palau.

Condoms are provided by the manager, who picks up free condoms from the public clinic. While Interviewee 2 reported always using condoms with clients, Interviewee 1 stated that condom use depended on the client. The clients do not pay more if they do not want to use condoms, so there is no difference in income. Interviewee 2 viewed condoms primarily as contraceptives and when not using condoms she relies on the oral contraceptive. This interviewee knew very little about HIV and STI and said that she has no access to health information or medical services. Interviewee 2 told us that she always used condoms because if she missed one time and caught a disease she would not be able to explain that to her family. She understood that she ran the risk of disease transmission and that condoms offered protection in this regard.

The women are not earning large sums of money. Those working in the massage industry say that the massage business is in decline due to a decrease in custom. Also, a number of KTV bars have closed since the researchers last visited in 2014. No new KTV bars have opened. However, there are few reasonable work options open for these women in China.

There are no FSW networks in Palau outside the workplace, and FSW are isolated from their own families (which they are often supporting financially) and are marginalised in Palau. Migrant workers are poorly paid and have little status in Palau in general. KTV hostesses have low status. They are the most highly stigmatised group, as they are considered to be FSW. Among Palauans, KTV workers are all considered to be sex workers. Interviewee 2 felt that she was considered the lowest class of person and had been 'abandoned' in Palau. She said that there is no Chinese embassy and the Palauan government does not care about the Chinese women living and working there. She said that she can't afford to go home to China.

The women we talked to had not been trafficked. The three women we talked to informally all said that they were aware of the kind of work they would be doing before they arrived. At least one of the staff worked at both the massage parlour and the KTV bar. Another said that she was coming and going between China and Palau on tourist visas, staying and working in Palau for three months at a time. The third woman had only been in Palau for five days. Interviewee 1 did not have a contract. She was neither forced by anyone else to do sex work, nor would she have been stopped from leaving whenever she wanted.

Anti-trafficking efforts seriously hinder engagement with FSW, further isolating them and generating fear. Police action, and subsequent media coverage, exacerbate a focus on trafficking as sex work and sex work as trafficking – at the same time diverting attention from the pervasive problem of the lack of rights and the poor working conditions of all migrant workers in Palau.

FSW are reliant on their own resources and on the advice and medicines of others in the workplace. Interviewee 1, who was in her mid-30s and a single mother, thought that the health services in Palau were poor, the equipment was inadequate, and language was a barrier to interacting with any service providers. If she got ill, she would rely on the antibiotics that she brought with her from China, and on taking some days off to recover. If she didn't recover this way, she would rather go back to China to see a doctor than see one in Palau. Interviewee 2 told us that despite being sick (she had been off work for several weeks), she had not tried to use any Palauan health services because they were too expensive. Interviewee 2 also said that no outreach workers had ever come in the two years that she had been working at the KTV. Interviewee 3 was a key informant who been a manager of a KTV bar brothel for eight years but was not now in that business. She said that during that time she had appreciated the outreach work and the Taiwanese doctor visits, which she had welcomed to her business. But then they ceased.

4.2.2 Transgender and men who have sex with men

In-depth interviews were carried out with three transgender. Two of these interviews were recorded and one refused to be audiotaped. All lived in Koror. No men who have sex with men consented to be interviewed.

4.2.2.1 Social and structural factors

Male-to-male sex is illegal in Palau, and sodomy is a crime under the *Code of Palau,* Title 17 Cap 28 Section 2803. The penalty is imprisonment for not more than 10 years. This law is based on those of the US, which draw from common law traditions. While Palau law enforcement does not appear to enforce its sodomy laws, the existence of male-to-male sex criminal offences contributes to stigma and is harmful to HIV responses (Godwin 2010).

4.2.2.2 Stigma

MSM and TG are highly stigmatised. Unless they are at work, or out with family and friends, Palauan TG tend to keep a low profile, so as to avoid harassment. Migrant TG suffer the most blatant harassment when out alone. All of our transgender interviewees reported some abuse towards them from the general public (especially those from the Philippines, who lack the protection of family) on the streets and in venues. One interviewee said:

> Once in a bar, one guy around 40 years old, he called me names … he said to me in Palauan, 'You are gay what are you doing here?' He got pissed off and started saying a lot of things and cursing and came running towards me … I'm scared and ran away.

However, none of the interviewees reported physical violence. Most of the name calling against Palauans identifying as TG began in high school, as the interviewees began to show their feminine identities in behaviour and dress, 'just bad words … I just ignore them and don't let them touch me' (Interviewee 3).

Public attitudes are said to be more accepting as more individuals 'come out' (to their families and immediate social circles). In Palau, TG generally feel safe and comfortable among intimate friends and family groups, but outside these circles they feel vulnerable. The close circles of friends, family and workplace are integral to social support. Mothers were very important in the process and most accepted and were supportive of their sons in the end:

> My mum gave up trying to stop me from wearing makeup. She'd always look at me and say, 'You're not a girl. You are a boy.' But I didn't change and in the end she stopped saying that. (Interviewee 1)

> I am the only transgender in my family, so I am the mama's boy, so my mum has been one hundred per cent supportive, but I don't know if she knows I am having sex with men. (Interviewee 2)

The church is not described as being accepting. It does not banish transgender; however, it is experienced as being judgemental:

> The only problem is religion, I go to church, I am Catholic [and] most of the elders they just stare and I know that they are like: 'Why is he dressed like this in church?' I am not dressed like a bad person. I dress nicely, wear some earrings.

4.2.2.3 Identity

Although this group has experienced homophobia and gossip, all are proud of their identity as transgender. Transgender describe themselves as 'she', are feminine, and say that they know of no cultural tradition of transgender in Palau. In Palau, coming out as transgender is usually a matter of dress and physical presentation, rather than anything spoken or discussed:

> A year or two ago I just identified as transgender. I told myself I was transgender, I never told anyone else … I would just dress up as a transgender and let them see me as a transgender. (Interviewee 2)

> When I finished high school then I started to come out … I started to put on some earrings and leave my hair long and put on some make-up, so I stared doing that, and I am happy that I am not ashamed of myself. (Interviewee 1)

Not all self-identified transgender (that is, born males who consider themselves to be a she) adopt a highly feminised presentation, however. This is not simply shyness but also a lack of interest in wearing feminised clothes and make-up.

4.2.2.4 Work

Migrant TG work in 'beauty shops' as hairdressers and manicurists. For all TG, the workplace appears as an important site of social acceptance and offers a safe place from which to be 'out' in the public eye. One interviewee told us:

> I wanted to work in the shopping centre – a grocery store because I like to meet a lot of people … and I talk to them, because I am not shy, so I'm trying to talk to them: 'Hi, my name is Clare, I am from …' and then 'Where are you from?' It kind of helps me – it makes me more open to everyone, and they accept me. Now I have a lot of customers.

Migrant TG say that they are more focused on work (earning money) than on sex, and that is why they are in Palau.

4.2.2.5 Sexual relationships

Most of the TG we spoke to had begun having sex with males while in high school. Some had sex with girls before having sex with men. While many TG would like a steady relationship, most relationships are short term – mostly involving local straight men:

> Most of the men I slept with, they don't want a steady relationship and stuff, they just want to do these sex things, once or twice just for pleasure, and that is it, so pretty much there is no relationship.

The relationships that they did have were sporadic, lasting only for a few months.

In general, Palauans are extremely discrete about their own sexual relationships and those of others. Discretion is expected, particularly in regard to TG sexual partners. TG have relationships with men who do not necessarily identify as homosexual and who may have wives or girlfriends. One interviewee said to us: 'Some [partners] wanted it to be secret, and I wanted it to be secret so I never told anyone … I kept my mouth shut.' MSM do not see any advantage to coming out, and will only do so to close family and friends by way of living with a boyfriend/husband. Interviewee 1 said:

> Some of the relationships we have to hide, my partner – he's not open; he was kind of scared his friends – they party they get drunk … they are masculine, he would be scared that if his friends knew he was like that his friends would never talk to him.

Similarly, lovers, boyfriends and sexual partners of TG tend to be known to the closest friends of TG but not to others. TG from the Philippines say that sexual diversity is less of an issue and is more acceptable in the larger cities that they come from than it is in Palau.

4.2.2.6 Condom use

Condom use seems normative with some TG, but not for others. Interviewee 2 said: 'My first sex I didn't use condoms, but now I have a peer mentor from the HIV unit I use condoms.' Interviewee 2 said that the first time she used a condom was with a man she considered risky. She always insists on condoms now because she is the partner who is penetrated, therefore she is the one who is vulnerable. Interviewee 3 told us:

> Yes, I do, I really believe in condoms and I don't really get it why people hate using condoms, well I don't know maybe others are like 'it is different when there is a condom and it is more pleasurable without it', but for me there is no difference.

TG are usually the initiators of condom use. One interviewee said:

> They resist condoms but I am gonna say, I am the feminine one. I am going to have the power to force them to use a condom … I can't take no for an answer. I just shout to him 'you have to use the condom or I will leave you hanging'.

Other interviewees were more equivocal about condom use every time, and some used their own judgement about whom to use condoms with: 'I only [use a condom] sometimes, but only when I sure that this person is OK.' Another said:

> Most of them don't like to use a condom … sometimes I ask them to use them and after that they would say, 'I don't want to use this anymore' … I think we have to force them to use condoms if you are not sure … like they are not tested, if they say I am not tested then that is the time I have to ask them to use condoms.

Like the TG who mentioned using condoms for a 'risky' partner, there is a perception that foreign men are those who put Palauan TG at risk: 'The reason I started using condoms is because I decided to sleep with a foreigner … It was just in the back of my mind.'

There seems to be an issue with the availability of lubricant in Palau (although the use on the last sexual occasion was high). One TG told us that they do not keep lubricants in stock because they don't think they are important, while another said: 'I told them you should get more lubricants, lube and condoms together are safer.' Yet another told us: 'We just recently started having lube because in the past few months we did not have vendors, a lot of people really like using the lubricants so we run out very quickly.'

4.2.2.7 Outreach

The Ministry of Health's HIV and STI Prevention Program is slowly making inroads through the Community Information and Resource Centres, which are consciously trying to engage TG and MSM. There are no formal MSM/TG networks among Palauans, and the community appears somewhat averse to networks. One interviewee said: '[We need] more outreach programs because I have been here a year and we don't have much outreach programs to talk about HIV.' Interviewee 3 commented: 'And here in Palau what I want is the HIV program to be more active.' Another interviewee told us:

> They are not really focusing on it, they do outreach about twice a year and I am not happy about that. They should do that a lot of time, they should do it every 2–3 months like they do for the youth … like when there is a game they support them, bring flyers, they should do that [for us] all the time.

It is more difficult to engage MSM than TG – to date, effective engagement of MSM has not been achieved by any of the HIV and STI Prevention Program efforts.

4.2.2.8 Services/HIV testing

All the TG we spoke to were aware of the services offered for HIV testing, and all had been tested for HIV. Interviewee 2 was quite matter-of-fact: 'I just go to the clinic and let them know that I wanna get tested and they are really nice and confidential.' However, this is not the experience of other TG. Interviewee 2 said:

> People want to get tested but they do not want to be seen, especially when they go inside the big hospital, they get their chart and have to go to the small clinic, and people are like 'maybe he's sick', and they would feel uncomfortable.

Similarly, another interviewee told us that she has tested once for HIV, and would like more private access to sexual health testing and care. She would prefer to use the Health Resource and Information Centre rather than the hospital clinic. Because it is a small community, she knows or is related to many people who work at the hospital and feels that they are judgemental and jump to conclusions. Interestingly, one of the interviewees who himself had referred others to the hospital managed to find a more discreet way of being tested.

4.3 Institutional capacity assessment

4.3.1 Background

Capacity assessments and interviews were held with the Palau Bureau of Health, which is the only identified agency providing HIV and STI-related services in Palau.

4.3.2 Organisational mapping

4.3.2.1 Palau Bureau of Health

Overview of the organisation

The Bureau of Health's HIV and STI Prevention Program, a sector of the Communicable Diseases Unit, is the key implementer of HIV and STI-related activities in Palau. The program undertakes condom distribution, voluntary confidential counselling and testing, the provision of HIV and STI prevention information, and peer education activities. It runs a Health Information and Resource Centre, which is the key hub for most of these activities. Service coverage effectively extends only to the country's largest town, Koror.

HIV/STI prevention mainly has a general population approach, though MSM and (particularly) TG are reached through peer and other initiatives. The only identified target is the broadly defined category of youth aged 18 to 35 years.

The Health Information and Resource Centre on the Main Road of Koror is easily accessible by the community. The Centre is a hub for condom distribution, counselling, HIV and STI prevention information, and peer mentor training and education. It also supports a smaller satellite Health Resource Centre located at the Community College. Both centres actively refer people for HIV and STI tests. Both are MSM and TG friendly and actively try to engage and refer MSM and TG.

While swab and urine tests can be taken at the Health Information and Resource Centre, it has no facilities for blood collection and must transport people to the lab (at the STD clinic of the main hospital in Koror) for any blood tests. This deters some people from taking the test. In-house clinic days at the Centre would be preferable and would ensure more privacy.

A Peer Mentoring Project began in 2007 and targets youth (classified as those aged 18–35 years). TG youth were first engaged in 2014. There are now two TG peer mentors.

The HIV and STI Prevention Program currently has no targeted engagement with, or connections to, FSW. Previously (approximately 2009 to 2013), a project called 'Ladies in the Entertainment Business' (LEB) provided outreach information services, testing referral and condom distribution to migrant female workers in KTV bars around Koror, as many of these workers engage in sex work. The LEB initiative included translated information brochures, as well as barracks (worker accommodation) visits by a nurse. Urine-based testing was offered on site, and referrals were made for pap smears and other reproductive health matters, as well as for HIV testing at the hospital clinic. The LEB project was funded under the Pacific Regional HIV/AIDS Project (Response Fund) after an SPC workshop identified sex workers in Palau as a vulnerable group. The LEB project closed when funding ceased and it has not been active since 2013. All connection with sex workers has been lost, as both staff and management of sex work venues have changed.

The country had a National HIV and Other STIs Strategic Plan 2009–2013. It is unknown if an updated strategic plan is developed or under development.

Although HIV/STI prevention initiatives targeting these two populations at higher risk of HIV are not a political priority in Palau, there is no major opposition to them. However, as earlier reported, there is a major conflict between 'anti-trafficking' efforts that conflate sex work with sex trafficking, and HIV prevention for sex workers.

Engagement with MSM/TG and FSW

MSM and TG

Despite the general population approach, the peer mentoring program has managed to engage and train a small number of Palauan transgender. After completing training, peer mentors get certification and are eligible for part-time work at the Health Resource Centre providing education and information, conducting condom distribution, and making referrals for testing. A separate peer mentoring training for LGBTQ was held in 2014. From eight potential peer mentors, only three ultimately continued with the training (due to interpersonal conflicts).

Through the Community Information and Resource Centre, some links with TG have developed. These remain tentative, as the target group is not a unified one and remains low profile where not completely hidden. Most individuals from this population are highly disinclined to be publicly identifiable, and will be offended by any direct approach. Recruitment of members to a TG or MSM group or program is therefore very difficult and, among Palauans in particular, there appears to be no desire for collectivisation.

It is more difficult to engage MSM than TG and, to date, effective engagement of MSM has not been achieved by any of the HIV and STI Prevention Program efforts. This is likely because most MSM are straight-identifying and therefore hidden from services.

Stigma and discrimination are still common experiences for TG in Palau. While public attitudes are said to be improving and acceptance increasing in the wider community, individuals are still very reticent about 'coming out'. While they may be comfortable in a small circle of friends, family members and workmates, they avoid being visible outside those circles. Based on key informant discussions, TG from the Philippines are more often subject to public abuse than are Palauan TG.

Identified capacities within the community include:

- the young TG who are already part of the peer program or otherwise linked to the Health Information and Resource Centre
- some connections with MSM through this Centre and the TG peers
- extant (if inactive) Philippine TG networks
- social media use by the LGBTQ population
- links with regional sexual diversity networks (GALA Guam, Pacific Sexual Diversity Network).

FSW

There is currently no direct engagement with FSW, and little information on the context of local sex work or HIV prevention needs of sex workers since the LEB project closed. Contact with FSW through their managers (*mamasans*) has been lost – as has the trust and communication that the project had built. The experience of LEB shows that engagement is possible, but it takes time, and efforts need to be sustained or any gains will be rapidly lost. There is currently no funding for a targeted FSW HIV/STI intervention. A major barrier to engagement with FSW is the climate of fear and distrust, among management in particular, that has been created by a series of charges of trafficking that have been laid against management of KTV and massage parlours in Palau since 2013.

Trafficking-in-persons charges are far more serious than sex-work/brothel-keeping charges. The laying of trafficking-in-persons charges is ongoing and is focused on venues where sex work is suspected. These cases have a high profile in the media and in the general community.

It is unlikely that sex work venue management will allow access to FSW, or admit to any need for condoms, while they fear (with good reason) that any such admission will lay them open to charges of sex trafficking. (The US State Department definition of 'trafficking in persons' effectively defines *any* migrant sex worker as a trafficked person.) A series of charges of trafficking has been laid against management of KTV and massage parlours in Palau since 2013, compounding this fear.

Organisational strengths

The current peer program is housed within a Ministry of Health HIV and STI prevention section and is well integrated with testing and treatment services.

The program has good experience in peer-based activities, both in the ongoing peer project and in the former LEB project targeting sex workers.

HIV and STI prevention staff have good community connections with TG and (to a lesser extent) MSM.

The Community Information and Resource Centre distributes an impressive selection and variety of high quality and appealing condoms and lube packs (which are far more attractive than the standard United Nations Population Fund fare). The female condom is also available but is less in demand.

Key capacity-building needs in order to deliver HIV prevention services to key populations

Staffing – there is a shortage of qualified staff.

Historically, funding has been too short term. Long-term funding sources are needed for both TG/MSM and (especially) FSW interventions.

Collaborations and partnerships with external expertise could occur to address capacity and support gaps (for example, Pacific Sexual Diversity Network, sex worker networks – especially for certain FSW groups).

Community-building activities for MSM/TG and FSW would be important in facilitating effective HIV prevention activities.

At least one Filipina and one Chinese paid program staff who have previously worked as hostesses are necessary for effective engagement with FSW.

The Centre has no data collection process to record the numbers of TG and MSM reached with outreach condom distribution and education services. While condom and lube packs are distributed to various places, they are not distributed to establishments where sex work is known to occur. Some managers of sex work venues may pick up free condoms from the hospital clinic, but there is no current measurement system to record if they do, or how many condoms are picked up. Records collected at testing centres require MSM to self-identify. This is highly unlikely, due to stigma and fear of discrimination and loss of confidentiality. Migrant FSW say that they prefer to return to their home country to use sexual health services and do not use testing services in Palau. They point out that they have to undertake health screening as a visa condition, reportedly including HIV testing.

Identified capacity-building resources (which organisations could tap into)

The following organisations were identified by public health staff:

- the Guahan Project – linked to Guam Public Health and providing HIV/STI services – has provided technical assistance in the past
- Life Foundation (Hawaii) has also provided technical assistance
- West Care Pacific Guam
- Empower Pacific has provided counselling and testing training and can provide technical assistance.

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4.4 Further Steps to encourage HIV prevention and support services for key populations

FSW: There is a need to reinvigorate the Ladies in the Entertainment Business HIV support program. However, Chinese and Filipina hostess or ex hostess staff will be absolutely key to the effectiveness of this HIV program, as it will only be successful if the community or population concerned can feel some ownership. There is plenty of unused potential among the migrant women workers. There is a clear need to embed sex worker services within hostess services (which are less stigmatising and more acceptable to the migrant workers)

MSM/TG: At present there are no TG/MSM networks and it may be too early to set one up, but the Ministry of Health needs to further engage with members of the community through outreach work, particularly engaging peer educators from the community

Overall, the Ministry of Health has good experience in key population peer-based activities, both in the ongoing peer project and in the former LEB project targeting sex workers, and this should be increased, utilising the Community Information and Resource Centre

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Annex 1: UNAIDS GARP data needs

Data - palau

Indicator relevance: Topic relevant, indicator relevant, data available

Data measurement Tool:

Please specify data measurement tool:

Data collection period:

Additional information related to entered data. e.g. reference to primary data source (please send data to My Documents if possible), methodological concerns:

Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source. Please send data to My Documents if possible:

Sample Size:

Number of Survey Respondents: 0

Sex Workers

	All	Males	Females	>25	25+
Percentage (%) Percentage of sex workers who answered "Yes" to both questions					
Numerator Number of sex workers who answered "Yes" to both questions					
Denominator Total number of sex workers surveyed					
Percentage (%) Percentage of sex workers who answered "Yes" to question 1, "Do you know where you can go if you wish to receive an HIV test?"					
Numerator Number of sex workers who replied "yes" to question 1					
Denominator Total number of sex workers surveyed					
Percentage (%) Percentage of sex workers who answered "Yes" to question 2 "In the last 12 months, have you been given condoms?					
Numerator Number of sex workers who answered "Yes" to question 2					
Denominator Total number of sex workers surveyed					

1.8 Percentage of female and male sex workers reporting the use of a condom with their most recent client

	All	Males	Females	>25	25+
Percentage (%) Percentage of female and male sex workers reporting the use of a condom with their most recent client					
Numerator Number of female and male sex workers reporting the use of a condom with their most recent client					
Denominator Number of sex workers who reported having commercial sex in the last 12 months					

1.9 Percentage of sex workers who received an HIV test in the last 12 months and who know their results

	All	**Males**	**Females**	**>25**	**25+**
Percentage (%) Percentage of sex workers who received an HIV test in the last 12 months and who know their results					
Numerator Number of sex workers who have been tested for HIV during the last 12 months and who know their results					
Denominator Number of sex workers who responded to the questions					

1.11 Percentage of MSM reached with prevention programs

	All	>25	25+
Percentage (%) Percentage of MSM who answered "Yes" to both questions	**50.0 %**		**50.0 %**
Numerator Number of MSM who answered "Yes" to both questions	**3**		**2**
Denominator Total number of MSM surveyed	**6**		**4**
Percentage (%) Percentage of MSM who answered "Yes" to question 1, "Do you know where you can go if you wish to receive an HIV test?"	**100.0 %**		**100.0 %**
Numerator Number of MSM who replied "yes" to question 1	**6**		**4**
Denominator Total number of MSM surveyed	**6**		**4**
Percentage (%) Percentage of MSM who answered "Yes" to question 2 "In the last 12 months, have you been given condoms? "	**50.0 %**		**50.0 %**
Numerator Number of MSM who answered "Yes" to question 2	**3**		**2**
Denominator Total number of MSM surveyed	**6**		**4**

1.12 Percentage of MSM reporting the use of a condom the last time they had anal sex with a male partner

	All	**>25**	**25+**
Percentage (%) Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	**33.3 %**		**25.0 %**
Numerator Number of men reporting the use of a condom the last time they had anal sex with a male partner	**2**		**1**
Denominator Number of respondents who reported having had anal sex with a male partner in the last six months	**6**		**4**

5 ?.?? Percentage of MSM who received an HIV test in the last 12 months and who know their results

	All	>25	25+
Percentage (%) Percentage of MSM who received an HIV test in the last 12 months and who know their results	**66.7 %**		**75.0 %**
Numerator Number of MSM who have been tested for HIV during the last 12 months and who know their results	**4**		**3**
Denominator Number of MSM who responded to the questions	**6**		**4**

1.13 Percentage of TRANSGENDER reached with prevention programs

	All	>25	25+
Percentage (%) Percentage of TG who answered "Yes" to both questions	**62.5 %**	**50.0 %**	**25.0 %**
Numerator Number of TG who answered "Yes" to both questions	**3**	**2**	**1**
Denominator Total number of TG surveyed	**8**	**4**	**4**
Percentage (%) Percentage of TG who answered "Yes" to question 1, "Do you know where you can go if you wish to receive an HIV test?"	**87.5 %**	**100.0 %**	**75.0 %**
Numerator Number of TG who replied "yes" to question 1	**7**	**4**	**3**
Denominator Total number of TG surveyed	**8**	**4**	**4**
Percentage (%) Percentage of TG who answered "Yes" to question 2 "In the last 12 months, have you been given condoms? "	**37.5 %**	**50.0 %**	**25.0 %**
Numerator Number of TG who answered "Yes" to question 2	**3**	**2**	**1**
Denominator Total number of TG surveyed	**8**	**4**	**4**

1.14 Percentage of transgender reporting the use of a condom the last time they had sex

	All	**>25**	**25+**
Percentage (%) Percentage of TG reporting the use of a condom the last time they had sex	**37.5 %**	**50.0 %**	**25.0 %**
Numerator Number of TG reporting the use of a condom the last time they had sex	**3**	**2**	**1**
Denominator Number of respondents who reported having had sex in the last 12 months	**8**	**4**	**4**

6 1.15 Percentage of transgender who received an HIV test in the last 12 months and who know their results

	All	**>25**	**25+**
Percentage (%) Percentage of TG who received an HIV test in the last 12 months and who know their results	**62.5 %**	**75.0 %**	**50.0 %**
Numerator Number of TG who have been tested for HIV during the last 12 months and who know their results	**5**	**3**	**2**
Denominator Number of TG who responded to the questions	**8**	**4**	**4**