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Title: I-Kiribati Youth Perceptions of HIV/AIDS and Related Risk Behaviors.

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The Republic of Kiribati is one of the last countries to face the HIV/AIDS epidemic in the Pacific. First appearing in the region in 1982, HIV/AIDS was recognized as a national concern during the late 90s. Partnering with the National AIDS Committee, research was conducted using qualitative and quantitative methods which included focus groups, surveys, personal interviews and quasi experiments. These methods were used to explore population and individual perceptions and behaviors related to HIV/AIDS. Once perceptions and behaviors were understood, HIV/AIDS was placed in a broader historical and social context. Placing the illness in these contexts, I examined how history and social environments influenced the spread of the virus. Focusing on youth, research exposed complex social structures which produced opportunities for varying levels of stigma, economic development, migration, education and modernity, all contributing to a systematic promotion and prevention of the spread of HIV/AIDS.

Conclusions showed that gender roles, modernity, educational and economic opportunity, overpopulation, religious beliefs and limited resources contributed to greater amounts of high risk behaviors taken by individuals. Conversely, gender roles, religious beliefs, and modernity also assisted in the prevention of transmission.

I-KIRIBATI YOUTH PERCEPTIONS OF HIV/AIDS AND RELATED RISK BEHAVIORS

by
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Te Mauri, Te Raoi ao Te Tabomoa.

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ACRONYMS

ABC : Abstain, Be faithful, Condom use

AIDS: Acquired Immune Deficiency Syndrome

ARH: Adolescent Reproductive Health

ARV: Antiretroviral drug

CDO: Capacity Development Office

EPR: Estimated Prevalence Rate

FSP: Foundation of South Pacific People

HAART: Highly Active Anti Retroviral Treatment

HBM: Health Belief Model

HIV: Human Immunodeficiency Virus

IEC Materials: Information, Education and Communication Materials

KHATF: Kiribati HIV/AIDS Task Force

KHATBTF: Kiribati HIV/AIDS/TB Task Force

KPC: Kiribati Protestant Church

KTC: Kiribati Teachers College

MOH: Ministry of Health

NAC: National AIDS Committee

NGO: Non Governmental Organization

PASA: Pacific AIDS STI Alert Bulletin

PIC: Pacific Island Country

PICs: Pacific Island Countries

PICT: Pacific Island Countries and Territories

PLWHA: People Living With HIV/AIDS

PRHP: Pacific Regional HIV Programme

SES: Socioeconomic Status

SPC: Secretariat for Pacific Communities

STI: Sexually Transmitted Infection

TB: Tuberculosis

TTI: Tarawa Technical Institute

UNAIDS: United Nations Joint AIDS Project

UNICEF: United Nations International Children's' Education Fund

WHO: World Health Organization

Chapter 1

THESIS ROADMAP

It (TB) was like HIV now, people were scared to live with people who had it... but once people were educated about it, the found out what to do... like not to share things...now people can live with people with TB. If you go visit their house they can live with you and tell you they have TB and you know how to be safe around them. [i]

This thesis will look at disease through emic and historical perspectives to understand the social construction of HIV/AIDS in I-Kiribati contemporary times. The understanding and discovery of these perspectives will allow us to examine this disease in the greater, more relevant biosocial context in which it exists. Research conducted included both qualitative and quantitative methods for the collection of data. Qualitative methods included personal interviews and focus group discussions. Quantitative methods included surveys and pre/post intervention tests. Interventions were developed from information gathered in personal and focus group interview sessions. Designed to inform individuals about HIV/AIDS while reducing amounts of stigma, the intervention included components of performed story telling, audience participation drama and music.

The first chapter of the thesis will provide background of the country, including geographic location, demographics and economic conditions. This chapter will also briefly explore other contemporary issues facing the population and examine how history has influenced the advancement of pollution, overpopulation and economic development in the country.

The second chapter examines the current day situation of HIV/AIDS in the country. Looking at contemporary definitions of gender, wealth, religion and power, I examine how these perceptions influence behaviors of individuals, paying particular attention to adolescent and young adult perceptions and behaviors.

Chapter three emphasizes how anthropological theory applies to HIV/AIDS prevention and treatment in the I-Kiribati society. Using combined anthropological theories of sociological thought, historical particularism, structuralism, post modernism and feminist theory; I am able to view reality with a deeper insight on daily lived

experience. Understanding the emic perspective gives the research greater validity and potential for applied use in the field.

Chapter four examines the history of Kiribati from European and I-Kiribati[ii] perspectives. Rather than blaming culture for problems associated with the spread of HIV/AIDS, this chapter examines how understanding the past is important to understanding current day situations and why it is difficult to alter harmful behaviors and perceptions.

Chapter five reviews the qualitative and quantitative methods used in collecting data. Research was divided into several sections. The first section of my research focused on learning what adolescents, young adults and adults perceived HIV/AIDS to be and what had been done by the NAC and other partner organizations to support prevention and treatment efforts in the country. Data for this portion was collected through surveys, focus groups and personal interviews. The second section of my research utilized the collected data for the development of an educational intervention. The intervention was conducted among several adolescent and adult groups. Pre and post tests were conducted to measure the effect of the intervention on participants. The third part of my research focused on learning how HIV/AIDS impacted family members, friends and individuals living with HIV or AIDS. Personal interviews were used to collect data. The last portion of my research included a public service survey. Store owners, restaurant workers and other employees of the main shopping district in Tarawa were surveyed on their practices and feelings towards having customers with HIV/AIDS. These surveys were accompanied with a brief educational intervention, posters and handouts after completion of surveys.

Chapter six shows the results from the four sections of research. Results from the first section showed that although the majority of surveyed individuals had heard of HIV/AIDS, little knowledge beyond it being spread through sexual contact and resulting mortality was present. Additionally, a high amount of stigma towards PLWHA existed in several individual and focus group interviews. Section two results showed that the intervention had little effect on increasing basic knowledge of HIV/AIDS among participants. However, the intervention did produce a significant impact on reducing

levels of stigma among participants. Section three exposed the shame, fear and isolation seropositive individuals experienced. This section also exemplified the need for support and medical treatment programs for families and individuals impacted by HIV or AIDS. The last section surprisingly showed a general acceptance of PLWHA in public shopping and entertainment districts in the main business district of Tarawa. The results varied among population samples; however expected and unexpected findings could be generalized into statements from the research.

Taking into account history, culture and present day social norms the last chapter places findings into context and discusses their implications for future program development in the country. Concluding the thesis, this chapter greatly focuses on the need for developing a national support program for PLWHA.

COUNTRY OVERVIEW

The history of Kiribati is rich with local legends and world events which have altered the course of Kiribati's history. Similar to human conflict, disease has changed the course of history in these islands. A sixty year period spanning from the mid 1800s to the early 1900s was a time of revolutionary change as whalers, beach combers, resident and labor traders brought new technologies, religious beliefs and disease. Often credited for bringing guns, liquor, tobacco and prostitution to the islands, western contact was additionally credited with the sharp rise in venereal disease during this period. (Talu, 1984) Later in time when the labor trade began the exportation of I-Kiribati individuals to different islands of the Pacific such as Hawaii and Banaba; unusual diseases began to come back to the islands with returning workers. "The trouble was that Gilbertese (I-Kiribati) and Ellice Islanders (Tuvaluans) worked beside the Orientals" (Resture, 2004) Doctor S. M. Lambert, 1942 recalls from his experience in Kiribati. "Pathologically, the march of disease was beginning to show. Yaws, which seemed to have been brought by civilization, was making heavy inroads. Tuberculosis was working its way into handsome youths, who lacked the European's immunity. Filariasis was a vexing puzzle, because it seemed impossible to control the mosquitoes

that carried it. Intestinal parasites were fortunately few; the people lived near the beaches, and tide-water is nature's handy sewage system" (Resture, 2004)

Later, diseases such as Leprosy and TB had great impacts on the I-Kiribati population, causing great amounts of illness and loss of life. Likened to the emerging HIV/AIDS epidemic today, Leprosy, TB, Filariasis and other diseases have a history of invaluable indigenous lessons to contribute to the knowledge of stopping the spread of and treatment of disease in Kiribati.

Gaining independence from Great Britain in 1979, the Republic of Kiribati, formerly known as the Gilbert Islands, is comprised of 33 low lying coral atolls, located in the middle of the Pacific Ocean. This seclusion from the rest of the world has helped protect its people from many things, such as wars and disease, form three island chains in the country - the Gilberts, the Phoenix and the Line Island chains. The total land area (811sqkm) is spread over 3.5 million sqkm of the Central Pacific Ocean. (KNACC, 2002) The majority of the population (92.6%) resides in the Western Gilbert chain, while nearly half of the total population lives on the main island of Tarawa.[iii]

Overpopulation continues to become a greater issue of concern as growing urban migration increases population density, causing several social, health and economic disparities among this population. Historically, population was controlled through various means including, abortion, infanticide and warfare. However, "with the arrival of colonial government and Christianity, such practices were banned." (Schutz, 1984)

Consequently, new forms of population management emerged. Beginning in the 1930s, Colonial rule imposed resettlement programs designed to lessen the burden of overpopulation on the southern Gilbert Islands. Many of these programs failed, as migrant populations struggled with unsuitable water supplies, undeveloped communication infrastructure and arid land.

Today, populations living outside of the Gilbert Chain represent less than 10% of the total population. Excluding Christmas Island, the nation's eastern most atoll, the remaining Phoenix and Line Island inhabitants represent just over 3.4% of the total population in Kiribati.[iv] Similar to preceding generations, isolation has continued to

present challenges of communication with the outside world. Being one of the greatest drawbacks, it is also the greatest asset in keeping their traditions culture and language.

Many people have chosen to live in the Gilbert chain (See Fig. 2) because of the technological advances and accessibility to modern services such as entertainment, communication and transportation found on these islands. According to the 2000 National Census, the total population was 84,494, of which, 43.5% lived on the main island of Tarawa. The national population increased by 1.69% over the four year time span between 2000 and 2004. Due urban migration trends, Tarawa has a 5.17% growth rate while outer islands report a rate of - .63%. A quote found in Island Business July 2004 demonstrates the current overpopulated situation of Tarawa. "With 2,324 people per square kilometer, South Tarawa is one of the world's most densely populated places." (Pareti, 2004) With so many people living in small amounts of space, urban migration strains limited resources as an increasingly inadequate water lens, land, and overpopulation contribute to physical/mental health problems and social disparities in the island.

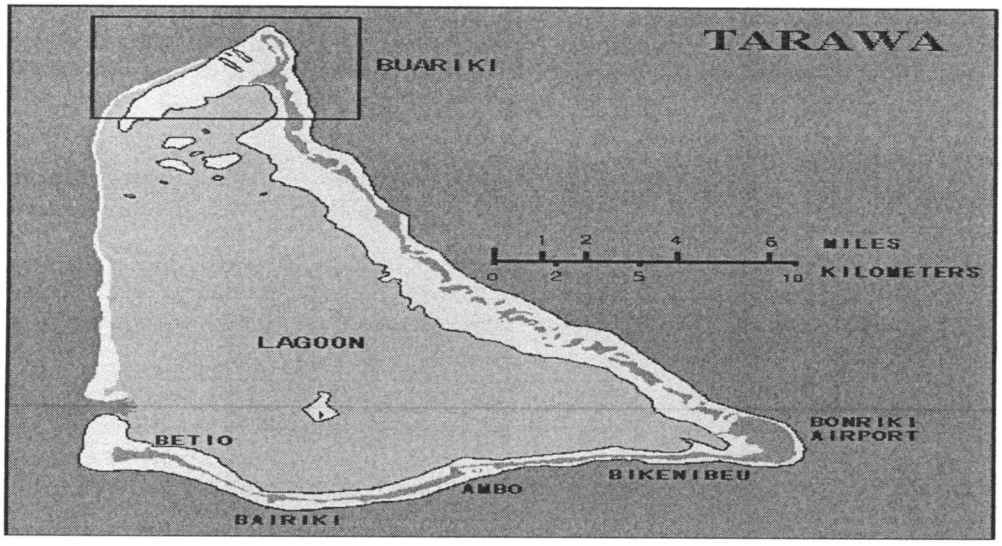

Fig 1: Map of Tarawa Island

National figures show unemployment rates at a surprising 1.5%.[v] Explaining this low percentage, an article printed in the summer of 2004 found the unemployment rate to have taken into account unpaid village duties as employment. (Pareti, 2004)

Village duties are important aspects on outer islands where tradition and subsistence living are the ways of life. As such this could explain why these duties were taken into account during the calculation of the figure; but the main island's emphasis has changed from a subsistence economy to a cash economy, where unpaid village duties should not be counted when calculating unemployment rates.

As of 2000 there were 12,615 reported households. National mean household size was 6.7 people per house. No statistics were provided, separating outer island and main island household size.[vi]

The chief exports are copra (a coconut byproduct), fish and to an increasingly degree, human labor. Because of constant low trading prices for fish and copra, the economy is greatly supported by wages earned overseas from young seafarers.

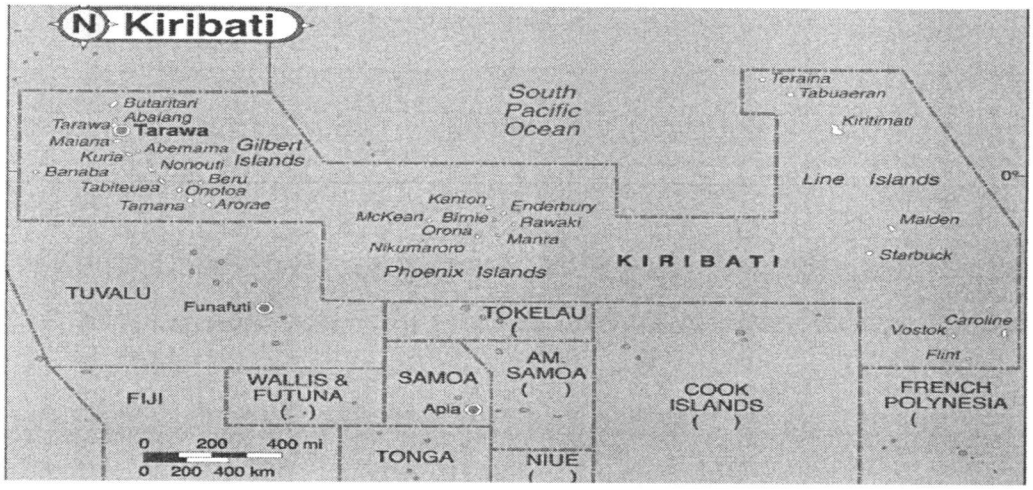

Fig 2: Map of Kiribati

Kiribati has a young population, with a median age of 19.7 years. (Kiribati, 1999) Because HIV/AIDS mostly impacts the young adult population, a full blown AIDS epidemic in the country could produce devastating consequences. 73% of people under 15 years of age are dependent on people between ages of 15 and 59. When including individuals who are 60 years of age or older, the dependency ratio increases to 82.6%. Although the dependency ratio increases by nearly 10 percentage points, it is not typical that the older generation would require long term support as the estimated average life expectancy in 2004 was only 61.32 years, males 58.34 years and females 64.44 years.

On the 2000 Human Development Index, Kiribati ranks 11th out of 14 countries in the Pacific region and 129th in the world. In the Pacific region, Kiribati's development indicators: infant mortality/child morbidity and per capita GDP/living conditions, particularly in regards to water and sanitation, are among the lowest. Combined factors of a youthful population, strained resources and poor living conditions indicate that Kiribati is a country which would suffer significantly from even a small HIV/AIDS prevalence rate. The estimated HIV/AIDS prevalence rate in 2000 was .0001065 (9/84,494), or one person for every 10,000 people. This rate increased to .0001389 (14/100,798) in 2004, or one point three persons for every 10,000 people.[vii]

TRANSFORMATION

From the arrival of missionaries to the introduction of 2-Pac, Kiribati has faced challenges of transformation. Variables of cultural transformation, such as westernization, capitalism and modernity have impacted decisions made by I-Kiribati caught in cultural transition since the early 1800s. It is important to understand the relationship between these changes to understand behavioral patterns. From these relationships, I hope to show how social structures influence individual decisions and behavior.

A study conducted in Micronesia looked at why suicide rates, had increased substantially among male youth post WW2, compared to the almost unchanged rates of suicide in female youth. The study concluded that social expectations of males had changed drastically while female expectations stayed the same. "Increasingly, the role of food provider in the subsistence economy has been replaced by the role of wage earner in the cash economy." (Rubinstein, 2002)[viii]

The majority of this change is occurring on the main island of Tarawa, where culture, lifestyles and attitudes have been at the forefront of transition since the 1920s. Then, "missionary influence led to an increased bodily covering" and opportunities to consume imported foods such as "flour, salt, sugar and rice," resulting in dependency of these imported goods, higher rates of diabetes, stroke, and obesity commonly associated

with illnesses of westernization. (Talu, 1984) Today, imported DVD players, televisions, radios and second hand cars have replaced cloth, flour and rice as items of wealth and status in the community.

The introduction of modernity and desire for material wealth brought a separation from the traditional paradigm of village collectivism. Most notably, this change can be seen in the urban population where a distinction between the haves and have-nots has developed. Uncanny to the Kiribati *katei,* some informants told me that they had been turned away from staying with family on Tarawa because they were not able to contribute income to the household.[ix] Although this example presents a rare glimpse of life in Tarawa, as all interviewees saw this selfish action as a disgrace to the larger family, it is an example of capitalist thought taking hold in residents of Tarawa.

Changes in beliefs, attitudes and practices are expected to occur in a population that has survived colonialism, three forced occupations, loss of physical environment, resources and independence. Yet, at every turn in history, Kiribati has made adapted to change through an I-Kiribati way.

Economic development is occurring simultaneously with social change creating new problems for the nation to face. I-Kiribati are recognizing these emerging problems and are developing strategies to solve them. Central to many campaigns is the theme of remembering the Kiribati *katei* or way of life, along with the promotion of cultural and national pride.

A 2004 camping addressing pollution on Tarawa was called *Kiribati Te Boboto,* or Kiribati the Beautiful. The campaign was co-sponsored by the Government of Kiribati and Kiribati FSP. Youth programs such as the National Olympic Committee and Adolescent Reproductive Health Centers were developed to provide outlets for recreation and entertainment as an alternative to gangs, alcohol abuse and drug use[x]. These campaigns promoted healthy lifestyles highlighting local athletes who appeared in Regional Pacific competitions. Work was being discussed for the newly returned Olympic athletes at the close of field work.

Just recently, the Kiribati government has understood that HIV/AIDS was a mounting problem. But as one report stated, "understanding and acting are two entirely

different things." (Pareti, 2004) On November 27, 2004 the I-Kiribati Parliament enacted a funds request from the Ministry of Health producing a 2004-2005 annual $40,000.00 AUD budget for work specifically with HIV/AIDS in Kiribati effective January, 2005. The funding for HIV/AIDS work will address the objectives of the HKATBTF through the development of awareness programs, social support initiatives for PLWHA and increase medical capacity for treatment of HIV/AIDS.

Awareness programs, developed in collaboration with the NAC and over thirty governmental, religious and non-governmental organizations reached thousands of individuals promoting messages of tolerance, respect and responsibility deconstructing the long standing fear message campaign developed in the early 90s. Additionally, increased financial assistance from international donors have elevated prevention and surveillance efforts. With the recognition and commitment to prevention from the national government, Kiribati has reached many milestones in the struggle against HIV/AIDS.

Another recent milestone in the country's HIV/AIDS work was the emergence of the first person to "come out" with their HIV status on September 28, 2004. Having this young man come public with his status has helped I-Kiribati put a human face to the disease. Through talking with doctors, parliamentarians, students and large crowds during the 2004 World AIDS Day Celebrations he has helped raise national awareness and empathy for people living with HIV/AIDS in the country. He has demonstrated courage and hope for individuals living in secret with HIV/AIDS. Throughout all of this, Tomati has shown utmost strength and courage for Kiribati and other individuals impacted by HIV/AIDS. The task force hopes to continue working with him to raise the national consciousness and support for PLWHA.

People of Kiribati, hold their *katei,* culture, in high regards. Kindness unity and strength are prominent elements of the I-Kiribati life. Many older people believe that the solutions to current day social and economic problems lie in the strengthening of *te katei ni Kiribati.* (Talu, 1984) From the arrival of the first missionary to the introduction of 2-Pac, remembering this way of life has helped Kiribati keep its culture. Outside influences have been known to impact clothing, most controversial probably

being the miniskirt in the seventies, lifestyles, environment and language; however none succeeded in erasing the mark of I-Kiribati identity. Honoring the ideas of "protection, listening, staying away from danger, loving, keeping good relationships, knowing ones genealogy and maintaining group harmony" (Talu, 1984) is the basis for *te katei ni Kiribati.* Keeping these values, attitudes and traditions alive has proven vital in times of relocation, drought, disaster and war. These ideas will continue to prove vital for future existence of Kiribati.

As Kiribati celebrates her 25th anniversary of independence, the country finds itself at an exciting yet turbulent time in social and technological development, remembering the *katei* may prove to be the key for Kiribati as she enters a new generation without forgetting her past.

Chapter 2

STATEMENT OF PROBLEM: THE MAKING OF KIRIBATI HIV/AIDS

HIV/AIDS is an economic problem that affects the most economically productive portion of our population. It is a youth problem because many young people are denied access to knowledge and appropriate health services. AIDS is a gender issue because of the inequalities in relationships and attitudes towards women. It is a poverty problem because if your basic needs are not being met, you are more vulnerable to risky behavior. AIDS is also a security issue. HIV, the virus that leads to AIDS, flourishes in times of conflict, civil strife and uncertainty.

Mr. Noel Levi, CBE, Secretary-General
Pacific Islands Forum Secretariat Dec. 1 2002

The spread of HIV/AIDS has impacted every country that has been touched by the disease. The virus has crossed countries, continents and oceans making it one of the largest pandemics in human history. In a January 10, 2005 address at Calvin College, Paul Farmer referred to this pandemic as a "Global public health emergency." Research (Brown 2002, UNAIDS 2004, Parker 2001) has shown that the virus thrives in places where deficiencies in education, extreme poverty and persistent social inequalities exist. Most prevalent in marginalized societies, these conditions exist all over the world, causing AIDS to become a long standing global concern.

Countries hardest hit by this pandemic, have faced population decline and economic loss, contributing to varying degrees of social disruption. Due to the nature of the disease, young adult populations experience the most dramatic impact. As in other countries world wide, the young adult population in Kiribati is the base for economic and population growth. Without this demographic group, national development becomes impeded, forcing younger and older generations to cope with resulting poverty, orphaned children and social disruption. From more progressed HIV/AIDS epidemics in other parts of the world, decline in human capital has been directly linked with higher incidence of increased poverty, food shortages, social inequalities and poorer living

conditions. (UNAIDS, 2004) A study completed in 1993 by J. Stover found for every 10 percentage point increase in the prevalence rate of HIV, population growth will be reduced by .6% to 1% per year. (Ahlburg, *et.al.*, 1998)

In September of 2004, Kiribati reported 43 seropositive cases, of which 20 were known to have passed away. Due to stigma, availability of testing facilities, cultural and religious beliefs, medical treatment and support for people living with HIV/AIDS in the country, both prevention and surveillance efforts are confounded. Additionally, actual amounts of cases are anticipated to be higher than the amount of reported cases. UNAIDS predicts an estimated ten unreported cases for every reported case, elevating Kiribati's estimated amount of cases to be as high as 430. WHO estimates that the ratio is three times higher than the ratio used by UNAIDS raising the estimated amount of cases to be as high as 1,290.[xi]

The country is already facing problems stemming from the emerging epidemic as economic loss through an infected workforce has caused several young seafarers to stop working. Social conflicts arising from the presence of stigma and fear have pinned community members against those living with HIV and their families. As of September 2004, Kiribati had lost 20 individuals from AIDS and more were expected in the immediate future.

THE CREATION OF SOCIAL STRUCTURES AND THEIR INFLUENCE

Examining the leading contributors of rising HIV/AIDS rates in Kiribati, I find many factors can be related to cultural beliefs, current country demographics and migration patterns. Kiribati's young population, small private business sector and rapid population growth in the main island has increased the risk of developing social and economic problems on Tarawa.

Many people view the main island as a representation of progress and modernity which they can become a part of if they migrate to the island. Individuals choose to go there to experience the "modern life," to attain a better education and "jobs that pay money." [xii] Desire to experience modern life is a commonly expressed theme

among many younger I-Kiribati. This group identifies with the emerging pop culture, consisting of e-mail, mobile phones and imported second-hand cars more than the traditional lifestyle of I-Kiribati youth.

The change from a subsistence lifestyle to a modern day lifestyle started to take hold of the country in the early 1900s. During this time "cooperative societies were introduced to the islands." (Talu, 1984) During this time, almost every outer island had a co-op society. Co-ops allowed people to earn income through the sale of coconuts and copra harvested from their own land which deemphasized the need for migration. Still in operation today, several co-ops provide the only source of cash flow for outer island individuals.

Over the years, especially after WW2 and Kiribati's independence from Great Britain in 1979, the economic center shifted away from the outer islands, to Tarawa. The growing importance of cash and education continue to attract many people to the main island, as the majority of wage earning jobs along with 60% of the nation's secondary schools and 100% of the nation's tertiary schools are located on Tarawa.

Overpopulation has been a long standing reality on Tarawa. As a result, land court cases are often contested in Tarawa, especially in the more populated villages. The importance of a cash flow for daily survival on Tarawa is sought by many families through the practice of leasing land to foreign or outside (not family) parties. This practice increases population density by increasing the amount of people on smaller plots of available land. More people impacts the quality of life by lessening the amount of available resources and space for individual growth.

Several individuals view cash as a dispensable resource. "It buys things that will be thrown away," but land is a different thing. Land is what a family is raised on and what is given to married couples to start new families; land can't be thrown away. Land is an indispensable source of wealth which stays in a family for generations.

Many other contributing factors exist which enable the spread of social disparities in the country, including increased amounts of poverty, limited access to sufficient health care and new ways of life unfamiliar to the Kiribati way of life. Linked with these factors are factors which enable the prevalence of HIV/AIDS to increase. Limited testing facilities, no access to medical treatments, increasing amounts of stigma and higher risk behavior influenced by availability of alcohol and lack of work for an increasingly educated youth population, contribute to an environment for increased prevalence. "The lack of law enforcement and the availability of any form of liquor from retailer shops and local markets enhances the abuse of alcohol by both adults and youths." (Kiribati, 1999) One leading factor in spread of STIs and premarital sexual activity is underage drinking in Kiribati. The general purpose of alcohol seemed to be liberation of the individual self from life the individual was facing in Kiribati. In many cases it was used as an agent of liberation from the cultural shyness that is prevalent in all islands of Kiribati. Drinking is a common activity for males; however female behavior such as this is unacceptable, although sentiment is changing on the main island as female intoxication is becoming a more common event. "Some youths see doing these things as being 'privileged and very modern" (Kiribati, 1999) elevating their status to adult like while creating a distinction between them and the more "backward" outer island youth.

The development of *sour toddy*, fermented coconut tree sap, came with the arrival of the permanent traders in the 1800s. Mixed with yeast, this drink is the most common form of alcohol found on the outer islands. Imported alcohol, from Australia, is most common form of alcohol found on the main island as the majority of the coconut trees have been cut down for urban development. Hard liquor, such as Jack Daniels or Jim Bean are available to purchase at an expensive cost. Typically, ex patriots or foreign visitors purchase these for special occasions. Urban youth commonly pool funds to purchase *sour toddy* from local vendors at a cheap 50 cent rate per cup and share amongst each other.

The police recognize that underage drinking in the main island is becoming out of control, but feel unequipped to handle the problem. "We can do little about it," as "deciphering minors' ages alone would require long and arduous detective work involving external offices."[xiii] The detective work involved with one underage case would involve hand sorting through thousands of birth certificates at the office of birth, death and marriage records which is open Monday through Friday from 9-4pm on Tarawa. Most underage drinking occurs outside of these hours.

Additionally, the large population density of this island has made individual anonymity easier to attain compared to the environment of the outer islands, making underage purchases more accessible to youth.

Population has influenced the availability of alcohol to minors, as several business owners have large families to support. Many have the "profit over persecution" mentality because under age drinking laws often lack enforcement. During several evenings spent in Betio I witnessed uniformed police officers driving through the streets picking up drunk individuals, mingling and drinking with the crowds but never confronting bouncers for letting youth into their establishments. As a result several interviews stated that "getting drinks is easy, I just hide between the taller people and walk in (into bars)."[xiv]

RELIGION

Brought to Kiribati by missionaries, religion remains one of the most dominant social structures in Kiribati today. The nation's religious make up is mostly comprised of Christian faiths. 54% of the population identifies themselves with the Roman Catholic Church, 38% identifies with the Kiribati Protestant Church, while the remaining 8% belong to the Mormon, Seventh Day Adventist or Ba'hai religions. The northern Gilberts predominantly consist of Catholics, while the Southern islands consist of Protestants.

Relating religion to STI prevention, both churches promote monogamous relationships and abstinence until marriage; practices which aid in controlling STI

transmission. However, religious beliefs and actual behavior vary among the Christian population of the country, especially for young couples who may be separated for extended amounts of time due to working situations overseas on cargo ships.

Kiribati is a society where gendered power inequalities have put females at a greater risk of contracting HIV/AIDS. These social hierarchies are common to many parts of the world and have been attributed to the greater global pandemic spread among women. "The political economic factors that drive the HIV/AIDS epidemic in virtually all social settings are intertwined with gender and sexuality, whose hierarchies make women, and low income women in particular, especially vulnerable to HIV infection" (Parker, 2001).

In November of 2003 I conducted a somewhat difficult interview with a friend of mine from Kiribati, focusing on how she sees HIV/AIDS in her life. She is an educated woman who has taken several introductory University courses through the USP in Fiji. She currently works as an officer at the Kiribati government sponsored communications station located on the Capitol Island of Tarawa. Her husband is currently studying in Fiji.

When I asked her about stigmatization in Kiribati the only things that she told me revolved around protection and proactive behavior. This makes me think that the NGO's who are targeting women to promote these attitudes have succeeded in their tactics but still have much more to do to counter the current social structure which contribute to the stigmas associated to the disease.

> *Be very careful, you know why? to make sure you don't get sick Always carry the contraceptive method with you or condoms just for safety always tell me which lady when you come over, cos I know those who might carry HIV/AIDS Virus.* [xv]

She seems to have created an idea of who is a carrier based on street information. I found it interesting that, she was not able to tell me about the individuals that she knew had HIV. Was this because she did not associate with such "filth" and therefore was not aware of their struggles and emotions? Or was it that she was afraid to have me think of her as someone who associated with them? I did not want to push

this interview too far beyond my welcome so I left these questions unasked. Nonetheless, it was extremely difficult to hear this from a friend.

Constituting the largest known seropositive population in Kiribati, one of the many things that can happen to seafarers when they go overseas is exposure to freedoms and anonymity uncharacteristic of island life where, departure from cultural norms and expectations is limited because of the social governance of small island communities. In the ports, they may encounter sex workers for their first time. This temptation mixed with alcohol consumption and the very male oriented atmosphere of seafarer life may be too tempting or too destructive to individual male pride to refuse. It is not uncommon for any person to be lured by sexual desires, much less seafarers who have withstood a long separation from their wives and seek feminine companionship. Many seafarers and their wives are counseled on this topic before they go overseas, yet when the seafarers are in the heat of the moment, some give in to their desires and contract unwanted STIs which have been spread to wives and families in Kiribati upon return. "Fifteen percent of HIV sufferers in Kiribati are the wives of seafarers and their children and there have been three cases where children have been infected with HIV as a result of mother to child transmission."[xvi]

Another issue that my friend faces is refusing to have sex with her husband when he comes back from overseas. It is commonly accepted in the culture that "boys will be boys" and have casual sex when they are away from home. "They just need to, they want to see, to test, how good it (sex) is, they know the danger but, (think) it won't happen to them."[xvii]

Conversely, women are expected to remain faithful and often will be watched by neighbors and relatives of the husband if infidelity is suspected. Upon return, this news would be shared with the husband and proper action would be taken. As much as I would like to see women empowered in these situations, it is not the women who have the power. "Many people who know about the danger of sexual transmission, especially many girls and women cannot avoid becoming infected because they cannot control the relations of power that put their lives at risk." (Schoepf, 2001)

When the men come home from overseas, testing and counseling services are available. Up to 2000, the shipping companies made testing mandatory for returning sailors. Since then, sailors have only been required to have pre-service testing.[xviii]

Making your husband become tested before having sex with him shows great disrespect and embarrassment on the part of the husband. In a paradoxical twist, making your husband get tested also goes against the common Christian and cultural beliefs of monogamy and trust in marriage. This is comparable to the Hmong society of Northern Thailand where "sexual double standards, which permits polygamy among men yet controls the sexuality of young women exist." (Parker, 2001)

Finally if she asserts her right to know and upsets her husband, it can lead to socially acceptable forms of spousal abuse, which is another issue that the country is currently trying to deal with. In the history of all lab work at the main hospital in Tarawa, only one case has been recorded where a woman made her fiancé become tested before they would get married.[xix] When you add up all of these stipulations along with the natural desire to have sex after months or even years without having sexual intimacy for the women, it is not often that they will stand up to their husbands in order to protect themselves from contracting the disease.

Recently the Kiribati Protestant Church (KPC) has taken a stand in support of condom use for the purpose of preventing the spread of STIs. The Kiribati Catholic Church governed by the Vatican does not support condom use, claiming that acceptance of any form of birth control would violate sacred church doctrine.

During the Fall of 2003, an influential leader in the Kiribati Catholic Church organized a week long workshop for practicing I-Kiribati clergy. The workshop addressed issues relating to personal experiences and opinions of HIV, theological perspectives of Jesus as a healer, facts and trends of HIV/AIDS in the region as well as sessions on understanding how culture, theological issues, and church responsibility interact with each other. Key to the week's message was the importance of condom use for the prevention of disease. Fundamental doctrine discussed during the workshop was the Humanae Vitae, written in 1968 by Pope Paul VI, which states "that each and every marital act must of necessity, retain its intrinsic relationship to the procreation of human

life" (McCabe, 2003). Used as the supportive doctrine, banning the use of contraception in the Catholic faith, the conference presented the idea of doctrine counter-productivity in the spread of HIV/AIDS. By not being inclusive of extramarital relationships or in cases where only one partner may be HIV positive, procreation of human life without protection may inversely lead to the destruction of human life. Results from the conference did not produce any political change in the church, however one informant did observe change in the clerical community stating, "there is a reality that we need to be caring and compassionate rather than judgmental."[xx] Because of the different cultures of the main island and outer islands, it was easier to discuss these kinds of issues on the westernized island of Tarawa. "Priests on outer islands lack confidence to tackle such a big issue, continuing to have conferences like these can help tackle this issue" [xxi] for further progress.

Due to a more conservative culture, geographical location and a lesser technologically advanced environment, the outer islands have developed different leading contributors to the spread of HIV/AIDS. The outer islands have a traditional system of governance which is not found on the main island. This system is known as the *maneaba* system. It is governed by an *unimwane*, elderly male council and minimizes deviant behavior in the community by using a form of public ridicule. Issues relating to deviant behavior such as violence, alcohol abuse, youth gang involvement, and teenage pregnancy cause less social disruption because of this system.

Additionally, men, women and children have a more defined purpose in the village on outer islands compared to main island society. Males, beginning at the onset of adolescents are often responsible for harvesting *toddy* (coconut tree sap) twice a day. Around the same time of adolescence they additionally become responsible for the raising of family owned pigs, chickens and other family owned animals. As they mature, fishing for the family becomes an added responsibility. Accordingly, females are raised with engendered responsibilities consisting of cooking, washing, cleaning and looking after younger brothers and sisters.

The traditional right of passage into womanhood comes with the arrival of their first menstrual cycle. This occurs, on average, around age 12 to 13 in Kiribati. Unlike

the American culture, this moment for a young I-Kiribati girl is a celebrated and publicized occasion. Traditionally, when the first menstrual cycle began a young girl would be secluded in a house or room with an older female relative. It was here that she would learn her role as an I-Kiribati female. Terri explains, "I had 3 days staying in the house only with grandma ... doing those things like work for womanhood" [xxii] Young girls would be segregated for three days and given little food while their stomach was tied. This was done in order to prepare her for eating little amounts of food, as many I-Kiribati women take on a subservient role and eat after men have finished. Furthermore, she would be given a traditional task to complete, such as making a mat from pandanus leaves or producing twine like material from coconut husks. After a three day seclusion, the young girl emerged from her room with the produced material, her stomach was untied and a celebration was thrown in her honor.

Along with learning the traditional role of womanhood, the female is also taught her role in sexuality through this ritual, as her seclusion represents the limitations surrounding female sexuality in the culture. From this point on, she is also to a strict code of conduct in male/female relationships, a code unseen in the upbringing of a young male.

Tradition has been altered over the years as outside influences have impressed different customs and ideas about menstruation, Terri explains how her celebration was influenced by religious beliefs. "We only have a little party because it's not allowed for Catholics to make big parties for menstruation." [xxiii] The missionaries in Kiribati didn't allow Catholics to celebrate the first menstruation because it was viewed as sinful. In the past "the girl sat half naked only in a pandanus skirt with oil all over her body." [xxiv] Priests saw this as an "old, dark custom" [xxv] and discourage the continuation of this tradition.

EDUCATION

The 2000 national census reports that the total school enrolment rate was 92.9% for children ages 5-14. The government and churches provide free education starting

with kindergarten[xxvi] and ending with form 3 (ninth grade). Secondary education, is also provided by the government and churches, however, annual enrollment fees ranging from two to four hundred AUD per student are charged. Often, when these fees cannot be met, individuals choose not to continue their education; finding productive roles as village youth or community members. Instead, many find productive roles as fishermen or toddy cutters in the outer islands.

Consequently, urban youth who chose not to continue their education, have two options. The first is to go back to their home island, if Tarawa is not their island, and assume the role of a village youth. Their second option is to find a family member on Tarawa who would be willing to house and feed them. Several youth interviewed, indicated that they would rather stay on Tarawa instead of returning to their home islands, although several mentioned that they would want to go home for vacation during the holiday break in December. Stated reasons for wanting to stay on the main island include, the advantages of living in a modern environment, the youthful population of the island and the excitement Tarawa offers compared to the outer islands. Another advantage which was not mentioned, but strikingly obvious, was the lack of responsibility associated with youth living on the main island compared to responsibilities of youth on the outer islands.

In many instances, outer island youth are frequently "charged with the social responsibility of executing village projects," (Bataua, *et.al.,* 1985) yet have very little voice on what projects will be initiated. To give more voice to the youth, youth groups, sponsored by churches and government began organizing themselves in the early eighties. With influence from foreign aid programs, the groups were formed to "promote the liberalization of these village members." (Bataua, *et.al.,* 1985) As a result there are several National Youth Councils, located across Kiribati today, which promote leadership and responsibility. Most importantly, youth groups on Tarawa assist in keeping inactive youth occupied.

COMMUNICATION

Because conditions of life vary greatly between Tarawa and the outer islands; major contributors to the spread of HIV/AIDS also differ greatly. Major communication barriers lie in deep rooted generational and gender rolls. The fear of talking about sensitive issues contributes to the topical ignorance among the traditional outer island society. Sentiment such as the one expressed here, represent a common theme found among many parents and guardians of youth. "What will happen to Kiribati views about private or taboo parts of our bodies which (we) forbid our children to see, touch or even to talk about?" (Bataua, 1985)

A study on adolescent STI knowledge was completed on two outer islands during the summer of 2002 and found that "Adolescent's knowledge of STIs, other than HIV/AIDS, was almost non existent. Even for those who claimed to have heard of STIs, the levels of knowledge about types of STIs, their symptoms and means of avoidance were extremely low." (Seniloli, 2003)

Personal research found that teachers were afraid of upsetting parents and losing their jobs if they taught "this kind"[xxvii] of education in school. Additionally, many I-Kiribati parents find it difficult to talk about sexuality through inter-generational dialogue. Surprisingly, a study of 400 youths conducted in 2002 found that 64% of respondent indicated that their parents were fairly or very useful with discussions on sexual matters. However when the 259 respondents who indicated that their parents were useful in advising them on sexual matters years of age, the list of useful messages consisted of: "get married, use contraceptives, no premarital sex, no sex during school years, behave yourself well and don't know or not stated." (Seniloli, 2002) This indicates, that communication between parent and child is not emotionally based, but rather a listing of how to conduct oneself in a socially appropriate manner. Personal research found similar results, with the added dimension of engendered messages. Mothers were the ones who talked about sexuality and how to behave in a proper manner as opposed to father and son relationships that seemed to avoid such

conversation. My interviews showed that the main dialogue held between mothers and daughters dealt with issues of menstruation and abstaining from sexual intercourse.

Barriers of communication were reinforced by several members of the Ministry of Education who feel that sex education should not be taught to students, because "if sex education is taught, students will (become) curious and engage in sexual activity."[xxviii] This same ideology dictates much of the religious sentiment communicated to youth, which tend to avoid talking about HIV/AIDS in any way other than sinful connotation. However, a new movement towards teaching care, respect and love for your neighbor was being expressed by the KPC with the intent of diluting the HIV/AIDS stigma towards the close of fieldwork.

MEDICAL CARE

Access to medical care is afforded to every I-Kiribati citizen free of cost, medical facilities are not equipped to deal with an epidemic of this proportion. Counseling skills, specific medicinal regiments, confidentiality practices and basic training of the virus are all segments of training that have yet to be afforded to outer island medical staff.

Although influenced in different ways during different time periods, gender roles, ideology, customs, language and culture are defined in many of the same ways they are today as they were several hundred years ago. Roles designed for survival in a subsistence environment have proven themselves to be efficient and effective ways of governing village life. But, lifestyles are very different on the main island, youth violence, binge drinking, overpopulation, growing poverty, health disparities and other problems associated with urbanization are becoming immense problems for the population to handle.

These factors, combined with disparities in educational opportunity, rapid westernization, intolerant religious beliefs, medical deficiencies, broken and over burdened family structures, provide many contributing variables to the spread of HIV/AIDS in Kiribati.

Perspectives of disease have progressed far from the days when viewed as simply a biomedical enigma. Recognition that social structures have had an influence on individual behavior, knowledge and attitudes indicates that disease and illness are constructed from biosocial paradigms. Therefore, it is inappropriate to continue to view disease as simply a biomedical construction while ignoring the biosocial construction of illness.

Chapter 3

ANTHROPOLOGICAL THEORY: ANTHROPOLOGIST...HOW LONG YOU HAD THAT PROBLEM?

A clear understanding of the principles of anthropology illuminates the social processes of our times and may show us, if we are ready to listen to its teachings, what to do and what to avoid.

Fanz Boas

Kiribati's isolation has prevented many western influences from entering its far flung shores across the Pacific. Social, linguistical and cultural characteristics remain largely unchanged for over hundreds of years. Its isolation has deterred the arrival of several global epidemics such as malaria, small pox and SARS from impacting its population. Isolation has been one of Kiribati's greatest assets, however, it has also been one of its greatest drawbacks. Less than 7% of its islands have modern technologies such as electricity and running water. Infrastructure for modern day health care has been limited to two main islands, while other islands have little advanced biomedical infrastructure for the treatment of disease. Due to deficiencies in medical care, many I-Kiribati find relief from common illness through the use of medicinal plants or other means of healing learned from generations of experience.

Attempting to understand the emerging HIV/AIDS epidemic in Kiribati is a major feat to undertake. Although its isolation has protected it, influence from regional and global structures have impacted the spread of HIV/AIDS in Kiribati. The use of critical anthropological approaches has allowed us to examine how the relationships between the virus and economic disparities impact national prevalence rates within the country.

Anthropological perspectives allow us to view the other as something that we can learn from. It allows us to see environments as complex inner-workings of

separate social structures which form realties of lived experiences for participants in a particular social setting. The above passage is a description of my studied and lived experience in a small island nation. Utilizing several anthropological approaches I have been able to reflect on previous years of work and life in Kiribati; transforming my experiences into a more grounded anthropological understanding of human existence.

Using combined anthropological perspectives and sociological thought, I am able to enter the environment and view reality with a deeper insight on daily lived experience. With perspectives of historical impacts, societal structures, and applied approaches to medical anthropology I am able to critically examine the emerging HIV/AIDS epidemic in Kiribati.

Boas believed that living in a culture and experiencing their way of life was the only way to "accurately" learn how environmental, psychological and historical events impacted the present day environment. Teaching youth in elementary and junior secondary schools for two years, prior to field work, allowed me to learn the language, culture and social norms. It also developed in me an understanding of how historical events played a role in I-Kiribati behavior. Key to the concept of historical particularism is the role of historical events in patterns of behavior.

The arrival of whalers brought alcohol, tobacco, tools and guns to the islands. The whalers traded these materials in exchange for sexual favors, introducing prostitution to the islands. Comparable to modern day *korokorea* or prostitutes, sexual favors were most commonly carried out for tobacco. Today, female prostitution is associated with drinking and smoking on the main island. Seen as deviant behaviors for females, these actions are frowned upon by the general public.

Robert Merton's theory of the development of anomalies states, "Socially deviant behavior is a function of social structures" (Baker, 2005). Like the *korokorea* of the past who exchanged sexual favors to feed tobacco cravings, modern *korokorea* exchange sexual favors for alcohol, money and other desired material possessions.

My research has found Robert Merton's theory to have a strong relationship with present day events, especially among female *korokorea.*

An influential social structure in Kiribati today is the church. The arrival of missionaries brought religion and new ways of life to the I-Kiribati population. Included in these new ways of live were the banning of polygamy and the introduction of Christian beliefs. Additionally, when the importation of foods such as rice, flour and sugar, now staples of the I-Kiribati diets, began to arrive there were changes in diet and consequently subsistence living. No longer was it possible to live off of the land when preference for foreign foods taken root in the population. The development of a cash economy soon followed. Cash afforded clothing, required by the missionaries, foreign foods, preferred by the people, and tobacco, demanded by men.

Issues relating to alcoholism, overpopulation, loss of land, personal belief systems, spread of disease, gender roles, education and poverty can all be viewed as outcomes of historical events. Understanding how history plays a role in the initial onset of these problems allows the researcher to have a more holistic perspective when dealing with these complex issues.

Understanding historically, that STIs have been in Kiribati for hundreds of years and learning how I-Kiribati have taken care of the problem helps us understand conflicts that arise today when dealing with issues of stigma and discrimination. Individuals who don't see discrimination, under age smoking or drinking as a problem in their life probably don't view them as problems in their society. It was not until the arrival of western rule that conflict with modern law began. Modern law states that cigarette sales should be restricted to youth 18 or older; however, in Kiribati, it is often the child's responsibility to purchase tobacco for parent use. "Smoking is part of our culture, my 5 year old son gets cigarettes for me everyday at the store for 10 cents. They (store owners) don't care."[xxix] Often times, as in this case, cultural norms prevail over modern law.

Cultural norms are also known as social facts, or accepted ways of behaving in a given society. Social facts guide individuals through daily life. They are the means

by which individuals view themselves and others in their environment. Keeping in mind the history of Kiribati, social facts have changed with time periods and environments.

From my experience of living and working in the country, I believe that social facts have greatest power in small communities where anonomynity is difficult to achieve. On the other hand, social facts have lesser influence in larger environments where populations are greater and individual identity is easier to protect. Island life in Kiribati is filled with powerful social facts which guide daily life.

In relation to HIV/AIDS the rules regarding sexual behavior and gender greatly influence the spread of disease among young adult populations. We are able to see an example of this when we examine the relationships between seafarers and their wives. Learned behaviors gained through growing up in Kiribati restrict the wife from seeing other men while the husband is away. Very little changes occur in her environment when compared to the changes that occur with her spouse's environment. He enters a new world filled with new social structures and currents which he must adapt to. One of the largest social currents for him is the feeling of independence. While at sea, independence is often experienced for the first time as they do not have family or village institutions influencing their actions. Along with new sets of social structures; new languages, technologies and the constant changing environments add to the complexities of their environment.

Because of the extended time away from spouses, extramarital sexual relations while overseas may become an acceptable behavior on the ship. However, changing the environment from a ship to a small island would alter the social norms greatly. Although it is more acceptable that men would be the more promiscuous sex, social surroundings would create greater amounts of pressure on the individual to comply to a more strict conduct. As a result, the negative pressure may deter the behavior. Social facts and currents also play large roles in stigma, peer pressure, drinking and other factors which influence the current climate and social structures surrounding HIV and AIDS in Kiribati.

Social structures are institutions which heavily influence social facts and currents. When looking at society through the paradigm of structuralism an attempt is made to discover "rules that govern relationships between elements ... and uncover the unconscious meaning found in the binary relationships between them." (McGee, Warms, 2004) The overarching belief in structuralism is that individual realities are influenced by structures of life and it is through the understanding of these structures that one is able to understand lived experience. Although structuralism does not focus on historical aspects, history has an impact on contemporary social structures.

One influential social structure within Kiribati is the church. As previously mentioned the church has influenced paradigms of though and patterns of behavior for almost two hundred years in Kiribati. Polygamy, once thought of acceptable ways of being, are now frowned upon by society because of the church. However, unlike the church, not all social structures are mechanisms for reform; structures can also act as supporters of existing ways of being. Women's subservient role has been an accepted way in Kiribati. Christianity, more specifically, Roman Catholicism reinforces this idea through its teachings and traditions. Ephesians 5:22-24 states,

> *Wives, submit to your husbands as to the Lord. For the husband is the head of the wife as Christ is the head of the church, his body, of which he is the Savior. Now as the church submits to Christ, so also wives should submit to their husbands in everything." As deemed by the Vatican, women are not allowed to hold roles as priests or high leaders in the church.*

1 Corinthians 14:34, states, "women should remain silent in the churches. They are not allowed to speak, but must be in submission, as the Law says." The church continues to promote the subservient role of women in Kiribati through its actions and teachings.

Influenced by several structures such as churches, NGOs and government, the condom has taken on several different meanings in Kiribati society. To some individuals, it is seen as a beneficial means to population control and disease

prevention. To others, it represents infidelity or promiscuity. Having this negative view of the condom counteracts campaigns which promote the use for disease prevention. A promiscuous or infidel label placed on anyone is damaging to his or her self identity. To avoid these situations, individuals may choose to not use condoms. However, if condom use did not hold such a high stigma, condom use may be a more common practice.

In order to change the perceived notion of the condom from a negative object to a useful means of protection, a certain degree of deconstruction needs to occur. The notion of deconstruction begins with the presence of a duality in logic. For an idea to subsist there must be a counter idea to perpetuate its existence. The example of the condom demonstrates that the prevailing perception of the condom is that it is bad. The essential counter idea would be that the condom is good. Derrida believes that deconstruction can take an idea and show how its different meanings can overturn the beliefs that define it. Through deconstruction one is able to challenge the socially constructed reality with contradictory perceptions, creating a new reality.

In order for one to have successful deconstruction of an idea, one must first have an inherent understanding of the culture and societal norms in which one is working. Applied work encourages research to be done with the goal of understanding an emic or insider perspective as opposed to an outside objective viewpoint. In applied research, interpretation of the world is influenced by our surroundings. It is through these surroundings that we define our words through the reading of the world. Postmodernism challenges objectivity by stating that it is an impractical idea; "because we cannot separate our ways of knowing from our language and culture, it is impossible for us to interpret the world in a truly detached, objective manner." (McGee, Warms, 2004)

Another poignant concept in postmodernism is the idea of discourse which Foucault relates knowledge and power. Discourse allows for the representation of individual or collective thought through the accumulation of power and knowledge. As with social facts, the more power a discourse has, the more accepted it will become

in society. The ideas, people living with HIV/AIDS are bad people or that women are subservient to men, are discourses in themselves. These discourses have gained power in Kiribati society over a long period of time, from the affirmation of several social structures. It has only been recently that deconstruction efforts have begun efforts to demystify these beliefs with the ideas of women's rights and equality.

Applied medical anthropology makes use of all of these theories to find out how to alleviate or minimize illness and disease in populations. Using "biological, ecological, ethno medical, critical and applied approaches" (Brown, 1998) applied medical anthropology looks at health and healing through several lenses to understand illness and disease from a holistic perspective with the intention of improving the health of populations.

The use of multiple anthropological perspectives gives new meaning to observations. Applied meaning allows for the development and implementation of intervention. Like the use of multiple anthropological perspectives, interventions were designed using multiple approaches addressing medical anthropology.

The ecological approach allowed for greater understanding between interviewees and their physical, psychological and social environment. Youth who had mentioned their desire to live on the main island stated that they wished to reside there because; the environment was modern, there were more individuals around their age and there was better access to education and paying jobs in the main island.

Without going overseas, one can see influences of western life in Tarawa, through music, clothing, videos and behavior. Informants stated that gangs, drinking and smoking are all learned behaviors from movies. Youth dress in fashions which have been imported from western countries. Often times, these fashions worn during nightlife activities, violate cultural appropriateness, which has aroused sexual feelings from male youth.[xxx] Imported alcohol mixed with sexual attraction and low acceptability of condom use perpetuates the spread of this disease in the country.

Applied approaches, through use of ethnography, have been used "in an effort to formulate health programs that are culturally sensitive, applicable to local needs and effective in obtaining community support." (Brown, 1998) This approach was used in the development of "Straight Talk," the youth outreach intervention program that circulated throughout the main island during the time of field work.

Ethno medical approaches allowed for an understanding of how people impacted by HIV/AIDS saw themselves as well as those around them. It also lent itself to the examination of how individuals in Kiribati viewed HIV/AIDS. At the time of study, little treatment and small amounts of support were observed for individuals impacted by HIV/AIDS.

Theory is a guiding tool that informs research and applied elements of field work. Theoretical concepts such as structuralism, historical particularism and postmodernism have put meaning to lived realities. Theory used in this research has juxtaposed Kiribati HIV/AIDS between cultural, historical and contemporary contexts, allowing for a broader understanding of the complexities associated with this illness. Having this greater understanding we are able to identify how and why scenarios come into existence for certain individuals and populations.

"Anthropological theory is also important because it helps us think about who and what we are as human beings. It does this by forcing us to consider the ways in which we understand the 'other'." (McGee, Warms, 2004) Through this understanding, the praxis of applied anthropological theory may be executed with participation from culturally diverse individuals who will work together for the greater good of society and human experience.

Chapter 4

HISTORICAL PERSPECTIVE: FROM MISSIONARIES TO 2-PAC

Early European observers were transients who did not understand the indigenous languages and saw only fleeting glimpses of the local lifestyle. And, even at this early stage, they were themselves causing ripples of change. These qualifications not withstanding, there is little evidence to suggest that change was rapid or dramatic. Rather, Pacific Islanders learned how to adapt and adopt the ideologies, lifestyles and technologies of outsiders but always in such a way that the essence of their own cultural identity was preserved.

Barrie Macdonald

If you ask an I-Kiribati to tell you about creation, more than likely you will hear one of two stories; the story of Nareau The Spider or of God and his son, Jesus Christ. Nareau tells us that the world was created by him. It was he who walked above the black matter that was heaven and earth; stomping and pounding with his hand and feet, he awoke the spirits who were resting within. Commanding these spirits to rise and separate the matter which resembled a clam shell, he formed heaven and earth. He then created human life by commanding the spirits to procreate. From these created beings; earth, sea, animals, celestial objects and life as we know it developed.

Like the story of Nareau, the book of Genesis also claims creation as a process of developing celestial objects, humanity, and earthly foundations from darkness. (Whincup, 1979) The Christian God created light on day one, land and vegetation by day three, heavenly lights on day four and birds, fish, humans and animals by day six.[xxxi] Despite missionary influence, I-Kiribati are usually aware of both stories and have a respect for their traditional as well as modern beliefs. Among several older interviewees, there seemed to be a kind of innate ancestral pride in claiming relations with the kin of Nareau.

Intuitively, if you ask an I-Kiribati to tell you where their people migrated from, many will find difficulty in providing a definite answer. It was Nareau who created the islands and placed humans on the earth, yet missionaries came from *matang,*

heaven, to preach a different god and creation story. "Some people say we migrated from the South Asia but I don't really know for sure."[xxxii] Likewise, if you ask about the chronic threat of global warming many will know little about it or claim that God would not destroy something so beautiful as Kiribati, of which he created. Laughing disapprovingly of scientific evidence, one of my informants said, "they said that we would be under the ocean back in 1980, we are still here."[xxxiii] On February 9th of 2005, a press release from Greenpeace stated.

> *BETIO, Kiribati — Less than a week before the Kyoto Protocol enters into force, the tiny island nation of Kiribati is ravished by a 'king tide' -- an example of the kind of sea-level rise we can expect to see more of as global temperatures increase. Thousands of people living on the low-lying atoll of Kiribati in the central Pacific were hit by waves that reached 2.87 meters today. Farmland was swept out to sea and fresh water wells contaminated. Betio Hospital in the south of the island was flooded when waves breached sea defense walls.*

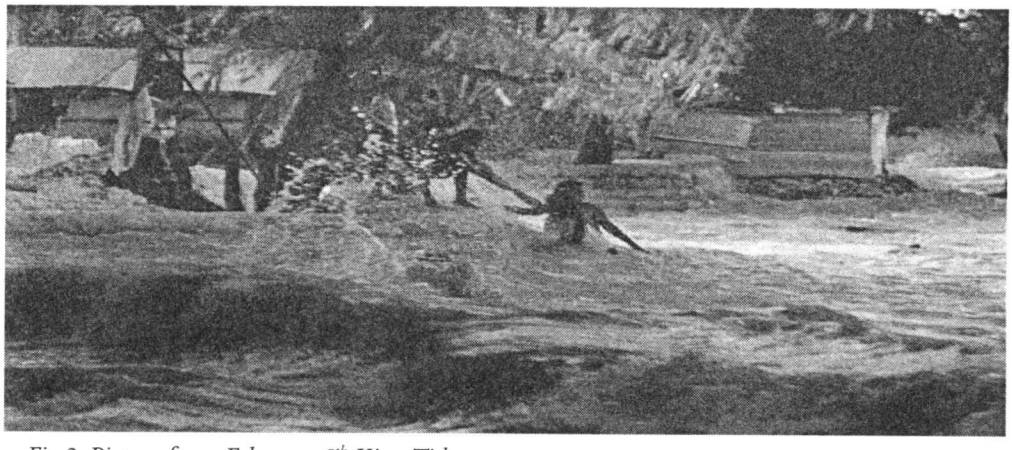

Fig 3: Picture from February 9th King Tide
http://www.greenpeace.org/international/news/king-tide-pummels-kiribati

Human inhabitation of Oceania is thought to have first started some 50,000 years ago in south west Melanesia (Macdonald, 1982). These individuals migrated from parts of south eastern Asia. First settlements were in parts of Australia, Indonesia and Papua New Guinea (PNG). Setting out on unprecedented journeys across the Pacific many individuals, either intentionally or unintentionally, ended up in large island nations, collectively known as Polynesia, such as Hawaii, Fiji, Tahiti, Samoa or in smaller island nations, collectively known as Micronesia, such as Kiribati, Tokelau, and Tuvalu were

settled. The first inhabitants of the Gilbert Islands were "small, black and frizzy haired," (Macdonald, 1982) consistent with physical features seen today in natives of the Melanesian state, PNG. According to recorded language patterns of Austronesian dialects, this migration brought to Kiribati a language which remains strongly related to the Austronesian family. (Macdonald, 1982)

The first settlers of Kiribati probably had difficulties in adjusting to the environment. The low elevation combined with "sandy soils and inconsistent rainfall often caused an extreme shortage of food and fresh water." (Macdonald, 1982) The land provided a harsh environment for any kind of vegetation outside of coconut trees, pandanus, papaya, breadfruit and taro. These same environmental conditions exist today for almost all of the islands in Kiribati.

Rising only a few meters above the ocean, water was often collected, through the digging of wells which went two to three meters below the surface of the land to the atoll's water lens. Northern islands such as Maken, Marakei and Butaritari, had significantly greater amounts of rain compared to the southern islands. The northern most island, Butaritari, is known for being one of the wettest islands. Because of this environment, exportation of bananas became one of the greater sources of income for island residents.

Along with terrestrial resources, the ocean provided great amounts of food, building supplies as well as opportunities of travel for the islanders. As certain as change has been for the I-Kiribati, the ocean has proved to be constant in its ways of providing the I-Kiribati with necessary components of daily life: food, travel and, opportunities for trade and income.

The 19th century brought great changes and challenges to the islands as three major events: Colonial rule, World War 2, and independence transpired in the Gilbert Islands. Beginning in the early 1900's Great Britain discovered that Kiribati's western most island, *Banaba*, was rich in phosphate. "Developed from "forty-foot deep solid (bird) guano," (Resture, 2005) this island proved to be beneficial for colonial economic development.

Albert Ellis, was in charge of The Pacific Island Trading Company in the 1900's. He was credited with discovering the rich mineral in Banaba. After discovery, he along with his company, *Pacific Island Trading Company,* later known as the "British Phosphate Commissioners," (Resture, 2005) focused on increasing the exportation of phosphate from the island. This demand, brought many labors from Kiribati, Nauru, Fiji and the Marshal Islands to Banaba. Because of the economic development, "Banaba became the center of administrative headquarters for the protectorate." (Binder, 1977) As a result, the Gilbert Islands became less of a concern for the commonwealth. The Gilberts now played an important role in staffing the mine operation, "relays of workers had been taken every two years to Ocean Island." (Resture, 2005) Many workers, often male, were taken away from their home islands, leaving Gilbertese women to be responsible for the land and family. The opposite happened for residents of Banaba, whose native land and population were depleted by the mining operation.

Banaban phosphate attracted more than the British. During WW2, the Japanese also took an interest in this island, labeling it as a "southern resource area." (Mamara, 1984) The first bombs were dropped on Banaba in 1941, 34 years after the establishment of phosphate mining, bringing WW2 to Kiribati.

Evans Carlson left for Makin Island, a northern island in the Gilbert Chain, to "secure intelligence about the Japanese installations, strength and inclination to fight for the atolls of the Central Pacific." (Hoyt, 1978) This first move by US forces killed "200 Japanese defenders, sunk a transport ship and burned 1,000 barrels of gasoline." The raid rapidly escalated the inevitable confrontation between US and Japanese forces. Between November 20th and 23rd, 1943 The Battle of Tarawa, claimed over 8,000 US, Japanese, I-Kiribati, and Korean lives.

My host grandfather recalled the images of the war as he stated, *I was a young boy back then, I remember getting into my canoe and paddling to the point where I could see the bright lights and hear the loud* (booms) *of the bombs.* Laughing, he stated, *there I was... in my little canoe.* Other friends of his recalled meeting US service men and compared them with the Japanese soldiers. *The Americans were very different, they*

gave us little meats and drinks in cans that made our noses itch. (From what I gathered, the food was hot dogs and coke.) *The Japanese did not do this, we wanted the Americans to win.*

It is recorded in several texts that the I-Kiribati did help the Americans by telling them where the Japanese soldiers were hiding and when to strike. For this, many I-Kiribati lost their lives "The men were put in a separate group from the women and children, they were lined up on the road and at the head of each row a machine gun was placed at the front of the road." Many I-Kiribati were killed during WW2, but today, American troops are remembered as heroes of the time.

Using the war as rationale for relocation, the British Government decided to move the Banabans to a distant island in Fiji. Rabi *(Ram-bee)* Island was purchased with phosphate royalties, leaving many resources unreturned to the I-Kiribati people. Several I-Kiribati communities still live in Rabi today, however many died initially upon arrival due to harsh weather conditions, a substantial change in diet and an unfamiliarity with the climate leading to large amounts of illness and disease.

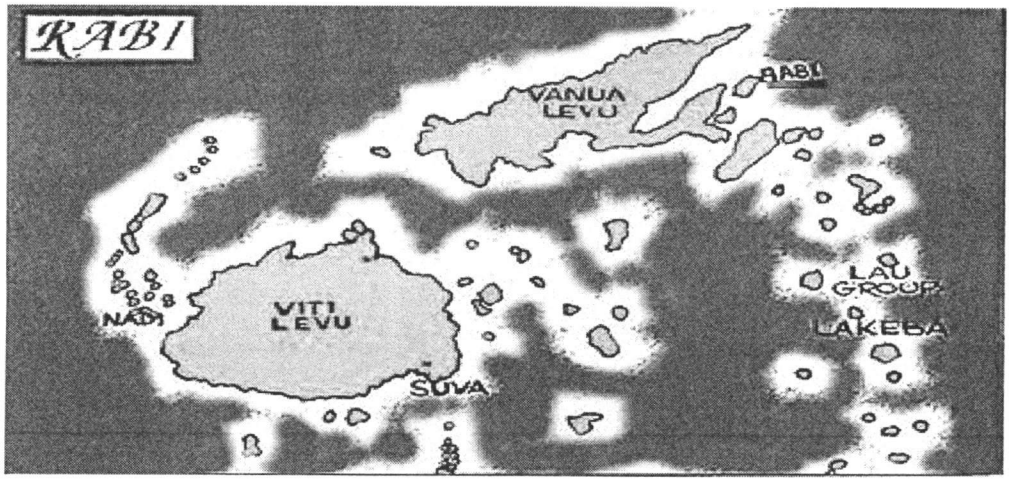

Fig 4: Rabi Island in Fiji
www.pacificislandtravel.com/kiribati/about_destin/banaba26.jpg

Kiribati remained a colony of Great Britan until 1979 when independence was granted. At that time "the United Kingdom was very keen to give us our independence, and whether we liked it or not, it was going to happen." (Pareti, 2004)

The beginning of independence marked a drastic change in society as Kiribati was no longer governed by external forces. Since independence, the country has gone

through three presidents with three different ideologies on how to run the country. Influencing the country in their own unique way, colonial rule seems to still have greatest influence on social structures as tea time, parliamentarian government, western law, Christian beliefs and the use of English in formal settings and school curriculum still influence individual lives today. Outside influence has left the I-Kiribati culture and people changed. That change has caused advances and setbacks in social and technological development and after 179 years of external rule, it remains up to I-Kiribati to lead their own direction for history to record.

Indicative of how several interviewees, would like to see the future of Kiribati evolve, is a story of a friend. Bill was living in Iowa when I met him. He was a US soldier who served in Kiribati during World War 2. He served on Makin Island. There was a family that he became very close with, *"They all wanted their picture taken"*[xxxiv] But he could never communicate that he would send it to them.

Knowing that I would return to Kiribati, he asked me if I would take the pictures back to Kiribati for him which he took in 1943. Nearly 60 years later, he wanted me to find his family and deliver the pictures to them. He remembered the I-Kiribati with great affection, stating that they were "some of the kindest people" he remembered meeting, a hallmark of Kiribati culture.[xxxv]

The feelings and memories he had held onto brought forth the cultural significance of kindness and unity that is Kiribati *katei,* which many older I-Kiribati interviewees feel is needed today for the future of tomorrow.

MY LAND, MY COCONUTS... MY TOBACACCO

Through living and working in Kiribati over the past five years, I have come to a different understanding of many unique aspects on life and different perspectives of human existence. Included in this understanding, is the definition of poverty and what it means to different people in different parts of the world.

Although Kiribati is at the lower end of the Human Development Index, and categorized as one of the poorest countries in the Pacific. Many I-Kiribati do not view

themselves as being impoverished. "We are not poor, we are not like the people in Africa who are starving and have no place to live." The problems of insufficient food, shelter, social poverty and other circumstances commonly associated with a poor quality of life, rarely exists in the country. However, according to the Human Development Index and the Universal definition of poverty, grounded in an economic paradigm, Kiribati is a highly impoverished nation.

In the United States, poverty is associated with urban areas where high rates of homelessness and crime exist. Although the largest urban area in Kiribati does not have as high of a population or reported crime rate as an average American city, it does have similar social problems associated with the urban environment. Urbanization brings with it "socioeconomic transformations" (Parker, 2001) as Parker describes, which create "vulnerability" in populations that are not apt to handle the radical changes associated with the urbanization process. Because of this vulnerability, the most disadvantaged populations succumb to desperate measures in order to survive the adjustments.

The current development of modernity and kinship relations in the capital island define a turning point in the history of Kiribati's social course, as they are increasingly departing radically from traditional ideology. The resurgence of prostitution along with the development of modern day child prostitution has had great social and political connotation for the country as it transitions from an ideologically traditional culture to a more modern day society.

One of the most turbulent times was when churches, collectively took a stance against the resurgence of prostitution in the country during 2002. Radio broadcasts along with sermons and printed news stories addressed the issue through the condemnation of such acts while failing to address the underlying social developments and structural violence associated with prostitution. Robert Merton's theory of the development of anomalies states, "socially deviant behavior is a function of social structures" (Baker, 2005). Greater than just a function, I argue that it is a result of social structures which converge, in this case, causing structural violence forcing several disadvantaged individuals to partake in unsafe practices.

Language, as society, evolves to fit the context of lived experiences. In general, the I-Kiribati language is exceptionally descriptive. Describing the defined concept in literal terms, the word meaning prostitute was at one time, *nikira n roro,* unmarried girl who was not a virgin. With the arrival of Korean fishing ships in Kiribati, this concept evolved into the modern day word *korokorea*, literally translated Korean cut, meaning the kind which Koreans like. When Korean vessels began fishing in Kiribati waters, the ships would often make frequent stops in Betio, the country's largest port located on Tarawa. As a way to earn extra money, get free beer and material items, young girls started to frequent the Betio harbor when these ships docked and exchange sexual favors for material items, in the late 1990s.[xxxvi] Police interviews revealed that it was difficult to prosecute cases under "prostitution" because "this idea is very new, it is strictly against our custom."

Socially, prostitution is looked down upon. Legally, there is no law banning prostitution. An interviewee informed me of the technicalities of the law that is used to arrest prostitutes and solicitors. If we arrest them, "we arrest them (foreigners) under immigration violations"[xxxvii] because they have restricted time to be on land while they are in port. Because of this law, it is common that seafarers will visit the numerous drinking establishments in Betio (as pictured below). Here they find willing individuals and take them to their ship in order to avoid arrest.

Fig. 5: Picture from Betio Warf, store/bar named after the Korokorea phenomena

Young I-Kiribati women and foreigners have had a historical relationship, dating as far back as the early 1840s when the first whalers traded tobacco for women. Tobacco was used to dull stomach pains caused by a constant shortage of food,

(Macdonald, 1982) eventually; this led to addiction and dependency on the drug, making prostitution a regular and accepted occurrence in exchange for tobacco. Women would board the ships for days or even weeks at a time, while the whalers took them on whaling expeditions, using them to feed their sexual appetite while at sea. Shipping records show that the sex trade was very business like between the men of the island and the traveling whalers. One lieutenant of the US exploration expedition "was shocked to see, 'fathers and brothers [acting as] pressing salesmen of their daughters and sisters, some of them only thirteen or fourteen years of age." (Macdonald, 1982)

Some *nikira n roro*, were married women who were not living with their husbands due to war or death and instead of remarriage they found greater opportunity and freedom in becoming involved with the sex trade. Other nikira n roro were girls who were enslaved because of family standing in the community. In most instances these girls belonged to families with little or no land, forcing them to work on the ships for the survival of the family. In many cases these women had a higher status in the community because they were able to generate income and attain new material wealth, additionally "when they returned to their own islands they were a major source about the outside world and I-matang (foreigners) ways." (Onorio, 1984)

Eventually as the I-Kiribati women became more familiar with I-matang surroundings, other material items such as axes, pots, beads, knives, liquor and guns were traded but tobacco remained the main currency for I-Kiribati women. Costs varied from woman to woman but the typical cost ranged from half a stick to one whole stick of tobacco. It was also at this time that the first "venereal diseases were said to have become wide spread" (Onorio, 1984) among the I-Kiribati population.

The sex trade continued to expand until the arrival of the missionaries in the late 1800s. With the missionaries came a change of life, culture and a stricter intolerance for sexual promiscuity. As a result, the introduction of abstinence and monogamous relationships caused female virginity to become an act of moral obligation to families and females. Alternatively, the concept of male chastity did not take hold in society. This double standard in sexuality created a paradigm of sexual oriented gender inequality, making females who know about the danger of sexually transmitted

infections, vulnerable to infection as they "cannot avoid becoming infected (with STIs)" (Schoepf, 2001)

Interviews revealed that practices akin to practices of the sex trade continue today. One interviewee stated that families would purposefully keep "experienced" girls on the main island in order to generate household income.[xxxviii] Attractions of modernity arrived through the introduction of electricity, telephones, internet, buses, a variety of foods, nightclubs and opportunities to see the world enticed them to stay on the main island.

Tonga and the Marshall Islands are currently facing similar problems with child prostitution. *"Culturally speaking, my country is a matrilineal society and we have very strong Christian values. We know something is wrong when girls are becoming prostitutes. Girls are highly valued and if prostitution continues then we're losing our culture,"* says Ione DeBrum who is the manager for the women in development program in the Marshall Islands. (SPC, 2001)

Chapter 5

RESEARCH METHODOLOGY: HE'S A DIFFERENT KIND OF BOY

If we knew what it was we were doing, it would not be called research, would it?

-Albert Einstein

This chapter reviews the qualitative and quantitative methods used in collecting data. Research was divided into several sections. The first section of my research focused on learning what adolescents, young adults and adults perceived HIV/AIDS to be and what had been done by the NAC and other partner organizations to support prevention and treatment efforts in the country. Data for this portion was collected through surveys, focus groups and personal interviews. Selection procedures for these surveys utilized the snowball sampling method. The second section of my research utilized the collected data for the development of an educational intervention. The intervention was conducted among several adolescent and adult groups. Pre and post tests were conducted to measure the effect of the intervention on participants. Teachers or administrators conducted the selection of participants for pre and post test involvement. The third part of my research focused on learning how HIV/AIDS impacted family members, friends and individuals living with HIV or AIDS. Selection for this section of research was conducted through a confidential snowball sampling method. Personal interviews were used to collect data. The last portion of my research included a public service survey. Store owners, restaurant workers and other employees of the main shopping district in Tarawa were surveyed on their practices and feelings towards having customers with HIV/AIDS. Selection of stores was based on a random sampling method where stores were assigned a number and selected from a hat at random. These surveys were accompanied with a brief educational intervention, posters and handouts after completion of surveys.

SETTING UP

Having lived in Kiribati for two years as a Peace Corps Volunteer prior to conducting this research, I acquired an emic understanding of the culture, language and developed several relationships with host country organizations and individuals. This background along with formal training in anthropological studies and methodology enhanced the research project.

Several months prior to fieldwork, I contacted the National Task Force on HIV/AIDS/TB (KHATBTF) inquiring about an internship. (See appendix A) The KHATF was formed in the late 90s with the intent on coordinating national efforts on HIV/AIDS awareness, treatment and support. It initially comprised of members from NGOs, religious organizations, village groups and government ministries. With financial help from the MOH, the KHATF established an office on the main island of Tarawa. In the early 2003, the organization became known as the KHATBTF, taking on added responsibilities for TB prevention. Today the organization works as the coordinating body for the national response to HIV/AIDS/TB in Kiribati.

It had been two years since I left Kiribati and while in the US, I worked with this organization to raise funds and develop I-Kiribati language IEC materials which were used in KHATBTF social marketing campaigns. Working closely with the KHATBTF, information and guidance had come from their office on what messages they wanted to portray. This work relationship led to the summer internship with the KHATBTF.

Once plans were finalized for the summer work, I proceeded to update myself on current background knowledge, issues, activities and situation in relation to HIV/AIDS in Kiribati. I gathered this information through emailing several friends, NGOs as well as the National Ministry of Health. A draw back of this method was that I was only able to get information from educated and generally well to do individuals. Accessing information from individuals living on the outer islands, where issues relating to HIV/AIDS differ from the main island, was impossible for the given time period.

To conduct research, I traveled back to Kiribati where I lived and worked in three islands from June 18 to September 20, 2004. Aligning fieldwork with my internship under the National Ministry of Health, I was based out of the Kiribati HIV/AIDS/TB Taskforce office. The majority of my research took place on South Tarawa, the main island of Kiribati.

At the time, the KHATBTF consisted of over 25 different organizations. The organizations ranged from schools, religious institutions and youth groups to women's associations, seafarer unions and governmental ministries. I partnered with several of these organizations to learn about HIV/AIDS in Kiribati. Methods used to gather information included personal interviewing, focus groups and an educational intervention quasi experiment. In several cases, I discovered that use of the English language was a barrier for communication, yet in other cases I found that individuals preferred to speak in English. To compensate for this I conducted interviews and interventions in both English and I-Kiribati.

Upon arrival, I asked a representative of the KHATBTF to direct me to an ethics committee with whom I could review my IRB proposal. He responded by saying that there was no such committee, and didn't see a problem with what I was intending on doing. Nonetheless, all interviewees were prefaced with the purpose of the research and how confidentiality was to be kept between myself and the interviewee.

Due to the threatening nature of formally signed papers, availability of electricity and copy machines; formal consent forms were replaced with verbal explanations of the project in the native tongue. Informants either granted or denied interviews and appropriate steps were taken. (See appendix B for script)

SECTION ONE: GATHERING INFORMATION

Outer Island Youth Surveys

The first section of my research consisted of gathering information. Data was attained through surveys and interviews which focused on understanding the current

social climate surrounding HIV/AIDS and what activities had been carried out or were being planned by the NAC and partnering organizations.

Surveys were the primary method used in learning what youth knew and felt about HIV/AIDS. Two large group surveys were developed and conducted on two outer islands (see appendix D). The first group consisted of 32 male and female Junior Secondary School youth. The second group consisted of 21 males and 19 females between the ages of 14 and 19. Each survey was followed up with either a lesson on HIV/AIDS or a handout which answered questions on HIV/AIDS, students were free to ask question afterwards as well. Both materials were presented in the I-Kiribati language.

An unforeseen limitation of the first survey, was the limitation put on it by our counter part who wanted his students to answer all questions in English, so they would be able practice their English for the day. This limited the amount of information gathered from the surveys.

The second survey was conducted with the understanding that students would be allowed to answer in I-Kiribati if they chose. Because of this decision, the second survey revealed greater information. The surveys showed not only what students knew but also their perceptions of PLWHA and where they had learned their knowledge.

Adult interviews

Gathering information from parents, school teachers and guardians of youth was an important piece of research as they have an influence on youth activities and behaviors. The primary method used for gathering information with this population was through seven personal interviews which ranged from half an hour to two hours of time. Informants were asked questions concerning knowledge of HIV/AIDS, sexual behavior instruction given to youth, as well as their ideas for education in schools and guidance of youth. (See appendix I) Special attention was paid to individual economic wealth, exposure to other cultures, occupation and educational level. From these characteristics I was able to generate comparisons of ideas and views on STIs, HIV/AIDS, appropriate

age for health education and preference on who should inform their children about matters relating to sex between more westernized and traditional individuals.

NAC and Partner Organization Activities

The primary method used for learning what had been conducted in Kiribati to prevent the spread of HIV/AIDS and support those impacted by the virus was personal interviews with seventeen organizations which lasted no longer than one hour each. In all interviews with partner organizations of the KHATBTF, appointments were made, although, the majority of the time, just showing up proved to be more effective as appointments were often forgotten or disregarded. Hand written notes were recorded throughout the duration of the interviews and later reviewed for clarity. A basic list of questions was used in all organizational interviews, however as interviews proceeded, more questions were developed to understand the context of their statements and opinions. (See appendix C)

SECTION TWO: INTERVENTION

Section two was developed from the collected survey data. It focused on examining the benefits of an educational intervention in providing basic knowledge with the intent of reducing individual negative feelings held against people living with HIV/AIDS in Kiribati. With the use of a quasi-experiment producing quantitative data, I tested two null hypotheses; Youth who go through an educational intervention program will not have any change in their knowledge of basic HIV/AIDS facts and Youth who go through an educational intervention program will have no change in their empathy towards people living with HIV/AIDS.

A pre and post test was developed in order to measure the impacts of the intervention. (See appendix F) Random individuals in the class were chosen to participate in the pre and post-test. However, because these individuals were not secluded from the group, the surveys turned into small group projects. The intervention initially included a recorded story of a real I-Kiribati who was impacted by HIV.

However, due to the quality of the sound system, this part of the intervention did not seem to have the impact we had hoped for. It bored the group because they could not hear the story.

Changes made to the intervention included; the addition of a one hour focus group session prior to the intervention, where pre tests along with small focus group interviews would be conducted separate from the larger intervention group (See appendix G), interactive activities between the audience and facilitators which kept the crowd involved in the lessons, a short drama depicting high risk behavior common to youth (discovered through interviews and focus groups) along with music and comedy based off of local media and contemporary events. Finally, depending on schedules, guest speakers who were impacted by HIV/AIDS spoke at sessions.

The majority of time and energy was devoted towards youth who were attending school because of the logistical organization that school provided for intervention and focus group sessions. Organizing time with youth who were not in school was much more difficult as there was no consistent location or time. I was however, able to conduct two informal focus groups sessions during my time with youth who were not in school. Recruitment for these groups followed a snowball effect method, where one person knew someone who knew someone who would be willing to talk with me. Key to these interviews was the personal relationships developed several years prior to field work. The first group consisted of two males ages 21 and 20 and three females ages 21, 16 and 18. The second group consisted of two females and one male age 16 to 21. Questions discussed can be found in appendix F.

Opportunities for further research developed towards the end of my time in Kiribati, when a national workshop for teachers took place on Tarawa. I was contacted by the workshop organizer and asked if I along with another member of the KHATBTF would present the intervention to their participants.

Because the intervention was designed for youth, several components needed to be changed for this population. Changes made, included the use of straight forward language, the teaching and disbursement of condoms and the annexing of the "cost of pregnancy" section, as many audience members already had children and grandchildren

of their own. The modified intervention provided basic facts on HIV/AIDS, how it spread in the body, what resources were available in Kiribati for testing and counseling as well as trying to reduce the amount of stigma associated with people impacted by HIV/AIDS. The intervention provided to the teachers included a pre/post test.

SECTION THREE: THE IMPACTS OF HIV/AIDS

The third section of my research involved talking with friends, family members and an individual impacted by HIV/AIDS. These interviews were the most sensitive of all research due to the current social climate in relation to HIV/AIDS. Because I could not advertise to talk to anyone who had HIV, I relied on a trusted network of friends whom I had previously known or worked with to schedule these interviews. For this section of research, one person, at the time, living with HIV, a relative of an individual who passed away from AIDS along with a friend of a person currently living with HIV were interviewed for this section. This part of the research was originally established to provide a needs assessment component for PLWHA and relatives who take care of them. Instead, interview questions (appendix G) enabled me to get a better understanding of how stigma, associated with HIV/AIDS, impacted the family unit and individuals with HIV/AIDS. From these interviews, I was able to hear their stories, fears and concerns. Appointments were not officially arranged for any of these interviews, nor were written records of confidentiality developed. These interviews provided insight for the intervention program, as a section was later added to highlight the present stigma associated with HIV/AIDS and what it means to individuals who are on the receiving end of it. Although none of these interviews lasted for long periods of time, they became the most meaningful pieces of this research which added greatly to the intervention component.

SECTION FOUR: PUBLIC SERVICE SURVEYS

The last section of research was developed and carried out with a counterpart on the main island of Tarawa. The goal of the survey was to find out how store, restaurant and entertainment facilities workers/owners felt about having PLWHA visit their establishments. This idea resulted from the theme of individual fear in going out in public that was brought up in all interviews with people who were impacted by HIV/AIDS. The shops were selected by their size and location, targeting the largest stores and entertainment attractions in Betio. 15 establishments, located on the main shopping strip in Betio were surveyed with three basic questions. (See appendix H) After questioning, each participant was provided with an I-Kiribati information booklet on HIV/AIDS, designed by the MOH, and if willing posters designed by the KHATBTF office were posted on store fronts to show their support for PLWHA. These posters served as social marketing pieces for the KHATBTF campaign as well as indicators of "safe establishments" for PLWHA.

All together, the study consisted of 73 Knowledge/Attitude surveys completed by youth on two outer islands. 121 Pre/Post intervention tests completed by 85 Youth & 36 adults on the main island, 41 Personal interviews with HIV/AIDS Service Providers, Teachers, Parents, Relatives & Friends of PLWHA, 14 youth focus groups *(12 in school two out of school),* 11 Education/Intervention sessions, one Public Service survey *(Bars, Restaurants, Theatres & Stores)* and two home stays, one on the main island and one on an outer island.

Collected data was analyzed in country by hand and presented to the Kiribati NAC in Kiribati and the UNAIDS Theme Taskforce in Suva, Fiji at the conclusion of my three month field work. Qualitative data was analyzed by reviewing the interviews and focus groups and highlighting themes found among individuals.

Quantitative data was analyzed by comparing pre and post test results. Three categories were developed to statistically analyze the data; female youth, male youth and male adults. Results were averaged and compared among and between the specified categories. More sophisticated statistical analysis was conducted using nonparametric procedures run on SPSS software upon return to OSU.

Chapter 6

RESULTS: JUST TUCK IN YOUR MOSQUITO NET AND YOU WON'T GET AIDS

This chapter shows the results from the four sections of research. Results from the first section showed that although the majority of surveyed individuals had heard of HIV/AIDS, little knowledge beyond it being spread through sexual contact and resulting mortality was present. Additionally, a high amount of stigma towards PLWHA existed in several individual and focus group interviews. Section two results showed that the intervention had little effect on increasing basic knowledge of HIV/AIDS among participants. However, the intervention did produce a significant impact on reducing levels of stigma among participants. Section three exposed the shame, fear and isolation seropositive individuals experienced. This section also exemplified the need for support and medical treatment programs for families and individuals impacted by HIV or AIDS. The last section surprisingly showed a general acceptance of PLWHA in public shopping and entertainment districts in the main business district of Tarawa. The results varied among population samples; however expected and unexpected findings could be generalized into statements from the research.

HIV/AIDS has introduced a platform for dialogue filled with a complicated blend of fear, hurt and confusion among I-Kiribati individuals. Interviews have shown that people living with HIV/AIDS are shunned from society. Focus groups have shown sexuality to be a hushed topic of discussion, yet very prevalently practiced among high risk populations. Coordinating bodies have stated that little infrastructure providing support and care for PLWHA exist in the country while high government officials have recognized that HIV/AIDS has brought with it a new challenge to running the country. The NAC has done its fare share of work in lobbying for governmental support, producing awareness campaigns and to the best of their ability provide counseling and support services for individuals living with HIV. On the contrary, significant amounts

of work have been accomplished with the few resources made available to them. The main point, as research will show, is that there is still much more that needs to be done in the future.

In this chapter, the results are broken into two main sections, quantitative and qualitative. The quantitative section analyzes initial survey data and intervention pre/post test data. Using bar charts and non-parametric statistical tests, the data is broken down into charts and tables. The second section analyzes focus group and personal interview sessions. Themes are highlighted and presented from the qualitative research. By combining quantitative and qualitative data analysis, I hope to present a more in-depth understanding of the research.

In the quantitative section, the results are presented in three sections highlighted by sub-headings; *Outer Island A Survey*, *Outer Island B Survey* and *Intervention Pre/Post Test Results*. The qualitative section presents results through subtitled themes; *Education*, *Youth, Alcohol, Sex and Sexes*, *Relationships and Sexuality*, *Poverty*, *Teen Pregnancy*, *People Impacted By HIV/AIDS and NGOs*.

QUANTITATIVE RESULTS

Initial outer island surveys:

These surveys gathered information from youth on what they knew of and perceived HIV/AIDS to be in their country. It also explored how they learned the information. The first survey was conducted in a Junior Senior Secondary school setting with 32 Form three students, equivalent to US ninth grade students, ranging from 13 to 15 years of age.

Responses from participants were written in English, creating a significant limitation in data collection. Form three students have a limited amount of English fluency; information gathered was often presented with fragmented and incomplete thoughts or sentences. Future work was conducted in both English and I-Kiribati to alleviate any further problems in data collection. Analysis was conducted by recording the amount of times a topic arose in their responses, leading to the creation of themes.

Often times, students mentioned several themes in one answer. For example, a student who answered, "HIV/AIDS is spread through sexing around, it is dangerous because it kills people" would have one answer stating two separate themes. The first theme is the recognition that HIV/AIDS is an STI, the second theme is the presence of stigma, danger and death that he/she had associated with the disease.

Outer island A Survey:

Survey questions included:

1. *What do you know about HIV/AIDS?*
2. *Do you know any ways that you can protect yourself from it?*
3. *Where did you learn this information?*
4. *Do you think HIV/AIDS is a problem in Kiribati? Why? or Why not?*

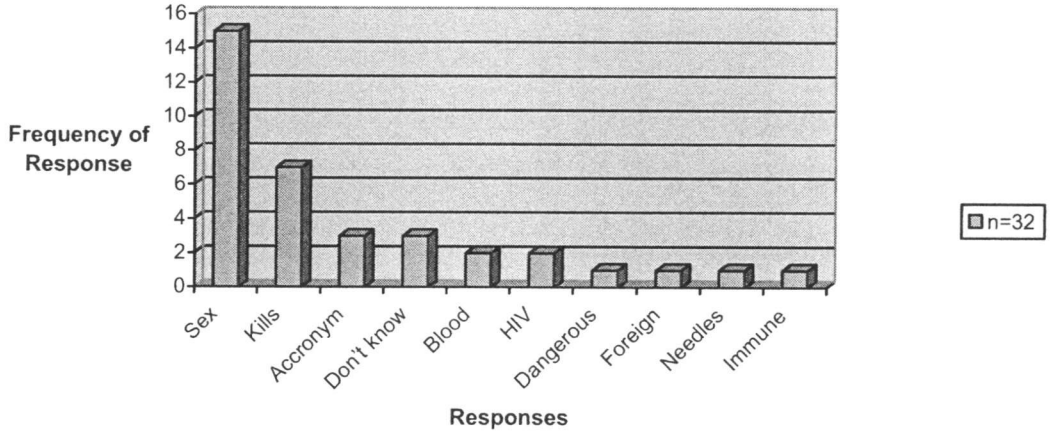

Fig. 6: What do you know about HIV/AIDS results, Outer Island A (See appendix L for Response Definitions)

This chart shows the most frequent response was that HIV and AIDS are spread through sexual intercourse and that it kills. Not surprising is this finding as most of the national public health campaigns have focused on the spread of the disease in this manner. Beginning in the 1990s a fear campaign was initiated. The campaign highlighted the dangers of sleeping with several partners. It depicted the AIDS virus as a devil's creation, complete with fangs, dripping blood and devilish smiles. In one billboard, the virus laughs to itself stating, "I am going to get another person here."

Another billboard portrays the virus as having the ability to eat away human flesh. Depictions of individuals living with HIV/AIDS were portrayed as individuals fallen to seduction or doing "evil things." (ARP, 1999)

Fig. 7: Main Island AIDS billboards, taken summer 2004

Like in many other parts of the world, the fear campaign was one of the initial public health campaign responses for HIV/AIDS in Kiribati. In the past, fear messages have proven to be both successful and unsuccessful. In areas where they have worked, fear messages have stimulated the public into a sense of urgency. From this sense of urgency arose a need to act in order to prevent the disease. This is where public health fear campaigns that fail, end. Fear campaigns that succeed, continued on by providing attainable means of prevention for the general public. By providing means of prevention, individuals were empowered to take appropriate measures of protection from the harmful agent.

Several fear campaigns would state that they provide appropriate means of prevention for the general public, yet many campaigns fail at prevention. Counterproductively, when plans to reduce incident rates fail, fear increases, promoting stigma and other means of discrimination and inequality in the general population.

Kiribati's fear campaign provides a good example to analyze as it seems to have run into complications with providing appropriate means of protection for the general public. Over the past ten years, the number of recorded HIV/AIDS cases has consistently risen.

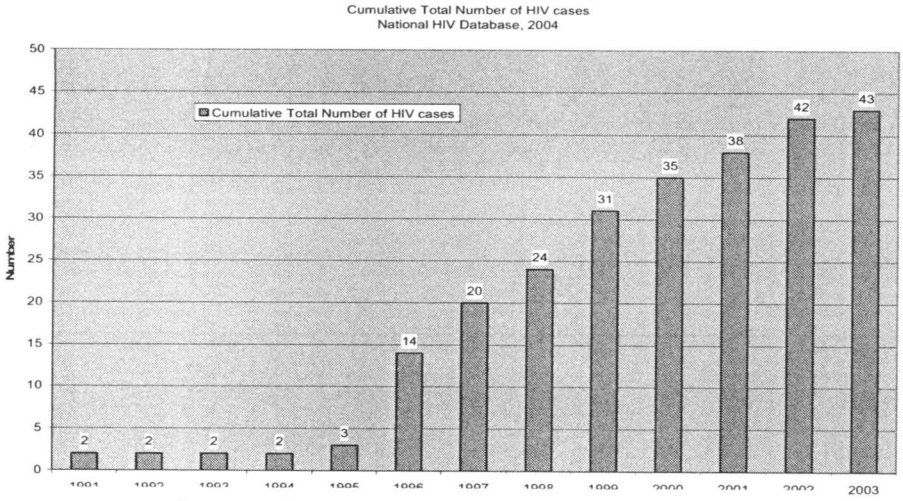

Fig. 8: Cumulative total number of HIV cases in Kiribati

The main prevention methods promoted in Kiribati are abstinence and being faithful to one's partner. Condom use is promoted but rather, to youth, it is promoted as an ABc instead of ABC, emphasizing abstinence and faithfulness over condom use.

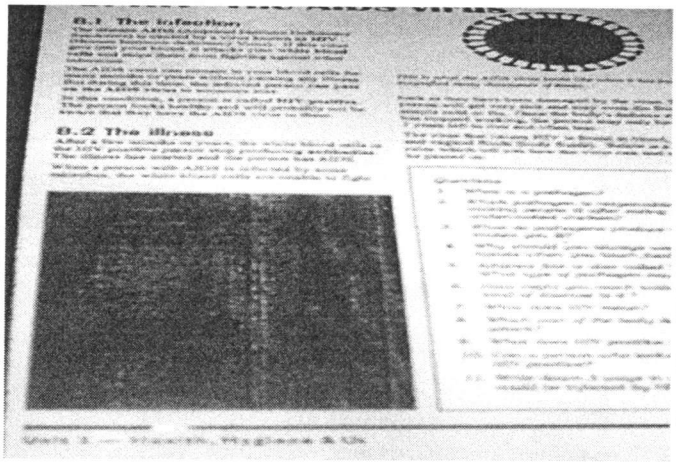

Fig. 9: HIV/AIDS National Curriculum

The following results will demonstrate, attainable prevention methods such as education and condom use in the country, although highly publicized, are often unattainable by youth, one of the countries largest high risk populations.

AIDS stands for "Acquired Immune Deficiency Syndrome." This was the third largest bit of information students knew about HIV/AIDS, unfortunately no one mentioned what acquired immune deficiency syndrome stood for. Form three, science unit #3 "Health, Hygiene & Us" covers HIV/AIDS. At the point when the survey was given, this unit had not been fully covered. But, in preparation of the event, the instructor did review the lesson briefly.

The first sentence of unit, 8.1 reads "The disease, AIDS (Acquired Immune Deficiency Syndrome) is caused by a virus known as HIV (Human Immuno-deficiency Virus)." Because of the fear held in teaching sex education to students, definitions are what typically form the base of health education relating to HIV/AIDS in Kiribati.

It is interesting to note that only twice did the idea of blood containing HIV/AIDS come out in the survey. This is indicative of the emphasis campaigns have not had on blood transmission. Two individuals mentioned that HIV causes AIDS, while themes of foreign introduction to the Kiribati population, needles as a way of transmission and the biological understanding of the disease were each mentioned once.

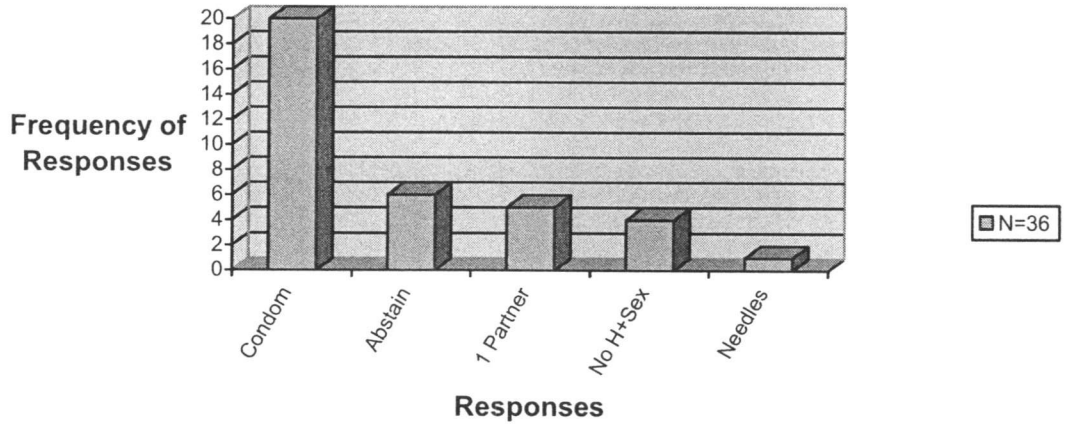

Fig. 10: List of prevention methods you know that can protect you from contracting HIV/AIDS, outer island A. (See

The country does promote the ABC model in its campaigns, however, surveyed youth had mentioned condom use most frequently followed by abstinence then being faithful in the survey. The remaining answers included not having sex with people who have HIV/AIDS and not sharing needles.

From focus groups and other interviews with youth, condom use, although highly recognized as something that can prevent the spread of HIV/AIDS, was not something feasible or desirable in several situations.

The main island had a condom distribution campaign, which had been in place several years prior to fieldwork. Red boxes were distributed to clinics, bars, hotels and other places viewed as high traffic areas. Condoms were placed in these boxes and put on display for the general public's use. Condoms provided by the UNFPA and other international development organizations were to replenish the boxes on a regular basis.

At the time of research, the amount of condom distribution activity varied from village to village on the main island. Betio, the most populated area of Tarawa, had a consistent program, which was overseen by an organization that focused on adolescent reproductive health. Other sites, located farther away from this village, did not have the consistency of Betio due to their distance from the urban center.

For some youth, the mere location of the red condom boxes, at hotels or clinics was problematic as they were located in open places where individuals could see youth taking them. Too shy to take condoms in an open area; they felt that condoms were socially off limits. Other interviewees stated that condoms were placed in areas that required assistance from bar maids or hotel attendants. "You feel embarrassed asking for a condom to the bar person."[xxxix]

An interview with a bar owner revealed an additional barrier to condom use. When first talking with this owner, they stated that they did not have any condoms that is why none were out on the bar for patrons to pick up. Upon my return, I brought a new box of 500 condoms; they thanked me for the condoms and proceeded to put them in a safe place until the opening of the bar. I returned several times to that bar during my three month stay and did not see condoms in the open for people to take. The owner stated that she personally disapproved of the condom. This was also seen in their decision not to avail them for public use. Alternatively, a competing bar located less than a minute away by foot, had an opposite view of condom distribution, as one informant put it, "you get a condom with your drink."[xl]

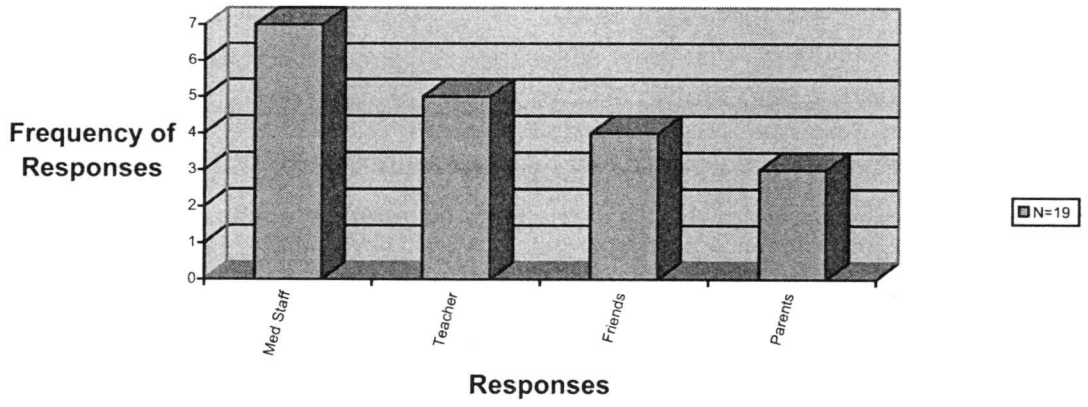

Fig. 11: Where did you learn this information? Outer island A. (See Appendix N for response

When asked, "Where did you learn the information?" most said they had learned this through some kind of medical professional such as a nurse, medical assistant or a doctor. When interviewing teachers and parents about the education of sexual health, several said they prefer to have someone in the medical profession explain these issues to their children because of the qualifications held by these individuals. Out of the seven who responded "Medical Staff," five noted that they had had a personally spoken with a doctor or nurse; the rest had heard MOH sponsored announcements on the daily radio national broadcast. Unexpected, was the five respondents who had stated that their teacher had informed them of HIV/AIDS. It should be noted that more than ten students did not answer this question, of which I attribute to the language barrier.

The last question asked if individuals perceived HIV/AIDS as a problem in Kiribati. The majority, twenty out of the twenty one individuals, responded that it was a problem. One individual did not believe that HIV/AIDS was a problem in Kiribati because they saw it as a problem that would resolve itself by killing all of the carriers.

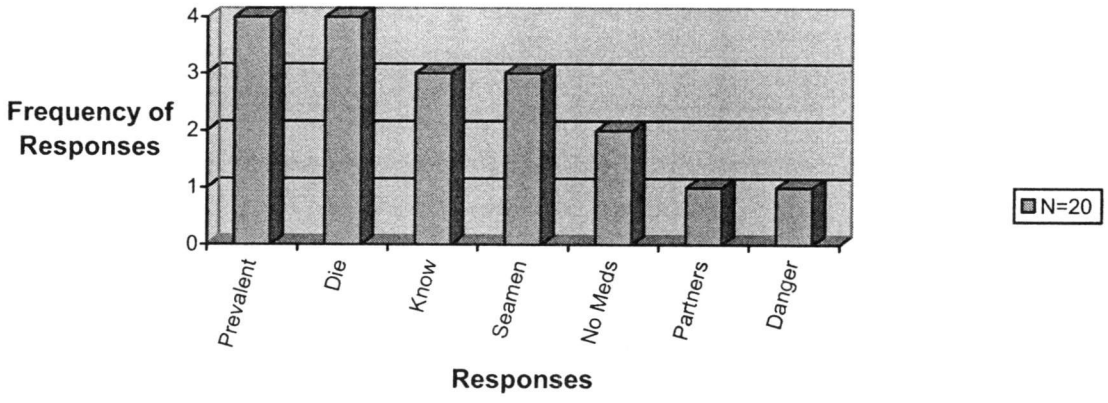

Fig. 12: Why is it a problem? Outer island A. (See Appendix O for response definitions)

Of the individuals who saw HIV/AIDS as a problem in Kiribati, the most frequent response was because of its prevalence in the country and the high mortality. Following these ideas were the associations the disease had with seafarers who work overseas and the inability to recognize a seropositive individual. Along the lines of the association between the disease and seafarers is the idea that HIV/AIDS is only introduced through foreigners or those who have gone overseas. Contrary to this idea of foreign infection, survey data does not indicate that individuals recognize HIV as a domestic infection. Indicative from high STI prevalence and fertility rates in the country the possibility of domestic infection seems to be unrealized.

Outer island B Survey:

Conducting the surveys in schools proved to have its advantages and disadvantages. The main advantage was the amount of youth, *n=40*, we were able to reach at scheduled times of the day, as many things in Kiribati do not run in accordance with time. The main disadvantage was the emphasis put on speaking and writing in English, especially for foreign visitors.

The second survey conducted during the initial phase of the study had two major adjustments as a result of issues encountered in the first survey. The first adjustment included the recording of ages and sexes of all participants. This was done in order to

examine any gender/age biases in perception and knowledge of HIV/AIDS. The second adjustment was allowing the respondents to answer questions in either English or the local I-Kiribati language. Negotiating my use of the I-Kiribati language, with teachers who only wanted me to communicate in English, became necessary for better understanding and collection of data. Apparent from the tables below, the frequency of responses was significantly greater than the first survey. This survey was conducted in a senior secondary school; the age range spanned from 14 to 19 years of age, mean age was 16 years old.

The survey questions for outer island B included:

1. *What do you know about HIV/AIDS?*
2. *Where did you learn this information?*
3. *If a person in your community had HIV, how do you think they would be treated? Why?*
4. *Who do you think is at risk for getting the disease?*

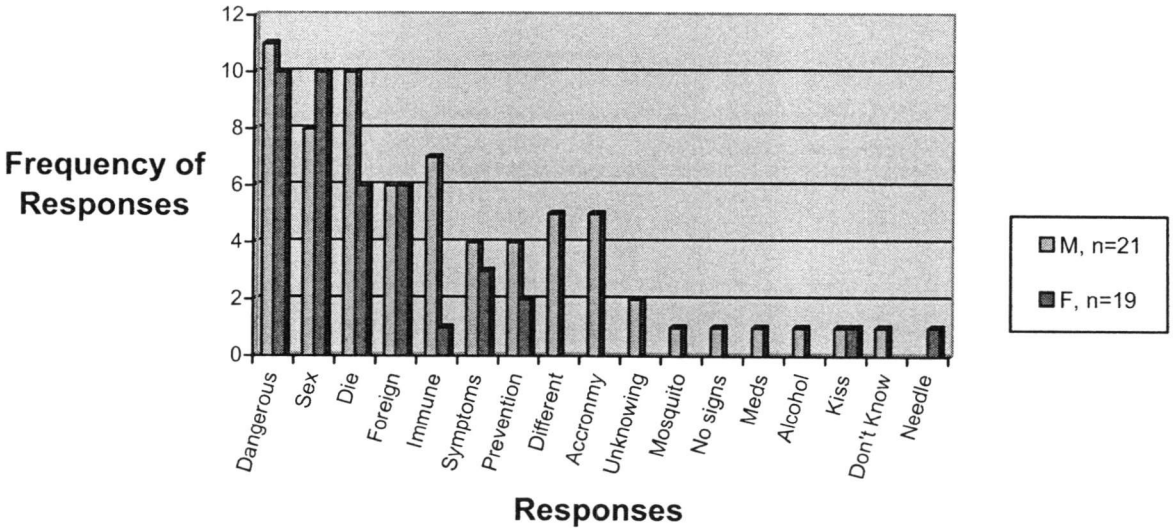

Fig. 13: What do you know about HIV/AIDS? Outer Island B. (See Appendix P for response

Like the previous survey, the majority of the students surveyed stated that HIV/AIDS was transmitted through sexual intercourse and that the people who had it died. It was for this reason that many called it a dangerous disease. This however is where the similarities ended between the two surveys. Only one respondent didn't know anything about HIV/AIDS. Comparing island B with island A's survey, more respondents stated that the disease was brought by foreigners or I-Kiribati who went

overseas and brought it back and more students knew the biological aspects of how the disease entered the immune system and weakened it as the viral load increased. Some students stated that the symptoms of HIV/AIDS, was the thinning of the face, hair and body. A few mentioned the falling off of skin, a white body and a constant urge to pee. I presume they were accidentally misinformed.

Respondents stated that known forms of prevention included staying with one partner, using a condom and not having sex until marriage. The category labeled "different" represents the idea that HIV and AIDS are two separate entities, several students made a point of stating this fact. The category labeled "acronym" represents students who wrote out the words represented by "HIV/AIDS". The last category, "unknowing" represents students who made reference to the inability to know who had HIV/AIDS. The following answers listed were mentioned once in the survey. (A mosquito can give you AIDS, the disease has no signs for a long time, getting drunk can make you have sex with anyone, kissing can transfer HIV and sharing of needles can share the disease.) The mosquito comment became more common in focus groups. I attribute this to the, public health campaign on filariasis that was being promoted throughout the islands at the time.

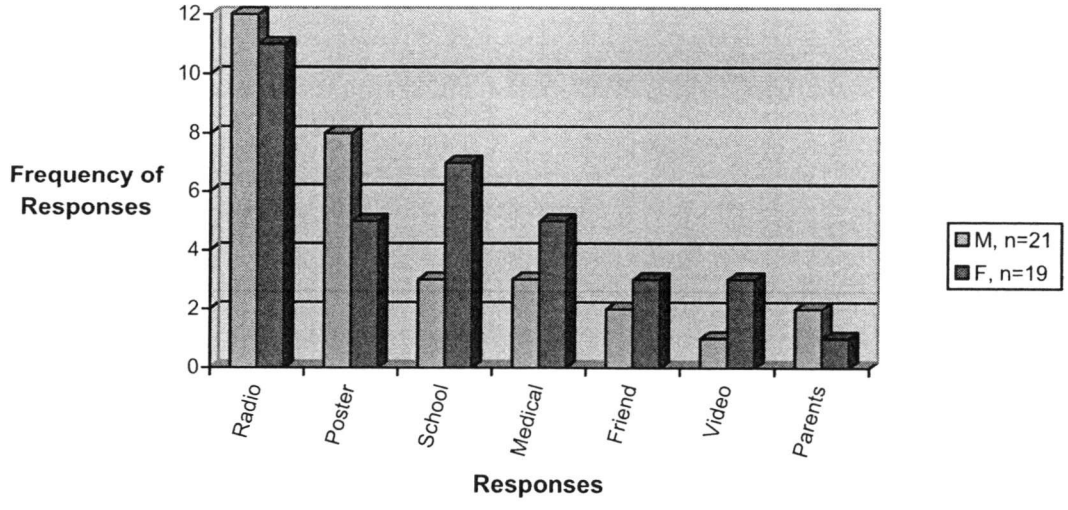

Fig. 14: Where did you learn this information? Outer island B. (See Appendix Q for

The majority of this older population learned their information from the radio. There are two radio stations in Kiribati. The first radio station, *Banaan Kiribati,* the

voice of Kiribati, has been in existence for over twenty years and is owned by the government. This radio station broadcasts daily programs from six am to ten pm throughout the country. Since it is owned by the government, all of the governmental ministries have allotted time slots where they can broadcast news from their respective ministries. It is common for the ministry to broadcast updates on diarrhea, TB, car safety and more recently HIV/AIDS. The second radio station, *new air FM*, is independently owned by the former president of the country. This station broadcasts to the main island only and is known for broadcasting a more modern variety of music and programs. In the past, weekly radio programs geared towards adolescent reproductive health issues were broadcast. It was a call in show where youth could ask questions about anything relating to sexual health. The program was popular among the youth and often highlighted HIV/AIDS education, however, at the time of research, the program had been discontinued because of financial constrains.

Second to the radio stations, posters and billboards were the most stated ways of learning about HIV/AIDS. MOH HIV/AIDS sponsored billboards are located on the main island. (see pg. 62) MOH HIV/AIDS posters and other forms of printed media were distributed via the KHATBTF and Peace Corps throughout the country prior to and during field work. The more recent publications have diverged from the fear approach method, one poster promotes the ABC method in a less offensive manner, another talks directly to PLWHA about preventing further cases and another talks to society in general about not making fun of people living with HIV/AIDS. Like these new posters, new messages are being aired on the national radio. "I hear announcements that we must treat them well from Radio Kiribati."[xli]

Surveys continued to reveal that there remains a large negative stigma associated with the disease, but steps are being taken to change the messages and these messages are being heard.

Fig. 15: Pictures of posters seen throughout the country during field work

The rest of the survey results followed the pattern of survey A, where parental guidance represented the least frequent response. The video mentioned was a production released in May of 1999, roughly 7 years ago, by a local video production company, based in the main island. Much of this video's script focused around a fear based message. Although informative and useful in breaking the silence of HIV/AIDS at the time, interviews with the producer and director of this video, stated that there was a great need for an updated version as times have changed, medicines have been developed, more knowledge is known about viral strains and patterns of thought have shifted away from fear campaigns.

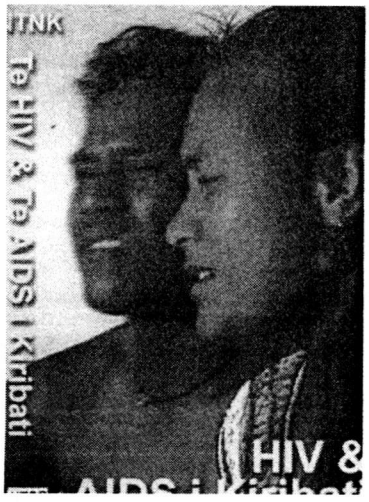

Fig. 16: NTNK HIV/AIDS Video 1999

The last question on the survey looked at how youth perceived an individual would be treated if he/she were to "come out" with their seropositive status. At the time of the survey, no living seropositive individual had publicly come out with their status. The majority of the respondents stated that the individual would not be treated nicely because he/she had this disease. "I will hate them" one survey stated, while several others stated that "they should be isolated." Only once was it directly mentioned that people would be afraid of the individual living with HIV/AIDS, more common was the idea that the person would be shamed in the community for getting HIV/AIDS.

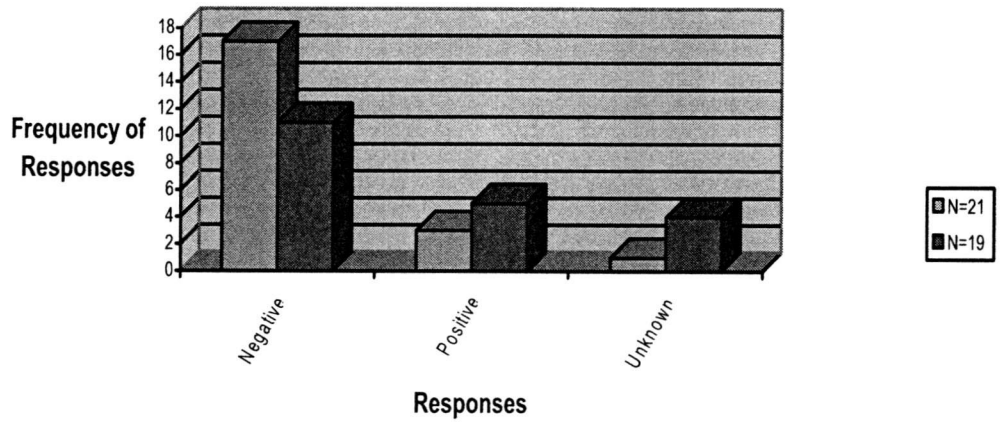

Fig. 17: If a person in your community had HIV/AIDS, how do you think they would be treated? Outer Island B

Fewer responses were given for positive reactions, but of these responses, the comments demonstrated a genuine sense of empathy for people living with HIV or AIDS. "I will help them so they don't spread it more, my family would help by sharing food and utensils with them, I would help them because people will abandon them, I want to help them be happy." Echoes of the *katei ni Kiribati,* these statements are examples of what the intervention strived to produce.

Examples of statements placed in the "Unknown" category include: "the person will feel ashamed, I would stop the disease by not having sex with them", "I would tell them not to sex around and wear condoms" and "I don't know."

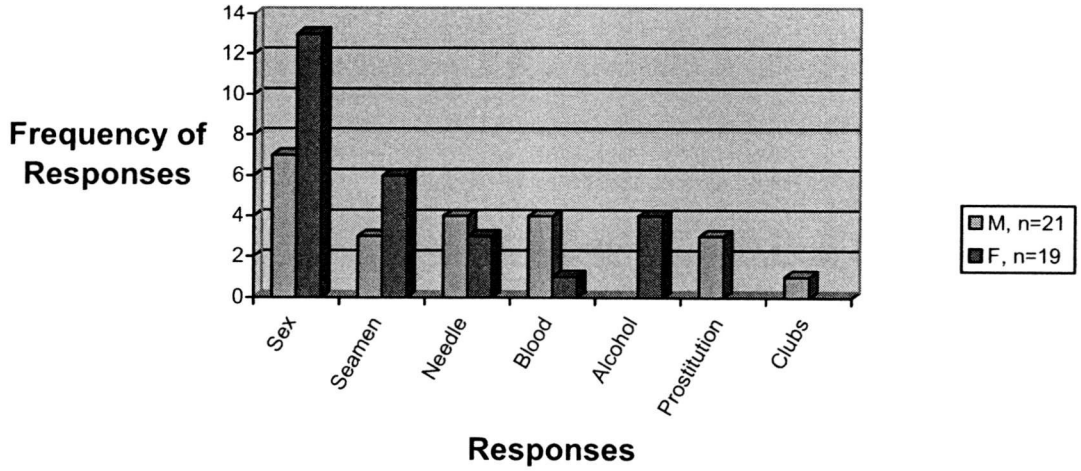

Fig. 18: How is the virus spread. (See Appendix R for Response Definitions)

This question originally read "Who is at risk," however for clarity, it was translated and presented as "how is the virus spread?" The most frequent response was that the disease was spread through sexual intercourse. Followed by, seafarer transmission. Diffusion through the sharing of needles, and blood followed respectively.

On a tour of the nation's blood lab unit located in the national hospital, I was informed that the country had a low supply of blood in their blood bank. During the tour I was shown the collection which was made up of less than twenty pints. It was explained that all blood donations were tested for HIV before any blood transfusion was conducted; however it was infrequent that the blood bank would have a substantial amount of blood on hand because donating blood was a foreign concept. Only when a close relative was in need of blood, would people donate. The left over blood went into the blood bank. Only a handful of individuals had found out that they were HIV positive through donating blood as of July 2004, the majority of the cases found out through required screening tests for work on merchant sea vessels.

The remaining answers involved drinking, clubbing and sleeping with prostitutes. It was interesting to see that females blamed drinking alcohol, a traditionally male activity, in the spread of the disease while males blamed prostitution, a traditionally female activity, in the spread of the disease. Clubs, although having a direct relation to prostitution and alcohol abuse on the main island, were only referenced once by a male participant.

In sum, the surveys highlighted several areas of knowledge and prevailing attitudes that would be ideal to address in an intervention. Most significantly, components designed to address modes of transmission outside of sexual contact, reducing the amount negative feelings held towards people living with HIV/AIDS and increasing the dialogue in the educational setting on the subject of HIV/AIDS from a scientific to a socially relevant context were ideal issues to address in an intervention.

Although known HIV/AIDS transmission is most commonly spread through sexual contact in Kiribati, a large majority of surveyed individuals did not show that they knew it was transmissible through blood, breast milk and other bodily fluids. Emphasizing sexual transmission is dangerous and has linked the virus with a sinful

connotation. Education on the topic of HIV/AIDS is clinical and difficult for comprehension. Emphasizing a social component with humanistic qualities may help to reduce stigma and allow for a deeper understanding of the virus and its impacts on people living with it as shown in the following section.

Intervention Pre/Post Test Results

Interventions were conducted in two different settings. The youth Seventeen male teachers from all outer islands were brought to the main island for a national teachers workshop. One part of this workshop was reserved for an HIV/AIDS component. Because the participant population was much older and facing many different challenges in life compared with our previous populations, the intervention was changed to accommodate an older and professional crowd of educators.

Using non parametric tests, S-plus and SPSS statistical data analysis software programs were used to analyze data. Comparisons were made between paired-sample's pre and post test medians to find out if the intervention produced a difference in knowledge or emotions relating to HIV/AIDS. The Wilcoxon Signed-Rank Test was used to test the null hypothesis; Ho: among the paired-samples examined, the median differences between pre-test and post-test results are zero. Data sets were divided into three distinct population groups: males, females and teachers. Pre/post tests were also divided into three sections; basic facts, stigma results and qualitative answers. The Wilcoxon Signed-Rank Test was performed on the first two sections. The Wilcoxon Signed-Rank tests results have been presented in appendix L.

The male and female youth basic facts portion of the pre/post test consisted of 13 yes or no questions. For data analysis, *yes* was assigned a number two and *no* was assigned a number one. In cases where no answer was provided, "NA" was assigned. These answers were not calculated into the analysis because of the missing data.

Survey questions include:

I can get HIV (the virus that causes AIDS) if:
a) I go to school with a student who has AIDS or HIV.
b) I kiss someone who has AIDS or HIV with bleeding gums.

c) I share needles for tatoos with someone who has HIV/AIDS.
d) I have sex without a condom with someone who has HIV/AIDS.
e) I am bitten by a misquito who has bitten a person with HIV/AIDS.
f) I give my blood at the hospital.
g) I share my plates, spoons or cups with a person who is sick.

4. I can tell if a person is infected with HIV by looking at him/her.
5. HIV can be given to others by someone who is infected but doesn't know he/she is.
6. There is a cure for HIV/AIDS.
7. There is medicine for HIV/AIDS.
8. Not having sex can protect you from being infected with HIV.
9. Many people who have HIV do not look sick.

Results show that the intervention had varying degrees of success for knowledge acquisition among both female and male youth. A p value of .05 or greater was indicative of no significant difference between the population's pre and post tests. Additionally, the larger the p-value the less of a difference there was between the pre and post test results. A p-value of less than .05 was indicative of a significant difference between the population's group. Likewise, the smaller the p-value, the greater the difference there was between pre and post test results. The tests declared significant difference if there was a net difference of 5 or more answers from the pre and post test.

Question	*Female p-value*	*Male p-value*
I can get HIV/AIDS if I: Go to school with PLWHA	.3421 (2-tailed)	1 (2-tailed)
Kiss with bleeding gums	.5844 (2-tailed)	.1684 (2-tailed)
Share needles with a PLWHA	.5884 (2-tailed)	.3421 (2-tailed)
Having unprotected sex with a PLWHA	.1879 (2-tailed)	.3449 (2-tailed)
I can get HIV through mosquitoes	.0087 (2-tailed)	.0087 (2-tailed)
I can get HIV through donating blood	.5856 (2-tailed)	.0888 (2-tailed)
I can get HIV through sharing utensils	.0487 (2-tailed)	.3306 (2-tailed)
You tan who a PLWHA is by looking at them	.3275 (2-tailed)	.0888 (2-tailed)
HIV can be unknowingly passed	.3306 (2-tailed)	.4277 (2-tailed)
There is a cure for HIV/AIDS	.5844 (2-tailed)	.1879 (2-tailed)
There is medicine for HIV/AIDS	.0041 (2-tailed)	.001 (2-tailed)
Abstaining can help prevent HIV transmission	1 (2-tailed)	.0895 (2-tailed)
Many PLWHA do not look sick.	.291 (2-tailed)	.3449 (2-tailed)

Fig. 19: Male Female Wilcoxon-Signed Rank Test Results. P-Values signify the difference in medians between pre and post test results. P<.05 represents a statistically significant difference.

Questions 5, 7 and 11 showed significant (p>.05) differences between pre and post tests for the female population while questions 5 and 11 showed significant differences between pre and post tests for the male population. It is good to know that the intervention was successful in creating a significant difference in medians for these five questions, but more helpful would be to know how they changed.

The table on page 82 will help us determine the direction of the change the intervention produced. The sign chart is a representation of the signs resulting from the equation, [Pre test - Post test]. For example: if the question was I can get HIV if I sit next to a student who has HIV/AIDS, the desired direction would be (-). (The desired direction is the desired result of the intervention.) Since yes is equated to the number 2 and no is equated to the number 1, a student who answered yes in the pre test would ideally answer no in the post test, resulting in a decrease in value signified by a (-) sign. Alternatively, a student who answered no in both, the pre and post test would have no change in value, signified by a (0) sign and a student who answered no in the pre test and yes in the post test would have an increase in value signified by a (+) sign.

Desired Direction	Questions	Female Directional Results	Male Directional Results
-	Got to school with PLWHA	19(0), 1(+)	20(0)
+	Kiss with bleeding gums	17(0), 2(-), 1(+)	18(0),1(+)
+	Share needles with a PLWHA	17(0), 2(-), 1(+)	19(0),1(-)
+	Having unprotected sex with a PLWHA	15(0),4(-),1(+)	19(0),1(-)
-	I can get HIV through mosquitoes	13(0),7(-)	13(0),7(-)
-	I can get HIV through donating blood	16(0),2(-),1(+)	17(0),3(+)
-	I can get HIV through sharing utensils	16(0),4(-)	16(0),3(-),1(+)
-	You tan who a PLWHA is by looking at them	11(0), 6(-),2(+)	17(0),3(+)
+	HIV can be unknowingly passed	16(0),3(+),1(-)	14(0),3(+),3(-)
-	There is a cure for HIV/AIDS	17(0),2(+),1(-)	15(0),4(+),1(-)
+	There is medicine for HIV/AIDS	8(0),11(+),1(-)	9(0), 11(+)
+	Abstaining can help prevent HIV transmission	15(0),1(+)	15(0),3(-)
+	Many PLWHA do not look sick.	15(0),1(+)	17(0), 1(-)

Fig. 20: Male Female direction chart. Desired direction represents the desired result from the intervention. (0) represents no change, (+) represents a positive change, (-) represents a negative

Questions 5, 7 and 11 had a substantially smaller amount of (0)'s in comparison with other questions showing that the intervention had an effect on these questions for the female population. Reviewing the data, question 5 achieved its goal of producing an overall negative direction; only two individuals did not change their answer from 2 to 1. Question 7 achieved its goal of producing an overall negative direction as well; no individuals answered 2 in the post test. Question 11 achieved its goal of producing an overall positive direction; only 4 individuals answered 1 in the post test.

The male population had significant difference in questions 5 and 11. For them, question 5 achieved its goal of producing an overall negative direction as only 2 individuals did not change their answer from 2 to 1. Likewise, question 11 achieved its goal of producing an overall positive direction with only 4 individuals answering 1 in the post test.

Teachers went through a different intervention; therefore, their results were analyzed separately from the youth populations. Using the same techniques for data analysis, the teachers' results also showed varying degrees of success from the intervention. Teachers showed greatest difference in questions 10 and 11 with questions 5 and 9 nearly reaching significance.

Teachers	*p-value*	Desired Direction	Directional Results
I can get HIV if I teach a student with HIV.	.675 (2-tailed)	-	13(0),3(+),2(-)
Proper first Aid can prevent transmission.	.5869 (2-tailed)	+	15(0),2(+),1(-)
Children with lower levels of education are more likely to do high risk behaviors.	.3322 (2-tailed)	+	16(0),1(+),1(-)
Education on HIV/AIDS/STIs gives children the knowledge to make safe decisions.	1 (2-tailed)	+	16(0),1(+),1(-)
I can get HIV: from a mosquito.	.0903 (2-tailed)	-	13(0),3(-)
If I donate blood.	.5869 (2-tailed)	-	15(0), 2(+),1(-)
If I share utensils with a PLWHA.	.3449 (2-tailed)	-	17(0),1(-)
I can tell if a person has HIV by their looks.	1 (2-tailed)	-	12(0),2(+), 3(-)
HIV can be passed unknowingly.	.1806 (2-tailed)	+	13(0), 2(+),1(-)
There is medicine for HIV/AIDS.	.0494 (2-tailed)	+	12(0),4(+)
HIV is only spread through sex.	.0272 (2-tailed)	-	13(0),5(-)

Fig. 21: Teacher Wilcoxon-Signed Rank Test and directional Results. P value of less than .05 is representative of a significant result. Desired direction represents the desired result from the intervention. (0) represents no change, (+) represents a positive change, (-) represents a negative change.

The second piece of the pre and post test that went through statistical analysis was the stigma/self assessment portion. This part was designed to test the reduction of stigma and increasing self awareness as a result of the intervention. Likert scales, numbered from one to five represented feelings ranging from strongly agree to strongly disagree were used for this portion of the test.

Three questions were used to examine the stigma component and two questions were used to evaluate the self awareness component for the students. Four questions to examine self awareness and nine questions to examine stigma reduction for the teachers.

The same methods of evaluation were used as the previous "basic facts" component. However, instead of using numbers 1 and 2 to signify yes and no, numbers 1-5 were used. As before, a pre test score of 1 (Strongly Agree), which changed to 5 (Strongly Disagree) during the post test would indicate a (-) direction while a (+) direction would be produced if numbers were reversed.

Student populations answered the following statements relating to stigma and self awareness.

1. I am happy to be in a class with a student who has HIV/AIDS.
2. I would not be friends with someone who has HIV/AIDS.
3. I think People with HIV/AIDS are bad people.

Self awareness statements:

1. I am afraid that I could get HIV/AIDS
2. I am afraid that I could pass it on if I get it.

Results showed that the intervention was highly effective in reducing both stigma and increasing self awareness. Greater significant difference was noted in the stigma section. The stigma component produced 3 out of 6 significant p values ($p < .05$). The remaining values were less than .07 away from a level of statistical significance.

Questions	*Female p-value*	*Male p-value*
Happy to be in a class with a PLWHA	.002 (2-tailed)	.0678 (2-tailed)
Would not be friends with a PLWHA	.0772 (2-tailed)	.117 (2-tailed)
PLWHA are bad people	.0075 (2-tailed)	.0357 (2-tailed)
Afraid that I could get HIV/AIDS	.2689 (2-tailed)	.8198 (2-tailed)
Afraid I could pass it on if I get it	.702 (2-tailed)	.6243 (2-tailed)

Fig. 22: Male/Female Stigma/Awareness Wilcoxon-Signed Rank Test Results. P value of less than .05 is representative of a significant result.

Although the self awareness component showed no significant differentiation between the pre and post tests, male results had significantly larger p values than the female results. Large p-values indicated little variation in sample medians from pre to post tests; however, data clearly indicates that 16 individuals changed their answers from pre to post tests. This information, along with the high p-value would indicate that the majority of the individuals, who participated, cancelled each other out, by having an equal amount of individuals who increased and decreased their score.

Questions	Desired direction	Female directional results	Male directional results
Happy to be in a class with a PLWHA	-	7(0),12(-),1(+)	6(0),10(-),4(+)
Would not be friends with a PLWHA	+	8(0),4(-),8(0)	4(0),5(-),11(+)
PLWHA are bad people	+	8(0),1(-),10(+)	4(0),3(-),13(+)
Afraid that I could get HIV/AIDS	NA	5(0),6(-),9(+)	4(0),9(-),7(+)
Afraid I could pass it on if I get it	NA	5(0),5(-),5(+)	3(0),8(-),9(+)

Fig. 23: Desired direction represents the desired result from the intervention. (0) represents no change. (+) represents a positive change. (-) represents a negative change.

Looking into the data, we see that the intervention did have a strong effect on individuals. The data shows that individuals were either by reaffirmed that they were not at risk for contracting HIV or they were confronted with the fact that they could be at higher risk than they had first thought. Only three individuals had a null result, 17 others change their answers and as before the answers cancelled each other out, 9(+) 8(-), producing a higher p-value. Female p-values indicated no significant changes; however, their p-values were in closer range to a level of significance than the males.

The teachers' intervention as well as pre and post test surveys was a bit different than the youth interventions. In the stigma/self awareness portion, teachers had 8 more questions than the students. These questions not only focused more deeply on personal and professional life.

Questions used in this intervention included:

1. I am happy to teach a class with a student who has HIV/AIDS

2. I am happy to work with a teacher who has HIV/AIDS
3. I think many teachers are uncomfortable teaching HIV/AIDS lessons because of the culture.
4. I think teachers know enough about HIV/AIDS to teach this subject in school.
5. I would like my children to learn about HIV/AIDS from school.
6. I would like my children to learn about HIV/AIDS from home instead of school.
7. If students learn sex education in school, they will be encouraged to have sex.
8. I would not be friends with someone who has HIV/AIDS.
9. I think people with HIV/AIDS are bad people.
10. I am afraid that I could get HIV/AIDS
11. I would provide care and support to someone in my community with HIV/AIDS.
12. I would consider separation from a spouse if I found out she was HIV+.
13. I know how to protect myself from getting HIV/AIDS if my wife is infected.

A question 3, 4, 5 and 6 were developed with no desired direction, nor was any intervention portion designated to address these questions. Rather, the goal was to gather more insight on issues raised by the questions. It was interesting to see that question 3, I think teachers have enough information to teach about HIV/AIDS came close to a level of significance, with a negative direction, meaning teachers felt they had better knowledge to teach about HIV/AIDS after the intervention than they did previously.

Interviews conducted prior to this intervention revealed that teachers would avoid talking about HIV/AIDS/STIs or other issues relating to sex in the classroom. Culture, job security and curriculum were stated reasons as to why they avoided this. "Parents disagree with talking about HIV/AIDS because of sex, so we only teach the curriculum."[xlii] Uniquely, these teachers had a stronger desire for their children to learn about HIV/AIDS in school rather than at home or a different place. As one parent, interviewed, this group saw the benefit in having help in teaching their child about sex. "I'd like for it to be taught at school, I have a girl and I can't talk to her about it. Maybe they learn some stuff there and I could teach her some stuff too."[xliii]

Results show that teachers had greater significance in differentiation of medians compared to the youth. Questions 1, 2 and 3 proved to be statistically significant, while

questions 8, 12 and 13 were all less than .07 away from a level of significance. All of these results were skewed in the desired direction. These results indicate that, like the student population, the stigma reduction portion of the intervention was more successful than the basic facts portion.

Teacher Population	*P-value*	Desired direction	Directional Result
I am happy to teach a class with a student who has HIV/AIDS	.0281 (2-tailed)	-	11(0),5(-)
I am happy to work with a teacher who has HIV/AIDS	.0093 (2-tailed)	-	10(0),7(-)
I think many teachers are uncomfortable teaching HIV/AIDS lessons because of the culture.	.0035 (2-tailed)	NA	8(0),8(-)
I think teachers know enough about HIV/AIDS to teach this subject in school	.1062 (2-tailed)	NA	8(0),2(+),7(-)
I would like my children to learn about HIV/AIDS from school.	1 (2-tailed)	NA	9(0),4(+),4(-)
I would like my children to learn about HIV/AIDS from home instead of school.	.2446 (2-tailed)	NA	9(0),2(+),6(-)
If students learn sex education in school, they will be encouraged to have sex.	.3569 (2-tailed)	+	4(0),4(+),4(-)
I would not be friends with someone who has HIV/AIDS.	.0843 (2-tailed)	+	9(0),6(+),1(-)
I think people with HIV/AIDS are bad people.	.7076 (2-tailed)	+	6(0),6(+),4(-)
I am afraid that I could get HIV/AIDS	.5904 (2-tailed)	NA	5(0),5(+),6(-)
I would provide care and support to someone in my community with HIV/AIDS	.8169 (2-tailed)	-	9(0),4(+),3(-)
I would consider separation from a spouse if I found out she was HIV+.	.1217 (2-tailed)	+	4(0),8(+),2(-)
I know how to protect myself from getting HIV/AIDS if my wife is infected.	.0658 (2-tailed)	-	7(0),3(+),6(-)

Fig. 24: Teacher Wilcoxon-Signed Rank Test and directional Results. P value of less than .05 is representative of a significant result. Desired direction represents the desired result from the intervention. (0) represents no change, (+) represents a positive change, (-) represents a negative

Varying degrees of intervention success existed among the three populations. Statistically, the "basic facts" portion of the intervention showed weaker results than the "stigma/self awareness" portion for both the youth and the adult populations. Surprisingly, although there was a substantial amount of stigma reduction among the youth populations, the greatest amount of attitude change towards PLWHA occurred in the adult population.

The self awareness questions did shed light on individual consciousness of behaviors. For some individuals, the intervention helped them realize that they were at less of a risk than they had previously thought and for others it made them realize that they were at a greater risk. Frequently after interventions, students would meet with me after everyone had left and enquire about testing opportunities and open hours of the KHATBTF office for them to get more information. We were fortunate to have had several visitors to our office following the intervention programs.

At the end of my three month stay, the office had been invited to the first ever career day for graduating students from senior secondary schools. The office had designed a position for a volunteer intern who would assist in translating materials, developing programs and perform daily office tasks. 80 applications were printed for this event and 80 applications were taken.

QUALITATIVE RESULTS

The results of this section represent data collected from 30 interviews and seven focus groups. Interviews consisted of individual sessions with parents, teachers, youth, NGOs, medical professionals, people impacted by HIV/AIDS, government officials, foreign dignitaries and religious leaders on both outer islands and the main island. Ten focus group sessions were conducted with youth who resided on the main island. Each group contained four to five individuals between the ages of 14 and 21. Eight of the focus groups were held in a formal education setting. Because of the nature of sexual topics discussed, and setting (held in a religious school) each of these focus groups were segregated into male and female groups. The remaining two focus groups were

conducted outside of a formal school setting. Because of familiarity I had with these groups and their comfortability with each other, these groups preferred not to be segregated. The following analysis is a representation of themes that arose from the interviews and focus groups.

Education

Education on HIV/AIDS in a formal setting has been limited to biological factors and scientific knowledge. Teachers see HIV/AIDS as a dangerous topic because it deals with sex education. The culture does not allow talk of issues pertaining to sex between parents and children, "*Unimwane* and *uniane* can't talk to them about sex, it is taboo." [xliv] Even greater social restrictions are placed on those who are not related to the children. Teachers who have tried have found it "very hard to draw out sex ideas from youth."[xlv]

In the formal educational setting, the fear of talking about sex, extends into one's professional reputation. Teachers only "teach what is in the curriculum, they may get fired if they talk about sex. People think once we teach it, kids will be encouraged to have sex because they will know how to not get pregnant."[xlvi] These issues of social expectations and limitations restrict any discussion of feelings and emotions that accompany the holistic experience of sexual relationships and, in this case, related STIs to outside individuals who are seen as highly qualified to discuss such topics. Doctors, nurses and people from the ministry of health can speak on these issues, "because they are more qualified to talk this way."[xlvii] There is recognition by the teachers that something needs to be done to prevent the spread of the disease, but many are fearful to overstep the boundaries set by the curriculum and culture. One informant saw things differently. "On the main island, things have been changing. Now it is modern and changing, I can talk to my kids about sex... the training I had received (as a counselor) has helped me do this."[xlviii]

Some teachers were supportive of teaching communication skills, holding health education classes and creating after school programs for the students to keep them occupied, but admitted that not many teachers feel the same way. "Most teachers don't

want to stay after school, it is not something stated from the ministry or the KTC, they are only here to teach."[xlix]

There are also issues of overcrowding in public schools, over worked teachers, lack of facilities and transportation which take capacity away from such program development. There is a center for youth which was recently opened in Betio, however several teachers mentioned that location is a problem for their students. "The one center that is open for youth after school is more than one hour away from here."[l] The time that it takes to catch a bus could be up to an hour when school lets out. At this point in the day, buses are often full with students who are traveling home. Another confounding factor that youth face in transportation is the discrimination received by some bus drivers. Frequently, students in uniforms are passed by because they are only charged a flat student rate of 50 cents, an adult or a student out of uniform would pay a higher price. The feasibility of youth from the northern part of the island traveling to the adolescent center is minimized by the costs and time associated with the activity. "They should build one closer to our schools, not just in Betio."[li] Alternatively, many youth form gangs and hang out after school.

"Gangs are common in school, there are good gangs and bad gangs, both boys and girls hang out together."[lii] The good gangs hang out and do their homework, they don't cause trouble, but the bad gangs hang out and find various ways to entertain themselves. "My school has 800 students and about 200 of them drink with their gangs. It used to be DMX vs. 2 PAC (names of rival gangs), they would challenge (fight) each other on the cause way. Police stopped that and then gangs started renting trucks with loud music and rode up and down the street. Now they drink alcohol."[liii] Alcohol was provided to youth from make-shift distilleries located in close proximity to several schools. This was made apparent by the number of students and youth who knew where distilleries were located in two school focus group sessions. The houses were often in walking distance of the schools. "The police don't do anything about it, they are not too busy, they are just lazy," said one interviewee as he commented on the drinking problem in Tarawa. "In 2000 they were more tough, we would go to the hotel and get caught by the police, but they became lazy in 2001."[liv] One interviewee drew a map of where the

distillery was in location to her junior high school. "Its only about five minutes down that way from my school,"[lv] she said.

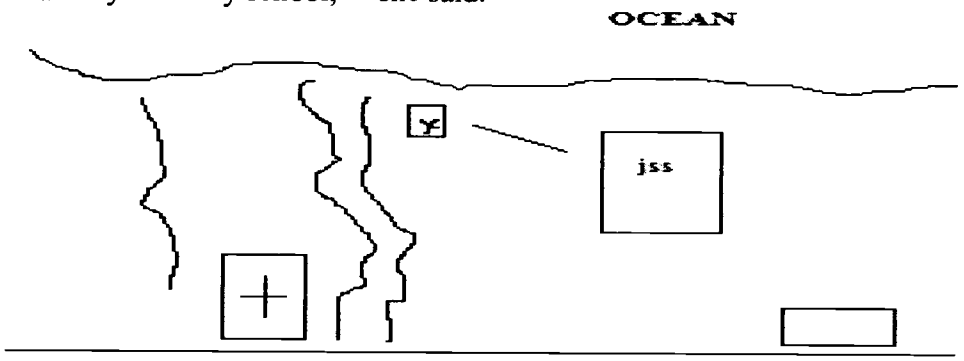

Fig. 25: Representation of picture drawn for me during

"This week a drunk student came to school... and started yelling and hitting the teachers. The teachers hit back and he got expelled."[lvi] This student was known, according to my interviewee, to be in one of the bad gangs at school.

Youth, Alcohol, Sex and Sexes

Alcohol and sex seemed to go together synonymously during focus groups with male youth. "It's easy to get alcohol, sometimes we just sneak into bars... we hide between taller people...Boys drink to get confidence to meet with the girl, it is easier to have sex with girls when you are not shy." [lvii] Many youth drink in gangs, they "use bus fair to buy drinks and don't go to school that day."[lviii] For other students, they may make it to school and then decide to purchase alcohol at the local distillery instead of going to class. "My students have been caught having sex in the bush during school hours, students from the (neighboring) primary school were watching. She was drunk and he was having sex with her." [lix]

Several parents, and youth mentioned that these ideas and behaviors are picked up from movies. The country does have "a sensory board that collect the bad films and throw them away,"[lx] however, pornographic and violent films have always been prevalent in the islands I have lived on. Illuminating this influence from the west are the names of gangs. 2 PAC and DMX are named after African American Gangster rap icons, X PAC is named after an American WWE wrestler and DFI (Dancers From

India) are known for their Indian hip hop dancing. Like gangs in the USA, clothing plays a defining role in gang identity. The typical day in Kiribati is sunny, little wind with a temperature hovering around the 90 degree mark. Along the shopping district in Betio I see members of these gangs, young girls dressed in tight fitting denim jeans, while boys wear a mix of baggy khakis and jeans that scrape the pavement as they walk by. "They do this because they want to be cool, like the movies," one male youth tells me. Leaning back in his chair... "Stylish... mmmm" as he smiles while the other boys nod and make supporting sounds of approval.

Another stylish component of modern day life for several I-Kiribati youth is the utilization of the Tarawa bus system. Both male and females youth mentioned the enjoyment brought to them from bus rides. Of all the busses, the newer "stylish" buses seemed to be the most preferred busses. Busses are categorized as being stylish by the newness of the bus, the quality of the sound system in the bus, the music that is playing and the bus driver. Bus drivers have become a target group for one informant who works with them in the promotion of safer sex. "I know they have sex in places close to the ocean by the airport." Lots of young girls are attracted to the bus rides. When I questioned one as to why she liked bus rides, she stated "because you get to see people and you get to listen to loud modern music."[lxi] According to her, the best place to sit was in the back so that you didn't have to get up when people wanted to get out. Because bus fair can be quiet expensive for non students "girls try to attract bus drivers by giving them ice or snacks from the stores."[lxii] This was done as a way to get free rides from the drivers. Other "girls want to have a free bus ride, so they have sex with the bus drivers... The drivers desire to have sex with the virgin girls."[lxiii] Mostly all of the bus drivers are males in Kiribati, a large percentage of these drivers are male youth. The one inch rule is something which a lot of youth questioned me about during focus groups and interviews. The rule states that "girls can't get pregnant if you only go (stick your penis) in one inch." The reasoning behind this is that the hymen is thought not to break if penetration is little, therefore since the female is still technically a virgin, because no bleeding occurred, she cannot get pregnant. Traditionally, wedding nights are when a couple's first sexual intercourse together should happen. It is on these nights

that families would wait outside of the bride and grooms room for the stained mat. Celebrations would follow where in some cases the blood of the virgin would be shared among the male relatives and placed on faces for decoration. This is, I perceive, why the one inch rule highly associates itself with the breaking of the hymen.

Relationships and Sexuality

"Parents don't teach about sex... its against culture to talk about sex, if there is kissing on the TV... they tell us to turn our heads." But it happens, it happens frequently and according to a focus group of street youth it often involves several partners. Some men who have a wife start seeing other women. "They go out to dinner, share problems and that's when they start falling in love with each other." People ask "don't you know he has a wife?" But the girls say, "yeah, we are just having fun." Some men will leave their wives to live with the new relationship, "but he ends up missing his children so he goes back to his wife."

This practice of having several female acquaintances has been accepted for the most part by women in Kiribati. One reason given to me for this acceptance was that "it's part of a custom... that some women are afraid to be widow/widower."[lxiv] It is also part of a custom that dates back prior to when missionaries arrived and banned the practice of polygamy, which has propagated to this present day through the gender roles that have been passed down from previous generations.

Another accepted behavior which can be seen as detrimental for I-Kiribati women is the jealous kind of love, known in Kiribati as *Te koko.* Te koko can lead to abusive relationships which some females may feel obligated to stay in. Some men, "think jealousy is love ... I don't think so... they beat up their girlfriend or wives for jealousy."[lxv] There have been laws established for women to prevent spousal abuse in Kiribati, however this has not as widely accepted as beatings because of its foreign nature. "Women in Kiribati don't use the law, because they know that if they use it, it's like (they will be) saying goodbye to their husband. I think it is culture... most women in Kiribati are used to that kind of problem with husbands at home without the law. They just live with their problems."[lxvi] The feeling of obligation to stay in this kind of

relationship increases when children are involved in the marriage. "I don't know if all women in Kiribati are upset about it, maybe some are but they just can't do anything about it ...because sometimes there are other problems that stop them from leaving their husband. If they have kids, they wouldn't be able to take care all that by themselves but those who don't have kids , I think that it's just love that stops them.[lxvii]

With the growing awareness of women's rights for equality, ideologies of subservient roles are being replaced with ideas of equal opportunity and fairness between males and females among the younger generation. "We must be equal, men don't want equality...its not like the culture." [lxviii] The culture dictates that women's roles are likened to those of "a servant or cooker" while male roles are likened to "a boss or leader." Interesting is the fact that women are the ones who hold the financial responsibility of the household. "If we gave the money to the men, they would spend it on beer, we know what food to buy and how to keep the house."[lxix]

Additionally, men are seen as the initiators of sexual intercourse. They are seen as having less control over their sexual urges. "Ahh... the man's life, the men are more powerful than women, if he has many partners .... Its ok, if a woman does it, it's bad."[lxx] As stated previously, the idea of leaving a husband is often difficult for a woman to conceive, especially when there are children involved. Equally as hard, for both sexes may be the concept of using a condom during sexual intercourse.

According to several informants, the condom is negatively perceived in the culture. If women request to use the condom "they (men) say, we will kill them, we will punch her. Husband assumes she has been in an affair or that he doesn't like her. But men also cannot say lets use condom to wife, because she may think that he doesn't like her."[lxxi] The idea of a woman wanting to kill or punch her husband for asking to use a condom was never mentioned. Instead, more common to see as a result of domestic disputes whether it was abuse, cheating or other incidents was the idea of divorce which came up during interviews. As equality becomes more of an accepted idea among young women in Kiribati, I believe divorce will become a more frequent occurrence on Tarawa.

Both in traditional and contemporary times, rape has been an offense which has been punishable by death or life in prison. "Individuals, who commit rape today, are mostly youth and adult males."[lxxii] Their punishment, by modern day law is usually life in prison, however good behavior is often taken into account, reducing a life term to "ten years."[lxxiii] Although rape was not mentioned as a way that HIV spreads in the population, it is indicative of two things. The first is the re-emphasis placed on female inequality brought about by rape. Some females will not admit that they were raped because it is a sign of weakness. To admit that they were weak would make them feel ashamed. Like the spousal abuse that occurs in Kiribati, rape is another occurrence that women have come to live with over the years and to a great degree accept. However, for women who do admit that they were raped, severe consequences can arise for the males that committed the act, especially if she was a virgin at the time of the incident. "Her uncles, or brothers or male relatives would take revenge."[lxxiv] They would more than likely either find the individual and "kill him or do the same thing to one of his relatives"[lxxv] one informant stated. These acts of revenge although, still occurring today, have been challenged by modern day law. During my field work, a highly publicized sexual assault case was brought before a court. A young girl, in her early teens, was sexually assaulted by a government official. Using modern day law, the official was taken to trial and convicted of sexual assault on a minor. The event made newspaper headlines and radio broadcasts were highlighting updates from the case as it progressed. The national group for women chimed in with frequent news stories about women's rights and male responsibilities in Kiribati.

From events witnessed and recorded through interviews and focus groups, it is clear that gender roles are going through a state of transition on the main island. Young women seem to be at the forefront of this movement, encouraging others to follow their actions in both subtle and overt expressions for equality.

Poverty

It is obvious that issues relating to HIV/AIDS prevention are not limited to issues of education and youth in Kiribati. Issues of poverty play a great role in the

spread of the disease, "unemployment rates are soaring," after form 7, the equivalency of 12th grade, "a lot of youth try to go to the USP for further education"[lxxvi] but even with this education many have trouble finding jobs in Tarawa. Due to the small private business sector, the majority of the jobs are with the government. People are not fired from government jobs in Kiribati. An individual who performs poorly is typically moved to a different position in the ministry. Once an individual is employed, it is very difficult to lose a job unless he or she quits. Because of these factors, many highly educated and qualified individuals are left unemployed, "some people in Betio are really poor, you know, they are only drinking water. There is no cargo here and so no rice, but you know, there are really bad poverty places starting to show up."[lxxvii] During this past summer, a shipping error was made which left the country without rice, flour, sugar and salt, staples of Kiribati consumption, for weeks. Rice rations were being portioned out to the public and chartered planes were being flown in to replenish the depleted national hospital's supply of rice.

This case of poverty is representative of several newly impoverished areas forming in the economic center of Tarawa. The emergence of poverty in an economically impoverished nation became apparent when I saw children selling flowered garlands in night clubs at 11pm, or when I purchased food and drinks for a homeless boy whom I ran into frequently during my stay. He was a stowaway from an outer island who traveled to Tarawa. His mother had passed away and it was apparent that he had a mental disability. I was helping distribute condoms with informants when a young girl approached me one day around three pm at a bar in Betio. She was drunk and asking if I would like to have any sexual favors performed. Like several stories of young girls who have sold their bodies for profit, she had become a victim on an unequal societal structure. Homelessness, poverty and inequalities are all products of structural violence which lead to increased amounts of failed societal structures, where HIV/AIDS has been known to flourish.

Teen Pregnancy

According to the national hospital in Tarawa, recorded teen pregnancy statistics in Kiribati have been on a gradual rise over the past decade. A chart in the national hospital depicts teen pregnancy as a trend which has continued to rise over the past years.[lxxviii]

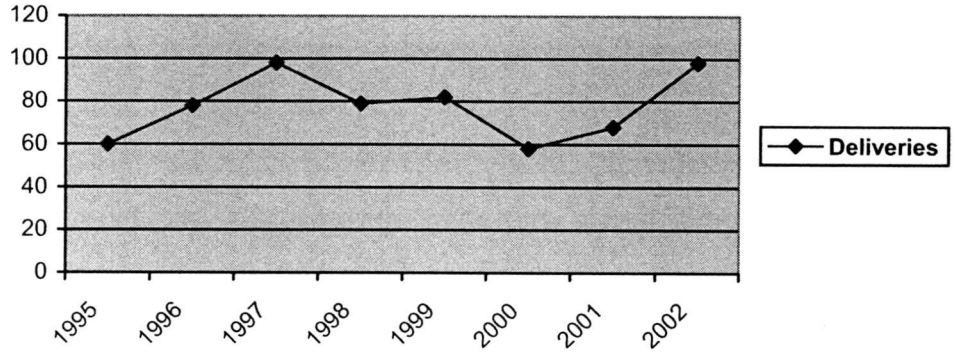

Fig. 26: Teen deliveries in Tungaru National Hospital ages 13-

Children are seen as the pearl of the family in Kiribati. In traditional times and still today in traditional settings a woman is "expected to become pregnant as soon as possible after marriage,"[lxxix] as this is the appropriate time for sexual relations to begin. However more frequently, on the main island, teenagers are engaging in unprotected sexual activity. Two informants relate this to the story of one of their relatives in this excerpt.

> *She was with her gang, I believe alcohol was involved and she ended up sleeping at his house. When she didn't return my family was very worried and they went looking for her. They found her in a different village, but when they found her she started to run away and they couldn't catch her that time. They went back again to bring her back home, but she refused to come because she had eloped and said that she loved him.*

The social dynamics of an early pregnancy in the culture is interesting. Teen pregnancy is something that is gravely looked down upon; however once the child is born, the pregnancy typically turns into a joyous time for the family. "I think our family is angry now, but when the baby is born they will be happy for the baby."[lxxx] There was a general consensus between the two of them that the baby did not deserve to be

welcomed into the world with a negative attitude. The teenage girl did decide to keep the baby, however there were other options presented to her as well.

Abortion does exist and in the early times of Kiribati, this was often practiced as a way of population control through infanticide and drowning of young infants. Today, because of religious beliefs, abortion is not an accepted practice as before. "There is abortion, people try to kill the baby by drinking poison... our relative didn't want to do this because of her religion, but some of her relatives did encourage it."[lxxxi]

Adoption was another option that was presented to this female youth. Adoption in Kiribati has been a long standing practice that has been a "symbol of love, love to live together, to share things and to help one another" (Bataua, *et.al*, 1985). For I-Kiribati, adoption "strengthens ties in the extended family and has the ability to create new bonds between unrelated families" (Bataua, *et.al*, 1985). These meanings still apply today as they did in the past; however a change has occurred in adoption over the years, especially on Tarawa where resources are limited. As children grow older, differential treatment has been observed to occur between the two. In some cases, the adopted children are given "hard and nasty jobs, while the real sons and daughters are asked to do the light and good jobs" (Bataua, *et.al*, 1985). In other cases, "parents will refuse to pay adoptive children school fees" (Bataua, *et.al*, 1985). These fears and reasons, although not stated as why adoption was not chosen, may have had an influence on her decision to keep the child.

Unlike males, for females, the time of first sexual intercourse is associated with marriage. A study completed in 2002 found that the mean ideal age for first sexual intercourse among 404 I-Kiribati youths between the ages of 13 and 19 was 20.5 years of age. [lxxxii] Close to the 2000 national census figures, which reported the average age at first marriage for males to be 25 and females 22.2, these numbers demonstrate a healthy environment for strong fertility rates encouraging a strong growth rate.

With an average viral incubation period of 5-10 years in Kiribati,[lxxxiii] an epidemic without medical treatment would not stop young women from reaching these years of fertility; however it would greatly reduce the number of fertile years lived, reducing national fertility rates of 4.20. (CIA, 2004) Additional factors such as when or

how many children to conceive would also influence growth rates; estimated at 2.25% for 2004. (CIA, 2004) Infected couples may consciously choose not to have children knowing the possibility of passing on the disease to their children. Conversely, in small communities where HIV/AIDS is highly stigmatized, seropositive couples who chose to stop having children may feel obligated to continue having children in order to prevent suspicion of having HIV/AIDS.

In more progressed states of the epidemic, often found outside of Oceania, children have become the most impacted population as they inherit a future without adults, forcing many to take on adult roles. A study conducted in Thailand "found that 15% of families affected by AIDS had to take their children out of school" (UN, 2004). For many, their lives took on roles of caregivers and providers as their parents became unable to care for themselves. Additionally, Ahlburg et al. point out that the burdens of orphaned children are often placed on close relatives, such as aunties or uncles. By shifting the responsibility of orphaned children onto uninfected fertile couples, "the number of children couples decide to have is changed" (Ahlburg *et. al.*, 1989).

Kiribati's adoption practice leaves little doubt in my mind that the children would be taken care of by extended family members. However, differential treatment, as discussed before, may have severe consequences for the children if families choose to treat them as second class kin.

During the time of field work, I was made aware of one incident such as this, where a child was being cared for. There was no reported harsh treatment in this case. Although rare, that differential treatment occurs in my experience, I believe it does happen and I believe that it would be a possibility in future cases of HIV/AIDS orphans.

People Impacted By HIV/AIDS

"Time-Bomb in the Atoll... But is Kiribati Ready for the Fallout?" (Pareti,2004) The introductory paragraph of a news story on HIV/AIDS in Kiribati read:

Hers was a lonely, forlorn death. Abandoned by her family and friends, the young woman was neglected with no single relative visiting her in hospital. The ostracism didn't end even at her death. No one came to claim her body, so a few

concerned people had to pay for a decent burial. The woman's crime? She was HIV positive.

Stories such as this came out as themes in my interviews with people impacted by the disease. For some, it was difficult to talk about, for others not as difficult because I gather they have talked about this subject more frequently. With the exception of one interview, the majority of the emotions that came out were negative emotions. Themes of loneliness, sadness, fear and unfair treatment came up repeatedly. "People would mock, where is your relative with HIV are they still alive? Or this is what they deserve, when are they going to die?"[lxxxiv] Much of the mocking seemed to come from youth. "It's not true, the things that people have been saying."[lxxxv] One interviewee told me about a rumor which was started about their relative. The rumors deal with everything from food having HIV/AIDS put into it to the ocean contaminating fish with it because someone with HIV took a bath in it. Rumors were something that seemingly came with the disease. Additionally was the feeling of loss, "You lose your job, friends, family and (feel like you have to) hang your head in shame and you want to die"[lxxxvi] one informant told me.

People have a belief that Kiribati is a Christian country and "those who get HIV are sinners."[lxxxvii] They deserve what God gives to them for sinning in essence, even if that means losing their family. "I visited them, she wouldn't care to feed them or anything, she couldn't accept them in her life, I gave them food and changed them."[lxxxviii] They were too weak to change themselves, one informant remembers, human fecal matter had gathered up around them and they were left on their own with no help. "I remember their child was crying," [lxxxix] My friend stated. The fear comes when the body starts to change. There is an overwhelming fear of going out and "showing face in public." Sometimes making eye contact with people would be to much and the fear that people would see it would be enough to keep one from going out. "Parents don't want to see (their) children die, but (it) is so hard to see them with this disease."[xc] Some have chosen not to see them until it is too late because shame had held them back while others have been known to disown them from the family. "We took take care of them because no one else would."[xci]

It is clear that care and support for PLWHA, families and friends need to be developed on a national scale. The pain that is caused by the lack of such facilities and programs is evident in stories shared with me over the summer field work. ARVs and counseling services are available in several other PICs currently. Kiribati needs to have these made available to her citizens as well.

For many of these individuals initial care needs to start at home and in the community. Having them feel welcome and not at fault for their situation may be the hardest step but it will be just the first step in the deconstruction of the HIV/AIDS stigma.

NGOs

NGOs in Kiribati and around the world have been part of fight against HIV/AIDS for over twenty years. To learn what initiatives have been taken to stop the spread of the disease in Kiribati, I sat down with thirteen NGO representatives associated with the KHATBTF. Activities have focused on education and awareness raising. There is a great desire to provide care and support, especially in the religious communities; however these objectives have not been realized.

Among almost every NGO a common theme exposed was found. Financial instability held back several ideas and initiatives of NGO coordinators. Organizations mentioned trouble with either attaining funds for programming or past inappropriate use of funds, leading to trouble in attaining funds for present work. "Successful activities need to have successful planning meetings. In order to have successful planning meetings you need to have transport, tea and cookies, these are very important things, it seems that everyone always wants these, it takes money to arrange these."[xcii] For this individual, obtaining funds was difficult because of the "bureaucracy" they had to go through to get funding. "It goes through so many hands before it can be used for its original purpose."[xciii]

Many times, there are great ideas that don't receive funding because there is an inability to develop proposals. "We have a lot of capability here to get things off of the ground, but they just don't have the capacity to do (proposal writing) it."[xciv] The biggest challenge to receive funding may be the inability to clearly communicate ideas.

Complicating this issue is the communications barrier that exists between local organizations and foreign donor agencies. All e-mail, telephone and fax services are run through one Telecommunications Company. Rates for services are very high and often too expensive for many NGOs to afford.

Frequently, conferences or workshops were held, with a goal of building capacity for leaders of organizations. Trips to Fiji, PNG, Bangkok and other areas of the Pacific/Asia region were common sites of travel during the duration of my field work. Ideally, workshops would bring individuals together from several countries to discuss ideas and present programs, papers and other items of interest related to adolescent sexuality, HIV/AIDS or reproductive health. From here, ideas and plans would be developed. They would be brought back to the country and shared on a broader national level with stakeholders. This has not worked. In several instances, NGO representatives mentioned that "Information stays at top and it doesn't come down." [xcv] The trips were viewed as vacations, by several individuals rather than work trips and the idea of conferences seemed to stir up negative feelings within the NGO community rather than a way of capacity building and program development.

A need for better external and internal communication was a major theme that came from several NGO representatives. Although conferences and workshops are elements designed to improve national efforts, many times messages given at these workshops had stayed with individuals who attended the workshops. Along with this, another consistent theme that arose was the desire to have a central HIV/AIDS office which would be in charge of not only coordinating efforts between organizations involved with the KHATBTF, but also producing consistent messages and promotional materials for distribution. Several organizations had their own materials for HIV/AIDS awareness, often times, other organizations working with the KHATBTF were unaware of existing materials. Although there was no problem with an over-abundance of duplicated materials, the number of organizations that were unaware of each others IEC materials was high.

The last major theme to be brought up in these interviews was the need for funding. Kiribati's HIV/AIDS/STI and ARH programs have been plagued with a lack

of capacity to develop well planned proposals and misuse of funds and materials. The ability to pull off great programs is evident in several youth workshops, positive youth activities and events, large scale social marketing campaigns and well written and performed dramas that I observed during field work. A need lies greatly in proposal development and written English skills.

NGOs in Kiribati have made enormous strides in pushing agendas on national levels. On October 27, of 2004 Kiribati had its first individual come out with their status. He is a former seaman, who has a desire to educate Kiribati about HIV/AIDS. Having courageous individuals come out with their status is an invaluable asset for HIV/AIDS awareness and support campaigns because they put a human face to the disease. He has shown tremendous effort in raising awareness by talking with doctors, parliamentarians, students and large crowds in Kiribati. On November 27, 2004 the I-Kiribati Parliament enacted a funds request from the Ministry of Health producing, for the first time ever, an annual $40,000.00 AUD budget for work with HIV/AIDS in Kiribati effective January, 2005.

I-Kiribati citizens and parliamentarians are seeing HIV/AIDS as an issue which needs to be addressed because of the work that NGO's and likeminded individuals are doing in the country. Although there has at times been internal conflict within the National AIDS Committee, it has been effective in changing the minds of high government officials who now see AIDS as an issue of importance. It is through this work that I-Kiribati citizens will prevent the full impacts of HIV/AIDS from reaching them.

Study Limitations

Two major limitations to this study became apparent after data analysis. It is hoped that readers would observe some of the noted limitations and make improvements for future research. The first limitation of the study involves the geographical area covered within the study. Kiribati has 33 atolls, each with varying degrees of cultural,

environmental and social differences, which influence social norms, behaviors and perceptions of disease. This study conducted research on only four of the 33 atolls; all within the northern/central Gilbert chain, leaving the southern Gilberts unrepresented.

Initial surveys which gathered information on youth and adult knowledge of HIV/AIDS were conducted among outer island populations, different from the main island intervention populations. It is possible that the main island intervention populations knew more basic HIV/AIDS facts than outer island surveyed populations. However, assuming that these populations would have similar knowledge the intervention was carried out in hopes of raising the amount of basic fact knowledge.

Suggestions for future research in this area would include encompassing a greater geographic area of study as well as maintaining consistent study populations which would be involved with conducting initial knowledge gathering surveys and pre/post intervention tests.

Chapter 7

DISCUSSION: IN THE END

People of Kiribati have dealt with STI epidemics dating as far back as the early 1800s when the arrival of European explorers and whalers "brought with them their need for refreshment and desire for women" (Talu, 1984) It was also around this time that the I-Kiribati population was introduced to alcohol, guns, tobacco and prostitution. Influences from these times still resonate in the modern day I- Kiribati life as alcoholism, sexual relations and violence continue to contribute to the spread of venereal disease over the past 200 years.

As it was thought then and, to some extent today, illness is a result of *te maraia,* or a curse cast upon individuals and families who had violated others. Like alcoholism, spousal abuse, cancer or other misfortunes of life, *te maraia* was a reasonable explanation for these misfortunes. According to this belief, only those who had stronger magic or could somehow attain it would be cured of the curse.

The idea of the curse still exists today, but more so as a superstition. In modern times, with the arrival of Christianity, individuals have viewed stigmatized illness as punishment for sinful behaviors. With this new way of thought, HIV/AIDS is a deserved punishment for sexual perversion and promiscuity brought about by ones own actions. Supporting this hypothesis is the fact that the majority of the surveys showed little compassion for these individuals, labeling them as bad people.

An assumption made by the general public is that seafarers, who work overseas on cargo ships for months at a time, are to blame for bringing HIV/AIDS into Kiribati. However, this blame lies on no single individual or specific group of individuals, but rather the inequalities that exist in the context of our global society. It is clear that HIV/AIDS is a disease of power, stemming from individual to national inequities. Countries most impacted by the epidemic have been and continue to be emerging nations due to their lower socioeconomic status, opportunities for growth and

development. Short of a biomedical cure, solving the problem of HIV/AIDS will require solving the problem of inequality and poverty among disadvantaged populations. Developing greater opportunities for prosperity helps to minimize disparities of power, which allows for the reduction of risk behaviors and cultivation of environments known for causing increased amounts of poverty and disease.

In Kiribati's case, HIV/AIDS is first a social illness, then a biological disease. Because biomedical aspects of the disease are addressed in limited fashion in the national dialogue, efforts of prevention have been reduced to ineffective programs which in the past, have promoted fear and unpractical prevention practices. Collected statistical, survey (Seniloli, 2003) and interview data have shown that these efforts were ineffective in the prevention of disease as numbers have continued to rise over the past several years. The country has limited medical capacity to actively dispense and monitor ARVs. Additionally, few counselors are made available to people who are living with HIV/AIDS, which reduces the strength of an overall care and support program.

In-country research conducted on HIV/AIDS/STIs and reproductive health knowledge along with sexual attitudes from 1999 to present has provided rich data for intervention development. Among key concepts seen as vital to address are issues relating to stigma, the need for better care/support programs and availability of knowledge on sexuality and the virus. Socially, limited economic and educational opportunity, population growth and gender inequality are seen as important issues to address.

In a country where medical treatment is unavailable these aspects become the social constructs of treatment. It is by addressing these issues on both micro and macro levels that we are able to address three major social cultivators of illness; poverty, inequality and opportunity.

In an address delivered by the secretary general of the pacific island forums on world AIDS day 2002 Noel Levi stated that AIDS is a poverty problem because if individual "basic needs are not being met, individuals are more vulnerable to high risk

behavior." The youth/young adult population represents a large portion of the national population. It also represents one of the largest vulnerable groups in the country.

Young adults provide the workforce needed to keep national economies growing in many Pacific Islands. In Kiribati, the main work force can be found either on the Capitol Island of Tarawa or overseas working on cargo ships for various foreign shipping companies. Tarawa is the national economic center due to development projects in communications, electrical power and other technological advances found only on this island, thus, attracting a large population to its shores. According to WHO statistics 2004[xcvi] more than 40% of the country's population lives on the main island of Tarawa today.

As stated in chapter one, copra and fish are the nations main exports, however, low trading prices for these items produce an inadequate business sector needed to fulfill the economic demands of a large population. As a result, many young I-Kiribati men, known as *kaimoa*, or seafarers, seek employment elsewhere, in order to support their families. The remittances sent home from these young men not only support their families, but also the country's economy. According to the Kiribati Bureau of Statistics, "the total amount of remittance represented 17% of the country's GDP" (Pareti, 2005).

As seen in chapter two, reported cases of HIV/AIDS in Kiribati are highest among this population. Another emerging trend seen is the increasing number of seafarer wives falling ill to HIV/AIDS. Without a healthy work force, economic instability will develop as we have seen in other parts of the world. In Zambia, where "2/3 of families who have lost a father to AIDS, (had consequently) lost more than 80% of their disposable income" (UN, 2004) Trends such as these have caused far greater consequences for whole communities as collective loss of household income contributed to faster increases of poverty, lower levels of education and reduced amounts of resources.

As seen in the chart, depicting the age distribution of HIV in Kiribati, the majority of the identified cases are males ages 10-25. Following this group are females ages 25-45. It is hypothesized that these women represent the wives of the seafarers

who contract the disease after their husbands return. The remaining group of individuals is the pediatric population. Many of whom are children of seropositive couples.

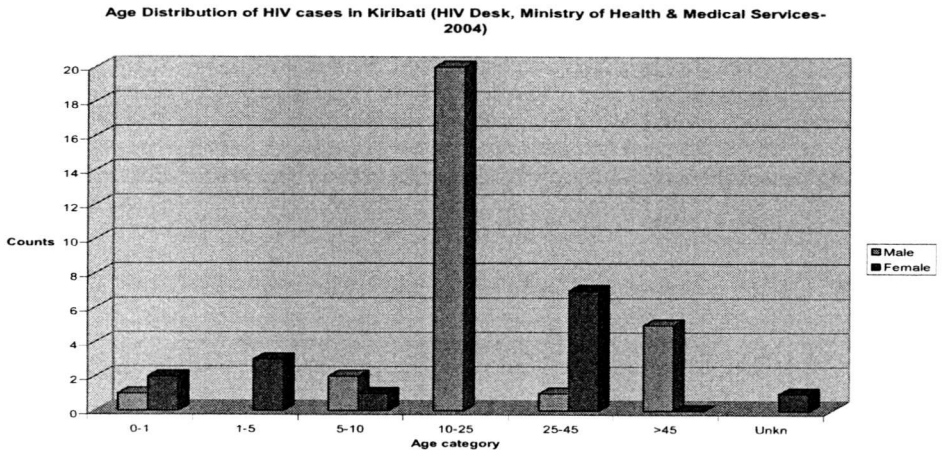

Fig. 27: Age distribution of HIV cases in Kiribati

Traditionally, females are the subservient sex, which makes them more susceptible to infection from husbands. Associations between disadvantaged populations and higher rates of disease have been recognized for several years; it is only recently that leading HIV/AIDS organizations around the world have made this connection between HIV/AIDS and female populations. The UNAIDS 2004 Global Report on HIV/AIDS states that women are now the most affected population. "The proportion of females infected worldwide steadily grew until by 2002 about half of all people were women and girls" (UNAIDS, 2004) Most detrimental for female STI rates, is the double standard allowed for males in sexual relationships; in Kiribati and many other parts of the world.

Kiribati has two unique environments, which generate diverse lived experiences distinguishable from the other. The outer islands have a greater balance of shared wealth and power due to their dependency on and supply of shared natural resources. Small communities which make up village settings encourage communal responsibility not seen in Tarawa. The main island population relies on imported manufactured goods. A cash economy is required to fuel this market, which encourages dependency on cash income. A more independent lifestyle is found on this island, in contrast to the communal lifestyle of the outer islands. The resulting social environment produced

from the intermingling of these two environments cultivates the growth of inequality with Tarawa.

Developing an effective strategic plan for HIV/AIDS in Kiribati requires an emic understanding of the culture, language and environment. It is important not to blanket the whole country with one public health campaign, but rather, to recognize these separate environments and treat them appropriately by developing several separate strategies. It is expected that goals, objectives and even implementation strategies may overlap, however different religious beliefs, island norms, age and gender need to be addressed accordingly.

Macrostructures of society need to be coupled with the microcosms of human behavior in order to produce the greatest impact for intervention success. Most interventions completed by the KHATBTF in Kiribati have utilized the HBM, where educational interventions have been included in workshops. Intervention strategies developed outside of workshop settings have included the creation of IEC materials, radio shows, peer education programs, condom distribution activities, dramas and awareness days in schools and public areas. Several awareness raising activities such as plays by the red cross, HIV/AIDS days held in the capital square and workshops for government officials and local leaders have been produced which start dialogues on the HIV/AIDS problem in Kiribati. However, more than dialogue needs to take place in order to address the larger social issues which place people at higher risk for contracting this disease. Attention needs to be placed policy development addressing discrimination, equal rights and the right to affordable treatment.

Several personal interviews[xcvii] revealed the need for educational and occupational opportunity. Interviews with people impacted by HIV/AIDS have shown that they have faced several incidents of discrimination. Policy to prevent discrimination will not be effective without enforcement. Although, I recognize the importance of nondiscrimination policies in societies, I believe that connection with a human experience of discrimination is most effective in reducing the amounts of stigma as the quasi experiment has shown. It is these human contacts that will spur the enforcement of developed policy.

To many I-Kiribati, religious beliefs are vital to daily life, especially among the southern islands. People with strong religious convictions, stated that PLWHA should be treated like the leopards in the bible, which were separated and cast from society. Often these individuals lived in separate colonies amongst other lepers and away from healthy populations. Nanakai, a village located in the middle of South Tarawa was a leprosy colony at one point in time. A call for this kind of environment has reestablished itself with the rise of HIV/AIDS. HIV/AIDS has aligned itself with the miasma theory of disease, "the idea that moral and/or religious turpitude causes disease" (Rossignol, 2004). Ideologies such as these become the biggest barrier to prevention efforts which hinder prevention efforts in the outer islands.

As referred to in chapter three, Biblical passages and parables have been used to explain facets of life with in Kiribati for generations. One informant working separately from the KHATBTF found a successful way of incorporating the bible into prevention methods through the use of parables and teachings which promote the helping of and caring for sick individuals.

Perception of illness has changed overtime. Most significantly, the exposure to western medicine on the main island has changed perceptions of disease from a miasmatic way of thinking to a clinical paradigm. As more people are coming to the main island, more are being exposed to this way of thinking.

As of December 31st, 2003 the SPC reported 8,260 known cases of HIV/AIDS in the 22 PICs, Pacific Island Countries (Sladdin, 2004). Accounting for nearly 90% of the total cases in the PICs, Papua New Guinea, reported the highest concentration with 7,320 cases.

Country	*As of*	*HIV/AIDS Reported Cases*
Papua New Guinea	Aug 2002	7,320
New Caledonia	Dec 2003	263
French Polynesia	Nov 2003	229
Guam	Jun 2002	168
Fiji	Dec 2003	142
Kiribati	Dec 2003	42
Northern Mariana Islands	Oct 2002	25
Federated States of Micronesia	Dec 2003	14
Tonga	Dec 2003	13
Samoa	Oct 2002	12
Marshal Islands	Jun 2002	9
Tuvalu	Dec 2003	9

Palau	Dec 2003	4
American Samoa	Dec 2003	2
Solomon Islands	Feb 2004	2
Vanuatu	Dec 2003	2
Wallis and Futuna	Oct 2000	2
Nauru	Dec 2003	1
Cook Islands	Dec 2003	1
Niue	Dec 2003	0
Pitcairn	Dec 2003	0
Tokelau Islands	Dec 2003	0
TOTAL	Dec2003	8,260
Total (excluding PNG)	Dec 2003	940

Fig. 28: Total cases of HIV/AIDS in the Pacific Dec 2003

Many of the smaller PICs report numbers in the single or lower double digit range. However, as noted in the recent PASA; this, being the case for almost every PIC, should not be a call for complacency as the amount at stake is much greater, due to the small populations of these islands. (SPC, 2001)

Following the KHATBTF's mission, and findings shown throughout chapter 7, there are two priority areas which need to be addressed immediately. From the interviews with people impacted with HIV/AIDS, there is a great need for medical treatment and counseling services. National AIDS committee members have admitted that these components are missing. The second area is the development of human capacity in members of the National AIDS committee. Increasing performance capability through the instruction of grant writing capabilities, budgetary management and human resource development allows National AIDS committee members to efficiently address greater amounts of issues while providing more professional service.

Acquiring Anti-retroviral drugs (ARVs), especially for individuals who have come public with their status needs to be a priority in the country. Several donor organizations such as the UNAIDS, UNICEF, the Secretariat for Pacific Communities and the World Health Organization have expressed interest in working with Kiribati on HIV/AIDS prevention and treatment programs. ARVs have been afforded to populations in other pacific nations for prices as low as $240.00 AUD per month (Sturrock, 2004). UNICEF has specifically expressed interest in availing ARV

treatment for antenatal mothers and children, making treatment possible for this population.

By acquiring medication and developing support for PLWHA, Kiribati has the opportunity to enhance medical and counseling skills as well as build facilities for HIV/AIDS in the national medical system. Accomplishing these tasks not only fulfills goals of the KHATBTF's strategic plan, but also aligns Kiribati with the internationally supported 2004 Bangkok Declaration written by people living with HIV/AIDS in Asia and the Pacific.

The second priority, capacity development among the KHATBTF members would be vital to increase effectiveness of other parts of the campaign. Kiribati is one of the few nations in the Pacific to have a multi-sectored taskforce consisting of NGOs, Government Ministries, Religious institutions and individuals impacted by HIV/AIDS. Because this taskforce spans across multiple sectors of Kiribati society, the potential for effectiveness is great. Developing this potential is a must for effective and sustainable programs. Attention needs to focus on developing skills in proposal development, research, management and evaluation of programs for identified high risk populations.

Personal research has shown that programs need to be developed that address:

- Health education in schools:
  Currently there are six paragraphs in the national curriculum which discuss HIV/AIDS in the English language; proving difficult for comprehension to students not fluent in English.

- Economic and educational opportunities on main and outer islands:
  Informants reveal their desire to migrate to the main island for educational and occupational opportunity. Internal migration has created problems with overpopulation and lack of opportunity for growth and livelihood on Tarawa. Developing opportunities on home islands or more opportunities on the main island are needed to engage these individuals in more productive roles within society.

- Enforcement and supportive measures of alcohol policies:
  Interviews with police revealed the difficulty with enforcing underage alcohol consumption. Identification of age needs to become more accessible for police.

- Testing and medical service:
  Testing is only available on the main island and within the island there are two doctors who have the ability to test individuals. It is necessary for these services to expand and be afforded to all citizens.

- Seafarer support systems:
  Seafarers make up the largest known population of seropositive individuals within the country. There is little support beyond testing provided by their shipping companies. Support groups and medical treatment for seropositive individuals needs to be developed these individuals.

- Religious, cultural and generational barriers:
  Barriers exist within the culture which prevents intergenerational discussion of sex and sexuality between youth and adults. Programs which allow for discussion on sensitive topics in appropriate manners need to be developed.

- The use and development of native language IEC materials:
  Informative, Educational and Communication materials do not send proper messages when they are printed with foreign languages and images. Making campaigns have the Pacific feel rather than transplanting foreign concepts into I-Kiribati society is an important step in bringing meaning to prevention programs.

- Development of youth friendly medical services and activities:
  Interviewees mentioned their fear in going to clinics for condoms and testing. Fearing that they would be shamed several stated that they did not seek these medical services.

- Condom acceptability:
  Deconstruction of the stigma surrounding condom use is difficult due to the reinforcing structures of society which reinforce negative perceptions with powerful religious beliefs that discourage condom use. However, this needs to be seen as a mode of preventing disease for better acceptability among all religious faiths.

- Gender equality:
  Female rights have begun to emerge with the national women's association AMAK over the past few years. However, male dominance is still prevalent among the society which has had negative implications for female power and sexuality.
- Social systems for poverty reduction on main island:
  Welfare programs and social nets need to be introduced for the emerging impoverished populations on Tarawa. Economic opportunity

> has become limited with the influx of people to the main island forcing some to take high risk sexual behavior for lively hood opportunity.

As discussed in chapter three, environments are complex inner-workings of separate social structures which form realties of lived experiences. These experiences are continuously influenced by geographical location and points of time where health perceptions, behaviors and knowledge are constantly being shaped by contemporary social facts and currents. Listed recommendations reflect the theoretical perspectives that historical particularism and structuralism offer to this thesis.

Advancing the knowledge base of HIV and AIDS within Kiribati, this thesis brings forth emic perspectives of youth, adults and individuals living with the virus. It compares and contrasts their ideas with historical events and present day structures of society showing how society influences the spread of disease. As previous research has shown social inequalities, poverty and other characteristics of marginalized populations within society play an influential role in the spread of disease. (Rubenstein, Farmer, Parker) Similar to the research, this paper stresses the need for societal components in the process of improving health.

Social research has historically been seen as inferior to scientific research within the health and medical field among developed nations. This paradigm of thought has influenced emerging nations around the world.

> *To date, only a small fraction of epidemiological research has investigated the effects of racism, sexism and class differences on health. And yet social inequalities have sculpted not only the distribution of emerging diseases, but also the course of disease in those affected by them, a fact that is often downplayed.* (Farmer, 1996)

Seeking to understand how marginalized societies are impacted by limitations placed on them allows for broader possibilities of treatment by all community members as traditional *kaina* or Klan unity would have done in traditional I-Kiribati society.

Currently, Kiribati qualifies as an eligible PIC in several HIV/AIDS grant scheme programs which can address the listed issues. The global fund to fight HIV/AIDS, Malaria and TB has helped Kiribati set up the national office and is available for funding up to 2010. Recently launched are the Secretariat for Pacific Communities, Pacific Regional Health Program/AUSAID competitive grants programs which provides grants up to $50,000 AUD per year, for a maximum of three years. This program is run through the Capacity Development Organization (CDO) office in Kiribati which was established towards the end of my field work.

Kiribati must use the national funding it has received for 2005 to increase its resources for subsequent years in HIV/AIDS prevention and care. Additionally, it also must develop the human capacity that is needed in order to run effective and sustainable programs. For these reasons and reasons stated in chapter seven, it is essential that capacity development within the National AIDS committee and improved treatment/ care be prioritized in the national agenda. We must close this gap and broaden the efforts of HIV/AIDS prevention/support by addressing these areas for development.

GLOSSARY

Ao: (a'o) conj. And, with

Bana: (bah-nah) n. Voice, speech, words

Banaba: (bah-nah-bah) n. Ocean Island; Banaban n. From Ocean Island

I-Kiribati: (ee Kee-ree-bas) n. From Kiribati

I-Matang: (ee Mah-tang) n. From a foreign land

Kai Moa: Seafarer

Katei ni Kiribati: (kah-tay nee Kee-ree-bas) n. Traditional culture of Kiribati.

Koko: (Koe-koe) n. Jealousy sprung from love.

Kona: (Koe-nah) n. ability, power to do. v. doing

Korokorea: (koe-roe-koe-ray-ah) n. prostitute

Maraia: (Mah-rai-ah) n. curse, evil spell

Matang: (Mah-tang) n. heaven, foreign lands

Mauri: (Mao-ree) n. Greeting, health

Ni: (nee) prep. of

Nikira n roro: (Nee-kii-rah n roe-roe) n. dishonored girl, unmarried girl

Raoi: (roy) n. peace

Tabomoa: (tah-boe-moe-ah) n. prosperity

Te: (teh) art. the

Unaine: (oon-i-nay) n. elder female

Unimwae: (oon-ee-mah-nay) n. elder male

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29. Personal Interview. September 2004.

30. Personal Interview. September 2004.

31. Personal Interview. August 2004.

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37. Personal Interview. September 2004.

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39. Personal Interview. August 2004.

APPENDIX A

Oregon State University

DEPARTMENT OF ANTHROPOLOGY
238 Waldo Hall Corvallis, Oregon · 97331-2140
E-MAIL: Anthropology@oregonstate.edu PHONE: (541) 737-4515

April 12, 2004

Kona Mauri Dr. Kabwea,

My name is Mike Roman, I have been working with Sam Serunkuuma for the past year and a half raising money to create posters, bumper stickers, brochures, ribbons, balloons and other materials for the Kiribati HIV AIDS Task Force. This summer I have an opportunity to go back to Kiribati for further work with the MOH and KHATF in conjunction with my studies. I have secured a scholarship that will pay for my flights to Kiribati to do field research with a local organization. Would KHATF be interested in having a researcher this summer?

I was a Peace Corps volunteer in Kiribati from 2000-2002 under the Ministry of Education. My experiences in Kiribati have had a life changing impact on me, and I have continued on in my education in applied medical anthropology with a focus on HIV/AIDS in Pacific Island countries. Having received a BA in Education in the US as well as volunteering abroad through Peace Corps and Americorps, I have received a scholarship for graduate school and currently hold a 3.95 grade point average out of a 4.00 scale in my MA program.

I know that there is currently a lot of work being done through your organization as well as several other community organizations in promoting HIV/AIDS awareness and education. While I was in Kiribati, I noticed a lot of social stigmatization against people who were living with AIDS, unfortunately I am aware that this problem is still very much a reality today.

My research proposal deals with finding out what youth in Kiribati think about HIV/AIDS. I would conduct numerous interviews with different organizations and people to learn what they know and how they view the impact of HIV/AIDS in their islands. Ultimately this information could be used to evaluate the current strategic plan as well as developing and implement new strategies for your plan. The money I have would also allow for travel to outer islands. I have housing on Tarawa, Abaiang, Marakei and Aranuka. The major expenses, not covered, would be bus fare while I am in Tarawa, however, I feel that I would be able to cover that out of my own pocket. This research would also allow me to further understand what needs to be done and what future projects in America I could assist with in your ongoing work.

Let me know if you think this would be of help to you and KHATF!
Kowraba moa!

Mike Roman

APPENDIX B

Oregon State University

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INFORMED CONSENT DOCUMENT (English)

I am conducting a research project for my University and the Ministry of Health. The purpose of this project is to help us know what I-Kiribati people know about and how they feel about HIV/AIDS. I am asking you if you would want to be a part of this study. If you want to be in the project, I will ask you several questions relating to your understanding of HIV/AIDS. I will not tell anyone your name or share what you said to me through your name. If I do chose to use ideas that you said, I will use a fake name. During the interview I will be writing down notes. These notes are just used to remind me of what was said during the interview, only I will see them. If you want to stop the interview at any time, just let me know and we will stop, or if you do not want me to write down something you said, let me know and I will not write it down or erase it. If you do not want to answer a question, that is ok, let me know and we will move on to the next question. If you have any questions for me during the interview or afterwards let me know and I will try to answer them to my best knowledge. Do you understand this project and the ideas expressed? Would you like to do the interview?

APPENDIX C

QUESTIONS FOR ORGANIZATIONS

- What has been done to educate the Kiribati public on AIDS/HIV? How has it been done? Where has it been done? When has it been done? Are there documents of this that I may review?
- What partnerships have been created with other organizations? How are they assisting in the efforts?
- What has been done for PLWHA in terms of support? Where, When, How, Why?
- What kinds of test kits are available, where are they available?
- Is there antiretroviral medication available for those who need it? At what cost is it to the individual? Would the national health care cover the costs?
- What support has there been for the families of PLWHA?
- What has worked, what has not worked in your efforts of education and prevention?
- Is there support from different agencies/sectors? What kind of support?
- Are there current policies in Kiribati, which create consistent and effective ways of dealing with HIV/AIDS? What are they? (If yes) Are there any which are currently being worked on? (If no) What are they?
- Is there a blood bank in Kiribati? Does it practice safe blood collection, disbursement and disposal?
- Is transmission through tattooing a problem in Kiribati? If so what evidence is there of this and how do you keep the needles for these activities safe?
- Do you have HIV positive individuals on your planning teams? Do you think that they would have insight to offer in planning and designing programs? Is this an acceptable role in the culture?
- Are there workplace support policies that would allow PLWHA to continue working as long as possible without fear of discrimination? When were they implemented? Is this needed?

APPENDIX D

OUTER ISLAND SURVEY

Outer Island A:

- How is HIV/AIDS spread?
- How does it affect the body?
- How can you prevent it from infecting you?
- Where did you learn this information?
- Do you think HIV is a problem in Kiribati? Why or why not?
- If a person with HIV were to enter into your village, how do you think he or she would be treated? Why?

Outer Island B:

- What is your age?
- What is your sex?
- What do you know about HIV/AIDS?
- Where did you learn this information?
- Who is at risk to catch the disease?
- How is it transmitted?
- If a person with HIV were to enter into your village, how do you think he or she would be treated? Why?

APPENDIX E

STRAIGHT TALK CURRICULUM

This program is typically geared for a classroom setting as its components include posters which may be difficult to see from far distances as well as instruction and explanation of posters which may be difficult to hear in a larger setting. In addition, personal stories of HIV/AIDS are also shared during this presentation which is a new and difficult thing in Kiribati as the current environment towards HIV and people living with it is often hostile creating intrinsic difficulty in sharing personal stories publicly in Kiribati.

Program

1. Information Gathering—interactive

What do you know about HIV/AIDS? We ask the audience to voice what they know about HIV/AIDS and collectively create a chart of knowledge. This chart stays up throughout the presentation as we commonly refer to this throughout the presentation to dispel or affirm statements recorded.

2. Going over the Facts

During this part, we go over the biomedical facts on how the virus multiplies in the T4 cells and how the immune system is weakened by the virus. A common myth that is brought up during this period is that people die of AIDS. This myth is often dispelled when we show how a person doesn't physically die of AIDS but rather from opportunistic infections such as the flu or diarrhea. We use a lesson plan which simplifies the virus adapted from the Peace Corps life skills manual to discuss the biomedical facts on HIV/AIDS which draws an analogy between the human body and a factory system. This part is also accompanied by some statistics on HIV/AIDS presence in Kiribati and the general Pacific region. Kiribati is currently the number 6 nation with the highest prevalence of HIV/AIDS in its population. We have found that showing the true picture of the epidemic in the Pacific and Kiribati to be sobering for all who attend.

3. The weakening of the immune system

This demonstration involves audience members who show how the immune system weakens as the body progresses from HIV- to a sero-positive state. We have found that physical demonstrations help I Kiribati understand these concepts better. In addition, we have also found that personal involvement makes lessons more meaningful and entertaining for participants. The demonstration shows how the body becomes more susceptible to common illnesses such as diarrhea, the flu, pink eye, TB, cough, sore throat, fever, vomiting, etc. as the amount of T4 white blood cells decrease in number. As the T4 cells decrease, the amount of the HIV virus increases causing a direct relationship between the health and the amount of T4 cells in the individual. We also show how HIV differs from AIDS as many have thought that HIV and AIDS are

the same thing, it is through this demonstration that audience members see the T cell count as a defining difference between HIV and AIDS.

It is from this demonstration that audience members see that people don't die from AIDS, but rather from common illnesses because their body can no longer fight them off due to a weakened immune system.

4. People Living with HIV/AIDS in Kiribati and abroad

Many stories have been gathered for this part of the presentation through qualitative research and personal experience. It is here that we tell stories from families of and people living with HIV/AIDS overseas as well as here in Kiribati. Most of what is discussed is the social mistreatment which these people endure as a result of the stigma currently in place of many of the Pacific Island Countries (PICs). Some messages that we convey are that people living with HIV/AIDS are not bad people; they deserve to be treated like anyone else. They are tired, sick and often lonely. At this point in their illness they need a great amount of support but often have little or no support. We try to show that treating people living with HIV/AIDS with kindness is not something that people should be afraid of doing and that helping others is a part of the Kiribati culture, we should not forget that culture because of a virus.

5. Create a Character

In this part of the session, our group works together to create a fictional character who is from Kiribati. Audience members create characteristics of this individual such as their sex, age, name, relationships, job/school and socioeconomic status. After constructing this individual we work together to determine how his/her life will be different after finding out he/she is HIV positive. The group determines who will stay and support them, if they can stay in school or work, what having HIV would mean to their economic status as well as their social ring. Often it is hypothesized that the individual will lose almost everything. This creates a great teachable moment for the audience members to reflect on their possible actions.

6. Skit on transmission

The two most common ways that STIs are transmitted throughout Kiribati are through polygamous heterosexual relationships and the sharing of devices which transfer blood. Many youth in Kiribati use tattoos as a way of personal identity and definition by way of tattooing of parent's or school names on their forearms or legs. More commonly now, many youth are using tattooing as a way of self expression through artistic design. Popular influences now include designs from New Zealand Maori warriors and other foreign Polynesian influences.

Tattooing is also seen as a bonding ritual which many youth take part in. Creating a social ring throughout the adolescent stage of life is extremely important as this period of time is focused on fitting in and not being left out of the crowd. Like many other adolescents, these youth go through many physical, emotional and individualistic changes; the need for establishing a secure group of friends at this point may be intensified in Kiribati youth who leave their home island to attend school in Tarawa. The lack of an immediate family and or familiarity with the more modern

culture of Tarawa in comparison with the outer island life may make youth necessitate a support group in a more intense manner.

Currently there is no structure for the licensed tattoo artists in Kiribati which would required service providers to abide by set health standards and utilization of universal precautions. Because of lack in infrastructure, many youth get their tattoos from friends or relatives who do not practice safe tattooing. Often times, needles are not available for these procedures, so sewing needles, ball point pens, knives and other devices not designed for sterile tattooing are used placing many youth at higher risk for infection. The most common STI transmitted from tattooing is hepatitis B, although the risk for transmitting the HIV virus is relatively low, the lack of hygienic procedures and tools warrants a higher risk for individuals partaking in tattooing procedures in Kiribati.

Because the culture emphasizes the importance of unity and dependency in the family structure, it is often practiced that personal items belong to the whole family. Items such as soap, shampoo, razors, toothbrushes and other personal hygienic devices are commonly shared among family members creating greater chances for transmission of certain STIs. Our focus is on the sharing of razors because they carry the highest potential for transmission of STIs between family members due to the nature of possible blood contact.

Adolescent sexuality also generates a higher chance STI transmission in this population due to the emerging sexual desires at this age. Many youth in Kiribati are not taught about sexuality at home because many parents find it difficult to talk to their children about this subject. Many older parents feel that talking to youth about sex would only encourage them to have sex with other youth. However this view is changing especially with the younger more educated generation of parents on Tarawa who see it as something important to talk about with their children. All parents interviewed agree that sex education should be discussed in school but the younger, more educated generation feels that it is important to discuss the subject both at home and at school.

Educating youth on reproductive health, social responsibilities, pleasures and consequences of adolescent sexual contact has been seen to empower adolescent populations to make informed decisions on their sexuality in other parts of the world. It is through this education that we hope to be able to present the information to the youth and have them be able to decide for themselves what is best for them.

Lastly the skit deals with the use of adolescent alcohol consumption. The amount of youth who engage in consumption of sour toddy during school hours or in alcoholic beverages during the weekends in local dance halls or bars is on the rise in Tarawa. Both atmospheres provide a unique setting for the youth where many are free to gather while supervision by family members is minimal or nonexistent. The consumption of alcohol in a group of adolescents alters the mind state of these individuals who demonstrate a more relaxed and less conscious state of mind. This time can also be seen as a time where youth engage in this risky behavior to "fit in" with the group, creating a stronger social bond with the group for the individual. It is during this time that many youth are reported to explore their sexuality with other youth. The consequences of these times are greatest for the females who are at risk of becoming

pregnant or infected with an STI. The risk for STI transmission is always greater in females as their physical as well as social attributes place then in this role.

Aside from foreigner sailors who occasionally dock in the country, drug paraphernalia such as intravenous injections or works do not seem to have very large presences in Kiribati. The use of these has not shown itself to be a large problem in Kiribati. As such we have not included a section on this type of transmission.

7. Testing for HIV/AIDS

Testing is something that many people are talking about, but I have found that not many individuals have actually gone to get tested for many different reasons here in Kiribati. It won't happen to me, I don't need to go get tested, I am not at risk, Why would I go get tested, only bad people get tested, I am not bad. If I were to get tested and find out that I was HIV+ I would lose everything, there is no treatment for it, so why would people get tested; they would have to hide something from everyone so it doesn't make sense. The truth is that many people get tested for many different reasons, one man got tested before he got married because the wife wanted a test to make sure that they could be safe together, many other men get tested because their overseas employers make them, "the Japanese don't like the Kiribati seamen so they make them get tested for hepatitis too", men and women get tested to further their education when scholarships require such medical documentation.

We bring in an HIV test and show individuals just how a test is conducted so that they can see exactly what is done when a person gets tested for HIV in Kiribati.

8. Teen Pregnancy

The numbers of teenage pregnancy cases are rising in Kiribati, like many other trends in Kiribati, the most noticeable growth is found on the capitol island of Tarawa. Many young girls are losing their childhood due to unplanned or unwanted pregnancies. For some, this emerging trend has brought about the practice of abortion through traditional practitioners and/or self poisoning practices in efforts to avoid a prolonged pregnancy. Having a culture which prides itself on marrying away virgin females, early pregnancy has the power to immediately disrupt the harmony of the family structure by bringing about shame on both the family and the young girl. Thinking long term, early pregnancy in the culture has the power to end the educational advances and future growth for the adolescent female, causing direct consequences for the child and the future family as a whole.

In this section we try and show that having a baby is something that should be done when the time is right. Through interviews with nurses, as well as young and old mothers in Kiribati we have gathered some of the challenges that come with raising a child. We will present these challenges to the class, with a focus on the financial burden a child places on the individuals responsible for the raising of the child.

9. Questions from audience

This time is left open for any questions that people may have on our presentation. Often times, we receive only a few questions. We are not sure how to improve the amount of

questions that we receive but if you have any suggestions, let us know! We tried doing a question box so that the questions would seem more anonymous from the audience but that didn't work out so well because no one put questions in the box.

10. Quilt

Remembrance is something important in the HIV/AIDS epidemic. Loved ones in Kiribati are often remembered by the placement of their remains in their household front yards or lands. It is not infrequent to see children resting or playing around these graves. The quilt is a tribute to those who have passed away as well, remembering and honoring the lives that have gone before us intends to be a solemn reminder to all who view the quilt.

11. What does a person look like who is HIV+?

Lastly, we try to show that people living with HIV/AIDS look exactly like everyone else. You can never tell who has HIV or AIDS because they look perfectly healthy until the T4 cell count drops below a certain amount in comparison with the viral load in the individual and that could take years to occur. To prove this point, we ask audience members to look into a box which contains a collage of people from all over the world and a mirror. The box contains only one picture of a person who has made public their HIV status, but the point of the activity is that everyone depicted—including your reflection in the mirror—looks healthy and you can never "tell" what a person with HIV looks like.

APPENDIX F

PRE/POST INTERVENTION TESTS

HIV KAP Pre-Test

Tai korea arami ma ti tangiria bwa kam nna bon kaekai raoi titiraki aikai ma te koaua.

Korei ami reke iaon te beba aio.

1. Are you male or female?
Ngai te: *Mwane* ☐ *Aine* ☐

2. What is your age?
Maitin au ririki _____

==========

3. Please circle the responses on the right. *Kamrorona am reke.*

I can get HIV (the virus that causes AIDS) if:
E kona n reke irou te HIV (manin aoraki ae karekea te AIDS) ngkana:

a) I go to school with a student who has AIDS or HIV. **YES NO**
I nakon te reirei ma te aomata ae iai irouna te aoraki aio.

b) I kiss someone who has AIDS or HIV with bleeding gums. **YES NO**
I kang newe ma te aomata ae AIDS ke HIV ao e rara ngarona.

c) I share needles for tatoos with someone who has AIDS or HIV. **YES NO**
I buobuoka te neiran taitai ma te aomata ae AIDS.

d) I have sex without a condom with someone who has AIDS or HIV. **YES NO**
I botaki (buno) ma te aomata ae AIDS ao I aki kabongana te condom.

e) I ambitten by a misquito who has bitten a person with HIV or AIDS. **YES NO**
I tenaki n te maninnara ae ea tia n tena te aomata ae iai manin te HIV ke E AIDS.

f) I give my blood at the hospital. **YES NO**
I anga rarau nakon te O-n aoraki.

g) I share my plates, spoons or cups with a person who is sick. **YES NO**
I buobuoka au bwai n amarake ma te AIDS.

==========

4. I can tell if a person is infected with HIV by looking at him/her. **YES NO**
I kona n ataia ba e HIV te aomatan n aron tarana.

5. HIV can be given to others by someone who is infected but doesn't know he/she are. **YES NO**
E k*ona n ewe te aoraki aio mai iroun te aomata ae iai irouna te aoraki ma eaki ataia.*

6. There is a cure for HIV/AIDS. **YES NO**
Iai katokan te aoraki ae te HIV/AIDS.

7. There is medicine for HIV/AIDS. **YES NO**
Iai bai n aorakian te HIV/AIDS.

8. Not having sex can protect you from being infected with HIV. **YES NO**
Te aki wene ni bure e totokoa reken te HIV.

9. Many people who have HIV do not look sick. **YES NO**
A maiti aomata aika iai irouia manin te aoraki ae te HIV ma aki tara n aoraki .

10. Please circle the best number that fits your position.
Kamonrona te kaeka ae e bootau ma iango.

1= Strongly agree 2= Agree 3= Don't know 4= Disagree 5= Strongly Disagree
1= I rangi ni kakoaua 2= I kakoaua 3= Akea au iango 4= I kakewea 5= I rangini kakewea

I am happy to be in a class with a student who has AIDS or is infected with HIV.
I kukurei n reirei ma te aomata ae iai irouna te AIDS ke te manin aoraki ae te HIV.

1 2 3 4 5

I would not be friends with someone who has AIDS.
Nna rawa ni iraorao ma te aomata ae iai irouna te AIDS.

1 2 3 4 5

I think people with AIDS are bad people.
I taku ba a kamara aomata aika iai te aoraki ae te AIDS irouia.
1 2 3 4 5

I am afraid that someday I could get AIDS.
Nnau koaua ao I bon kona ni kamanoai ma irouia aomata aika a reke irouia te aoraki aio.
1 2 3 4 5

I am afraid that I can pass it on if I get it. *I raraoma bwa ae nna bon kona ni kaea te aoraki aio nakon temanna riki ngkana arona bwa e reke irou.*

1 2 3 4 5

Please write your answers below. ***Taioka korea am reke n te tabo ane kataurаoki.***

11. List three ways to protect yourself from being infected with HIV/AIDS.
Korei tenuia am anga ae kokona ni karaoi ibukin totokoan reken te aoraki mai iroum.

_____ _____ _____

(Post Test Addition)

After learning about HIV/AIDS/STIs, pregnancy, abstinence and other issues related to sexual intercourse today I feel encouraged to have sex. *Imwin reireinakim te HIV/AIDS/STIs, te bikoukou ao te aki wene ni bure, ni bong aikai, kokaungaki riki bwakona wene ni bur eke ko aki n am ririki aio?*

_____

_____

_____

APPENDIX G

FOCUS GROUP QUESTIONS

Do you know people your age who drink? Where do they get their drinks from? What happens when they drink? Why do they drink?

Do you think people your age know a lot about HIV? What do they know? Where do they learn this information? Is this a topic people would be interested in learning about?

Do people your age have sex? Do they stick just to one partner? How many people do you know who have more than one partner? Why do they have sex at such an early age?

Can a girl tell a boy no if he wants to have sex with her? How would she do it?

Is it hard for boys to control themselves from having sex until they are married? Why?

How many of you live with your biological parents here?

How do people make tattoos in Kiribati?

Do you think it is wrong to drink at your ages? Is it wrong for girls? Is it wrong for boys?

Many people say that you shouldn't learn about sex education because it will encourage youth to have sex. Do you believe this is true? Why?

Has anyone spoken to you about HIV before? STIs? Sex? Who?

Why do kids join gangs? Do you think gangs promote sex, tattoos and drinking? Why?

APPENDIX H

QUESTIONS FOR STREET YOUTH

- Do a lot of people have unprotected sex?
- How do they choose a partner?
- Do a lot of people believe that they are at risk for HIV?
- Are young women more concerned about their reputation than young men when it comes to casual sex?
- Do people discuss their sexual history with their partner before they have sex?
- Is it expected that young men will be experienced in sex before marriage?
- What age do boys and girls start exploring sexual urges?
- Do wives forgive husbands if he cheats on her?
- Can boys control their sexual urges?
- Is it common for women to have sex when they don't want to? Why? How do the girls feel afterward?
- Is it a bad thing if a man wants to use a condom?

APPENDIX I

QUESTIONS FOR INDIVIDUALS IMPACTED BY HIV AND AIDS

- What is your age?
- What form are you in or what form did you last complete?
- Do you have a paying occupation?
- Do you have a religion? Which one is it?
- Will you describe for me what your day is like; from the time when you wake up to the time you fall asleep?
- Do you know how you or your loved one got HIV/AIDS?
- Do people outside of your family know that you or your loved one has HIV? If so, do you think that you have been treated differently because of HIV/AIDS? How? Why?
- Do you feel that you need help with daily activities? If so what kind of help?
- What kind of help do you get now? From who?
- What kind of help would you like to have in the future? From who? Why?
- Did you have a partner when you found out you had HIV/AIDS?
- Do you still have that partner? Why or why not?
- Did you talk about HIV/AIDS with anyone before you were infected? With who?
- If you were to suggest ideas for a program to help keep people safe from HIV/AIDS what would be some important ideas or activities to include?
- If you were to suggest ideas for programs to help families of people living with HIV/AIDS what would be some important ideas or activities to include?
- What kinds of things should people know about interacting with people who have HIV/AIDS?
- What do you want other people to know about yourself or your loved one?
- Is there anything else you would like to say?

APPENDIX J

PUBLIC SERVICE SURVEY

- Would you be happy to serve an individual living with HIV/AIDS in your facility?

- If so, why? If not, why?

APPENDIX K

QUESTIONS FOR PARENTS/TEACHERS/GUARDIANS

- What form did you finish?
- Do you have a religion? Which one is it?
- Do you have a paying occupation?
- Location: Outer island or Main Island?
- How much land do you own?
- Have you heard about HIV/AIDS, if so what do you know about it?
- How did you learn this information?
- Is HIV/AIDS something that you can talk about with your children/students? Why? or Why not?
- Is HIV/AIDS something that you can talk about with other community members?
- Do you think that schools should teach about it in their curriculum?
- Do you think that HIV/AIDS is a problem in Kiribati?
- Do you think that people can protect themselves from getting HIV/AIDS if you had to? How? If not, then why?
- Do you know what condoms are?
- Do you think that condom use is common in Kiribati? Why or why not?
- Should people who have HIV/AIDS be treated differently? Why?
- What kinds of people are most likely to get HIV/AIDS? Why?
- How do people learn about sex? What do they learn? From who? When?
- Who do you think poses the greatest risk for contracting HIV/AIDS? Why?
- If there is a person with HIV/AIDS in your community do you think anything will change? What, why, how?

APPENDIX L

Sex: Spread through sex
Kills: It kills
Acronym: Acronym was defined
Don't Know
Blood: Spread through blood
HIV: Caused by HIV
Dangerous: It is a dangerous disease
Foreign: Is a foreign disease
Needles: Transferred through needles
Immune: Impacts the immune system

APPENDIX M

Condom: Use a condom
Abstain: Not having sexual relations
1 Partner: Stay with one partner
No H+ Sex: Don't have sex with seropositive individuals
Needles: Don't share needles

APPENDIX N

Medical Staff- Doctors or nurses
Teacher
Friends
Parents

APPENDIX O

Prevalent: It is very prevalent
Die: It kills
Know: You don't know who has it
Seamen: Seamen give it to their wives
No Meds: There is not any medicine
Partners: People have many partners
Danger: It is dangerous

APPENDIX P

Dangerous: It is dangerous
Sex: Spread through Sex
Die: Causes death
Foreign: Is brought by foreigners

Immune: Attacks immune system
Symptoms: Defined symptoms
Prevention: Mentioned ways of prevention
Different: AIDS is different from HIV
Acronym: Defined acronym
Unknowing: Don't know the carriers
Mosquito: Spread through mosquitoes
No signs: People can't tell who has it because there are no immediate signs of infection
Meds: No medication available
Alcohol: Cause unsafe sex
Kiss: Can be spread through kissing
Don't know
Needle: Spread through needles

APPENDIX Q

Radio
Poster
School
Medical: Heard through medical staff
Friend
Video: Saw the I-Kiribati video
Parents

APPENDIX R

Sex: Spread through sex
Seamen: Seamen spread the virus
Needles: Spread through needles
Blood: Spread through blood
Alcohol: Alcohol causes unsafe sex
Prostitution: Prostitutes spread the virus
Club: Nightclubs and alcohol cause unsafe sex

APPENDIX S

ENDNOTES

[i] Interview 28

[ii] From Kiribati or a person of Kiribati

[iii] Excluding Banaba Island

[iv] WHO statistics self calculated

[v] This rate is surprising because my experiences in the country would predict a higher rate, especially in the main island.

[vi] I predict the main island households to be substantially larger than the outer island households due to current urban migration patterns. My summer household had 12 individuals which included 7 individuals less than 20 years of age, 3 between 21 and 50 and 2 older than 50 years of age. Many of whom were students seeking better educational opportunities on Tarawa.

[vii] Rates calculated with CIA, 2004 Estimates

[viii] Examining Kiribati's similar social changes; I hypothesize that the shift from a subsistence economy to a cash economy is a key factor in examining the differences between Main Island and outer island environments in Kiribati.

[ix] Informant: this is against customs to turn away a guest, no matter how long they stay you must treat them as a guest.

[x] Smoking cigarettes is the main drug found in Kiribati. WHO categorizes over 80% of the population as smokers.

[xi] Interview 23

[xii] Interview 12

[xiii] Interview 21

[xiv] Interview 37

[xv] Interview 28

[xvi] Marie Stopes HIV/AIDS Newsletter 2004, KHATBTF

[xvii] Interview 37

[xviii] Interview 11

[xix] Interview 2

[xx] Interview 18

[xxi] Interview 18

[xxii] Interview 33

[xxiii] Interview 33

[xxiv] Interview 33

[xxv] Interview 33

[xxvi] There are recent trends in several island of pre kindergarten classes

[xxvii] Interview 26

[xxviii] Interview 28

[xxix] Interview 12

[xxx] Interview 26

[xxxi] Book of Genesis, Bible

[xxxii] Interview 28

[xxxiii] Interview 40

[xxxiv] From a letter I translated addressed to the Unimwane council of Makin.

[xxxv] part of the I-Kiribati *katei is* to make guests feel welcome

[xxxvi] Interview 18

[xxxvii] Interview 21

[xxxviii] Interview 18

[xxxix] Interview 26

[xl] Interview 30

[xli] Interview 26

[xlii] Interview 17

[xliii] Interview 8

[xliv] Interview 17

[xlv] Interview 17

[xlvi] Interview 26

[xlvii] Interview 17

[xlviii] Interview 17

[xlix] Interview 26

[l] Interview 17

[li] Interview 26

[lii] Interview 26

[liii] Interview 31

[liv] Interview 32

[lv] Interview 31

[lvi] Interview 31

[lvii] Interview 37

[lviii] Interview 38

[lix] Interview 26

[lx] Interview 21

[lxi] Interview 35

[lxii] Interview 30

[lxiii] Interview 30

[lxiv] Interview 33

[lxv] Interview 33

[lxvi] Interview 33

[lxvii] Interview 33

[lxviii] Interview 25

[lxix] Interview 28

[lxx] Interview 25

[lxxi] Interview 25

[lxxii] Interview 21

[lxxiii] Interview 21

[lxxiv] Interview 34

[lxxv] Interview 34

[lxxvi] Interview 29

[lxxvii] Interview 28

[lxxviii] Interview 17

[lxxix] Interview 31

[lxxx] Interview 32

[lxxxi] Interview 24

[lxxxii] I-Kiribati here, stands for a native of Kiribati in the native tongue.

[lxxxiii] Interview 39

[lxxxiv] Interview 8

[lxxxv] Interview 36

[lxxxvi] Interview 25

[lxxxvii] Interview 39

[lxxxviii] Interview 5

[lxxxix] Interview 5

[xc] Interview 5

[xci] Interview 5

[xcii] Interview 9

[xciii] Interview 9

[xciv] Interview 14

[xcv] Interview 9

[xcvi] Self calculated from files received from WHO.

[xcvii] Interviews 33, 12, 18