

Integrated Biological Behavioural Surveillance Survey and Size Estimation of Sex Workers in Fiji: HIV Prevention Project

COMMISSIONED BY:
UNAIDS Pacific Office and the Ministry of Health in partnership with Survival Advocacy Network Fiji
and the Fiji National University



Prepared by: Dr Elaine Mossman and Dr Michael Roguski,¹ Rani Ravuidi,² Dr Rachel Devi.³



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GLOSSARY OF TERMS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immunodeficiency Virus
FNU	Fiji National University
GARPR	Global AIDS Response Progress Reporting
IBBS	Integrated Biological and Behavioural Surveillance
iTaukei	Indigenous Fijians
Indo-Fijian	Fijians of Indian descent
MEN-Fiji	Men's Empowerment Network of Fiji
MOH	Ministry of Health
MSM	Men who have sex with men
SAN	Survival Advocacy Network
SGS	Second Generation Surveillance
STI	Sexually transmitted infection
SPC	Secretariat of the Pacific Community
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
WAC	Women's Action for Change
WHO	World Health Organisation



EXECUTIVE SUMMARY

This research is the first large scale quantitative research on sex workers in Fiji. It has enabled an understanding of the nature and extent of sex work in Fiji, rates of HIV and STI infection among sex workers and their knowledge and behaviour around safer sex practices. This research will complement valuable insights gained from previous qualitative research. The findings from this research will assist in the appropriate targeting and provision of education, resources and health care services to a group previously defined by UNAIDS as a most-at-risk population. Research findings will also assist UNAIDS Pacific Office and the Ministry of Health meet both national and international reporting requirements, including reporting on the Global AIDS Response Progress Report (GARPR) and Universal Access to HIV and STI Prevention, Treatment and Care. They also provide an evidence-base to inform SAN Fiji's three year work programme.

THE DESIGN OF THE STUDY

The study consisted of two main components (i) a population size estimation of sex workers in Fiji, based on counts in seven centres (Suva, Nausori, Lautoka, Ba, Nadi, Labasa, Savusavu); and (ii) an integrated biological and behavioural surveillance (IBBS) survey administered to 298 sex workers. Biological samples provided by the sex workers were tested for HIV, Hep B, syphilis, chlamydia and gonorrhoea. The behavioural survey was developed based on previous UNAIDS IBBS sex worker research, New Zealand-based sex worker-focused HIV and safer sex behavioural surveys and UNGASS indicator monitoring guidelines. Importantly, the instrument was revised following feedback from representatives from the sex worker community and other key stakeholders (eg. UNAIDS, MoH, UNDP and UNFPA). The final survey consisted of 127 closed ended questions, divided into 10 sections and took an average of 25 minutes to complete.

A community-based participatory research approach was adopted to guide the overall research design. This involved an active and on-going partnership between the researchers and the sex worker community together with other key stakeholders at all stages of the research process including the final analysis and interpretation.

THE PARTICIPANTS

A total of 298 sex workers participated in the IBBS survey (with 297 valid surveys for the behavioural survey and 293 valid biological samples for the biological component). This represented 38% of the total estimated sex worker population. Participants were recruited by peer sex workers using a combination of sex worker network-based direct sampling and snowballing techniques.

KEY FINDINGS

Population size estimate

- In total, 857 female and transgender sex workers were identified as actively working in the previous two weeks in Suva, Nausori, Lautoka, Ba, Nadi, Labasa, Savusavu; and
- under two-thirds of sex workers were female, with just over a third being transgender. Around three-quarters were iTaukei, with a smaller 20% being Indo-Fijian.

Nature of sex work in Fiji

- Sex work in Fiji appears to be less structured than other countries, with virtually no managed sector (e.g. brothels) and workers tend to operate in a more casual manner conducting business as the opportunity arises. The most common venue participants reported operating from was the street, followed by bars, nightclubs and/or restaurants. There appeared to be no public advertising with sex workers relying on word-of-mouth referrals or being directly picked up clients. For two-thirds, sex work was their only source of income; and
- most interviewees began sex work when they were young (under 20 years of age), particularly the transgender group. The top three reasons for engaging in sex work were because 'friends were doing it' (33%), it was 'a good way to earn a living' (31%) and they needed to 'support their children/family' (25%). Consistent with previous research, sex workers appeared to have personally decided to work as sex workers with little evidence of coercion or being forced.

Prevalence of HIV and STIs

- **Only three positive cases of HIV were found suggesting sex workers are not experiencing a concentrated epidemic and that the HIV epidemic in Fiji is not expanding through sex workers; and**
- rates of STI infection, particularly chlamydia, were found to be high in Fiji's general population which suggests high levels of unprotected sex. Similarly, levels of infection were also high among sex workers, with syphilis infection found to be higher than the general population. Rates of infection varied by gender, location and ethnicity which suggests that specialised and targeted responses are required.

Knowledge and behaviour

- **Overall condom use with clients was high (91% reporting use with last client) and used far more frequently than the general population. A lower proportion reported using condoms consistently, with over half (57%) reporting they 'always' used condoms;**
- two-thirds of sex workers had the misconception that using two condoms is safer than using one (despite this practice actually increasing the risk of a condom breakage due to the friction created). The high number of condom breakages was also of concern (43% had one or more experiences of condom breakage in the previous three months);
- condom use with intimate partners was similar to other groups researched in Fiji, with 22% reporting they always used a condom with their intimate partner;
- **over a third of sex workers correctly answered five questions that identified ways of preventing sexual transmission of HIV and rejected misconceptions about HIV transmission. HIV prevention knowledge among sex workers appeared less than that of men who have sex with men, another group identified as a 'key affected group';**
- there was a high demand among sex workers for more information and services on how to protect themselves from HIV and STI infection, with peer educators being the preferred source to provide this information;

- over a third of sex workers reported being tested for HIV and receiving their results in the previous 12-months;
- **40% of participants reported never having had sexual health check (this equates to over half if the 'don't know' or 'no responses' are included). Addressing barriers to accessing sexual health services appears to be an area requiring attention, as regular health checks are an essential health and safety practice for those working in the sex industry;**
- concerns over confidentiality appeared to be the biggest potential barrier to accessing sexual health services, followed by another privacy issue that the entrance to the clinic was too visible (i.e. they might be identified as a sex worker by going into the sexual health clinic). Having a sex worker friendly clinic was the most commonly reported factor to make going for a sexual health check-up easier;
- over a third of sex workers reported being physically assaulted by clients in the previous 12-months. However, there appeared to be no organised scheme to help sex workers identify 'bad' clients commonly used in other countries;
- **13% of sex workers reported being raped by a client in the previous 12-months. However, just under a third of sex workers said they would not feel comfortable telling anyone if they were raped. This means they would not be able to receive the appropriate emotional and health support and services;**
- correct knowledge of legal and human rights related to sex work can help sex workers protect their health and safety and avoid inappropriate harassment by police. The majority of sex workers understood that they have the right to refuse a client. However, fewer understood their right to remain silent and that it was illegal under the HIV/AIDS decree for a client to refuse to use a condom;

Overall, results varied across gender, age, geographical location. Sex workers in Labasa had a lower rate of condom use, lower HIV awareness knowledge and reported difficulties accessing safer sex resources and support services. HIV and STI awareness knowledge and access to support and services appeared less well provided for among Indo-Fijian sex workers. Transgender sex workers were at increased risk of physical, verbal and financial abuse.

RECOMMENDATIONS

In response to the findings of this research, the following 13 recommendations are made. These recommendations have been endorsed by the advisory group and other key stakeholders (e.g. SPC, UNDP, UNFPA, UNICEF, MEN Fiji) following the presentation of the findings in a workshop in Suva on 19th November 2012.

In order to reduce prevalence of HIV and STIs among sex worker:

1. deliver presumptive treatment for syphilis, chlamydia and gonorrhoea for sex workers;
2. increase availability of lube and availability and quality of condoms and improve access to both of these (eg. funding for outreach services provided by peer educators or supply accessed points close to where sex workers are working);
3. remove barriers to sex workers carrying condoms, including working with law enforcement agencies to ensure sex workers do not fear prosecution if they are carrying condoms. This may require a review of the Crimes Decree;

To increase access and uptake of sexual health services by sex workers:

4. improve provision and nature of sexual health services (eg. sex worker friendly clinics - preferably dedicated services for sex workers and/or other marginalised groups, with discrete entrances and convenient opening hours, or provision of outreach/mobile sexual health services). This is consistent with the 'Continuum of Care approach' outlined in the Fiji HIV and STI National strategy that recognises the need for specialised health services for key populations such as sex workers (Ministry of Health, 2012);

To improve awareness and understanding among sex workers of HIV/ STIs and safer sex practices

5. increase funding to enable sex worker peer educators to be properly trained and resourced, including training on sex work related legal rights and safer sex practices (eg. importance of using lube and not using two condoms together). This is consistent with the 'strategic health and development communication' recommended in the 2012-2015 Fiji National HIV and STI Strategic Plan (Ministry of Health, 2012);
6. fund regional workshops for sex workers to increase HIV and STI awareness and prevention knowledge and understanding of sex work related legal rights;
7. explore funding for provision of sex worker safe houses / resource centres / drop in centres to provide on-going accessible education and awareness and support;
8. deliver workshops with key stakeholders to enable repackaging of awareness raising and information, education and communication (IEC) packages;

Ensure interventions reach the locations and groups most in need treatment

9. certain groups require increased focus and require a targeted intervention based on the needs of those of different genders, ethnicity, age and geographical location;

Address stigma, discrimination and human rights violations faced by sex workers

10. encourage the Fijian government to decriminalise sex work taking a human rights approach consistent with the current HIV Decree. There is currently no legal redress for sex workers making them vulnerable to adverse experiences including physical and sexual abuse and financial exploitation. Decriminalisation would assist sex workers to better negotiate safer sex practices with clients as provided for in the HIV Decree;
11. deliver public awareness campaigns that promote the human rights and respect of all Fijians including sex workers; and
12. deliver training to law enforcement agencies (frontline officers) on sex worker related legal rights to ensure consistent good legal practice and eliminate cases of inappropriate harassment and/or exploitation. Continue productive work with senior police and develop action plans to fully engage frontline officers;

Address identified research gaps

13. Develop a programme of research to address knowledge gaps including:
 - issues related to underage sex workers (eg. understanding entry into sex work and appropriate support action and systems of referrals for those identified)
 - sex workers knowledge and use of lube;
 - research on clients (eg. nature of clients - regular or one-offs and impact on safer sex practices, and client understanding and expectations around use of safer sex understanding and practices and awareness of implications of HIV Decree around refusal to use a condom);
 - in-depth research on transgender sex workers including entry into sex work and nature of sex work provided (insertive vs receptive behaviour);
 - understanding of extent of injecting drugs among other groups in Fiji; and
 - trial sentinel surveillance monitoring once access and uptake of sexual health clinics by sex workers has been addressed.



1 INTRODUCTION

The UNAIDS Pacific Office in partnership with Fiji's Ministry of Health submitted a request for proposals to external researchers to conduct a population size estimate and IBBS among sex workers in Fiji. The proposal from the research team in New Zealand was accepted and forms the basis for the research presented in this report. The overall aim of this research was to address knowledge gaps around HIV and STI prevalence and understand levels of safer sex knowledge and behaviour among sex workers, a group identified as high risk.¹ To achieve these research goals, an estimation of the size of the population of sex workers in Fiji was carried out together with an Integrated Biological and Behavioural Surveillance Survey (IBBS).

This research was an extension of an initial research proposal developed by the Survival Advocacy Network (SAN Fiji),² a network of past and present sex workers in Fiji. SAN Fiji thus became core members of the research team, participating in the development of an appropriate research methodology and the successful collection and interpretation of research data.

1.1 BACKGROUND

1.1.1 Socio-economic context

The Republic of Fiji Islands is made up of approximately 330 islands and coral atolls, around a third of which are uninhabited. Fiji is considered to be lower middle-income country and is multi-cultural and multi-religious (Fiji UNGASS Working Group, 2012). The 2007 census found the Fijian population to be 837,271 comprising of two main ethnic groups indigenous Fijian (57%) referred to in this report as iTaukei and Fijian's of Indian descent (37%) referred to in this report as Indo-Fijian (37%). Other minorities include Caucasian and Chinese. iTaukei are predominantly of Christian faith and Indo-Fijians of Hindu and Muslim faith. The total rural population comprises 49.3% of the national population with 50.7% located in urban centres (Fiji Bureau of Statistics, 2011). The major sources of income in Fiji are derived from tourism, sugar, mining, fishing, forestry and remittances (Ministry of Health, 2010).

1.1.2 HIV in Fiji

The Commission on AIDS in the Pacific (2009) views Papua New Guinea as the 'overwhelming locus of the Pacific epidemic', however, Fiji was considered to be one of four countries with 'significant numbers of HIV cases'. As of 31 December 2011, cumulatively there have been 420 confirmed cases of HIV in Fiji since the first reported case in 1989 (Fiji UNGASS Working Group, 2012).

¹ At-risk populations are those with the highest HIV prevalence. United Nations AIDS have identified sex workers, injecting drug users and men who have sex with men as 'most-at-risk' groups

² There are a number of sex worker organisations in Fiji with the Survival Advocacy Network (SAN Fiji) perhaps being the most well-established. SAN Fiji is a project of Women's Action for Change (WAC) and is run by sex workers for sex workers.

Reported cases are mainly among the 30-39 and 40-49 age groups. There have been no epidemiological HIV sero-surveys of the general population, but based on available testing the overall prevalence is estimated to be below 0.12% (Fiji UNGASS Working Group, 2012). While these statistics entitle Fiji to remain designated by UNAIDS as a 'low prevalence country', concern has been raised that there is a high potential for an acceleration in the spread of HIV in Fiji (Fiji UNGASS Working Group, 2010). This concern has arisen because of an increasing number of new HIV cases reported annually. For instance, 33 and 54 new cases were reported in 2010 and 2011 respectively, which was the 2011 figures being the highest since records began in 1989 (Fiji UNGASS Working Group, 2012). When the number of new infections in many parts of the world is either decreasing or stable, the prediction of an exponentially rising epidemic in Fiji is of great concern (Fiji UNGASS Working Group, 2012).

There is evidence of key groups having multiple sexual partners, with condom use being low and at best inconsistent (Fiji UNGASS Working Group, 2010). However, perhaps of greatest concern has been the high level of sexually transmitted infection (STI) among pregnant women in Fiji. High levels of STI is a proxy indicator of high levels of unprotected sex and second generation surveillance studies carried out in 2004-2005 and 2008 have found rates of infection for chlamydia as high as 37.5% in pregnant women under the age of 25 (2.1% were found to have gonorrhoea and 5.6% syphilis) (cited in Fiji UNGASS Working Group, 2010). Also, rates of chlamydia infection were high compared to many other countries but similar to reports from Papua New Guinea; a country with an expanding HIV epidemic (Fiji UNGASS Working Group, 2012). This high rate of infection suggests widespread unsafe sexual behaviour, which means if HIV cases continue to increase, conditions would support a rapid spread of infection across Fiji.

Understanding how HIV is transmitted is key to informing effective prevention strategies. Ministry of Health data, up to 2009, suggested the majority of confirmed HIV cases were through sexual transmission (91%),³ with 'perinatal transmission' as the second most common recorded mode of transmission (7%) (Fiji UNGASS Working Group, 2010). Transmission through injecting drugs and blood transfusion was low (0.3% each). The high rates of STI further support the finding that unprotected sex has been a key factor in HIV transmission in Fiji.

Commercial and transactional sex has been recognised as a source of risk and vulnerability to HIV transmission (Commission on AIDS in the Pacific, 2009). Fijian sex workers have been identified as at increased risk of infection due to multiple and concurrent sexual parties and difficulties accessing and negotiating condom use (McMillan & Worth, 2010). Further, some client groups are also considered high risk (e.g. seafarers). It has also been noted that stigma associated with sex work can prevent sex workers from accessing HIV prevention and treatment services. As such sex workers have been identified by UNAIDS as a 'most-at-risk-group' that require special attention, and would seem an important group to assess in Fiji, particularly considering evidence that the majority of HIV cases in Fiji were the result of sexual transmission. However, little is known about HIV prevention knowledge and behaviour among sex workers, or what, if any role this group play in the transmission of HIV in Fiji.

Across Asia and the Pacific, HIV prevalence among sex workers varies. In 2011, UNAIDS presented data that showed Nepal, Thailand and Vietnam being below 5%,⁴ while Myanmar was just over 10%. Figures for 2007 showed Maharashtra in India had a rate of 18%, although this was a sharp decline from 2003 figures of over 50%. To date, there has been no research to determine rates of prevalence among sex workers in the Pacific Islands.

³ 88.3% heterosexual transmission and 2.4% through men having sex with men (MSM).

⁴ Countries in Asia and Pacific that have reduced their national HIV infection levels attribute this to a determined drive to increase condom use during paid sex (UNAIDS, 2011)

Carrying out research to assist prevention efforts is more urgent now than ever before. UNAIDS (2011) noted that sex work is an evolving phenomenon that is making it increasingly difficult to collect reliable and relevant HIV information. There is increased migration and mobility, greater economic uncertainty and the proliferation of networking opportunities such as mobile phones or the internet has enabled sex workers to shift to more indirect, mobile and flexible forms of sex work.

The lack of data on the epidemics course and key affected populations such as sex workers was clearly identified in the Fiji UNGASS 2010 country progress report as one of four key challenges requiring attention. Conducting a population estimate, and surveys on prevalence and behavioural risks were all specified research activities requiring attention. Integrated Biological and Behavioural Surveillance (IBBS) surveys of most-at-risk-groups including sex workers was recognised as necessary to provide data for five UNGASS indicators (8,9,14,18, 23). It was reported that such surveys would address shortfalls in the monitoring and evaluation framework outlined in the Fiji HIV National Strategic Plan 2007-2011 (Ministry of Health, 2007).

In addition to understanding HIV and STI prevalence, knowledge and behaviour among sex workers, it is also important to understand the nature and extent of effective prevention programmes and services that are available for vulnerable groups. Lack of monitoring and evaluation in this area was identified as an obstacle impeding scaling up towards universal access (Fiji UNGASS Working Group, 2010). Qualitative research by McMillan and Worth (2010) pointed to problems for sex workers being able to access services where their confidentiality was assured, where they would not be stigmatised, were conveniently located with appropriate open hours.

1.1.3 Sex work in Fiji

There is little published information available on the characteristics of sex work in Fiji. There appears to have been an early and brief survey of sex workers in Fiji carried out by Plange in 1990, a researcher from the Sociology Department of the University of the South Pacific.⁵ There were two other early descriptive articles on the nature of sex work in Fiji. One was written in 1994 by Dr Mridula Sainath, a physician specialising in the treatment of sexually transmitted infection (STI). The other was a more detailed article by Alburg and Larson in 1995. More recently, in 2006 there was a piece of work carried out by the late Carol Jenkins, but unfortunately this was never published. Following this, there was a qualitative study, 'Risky Business' by Karen McMillan and Heather Worth of the University of New South Wales that was published in 2010. This latter research report has been the main source of what is known about sex work in Fiji. In their report, McMillan and Worth pointed to the lack of research in this area, noting their own study raised as many questions as it answered. This predominantly quantitative study will complement valuable insights gained through this qualitative research.

Despite being a long established industry (Plange, 1990), commercial sex work in Fiji has always been an illegal activity,⁶ and remains so under Part 13 of the recent Crimes Decree 2009 (Decree No. 44) of the Republic of Fiji Islands. This latter legislation, whilst continuing to criminalise prostitution related behaviours, has raised the level of evidence required for prosecution making it more difficult to legally arrest and then prosecute a sex worker. What makes sex work difficult to prosecute under the 2009 Crimes Decree is the need to have evidence that a person is 'loitering in a public place for the purpose of offering himself or herself for sex in return for a payment of any kind' (s231.1a, Part 13 – Prostitution Offences, Crimes Decree 2009 (Decree No. 44) of the Republic of Fiji Islands). This offence requires evidence (as is the case in most criminal offences) beyond reasonable doubt. The 2009 Crimes Decree for the first time also criminalised the clients. The illegal status of sex work can act as barrier for research to be carried out and hence the vital importance of having support for any research from the sex worker community themselves.

⁵ Cited in Alburg, G and Larson, H. (1995).

⁶ It is sex work related activities that are illegal, not sex work itself.

1.2 RESEARCH RATIONALE

To summarise, and further elaborate, this research has significance for the following reasons:

- > **advancement of knowledge** – to date there has been no large scale quantitative research in Fiji on sex workers STI/HIV-related knowledge and behaviour. There has also been no attempt to estimate the size of this population;
- > **health care for the community** – understanding levels of infection among sex workers, together with their knowledge and behaviour around safer sex practices will enable the appropriate targeting of education, resources and health care services to a group defined by UNAIDS as a most-at-risk population. Whilst identified as ‘most-at-risk’; currently it is unknown if this group is in anyway driving the HIV in Fiji. Previous research has revealed concern among sex workers that they are discriminated against by clinic staff (see McMillan and Worth, 2010). It is hoped that involvement in the study will enable more sex workers to become familiar with STI clinics providing an opportunity to increase their confidence in the Ministry of Health services provided.
- > **capacity strengthening** – the research draws on the expertise of diverse stakeholders that include the UNAIDS, Ministry of Health, SAN Fiji, UNDP, UNFPA and FNU. It is hoped an outcome of the research will be to forge relationships between the various parties and create opportunities for increased understanding about the sex worker communities. As a research partner, SAN Fiji has been exposed to a variety of research methods including their members’ participation as research assistants. Developing research skills among the sex worker community is consistent with best practice principles of sex worker research being carried by sex workers (UNAIDS: 2011).



2 RESEARCH METHODS

This section of the report outlines the research objectives and describes the research methodology that was developed to address these objectives.

2.1 RESEARCH AIMS AND OBJECTIVES

The overall aim of the research was to understand the nature and extent of sex work in Fiji and the population's knowledge and practices around HIV and STI prevention. This will assist UNAIDS Pacific Office, the Ministry of Health and other partners in meeting their strategic objectives around HIV and STI prevention, and assist in meeting national and global reporting requirements in reaching 2011 HLM targets and universal access to HIV prevention, care and treatment.⁷

It was also intended that the research provide an evidence-base to inform SAN Fiji's three year plan of action which includes the:

- > development of appropriate information and educational material for the sex worker community on HIV and safer sex practices;
- > training of peer educators; and
- > establishment of a network for condom distribution to sex workers.

2.1.1 Specific research objectives

With the overall aim of the research in mind, together with needs of national reporting exercises, below are eight specific research objectives (specific reference to the indicators of the UNGASS and the Global AIDS Response Progress Reporting (GARPR) process appear in brackets):

- > estimate the size of the sex worker population in Fiji;
- > estimate the prevalence of HIV, Hep B, and STIs (syphilis, gonorrhoea and chlamydia) among sex workers (UNGASS indicator 23/GARPR 1.10);
- > assess the extent of HIV testing among sex workers (UNGASS indicator 8/GARPR 1.9);
- > understand sex workers knowledge of HIV prevention and areas of major misconceptions (UNGASS indicator 14);
- > assess the level of condom use and other safer sex practices among sex workers (UNGASS indicator 18/GARPR 1.8);
- > assess the extent of injecting drug and other substance use among sex workers;
- > assess what services and prevention programmes are currently being utilised by sex workers;
- > assess the level of coverage of HIV prevention programmes among sex workers (UNGASS indicator 9/GARPR 1.7).

⁷ The WHO, along with UNICEF and UNAIDS Secretariat, has been issuing annual "Towards Universal Access" progress reports, monitoring key components of the worldwide health sector response to HIV, since 2006, when UN Member States committed to universal access to HIV prevention, treatment, care and support by 2010.

In addition to these, SAN Fiji was also interested in:

- > surveying what sex workers want in the area of HIV awareness and advocacy;
- > assessing the barriers to sex workers negotiating safer sex practices with clients;
- > understanding how the risk of violence to sex workers can be reduced; and
- > surveying sex workers' understanding of their rights under Fiji law.

These broader research aims and objectives were addressed through the following two components:

- > **population size estimation** – an essential component of programme planning as they provide an appreciation of scope of issues and the scale of the response needed.⁸ The nationwide population estimate of sex workers in Fiji is required which compares the sample of sex workers surveyed to the population of all sex workers in Fiji. This is calculated and reported on UNGASS/GARPR indicators (detailed in objectives above). It also assists in the accurate interpretation and later implementation of the survey findings; and
- > **Integrated Biological and Behavioural Surveillance (IBBS) survey** – the administration of an IBBS survey to collect self-reported information from sex workers on their HIV/STI-related knowledge and behaviour. At the same time, biological data (blood and urine) will be collected to determine the prevalence of HIV and STIs among a sample of sex workers.

2.2 RESEARCH APPROACH

A community-based participatory research approach was adopted to guide the overall research design. This approach involves an active and on-going partnership between the researchers and the community at all stages of the research process and is consistent with UNAIDS philosophy and guidelines.⁹ It has been recognised as a particularly beneficial approach to researching hidden or marginalised groups such as sex workers (Abel et al., 2007). Further, as the lead researchers were external consultants from New Zealand, adopting this approach ensured local input and ownership into the research ensuring the sex worker community and the wider Fijian community would ultimately be able to gain maximum benefit from the research.

The predominant partnership was between the researchers and the Fijian sex worker community (SAN Fiji) but extended to local stakeholders in Fiji including UNAIDS, Ministry of Health, academics from Fiji National University, legal experts and Women's Action for Change (WAC). These groups provided local expert knowledge to assist in the design and implementation of the research. It also ensured the research benefitted the community groups particularly those who would be involved in implementing positive changes resulting from the research findings.¹⁰

2.2.1 Community consultation

SAN Fiji was involved from the inception having developed the initial research proposal. UNAIDS secured the funding, commissioned the research in partnership with the Ministry of Health, and provided overall supervision and oversight throughout the study. At a later stage additional funding was provided by Fiji National University.

⁸ See 'A Framework for Monitoring and Evaluation of HIV Prevention Programmes for Most-At-Risk Populations', UNAIDS (2008).

⁹ UNAIDS (2011) stress the importance of sex workers having a say in the design and implementation of programmes that affect them.

¹⁰ Previous research on sex workers in Fiji found that most sex workers learnt about condoms and HIV prevention from other sex workers and peer educators (McMillan and Worth, 2010).

A week of in-country planning occurred in September 2011. This resulted in the identification and agreement on the research objectives and research methodology. Key to this was a planning workshop that included 12 representatives from three sex worker organisations (SAN Fiji, Rainbow Women's Network, Pacific Rainbow Network), along with representatives from MOH, UNAIDS, UNFPA. The workshop provided a forum to discuss the research needs of the various groups, and to review and revise draft methodology and the IBBS survey instrument. In addition to the workshop the research team met with a number of other individuals and groups during this planning week.¹¹

Prior to commencement of fieldwork in September 2012, a research advisory group was established to provide advice and support to the fieldwork research team and would over the course of the survey also review draft research findings. The group, made up of eight members, had been identified as having one or more of the following attributes:

- > direct involvement and knowledge with Fiji's sex worker communities;
- > skills directly linked to logistical aspects of the fieldwork (such as oversight of pre- and post-test counselling, phlebotomy, analysis of biological); and/or
- > knowledge of the Fijian law.

Community consultation extended through to the end of the project with draft findings presented to the advisory group and other key stakeholders (e.g. SPC, UNDP, UNFPA, UNICEF, and MEN Fiji) in a workshop in Suva on the 19th November 2012. Findings and their implications were discussed and appropriate responses agreed upon.

2.2.2 Research team

New Zealand research consultants Dr Elaine Mossman and Dr Michael Roguski led the research for the UNAIDS Pacific Office. Dr Roguski led the fieldwork and Dr Mossman had oversight of the overall research design, analysis and write-up.¹²

Additional core members of the research team included Rani Ravudi the National Co-ordinator of SAN Fiji who led the recruitment of research participants and Dr Rachel Devi, Senior Medical Officer of Reproductive Health, Ministry of Health, who led the biological testing and analysis components of the research.

At each research site, the core research team were supported by up to 5 research assistants recruited from the local sex worker community, a phlebotomist who collected, stored and arranged for analysis of biological samples and up to four pre-test counsellors.

Research assistants underwent one day of training which focused on survey administration, confidentiality, interview skills, recruitment and scheduling/staggering participants.

2.2.3 Ethics approval

A research ethics application was prepared and submitted to the Fiji National Health Committee and the Fiji National Research Ethics Committee. The ethics application outlined the purpose of the research, its context, and drew attention to particular areas of sensitivity. It also detailed procedures for fully informing those being asked to take part in the IBBS, obtaining their consent, and procedures around ensuring participants have access to test results and the storage of confidential information.

Ethical approval was granted 20 March 2012 (FNRERC reference number 2011042).

¹¹ In addition to workshop participants the following individuals and groups the research team met with Penni Moore, the director of Women's Action For Change (WAC); Nazhat Shameem, Barrister-at-law, an expert on the status of Fijian law for sex workers; Sepesa Rasili, the coordinator of MEN Fiji who has recently completed a similar IBBS survey with men who have sex with men (MSM); Ministry of Health representatives (Dr Frances Bingwor, Mere Devi, Dr Rachel Devi); MOH laboratory experts at Mataika House (Dr Uraia Rabuatoka, Dr Vijesh Lal and Dr Prem Singh); Veronica Chand Sekoula National Program Coordinator, Pacific Counselling and Social Services.

¹² SAN Fiji initially identified the suitability of the researchers when representatives came to New Zealand in February 2011 to meet with the New Zealand Prostitutes Collective (NZPC). Both external consultants have worked in partnership with NZPC to carry out numerous sex-worker related projects including research to review the 2003 Prostitution Reform Act and researching the health and safety of foreign nationals working in the sex industry in New Zealand.

2.3 POPULATION ESTIMATE

The population size estimation of sex worker in Fiji was required to enable comparisons of the sample of sex workers surveyed to the population of all sex workers in Fiji and to be able to calculate and report on UNGASS/GARPR indicators (detailed in objectives above). It was also important for the later planning of responses to survey findings.

The size of the sex worker population was estimated in each of the following seven centres:

- > Suva
- > Nausori
- > Lautoka
- > Ba
- > Nadi
- > Labasa
- > Savusavu.

SAN Fiji identified these centres together with representatives from other sex worker networks as the main centres where sex work takes place.

In addition to the overall numbers of sex workers working in each location, the following demographic characteristics were recorded:

- > gender (female, transgender or male);
- > ethnicity (iTaukei, Indo-Fijian, Chinese and other); and
- > main working venue (street, nightclubs/restaurants, hotels/motels, massage parlours/ brothels, private homes).¹³

2.3.1 Counting methods

Ideally the population size estimate would have been carried out prior to the administration of the IBBS survey to assist with sampling strategies. However, the cost of doing the two exercises separately exceeded available funding and, consequently, the two exercises were conducted simultaneously.

The population size of sex workers in Fiji was estimated using an approach successfully utilised to estimate the size and nature of the New Zealand sex industry (Abel et al., 2007; Bennachie et al., 2007). This approach entailed SAN Fiji project officers and provincial representatives developing an initial list of known sex workers who were actively working over the previous two week period. These lists were developed with the assistance of an external facilitator who carried out a series of workshops and individual interviews in each centre. Between three and 12 sex workers participated in the counting workshops depending on the size of the centre. Participants were identified by the local coordinator as being community connectors and, as such, possessing an extensive knowledge of the local sex worker community. Each sex worker on the list was identified by only their working name, ethnicity, gender, geographical location and main place of work.¹⁴ It should be noted that the risk of double counting was reduced through SAN Fiji staff and participants personally knowing workers.

¹³ In other jurisdictions main venues are typically clearly defined as street, brothels, escorts or private homes. Representatives from sex worker networks informed us this breakdown did not work for the sex work as it is carried out in Fiji and came up with this alternative categorisation.

¹⁴ Given the illegal status of sex work in Fiji, it was essential the personal identity of the sex worker could not be identified from the list, hence the use of working names only.

2.4 INTEGRATED BIOLOGICAL AND BEHAVIOURAL SURVEILLANCE (IBBS) SURVEY

Integrated Biological and Behavioural Surveillance (IBBS) surveys are a well-established method of gathering information that is helpful in the reduction and prevention of HIV and STIs. An IBBS combines the collection of biological data (eg. collection of blood and urine) to determine levels of HIV and STI prevalence with self-reported information from survey participants on their HIV/STI-related knowledge and risk behaviours.

2.4.1 Study sites and period of data collection

The IBBS survey was administered to sex workers from seven centres with fieldwork divided up into the following four sites:

- > Suva including Nasinu and Nausori (Our Place, Suva Hub);
- > Lautoka and Ba (Lautoka Hub);
- > Nadi (Nadi Hospital STI clinic); and
- > Labasa (Labasa Hub).

In total, there were 33 days of training and data collection completed across the four sites between 7 June 2012 and 25 August 2012. The survey was administered from between nine and six days per site. The actual amount of survey administration time was dependent upon the size of the local sex worker population.

2.4.2 Selection criteria

The following inclusion and exclusion criteria were applied.

Table 2.1: Inclusion and exclusion criteria

Key Consideration	Inclusion Criteria	Exclusion Criteria
GENDER	Female and male-to-female transgender	Male
SEX WORK	Self-identified as engaging in transactional sex work (i.e. the provision of sexual services in exchange for cash, goods or service)	Self-identified as NOT engaging in transactional sex work.
AGE	18 years and over	Below 18 years of age (this will exclude those under 18 years who are below the age of consent)

2.4.3 Sample size and recruitment

An initial sample size of between 150 and 200 had been proposed, however, this was extended up to 300 following initial counts in Suva and a positive early response to recruitment. This extension in numbers was made possible through funding from Fiji National University. The number was capped at 300 due to constraints on funding available for biological testing and to compensate participants for travel.¹⁵

In total 299 IBBS surveys were administered, however, one survey was completed but later discarded as it became evident the participant was not a sex worker. Another participant had unreliable responses to the survey data, and was also discarded from the analysis. Four participants declined to give biological samples. This meant there were a total 297 valid surveys for the behavioural survey and 293 valid samples for the biological component.

¹⁵ The extension in numbers was made possible through funding from Fiji National University.

Recruitment of participants for the IBBS was carried out using a combination of sex worker network-based direct sampling and snowballing techniques. Snowballing was greatly aided by the close ties each of the sex worker research assistants had with sex workers in each of the different communities.¹⁶ The participants were recruited in the community and came to the clinic especially to participate in the research. This ensured participants were not bias towards those sex workers typically attending the STI clinic. Care was taken to ensure that research assistants did not use their friendship or personal knowledge of sex workers to convince or coerce participation. Sex workers' autonomous decision-making was respected at all times and reinforced in information and consent forms and described verbally to participants by the external researchers.

Best efforts were made to schedule participation to avoid long waiting times. In practice, up to seven sex workers were recruited the night prior to administering the survey and asked to participate the next day. Only seven people were recruited because of an assumption that the number of participants would increase as awareness of the survey spread.

As recruitment progressed, the number of participants of each gender, ethnicity and place of work was monitored. If representation of each group did not reflect that of the estimated in that particular site, purposeful quota sampling was implemented to ensure sufficient numbers in each group (eg. if there were insufficient females compared to transgender participants, special efforts will be made to invite female sex workers to participate).

2.4.4 IBBS administration

On arrival, participants were given a card with a unique identifying number which was then recorded on their behavioural survey and their biological samples. This procedure had been used successfully in other similar studies ensuring participants identity remains anonymous but enabling them to access their test results on presentation of this card (See AC Neilson Ltd, 2009).

It was important to get a balance between respecting a participant's privacy when responding to sensitive questions and also ensuring their understanding of the survey. Hence, participants could choose if they wanted to complete a self-administered survey or receive assistance from a peer research assistant from a sex worker organisation.¹⁷ Research assistants also assisted with interpretation and translation as required.

An important role for research assistants was to screen participants to ensure they met the selection criteria. Some potential participants were turned away as they were identified as underage and/or not currently engaged in sex work. Once the survey was completed, participants received pre-test counselling before proceeding for their biological tests.

Tests results were made available for participants to collect at the same STI clinic the survey was carried out, approximately four weeks after their test. Results were released after post-test counselling and on presentation of the participants' unique identifying card.

Participants received \$20Fiji to compensate for any costs associated with travel and time taken away from work.

¹⁶ The use of the sex worker networks is consistent with UNAIDS guidelines that strongly recommend data collected on most-at-risk populations such as sex workers, is collected through the civil society organisations that work closely with the population.

¹⁷ Approximately half elected to receive assistance.

2.4.5 Informed consent

When carrying out surveillance research on vulnerable populations such as sex workers, UNAIDS protocols and World Health Organisation (WHO) guidelines stress the importance of protecting participants from the risk of harm that could occur if they were personally identified as a research participant (see UNAIDS, 2008; WHO, 2011).

For this reason, rather than collecting written informed consent which would reveal their identity,¹⁸ it was decided that collecting oral informed consent would be more ethical. Oral consent was collected following a verbal explanation of the research, which was then witnessed and signed by the research assistant and the supervisor.¹⁹ This process involved signatures from two witnesses ensuring that data collected was free from collusion and incorrect reporting and was completed at two points, prior to completing the behavioural survey and prior to proceeding on to the biological testing. As a consequence, participant data was only identifiable by the unique identifying number which could later be linked with other research data such as their tests results.

2.4.6 Behavioural survey

A draft survey was developed based on previous UNAIDS IBBS sex worker research, New Zealand-based sex worker-focused HIV and safer sex behavioural surveys and UNGASS indicator monitoring guidelines.²⁰ This draft survey was then reviewed and extensively revised at the community consultation workshop by representatives from the sex worker community, UNAIDS, MOH, UNDP and UNFPA.

The final survey was designed to either be self-administered or interview assisted should the participant below have functional literacy or request assistance for some other reason (e.g. such as poor eye sight).²¹ The survey consisted of 127 closed ended questions, divided into 10 sections and took an average of 25 minutes to complete.

The main areas of information collected through the survey were:

- > socio-demographic characteristics;
- > descriptive details of the nature of sex work;
- > condom use and other safer sex practices;
- > knowledge of HIV and STI prevention;
- > HIV and STI testing;
- > use of alcohol, drugs and other substances;
- > sex worker preferences in the area of HIV awareness and advocacy;
- > safety concerns whilst carrying out sex work; and
- > awareness of sex worker rights under Fiji law.

Included in the survey was information relating to four UNGASS / GARPR indicators:

- > UNGASS core indicator 8 / GARPR 1.9 – percentage of most-at-risk populations who received an HIV test in the last 12-months and who know their results;
- > UNGASS core indicator 9 / GARPR 1.7 – percentage of most-at-risk populations reached with HIV prevention programmes;

¹⁸ As highlighted in WHO guidelines see 'Ethical issues to be considered in second generation surveillance' World Health Organisation. (2004).

¹⁹ This approach is a well-established approach to collecting consent see ACNielsen Ltd, 2009; National AIDS Control Program, 2008; WHO, 2008.

²⁰ Sources included Abel et al., 2007; ACNielsen Ltd, 2009; National AIDS Control Program, Pakistan, 2008; UNAIDS, 2008.

²¹ After consultation with SAN Fiji and the Ministry of Health it was decided that the survey instrument should be translated into Chinese and English (Chinese translation is attached). However, advice from workshop participants was not to translate the survey into Fijian due to the difficulties in finding similar words for sexual related content. SAN Fiji research assistants will be available in the event that specific words are needed to be translated from English to Fijian for Fijian participants.

- > UNGASS core indicator 14 – percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions;
- > UNGASS core indicator 18 / GARPR 1.8 – percentage of female and male sex workers reporting the use of a condom with their most recent client.

2.4.7 Biological testing

After completing the behavioural survey, participants were required to meet with an HIV pre-test counsellor who explained what HIV testing involved and the implications of testing and not being testing. Participants were then asked for their oral consent to give blood and urine.

With participants' consent, a 5ml blood sample and 15ml of mid-stream urine were collected. Samples were labelled with participant's unique identification number. Urine samples were stored in special UPT containers with preservative to enable samples to remain stable for eight days in the transport medium (UPT). The following five tests were able to be performed from these samples:

- > HIV, Hepatitis B (HBV) and Syphilis from the blood samples; and
- > Chlamydia and Gonorrhoea from the urine samples.

Laboratory analysis varied by research location. All urine samples were frozen and sent back to Mataika laboratory for storage and analysis. Nadi hospital laboratory analysed some blood samples for syphilis, Hep B and screened for HIV. All other analysis and HIV confirmatory testing were carried out at Mataika House Laboratory.

Blood samples from all four testing locations were analysed. Urine samples could only be analysed for Suva and Labasa participants and a sub-sample of participants from Lautoka and Nadi.²²

HIV testing – as per current HIV testing strategy, (see appendix A) blood samples were screened for HIV using a Rapid Determine HIV test.²³ Following the laboratory HIV testing algorithm, positive or equivocal samples from a Determine HIV test underwent a confirmatory testing at Mataika House that involved a further three tests Determine, Veronoztika and Enzygnost.

National HIV Guidelines used in Fiji for the interpretation of the HIV confirmatory test results are as follows (algorithm shown in Appendix A):

- > Negative result = 3 non-reactive test results;
- > Positive result = 3 reactive test results; and
- > Indeterminate result = any other combination result obtained.

Hepatitis B – samples were referred to either a divisional or sub-divisional laboratory (ie to a facility where research conducted is close by). All divisional hospitals run ELISA methodology where one ELISA is negative, the result will be given out as negative and if the test turns out to be positive than the same sample is run on the ELISA machine and if positive, the sample is reported as positive. For sub-divisional laboratories (primary health care setting), all samples were run on Determine HBsAg strips where a one run remains as either negative or positive and results are reported. Since the testing is a screening test, the reporting is either negative or positive based on the type of methodology used.

²² The initial proposal was to test only for HIV, Hepatitis B and Syphilis using blood samples. Last minute funding offered by FNU enabled Chlamydia and Gonorrhoea to also be tested. However, there were only a sufficient number of testing kits and urine preservatives in Fiji to test Suva participants and a sub-sample of Lautoka and Nadi participants. New supplies arrived in time to then test all participants from Labasa.

²³ This algorithm is currently being revised.

Syphilis – blood samples were tested for past or present syphilis using the TPHA test. All positive TPHA results were then tested for active syphilis using either the Venereal Diseases Research Laboratory test (VDRL) or the BD Micro-Vue Rapid Plasma Regain (RPR) testing. These tests provide a dilution factor that indicates how severe the infection is (the higher dilutions the more severe the infection). For example, a result greater than 16 dil indicates the person has been infected for some time. Lower dilution suggests either the person has recently been infected or has received treatment for syphilis and therefore, the dilution is decreasing.

Chlamydia and Gonorrhoea – a dual testing BD Probe kit was used for testing of Chlamydia Trachomatis and Neisseria Gonorrhoea.

Tests results were available for participants to collect at their local STI clinic approximately four weeks after their testing. Results were released after post-test counselling and on presentation of the participants' unique identifying card.

2.5 ANALYSIS

Behavioural survey results were inputted into a pre-coded excel spread sheet in Fiji. This spread sheet along with biological results were emailed to Dr Elaine Mossman in New Zealand for data analysis. Hard copies of the surveys were also couriered to New Zealand to enable cross-checking of results.

All data were carefully screened for any errors, inconsistencies or omissions. Anomalies were checked and if appropriate recoded. With the behaviour survey results, skip options were checked and responses made to questions that should not have been removed. Once data was screened and cleaned, it was imported to the Statistical Package for the Social Sciences (SPSS) for analysis. The primary analysis was descriptive using simple frequencies counts and percentages.

Weighting – the population size estimation was used to calculate weights to adjust variations in sampling. IBBS results were weighted to more accurately reflect the distribution of sex workers in the various locations together with their gender, as per the population estimate. There was insufficient sample size to also weight for ethnicity; however the IBBS sample closely represented that found in the population count, overall and within specific geographical areas (see Section 4.2 for more details).

Subsequent analysis and presentation of findings, report sample sizes based on unweighted numbers but all percentages are calculated using weighted results.

Analysis of UNGASS indicators – the process of adjusting (i.e. weighting) survey findings to reflect that of the estimated population of sex workers also enabled appropriate reporting of UNGASS indicators (e.g. UNGASS indicator 23 estimate the prevalence of HIV and STIs among sex workers).

It should be noted that the sample size of 300 is insufficient for the most accurate assessment of HIV prevalence as testing at STI clinics has found a prevalence of 0.12% (Ministry of Health, 2010). To detect this rate of prevalence a sample of 1000 is required, which is greater than the estimated population of sex workers in Fiji. However, if prevalence is greatly elevated in this group, then this would be detected with the sample size achieved.

UNGASS reporting also requires results to be broken down by gender and by age (under 25 years and over 25 years), and at-risk behaviour status (eg. age of first intercourse, number of sexual partners and condom use). Information on these variables was collected in the survey, enabling UNGASS indicators and other findings as applicable to be broken down by these variables.

The design effect of 1.15 was incorporated into the calculation of confidence intervals. Tables presenting UNGASS indicator data are shaded red to contrast them from other result tables which are shaded blue.

Statistical testing – most results presented compare responses of participants across a number of sub-groups (e.g. location, age, genders and ethnicity). Z tests were performed to test for statistical significance of differences in proportions. A 95% confidence level was selected that was adjusted for multiple comparisons (Bonferroni method). Only significant differences are reported.



3 POPULATION SIZE ESTIMATE

A key objective of this research was to estimate the population size of sex workers in Fiji. This was the first time a systematic count and estimate had been attempted.

Conducting accurate estimations of the numbers of sex workers in a particular location is well recognised as a challenging task. In Fiji, sex work-related behaviour is illegal, which together with the stigma associated with this type of work means it remains a hidden population, with limited disclosure to those outside of the industry. Further, sex work can be a transitory occupation; some workers remaining in the industry for only a short time while others may work for longer durations but frequently enter and exit the industry over this time.

Good estimates rely on the involvement of those within the sex worker community who have good knowledge of other members in their community. For the population size estimate in Fiji, this was made possible through assistance of regional representatives from three sex worker networks engaged with the research process (e.g. SAN Fiji, Rainbow Women’s Network, and Pacific Rainbow Network). Another factor assisting with a reliable count in Fiji was the relatively small size of the main centres where sex work is conducted; each with a well-established sex worker network with close ties within those working in their area.

This nationwide population estimate was required to provide a basis to interpret findings from the sample of sex workers surveyed and to be able to convert survey findings into UNGASS / GARPR indicators. It was also important to be able to understand the true scale of potential problems identified through the survey and ensure appropriate scaling and targeting of responses.

3.1 ESTIMATED NUMBER OF SEX WORKERS

Results from the count appear in Table 3.1 broken down by location, gender and ethnicity.

Table 3.1: Estimated population of sex workers in Fiji

		Suva	Nadi	Lautoka	Labasa	Savsavu	Total	
TOTAL		364	152	255	58	28	857	100%
GENDER	Female	282	102	106	33	15	538	63%
	Transgender	82	50	149	25	13	319	37%
ETHNICITY	iTaukei	273	131	203	24	15	646	75%
	Indo-Fijian	45	21	45	34	8	153	18%
	Chinese	45	0	0	0	0	45	5%
	Other	1	0	7	0	5	13	2%

In total, 857 female and transgender sex workers were identified as actively working in the previous two weeks (this equates to less than 0.01% of the total population of the Fijian Islands). This was over twice as many previously estimated by the sex worker community prior to commencing the count.

An additional 45 male sex workers were identified during the count, working in Suva (n=7), Lautoka (n=28) and Nadi (n=10). Twenty-five were iTaukei and 20 Indo-Fijian. These have not been included in Table 2 as it was strongly felt to be an under-count. Male sex workers have few ties with the main sex worker networks making their identification difficult. Further, male sex workers did not participate in the survey and so were not required to assist in the analysis and interpretation of the IBBS results. The majority of sex workers were female (n=538, 63%), with just over a third being transgender (n=319, 37%). Three quarters were identified as being iTaukei (n=646, 75%), with 18% (n=153) being Indo-Fijian. There were 46 Chinese sex workers counted. The majority of these were located in Suva and one in Lautoka. Remaining ethnicities included those identified as mixed-raced (n=5), Rotuman (n=4) and Rabi (n=1).

As anticipated, Suva had the highest population of sex workers (n=364, 42%). These were sub-divided into 240 working in Suva, 113 in Nasinu and 11 in Nausori.²⁴ Next highest were from the Lautoka area (n=255, 30%), of these 170 worked in Lautoka, 78 in Ba and 7 worked mainly in Tavua. The best estimate for Nadi was 152 sex workers (18%). However, it was noted that Nadi has the most transient population with many workers visiting the city from other areas (eg. Suva). Also a high proportion of workers who permanently reside in Nadi's surrounding areas travel into Nadi for work. This meant sex worker networks were not as strong as other areas and it was felt the number identified was likely to be an undercount. Smaller areas like Labasa (n=58) and Savasavu (n=28) were far easier to estimate reliably. Strong sex worker networks also increased reliability of counts (eg. Suva and Lautoka).

The mobility of the sex worker population was explored in the survey and suggested two-thirds worked in one or more venues in a 12 month period, with 16% working in four or more locations.

Limitations of the population estimate

Counts were limited to seven centres.²⁵ These were those centres identified by the sex worker communities as the main areas where sex work was known to take place. No attempt was made to estimate or project the number of sex workers that may or may not work in smaller centres around Fiji. Advice from the sex worker community was that sex workers living in smaller centres travelled to the larger centres for work so would have been included in the count.

Some sex workers move around for work (two thirds had worked in two or more centres in the previous 12 months). However, counts were based on those known to be working in the previous two weeks and were carried out consecutively over a six week period which minimised the risk of double counting.

Another limitation of the counts is that they were based on those sex workers known to the key individuals within the sex worker network organisations. There may have been others working 'underground' that were not known to these organisations and so not included in the counts. For this reason it is likely the estimated population is an underestimation.

Further, it is acknowledged that the number of sex workers can fluctuate according to the season and activities (e.g. Christmas, sugar cane harvesting, peak tourist seasons). Counts were carried out in June and July and it is likely the number working would be lower than in the warmer months.

²⁴ It should be noted that many workers from Nasinu, Nausori and Suva altered which areas in which they worked.

²⁵ Initially six were identified but Savasavu was added as the seventh centre due to available resources and small size making a count a relatively easy exercise.

3.2 TYPE OF SEX WORK

In addition to the overall size, geographical location and demographics of the population, the main venue where sex work occurs was also of interest. Attempting to understand this is important, as those working in different venues are likely to have different service response needs.

In other countries, this tends to be categorised as those working on the street, those working under a system of management (eg. brothels, massage parlours, escort agencies) and those working privately operating their business from their own home. Sex workers tend to fall clearly into one of these three categories.

It became evident during the consultation workshop that the structure of sex work in Fiji did not conform well to this system of classification. There was virtually no managed sector (despite this being the largest sector in many jurisdictions),²⁶ and there appeared considerable overlap in other sectors. While some workers did work in just one venue (e.g. street or private home), it was also common to work from a variety of venues.

Participants at the consultation workshop suggested the following main categories were recognised places where sex work took place in Fiji:

- > Street;
- > Bars / Clubs / Restaurants;
- > Brothels / Massage parlours;
- > Hotels / Motels; and
- > Private homes.

These were the venues used for the count. Deciding on the criteria for selecting a venue generated much discussion at the workshop. For example, should it be the place where soliciting for clients took place (eg. street, bars, and brothels) or where the client received a service (eg. hotels, private homes). The mode of soliciting was also considered, with some sex workers being phoned for business whereas others solicited for clients in a physical location. The operational definition decided on for the count was the main venue where the sex worker operated their business from in the last two weeks or where the financial transaction took place. It was agreed that other characteristics such as how and where clients were solicited should be explored in more detail in the behavioural survey.

The population estimate revealed that 565 out of 857 (66%) sex workers were identified as working in from one of the five main venues. The remaining 35% appeared to regularly work in more than one (20% working in two venues, 13% in three, and 2% in 4 venues).

Of those carrying out sex work from just one main location, the venues where they operated from as follows:

- > 60% (n=341) street;
- > 19% (n=105) bar/club/restaurants;
- > 11% (n=63) private home;
- > 2% (n=10) hotel/motel;
- > 1% (n=8) brothel/massage parlour;
- > 7% (n=38) from another venue
(35 working in a kava shop, two in a hair salon and one in Billiards Hall).

²⁶ There had been brothel type operations where some sex workers worked out of particular hotels, motels or massage parlours, but recent police crack-downs particularly in Suva had curtailed this mode of operation.

Table 3.2 below presents the percentage working in each venue in each area, and by gender and ethnicity (as noted above, 35% worked in more than one venue, therefore percentages working in the various venues do not equal 100).

Table 3.2: Breakdown of type of sex work conducted in Fiji

		Street	Bar/Club /Restaurant	Hotel/ Motel	Brothel/ Parlour	Private Home	Other	Total
TOTAL		67%	42%	19%	1%	16%	5%	857
LOCATION	Suva	73%	59%	37%	0%	15%	0%	364
	Nadi	64%	26%	0%	1%	6%	28%	152
	Lautoka	78%	11%	4%	3%	21%	0%	255
	Labasa	17%	88%	14%	0%	12%	2%	58
	Savusavu	0%	100%	25%	0%	57%	0%	28
GENDER	Female	63%	47%	23%	1%	14%	4%	538
	Transgender	73%	34%	11%	2%	20%	7%	319
ETHNICITY	iTaukei	77%	37%	18%	1%	14%	6%	646
	Indo-Fijian	46%	48%	25%	3%	28%	2%	153
	Chinese	0%	100%	0%	0%	0%	0%	45
	Other	38%	54%	23%	0%	38%	0%	13

More details related to these findings appear below, broken down by the type of venue.

- > **Street work** – overall the most common venue for sex work to be carried out was on the street (67%). This was slightly more common among transgender workers (73%) and for iTaukei (77%). It was less common in smaller centres such as Labasa (17%) or Savsavu (none). Soliciting from the street was explained as being too visible in small centres where everyone knows one another, and therefore unpopular;
- > **Bars / clubs / nightclubs** – the next most common venue were bars, nightclubs and/or restaurants (42%). This is the most common venue in Labasa (88%) and the only venue in Savusavu, where street work was less common. It was also the only venue where Chinese workers were identified as working (which was generally limited to Suva). There was considerable overlap between those working in bars, nightclubs or restaurants and those working from the street as over half (56%) of those working in bars also worked on the street;
- > **Hotels / motels** – one in five sex workers also conducted their business in hotels or motels (19%). Just 6% of workers identified as only conducting their business from this venue whereas the remaining were identified as also working from their private home or soliciting from other public venues.

This was a difficult category to classify as clients could be staying at the hotel or reside locally and pay for the hotel room in order to meet with the worker. Most commonly, clients appeared to pay for the use of the room by the hour. It appeared some workers were phoned either directly by clients or another third-party to meet clients at a hotel or motel. Classification was further problematic because some workers may also only receive calls at home and could be classed as ‘private workers’. Other workers could solicit elsewhere and receive a call on their cell phone. There were also workers who solicited their clients from the street or elsewhere and then took their clients to the hotel or motel, and so could be categorised to be the same as other workers soliciting their clients in these venues;

- > **Private home** – there were 16% of workers identified as conducting their business from their private home. This appeared more common for Indo-Fijians (28%) and was particularly common in Savusavu (57%). Some workers met their clients in their private home, others operated their business from home but met clients elsewhere (eg. hotels), and some solicited clients in a public venue but entertained the clients at home. In Suva, some female sex workers just stay in their homes and get clients referred to them by transgender sex workers from the street;
- > **Brothels/massage parlours** – there were only 1% of workers identified as working in brothels (n=4) or massage parlours (n=7). The four identified as working in a brothel all worked in Lautoka. Those working in a massage parlour worked either in Lautoka or Nadi;
- > **Other venues** – there were 44 sex workers (5%) who were identified as working from another venues. This included 38 working from kava shops in Nadi, four from hair salons in Nadi, one from a billiards hall in Lautoka and one in Labasa who only received clients' calls from their mobile phones.

Overall, it appeared the nature of the sex industry in Fiji is less structured than other countries. There was virtually no managed sector as workers tended to operate in a more casual manner conducting business as the opportunity arose. For example, one scenario observed by one of the researchers involved a group of sex workers who had decided not to work that evening and had met up for a drink in a local bar. During the evening, one of the workers received a call from a third party and then agreed to meet a client at a hotel. The same individual may just have likely been approached by a patron at the bar or introduced through a third party such as a taxi driver, bouncer or bar tenders. This causal approach to sex work was also noted by McMillan and Worth (2010) described as a group that 'went with the flow'. However, these researchers contrasted this group to a group that took a more professional approach, which was less evident in our analysis of work venue.

There appeared to be little advertising, unlike other countries where advertising on the internet or in newspapers is common. In Fiji, business was mainly conducted through word of mouth referrals or from direct soliciting in public areas. Transactional sex also added to the casual nature of the industry, where individuals (who identify themselves as sex workers) agree to have sex in exchange for drinks or some other non-monetary commodity.

The behavioural survey further explores the nature of sex work, with questions on how clients are picked up, where they are serviced, if it is for money or other commodities and the extent depends on sex work for their livelihood.



4 IBBS SAMPLE CHARACTERISTICS

This section provides a description of the sample of sex workers who participated in the IBBS research. The characteristics of the research sample are compared to those in the estimated population and the process of adjusting for differences between the sample and the population are described.

4.1 NUMBER OF IBBS PARTICIPANTS

A total of 298 sex workers participated in the IBBS survey (with 297 valid surveys for the behavioural survey and 293 valid biological samples for the biological component).²⁷ This represents 38% of the total estimated population.²⁸

Table 4.1 provides a breakdown of the number of surveys completed in each location by gender and ethnicity. Nearly half the sample (47%) had been working as a sex worker for over five years.

Table 4.1: Characteristics of sex workers sampled for the IBBS survey

		Suva	Nadi	Lautoka	Labasa	Total	
TOTAL		122	88	63	25	298	100%
PROPORTION OF POPULATION¹		38%	58%	25%	43%	38%	-
GENDER	Female	79	58	35	13	185	62%
	Transgender	42	30	28	12	112	38%
	Unspecified	1	-	-	-	1	0.3%
ETHNICITY	iTaukei	102	78	45	6	231	78%
	Indo-Fijian	17	8	13	18	56	19%
	Chinese	-	1	1	-	2	1%
	Other	2	1	4	1	8	3%
	Unspecified	1	-	-	-	0	0.3%

¹ Proportion of population based on numbers in each relevant location but the total population excludes those working in Savusavu and Chinese workers from Suva who were not recruited for the study.

²⁷ A total of 299 participants were recruited but participants and their results were discarded as it became evident the participant was not a sex worker. Another participant had unreliable responses to the survey data and was also discarded from the analysis.

²⁸ Total estimated population size was n=784 when those who did not participate in the IBBS are removed (i.e. those working in Savusavu and the Chinese sex workers in Suva).

4.2 ADJUSTING FOR RESPONSE BIAS

For survey findings to be generalizable to the Fijian sex worker population, the IBBS survey needs to be based on a representative sample of the population. The optimum way to achieve this would be to select and recruit a random sample of the population of interest. However, with a hidden population, such as sex workers, this is not practical. Instead, the sample was derived through active recruitment by SAN Fiji representatives followed by word-of-mouth snow-balling. It was therefore important to assess how well the characteristic of the non-randomly recruited sample reflected the general sex worker population (see characteristics of the population presented in Table 3.1). Where differences are evident, adjustments can be made through post-stratification weighting to improve the representativeness of the sample.²⁹

Despite non-random sampling, the overall demographic characteristics of the sample and estimated population were remarkably similar. The count estimated that 63% of the sex workers were female, and the survey recruited 62%. The count estimated 75% of sex workers were iTaukei and 18% are Indo-Fijian; the survey recruited 78% iTaukei workers and 18% Indo-Fijian. There was however, a discrepancy in the number of Chinese sex workers counted (5%, n=45) and surveyed (1%, n=2). This was because the Chinese sex workers working in Suva were unable to be recruited for the survey.³⁰ The two recruited for the survey came from the Western provinces.

In terms of geographical location, the population and survey sample were similar in Suva (42% and 41% respectively) and Labasa (7% and 8%). However, sex workers from Nadi were over-represented (the population estimated for Nadi was 18% and 30% of the survey sample came from Nadi) and sex workers from Lautoka under-recruited (the population estimated for Lautoka was 30% whereas 21% of the survey sample came from Lautoka).

To account for these differences minor adjustments were made based on the estimated numbers of sex workers in each of the main centres and of each gender.³¹

Table 4.2 presents the estimated proportion of the population and the proportion recruited for the survey, together with the weights adjusted for discrepancies.³²

These weights are applied to the survey data to improve generalizability of results. A value greater than 1 increases the weight given to corresponding survey results. Value less than 1 decreases the weight given and a value of 1 would make no adjustment to survey results.

Presentations of results – sample sizes reported are based on unweighted numbers, but all percentages are calculated using weighted results.

²⁹ It is important to note that weighting cannot fully account for all response bias, for example those recruited for the survey are likely to have closer ties with sex worker networks and benefit from peer education. It is also possible that there are differences in HIV prevention behaviours and rates of infection for those who chose to participate compare to those that did not.

³⁰ SAN Fiji had limited networks within this sector due to the transient nature of the Chinese sex worker population and the lack of integration with non-Chinese sex workers. This limited SAN's ability to recruit participants for the study.

³¹ Gender and geographical location were selected as there was an insufficient population breakdown by ethnicity to make reliable adjustments. It was also felt the nature of sex work and rates of infection were more likely to vary according to geographical location and gender, than ethnicity.

³² The estimated population percentages were excluded those who did not participate in the IBBS survey (i.e. those working in Savusavu and the Chinese sex workers in Suva). There was one survey participant whose gender had not been recorded and was not included in the sample survey percentages.

Table 4.2: Adjustments for inconsistencies in sampling

Main Centre	Population estimate (n=784)		Sample surveyed (n=297)		Weights for adjustment ¹	
	Female	TG	Female	TG	Female	TG
Suva	30.2%	10.5%	26.6%	14.1%	1.14	0.74
Nadi	13.0%	6.4%	19.5%	10.1%	0.67	0.63
Lautoka	13.5%	19.0%	11.8%	9.4%	1.15	2.02
Labasa	4.2%	3.2%	4.4%	4.0%	0.96	0.79

¹ Population proportion divided by sample proportion.

4.3 SOCIO-DEMOGRAPHIC CHARACTERISTICS

Socio-demographic characteristics of sex workers in Fiji based on the IBBS sample are presented in Table 4.3. Characteristics are presented for the whole sample and are broken down by gender.

Table 4.3: Socio-demographic characteristics

		Female (n=185)	Transgender (n=112)	Total (n=297)
ETHNICITY	iTaukei	76%	76%	76%
	Indo-Fijian	23%	15%	20%
	Other	2%	9%	4%
AGE	Under 20 years	14%	18%	16%
	21 to 25 years	28%	29%	28%
	26 to 30 years	22%	24%	23%
	31 to 40 years	23%	20%	22%
	41 to 50 years	12%	8%	10%
	Over 50 years	1%	1%	1%
	DK/No response	1%	1%	1%
EDUCATION	Tertiary	15%	42%	25%
	Secondary	64%	44%	56%
	Primary	19%	13%	16%
	None	1%	0%	1%
	DK/No response	2%	1%	1%
OTHER WORK	No	69%	46%	61%
	Yes	31%	54%	39%

¹ Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighted numbers.

All IBBS participants were Fiji nationals that had been born in Fiji, and around half (51%) were still living in the town where they were born. Around two thirds of the sample were transient (32% working in two different towns in the previous 12 months, and 29% working in three or more).

Other key descriptors of the socio-demographic make-up of the sample include:

- > after weighting the proportion of transgender sex workers became 39%, with females making up 61%;
- > just over three-quarters (76%) of the sex workers identified as iTaukei and 20% identified as Indo-Fijian. Indo-Fijian sex workers were more likely to be female (23%) than transgender (15%);
- > two-thirds of the sex workers were under 30 years of age, with the largest age group being 21 to 25 years (28%);
- > 4 out of 5 sex workers (81%) had completed secondary school education or higher;
- > sex work was their only source of income for 61% of participants, although this was more common for female sex workers (69%) than transgendered workers (46%). Of the 39% of participants who engaged in other types of work; the three most common types of occupation were:
 - domestic duties (n=30) (such as being a house keeper or babysitting);
 - the beauty industry (n=24) (including hairdressing and make-up artist; and
 - retail (n=18) (such as sales assistance).

Other types of work included hospitality/entertainment (n=8), peer education (n=7), manufacturing (n=6), business (n=4), travel industry (n=3) and sex worker advocacy (n=3). One respondent said they were also a beggar and 13 chose not to respond to this question;

- > 71% of sex workers currently had a partner (86% of all females and 47% of transgender sex workers). For 85% of female sex workers this was a heterosexual relationship. For transgender sex workers, 93% described their partner as male, 3% described them specifically as transgender and a further 3% described them as female. In hindsight a more direct question on their sexual preference (hetero-sexual, bi-sexual or homo-sexual) may have been more appropriate;
- > of the 71% who currently had an intimate partner, 56% described the relationship as a long-term/stable relationship, with 18% reporting they were married and 38% living in a de-facto relationship;
- > just under half (48%) of sex workers indicated there were others who were currently dependent on their income. For the majority (41%), dependents included a combination of children and adults. For a quarter; (25%) dependents were children only. Similarly, 23% reported that their dependents were adults only.³³

³³ These children could be siblings or their own children. While 36% of sex workers reported having had one or more child at some point in their lives, just 15% also reported children currently being dependent on their income.



5 NATURE OF SEX WORK IN FIJI

This IBBS is the first large scale survey of sex workers in Fiji and has provided the opportunity to understand the characteristics of sex workers and the nature of their work. This section describes career characteristics such as the age participants began working in the industry, duration and reasons for starting sex work. Also described are the type and frequency of sex work, together with some details on client characteristics. Details of the type of income generated and access to support are also presented.

5.1 CAREER DURATION

Of the 297 sex workers who completed the IBBS survey, the majority (69%) had been carrying out sex work for two years or more. A fifth (21%) had been working for between six months and two years, and 5% for less than six months. The longest duration practicing sex work was 38 years.³⁴

The overall duration of the intended career appeared to vary and for some was unpredictable. When asked how long they intended to stay being a sex worker, the largest proportion (37%) said they did not know. For a similar proportion, their intention was to work for another two years or more (16% reported '2 to 5 years, 6% reported '6 to 10 years' and 15% reported 'always').³⁵ For around a quarter, their intention was for a shorter duration of less than year (15% reported their intention was for 'one year or less', and another 10% said it would only be for a few more months).

While the duration appeared to vary, it was also common for sex workers to take a break. Three-quarters (75%) said they had taken a break from sex work, although for most (62%) the break was just for a few weeks or months.³⁶

5.2 CAREER INITIATION

5.2.1 Age beginning sex work

Figure 5.1 shows the age sex workers started working as a sex worker. Two-thirds started sex work by the time they were 20 years old (30% were under 18 years and 33% were between 18 to 20 years). As seen in Figure 5.1, transgender sex workers were significantly more likely to start at an earlier age (under 18 years). The youngest starting age reported was nine years old, with a total of 31 sex workers, out of the 297 IBBS participants, reported they started working as a sex worker before the age of 16 years.

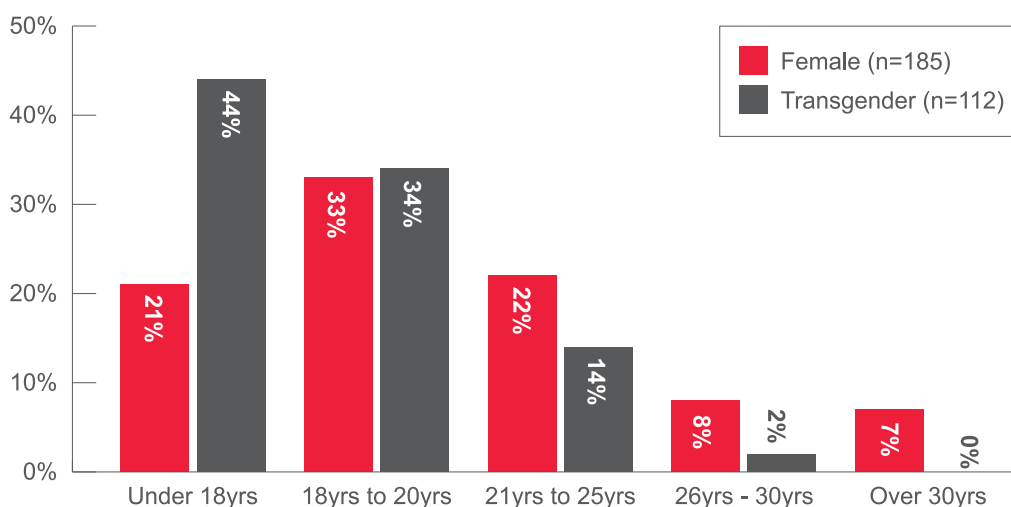
³⁴ Four percent either did not respond to this question or responded with don't know.

³⁵ Transgender sex workers were significantly more likely to report 'always'.

³⁶ Female sex workers were significantly more likely to report taking a break (82%) compared to transgendered sex workers (66%).

Of the 6% who reported starting at an older age (26 to 30 years), these were significantly more likely to be Indo-Fijian (18%) than iTaukei (2%) and Female (8%).

Figure 5.1: Age first began sex work



NOTE: Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighted numbers.

5.2.2 Reasons for starting sex work

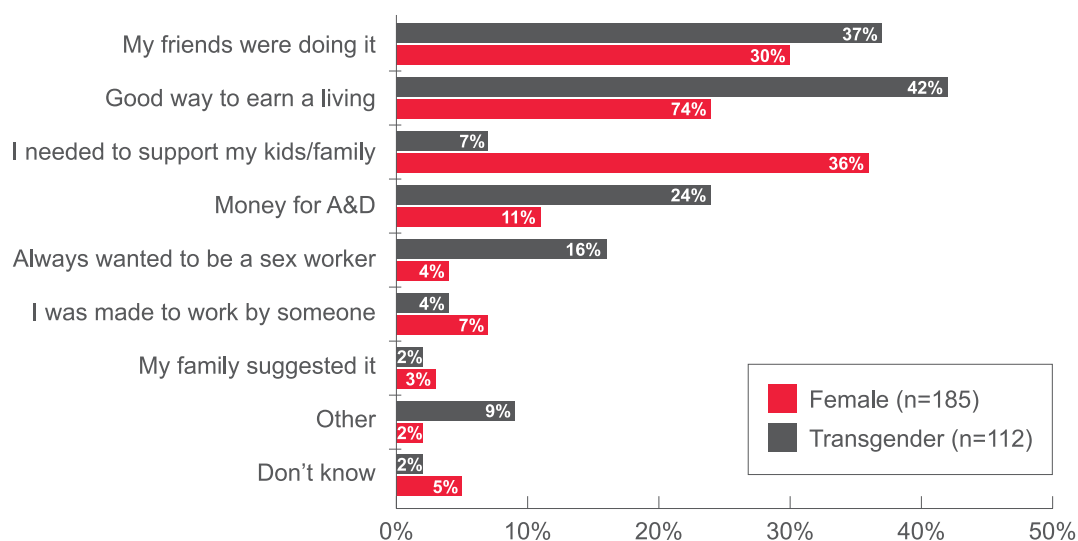
IBBS participants were asked why they first became a sex worker. They were given a list of seven possible reasons and asked to tick all that applied. Figure 5.2 presents these reasons ranked in order of frequency. Overall, the top three reasons were because ‘friends were doing it’ (33%), because ‘it was a good way to earn a living’ (31%) and because they needed ‘to support their children/family’ (25%). Consistent with other research, sex workers appeared to have personally decided to work as sex workers as there was little evidence of coercion or being forced or sold against their will.

Transgender sex workers were significantly more likely than female sex workers to report they began working as sex workers because it was good way to earn a living, to get money for drugs and alcohol and because they always wanted to be a sex worker. Female sex workers were significantly more likely than transgender workers to report it was to be able to support their children/family.

Indo-Fijian sex workers were significantly more likely than iTaukei sex workers to commence sex work to support their family (51%), because they were made to (13%) or because their family suggested it (11%).

Participants were also asked how they got introduced to sex work. The vast majority (70%) said a friend had encouraged them. 8% said they had been forced, 7% said it was a family tradition and 6% said a neighbour had helped them. Around 8% mentioned other means, the most common of which was they had initiated it themselves without help from anyone (2%).

Figure 5.2: Reason for starting to sell sex



NOTE: Percentages do not add up to 100% as participants could select all the reasons that applied. Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighted numbers.

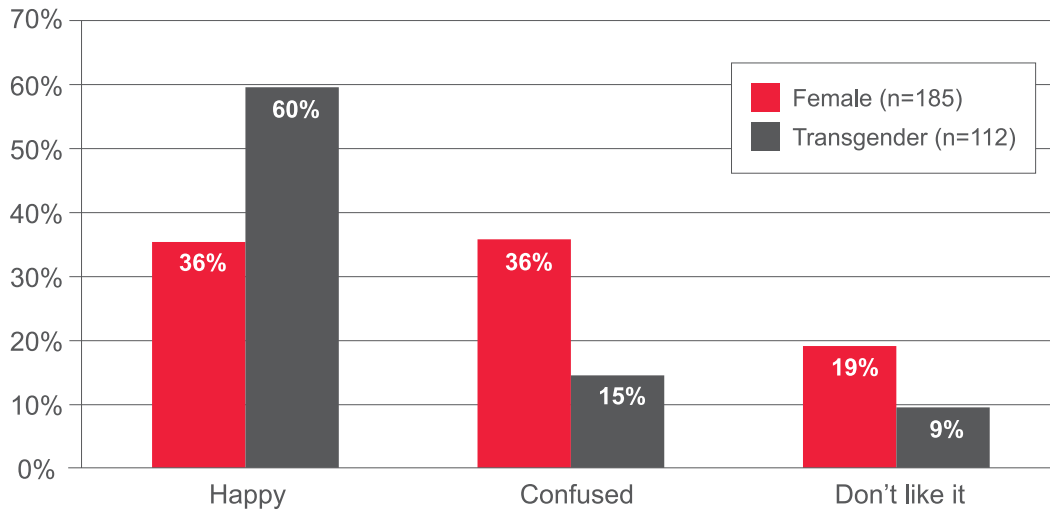
While there was little evidence of direct coercion, more in-depth research is needed on the indirect pressures that may impact on an individual's choice to carry out sex work. Of particular interest are the circumstances around those starting work at an earlier age and those more vulnerable to marginalisation such as transgender workers.

5.3 CHARACTERISTICS OF SEX WORK

Survey respondents were asked how they felt about being a sex worker. Results appear in Figure 5.3. The most common response by 45% of all sex workers was that they were happy being a sex worker, however significantly more transgender sex workers (60%) reported this than female sex workers (36%). Overall 55% of female sex workers reported being either confused or reporting that they did not like it (significantly more than transgender workers).³⁷ There were also significantly more Indo-Fijian sex workers (28%) than iTaukei (13%) who reported they did not like being a sex worker. 10% either elected not to answer this question or responded with 'don't know'.

³⁷ A further 10% either did not respond to this question or selected 'don't know'.

Figure 5.3: Feelings about being a sex worker



NOTE: Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighted numbers.

5.3.1 Type of work

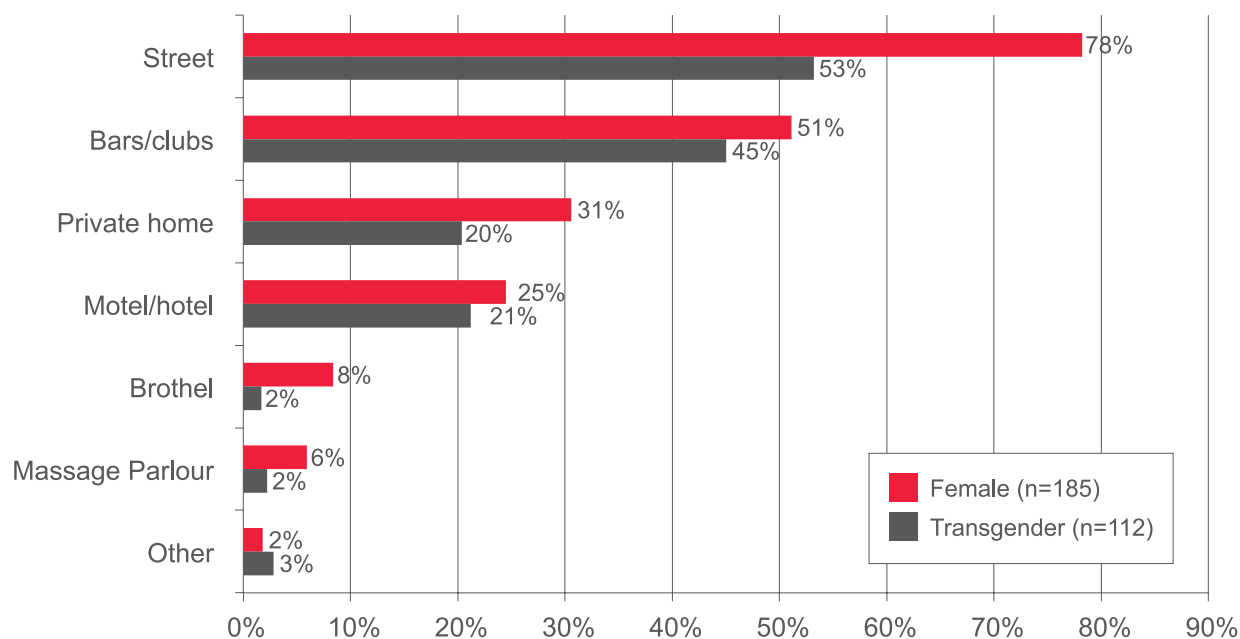
Survey respondents were asked to indicate where they most commonly work from when carrying out sex work. They were given six options and asked to indicate all that applied, results are presented in Figure 5.4 in order of frequency.

As established in chapter three, the most common location for sex work is the street (63% of all sex workers), although this was significantly more likely for transgender sex workers (78%) than female workers (53%). It was also significantly more common in Lautoka (78%) than the other three centres. The next most common venue was bars/clubs (47%), followed by a private home (24%) and motel/hotels (23%). The proportion reporting carrying out sex work from a private home was slightly more than that estimated through the count (16%). Given the hidden nature of this venue, it is likely the results from the survey are a more accurate estimate. There were also slightly more sex workers reporting working in a massage parlour (4%) or brothel (4%) than had been estimated through the count. It is unclear if this is due to differences in interpretation by survey respondents. For example, there were some sex workers known to work together in a motel/apartment that may have considered this a brothel.³⁸

2% of survey respondents reported working from another venue. This included kava shops (n=5), a hair salon (n=1) and a garment store (n=1).

³⁸ Transgender sex workers were more likely than female sex workers to report working from a private home or a brothel.

Figure 5.4: Main venue for sex work



NOTE: Percentages do not add up to 100% as participants could select more than one venue. Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighted numbers.

The number of venues reported was calculated revealing that 55% had indicated only one venue, 36% had selected two venues, and 9% had selected three. Transgender workers were significantly more likely (15%) to work in more than one venue (which is also evident in Figure 5.4), with 15% selecting three different venues.

In an effort to determine if venue preference changed over time, participants were asked which venue they started working from. There appeared to be little difference between original and current venues although fewer sex workers reported that they started working from a bar or club (35%) or from a private home (14%).

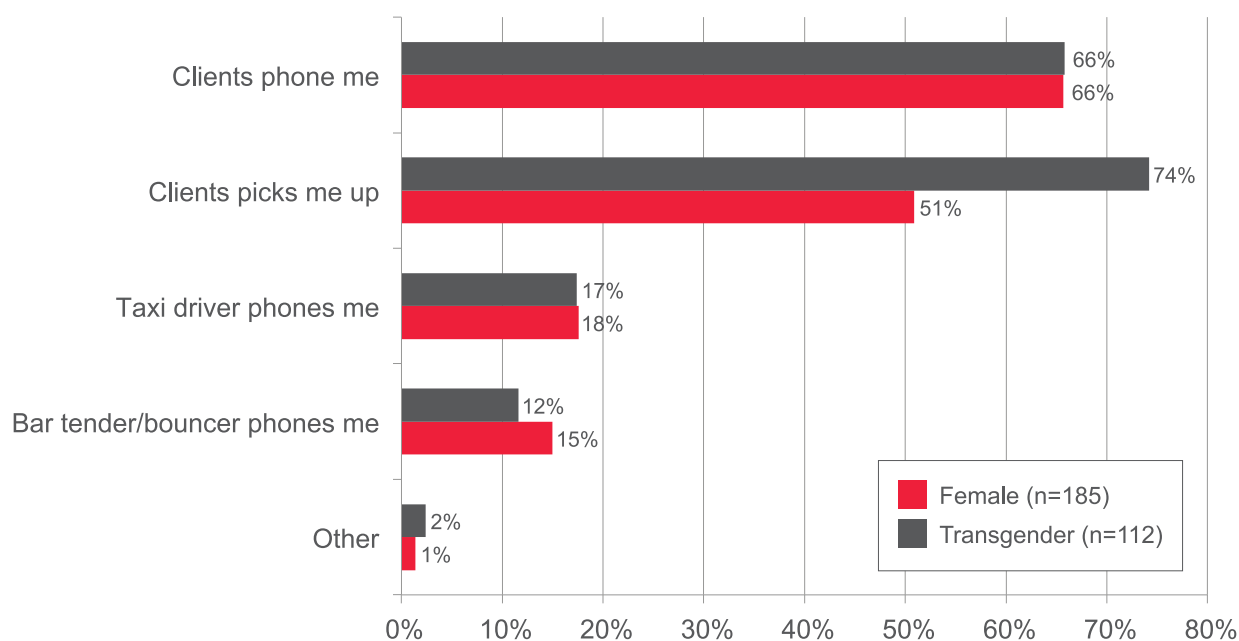
In other countries carrying out sex work on the street is typically considered more risky / less safe than other types of venue. The majority (67%) of sex workers reported feeling safe where they worked and this number did not appear to be affected by venue.

5.3.2 How contact with clients is made

Survey participants were also asked how they usually made contact with their clients. They were given a list of four possible methods and again they were able to select all that applied. Results appear in Figure 5.5 ranked in order of frequency.

Overall, participants were most commonly contacted by clients via the telephone (66%). The next most common method was to get picked up by the client (66%). This was significantly more common for transgender workers (74%) compared to female workers (51%). Other methods included being contacted through a taxi driver (18%), a bar tender/ bouncer (14%), through a kava shop (n=2), a neighbour (n=1), a friend (n=1) and, for one sex worker, clients went directly to her private home.

Figure 5.5: How contact with clients is made



NOTE: Percentages do not add up to 100% as participants could select more than one venue. Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighted numbers.

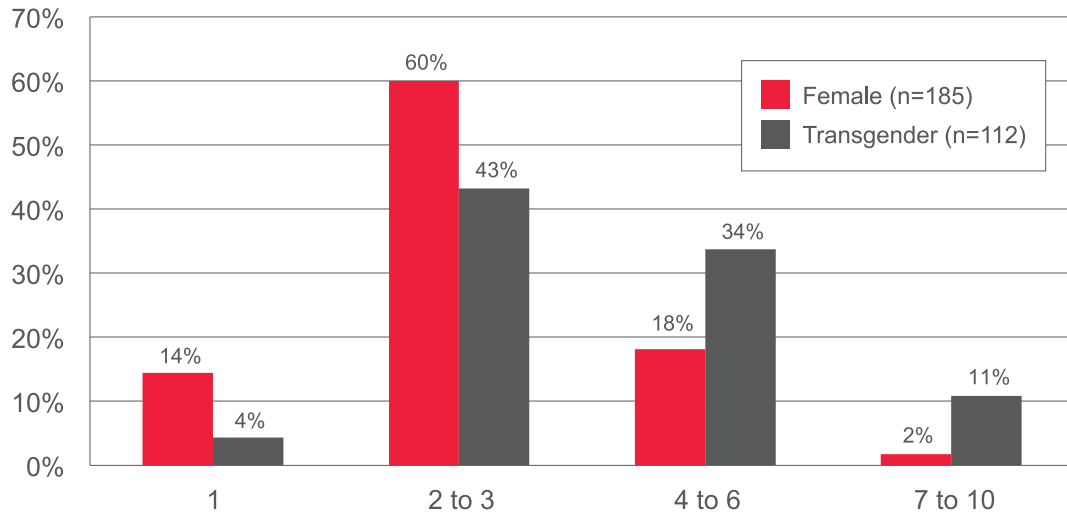
5.3.3 Frequency of work

Sex workers were asked to estimate, on average, how many clients they saw in a single night and the average number of days per week worked. Results appear in Figures 5.6 and 5.7.

The most common number of clients was 2-3 per day, reported by just over half of the sex workers (53%). Female sex workers tended to have fewer clients per night than transgender sex workers (these were statistically significant differences). A minority (5%) saw between 7 and 10 clients per night, and these were significantly more likely to be transgender sex workers (11%) and those of Indo-Fijian ethnicity (12%). No obvious pattern emerged over the main venue sex workers operated from and the number of clients per day.

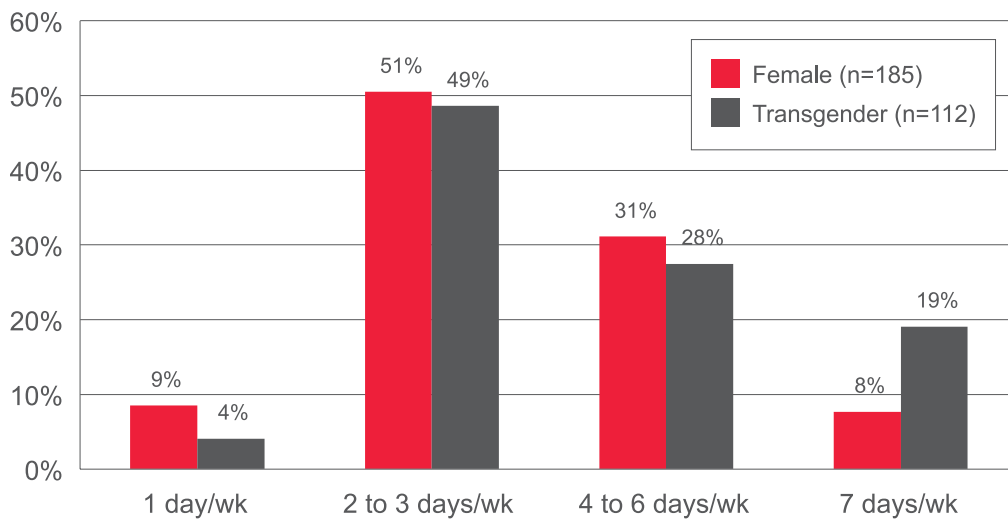
The most common number of days was two to three a week (50% of all sex workers reported this to be the typical frequency). Only 12% reported working seven days a week. These were significantly more likely to be transgender workers (19%) and sex workers of Indo-Fijian ethnicity (21%).

Figure 5.6: Average number of clients per day



NOTE: Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighted numbers.

Figure 5.7: Average number of days per week of sex work



NOTE: Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighted numbers.

5.3.4 Client characteristics

Participants were asked about the professional background and ethnicity of their last client. The professional background of their last client in order of frequency appears below.

- > professional/business person (29%);
- > tourist (25%);
- > taxi driver (9%);
- > policeman (6%);
- > sportsman (5%);
- > military person (5%);
- > sailor (5%);
- > expat (2%);
- > government official (2%);
- > church minister (0.2%);
- > other (3%) included a salesperson, tertiary student, pastry chef, carpenter, fisherman and an unemployed person; and
- > don't know (9%).

Tourists were significantly more likely to be clients of female sex workers (29%), whereas military and taxi drivers were more likely to be clients of transgender sex workers (9% and 13% respectively). Perhaps not surprisingly, tourists were significantly more likely to be clients of sex workers located in Nadi (50%) than sex workers located in the other three main centres.

While tourists were likely to be one-off clients, it is unknown if other clients were regular or one-off type clients. Anecdotal accounts from the sex worker community suggested it was more common for clients to be regular.

The ethnicities of the last clients were as follows:

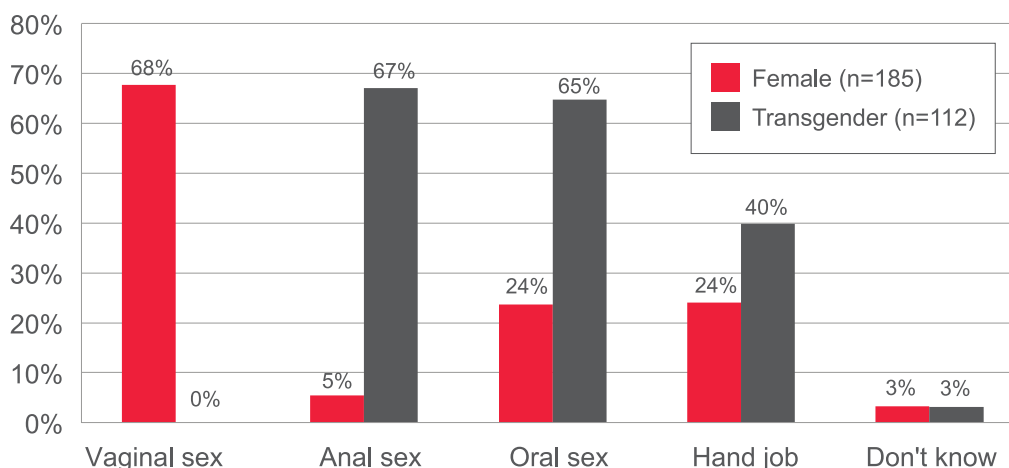
- > Indo-Fijian (41%);
- > iTaukei (30%);
- > Other (12%) included European (n=23), Australian (n=6), PNG (n=2), Rotuman (n=2), mixed race (n=1), Filipino (n=1), Samoan (n=1);
- > Chinese (7%);
- > Don't know (10%).

Indo-Fijians were significantly more likely to be clients of transgender sex workers (52%), and of Indo-Fijian sex workers (67%). Similarly, iTaukei were significantly more likely to be clients of iTaukei sex workers (34%). Those of foreign nationality were more likely to be clients of sex workers working in Nadi (26%).

Services requested by clients

Figure 5.8 presents details of the type of service requested by the sex workers from their last client. Because sex workers were often asked to provide more than one type of service, participants were asked to indicate all services that were provided to their last client.

Figure 5.8: Type of service requested by clients



NOTE: Percentages do not add up to 100% as participants could select more than one venue. Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighted numbers.

As can be seen in Figure 5.7, the type of services provided varies by gender. For female sex workers the most common service provided was vaginal sex (68%), whilst transgender sex workers most commonly provided anal (67%) and/or oral sex (65%). Transgender sex workers were also more likely to perform hand jobs than female sex workers.

Unfortunately, transgendered workers were not asked their role when providing anal sex (i.e. insertive or receptive). Anecdotal reports in Fiji, suggest it is not uncommon for transgender sex workers to be asked to perform both roles, whilst in other countries the role is almost exclusively receptive.

5.4 INCOME FROM SEX WORK

As noted in Section 4.3, 69% of sex workers reported having no work other than sex work. A question was included in the survey that attempted to determine participants' weekly sex work-related income. Responses ranged from \$20 Fijian dollars to \$600 Fijian dollars per week, however, there was some suspicion that some participants were reporting the fee per client rather than the total weekly earnings.

Transactional sex for goods other than money were reported as common in Fiji, hence, the survey sought to find out from participants what form of payment they most often received in return for sex. They were given five options and they were to tick all that applied. The most common form of payment was money, reported by nearly all the sex workers (97%). However, around one in five also reported commonly receiving alcohol in exchange for sex (20%) and a similar proportion received food (19%). Smaller numbers exchanged sex for drugs (8%) or a place to stay (5%).

Transgender sex workers were significantly more likely than female sex workers to engage in transactional sex for alcohol (31% compared to 13% respectively) or drugs (14% compared to 4% respectively). Indo-Fijian sex workers were more likely to exchange sex for food (34%) than iTaukei sex workers (16%). The only other key differences were sex workers located in Labasa and Lautoka were more likely to exchange sex for alcohol (42% and 30% respectively) compared to those in Nadi or Suva (10% and 13% respectively). In addition, those located in Labasa were more likely than those located elsewhere to exchange sex for food (63%).

In some countries, where sex workers are commonly managed (e.g. brothels) or where pimps/minders are used, sex workers often have to give a proportion of their earnings to others. However, according to the findings from the survey in Fiji, most sex workers (85%) get to keep all the money/goods they earned. This was particularly true of Indo-Fijian sex workers of whom 93% reported keeping all their money. In contrast, those who reported not keeping all their earnings were more likely to be of iTaukei ethnicity (17%).

5.5 AVAILABILITY OF SUPPORT

Entrenched traditional cultural and religious beliefs can result in extreme stigmatisation of sex work. This means sex workers may be reluctant to disclose their occupation to others making it difficult for them to access informal or formal support. For example, for sex workers to receive appropriate and specialised health treatment, it is important that they feel comfortable disclosing their sex work to health professionals. As a consequence, participants were asked about their willingness to disclose their occupation and information sources.

Disclosure to others – the majority of participants (85%) had told their friends that they were a sex worker. However, only 21% had told their family and just over a quarter (26%) had told a health worker. In all cases, transgender sex workers were more likely to disclose their work than female sex workers. Of the 71% who reported having a partner, around 36% of these reported they had told their partner they were a sex worker.

Useful advice or information when first started – the majority (63%) said they relied on information and advice from another sex worker. Around a third (30%) had received support from a sex worker organisation and a smaller 22% from a peer educator (this was significantly more common for transgender sex workers).³⁹ These later two sources also appeared more accessible to iTaukei than Indo-Fijian sex workers. Just under one fifth of participants (16%) reported that they had not received any useful advice or information when they first started.

5.6 SUMMARY

A summary of this section's findings include:

- > the overall intended duration of a career as a sex worker varied. For over a third, it was longer duration from over two years to an indefinite period, for a quarter, it was shorter period of less than a year. For many (37%), it was unpredictable. Taking breaks from sex work was common but they were typically for short periods;
- > most sex workers began sex work when they were young (under 20 years of age). The top three reasons for starting were because 'friends were doing it' (33%), it was 'a good way to earn a living' (31%) and they needed to 'support their children/family' (25%). Consistent with other research, sex workers appeared to have personally decided to work as sex workers with little evidence of coercion or being forced;
- > street work was the most common venue where sex workers operated (63% of all sex workers) and was significantly more common in Lautoka (78%) than the other three centres (Suva, Nadi, Labasa). Those working from the street did not report feeling less safe than those working from other venues. The next most common venue was bars/clubs (47%), then a private home (24%) and motel/hotels (23%). Just over half of the sex workers reported operating mainly from just one venue, other operated from more than one type;

³⁹ Peer educators are as the name suggests sex workers assigned to the role of educating their peers. Peer educators will also be members of the sex work organisations such as SAN Fiji, Rainbow Women's Network, Pacific Rainbow Network).

- > clients most commonly either phoned the sex worker to arrange to meet or picked them up. Clients came from a diverse range of professional backgrounds, and were slightly over-represented by those of Indo-Fijian ethnicity. The number of clients entertained varied but most typically it was between two and three per day;
- > transactional sex for good other than money was only reported by one-in-five sex workers, although this varied by location. Sex workers located in Labasa and Lautoka were more likely to exchange sex for alcohol (42% and 30% respectively) compared to those in Nadi or Suva (10% and 13% respectively). Also, those located in Labasa were more likely than those located elsewhere to exchange sex for food (63%);
- > the majority of sex workers had disclosed being a sex worker to friends, but only a quarter had disclosed their work to a health worker, making it difficult for sex workers to get specialised health care;
- > transgender sex workers tended to start working younger, and were more likely to start being a sex worker because it was good way to earn a living, to get money for drugs and alcohol and because they always wanted to be a sex worker. They were more likely to report they were happy being a sex worker and that they intended to always be a sex worker. It was also more common for transgendered sex workers to work from the street (78%) and to be directly picked up by clients and to work more frequently than female sex workers. Transgender sex workers most commonly offered anal or oral sex to clients;
- > female sex workers were significantly more likely than transgender workers to report they started work to be able to support their children/family. The most common service offered to clients was vaginal sex. It was less likely for female sex workers to engage in transactional sex for goods other than money;
- > comparatively, more Indo-Fijian sex workers (18%) started worker at an older age (between 26 and 30 years) than iTaukei (2%), although most still started work at a young age. More Indo-Fijian sex workers (28%) than iTaukei (13%) reported they did not like being a sex worker, although this was less than the number of Indo-Fijians (453%) who reported that they were happy being a sex worker. Indo-Fijian sex workers tended to work more frequently than iTaukei sex workers and were more likely to exchange sex for food (34%) than iTaukei sex workers (16%).



6 CONDOM USE AND SAFER SEX PRACTICES

This section presents findings in relation to condom use and other safer sex practices amongst sex workers in Fiji. This provides essential information on the nature and extent of unsafe behaviour to inform the development of appropriately targeted educational programmes. This section also provides information required to report on UNGASS core indicator 18 (condom with most recent client).

6.1 FREQUENCY OF CONDOM USE (UNGASS INDICATOR 18 / GARPR 1.8)

UNGASS core indicator 18 requires the calculation of the percentage of sex workers (as a most-at-risk population) reporting the use of a condom with their most recent client.

Of the 297 sex workers who completed the survey, 91% reported that they had used a condom with their last client. Only 7 percent reported that they had not used a condom with their last client, with an additional 2% either responding with 'don't know' or 'prefer not to answer'. Table 6.1 presents these results together with their breakdown by key UNGASS demographic variables.

Table 6.1: UNGASS Core Indicator 18 (GARPR 1.8) - Percentage of most-at-risk populations reporting the use of a condom with their most recent client¹

	Total	Female	Transgender	Under 25 yrs	25 yrs plus
Sample size	297	185	112	118	174
Percentage	91%	93%	89%	91%	91%
95% CI	88% - 94%	90% - 96%	86% - 92%	88% - 94%	88% - 94%

¹ Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighed numbers.

It appeared condom use was less prevalent among sex workers from Labasa (64%), and greatest in Lautoka (97%), the proportion in Suva and Nadi both were comparatively high (92%).⁴⁰ Condom use was reported more frequently among iTaukei (92%) than Indo-Fijian sex workers (88%) but this was not a statistically significant difference.

⁴⁰ The number of sex workers reporting not to use a condom in Labasa (20%) was significantly higher than the other three main centres.

The rate of condom use among sex workers appears far higher than other groups researched in Fiji. The UNAIDS 2012 country progress report cites rates of condom use with respondents' last partner ranging from 5% for women attending ante natal clinics (aged 15-49 years) up to 47% of male tertiary male students (aged 15-24 years).⁴¹ The percentage of transgender and men reporting the use of a condom the last time they had anal sex with a male partner was cited as 50.5% (Rawstorne et al., 2012 cited in UNAIDS, 2012).⁴² However, it should be noted that condom use with a client has different implications to condom use with a partner, particularly a regular partner. Condom use by sex workers with intimate (non-paying) partners is reviewed in Section 6.4.

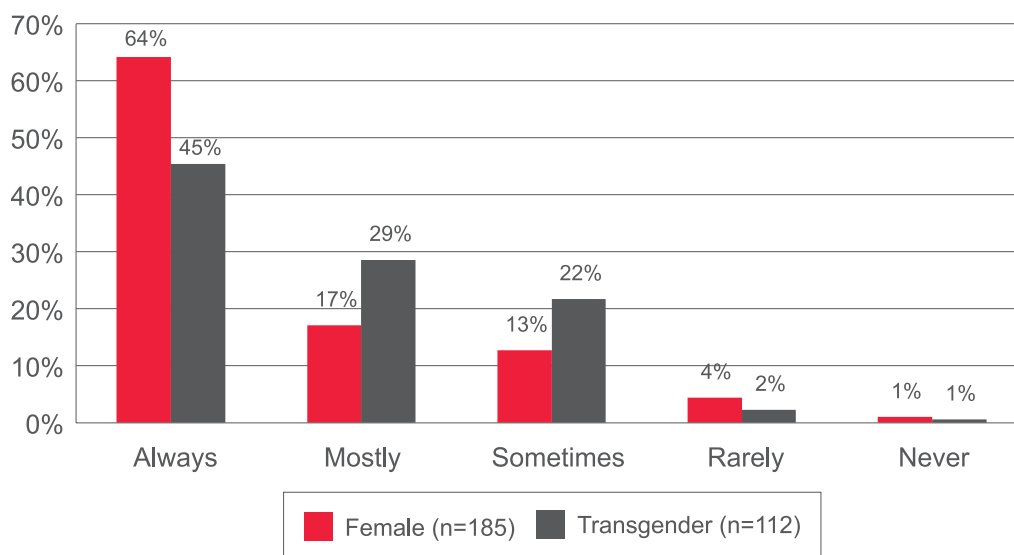
6.1.1 Type of condom used

Sex workers have the option of two types of condoms, a 'male' condom used by males over the penis or 'female' condom inserted into the vagina or anus. The use of a female condom gives the control over condom use to the sex worker. Of those female sex workers that used a condom with their last client, 88% used a male condom with just 10% reporting using a female condom.⁴³ Of those transgender sex workers who engaged in anal sex with their last client, 99% used a male condom, with just two sex workers (1%) using a female condom.

6.1.2 Consistent use

Condom use is more effective if used consistently rather than occasionally. UNAIDS recognises that asking about condom use with the last client will provide an overestimate of consistent use, but this question is considered more reliable as recall is more accurate. However, IBBS participants were also asked how often in the previous 12-months they *typically* used condoms with clients. Results are presented in Figure 6.1.

Figure 6.1: Consistent use of condoms



NOTE: Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighted numbers. Three participants did not respond to this question.

⁴¹ Rates based on 2008 Second Generation Surveillance research reported in the Fiji's 2010 UNGASS report.

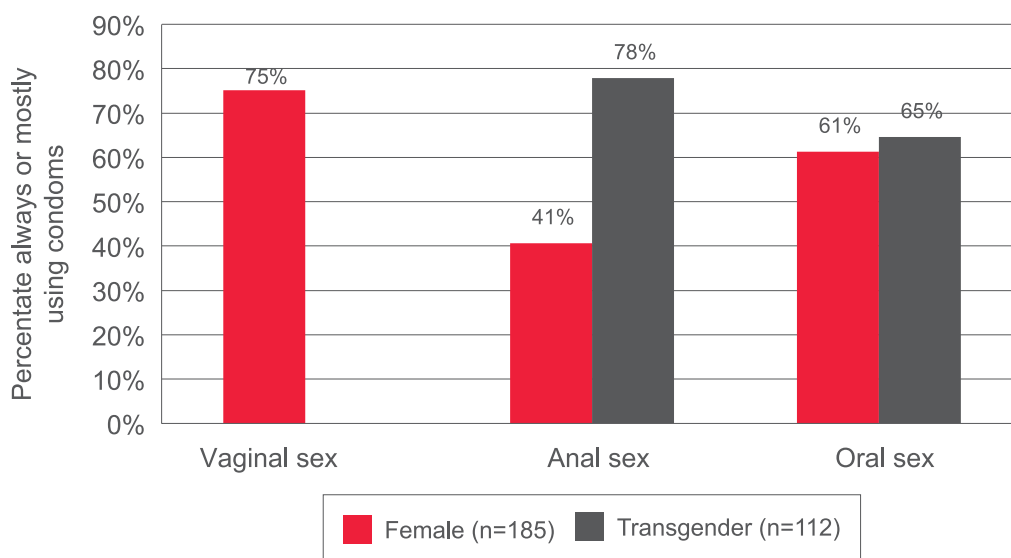
⁴² The source of the data is the draft report of the 2011 Integrated behavioural survey of transgender and men who have sex men in Suva and Lautoka conducted by MENFiji.

⁴³ 2% did not respond to this question.

Results further support UNGASS indicator 18, with just 5% reporting that they rarely or never use a condom. However, the results highlight that a lower proportion report using condoms consistently, with just over half (57%) reporting they ‘always’ used condoms, which means 43% were not always using condoms.

IBBS participants were also asked how often they typically used condoms for different types of sexual services. Figure 6.2 presents the proportion of sex workers who reported ‘always’ or ‘mostly’ using condoms for different activities. Respondents could select how frequently they used a condom or if they did not perform this service and for example half of the female sex workers reported not performing anal sex.⁴⁴ Percentages are based on those that reported they did offer this type of service.

Figure 6.2: Percentage of sex workers ‘always’ or ‘mostly’ using condoms for different sexual services



NOTE: Percentages are weighted estimates to account for variations in sampling and response rate. Those who reported they did not perform this service were deducted from the base total. Sample sizes are unweighted numbers.

Results suggest condoms are used less consistently for oral sex than other services. The exception to this is the reported use of condoms by female sex workers for anal sex, with only 41% reporting they consistently used condoms for this type of service. An almost equal proportion (36%) reported they ‘never’ used condoms for anal sex. It is likely however; that some participants misinterpreted this question and responded ‘never’, as they never performed anal sex.

As noted in section 5.3.4 it would have been useful to include a question on the role of transgendered workers when providing anal sex (i.e. insertive or receptive) enabling a better understanding of possible modes of infection transmission and ability to negotiate condom use. It would also have been useful to know if condom use was affected by whether a client was a regular client as opposed to an anonymous ‘one-off’ client.

6.1.3 Unsafe practices and condom breakage

While using a condom reduces the risk of infection from HIV or other STIs, a common misconception can be that using two condoms is even safer. This is incorrect as using together creates friction and increases the likelihood of condoms breaking.

⁴⁴ Those who reported they did not perform a type of service were deducted from the base total when calculating percentages.

A quarter of sex workers (25%) reported ‘always’ or ‘mostly’ using two condoms together, with a further 41% saying they sometimes did this. This appears to be an area requiring attention with repackaging of existing awareness raising information and information, education and communication (IEC) packages.

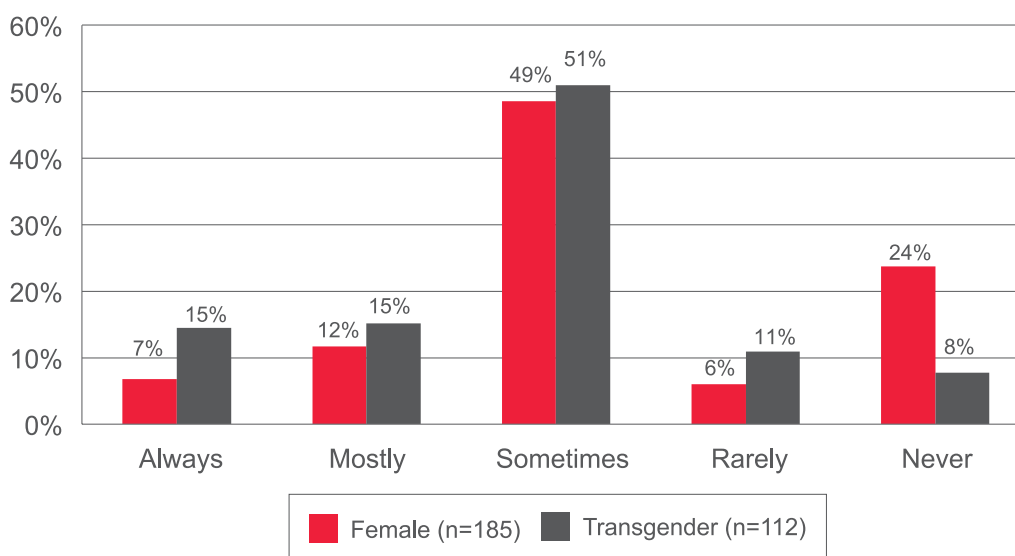
The chances of a condom breaking can increase due to inappropriate use (eg. using two condoms together, not using lube etc.) or due to poor quality. If a condom breaks, then the condom is not protecting the sex worker or their client. Participants were asked how many times in the previous three months they had had a condom break on them. Forty-four percent of the sex workers had not experienced a condom breaking in the previous three months, however, 10% had had one condom break, 28% had had two to five condoms break and 5% reported having more than five condoms break in the previous three months. Condom breakage was slightly more common among transgendered workers (47%) than female (39%). This level of breakage is also a concern and requires more research to understand why this is occurring.

Carrying out sex work under the influence of alcohol or other drugs

Carrying out sex work whilst under the influence of alcohol or other drugs can reduce the ability of a sex worker to negotiate safer sex practices. Self-reported drug and alcohol use did not appear high for sex workers in Fiji, just 8% reported drinking alcohol daily, 55% reported using marijuana and 14% glue sniffing. Less than 2% reported using any other types of drugs in the last month. Eleven percent reported injecting drugs in the previous 12-months.

Figure 6.3 presents the frequency sex workers reported carrying out sex work under the influence of drugs or alcohol. Despite relatively low self-reported drug or alcohol use, 73% of all sex workers reported sometimes or more frequently carrying out sex work under the influence (13% reported ‘mostly’ and 10% ‘always’). As seen in Figure 6.3, in general, it was more common among some transgender sex workers than female sex workers. Those under 25 years of age were also more likely with 13% reporting ‘always’ being under the influence when working. In contrast, Indo-Fijian sex workers appeared less likely with 32% reporting never to do this.

Figure 6.3: Frequency of carrying out sex work under the influence of drugs/alcohol



NOTE: Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighted numbers. Three participants did not respond to this question.

6.2 REASONS FOR USING / NOT USING CONDOMS

Understanding why some sex workers use condoms and others do not is useful information when developing interventions aimed at increasing condom use.

Of the 91% of sex workers who used a condom with their last client, in 85% of cases it was on the suggestion of the sex worker themselves. In 12% of cases it was the client's suggestion and in a further 2% of cases, the use of the condom wasn't discussed, it was just used.

Those who used a condom (91%) were asked why they had elected to use a condom. They were given five possible reasons and asked to indicate all that applied to them. Reasons given in order of frequency are presented below.⁴⁵

- > to prevent HIV infection - **82%**;
- > to prevent sexually transmitted infections (STIs) - **60%**;
- > to prevent pregnancy (females only asked) – **46%**; and
- > because the client insisted - **8%**.

The seven percent (n=23) who did not use a condom with their last client were asked to indicate, from a list of 11 possible reasons for not using a condom, all those that applied to them. Reason's given, again in order of frequency were as follows:

- > client did not want to – **40%**;
- > did not want to lose client – **35%**;
- > client offered more money not to – **30%**;
- > I was too drunk – **30%**;
- > it was a regular client – **20%**;
- > no condom was available – **20%**;
- > I don't like to use them – **10%**;
- > client forced me not to – **5%**;
- > condoms too expensive – **0%**; and
- > I don't know about condoms – **0%**.

Only 10% of the sex workers who did not use a condom said this was because they did not like to use them. This is supported by responses to a question that asked all participants if they preferred to use a condom. Ninety-three percent said they prefer to use a condom.

The expense of condoms was not given by any sex worker as a reason for not using them. Of note only 19% of sex workers reported that they usually paid for condoms, with 30% saying they sometimes did, and 51% reporting they never paid for them.

⁴⁵ The number who used a condom was used as the base number for calculating percentages. The percentage that used them to prevent pregnancy is based only on female sex workers who used a condom with their last client. Four sex workers (1%) responded 'don't know'.

6.2.1 Helpful strategies

As seen above, a common reason for not using condom is because of client reluctance. Sex workers were asked what type of strategies they employed to change the mind of a client who refused to use a condom. Strategies participants found useful are presented below in order of frequency of selection.⁴⁶

- > tell them about HIV/STIs – 72%;
- > tell them it is best for their family – 23%;
- > refuse to do the job – 32%;
- > use tricks (e.g. thigh sex) – 26%;
- > get the client tipsy – 12%;
- > nothing makes a difference – 3%; and
- > other – 1%⁴⁷

Telling clients about the risk of HIV/STIs and doing ‘tricks’ were more common amongst transgendered workers than female sex workers. More sex workers from Nadi (45%) reported finding tricks as a useful strategy than those from the other centres.

6.3 ACCESS TO CONDOMS

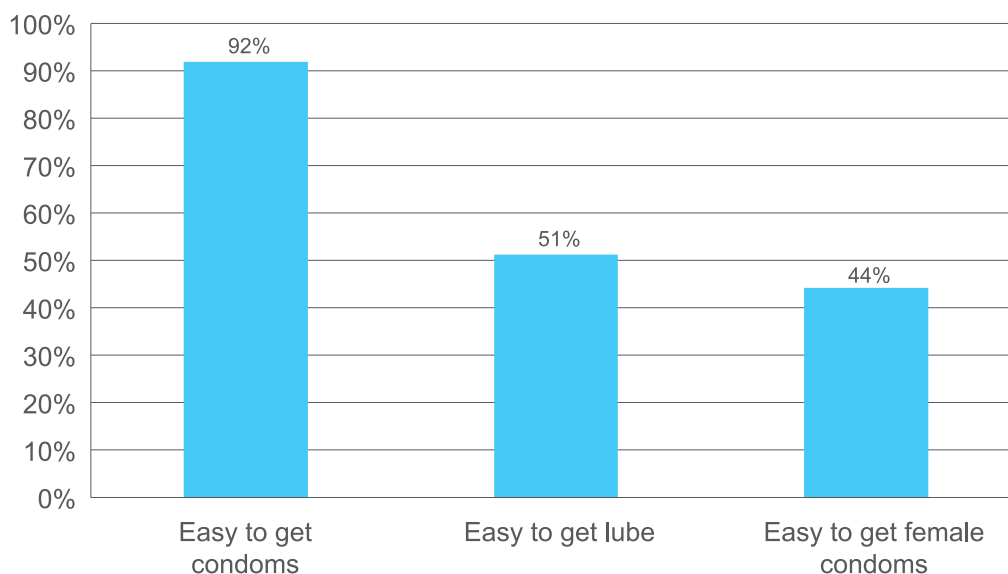
Another potential barrier to condom use is compromised accessibility. Survey participants were asked a few questions around ease of access. The first question was if they usually carry condoms, as carrying condoms ensures ease of access. Previous researches both in Fiji and elsewhere have suggested carrying condoms may place sex workers at risk of being arrested, as they could be used as evidence of the intention to engage in a commercial sex activity (McMillan & Worth, 2010; Roguski, 1997; 2012) which was supported by anecdotal comments from sex workers. However, the majority of sex workers (90%) reported despite this, they did usually carry condoms. Just 9% (n=29) reported they did not usually carry them. The most common reason offered for not carrying condoms was that they did not like to use them (n=6), and 4 participants said it was because they were concerned about police harassment. 2 others said clients would buy them and one reported that they did not know about condoms.

Sex workers were asked, in general, how easy it was to access male condoms, female condoms and lube. Results appear in Figure 6.3. While male condoms appeared easy to access by the majority of sex workers (92%), fewer sex workers found lube (51%) and female condoms (44%) easy to access. The effectiveness of condoms is reduced without the use of lube, so it appears important for greater access to lube to be achieved.

⁴⁶ 4% responded with ‘don’t know’

⁴⁷ Two other strategies mentioned were to ‘just tell them they have to’ and ‘to take the money and don’t do the job’

Figure 6.3: Proportion of sex workers finding it easy to access condoms and lube



NOTE: Percentages are weighted estimates to account for variations in sampling and response rate. Those who reported they did not perform this service were deducted from the base total. Sample sizes are unweighted numbers.

Of note there were more sex workers in Labasa (29%) than other centres that reported it was difficult to get hold of male condoms. This is significant as sex workers in Labasa were also found to be less likely than other centres to use condoms (see Section 6.1). There were also a few more Indo-Fijian sex workers (16%) than iTaukei (3%) reporting difficulties accessing male condoms.

While these reports suggest sex workers can get condoms, as seen in section 7.3, 40% called for better access to condoms (e.g. improving their ability to access condoms in the hours they are working and close to the location they are working).

Sex workers were asked where they usually got their condoms from.⁴⁸ Responses appear below in order of frequency.⁴⁹

- > health clinic – **42%**;
- > sex worker organisation – **41%**;
- > another sex worker – **38%**;
- > peer educator - **37%**;
- > friends – **30%**;
- > pharmacy – **26%**;
- > clients – **18%**;
- > supermarket – **10%**;
- > nightclub/hotel/bar/restaurant – **7%**; and
- > other (Pacific Counselling Social Services) – **1%**.

⁴⁸ Sex workers were not asked where they would prefer to access condoms from. However, anecdotal comments strongly suggested sex workers would prefer condoms to be distributed to them whilst they are working by peer educators. Distribution points at safe houses close to where they worked were suggested as the next best option.

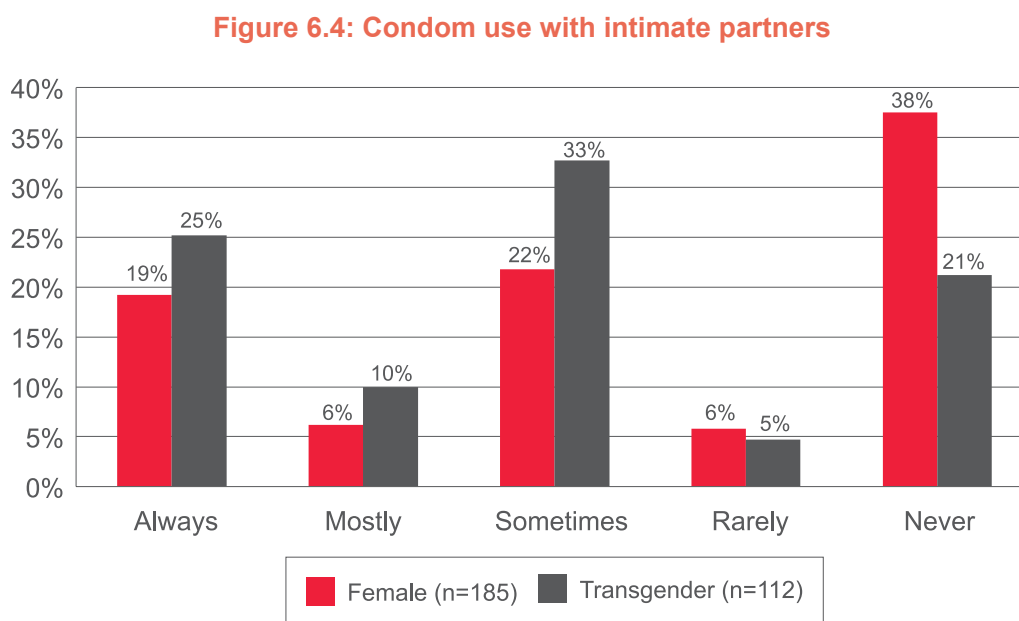
⁴⁹ Consistent with other questions 4% reported not usually using condoms.

Participants reported that health clinics and sex worker organisations were the most common venues they accessed condoms. Nadi appeared particularly well serviced by peer educators, with 65% of sex workers, based in Nadi, accessing condoms through this source. Transgender workers appeared more likely to use multiple outlets compared to female sex workers. Those outlets effective in distributing condoms to sex workers such as health clinics, sex worker organisations and peer educators, should be resourced to continue this work. They are also key points of contact where HIV/STI prevention messages could be distributed.

6.4 CONDOM USE WITH INTIMATE PARTNERS

Sex workers have been identified as being at increased risk of infection due to often multiple and concurrent sexual parties (McMillan & Worth, 2010). Hence, it is important to understand condom use with intimate (non-paying) partners in addition to clients.

Figure 6.4 presents reported condom use with intimate partners. Section 6.2 noted that just 5% reported that they rarely or never used a condom with a client. In contrast, 36% of sex workers reported they never or rarely wore a condom with an intimate partner. As seen in Figure 6.3, this was more common with female sex workers. However, a closer examination of their relationship status finds that the majority (79%) of these sex workers who were not using condoms regularly were either married or in a stable relationship with just one partner.



NOTE: Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighted numbers.

Rates of condom use with intimate partners appear similar to other groups researched in Fiji. For example, in the recent IBBS study (see Rawstorne et al., 2012) 22% of transgender and men who have sex with men reported using a condom every time they had anal sex (regular or casual partners). The same rate found in an earlier MSM study (Bavington et al, 2011).

Of participants not using condoms, 7% (n=7) had sex with two to five intimate partners in the previous month, and 4% (n=2) had had sex with six or more partners. There were nine sex workers (3%) who reported rarely or never wearing a condom with intimate partners, who also reported not wearing a condom with their last client. While low in numbers, sex workers with multiple and concurrent partners who are not consistently using condoms, pose a significant risk of being and transmitting infections.

6.5 SUMMARY

A summary of this section's findings include:

- > 9 out of 10 sex workers reported using a condom with their last client. However, it was less prevalent among sex workers in Labasa with just two thirds reporting using a condom with their last client. Sex workers in Labasa also reported more difficulties in accessing condoms;
- > a lower proportion report using condoms consistently, with just over half (57%) reporting they 'always' used condoms meaning 43% were not always using condoms;
- > the rate of condom use among sex workers and their clients was higher than that used by other groups researched in Fiji when they last had sex with a partner. However, condom use by sex workers with intimate partners was similar to another most-at-risk group researched in Fiji (men who have sex with men);
- > condoms were widely available (although could be made more accessible), but lube was difficult to access, with around half reporting difficulties getting lube;
- > the use of female condoms was relatively uncommon with just 10% of female sex workers and 1% of transgendered sex workers reporting using a female condom with their last client. Access to male condoms was also reported as generally good, but getting hold of lube and female condoms was reported as more difficult. Condoms need to be used with lube so it is essential sex workers have easy access to all safer sex supplies;
- > condoms are used less consistently for oral sex and anal sex offered by female sex workers;
- > two-thirds of sex workers appeared to have the misconception that using two condoms is safer than using one, despite this practice actually increasing the risk of a condom breaking due to the friction created. A third of sex workers had experienced two or more condoms break in the previous three months;
- > carrying out sex work whilst under the influence of alcohol or other drugs can reduce the ability of a sex worker to negotiate safer sex practices with clients including the use of a condom. While, self-reported drug and alcohol use did not appear high for sex workers in Fiji, nearly three-quarters reported sometimes or always carrying out sex under the influence of alcohol or other drugs. This was more common for transgender worker than female sex workers. In contrast, Indo-Fijian sex workers appeared less likely with 32% reporting never to do this. There were some reports of injecting drugs which appears to be an area requiring more research within Fiji; and
- > the majority of sex workers (93%) said they preferred to use condoms. Sex workers usually initiated the use of a condom and most commonly to prevent HIV or other STI infections. Informing clients of the risk of HIV/STI infection was found a useful strategy to getting client to agree. Of the minority (7%) who did not use a condom with their last client they gave a number of reasons for this including the client did not want to, they did not want to lose the client, the client offered more money and because they were too drunk to insist.



7 HIV AND STI PREVENTION KNOWLEDGE

Assessing sex worker knowledge around safer sex practices and the prevention of the transmission of HIV provides an evidence-base from which to develop education programmes. This section presents survey findings in relation to sex worker HIV and STI prevention knowledge including that required for reporting on UNGASS core indicator 14. UNGASS core indicator 14 requires the calculation of percentage of sex workers (as a most-at-risk population) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

As per UNAIDS guidelines, this was assessed by answering correctly the following five questions included in the IBBS survey:

1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission? (Yes)
2. Can using condoms reduce the risk of HIV transmission? (Yes)
3. Can a healthy-looking person have HIV? (Yes)
4. Can a person get HIV from a mosquito bite? (No)
5. Can a person get HIV by sharing a meal with someone who is infected? (No)

7.1 HIV KNOWLEDGE ABOUT HIV PREVENTION (UNGASS INDICATOR 14)

Of the 297 sex workers who completed the IBBS, 37% answered all five questions correctly. Table 7.1 presents these results broken down by key demographic variables.

Table 7.1: UNGASS Core Indicator 14 - Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission ¹

	TOTAL	FEMALE	TRANSGENDER	UNDER 25 YRS	25 YRS PLUS
Sample size	297	185	112	118	174
Percentage	37%	35%	41%	34%	41%
95% CI	32% - 42%	30% - 40%	36% - 46%	29% - 39%	36%-46%

¹ Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighted numbers.

Further, differences in HIV-related knowledge were found between centres. The lowest levels of HIV-related knowledge were found in Labasa with just 15% getting all five questions correct. This was followed by Suva (34%) and Lautoka (41%) with Nadi having the greatest proportion with 48% of sex workers getting all five correct located. HIV knowledge appeared greater among iTaukei sex workers (38%) compared to Indo-Fijian (31%) but this was not a statistically significant difference.

The number of incorrect responses varied between 15% and 41% to the different questions. This is useful information on where educational efforts need to focus. The five questions below are ranked in their order of incorrect responses, with the greatest number appearing first (i.e. greatest need for education):

- > Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission? (41% responding with either 'no' or 'don't know')
- > Can a person get HIV from a mosquito bite? (24% responding with either 'yes' or 'don't know')
- > Can using condoms reduce the risk of HIV transmission? (20% responding with either 'no' or 'don't know')
- > Can a person get HIV by sharing a meal with someone who is infected? (19% responding with either 'yes' or 'don't know')
- > Can a healthy-looking person have HIV? (15% responding with either 'no' or 'don't know').

HIV prevention knowledge among sex workers appeared slightly less than that of men who have sex with men where the percentage of incorrect answers to the above questions ranged from 9% to 23% (Rawstorne et al., 2012), with the number correctly answering all questions correctly in an earlier study being 66% (Bavington et al., 2011).

7.1.1 Sources of useful information on how to avoid HIV infection

Sex workers were asked, from a list of 10 possible information sources, where they had received useful HIV-related information. Below are those reported as useful in decreasing order of frequency.

- > Health professional - 47%;
- > Peer educator – 46%;
- > Another sex worker – 36%;
- > Television – 35%;
- > Newspaper – 33%;
- > Radio – 31%;
- > Internet – 22%;
- > Community agency – 10%;
- > Church – 9%; and
- > Other – 2% including family, friends and three specifically mentioned a sex worker organisation.

Lautoka and Nadi appeared better serviced by peer educators than Labasa or Suva and, as with other information sources, transgender sex workers generally seemed to access more sources than female sex workers.

7.2 OTHER STI PREVENTION KNOWLEDGE

The IBBS participants were asked two additional questions about their knowledge of other STIs and STI-related prevention. The first question asked if they were aware of any diseases which are transmitted sexually. Three quarters (76%) reported they were, however 23% either responded with 'no' or 'don't know'. Reports of being aware were slightly higher among transgender workers (83%) and those over 25 years (80%).

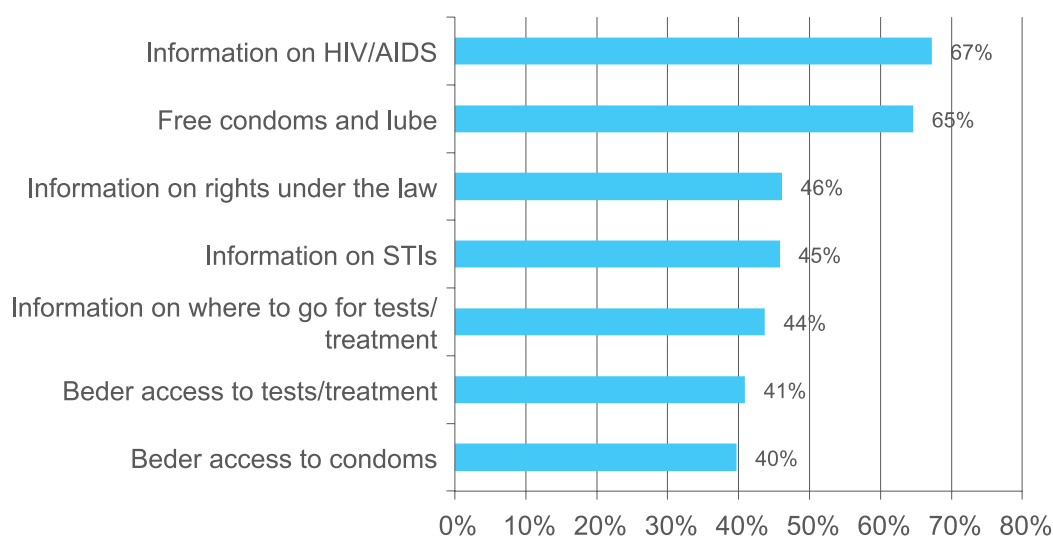
Next, participants were asked what they did to avoid getting sexually transmitted diseases. Responses ranked in order of frequency were as follows:

- > use a condom (79%);
- > take medicine (12%);
- > wash with Dettol (8%);
- > urinate after sex (3%); and
- > other (2%) included only doing hand jobs or thigh sex, to douche/wash.

7.3 INFORMATION AND ASSISTANCE WANTED

Sex workers were surveyed to find out what they most wanted in the area of HIV awareness and advocacy. Their requests appear in Figure 7.1 below (survey participants could request more than one type of information or service).

Figure 7.1: Types of information and services wanted by sex workers

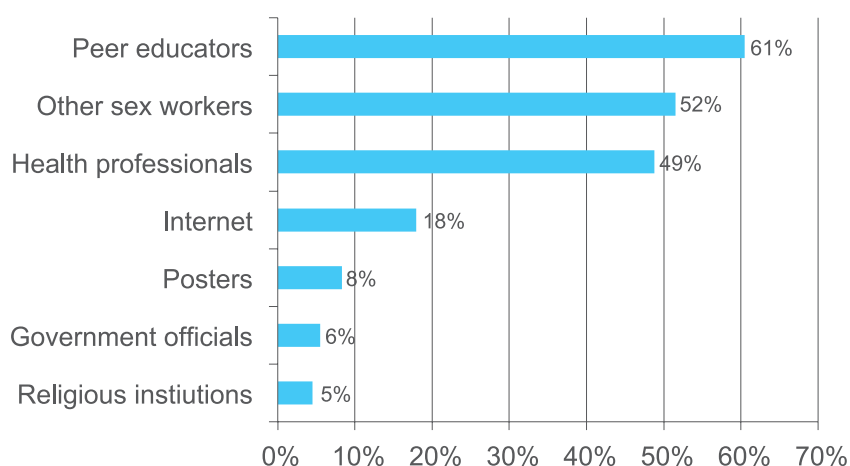


NOTE: Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighted numbers.

The top two requests, from two-thirds of participants, were for more information on HIV and being given free condoms and lube. All other types of services and information were also wanted by between 40% and 46% of sex workers which suggests a strong need for improved access to information and services. As noted earlier, there appeared to be a discrepancy between 92% of sex workers reporting it was easy to access condoms, and 40% wanting better access. Anecdotal comments from sex workers suggested the difference was due to needing better access during the hours they were working and close to the locations they were working (e.g. distributed by peer educators or accessed from a distribution point in a safe house nearby to where they were working).

There were some differences between groups, with significantly more transgender workers wanting free condoms (77%) and comparatively more iTaukei sex workers wanting information on STIs (50%). A further question asked participants from whom they would prefer to receive HIV/STI prevention and awareness information. Results appear in Figure 7.2.

Figure 7.2: Preference for receiving HIV/STI information from



NOTE: Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighted numbers.

The top three preferred sources of information included peer educators (61%), other sex workers (52%) and health professionals (49%). Self-help information sources and those provided by government officials or religious institutions were less popular.

Comparatively more iTaukei (55%) than Indo-Fijian (24%) sex workers expressed a preference for information from health professionals, but fewer sex workers from Labasa (just 17%) compared to around 50% in the other centres.

7.4 SUMMARY

A summary of this section's findings include:

- > just over a third of sex workers correctly answered five questions that identified ways of preventing sexual transmission of HIV and rejected misconceptions about HIV transmission. HIV awareness knowledge was least among sex worker from Labasa (an area where condom use was also less prevalent). The most common misunderstanding by 41% of sex workers was that sex with only one faithful, uninfected partner reduces the risk of HIV transmission;
- > a number of useful sources of information on how to avoid HIV infection were noted, the most common were from a health professional or peer educator. More transgender sex workers reported having access to useful sources of information on HIV infection than female sex workers;
- > a quarter of sex workers reported a lack of knowledge of STIs and how to protect themselves;
- > there was a high demand among sex workers for information and services on how to protect themselves from HIV and STI infection. The top two requests from two-thirds of sex workers was for more information on HIV and being given free condoms and lube; and
- > the top three preferred sources of providing HIV/STI information were peer educators (61%), other sex workers (52%) and health professionals (49%). Self-help information sources and those provided by government officials or religious institutions were less popular.



8 HIV AND STI TESTING AND COVERAGE OF PREVENTION PROGRAMMES

This section presents the IBBS findings in relation to the quality and intensity of available HIV prevention services and an exploration of access-related barriers. Further, this section reviews the coverage of HIV prevention programmes (UNGASS indicator 9 / GARPR 1.7) and HIV testing (UNGASS indicator 8 / GARPR 1.9) and sex worker perspectives and preferences in relation to these services.

UNGASS 201 core indicator 8 (GARPR 1.9) requires the calculation of percentage of sex workers (as a most-at-risk population) who have received an HIV test in the last 12-months and who obtained their test results. As per UNAIDS guidelines this was covered in the IBBS survey with two questions:

1. Have you been tested for HIV in the last 12-months?
2. Did you receive the results?

8.1 FREQUENCY OF HIV TESTING (UNGASS INDICATOR 8 / GARPR 1.9)

Of the 297 sex workers who completed the IBBS, 35% reported they had been tested for HIV in the last 12-months and received the results (an additional 7% reported being tested but not receiving the results). Table 8.1 presents these results broken down by key demographic variables.

Table 8.1: UNGASS Core Indicator 8 (GARPR 1.9)- Percentage of most-at-risk populations that have received an HIV test in the last 12-months and know the results¹

	Total	Female	Transgender	Under 25 Yrs	25 Yrs Plus
Sample size	297	185	112	118	174
Percentage	35%	25%	44%	27%	36%
95% CI	30% - 40%	20% - 30%	39% - 49%	22% - 32%	31%-41%

¹ Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighted numbers.

Participants from Labasa were the least likely (16%) to have had an HIV test and received their results. Increasing rates of having had an HIV test were reported by participants in Nadi (24%) and Suva (36%) with the greatest proportion located in Lautoka (43%). A greater proportion of iTaukei sex workers (34%) compared to Indo-Fijian (20%) had had an HIV test and received the results.

The overall rate of HIV testing appears higher than MSM where 15.3% were reported to have received a HIV test and knew their results (Rawstorne et al., 2012) or the 10.5% found by Bavington and colleagues in 2011. It is likely that the transgender workers' high prevalence rate may be due to a large proportion that had been tested and found out their result due to their participation in this earlier study. Whilst rate of testing was higher than MSMs, given the nature of their work, it is essential all sex workers have easy access to regular HIV testing and treatment (see also section 8.2 and 8.4).

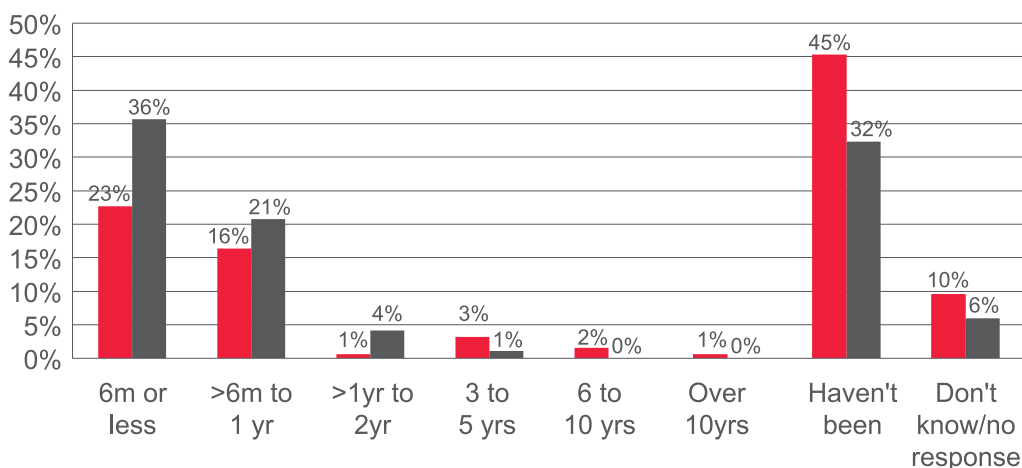
8.1.1 Barriers to not collecting test results

As noted above, 7% (n=23) of sex workers reported having a test conducted but not finding out their result. Around half of these offered an explanation. Eight said they had forgotten, two had not returned because they did not like the clinic, and one because they did not like the entrance, another because they did not have transport and one said they were waiting for their test result. See also section 8.4 for general barriers to accessing sexual health services (testing and treatment).

8.2 FREQUENCY OF OTHER SEXUAL HEALTH CHECK

Figure 8.1 shows when the sex workers reported they last went for a sexual health check.

Figure 8.1: Time last went for a sexual health check



NOTE: Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighted numbers.

Overall 46% had been for a sexual health check in the last 12-months. However, 40% reported never having had a sexual health check and if the 'don't know' and 'no responses' are included, this means over half have never been for a sexual health check. Transgendered sex workers were more likely to have been for a sexual health check than female sex workers, as were Indo-Fijian workers.

Of the 52% that had been for sexual health check, 71% of these reported they went for regular checks,⁵⁰ whereas 39% said they would go for a check-up when they realise they have symptoms. Others said they went when they felt like it, if a friend encouraged them, if they felt insecure or when they suspected they were pregnant.

Just over half said they would usually (35%) or sometimes (19%) check their clients for STIs. An even higher percentage (65%) reported they would encourage their clients to go for sexual health checks.

⁵⁰ Of those who went for sexual health check, 8% reported going monthly, 42% every three months, 15% twice a year.

8.3 ACCESS TO HIV PREVENTION PROGRAMMES (UNGASS INDICATOR 9 / GARPR 1.7)

UNGASS core indicator 9 (GARPR 1.7) requires the calculation of the percentage of sex workers (as a most-at-risk population) reached with HIV prevention programmes. For monitoring purposes this is assessed based on the percentage who answered yes to the following IBBS survey questions:

1. Do you know where you can go if you wish to receive an HIV test?
2. In the last 12-months, have you been given condoms? (eg. through an outreach service, drop-in centre or sexual health clinic).

These two questions have been developed for monitoring purposes and should not be interpreted to mean these services alone are sufficient for HIV prevention programmes.

Of the 297 sex workers who completed the IBBS, 68% responded yes to both these questions (79% reported that they knew where to go to get an HIV test and the same proportion (79%) reported that they had been given condoms). Table 8.2 presents these results broken down by key demographic variables.

Table 8.2: UNGASS Core Indicator 9 (GARPR 1.7) – Percentage of most-at-risk populations reached with HIV prevention programmes¹

	Total	Female	Transgender	Under 25 Yrs	25 Yrs Plus
Sample size	297	185	112	118	174
Percentage	69%	62%	77%	40%	70%
95% CI	64% - 74%	57% - 67%	73% - 83%	35% - 45%	65% - 75%

¹ Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighted numbers.

As with UNGASS indicator 8, sex workers in Labasa appeared to have less coverage of prevention programmes with just 32% reporting yes to both questions. This was followed by Nadi (65%), then Suva (69%), with the greatest proportion of sex workers in receipt of a service in Lautoka (77%). Coverage of HIV prevention programmes was greater for iTaukei sex workers (72%) than Indo-Fijian (45%).

Compared to the participants in the MSM IBBS research (Rawstone et al., 2012 cited in UNAIDS, 2012), sex workers were less aware of where to go to get an HIV test (79% compared to 97%), but were more likely to have received condoms (79% compared to 68% of MSM participants).

8.4 ACCESS TO SEXUAL HEALTH CARE SERVICES

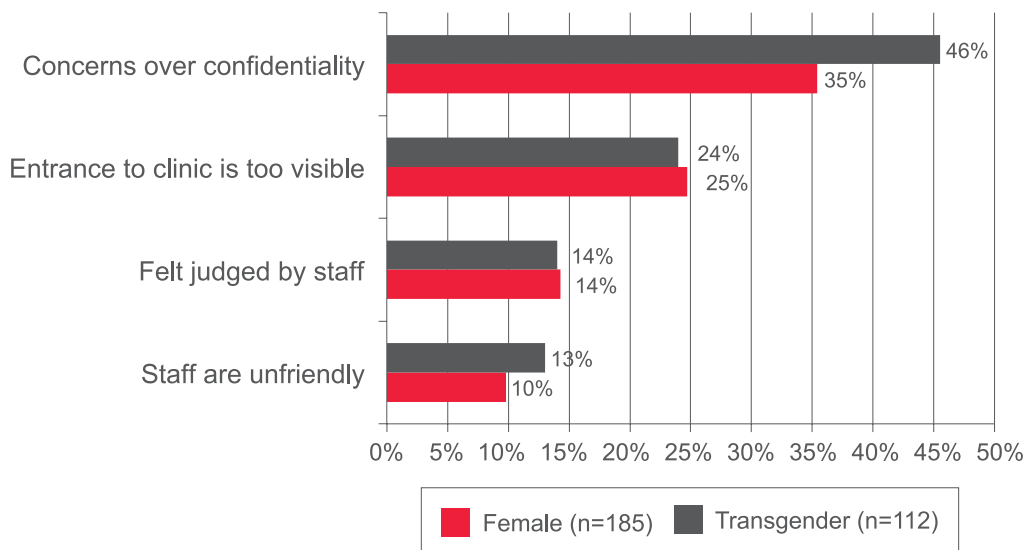
The sex workers were asked where they would go for either a HIV or STI test, check-up or treatment from a list of four possible options (they could tick all the applied). The most common selection was a Hub centre (58%) followed by a STI clinic (41%), then private doctor (24%) or other community agency (23%). Of note 8% said they did not know where they would go.

Over half (56%) of the survey respondents estimated it would take them less than 30 minutes to get to and HIV/STI or treatment site. However, for 17% it would take them over an hour.

8.4.1 Barriers to accessing sexual health services

Previous sex worker research has noted a number of concerns about available sexual health services and the way in which services can act as a barrier to service access (McMillan & Worth, 2010). The current study further explored some of these identified barriers to accessing sexual health services. Those sex workers who reported they had been for a sexual health check were asked to comment on their experience of each of four potential barriers. Results appear in Figure 8.2 below.

Figure 8.2: Negative experiences of sexual health clinics



Note: Percentages are weighted estimates to account for variations in sampling and response rate.

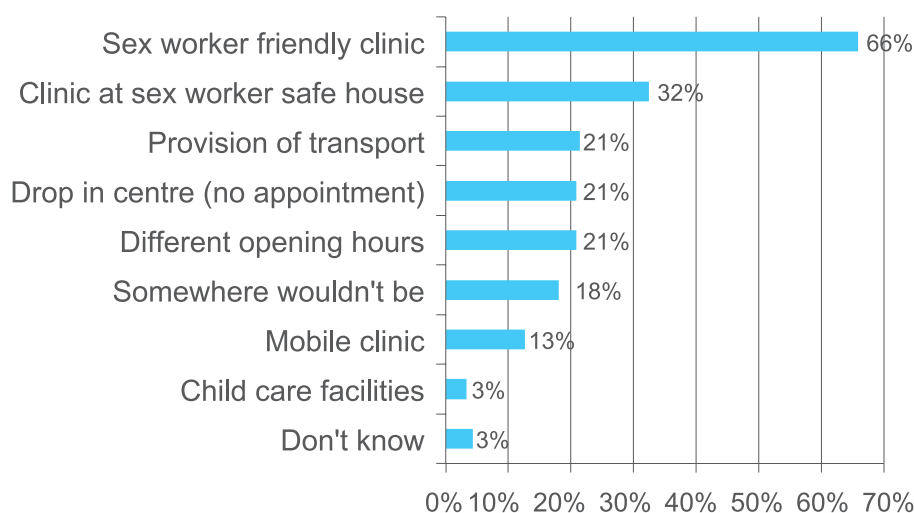
The base rate for calculating the percentages was those who had been for a sexual health check. Sample sizes are unweighted numbers

Concerns over confidentiality appeared to be the greatest potential barrier for female and transgendered sex workers, followed by another privacy issue, the visibility of the clinic's entrance (i.e. they might be identified as a sex worker by going into the sexual health clinic).

Sex workers were also asked what would make it easier for them to go for a test or treatment. They were given nine options and could tick all that applied to them. Results appear in Figure 8.3 with the most commonly reported factor first.

Having a sex worker friendly clinic was most commonly reported as increasing accessibility to sexual health services. The second factor was to have the clinic at a sex worker safe house (i.e. outreach service). This had been identified by previous research as a preference of sex workers (McMillan & Worth, 2010).

Figure 8.3: Making it easier to access sexual health services



NOTE: Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighted numbers

Indo-Fijian sex workers were more likely to suggest the provision of transport would make things easier (35%), while sex workers in Labasa were more likely to find a mobile clinic more useful (39%). Compared to other centres comparatively fewer sex workers (33%) from Labasa suggested a sex worker friendly clinic would make it easier to go for a sexual health check.

8.5 SUMMARY

A summary of this section's findings include:

- > just over a third of sex workers reported being tested for HIV and receiving their results in the previous 12-months. This was least likely to have occurred for sex workers located in Labasa (16%) but more common for iTaukei sex workers (34%) compared to Indo-Fijian (20%);
- > just under half of sex workers reported going for a sexual health check in the last 12-months, but 40% reported never having had sexual health check or over half if the 'don't know' or 'no responses' are included. This appears to be an area requiring attention, as regular health checks are an essential health and safety practice for those working in the sex industry;
- > 7 out of 10 sex workers reported having access to HIV prevention programmes (knowing where to go to receive a HIV test and reported having been given condoms in the previous 12-months). Again sex workers in Labasa fared less well with just 32% reporting access to such programmes. Coverage was significantly better for iTaukei sex workers (72%) than Indo-Fijian (45%).
- > concerns over confidentiality appeared to be the biggest potential barrier to accessing sexual health services, followed by another privacy issue that the entrance to the clinic was too visible (ie. they might be identified as a sex worker by going into the sexual health clinic)
- > having a sex worker friendly clinic was the most commonly reported factor to make going for a sexual health check-up easier. The second factor was to have the clinic at a sex worker safe house. This is the model that has been used very successfully in New Zealand where sex worker network organisations hold confidential free sexual health check-ups on a regular basis.



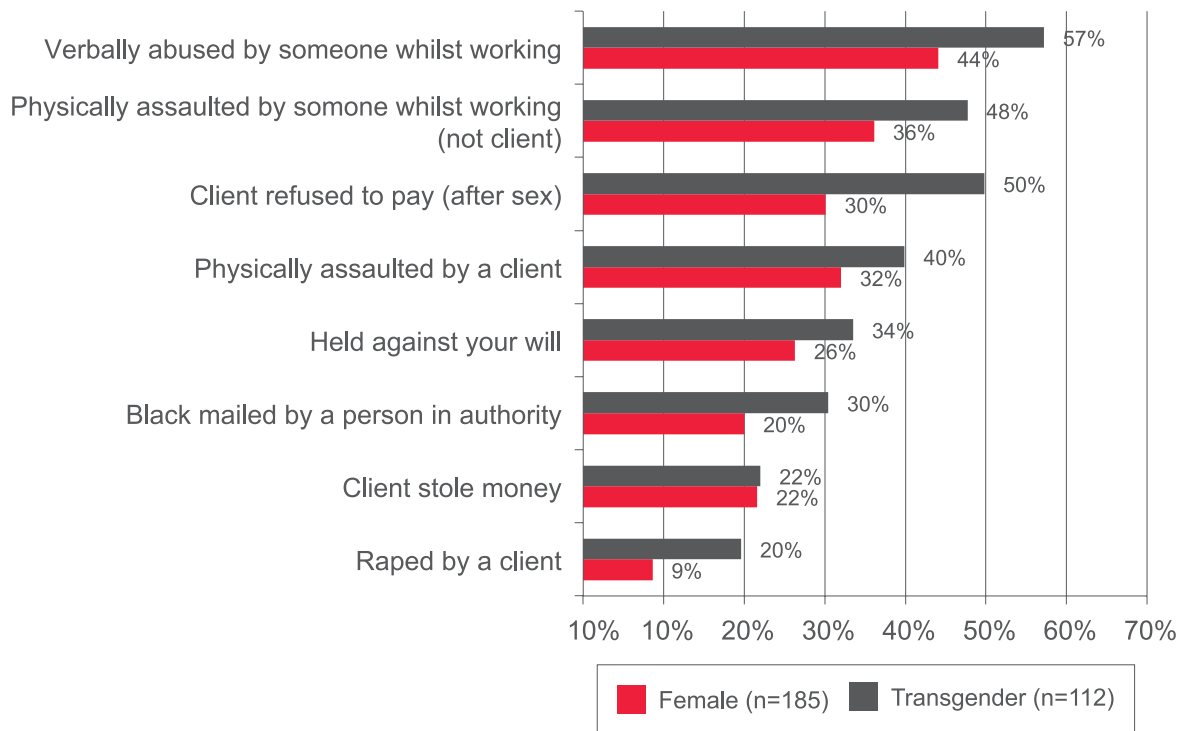
9 SAFETY AND LEGAL KNOWLEDGE

This section presents research findings about the safety of sex workers and their access to support and information. Also presented is participants' knowledge about their legal rights.

9.1 SEX WORKER SAFETY

Sex work, particularly in countries where it remains an illegal activity can be a risky activity; there are no means of legal redress for sex workers making them vulnerable to experiencing adverse experiences including physical and sexual abuse or financial exploitation by clients or others. Participants were asked whether they had experienced a number of adverse sex work-related experiences in the previous 12-months. Results appear in Figure 9.1 below.

Figure 9.1: Sex worker safety



Note: Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighted numbers

A higher proportion of transgender sex workers than female sex workers experienced nearly all types of adverse experiences, and significantly more experienced verbal and physical abuse by members of the public, clients refusing to pay and being raped and black mailed. Being raped by a client was also significantly more likely for Indo-Fijian sex workers (23% reporting they had experienced this in the past 12-months).

Being black mailed or held against their will was typically referring to treatment by police if they had been picked up and taken back to the station.

9.1.1 Access to support

Overall 13% of sex workers reported having been raped by a client (9% of female sex workers and 20% of transgendered workers and 23% of Indo-Fijian sex workers and 9% of iTaukei sex workers). In countries where sex work is illegal, there is no legal recourse for these sex workers. Further, the stigma associated with their work can make it difficult to confide in anyone in order to be able to receive support and assistance.

65% of sex workers said they would tell someone if they had been raped. The most likely person they would confide in would be another sex worker (56%), followed by a friend (53%) and then a sex worker organisation (33%) or peer educator (31%). Just 25% would tell their partner, 11% their family and 3% said they would tell nightclub staff. Only 11% said they would tell a health worker which suggests that few participants have access to professional emotional and physical health services. Just four sex workers (1%) said they would feel comfortable to tell the police.

9.1.2 Access to safety information

Thirty-five percent of sex workers reported being physically assaulted by clients. In some countries, there are organised schemes for sharing information on 'bad' clients involving sex worker organisations and sometimes the police. One in ten sex workers said they did not receive this kind of information from anyone, 85% relied on other sex workers for information on bad clients, with smaller numbers getting information from better networked sources such as sex worker organisations (14%) and peer educators (9%).

9.2 LEGAL KNOWLEDGE

Correct knowledge of legal and human rights related to sex work can help sex workers protect their health and safety and avoid inappropriate harassment by police.

In Fiji, as in many other countries, sex work per se is not illegal; it is the related activities that are criminalised (e.g. loitering in a public place for the purpose of offering himself or herself for sex in return for a payment of any kind).⁵¹ Further, the 2009 Crimes Decree has, for the first time, criminalised client behaviour and made it illegal to seek or arrange the services of a prostitute.

However, the new Crimes Decree makes it more difficult to prosecute a sex worker for this behaviour as police must have evidence beyond reasonable doubt that it has occurred.⁵² This level of evidence is difficult to obtain unless the sex worker makes a confession.

Despite the 2009 Crimes Decree making it more difficult to prosecute sex workers for prostitution related behaviour, there still appears to be quite a lot of police action against sex workers with over a quarter reporting being arrested by police in the previous 12 months.⁵³

⁵¹ See Part 13 of the recent Crimes Decree 2009 (Decree No. 44) of the Republic of Fiji Islands

⁵² In the three years since the 2009 Crimes Decree was introduced, there has been only one prostitution related conviction (under section 231 of the Crimes Decree Age – under 16). This compares to 18 cases in the previous three years convicted for 'loitering with intent'.

⁵³ It is unclear if sex workers were actually formally arrested. Anecdotal reports from the sex worker community suggest it is more common to be picked up by police and taken to the police station and then later released with a formal arrest or charge laid.

While sex work related activities are illegal, sex workers have certain rights under Fiji law as other citizens in the country including the right to remain silent. If sex workers understand this right (ie. that they do not have to confess when questioned), it is more difficult for police to have grounds to arrest them.

Sex workers also have legal rights related to condom use under the 2012 Fiji HIV/AIDS Decree. The Decree makes it unlawful 'to refuse a person means of protection from HIV/AIDS' where 'means of protection' includes condoms. This makes it unlawful for a client to refuse to use a condom. Sex workers were asked their understanding of these rights and a number of other legal and human rights to assess their current level of knowledge. Figure 9.2 shows the percentage that correctly understood their rights.

Figure 9.2: Percentage of sex workers correctly understanding legal rights



NOTE: Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighted numbers.

Knowledge of legal and personal rights related to sex work varied considerably. The majority of sex workers understood that they have the right to refuse a client and cannot be arrested for carrying a condom. However, fewer understood their right to remain silent and that it is illegal under the HIV/AIDS decree for a client to refuse to use a condom.

A quarter of participants said that they had not discussed their legal rights with anyone. However, 42% said a sex worker organisation had given them information with another 40% receiving information from a peer educator.

9.3 SUMMARY

A summary of this section's findings include:

- > in countries such as Fiji where sex work is considered an illegal activity, there is no means of legal redress for sex workers. This makes them vulnerable to experiencing adverse experiences including physical and sexual abuse and financial exploitation by clients. A higher proportion of transgender sex workers than female sex workers experienced nearly all types of adverse experiences with verbal and physical assault by passers-by and financial exploitation by clients being most common;
- > 13% of sex workers reported being raped by a client in the previous 12-months. However, risk of rape was significantly higher among Indo-Fijian sex workers (23%) and transgender workers (20%). Just under a third of sex workers said they would not feel comfortable telling anyone if they were raped. This means they would not be able to receive the appropriate emotional and health services;
- > over a third of sex workers reported being physically assaulted by clients in the previous 12-months. However, there appeared no organised scheme to help sex workers identify 'bad' clients commonly used in other countries; and
- > correct knowledge of legal and human rights related to sex work can help sex workers protect their health and safety and avoid inappropriate harassment by police. The majority of sex workers understood that they have the right to refuse a client and cannot be arrested for carrying a condom. However, fewer understood their right to remain silent and that it was illegal under the HIV/AIDS decree for a client to refuse to use a condom.



10 BIOLOGICAL RESULTS

This section presents the results of the biological component of the IBBS survey. This involved the collection of urine and blood from research participants to enable testing of HIV, Hepatitis B, Syphilis, Chlamydia and Gonorrhoea. A detailed description of the methodology and tests used can be found in section 2.4.7.

All but 4 participants volunteered a blood and urine sample.⁵⁴ This enabled HIV, Hepatitis B and Syphilis testing to be carried out on a total of 293 participants. However, test results for Chlamydia and Gonorrhoea are reported for a smaller sample of 135 participants.^{55, 56}

10.1 HIV PREVALENCE (UNGASS INDICATOR 23 / GARPR 1.10)

Among the 293 IBBS participants that gave a blood sample, there were three HIV-positive results and one indeterminant test result.⁵⁷ All three positive results were transgendered sex workers, while the indeterminant result was a female sex worker.⁵⁸ Two of the HIV-positive results were from Suva and the third from Nadi, all were iTaukei and over 25 years. Only one of the positive results reported that they had previously been tested for HIV and knew their result.

Using the weighted sample that had been adjusted to more accurately reflect the distribution of sex workers in Fiji, this rate of HIV infection equates to an overall prevalence rate of 0.7% (95% CI: 0% - 1.5%) across all sex workers or 1.8% (95% CI: 0.4% - 3.2%) for transgendered workers.

This is higher than the best estimate for the prevalence rate in the Fijian population (0.12%, Fiji UNGASS Working Group, 2012), but very similar to the prevalence rate found for transgender individuals (1.3%) in the recent research on men who have sex with men (MSM) by Rawstone and colleagues (2012). This perhaps is not surprising as it was anticipated that many of the transgendered sex workers also participated in the MSM study. The rate of HIV infection among sex workers in Fiji is however, still lower than that in other Asian and Pacific countries that have been found to range between 5% and 18%.⁵⁹

⁵⁴ Two participants declined biological testing as they had recently undergone testing. A misunderstanding by pre-test counsellors resulted in an additional two being deferred for testing at a later date.

⁵⁵ The initial proposal was to test only for HIV, Hepatitis B and Syphilis using blood samples. Last minute funding offered by FNU enabled Chlamydia and Gonorrhoea to also be tested. However, there were only a sufficient number of testing kits and urine preservatives in Fiji to test Suva participants and a sub-sample of Lautoka and Nadi participants. New supplies arrived in time to then test all participants from Labasa.

⁵⁶ Results from the sub-samples of Lautoka and Nadi are noted in footnotes but are not included with the main findings. They were considered to be unreliable being incomplete samples and therefore open to bias (e.g. test results may have been influenced by order of testing with those with greater or less reason to undergo testing volunteering for the research at different stages of the recruitment).

⁵⁷ Indeterminant results are those which cannot be confirmed as positive or negative and require re-testing as a later date (see Appendix A). This is the current testing policy in Fiji.

⁵⁸ The indeterminant test result was for a female, Fijian sex worker, under 25 years of age working in Suva.

⁵⁹ UNAIDS (2011) presented data that showed Nepal, Thailand and Vietnam have HIV-infections rates below 5%, while Myanmar was just over 10%. Figures for 2007 showed Maharashtra in India being 18%.

**Table 10.1: UNGASS Core Indicator 23 (GARPR 1.10)
– Percentage of most-at-risk populations who are HIV infected¹**

	Total	Female	Transgender	Under 25 yrs	25 yrs plus
Sample size	293	183	109	115	173
Percentage	0.7%	Zero	1.8%	Zero	1.2%
95% CI	0% - 1.5%	-	0.4% - 3.2%	-	0% - 2.3%

¹ Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes are unweighed numbers.

As noted in the methodology section a sample size of 300 is insufficient for the most accurate assessment of HIV prevalence but could indicate if prevalence is greatly elevated in this group. The overall prevalence of HIV was higher than that estimated in the general population, but not sufficiently high to indicate sex workers are yet experiencing a concentrated epidemic and that HIV epidemic in Fiji is not expanding through sex workers.

10.2 HEPATITIS B PREVALENCE

Among the 293 IBBS participants that gave a blood sample, there were 13 Hepatitis-B positive results. Using the weighted sample that had been adjusted to more accurately reflect the distribution of sex workers in Fiji, this number of Hepatitis-B infections equates to an overall prevalence rate of 4.8% (95% CI: 2.5% - 7.1%) across all sex workers. This rate appears similar to the 4% found in the MSM study (Rawstorne et al., 2012). Table 10.2 below presents the estimated rate of prevalence by location and demographics.

Table 10.2: Estimated Hepatitis-B prevalence¹

		Suva (n=118)	Nadi (n=88)	Lautoka (n=62)	Labasa (n=25)	Total (n=293)
Overall		1.7%	8.6%	7.4%	0%	4.8%
Gender	Female (n=183)	2.3%	7.7%	2.6%	0%	3.4%
	Transgender (n=109)	0%	10.5%	10.7%	0%	7.1%
	Unknown (n=1)	0%	-	-	-	0%
Ethnicity	iTaukei Fijian (n=228)	2.0%	3.9%	5.8%	0%	5.8%
	Indo-Fijian (n=55)	0%	0%	5.6%	0%	1.8%
	Other (n=9)	0%	0%	0%	0%	0%
	Unknown (n=1)	0%	-	-	-	0%
Age	Under 25 yrs (n=115)	0%	13.6%	11.8%	0%	6.0%
	25 yrs plus (n=173)	3.2%	5.7%	4.8%	0%	4.0%
	Unknown (n=5)	0%	0%	-	-	0%

¹ Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes indicated in brackets are unweighed numbers.

The figures presented in Table 10.2 suggest the infection rates are not equally distributed. Rates appeared higher in Nadi (8.6%) and Lautoka (7.4%) than in Suva (1.7%), and there were no cases detected in Labasa. Rates appeared slightly higher among transgendered sex workers (7.1%), and those who were iTaukei Fijian (5.8%).

10.3 SYPHILIS PREVALENCE

Among the 293 IBBS participants that gave a blood sample, there were 82 cases of currently active syphilis infection (VDRL/RPR) and 84 cases where the participant had been infected historically (TPHA). Using the weighted sample that had been adjusted to more accurately reflect the distribution of sex workers in Fiji, this number of active cases of syphilis infection equates to an overall prevalence rate of 25% (95% CI: 20.4% - 29.6%) across all sex workers. While this rate among the sex workers was again similar to the MSM participants (20%) (Rawstorne et al., 2012), it was considerably higher than the best estimate for the general population of Fiji 2.7% (Fiji UNGASS Working Group, 2010). Table 10.3 below presents the estimated rate of prevalence further broken down by location and demographics.

Table 10.3: Estimated Syphilis prevalence¹

		Suva (n=118)	Nadi (n=88)	Lautoka (n=62)	Labasa (n=25)	Total (n=293)
Overall		24%	46%	19%	5%	25%
Gender	Female (n=183)	18%	45%	15%	0%	22%
	Transgender (n=109)	41%	47%	21%	10%	30%
	Unknown (n=1)	0%	-	-	-	0%
Ethnicity	iTaukei Fijian (n=228)	25%	47%	20%	20%	29%
	Indo-Fijian (n=55)	12%	40%	11%	0%	11%
	Other (n=9)	<i>50%</i>	<i>50%</i>	<i>25%</i>	<i>0%</i>	<i>31%</i>
	Unknown (n=1)	0%	-	-	-	0%
Age	Under 25 yrs (n=115)	15%	32%	3%	0%	14%
	25 yrs plus (n=173)	29%	54%	27%	7%	31%
	Unknown (n=5)	<i>50%</i>	<i>100%</i>	-	-	<i>60%</i>

¹ Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes indicated in brackets are unweighed numbers. Percentages in italics are unreliable due to their low base rate.

The figures presented in Table 10.3 again suggest the infection rates are not equally distributed. Rates appeared far higher in Nadi (46%) than other centres (Suva 24%, Lautoka 19%; and Labasa 5%), with rates of infection being elevated for all demographic groups in Nadi. Overall rates appeared slightly higher among transgendered sex workers (30%), those who were iTaukei (29%) and those over 25 years of age (31%).

The overall rate of active syphilis infection was very high and of considerable concern. The testing methodology should be carefully reviewed, but similar rates to that found in the MSM study support their validity. High rates of syphilis are generally used to indicate a population that would also be at risk of HIV infection if exposed to the virus.

10.4 CHLAMYDIA PREVALENCE

Among the 135 IBBS participants from Suva and Labasa that gave a urine sample, there were 26 cases of chlamydia infection with a further 6 cases where the result was in determinant. Using the weighted sample that had been adjusted to more accurately reflect the distribution of sex workers in Fiji, this number of cases of chlamydia infection equates to an overall prevalence rate of 22% (95% CI: 17.6% - 26.4%) across all sex workers. This was higher than the 5-6% rate found in the MSM study (Rawstorne et al., 2011), but lower than the rate of infection of Fijian pregnant women under the age of 25 (37.5%, Fiji UNGASS Working Group, 2010). Table 10.4 below presents the estimated rate of prevalence further broken down by location and demographics.

Table 10.4: Estimated Chlamydia prevalence¹

		Suva (n=110)	Labasa (n=25)	Total (n=135)
Overall		22%	23%	22%
Gender	Female (n=86)	29%	38%	30%
	Transgender (n=48)	0%	0%	0%
	Unknown (n=1)	0%	-	0%
Ethnicity	iTaukei Fijian (n=98)	20%	20%	20%
	Indo-Fijian (n=34)	33%	25%	29%
	Other (n=2)	0%	0%	0%
	Unknown (n=1)	0%	-	0%
Age	Under 25 yrs (n=62)	28%	13%	26%
	25 yrs plus (n=69)	13%	27%	16%
	Unknown (n=4)	50%	-	50%

¹ Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes indicated in brackets are unweighed numbers. Percentages in italics are unreliable due to their low base rate.

The figures presented in Table 10.4 again suggest while rates were similar in Suva and Labasa, rates of infection varied on other demographic variables.⁶⁰ The most significant disparity noted was the absence of infection in transgendered sex workers, all those found to be infected were female (this equated to 30% prevalence rate among female sex workers). The rate among females was closer to the reported rate of pregnant women under 25 years of age in Fiji (Fiji UNGASS Working Group, 2010). Those under 25 were found to have higher rates (26%), and Indo-Fijians (29%).

The absence of infection in transgendered workers was unexpected. Anal swabs may have been a more appropriate methodology, directly capturing the more likely site of the infection. However, the cost of these swabs would have been prohibitive for the current study. Of note, this study used the same methodology as the MSM study (urine sample) which found a prevalence of between 5-6% among men and transgendered individuals. The current study did identify a similar number of females and transgendered workers with 'in determinant' test results. **However, it is important that results be interpreted with caution and the testing methodology be carefully reviewed.**

10.5 GONORRHOEA PREVALENCE

Among the 135 IBBS participants from Suva and Labasa that gave a urine sample, there were 13 cases of gonorrhoea infection with a further 6 cases where the result was in determinant. Using the weighted sample that had been adjusted to more accurately reflect the distribution of sex workers in Fiji, the number of cases of gonorrhoea infection equates to an overall prevalence rate of 11% (95% CI: 7.7% - 14.3%) across all sex workers. This is higher than the 2.1% rate of infection of Fijian pregnant women under the age of 25 (Fiji UNGASS Working Group, 2010). Table 10.5 below presents the estimated rate of prevalence further broken down by location and demographics.

⁶⁰ Analysis of sub samples of urine from Nadi (n=11) and Lautoka (n=31) found estimated prevalence rates of 9% and 10% respectively, lower than in Suva or Labasa.

Table 10.5: Estimated Gonorrhoea prevalence¹

		Suva (n=110)	Labasa (n=25)	Total (n=135)
Overall		13%	5%	11%
Gender	Female (n=86)	16%	8%	19%
	Transgender (n=48)	0%	0%	0%
	Unknown (n=1)	<i>100%</i>	-	<i>100%</i>
Ethnicity	iTaukei Fijian (n=98)	11%	0%	13%
	Indo-Fijian (n=34)	12%	6%	15%
	Other (n=2)	0%	0%	0%
	Unknown (n=1)	100%		100%
Age	Under 25 yrs (n=62)	17%	0%	20%
	25 yrs plus (n=69)	6%	7%	7%
	Unknown (n=4)	25%	-	25%

¹ Percentages are weighted estimates to account for variations in sampling and response rate. Sample sizes indicated in brackets are unweighed numbers. Percentages in italics are unreliable due to their low base rate.

The rate of infection for gonorrhoea appeared higher in Suva (13%) than Labasa (5%).⁶¹ The rate of infection among sex workers in Suva was higher than the 3% found with Suva men who have sex with men (Rawstone et al., 2012). Rates of infection were highest among females (19%), with again no transgendered sex workers found to be infected (see notes above on implications of testing methodology). Those under 25 were found to have higher rates (20%) but there appeared little difference according to ethnicity.

10.6 SUMMARY

Table 10.6 below summarises the HIV and STI prevalence rates found in this study to best estimates available from other research.

Table 10.6: Rates of HIV and STI among sex workers compared to other groups¹

	HIV	Hep B	Syphilis (active)	Chlamydia	Gonorrhoea
Sex workers	0.7%	4.8%	25%	22%	11%
Female	0%	3.4%	22%	30%	19%
Transgender	1.8%	7.1%	30%	0%	0%
General Pop (15-49 yrs)	0.12%	-	-	-	-
Preg women 2004 (SGC)	-	-	2.6%	29%	1.7%
Preg women 2008 (SGS)	0%	2.2%	2.7%	27%	2.2%
MSM	0.5%	-	-	-	-
Male	0%	5-7%	22-24%	6%	4-16%
Transgender	1.3%	4%	17-24%	3-5%	1.5-7%

¹ Data for this table was sourced from the Global AIDS Progress Report 2012 (UNGASS Working Group, 2010) and the IBBS MSM study (Rawstone et al, 2012).

⁶¹ Analysis of sub samples of urine from Nadi (n=11) and Lautoka (n=31) found estimated prevalence rates of 8% and 10% respectively, lower than in Suva or Labasa.

Other key findings from this section include:

- > transgender sex workers appear to be of higher risk for HIV, Hepatitis B and syphilis, while female sex workers have increased risk of chlamydia and gonorrhoea (although also high rates of syphilis). Rates of infection appear similar to Fijian men who have sex with other men, another group defined by UNAIDS as a most at risk (MARF), although sex workers appeared to have higher rates of chlamydia;
- > iTaukei sex workers tended to have higher rates of infection of Hepatitis B and syphilis, while Indo-Fijian had higher rates of chlamydia although this is likely to be due to relatively higher numbers of female Indo-Fijian workers;
- > Nadi had particularly high rates of syphilis and Hepatitis B infection, Lautoka also had higher rates of Hepatitis B. In contrast, Labasa had no cases of Hepatitis B, and lower rates of syphilis infection, although, similar rates of chlamydia to Suva. Suva appeared to have higher rates of gonorrhoea infection than the other centres; and
- > those sex workers 25 years or older, had increased risk of infection for syphilis, but a lower risk of chlamydia and gonorrhoea compared to those under 25 years.



11 CONCLUSIONS AND RECOMMENDATIONS

This research is the first large scale quantitative research on sex workers in Fiji. It has enabled an understanding of the nature and extent of sex work in Fiji, rates of HIV and STI infection among sex workers and their knowledge and behaviour around safer sex practices. This research will compliment valuable insights gained from previous qualitative research. The findings will assist in the appropriate targeting and provision of education, resources and health care services of sex workers reducing their risk of future HIV transmission. Research findings will also assist UNAIDS Pacific Office and the Ministry of Health meet both national and international reporting requirements, including reporting on the Global AIDS Response Progress (GARP) and Universal Access to HIV and STI Prevention, Treatment and Care. They also provide an evidence-base to inform SAN Fiji's three year work programme aimed at improving the health, safety and well-being of sex workers in Fiji through their advocacy work and interventions delivered through their peer educators.

11.1 KEY FINDINGS

Some of the key findings from the research are highlighted below.

Population size estimate

- > in total, 857 female and transgender sex workers were identified as actively working in the previous two weeks in Suva, Nausori, Lautoka, Ba, Nadi, Labasa, Savusavu;
- > under two-thirds of sex workers were female, with just over a third being transgender. Around three-quarters were iTaukei, with a smaller 20% being Indo-Fijian.

Nature of sex work in Fiji

- > sex work in Fiji appears to be less structured than other countries, with virtually no managed sector (e.g. brothels) and workers tend to operate in a more casual manner conducting business as the opportunity arises. The most common venue participants reported operating from was the street, followed by bars, nightclubs and/or restaurants. There appeared to be no public advertising with sex workers relying on word-of-mouth referrals or being directly picked up clients. For two-thirds, sex work as their only source of income; and
- > most participants began sex work when they were young (under 20 years of age), particularly transgender workers. The top three reasons for starting were because 'friends were doing it' (33%), it was 'a good way to earn a living' (31%) and they needed to 'support their children/family' (25%). Consistent with previous research, sex workers appeared to have personally decided to work as sex workers with little evidence of coercion or being forced.

Prevalence of HIV and STIs

- > **three positive cases of HIV were found suggesting sex workers are not experiencing a concentrated epidemic and that the HIV epidemic in Fiji is not expanding through sex workers;** and
- > rates of STI infection, particularly chlamydia, have been found to be high in Fiji's general population which suggests high levels of unprotected sex. Similarly, levels of infection were also high among sex workers, with just syphilis infection found to be higher than the general population. Rates of infection varied by gender, location and ethnicity suggesting specialised and targeted responses are required.

Knowledge and behaviour

- > **overall condom use with clients was high (91% reporting use with last client) and used far more frequently than the general population. A lower proportion reported using condoms consistently, with just over half (57%) reporting they 'always' used condoms;**
- > two-thirds of sex workers had the misconception that using two condoms is safer than using one (despite this practice actually increasing the risk of a condom breakage due to the friction created). The high number of condom breakages was also of concern (43% had one or more experiences of condom breakage in the previous three months);
- > condom use with intimate partners was similar to other groups researched in Fiji, with 22% reporting they always used a condom with their intimate partner;
- > **just over a third of sex workers correctly answered five questions that identified ways of preventing sexual transmission of HIV and rejected misconceptions about HIV transmission. HIV prevention knowledge among sex workers appeared less than that of men who have sex with men, another group identified as a 'key affected group';**
- > there was a high demand among sex workers for more information and services on how to protect themselves from HIV and STI infection, with peer educators being the preferred source to provide this information;
- > just over a third of sex workers reported being tested for HIV and receiving their results in the previous 12-months;
- > **40% of participants reported never having had sexual health check (this equates to over half if the 'don't know' or 'no responses' are included). Addressing barriers to accessing sexual health services appears to be an area requiring attention, as regular health checks are an essential health and safety practice for those working in the sex industry;**
- > concerns over confidentiality appeared to be the biggest potential barrier to accessing sexual health services, followed by another privacy issue that the entrance to the clinic was too visible (i.e. they might be identified as a sex worker by going into the sexual health clinic). Having a sex worker friendly clinic was the most commonly reported factor to make going for a sexual health check-up easier;
- > just over a third of sex workers reported being physically assaulted by clients in the previous 12-months. However, there appeared no organised scheme to help sex workers identify 'bad' clients commonly used in other countries;
- > **13% sex workers reported being raped by a client in the previous 12-months. However, just under a third of sex workers said they would not feel comfortable telling anyone if they were raped. This means they would not be able to receive the appropriate emotional and health support and services;**

- > correct knowledge of legal and human rights related to sex work can help sex workers protect their health and safety and avoid inappropriate harassment by police. The majority of sex workers understood that they have the right to refuse a client. However, fewer understood their right to remain silent and that it was illegal under the HIV/AIDS decree for a client to refuse to use a condom;
- > overall, results varied across gender, age, geographical location. Sex workers in Labasa had a lower rate of condom use, lower HIV awareness knowledge and reported difficulties accessing safer sex resources and support services. HIV and STI awareness knowledge and access to support and services appeared less well provided for among Indo-Fijian sex workers. Transgender sex workers were at increased risk of physical, verbal and financial abuse.

11.2 RECOMMENDATIONS

In response to the findings of this research, the following recommendations are made. These recommendations have been endorsed by the advisory group and other key stakeholders (e.g. SPC, UNDP, UNFPA, UNICEF, MEN Fiji) following the presentation of the findings in a workshop in Suva on the 19th November 2012.

Action needed: reduce prevalence of HIV and STIs among sex worker

- > **Recommendation 1** - deliver presumptive treatment for syphilis, chlamydia and gonorrhoea for sex workers;
- > **Recommendation 2** - increase availability of lube and availability and quality of condoms and improve access to both of these (e.g. funding for outreach services provided by peer educators or supply accessed points close to where sex workers are working);
- > **Recommendation 3** - remove barriers to sex workers carrying condoms, including working with law enforcement agencies to ensure sex workers do not fear prosecution if they are carrying condoms. This would require a review of the Crimes Decree;

Action needed: improve access and uptake of sexual health services (testing and treatment) by sex workers

- > **Recommendation 4** - improve provision and nature of sexual health services (e.g. sex worker friendly clinics - preferably dedicated services for sex workers and/or other marginalised groups, with discrete entrances and convenient opening hours, or provision of outreach/mobile sexual health services). This is consistent with the 'Continuum of Care approach' outlined in the Fiji HIV and STI National strategy that recognises the need for specialised health services for key populations such as sex workers (Ministry of Health, 2012);

Action needed: improve awareness and understanding among sex workers of HIV/ STIs and safer sex practices

- > **Recommendation 5** - increase funding to enable sex worker peer educators to be properly trained and resourced, including training on sex work related legal rights and safer sex practices (eg. importance of using lube and not using two condoms together). This is consistent with the 'strategic health and development communication' recommended in the 2012-2015 Fiji National HIV and STI strategic plan (Ministry of Health, 2012);

- > **Recommendation 6** - fund regional workshops for sex workers to increase HIV and STI awareness and prevention knowledge and understanding of sex work related legal rights;
- > **Recommendation 7** - explore funding for provision of sex worker safe houses / resource centres / drop in centres to provide on-going accessible education and awareness and support;
- > **Recommendation 8** - deliver workshops with key stakeholders to enable repackaging of awareness raising and information, education and communication (IEC) packages;

Action: ensure interventions reach the locations and groups most in need treatment

- > **Recommendation 9** - Certain groups require increased focus and require a targeted response. Sex workers in Labasa had a lower rate of condom use, lower HIV awareness knowledge and reported difficulties accessing safer sex resources and support services. HIV and STI awareness knowledge and access to support and services appeared less well provided for among Indo-Fijian sex workers. Transgender sex workers were at increased risk of physical, verbal and financial abuse;

Action needed: address stigma, discrimination and human rights violations faced by sex workers

- > **Recommendation 10** - encourage the Fijian government to decriminalise sex work taking a human rights approach consistent with the current HIV Decree. There is currently no legal redress for sex workers making them vulnerable to adverse experiences including physical and sexual abuse and financial exploitation. Decriminalisation would assist sex workers to better negotiate safer sex practices with clients as provided for in the HIV Decree;
- > **Recommendation 11** - deliver public awareness campaigns that promote the human rights and respect of all Fijians including sex workers;
- > **Recommendation 12** - deliver training to law enforcement agencies (frontline officers) on sex worker related legal rights to ensure consistent good legal practice and eliminate cases of inappropriate harassment and exploitation. Continue productive work with senior police and develop action plans to fully engage frontline officers;

Action needed: plan to address identified research gaps

- > Recommendation 13 - Develop a programme of research to address knowledge gaps including:
 - issues related to underage sex workers (understanding entry into sex work and appropriate support action and systems of referrals for those identified);
 - sex workers knowledge and use of lube;
 - research on clients (e.g. nature of clients - regular or one-offs and impact on safer sex practices, and client understanding and expectations around use of safer sex understanding and practices and awareness of implications of HIV Decree around refusal to use a condom);
 - in-depth research on transgender sex workers including entry into sex work and nature of sex work provided (insertive vs receptive behaviour);
 - understanding of extent of injecting drugs among other groups in Fiji;
 - trial sentinel surveillance monitoring of once access and uptake of sexual health clinics by sex workers has been addressed.



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APPENDICES

APPENDIX A: ALGORITHM FOR HIV TESTING

Current HIV Testing Strategy

Figure 1.1: Anti-HIV Testing Strategy for *high through-put routine testing of samples where they are tested in batches*

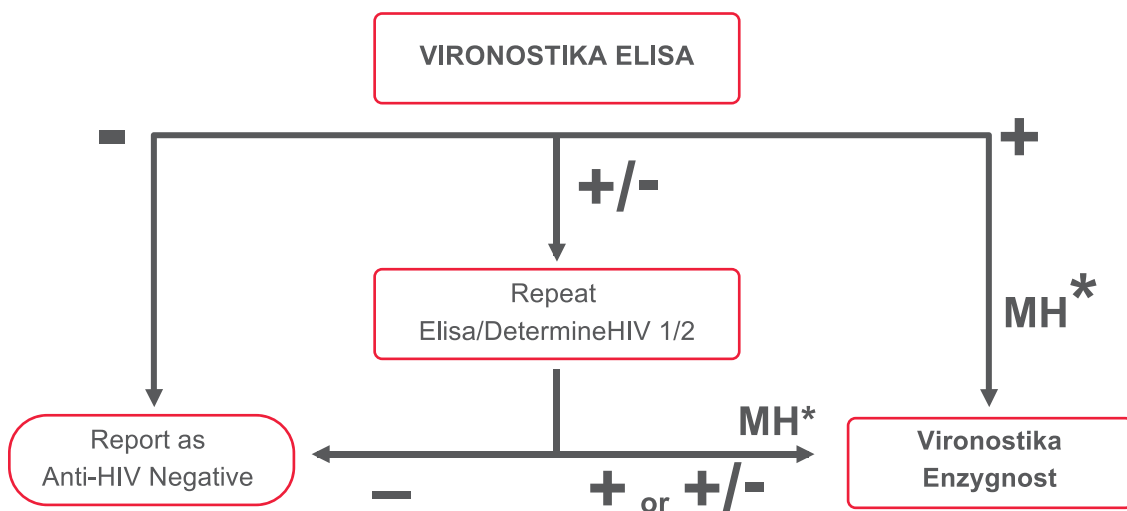
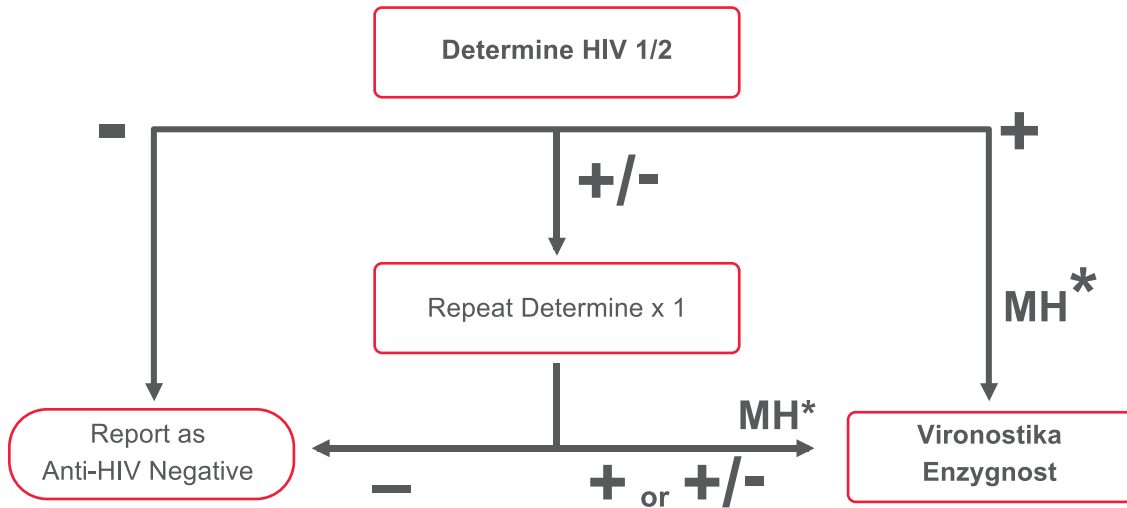


Figure1. 2: HIV Testing Strategy for low through-put (non-batched) routine testing



LEGENDS

MH* = Mataika House

(- = negative) (+ = reactive) (+/- = equivocal)



UNAIDS PACIFIC

Level 3, Kadavu House
Suva, Fiji
Private Mail Bag, Suva
T +679 331 0480 F +679 331 0425



**SAN FIJI
SURVIVAL ADVOCACY NETWORK FIJI**

Lot 4, Luke Street
Nabua
Suva, Fiji.



MINISTRY OF HEALTH

88 Amy Street, Toorak, Suva, Fiji
PO Box 2223, Government Buildings, Suva, Fiji
T +679 330 6177 F +679 331 2381



**COLLEGE OF MEDICINE NURSING &
HEALTH SCIENCES**

PO Box 7222, Hoodless House,
Brown Street, Suva, Fiji
T +679 331 1700 F +679 330 3469

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