

# **ASKIM NA SAVE (ASK AND UNDERSTAND): People who sell and exchange sex in Port Moresby**



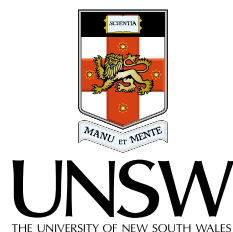
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ISBN: 978-0-7334-2972-9

**Suggested citation:**

Kelly, A., Kupul, M., Man, W.Y.N., Nosi, S., Lote, N., Rawstorne, P., Halim, G., Ryan, C. & Worth, H. (2011) Askim na save (Ask and understand): People who sell and/or exchange sex in Port Moresby. Key Quantitative Findings. Papua New Guinea Institute of Medical Research and the University of New South Wales: Sydney, Australia.

**Note about photos on the front and back cover:**

Permission was obtained from the people who attended the stakeholder meeting held on 3rd November 2010 for their photographs to be included in this monograph.

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# ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
ART	Anti-retroviral therapy
HIV	Human immunodeficiency virus
IHRG	International HIV Research Group
MSM	Men who have sex with men
NGO	non-governmental organisation
PDA	Personal digital assistant (mini-handheld computers)
PICT	Provider initiated counselling and testing
PMV	Public motor vehicle
PNG	Papua New Guinea
PNG IMR	Papua New Guinea Institute of Medical Research
RDS	Respondent-driven sampling
STI	Sexually transmitted infection
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VCT	Voluntary counselling and testing

# ACKNOWLEDGEMENTS

This project would not have been possible without the engagement of the participants. The research team for Askim na Save would like to thank the men, women and transgender who allowed us ask questions about their lives in order that we could understand and provide evidence to support efforts to reduce their vulnerability and risk to HIV and violence. Their bravery and willingness to participate is greatly appreciated. Much gratitude must also be extended to the members of the Port Moresby sex worker community who attended stakeholder meetings and whose insights and experiences guided the development of this project. Your time and efforts were appreciated. Thank you for your support and efforts in bringing this study to life in a way that was beneficial to and respectful of the sex worker community. In addition, we would like to thank staff at Poro Sapot, Save the Children in PNG and HOPE Worldwide who were advocates of this study in their organisations. Lastly, thanks must go to our research institutions, the PNG Institute of Medical Research and the University of New South Wales, for their tireless support of our pursuit for research excellence.

# A NOTE ON TERMINOLOGY

While every effort has been made to use inclusive rather than judgemental or labelling language, discussions with members of the sex worker community were held to use terms that were appropriate to them. Therefore we talk of gender (women, men and transgender) rather than sex (female and male). The acronyms of FSW (female sex worker) and MSW (male sex worker) are at odds with our study aim to work with gender. Furthermore, because not all participants in this study identify themselves as 'sex workers', we simply describe our participants as men, women and transgender or as participants. Where necessary, we use the phrase 'people who sell and exchange sex', a phrase agreed upon in the stakeholder meetings.



# EXECUTIVE SUMMARY

*Askim na Save (Ask and Understand): People who sell and exchange sex in Port Moresby* is a comprehensive bio-behavioural study of sex work in Port Moresby in Papua New Guinea. The study was designed to fill gaps in knowledge about the sex industry in PNG and to map the sale and exchange of sex in Port Moresby to create a richer and more detailed understanding of sex workers and their vulnerability to HIV.

*Askim na Save* is a mixed methods study. Respondent-driven sampling (RDS) was used to survey 593 participants in June and July 2010. Data were collected through a structured questionnaire administered through personal digital assistants (PDAs), and qualitative data were collected via 25 in-depth interviews. A biological component was included and this consisted of HIV and syphilis testing and HIV molecular epidemiology.

The findings of the study are too numerous to recount in full in this Executive Summary as are the recommendations. Listed below are the major findings.

## Socio-demographic characteristics

The sample consisted of 441 women, 96 men and 56 transgender. The mean age of the sample was 28 years old. Educational levels were low with 26% never having attended school. While all participants sold sex (and most had also exchanged sex) in the last six months, 74% of participants had other forms of work. The median age for sexual debut was 16 years, and the median age at initiation to sex work was 19 years. The majority were introduced to sex work by a friend.

## Current experience of sex work

The mean number of clients per week varied greatly according to gender. Women averaged 6.2 clients, transgender 5.7 clients and men 2.9 clients per week. Seventy-eight percent (78%) of the sample had only men as clients, but 58% of the men and 23% of the transgender had women clients. Traditional landowners were the most common clients, followed by company employees and public servants. The most common location for selling or exchanging sex was a settlement or village, followed by a guest house, and the house of a friend or client.

## Sexual practice

### Sex with clients

Vaginal intercourse was the most common overall form of commercial sex for 93% of the women and 69% of the men. Anal sex with opposite-sex clients was also common – 46% of the women, 56% of the men having anal sex with opposite-sex clients in the last six months. The majority of transgender (84%) and men (71%) had anal sex with same-sex clients in the last six months.

### Condom use with clients

Only 37% of the sample used a condom every time for vaginal sex in the last six months. Thirty percent (30%) of the sample used a condom every time for anal sex with an opposite-sex client in the last six months, and 46% used a condom every time for same-sex anal sex in that time period. The most important reason given for not using a condom at last sex was that condoms were not available (41%), followed by being under the influence of alcohol and/or drugs (22%). The majority (78%) reported sex with clients under the influence of drugs and/or alcohol in the last six months.

### Sex with non-paying partners

Less than half the sample had more than one casual non-paying partner in the last six months, with 36% having none. A half of the sample had more than one regular partner, while 29% had none. There was a high level of anal intercourse with both casual (53%) and regular (58%) opposite-sex partners, as with same-sex partners (88% for both casual and regular partners).

### Condom use with non-paying partners

Condom use was low with both casual and regular partners. Only 38% of those who had vaginal sex with casual partners and 24% of those who had vaginal sex with regular partners used a condom every time in the last six months. For anal sex with opposite-sex casual partners, 31% used a condom every time, and for regular opposite-sex partners this dropped to 24%. The proportion was slightly higher for anal sex with same-sex casual and regular partners (36% and 29% respectively).

## Violence related to sex work

Overall, 46% of the sample had experienced physical abuse related to sex and exchanging sex in the last six months. Proportionally, more women and transgender had been abused. The major perpetrators of violence were family members, police and regular partners.

Half (50%) of the sample had experienced forced sex in the last six months. The main perpetrators of forced sex were clients, police, and both casual and regular partners.

## Access to health services

Two-thirds of the sample had attended a health care service in the past six months. Fewer men attended than women and transgender. The main reason for attending was an HIV test (64%). Disclosure about selling sex to a health care worker was low, with only 29% almost always to always disclosing this.

## HIV status

Three-hundred and eighty-one (381) participants had tested for HIV, with 40% of those testing in the last six months. The unadjusted HIV prevalence was overall 17.6%, 19% among women, 8.8% among men and 23.7% among transgender.

# INTRODUCTION

Papua New Guinea's HIV epidemic is considered both generalised yet simultaneously clustered around locations and practices of marginality, including the sex industry.<sup>1</sup> PNG's HIV prevalence remains unclear, yet interest in protecting the vulnerability of people who sell or exchange sex remains a key research and policy area. Greater understanding of the sexual networks of those who sell and exchange sex was identified in the *National HIV Research Agenda* of PNG as a priority. In addition, the research agenda calls for work into exploring this population's preferences for health and support services. Furthermore, it seeks to advance understanding of this community's ability to engage in safe sex practices and the factors that create vulnerability.

The selling and exchanging of sex in PNG has a long history. The late Carol Jenkins cited Field Patrol Reports from the Wewak and Boiken areas of the East Sepik Province (1949/1950) prior to independence (Anderson 1949/1950 cited by Jenkins 2006) which identified the presence of a sex industry. The nature and context of this practice has changed with mobility, the development of mines, ports and logging camps, increasing numbers of people in large cities and towns and with changes in access to cash income. There have also been large-scale changes in social and in cultural roles for men and women.

Despite the long-standing presence of a sex industry in PNG, research into this phenomenon and the people involved was slow to develop. The identification of HIV meant that there was a need to begin understanding from a socio-cultural point of view as well as a behavioural one the lives of 'high risk groups' such as female sex workers. One of the first and most influential research studies on people who sell or exchange sex was the Transex Project (1996). Since that time, research has proliferated (for example, Hammar, 1999; Jenkins, 2000; Wardlow, 2002; Mgone *et al.*, 2002; Gare *et al.*, 2005; & Maibani-Michie *et al.*, 2007). Despite these studies, a number of key gaps persist in our knowledge of people who sell or exchange sex.

Identified as a 'high risk group', female sex workers have been the target of both discrimination and blame for spreading HIV, while at the same time being the target of intervention and research. Interest in male sex workers has

attracted less attention. Only one study began to examine males (not men) who sell sex as a sub-population of men who have sex with men (MSM) study (Maibani-Michie *et al.* 2007). No study has ever specifically targeted men and transgender, although members of the MSM community may and in fact do identify as both men and transgender. Jenkins noted in 2000 that there was poor recognition of male sex workers, despite clear evidence of its existence in Lae, Daru and Port Moresby. This study partly aimed to address this gap. Moreover, the emphasis on the sex (female or male) of the worker or their sexual behaviour (MSM) has limited our capacity to explore and understand the nuances in the experiences and practices of people who sell and exchange sex and to respond to their needs. In addition, this study, like only one other (conducted in 2010 by Save the Children in PNG), aimed to recruit under-age sex workers in order to advance our very limited knowledge of this sub-population.

As a result of these present gaps in knowledge, this study was designed to advance the body of research on the sex industry in PNG by addressing the population of people who sell or exchange sex.

This study's primary focus was to take a holistic approach to mapping the sale and exchange of sex in Port Moresby to create a richer and more detailed understanding of sex workers and their vulnerability to HIV. This will provide the Government of Papua New Guinea and other interested stakeholders with the most comprehensive understanding of sex work in Port Moresby to date.

This research was funded by AusAID through a *Targeted HIV Social Research Grant* to the International HIV Research Group (IHRG) of the University of New South Wales, Australia. The research was conducted in partnership with the Papua New Guinea Institute of Medical Research (PNG IMR) with the support of members of the community who sell and/or exchange sex in Port Moresby, PNG.

The aim of this report is to provide a comprehensive overview of the quantitative results of the study and is aimed at policy and program developers, service providers, researchers, civil society and community organisations, along with other individuals and groups. For the purpose of this report, the qualitative data is used for illustrative purposes only.

1 At the time of this study, PNG's HIV epidemic was considered generalised and at about 2.5% of the adult population. Just as we were disseminating the key findings of this study at stakeholder meetings in Port Moresby in November 2010, the Government of Papua New Guinea released a new estimate that down-scaled the prevalence to 0.9%.

# METHODOLOGY

Respondent-driven sampling (RDS) was used to recruit people who sell and exchange sex in Port Moresby. This was a mixed method study conducted between 10 June and 17 July 2010 in which survey data were collected through a structured questionnaire administered through PDAs, while qualitative data were collected through in-depth interviews amongst a smaller sub-set of the total sample. A biological component was included and this consisted of HIV and syphilis testing and HIV molecular epidemiology.

## Community consultation

In order to increase the relevance of the study for those who sell or exchange sex in Port Moresby, including ownership of it and its subsequent results, a two-day stakeholder meeting consisting of men, women and transgender who sell or exchange sex was held at Ela Beach Hotel, Port Moresby (23 and 24 April 2009). In addition to people who sell or exchange sex (9 men, women and transgender who currently sell or exchange sex and 2 who used to sell or exchange sex), key non-governmental organisation (NGO) staff who specialise in servicing the sex worker population in Port Moresby and PNG more generally were also invited to participate. These groups included Save the Children in PNG's Poro Sapot Project, Friends Frangipani (The PNG network of sex workers), Helpim Bilong Yumi Project, HOPE Worldwide's Lawes Road Clinic and Family Health International.

Following the completion of the draft report, a second stakeholder meeting was held at Ela Beach Hotel on 3 November 2010 for the community who sell or exchange sex in Port Moresby and the results were fed back for comment. Moreover, together and in partnership, key recommendations were identified and written for this study report. Members of the community presented the recommendations at a wider community feedback session held on 4 November 2010.

## Study site

The study site was chosen in consultation with members of the stakeholder group who identified a guest house in Boroko as the study site that was central for the majority of the population who sell or exchange sex in Port

Moresby while at the same time being a place where members of this population, in particular transgender, were safe and welcomed.

## Sampling and recruitment

### Respondent-driven sampling (RDS)

RDS is a sophisticated method of chain referral sampling where respondents are recruited by each other. RDS is recommended for hard-to-reach and hidden populations of which people who sell and/or exchange sex for goods are one. As typified in the RDS method, seeds were selected prior to the commencement of the study. Potential seeds were identified at the stakeholder meeting and their selection was based upon the size and diversity of their network with other people who sell and/or exchange sex. Three seeds (two women and one transgender) were utilised for this study.

### Inclusion criteria

Criteria for participating in the survey were:

- Had either sold or exchanged sex in the last six months in Port Moresby
- Had seen at least one other sex worker whom they knew by name in the last two months
- 9 years or older<sup>2</sup>

At the end of the survey, each participant had the RDS process explained to them, was provided with three coupons to give to three people who sold or exchanged sex whom they knew but who had not already been given a coupon and participated in the study. The longest wave created by a seed was 18 and almost half of the participants (48%) were recruited from the 9<sup>th</sup> wave or beyond.

As typified in the RDS method, primary and secondary incentives were given. The primary incentive for participation in the survey was 25 Kina and the secondary incentive was 5 Kina per successful recruit (up to the maximum of three). Therefore the maximum a participant could receive for successfully completing a questionnaire themselves and having three people successfully complete the questionnaire was 40 Kina.

2 Ethics approval was granted for a person of any age to participate in the study; however, at the time of the survey being finalised for use on a PDA, it was decided that no person under the age of 9 could reliably use the PDA, therefore 9 was arbitrarily selected as the age minimum.

## Data collection methods and analyses

This was a mixed method study utilising both quantitative and qualitative data collection methods.

### Questionnaire

In addition to the standard socio-demographic questions, the questionnaire had two primary areas of enquiry as determined by PNG's responsibility to report for the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) indicators and the research needs of the stakeholder group: sexual behaviour, and violence and discrimination. Sexual behaviour addressed sexual debut, paid sex, casual and regular sexual partners, condom use and disclosure of engagement in sex work to sexual partners. Violence and discrimination included access to health care services, physical and sexual abuse and other forms of discrimination. Additional areas of enquiry included use of drugs and alcohol, HIV knowledge, HIV testing, penile practices, and living with HIV.

Rather than using traditional paper surveys, we used mini-handheld computers known as personal digital assistants (PDAs). All that was required of participants to use the PDA was familiarity with a mobile phone. For illiterate participants, participants can listen to the pre-recorded questions which guide them through the questionnaire. A qualified researcher was readily available to assist participants. The benefits of this method are that it leads to greater accuracy in data gathering because it is private and the data is already in an electronic form which can be exported from the software, saving time on data entry and input error. All answers were downloaded from the PDAs at the end of each day.

A participant was deemed to have successfully completed the survey if they had answered to the end of the section on sex work. The questionnaire was available on the PDA in both English and *Tok Pisin*. For practical reasons, some sections of the questionnaire were different across the gender groups (e.g. questions on anal intercourse position, sexual identity, circumcision).

All data is simultaneously presented for the whole sample, while it is also divided into gender (transgender, men and women) where appropriate.<sup>3</sup> Almost all data are presented in bar charts or pie charts. Questions that yielded continuous data (e.g. age) generally also had their median or mean given in the text.

### In-depth interviews

A total of 25 in-depth interviews were conducted with participants who had completed the questionnaire. All participants who attended the study site in the middle

three weeks (when the interviews were scheduled) were invited to participate in an in-depth interview, and those who consented made an appointment for a later date that was convenient for them. In total, 16 women (2 under the age of 18 years) and 9 males (3 transgender, 5 gay men and 1 bisexual man) were interviewed. The in-depth interviews were designed to yield more detailed information on areas covered in the questionnaire. All interviews were digitally recorded, transcribed, translated and thematically coded. All identifiable information has been altered and pseudonyms given. Written informed consent was obtained from all participants. No further incentives were given for people to participate in the interviews. Extracts from the in-depth interviews are used for illustrative purposes only in this report.

### Biological specimens

Voluntary counselling and testing (VCT) for HIV and syphilis rapid tests were offered to each participant who completed the survey. Participants were required to give separate informed consent for this procedure. Only after pre-test counselling was complete and consent was granted was a rapid test undertaken by a qualified VCT counsellor. In line with PNG testing algorithms, two rapid tests for HIV were conducted and results given on the day. For participants who tested positive to HIV and/or syphilis, referral cards were provided which recommended that they attend a health facility for care and treatment.

Subtyping of HIV-1 was conducted on specimens obtained from consenting individuals who tested HIV-positive. This was performed by collecting a few drops of blood onto filter paper, which was subsequently air-dried, placed in a snap-lock bag and delivered to PNG IMR in Goroka for molecular analysis using previously evaluated protocols (Ryan *et al*, 2007). All specimens were coded to protect the individuals from identification. The results of this part of the study are for research only and are pending. These results will inform national surveillance data but are of unevaluated clinical relevance to the person with HIV. These results are not reported in this document.

### Ethics approval

Ethics approval for *Askim na Save* was granted by the Papua New Guinea Institute of Medical Research Internal Review Board, the Research Advisory Committee of the Papua New Guinea National AIDS Council, the Medical Research Advisory Committee of Papua New Guinea and the Human Research Ethics Committee of the University of New South Wales, Australia.

3 Although RDS was used for recruitment, the analysis in this report does not adjust estimates for the RDS design, except for HIV and syphilis prevalence. Therefore, instead of talking of population estimates, we write of sample estimates.

# RESULTS

## 1. Socio-demographic characteristics

### 1.1. Description of sample

Five hundred and ninety-three (593) people who sold or exchanged sex in Port Moresby who were eligible to participate in the study successfully completed the questionnaire. Of this total, 441 were women, 96 were men and 56 were transgender (male to female). That is, 152 participants were born male.

### 1.2. Sexual identity

The majority (90%) of women identified themselves as heterosexual. There was more diversity in the sexual identity of men and transgender. More men identified as either bisexual (42%) or heterosexual (36%) with less identifying as gay and MSM.<sup>4</sup> Not surprisingly, almost half of the transgender (43%) identified themselves as transgender, but, interestingly, 27% identified themselves sexually as heterosexual. See **Table 1.1**.

**Table 1.1 Sexual identity**

	WOMEN		MEN		TRANSGENDER		OVERALL	
	No.	%	No.	%	No.	%	No.	%
Heterosexual	397	90%	35	36%	15	27%	447	75%
Bisexual	20	5%	40	42%	1	2%	61	10%
Transgender	8	2%	0	0%	24	43%	32	5%
Gay	5	1%	8	8%	4	7%	17	3%
Lesbian	1	<1%	--	--	--	--	1	<1%
MSM	--	--	6	6%	10	18%	16	3%
Other	10	2%	7	7%	2	4%	19	3%
<b>TOTAL</b>	<b>441</b>	<b>100%</b>	<b>96</b>	<b>100%</b>	<b>56</b>	<b>100%</b>	<b>593</b>	<b>100%</b>

*“When I was small I used to stay with girls, most of the times I spent it with girls and then when I went to primary school I used to play with girls during lunch break ... or sports I would play netball rather than playing rugby. I would play girls’ game rather than playing boys’ game.”*

**(MOKANE, TRANSGENDER)**

*“They realise and they all understand about me that I was born like this and they are all honest and when I go to my other sister’s house, they will do their job and I will do my job. I will prepare and serve food to them, wash their clothes and their in-laws and they understand me because I am born like this and it is hard for them to stop it because it has happened already and it is hard for me to change my life so my family knows.”*

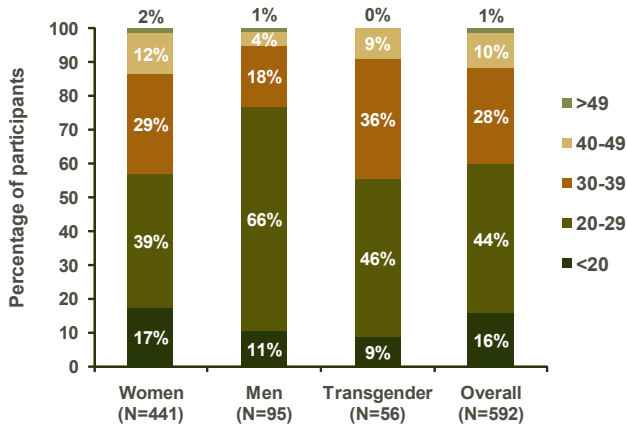
**(ALITA, TRANSGENDER)**

4 Although the acronym MSM was first coined to identify the behaviour of men who have sex with men but who do not identify as gay or even homosexual or bisexual, in PNG and in other parts of the developing world MSM has become an identity. It is because MSM is commonly used now in PNG as an identity with phrases such as “I’m an MSM” that MSM has been used in this way.



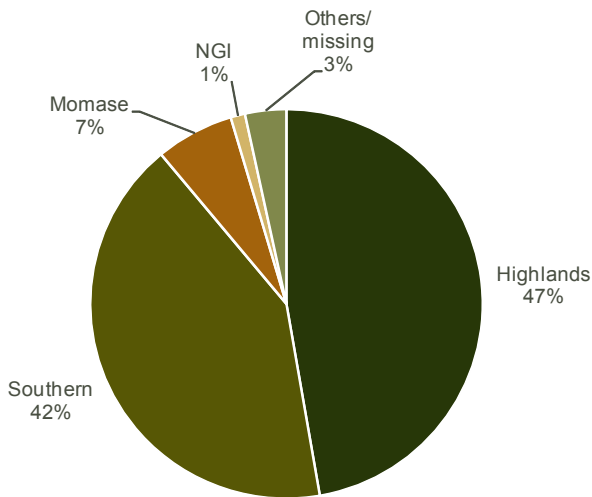
### 1.3. Basic socio-demographic characteristics

The median age of participants was 26 years old and the mean was 28.2 years. The two youngest were a 9-year-old boy and a 14-year-old girl. The oldest was a 64-year-old woman. See **Figure 1.1**.



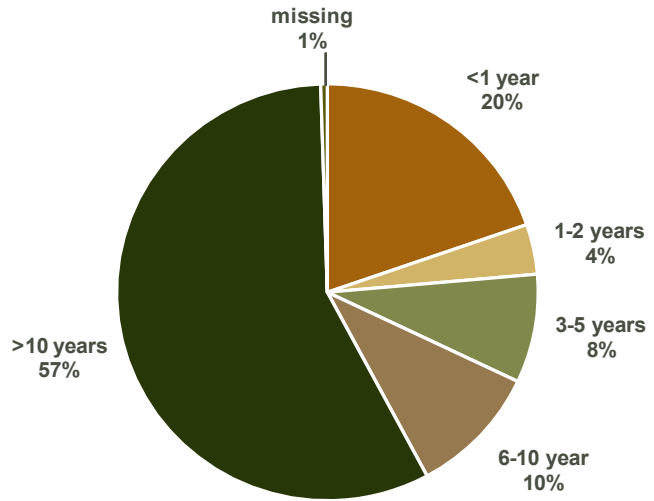
**Figure 1.1** Distribution of age (in years).

The most common regions of origin reported by the participants were Highlands (47%), followed by the Southern region (42%). Of the 246 participants who originated from the Southern region, only 9 stated that they originated from the National Capital District. See **Figure 1.2**.



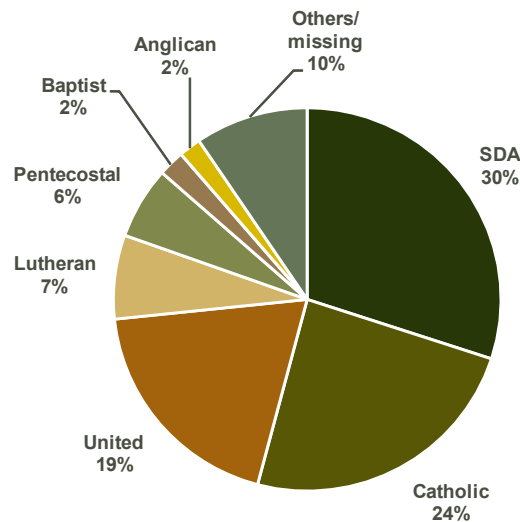
**Figure 1.2** Region of origin (N=593).

The majority of the participants (57%) had lived in Port Moresby for more than 10 years, while approximately a quarter (24%) reported having only newly migrated to Port Moresby within the last two years. See **Figure 1.3**.



**Figure 1.3** Years lived in Port Moresby (N=593).

Almost three-quarters of the whole sample (73%) identified that they were Seventh Day Adventist (SDA), Catholic or United. See **Figure 1.4**.



**Figure 1.4** Religion (N=593).

Educational levels of the sample were low but not altogether surprising, with more than a quarter (26%) of the participants reported never having attended school and men had slightly higher levels of education. See **Figure 1.5**.

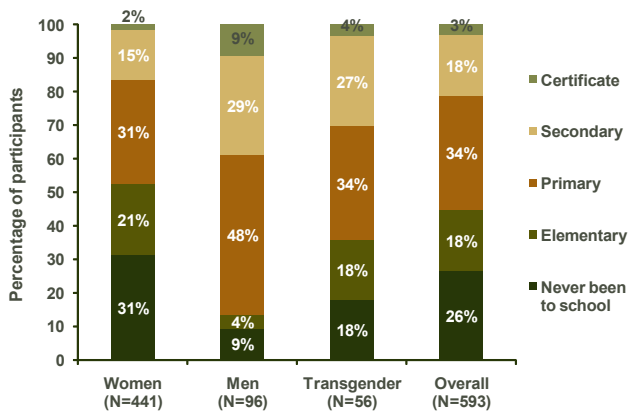


Figure 1.5 Highest education level completed.

### 1.4. Work other than selling or exchanging sex

Almost three-quarters (74%; n=436) reported they had work other than selling or exchanging sex. Of the 417 participants who specified other work, the most common type of work was selling betel nut (79%), followed by selling store goods (12%). See Figure 1.6.

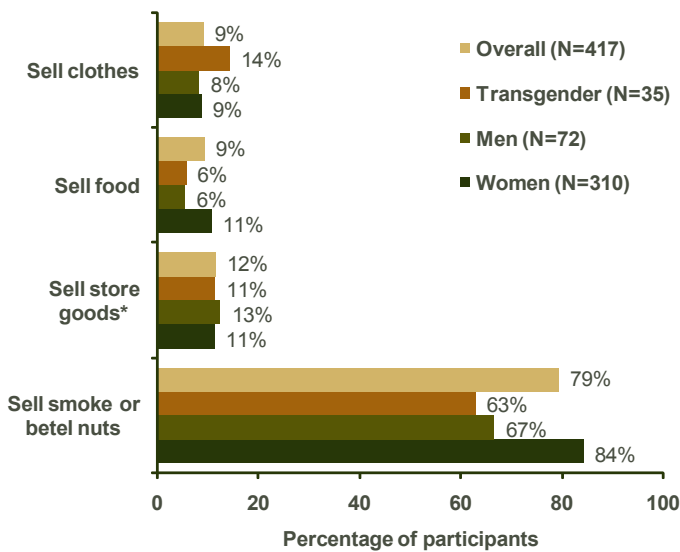


Figure 1.6 Types of work other than selling or exchanging sex.

\*“Sell store goods” include nine participants who were shop assistants, of whom five also sell store goods.

NB: A participant may have more than one of the above types of work.

### 1.5. Living arrangements and marital status

Overall, the participants most commonly reported living with their spouse/fiancé (33%) and/or relatives/parents (32%). While 6% of the sample reported living with dependent children, almost all were women. See Figure 1.7.

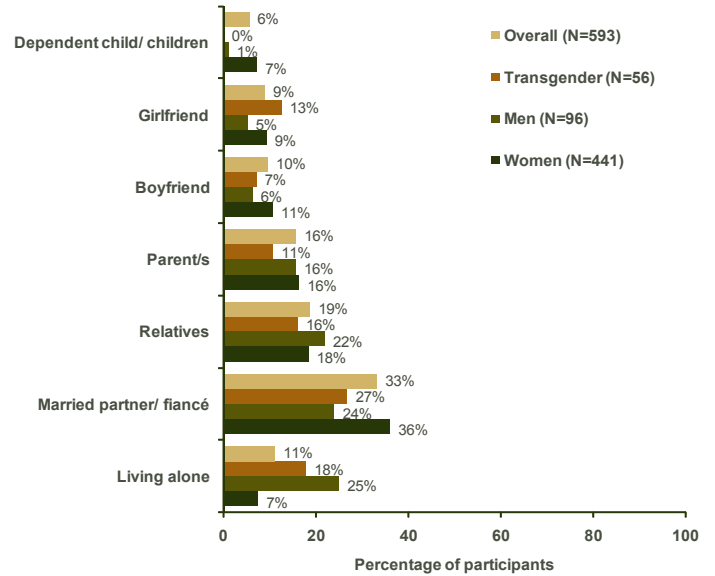


Figure 1.7 Living arrangements.

NB: Other than those who live alone (i.e. did not live with anyone), a participant may live with more than one of the above types of people.

A third (33%) of the participants were single, and only 26% were married or engaged. See Figure 1.8.

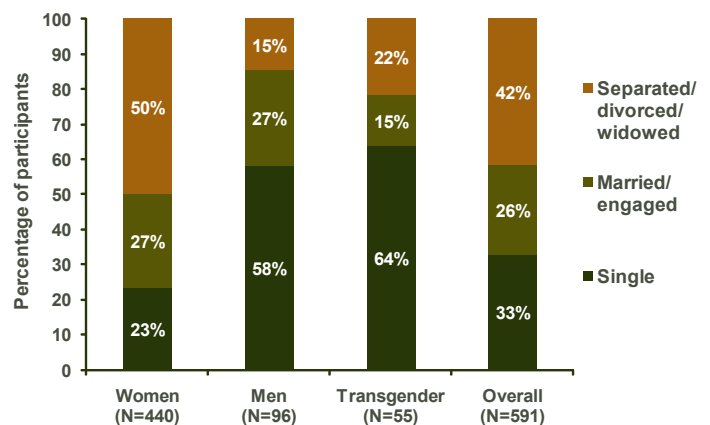


Figure 1.8 Current marital status.

Only 3% of participants reported that they did not have a main partner. See Figure 1.9. More than half (55%) of the participants with a main partner had disclosed to their main partner that they sold and/or exchanged sex. The majority (82%) of the participants' main partner had other partners, and relatively more women's main partner (85%) had other partners, compared to transgender (78%) and men (73%).



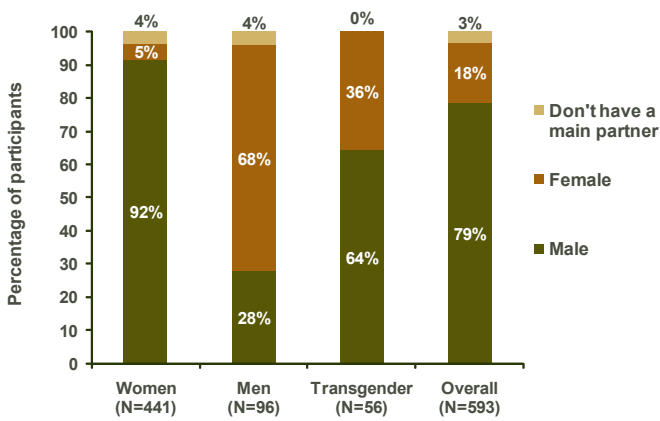


Figure 1.9 Gender of main partner.

## 2. Sexual experience

### 2.1. Sexual debut

The median age for sexual debut of the overall population of people who sell or exchange sex in Port Moresby is 16, with the majority of people experiencing sex for the first time between the ages of 16 and 20. Importantly, over a quarter of the population (28%) reported having sex before the age of 15 with more males (36%) than any other gender group reporting sex at such an age. The youngest age recorded for first sexual experience was as an 8-year-old for men and 9 for both women and transgender. See Figure 2.1.

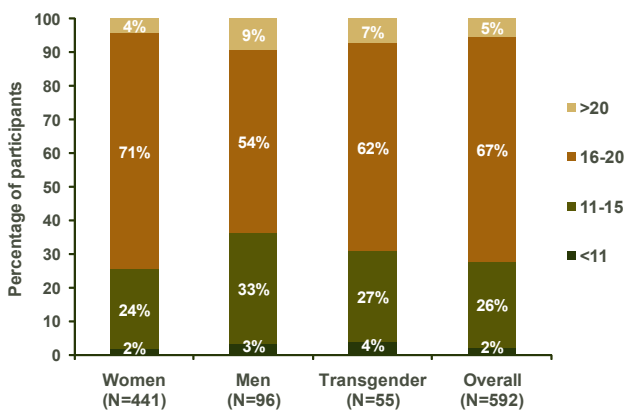


Figure 2.1 Age (in years) at sexual debut (first sex).

*"I was 16...I stayed with a white man at Gerehu, back road. I stayed with him there and I thought he was a normal white man who wanted to take care of me but he has this thought like a white man to have sex with men or have sex with gay."*

(ALITA, TRANSGENDER)

*"I was schooling and when I was 12 years old, I made friend with a boy and we used to go out together. Then one time he asked me to follow him but I was scared because this was my first time."*

(COLA, WOMAN)

Almost all women (99%) identified that at their sexual debut (their first time to have sex) they had sex with a man. Slightly more than a quarter (27%) of men identified that their sexual debut was with a man, while approximately equal proportions of transgender stated that they had sex with a woman or man on their first occasion. See Figure 2.2.

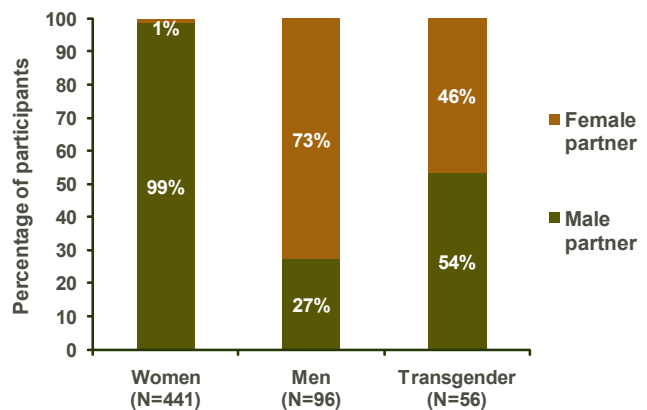


Figure 2.2 Sex of first partner by gender.

### 2.2. Initiation of sex work

The median age when the participants first sold sex was 19 years and the youngest age 9 years old for both women and men, and 13 years for transgender. The oldest ages were 32 years, 37 years, and 44 years for transgender, men and women, respectively. Proportionally more transgender first sold sex under the age of 20 (82%) than women or men, while proportionally more men began selling or exchanging sex at an older age with 35% commencing after 20 years of age. See Figure 2.3.

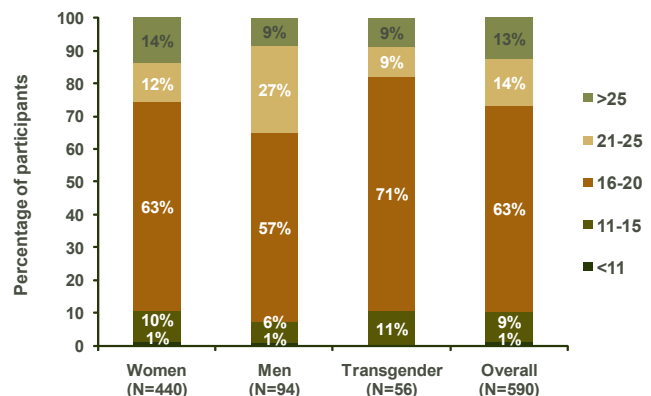
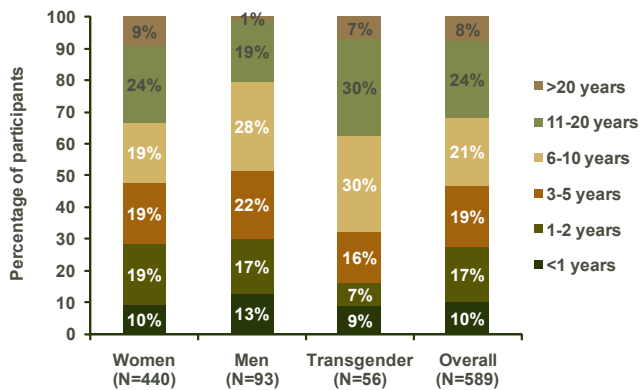


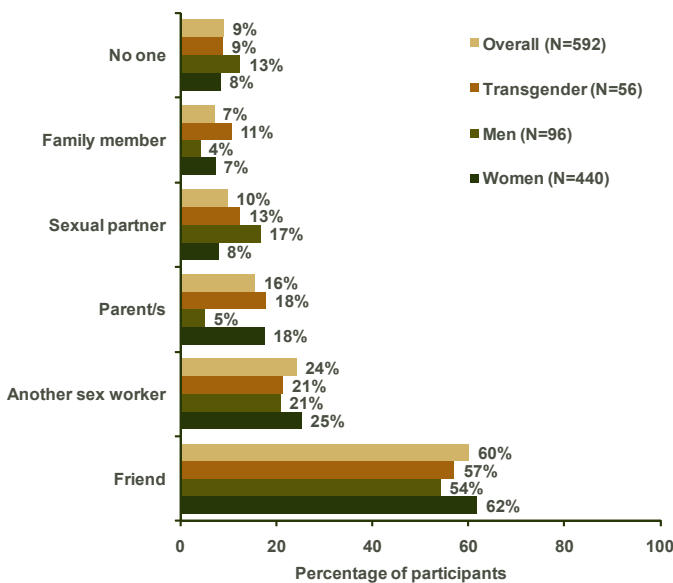
Figure 2.3 Age (in years) when first sold or exchanged sex.

As a result of the difference in current age and age at initiation of selling or exchanging sex, women and transgender reported having sold or exchanged sex for a longer time compared with men, with 33% and 38% respectively of women and transgender having first started selling or exchanging sex more than ten years ago, compared with only 20% of men. Overall, the majority of the population (67%) had been selling and exchanging sex for less than ten years. See **Figure 2.4**.



**Figure 2.4** Time since first started selling or exchanging sex.

Nearly two-thirds of the overall sample (60%) reported having been introduced to selling and or exchanging sex by a friend, with almost a quarter (24%) identifying another person who sold sex as introducing them. The third most common category of person identified that introduced this population into the sex industry was parent/s. Ten percent (10%) of participants had been introduced to selling or exchanging sex by their sexual partner. See **Figure 2.5**.



**Figure 2.5** Person introducing sex work.

**NB:** A participant may specify they were introduced to sex work by more than one of the above types of people.

*“When me and my husband were married, he married another woman, I was going out too. I went out with other men [selling sex] because I find it difficult to feed the child.”*

**(SAFA, WOMAN)**

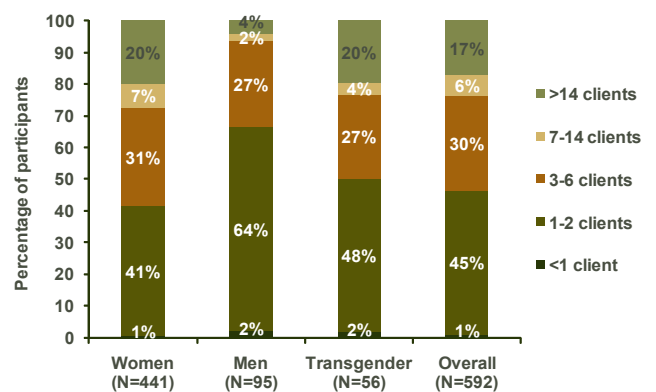
*“I started my first sex work like I used to go out to parties and see my gay friends engaged themselves and the way they dress and like some they have really nice things and I saw them and I said oh maybe I’ll practise that and then I’ll have enough money to get these things that’s what motivated me.”*

**(MOKANE, TRANSGENDER)**

### 3. Current experience of selling or exchanging sex

#### 3.1. Number of clients and methods of payment

Forty-five percent (45%) of the sample serviced between 1 and 2 clients in the average week, with another 30% servicing between 3 and 6 clients. The mean number of clients serviced in the average week for men, transgender and women was 2.9, 5.7 and 6.2, respectively. See **Figure 3.1**.



**Figure 3.1** Number of clients in the average week.

In the last week, only seven participants did not have any clients (and one participant did not give information on number of clients last week). Of the 585 participants with clients last week, two participants (<1%) received goods only in exchange for sex, 45 participants (8%) received money only, and the rest (538 participants or 92%) received both money and goods in exchange for sex last week. On average, the participants had 2.8 clients in exchange for goods and 5.6 clients in exchange for money in the last week.

"I have received 150 Kina to 200 Kina. The highest amount is 200 Kina. The lowest amount would be 50 Kina...when I started sex work like one night I go out with three or four to have sex and then I get paid."

(MOKANE, TRANSGENDER)

"Amongst these seven, five are pilots, one works with [company name] and one is a taxi driver...When I go around with them, I charge four, five hundred. That's what I charge. I say that my body it's important and I don't know what kind of disease is in your bodies."

(GAGA, WOMAN)

"I have nine men whom I used to go around with them. Among these nine men, six of them are top shots. Three of them are still from the settlements. When I go out with them they will give me K20, K10 or this sort. The six big shorts usually give me 200 Kina, 250 Kina, or 100 Kina; they used to pay me like that."

(LUCITA, WOMAN)

"I usually charge them for 200 Kina down to 150 Kina. So some of those who already paid for beer they will give me like 100 Kina down to 50 Kina, 60 Kina around there they will give me like 40 Kina."

(SAFA, WOMAN)

### 3.2. Sex work venues and client composition

Over three-quarters (78%) of the overall sample serviced men only. The majority of women (91%) and transgender (64%) had only men as clients. On the other hand, more than half of the men serviced (59%) either only women or mostly women clients. Interestingly, approximately a quarter of transgender (23%) service only women or mostly women. See **Figure 3.2**.

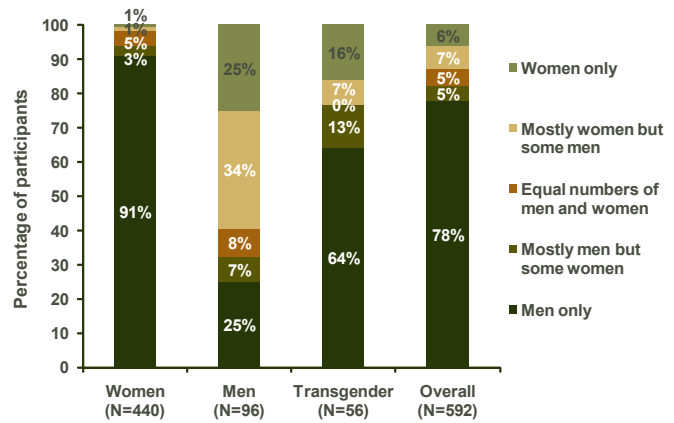


Figure 3.2 Sex of clients.

Traditional landowners<sup>5</sup> were the most common clients serviced by the sample (76%), followed by company employees (60%), public servants (52%), businessmen (50%), students (42%), expatriate men (40%), police, soldiers, security guards, street sellers and the unemployed (37% each). See **Figure 3.3**.

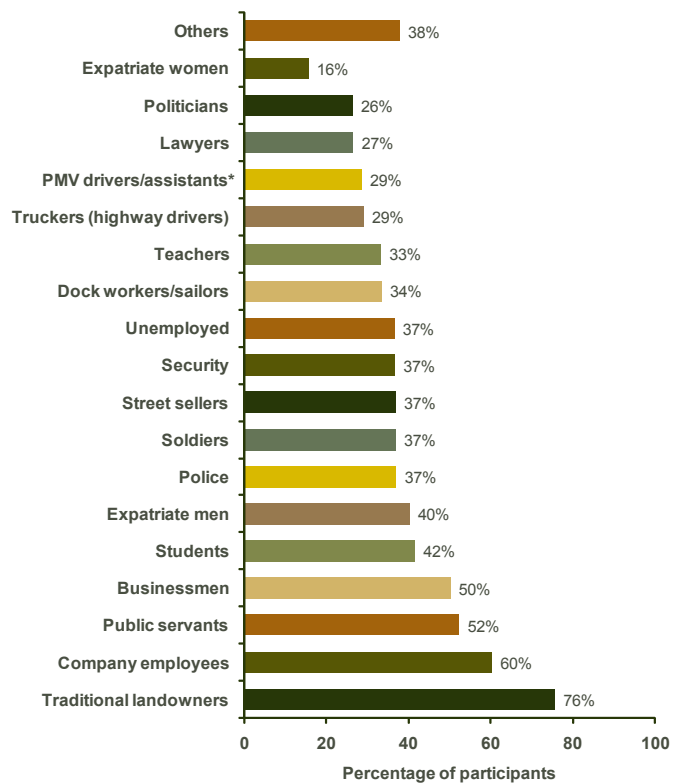


Figure 3.3 Type of sex work clients.

\*PMV stands for public motor vehicle, which is the predominant form of public transport in PNG.

**NB:** A participant may specify they have had more than one type of clients.

5 Most of the land in PNG is traditionally owned. Where the government and companies utilise natural resources on traditionally owned land, compensation or royalty payments are made to local landowner groups who represent the traditional landowners.

*“About my clients is that I only go out with the guys [landowners] from [name of area] the last Papuans, they are the only people that I go out with.”*

**(FABULIZ, WOMAN)**

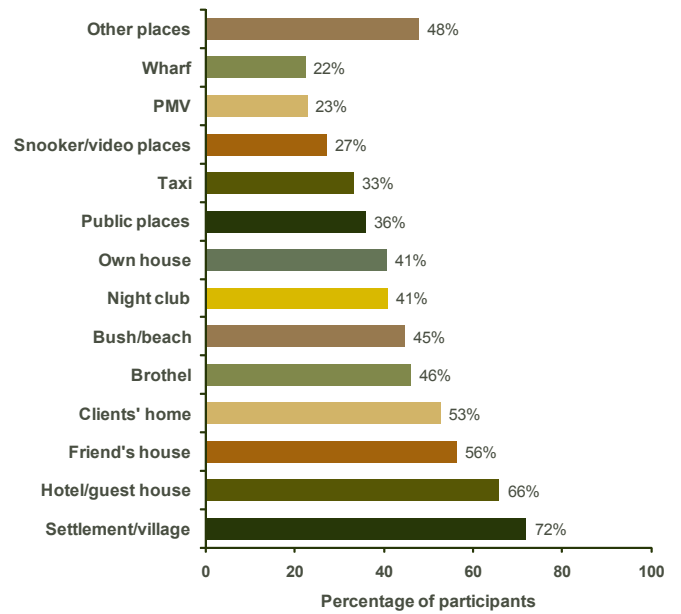
*“I go out with like managers, big shots and sometimes we look at landowners and all this and like the office people like the big boys. We see ourselves where they come and whatever, we already studied them. The big boys they have money and come, we already know.”*

**(AUTA, WOMAN)**

*“The payment is that some man when I have sex with them, two I have sex with, one I have sex with at the [Hotel name]. The other one I have sex with him at [Hotel name]; the two expatriates give me 250 Kina and like the Highlanders and the Centrals I have sex with, sometimes they pay me and sometimes they don't pay and the place that I reside, an old man wants to have sex with me, every time I go there he will say, come let's go and have sex. I just have sex with him only and I ask him and he pays me 10 Kina.”*

**(HETI, TRANSGENDER)**

The most common location where the participants identified selling or exchanging sex was in a settlement or a village (72%). Other common locations included in a hotel or guest house (66%), friend's or client's house (56% and 53% respectively). Almost half (48%) had sex work in 'other places' which were not specified by the participants. See **Figure 3.4**.



**Figure 3.4 Venues where sex work took place.**

**NB:** A participant may specify they have sold or exchanged sex at more than one venue.

*“When I used to have sex with the boys from my village I always carry condoms around because I don't want to get them infected. I always carry condom but it always comes to a stage when these boys are really tired of using condom.”*

**(MOKANE, TRANSGENDER)**

*“I just stay in the settlement and don't go around... We will chew betel nut and stand with them and then they will change their topic and say, “I want to have sex with you or come and eat my cock and I will pay you when you do it.”*

**(ALITA, TRANSGENDER)**

*“No, I don't go to the hotel. I don't even go to dances. I have never gone into a hotel...They take me to their houses or sometimes they come to my house and we sleep.”*

**(TIPEX, WOMAN)**

*"So we just stay and whoever man wants to come the owner of the house will say the women are inside already so you want to go to which room you can go...They will come, the men will come on their own choice open the room and he will go and sleep with which ever woman he wants. I stay in room 4 and my sister stays in room 5."*

**(NANCY, WOMAN)**

*"We go out with them to Taurama Barracks or we come to the Murray Barracks. With the police like we usually go stay at Waigani and take care of the police station"*

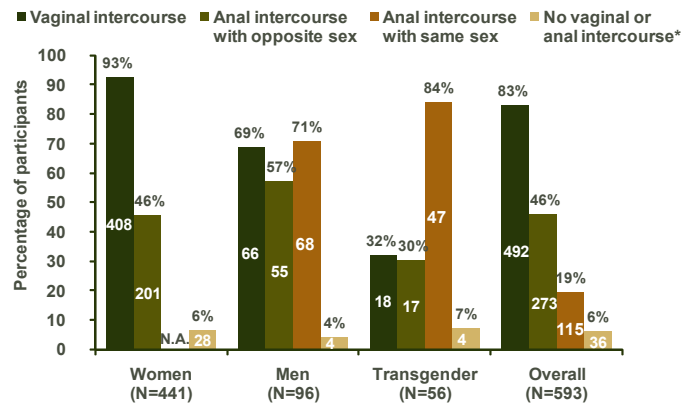
**(JUVANA, WOMAN)**

### 3.3. Vaginal and anal intercourse with clients

Vaginal intercourse remains the most common overall form of sex sold or exchanged (83%). Almost all women (93%) and slightly more than two-thirds of men (69%) reported having vaginal intercourse with a client of the opposite sex in the last six months. Relatively fewer transgender had vaginal intercourse with a client during the same time frame. See **Figure 3.5**.

Almost half (46%) the women reported that they had anal intercourse with their (opposite-sex) clients, while more than half (57%) the men reported having anal intercourse with opposite-sex clients in the last six months. Less than a third of transgender (30%) reported having opposite-sex anal intercourse with clients in the same time. The majority (84%) of transgender and 71% of male participants reported having had anal intercourse with same-sex clients in the last six months. While anal intercourse was common for each of the three gender groups for the overall sample, opposite-sex anal intercourse was more common than same-sex anal intercourse (46% versus 19%). See **Figure 3.5**.

\*Those participants with no vaginal or anal intercourse with clients reported either answered no or non-applicable to one or more of the three questions on whether they had vaginal or anal intercourse with clients in the last six months, some of whom only had oral sex with clients in the last six months.



**Figure 3.5 Vaginal and anal intercourse with clients in the last six months.**

**NB:** Actual number who had each type of sex with clients is given in each column and the percentage who had each type of sex with clients out of all participants of each gender is shown at the top of each column.

*"...Okay I can say that I prefer anal sex and oral sex as a transgender."*

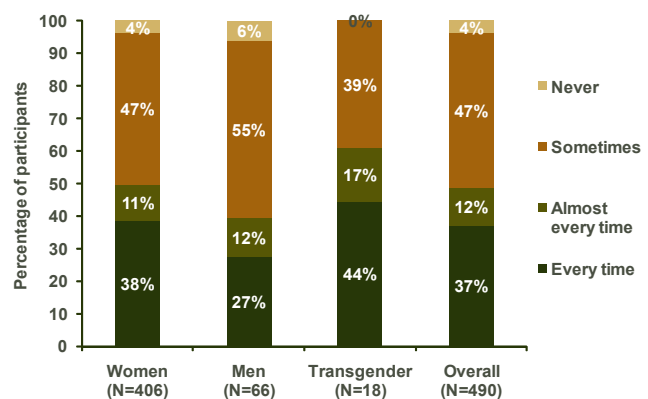
**(HEMONE, TRANSGENDER)**

*"When I have sex with them, I have sex in front and back only. They say to have it in the mouth but I say that the mouth is important as I eat food with my mouth and I won't use my mouth to do this kind of thing. They tell me that it's okay as they understand."*

**(GAGA, WOMAN)**

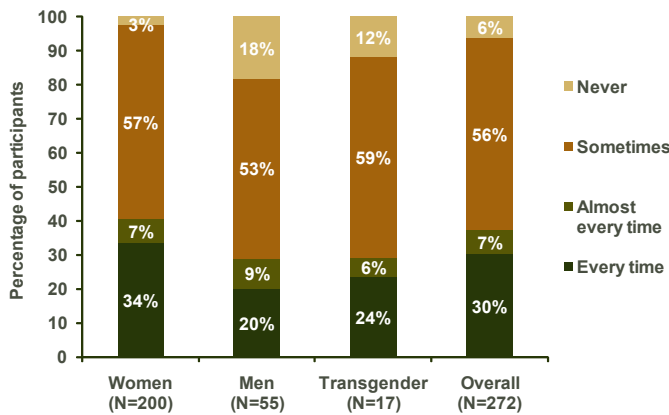
### 3.4. Condom use with clients

Thirty-seven percent (37%) of the sample used a condom every time during vaginal intercourse with their clients in the last six months. Transgender (44%) and women (38%) had higher rates of using a condom every time during vaginal intercourse than men (27%). See **Figure 3.6**.



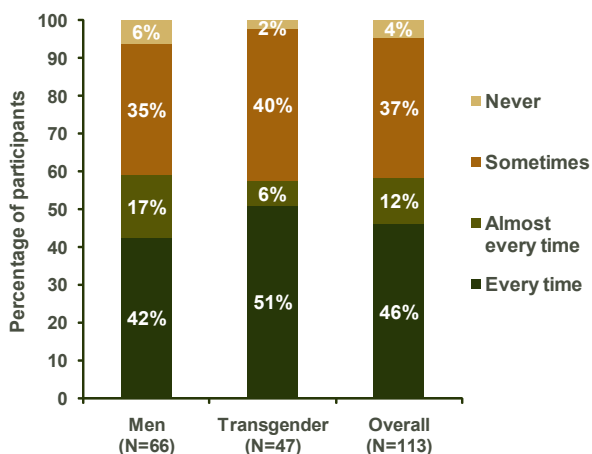
**Figure 3.6 Frequency of condom use during vaginal intercourse with clients in the last six months.**

Thirty percent (30%) of the sample used a condom every time during anal intercourse with opposite-sex clients in the last six months. Women (34%) had a higher rate than transgender (24%) and men (20%) of using a condom every time during anal intercourse with opposite-sex clients in the last six months. See **Figure 3.7**.



**Figure 3.7** Frequency of condom use during anal intercourse with opposite-sex clients in the last six months.

Forty-six percent (46%) of the sample (not including women) reported using a condom every time during anal intercourse with same-sex clients in the last six months. Transgender (51%) reported higher rates of using a condom every time during anal intercourse with a same-sex client in the last six months than men (42%). See **Figure 3.8**.



**Figure 3.8** Frequency of condom use during anal intercourse with same-sex clients in the last six months.

*“We will not tell him condom is here but just in our minds that there is a condom in the bag already.”*

**(JUVANA, WOMAN)**

*“When I say to use condom then they pay me 50 or 100 Kina and if they don’t want to use condom, I charge them bigger amount.”*

**(KULAME, TRANSGENDER)**

*“So when we have sex, I tell him that, how many rounds he wants, he has to prepare that many condoms to have sex with me.”*

**(GAGA, WOMAN)**

*“So when I go with a man, I tell them, before we do anything, we must negotiate. I give you the condoms, you give me the money and then later we will do whatever we came here to do.”*

**(TITO, WOMAN)**

*“I use condom both oral and anal, I do masturbation when there’s no condom...”*

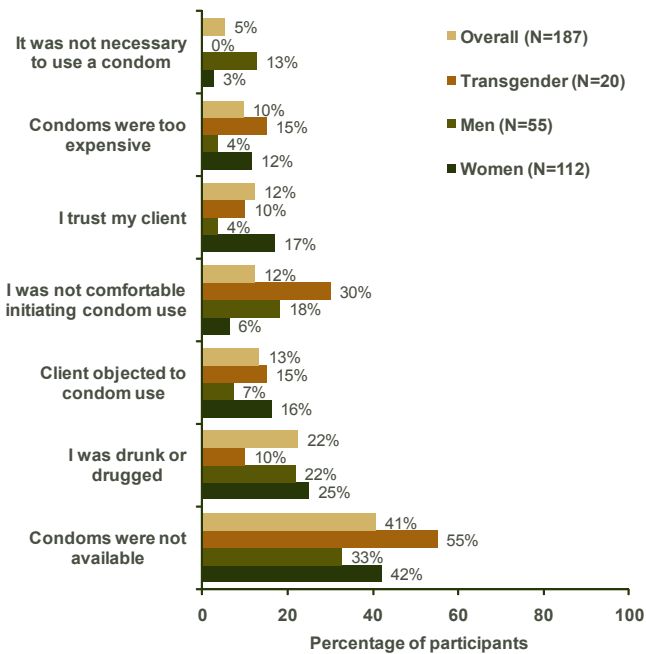
**(SEMUTO, TRANSGENDER)**

*“Yeah both oral and anal sex. I go through this. We have sex and they tell me to suck their penis, I suck it and when they say to have anal sex, I do it. I do oral and anal sex. So they give me money and I go home... Yeah once in a while they use condom. Sometimes yes and sometimes no condom.”*

**(KULAME, TRANSGENDER)**

With summing over all last occasions when a condom was not used across all types of sex with clients (total of 187 last sex occasions with clients when condom was not used), the two most common reasons reported by both men and women for not using a condom on the last sex occasion with a client were condoms not being available and being under the influence of drug/alcohol. The data on transgender not using a condom on the last sex occasion were too few to analyse reasons for not using a condom on the last sex occasion with a client. See **Figure 3.9**.

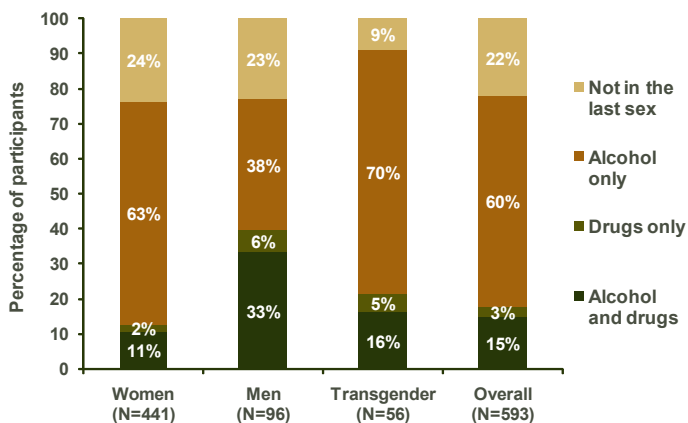




**Figure 3.9** Reasons for not using a condom on the last sex occasion with clients.

**NB:** There could be more than one reason for not using a condom at the last sex occasion.

Highlighting the overall importance of being under the influence of drugs and/or alcohol for not using a condom at the last sex occasion, the majority (78%) of all participants reported that they had sex with client(s) under the influence of alcohol and/or drugs at the last sex occasion with a client. Comparatively more transgender (91%) were under the influence of alcohol and/or drugs compared with women (76%) and men (77%) during the last sex occasion with a client. Relatively more men (39%) were under the influence of drugs (with or without alcohol) compared with women (13%) and transgender (21%). See **Figure 3.10**.



**Figure 3.10** Sex with clients under influence of alcohol and/or drugs during the last sex occasion.

*“That is because when we are really drunk we just have sex without the condom. When I’m not really drunk and have some sense in me, then I tell him to use condom. When I’m really drunk I just go without it.”*

**(NIGIE, WOMAN)**

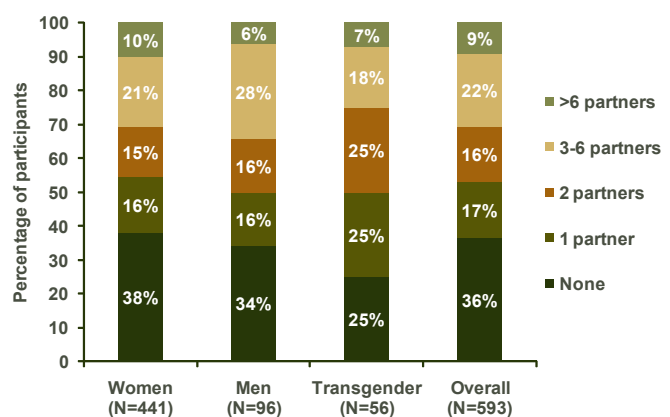
*“Yeah, I once had an experience getting drunk and having sex with my client without using condom. In the morning when I woke up I realised that he was sleeping naked and then the condoms that we were supposed to use was not open and it was on the table, from there I was cutting down on alcohol and I tried to change some of my ways.”*

**(SEMUTO, TRANSGENDER)**

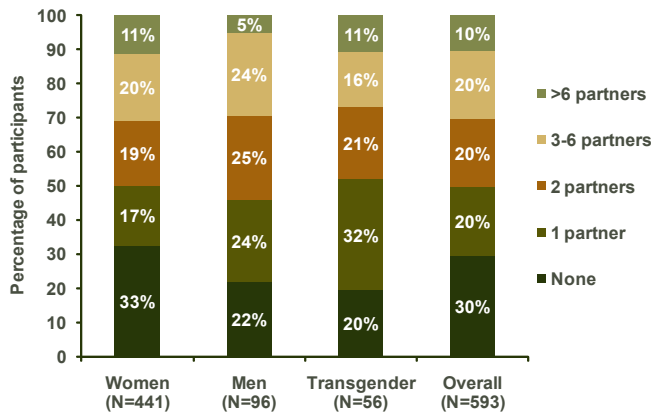
## 4. Sex with non-paying partners

### 4.1. Number of and type of sex with non-paying casual and regular partners

More than one-third (36%) of the participants had no casual non-paying sex partners, and slightly less than half of the overall sample (47%) had more than 1 casual partner in the last six months. See **Figure 4.1**. Twenty-nine percent (29%) of the participants had no regular non-paying partners, and a half of them (50%) had more than 1 regular partner in the same period. See **Figure 4.2**.



**Figure 4.1** Number of casual non-paying partners in the last six months.



**Figure 4.2** Number of regular non-paying partners in the last six months.

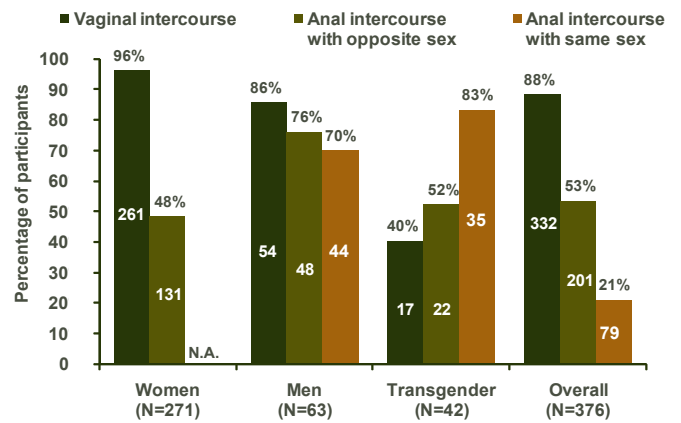
For the overall sample, vaginal intercourse was the most common type of sex with both casual and regular non-paying partner(s), with equal proportions reported having had this category of sex (88% each). While not as high as vaginal intercourse, more than half of the sample reported opposite-sex anal intercourse with casual (53%) and regular (58%) non-paying partner(s). See **Figures 4.3 & 4.4**.

Almost all women who had casual or regular non-paying sex partner(s) reported having had vaginal intercourse (96% and 98% respectively) with them in the last six months. Nearly half of women with casual (48%) non-paying partner(s) reported having had opposite-sex anal intercourse with them, while more than half with regular (56%) non-paying partner(s) reported having had opposite-sex anal intercourse with them. See **Figures 4.3 & 4.4**.

Men had consistently high rates of all three sex types across both casual and regular partners with no more than three percent difference for each type of sex by partner type. See **Figures 4.3 & 4.4**.

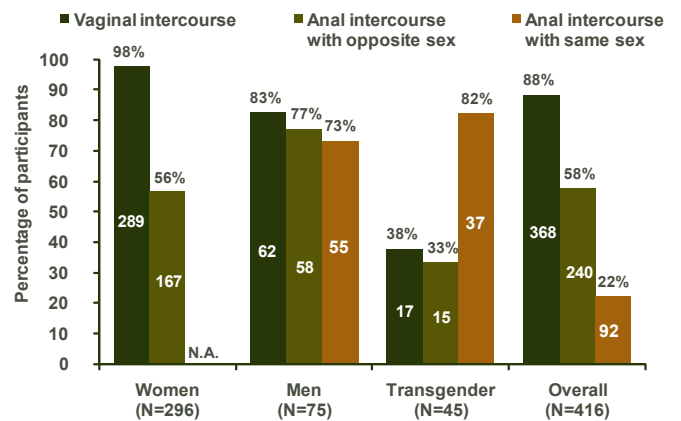
The majority of transgender participants (83% and 82% respectively) with casual or regular male non-paying partner(s) reported having had anal intercourse with them in the last six months. Transgender reported higher rates of opposite-sex anal intercourse with casual female partners (52%) than regular female partners (33%). See **Figures 4.3 & 4.4**.

**NB:** Actual number who had each type of sex with casual partner(s) is given in each column. The percentage out of all participants of each gender with casual partner(s) is shown at the top of each column.



**Figure 4.3** Vaginal and anal intercourse with casual partner in the last six months.

**NB:** Actual number who had each type of sex with regular partner(s) is given in each column and percentage of those who had each type of sex with regular partner(s) out of all participants of each gender with regular partner(s) is shown at the top of each column.



**Figure 4.4** Vaginal and anal intercourse with regular partner in the last six months.

#### 4.2. Condom use with non-paying casual partners

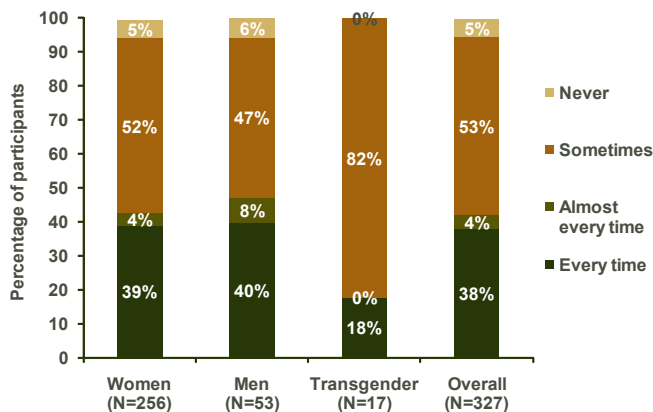
Condom use with casual non-paying partners was the lowest for anal intercourse with opposite-sex casual non-paying partner(s) with 31% (see overall column in **Figure 4.6**) reporting using a condom every time, compared with vaginal intercourse (38%; see overall column in **Figure 4.5**) and anal intercourse with same-sex non-paying partner (36%; see overall column in **Figure 4.7**).

Overall condom use was higher for clients than for casual non-paying partner(s) for anal intercourse with same-sex partner(s), but not for vaginal intercourse and anal intercourse with opposite-sex partner(s). By comparison, men reported higher rates of condom use with casual non-

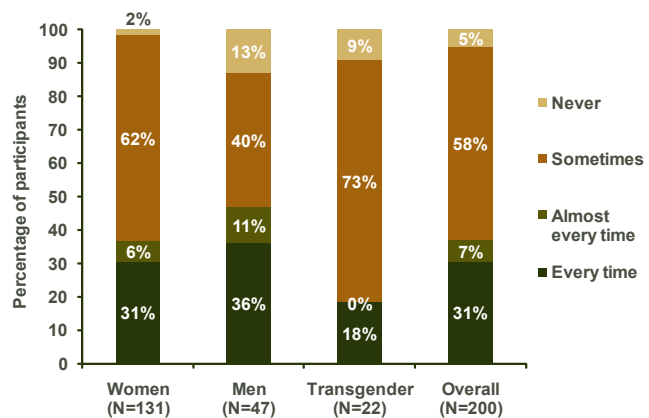


paying partner(s) during vaginal intercourse (40% versus 27%) and anal intercourse with opposite-sex partner(s) (36% versus 20%) than with clients for the same types of sex, while condom use for anal intercourse with same-sex partner(s) (42% versus 32%) was higher with clients than casual non-paying partner(s) of the opposite sex. Transgender reported higher condom use for all forms of sex with clients than casual non-paying partner(s) (vaginal – 44% versus 18%; anal intercourse with opposite-sex partner(s) 30% versus 18%; and anal intercourse with same-sex partner(s) 51% versus 41%).

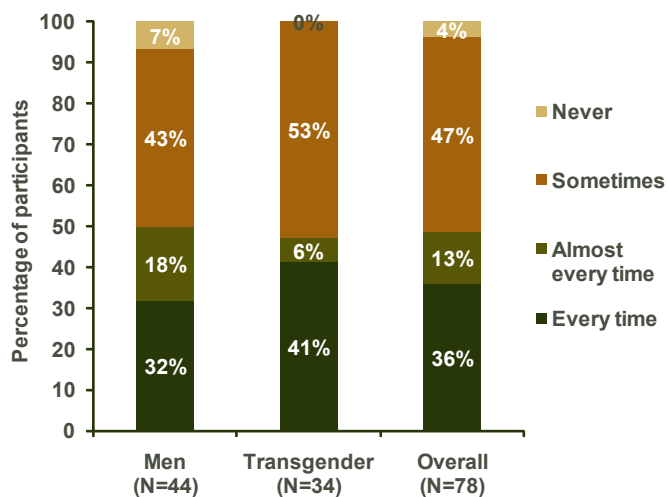
Proportionally more women reported using a condom every time for vaginal intercourse (39%; see **Figure 4.5**) with casual non-paying male partner(s) than for anal intercourse (31%; see **Figure 4.6**) with the casual partner(s). For men with casual non-paying partner(s), the proportion who reported using a condom every time was highest with vaginal intercourse (40%; see **Figure 4.5**), compared with anal intercourse with opposite-sex partners (36%; see **Figure 4.6**) and anal intercourse with same-sex partner(s) (32%; see **Figure 4.7**). Transgender reported highest frequency of always using a condom with casual non-paying partner(s) for anal intercourse with same-sex partner(s) (41%) compared to vaginal intercourse and anal intercourse with opposite-sex partner(s) (18% each). See **Figures 4.5, 4.6 & 4.7**.



**Figure 4.5** Frequency of condom use during vaginal intercourse with casual non-paying partner(s) in the last six months.



**Figure 4.6** Frequency of condom use during anal intercourse with opposite-sex casual non-paying partner(s) in the last six months.



**Figure 4.7** Frequency of condom use during anal intercourse with same-sex casual non-paying partner(s) in the last six months.

As with last sex with clients, a condom not being available (48%) was the most common reason across all gender groups with summing over all last sex occasions (regardless of type of sex) when condom was not used with a casual partner. Being under the influence of alcohol or drugs (20%), and partner objection (19%) were the next most common reasons for not using a condom on the last sex occasion with a casual partner. See **Figure 4.8**.

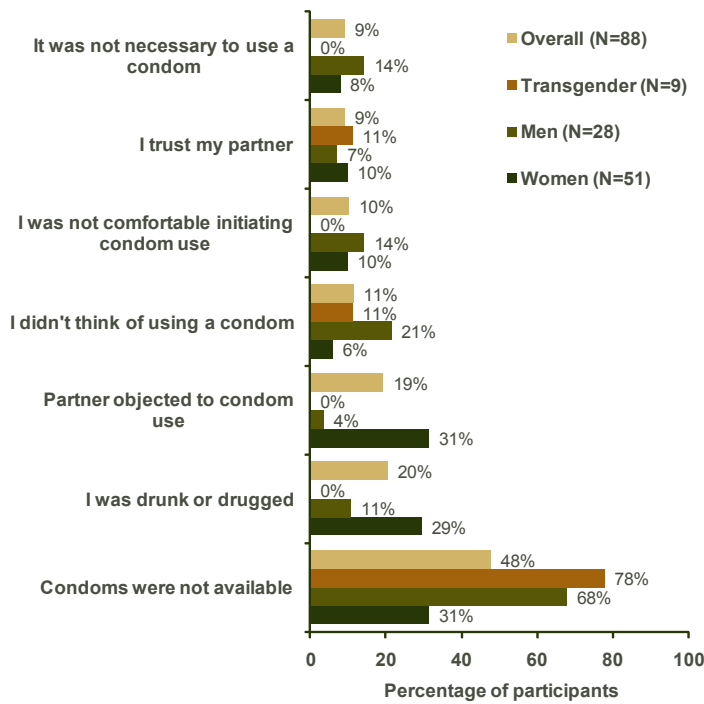


Figure 4.8 Reasons for not using a condom at the last sex occasion with a casual partner.

NB: There could be more than one reason for not using a condom at the last sex occasion.

### 4.3. Condom use with non-paying regular partners

The rates of condom use were relatively similar between the three genders and over the different types of sex with regular partners, which were between the range of 22% (for anal intercourse amongst women participants with their regular male partner(s)) and 33% (for anal intercourse amongst transgender participants with their regular same-sex partner(s)) for using a condom every time. See Figures 4.9, 4.10 & 4.11.

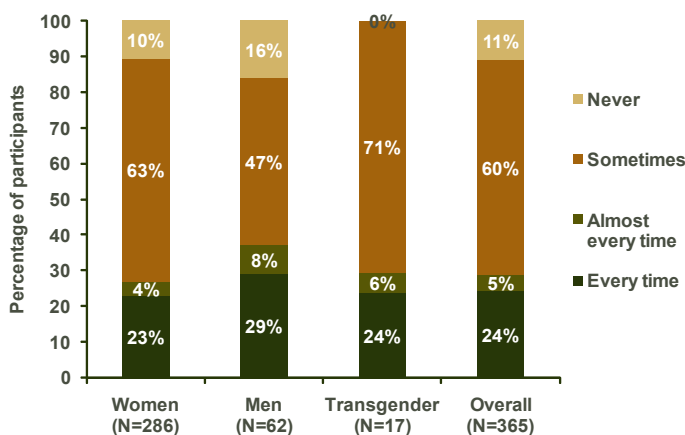


Figure 4.9 Frequency of condom use during vaginal intercourse with regular non-paying partner(s) in the last six months.

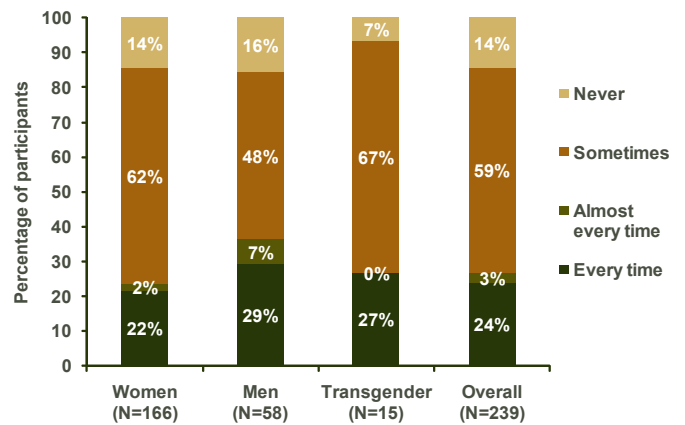


Figure 4.10 Frequency of condom use during anal intercourse with opposite-sex regular non-paying partner(s) in the last six months.

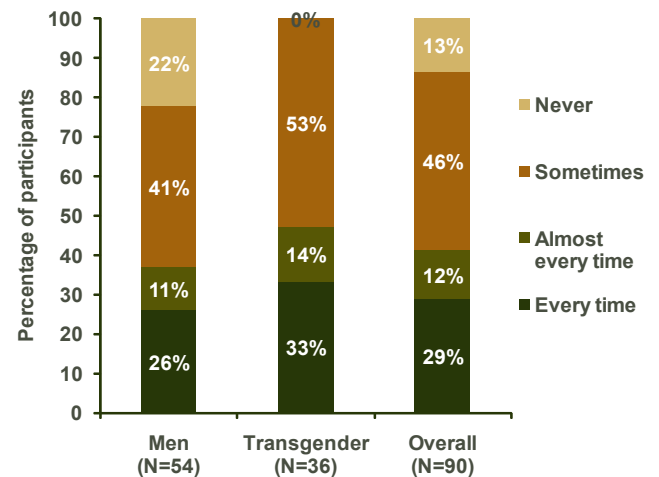
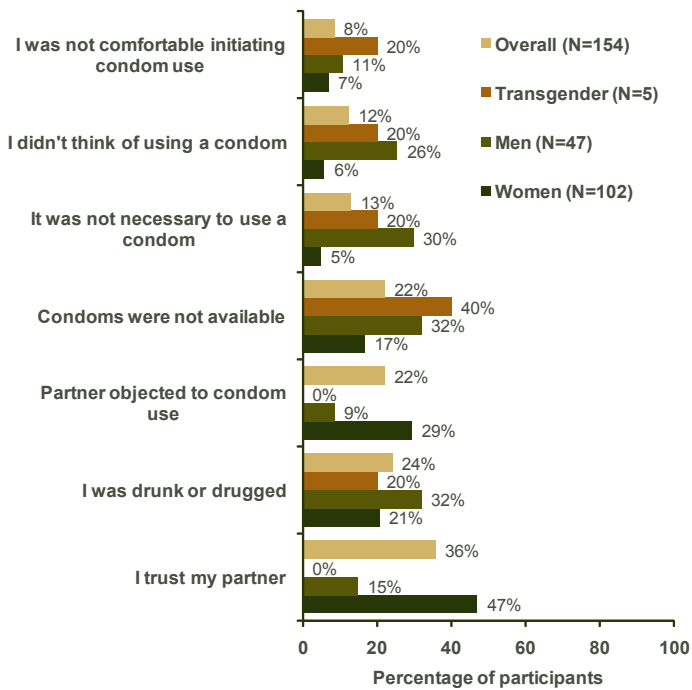


Figure 4.11 Frequency of condom use during anal intercourse with same-sex regular non-paying partner(s) in the last six months.

*"With my steady friends, sometimes I use it and sometimes I don't use it. That's what I do."*

(NIGIE, WOMAN)

With summing over the last occasions when condom was not used across all types of sex with regular partners (total of 154 last sex occasions with regular partners when condom was not used), trusting their regular partner (36%) was the most common reason for not using condoms. See Figure 4.12.



**Figure 4.12** Reasons for not using a condom at the last sex occasion with a regular partner.

**NB:** There could be more than one reason for not using a condom at the last sex occasion.

#### 4.4. Disclosure of selling or exchanging sex

Relatively fewer men had disclosed that they sold or exchanged sex to their regular partners, with 34% not disclosing to any of their regular partners, compared with 19% of women and 14% of transgender. Similarly, fewer men disclosed to their casual partners that they sold or exchanged sex, with 29% not disclosing to any of their casual partners, compared with 8% of women and 17% of transgender.

*“So I go out with other men and they give me money like 50 Kina. When I come back my husband asks me, I usually tell him, I went to my family and they gave me this thing. They felt sorry for me and gave me so I brought it for us to pay for food and eat.”*

**(ESNA, WOMAN)**

*“He never look after us, he does not have the thought of looking for jobs to take care of me and the three children so I told my eldest daughter, when you two go around with me don't tell your daddy about the behaviour that I do, your daddy never meets your needs and wants.”*

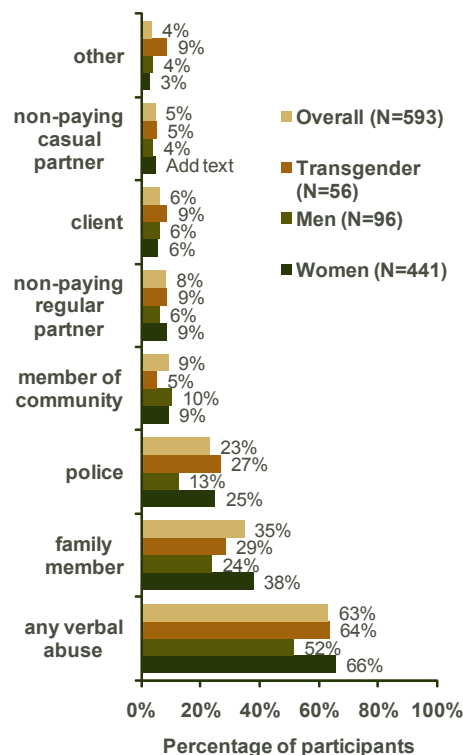
**(LUCITA, WOMAN)**

## 5. Targeted stigma, discrimination and violence

### 5.1. Physical abuse and forced sex in the last six months

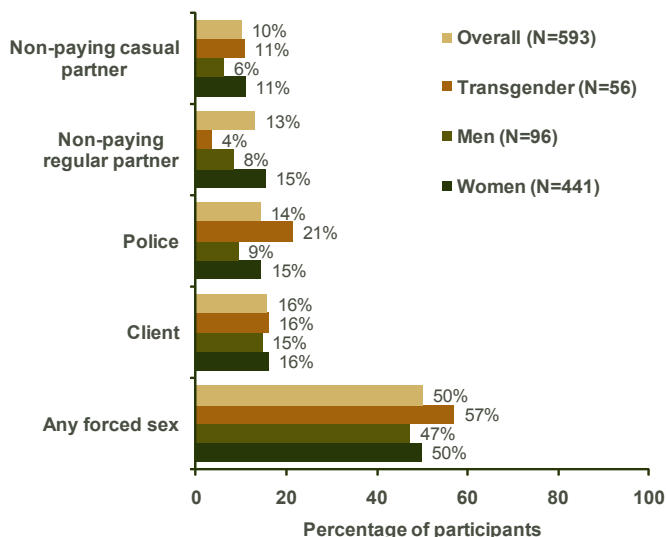
When participants were asked about any experience of physical abuse and forced sex as a result of selling or exchanging sex in the last six months, almost half (46%) reported physical abuse and half (50%) reported having been forced to have sex. Men experienced lower rates of both physical and sexual abuse compared with women and transgender.

Family members, followed by the police, were the two most common abusers in participants' experiences of physical abuse, while clients, followed by police, were the most common sexual abusers. Moreover, more transgender were forced to have sex by the police (21%), and physically abused by the police (21%) compared to women (15% for both physical abuse and forced sex) and men (both forms of abuse at 9%). Relatively more women (15%) were forced to have sex by their non-paying regular partners, compared with men (8%) and transgender (4%). See **Figures 5.1 & 5.2**.



**Figure 5.1** Experience of physical abuse and the person/people who abused in the last six months.

**NB:** Each participant who reported having experienced any physical abuse in the last six months specified the persons/people who abused them. They may have more than one type of people abusing them.



**Figure 5.2 Experience of forced sex (i.e. sexual abuse) and the person/people who abused in the last six months.**

**NB:** Each participant who reported having experienced any forced sex in the last six months then specified the person/people who abused them, and they may have more than one type of people abusing them.

*“Yeah this man ...I went around with, taxi driver, when he asks me [to have sex] and I say no, he beats me and pulls me and such. I just leave him. I tell him not to do that to me. I tell him that if he does that, I know his number and his taxi and I know where he stays. I will get the police and arrest you if you spoil my body. That’s what I tell him.”*

**(GAGA, WOMAN)**

*“They came and then broke into the house and then they dragged me out, they dragged me out and then pulled me right into the bush and then they raped me... I was bleeding all over and all sorts of cuts... we did not go to the police station, we were scared to go to the police station.”*

**(SEMUTO, TRANSGENDER)**

## 6. Access to health care services

### 6.1. Attendance at health care facility

Two-thirds of the participants had attended a health care facility in the past six months. Fewer men attended a health care facility (53%), compared with transgender (71%) and women (69%). See **Table 6.1**.

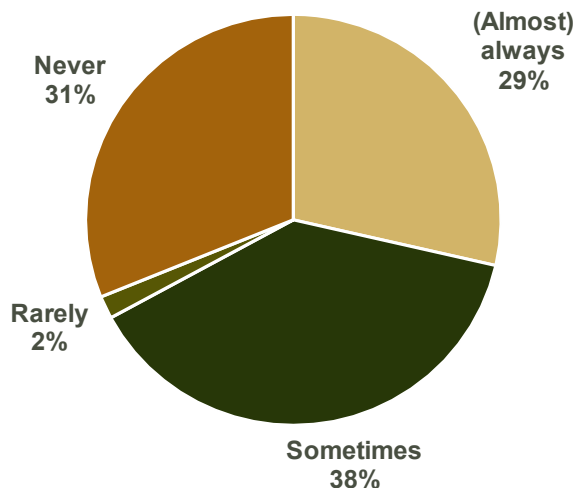
Of the 397 participants who attended a health care facility in the last six months, seeking a HIV antibody test (64%) was the most common reason. Attending to have an sexually transmitted infection (STI) test other than for HIV (13%), family planning (9%) and having a genital discharge (7%) were other reported reasons for accessing health care. Of the 28 women who presented for family planning, most sought the pill for contraception, followed by the termination of pregnancies.

**Table 6.1 Attended health care facility in the past 6 months**

	WOMEN		MEN		TRANSGENDER		OVERALL	
	No.	%	No.	%	No.	%	No.	%
Has not attended	135	31%	45	47%	16	29%	196	33%
Attended	306	69%	51	53%	40	71%	397	67%
<b>TOTAL</b>	<b>441</b>	<b>100%</b>	<b>96</b>	<b>100%</b>	<b>56</b>	<b>100%</b>	<b>593</b>	<b>100%</b>

## 6.2. Disclosure of sex work to health care staff

Roughly equal proportions of the participants who attended a health care facility in the last six months reported that they only sometimes (38%), never or rarely (33%) and almost always to always (29%) disclosed their involvement in the sex industry to the health care worker. See **Figure 6.1**.



**Figure 6.1** Frequency of disclosure of sex work to health care worker (N=392). Actual number and percentage of participants is shown.

Of the 274 participants who had disclosed their involvement in the sex industry to health care workers in the last six months, 43% identified that they were refused treatment after disclosure, 36% reported they were provided with condoms because of their work, 11% were provided with a comprehensive check-up following disclosure, with the same proportion (11%) encouraged to return for regular health check-ups. Although a rare experience, one in ten (10%) were told to stop selling or exchanging sex.

*“They [health care workers] did not get cross. They talked to me politely and gave this medicine. They said you must take good care of yourself and don’t again go out with men and all this.”*

**(SAFA, WOMAN)**

*“With the general hospital sometimes they don’t attend to me because of my sexuality and identity, they don’t really attend to me.”*

**(SEMUTO, TRANSGENDER)**

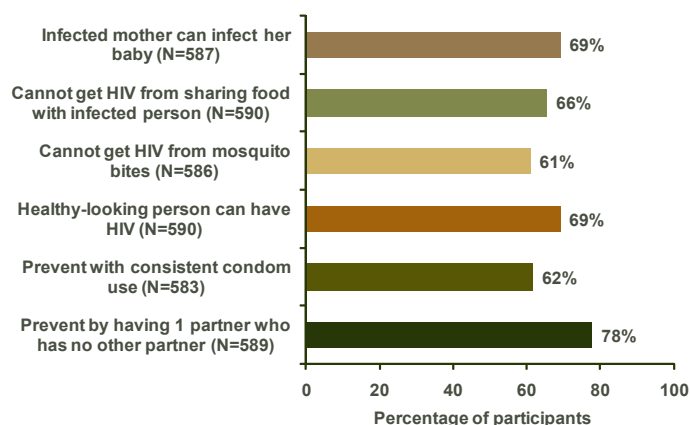
*“Yeah when I faced some of the challenges like sexual behavioural ups and downs I did overcome it by going to the clinic which personally I was checked by the doctor and like it’s kept confidential and he treats me on medication and he helps me about...”*

**(HEMONE, TRANSGENDER)**

## 7. Knowledge of HIV and access to sexual health promotion programs and services

### 7.1. Knowledge of HIV

The proportion who correctly answered each of the HIV knowledge questions ranged from 61% to 78%. That being faithful to one partner who has no other partners can prevent HIV scored the highest, with almost 80% answering correctly. The lowest level of knowledge was in relation to mosquitoes transmitting HIV, with less than two-thirds correctly answering this question. It appears that other misconceptions persist: 34% believed that HIV can be transmitted by sharing food with an HIV-positive person, while 31% believed that a pregnant woman could not infect her baby and/or foetus. A lower understanding persisted about when this prenatal transmission could occur: only 46%, 27% and 22% knew that this can occur during pregnancy, labour and breastfeeding, respectively. It appears that mistrust about condoms persists: 38% of the sample did not believe that consistent condom use can prevent HIV transmission. This is particularly relevant to addressing this community’s risk of HIV. See **Figure 7.1**.



**Figure 7.1** Correctly answered HIV knowledge questions.

*"If I don't use a condom, it will be easy for me to get the HIV/AIDS virus. If I use a condom I will avoid it."*

**(SAFA, WOMAN)**

*"AIDS is when a man is positive and he's sleeping with a woman and they exchange their fluids during sex like a man's semen enters the woman and the same to the woman, then the woman will be infected. And if a baby is formed then the baby will also be infected because he will feed from the mother's breast milk."*

**(LITU, WOMAN)**

*"We came to Poro Sapot. We came there so they gave us booklets so we sat under the wind house and they educate us there."*

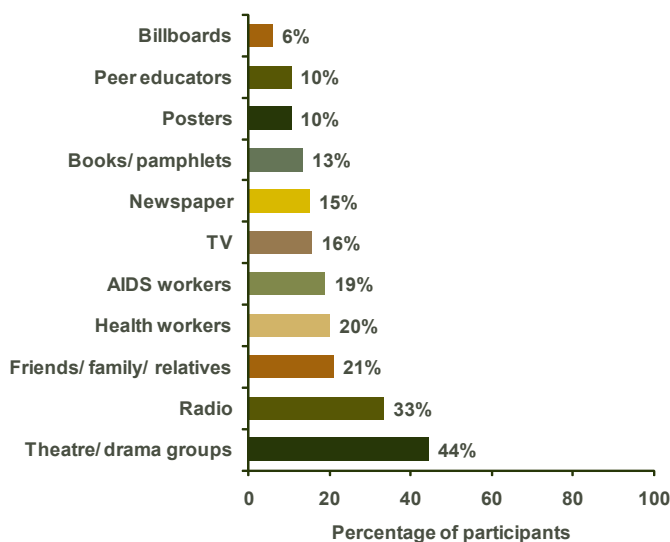
**(ESNA, WOMAN)**

*"I attended workshops with Poro Sapot project and with other NGOs and also I was been selected with some of the partners that we get along with, they elect us to go there...conduct workshop for us to go and attend especially for our sister girls, MSM, transgender in PNG."*

**(HEMONE, TRANSGENDER)**

## 7.2 Access to sexual health promotion programs and services

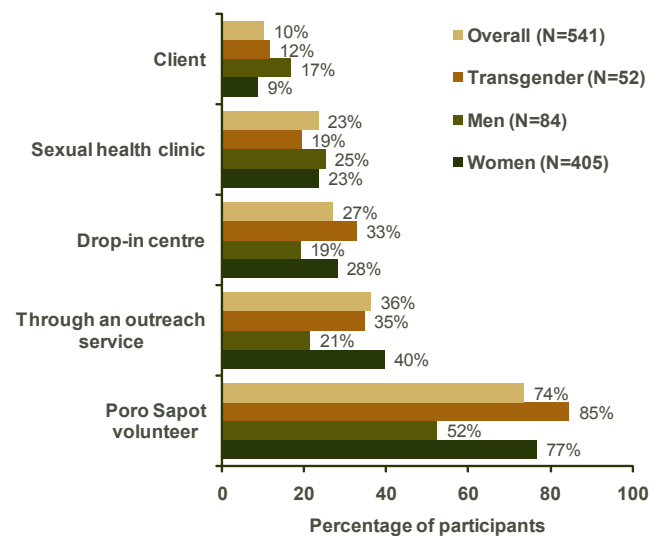
Close to half of the participants (44%) identified learning about HIV from a theatre/drama group, while a third (33%) had learned from the radio. Following theatre and radio, the next most common means by which participants learned about HIV was from family/friends/relatives (21%), health care workers (20%) and AIDS workers (19%). Of very limited reach in this sample appears to be the peer education (10%), billboards (6%) and posters (10%). See **Figure 7.2**.



**Figure 7.2 Source of information on HIV (n=593).**

**NB:** A participant can have more than one source of information.

Almost all participants (92%) had received free condom(s) in the last 12 months, with Poro Sapot peer support volunteers (74%) identified as the most common source of these condoms, followed by other outreach services (36%), drop-in centres (27%) and sexual health clinics (23%). Poro Sapot was by far the most important source of free condoms for transgender (85%) compared with women (77%) and men (52%).<sup>6</sup> See **Figure 7.3**.



**Figure 7.3 Sources of free condoms of those who had received one in the last 12 months.**

**NB:** A participant can have more than one source of free condoms.

When servicing clients, over three-quarters (78%) of the sample declared that they had supplied condoms and 54% reported that their clients supplied them.

<sup>6</sup> Although other NGOs and faith-based organisations (FBOs) distribute free condoms, the stakeholder group did not identify such organisations as an option to this question.



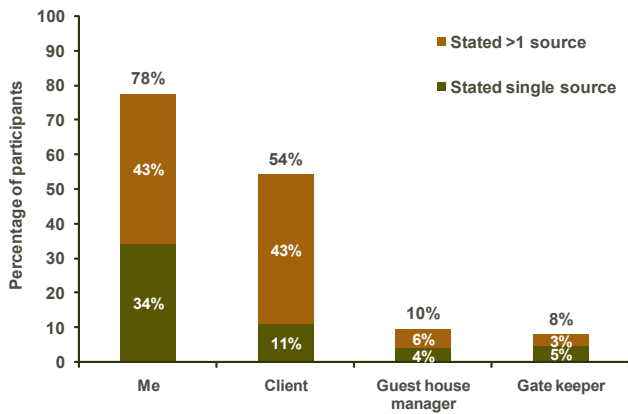


Figure 7.4 Supplier of condom (N=593).

NB: Percentages add up to more than 100% as a participant can have more than one supplier of condoms.

## 8. HIV and syphilis: Testing and prevalence

### 8.1. HIV testing

Seventy-two percent (72%) of participants knew where to go for HIV testing, and relatively more transgender (82%) knew where to go for HIV testing. Provider initiated counselling and testing (PICT) was reported by 49% of the sample, and STI clinics are the most common places for PICT (41%). See Figure 8.1.

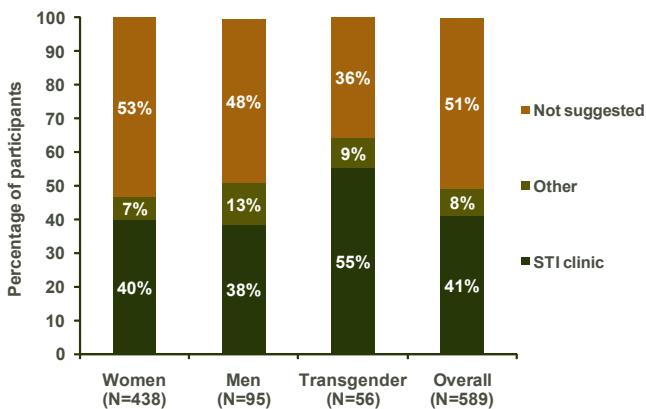


Figure 8.1 HIV test suggestion by a health care worker.

Excluding the 65 participants who self-reported as HIV-positive, equal proportions of the sample reported either that they had never tested (40%) or that they had tested in the last three months (40%). More men (46%) had never had an HIV test compared to women (34%) and transgender (30%). See Figure 8.2.

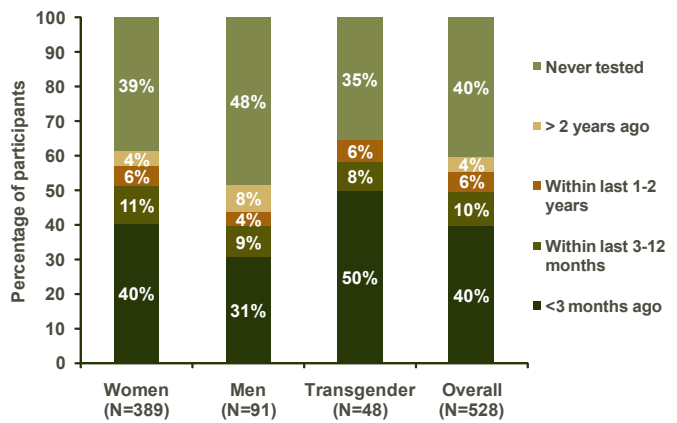


Figure 8.2 When was the most recent test.

*“Okay, currently when I came I got tested for HIV at Poro Support I joined them and got tested there and I don’t have it. Okay just last week I came because I really wanted to know my status again so I came back again so currently I’m on medication for STI.]”*

(MAKOPE, TRANSGENDER)

Of those 381 participants who had ever had a HIV test, 89% stated that the test was voluntary. Fifty-nine percent (59%) stated they had pre-test counselling only, 4% had post-test counselling only, 34% had both pre-test and post-test counselling while 3% received no counselling.

### 8.2. Estimated HIV and syphilis prevalence

The combined data from on-site testing of supplied blood and self-report from 416 participants were used to estimate HIV prevalence in the population. The unadjusted HIV prevalence was 17.8% in this sample. See Figure 8.3. The overall population estimate of prevalence that is adjusted for the RDS design is relatively similar at 16.9%.

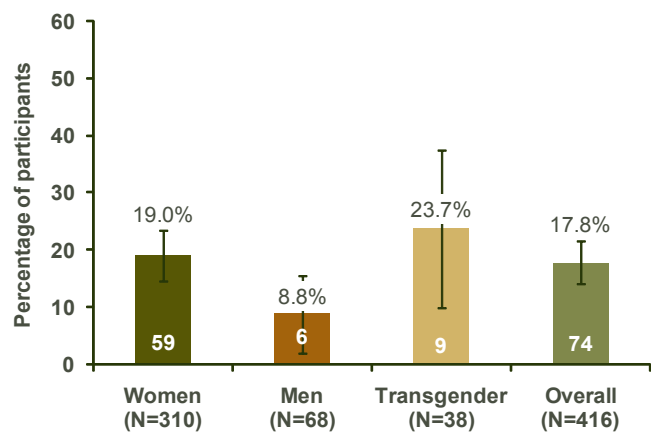
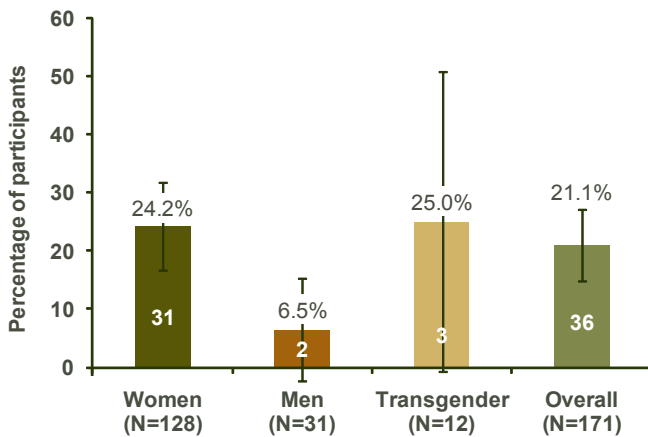


Figure 8.3 Estimated HIV prevalence from on-site testing of supplied blood and self-report.

NB: The error bars indicate the 95% confidence interval.

Data from testing of supplied blood gave an overall unadjusted prevalence of syphilis of 21.1%. See **Figure 8.4**. The RDS adjusted population estimate of prevalence is slightly higher at 23.4%.



**Figure 8.4** Estimated syphilis prevalence from on-site testing of supplied blood and self-report.

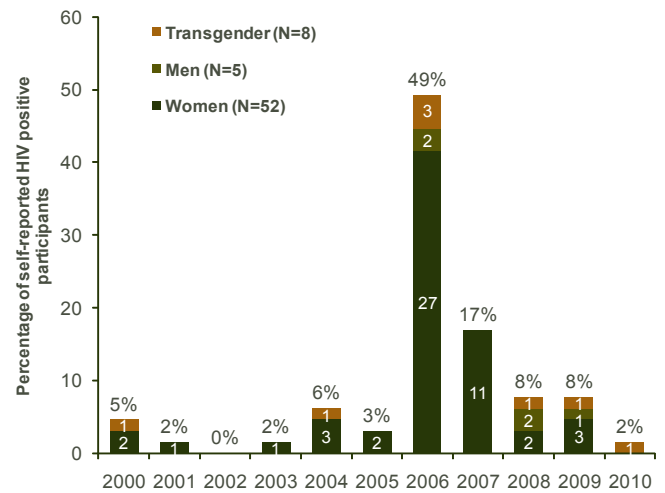
**NB:** The error bars indicate the 95% confidence interval.

## 9. Experience of living with HIV/AIDS

This section reports on the experiences of those in the sample who reported that they were living with HIV. Data for this section comprised the 65 participants who self-reported as being HIV-positive. This comprised 52 women, 5 men and 8 transgender participants.

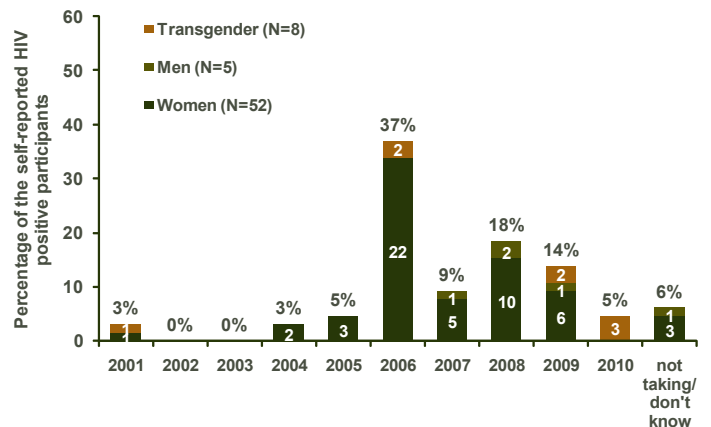
### 9.1. Year of HIV diagnosis and antiretroviral therapy (ART)

Approximately half (49%) of the 65 HIV-positive participants who self-reported were diagnosed in 2006.<sup>7</sup> See **Figure 9.1**. Almost all were on ART (94%), with the majority (78%) commencing treatment between 2006 and 2009. See **Figure 9.2**.



**Figure 9.1** Year of diagnosis of HIV (N=65).

**NB:** Actual number diagnosed for each gender in each year is given in the columns. The overall percentage diagnosed each year out of the 65 self-reported HIV-positive participants is shown at the top of each column.



**Figure 9.2** Year when participant started taking ART (N=65).

**NB:** Actual number that started ART for each gender in each year is given in the columns. The overall percentage that started ART each year out of the 65 self-reported HIV-positive participants is shown at the top of each column.

### 9.2. Access to and satisfaction with HIV health care services

The majority of the participants (92%) who self-reported as being HIV-positive accessed HIV health care services, with only four women and one man who did not. All but one of the participants who accessed these services found them to be helpful. The same woman who found the services unhelpful and two other men also reported that the HIV health care workers were not sensitive to the needs of a person who sells or exchanges sex. Overall, almost all found HIV health care services helpful for HIV-positive people who sell or exchange sex and as such sensitive to this population's needs.

<sup>7</sup> At the feedback session to the wider community in November 2010 it was suggested that this peak in diagnosis may be related to the opening of Save the Children in PNG's Poro Sapot Clinic in Port Moresby.

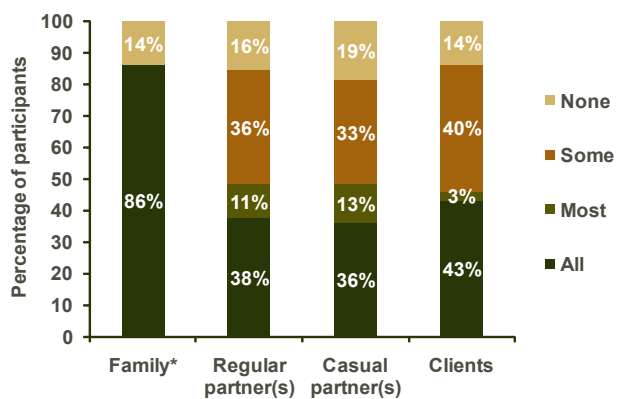


*"Monday I went straight to the clinic and... after they checked my CD4 it was okay they told me we are not going to put you on ART because your CD4 is still okay...and then the doctor advised me that I have to go for regular checkups to maintain my CD4."*

**(MOKANE, TRANSGENDER)**

### 9.3. Disclosure of HIV status

A very high proportion (86%) of those living with HIV had disclosed their status to their family members, while similar proportions reported having disclosed to all their regular (38%) and casual (36%) partners; slightly more said that they had disclosed to all of their clients (43%).



**Figure 9.3 Disclosure of HIV status to family, regular partner(s), casual partner(s) and clients (N=65).**

\*Participants responded yes or no (corresponding to all or none, respectively) to the question on whether they disclosed to their family.

*"...Apart from them like when I used to have sex with the boys from my village I always carry condoms around because I don't want to get them infected. I always carry condom but it always comes to a stage when these boys are really tired of using condom, they tell me themselves that they want skin to skin and then like when I stop them they always ask me if I have HIV and I always tell them well if I have HIV I don't want to infect you so you have to use a condom...Sometimes I tell them that I'm like this and most of them they tell me that they don't mind about me being HIV positive, they just want to, they always tell me that they just want to release themselves."*

**(MOKANE, TRANSGENDER)**

# RECOMMENDATIONS

## Sex under the influence of alcohol

Attention should be given to the role of alcohol in the selling and exchanging of sex, particularly as the ability to negotiate condom use is compromised under the influence of excess alcohol. One strategy to address this is to incorporate information on the risks of alcohol when selling or exchanging sex and into existing peer education workshops and in this way develop people's skills to separate work and drinking.

## Young sex workers

Even though only 10% of sex workers in this study started to sell or exchange sex at the age of 15 or under, this is an important subset of this community who are particularly vulnerable to HIV and requires increased attention in sex worker-related programs, policies and research.

## Safe working places

Because the majority of participants sold and exchanged sex in areas where lighting is limited, security is lacking and condoms not readily available, it is recommended that the repeal of criminal laws to provide greater protection for sex workers be prioritised.

## Anal sex

Low condom use for anal sex between men and women in this study is of concern, and greater attention needs to be urgently given to anal sex in all its forms, that is, not just men having anal sex with men but women, men and transgender having anal sex with opposite-sex clients/partners.

## Men

Attention must be given to gender (i.e. man or transgender) in policy, programs and research. Specific programs and policies should be developed in order to address men who sell or exchange sex. Although there are currently programs and policies that address female sex workers and MSM, none exist for men who sell sex irrespective of whether they sell or exchange sex with men and or women. Attention must also be given to transgender who sell or exchange sex with women. Men need to be trained to work as peer educators with other men. It is not appropriate for transgender peers to educate men.

## Clients

Landowners who receive royalty payments for resource use are the most frequent buyers of sex. Therefore HIV education should be a priority for these men. It is recommended that landowner organisations such as Mineral Resource Development Corporation work with National AIDS Council and sex worker organisations to bring this about with local landowner groups.

## Targeted physical and sexual abuse due to sex work

In order to address high rates of physical and sexual abuse, there needs to be the decriminalisation of sex work and the creation of safe workplaces.

- Current work with police sensitisation needs to be continued and expanded.
- Collective action by the community of people who sell or exchange sex is needed to resist targeted physical violence and forced sex.

## Sex workers who are not connected

Programs are required for people who sell or exchange sex who are not visible and not connected to NGOs and sex worker organisations. These programs should be designed and delivered in a way that respects their privacy.

## Basic HIV knowledge

Despite efforts to raise basic knowledge of HIV, more attention needs to be given to this area as overall knowledge was low. Particular attention needs to be given to addressing knowledge of people who sell or exchange sex that consistent condom use can prevent HIV.

## Condom distribution

Poro Sapot is seen as the leading distributor of free condoms and that support needs to be continued and scaled up. However, there needs to be an emphasis on free distribution in other venues such as clinics and guest houses. Condom-dispensing machines should be reinstated in villages and settlements (where the majority of people are selling or exchanging sex). It is also suggested that there is a need to lobby the government to increase distribution of free condoms in hotel bedrooms and guest houses.

## HIV information

Peer educators are poorly utilised as a source of HIV information, so the number of well-trained peer educators needs to increase. There is also the need to ensure that along with free condoms, peer educators disseminate accurate basic HIV knowledge.

## Attendance at health care facilities

In order to address the low level of attendance of men at health care facilities and HIV testing and the limited services available to them, health care facilities that best service these men should be expanded. This may include the expansion of well men's clinics.

## Knowing HIV status and its association with using condom every time

Safe HIV-testing facilities for people who sell or exchange sex continue to be needed and where possible expanded.

## ART sources

Access to ART for people who sell or exchange sex needs to be continued.

## HIV prevalence

Priority needs to be given to programs, policies and research which address the vulnerability to HIV of people who sell and exchange sex. This community continues to be at high risk of infection and it is urgent that its needs be addressed in a way that does not bring blame for PNG's epidemic.

## New research

Future research is needed into the selling and exchanging of sex by under-age persons, of HIV-positive sex workers and of men who sell sex.

## Sampela bikpela tingting bilong ol lain husat ol narapela i save baim ol long koap

### Pasin bilong koap long taim bilong spak

Yumi mas lukluk gut long pasin bilong spak long taim bilong baim koap long mani o long narapela samting. Planti taim tupela i no inap yusim gut kondom sapos wanpela o tupela yet i spak long taim bilong koap. Wanpela rot bilong stretim dispela em long taim bilong wokim sampela skultok long ol – olsem taim ol yet i skulim ol yet o sampela savelain i skulim ol, long dispela taim, ol i mas toktok tu long ol hevi em inap long kamap sapos ol i spak long taim bilong koap. I gutpela long halivim ol long save olsem i no gutpela long spak long taim bilong mekim dispela wok koap.

## Ol yangpela husat i save kisim mani long wok koap

Insait long dispela wok painimaut, wanpela namel long olgeta tenpela (10%) husat i save kisim mani long wok koap, i bin statim dispela wok taim ol i no winim pinis 15pela krismas. Yumi mas tingim tru dispela lain ol yangpela, bilong wanem HIV em inap tru long kalap long ol. Olsem na olgeta wok bilong lukluk long halivim o sapatim o skulim ol lain husat ol i kisim mani long wok koap, dispela wok i mas tingim tru ol yangpela husat i insait long dispela wok.

## Seif hap bilong wok

Dispela wok painimaut i soim olsem planti lain husat i mekim wok long kisim mani long wok koap, em ol i save mekim wok long ples tudak, na nogat sekuriti na tu nogat ples bilong kisim kondom. Olsem na mipela tok strong long gavmen i mas hariap na stretim lo long tok orait long haus bilong dispela wok i ken i stap.

## Kuap long as

Dispela wok painimaut i luksave olsem planti man na meri husat i save koap long as, ol i no save yusim kondom. Mipela i wari tru long dispela na bilip olsem i mas i gat bikpela program na skultok long givim skul olsem olgeta kain rot bilong koap long as (man koapim as bilong meri o man koapim as bilong man) em inap tru long kamapim hevi olsem sik STI na HIV sapos ol i no yusim kondom olgeta taim.

## Ol man

Nau yet yumi save skelim pasin man i mekim (man i koap wantaim man o man i koap wantaim meri). Mobeta yumi senisim dispela tingting na lukluk long wei ol man i save tingim ol yet – olsem ol yet i pilim olsem ol yet i man – o ol i pilim olsem bodi bilong ol i man tasol tingting na bilip em i olsem meri (transgender). Yumi mas kirapim wok long halivim na sapatim ol man husat i mekim wok long kisim mani o narapela samting long wok koap. Dispela i mas kamap bilong halivim ol man husat i save koap wantaim meri na ol man husat i save koap wantaim man, na man husat i save koap wantaim man na meri tu. I gutpela long ol man husat i save tingim ol yet i man – em ol i mas skulim ol arapela man, na man husat i save tingim em yet i meri (transgender) ol yet mas skulim ol arapela i wankain ol.

## Ol lain husat i save baim koap long narapela

Wok painimaut i soim olsem ol papagraun, em ol nambawan lain bilong baim koap. Olsem na em i bikpela samting tru long skulim ol dispela lain papagraun, long ol samting bilong HIV. Mipela i bilip strong long ol lain husat i save bungim ol lain papagraun (olsem MRDC) – ol i mas wok wantiam NACS na ol lain husat i save mekim wok

long kisim mani long wok koap, bilong kirapim dispela kain program na skul long ol LLG.

### **Pasin bilong bagarapim narapela bilong wanem, em i save mekim wok long kisim mani long wok koap**

Planti lain husat i save mekim wok long kisim mani long wok koap, em ol i save painim bikpela hevi long ol narapela i save bagarapim ol o paitim ol o koapim ol nating. Bilong stretim dispela hevi na tambuim i no ken kamap moa, gavmen i mas rausim dispela lo i tambuim wok bilong kisim pei long koap, na tu i mas i gat gupela ples bilong wok, we ol bai i no inap painim bagarap.

- Wok wantaim polis bilong senisim tingting na pasin bilong ol i mas stap yet na mas kamap bikpela.
- Ol lain manmeri husat i save mekim wok long kisim mani long wok koap, em ol yet i mas wok bung bilong strongim ol yet na painim wei bilong banisim ol yet long noken painim bagarap olsem ol arapela i paitim ol o koapim ol taim ol i no laik.

### **Ol lain husat i save mekim wok long kisim mani long wok koap, tasol ol i no save bung wantaim ol arapela husat i mekim wankain wok**

I mas i gat program o halivim bilong ol lain husat i save mekim wok long kisim mani long wok koap tasol ol i stap ples hait na ol i no save bung wantaim ol arapela husat i mekim wankain wok o ol NGO bilong helpim ol. Taim dispela kain sapot wok i kirap – noken kamapim ol long ples klia. Sapos sampela i laik stap ples hait – yumi mas bihainim laik bilong ol yet.

### **Kisim save long HIV**

I bin i gat sampela skul wok long givim save long HIV, tasol dispela wok painimaut i soim olsem planti lain ol i gat liklik save tru na i no inap helivim ol long abrusim HIV. I mas i gat moa skul long ol lain husat i save mekim wok long kisim mani long wok koap, bilong helpim ol long abrusim STI na HIV. Ol i mas klia tru olsem ol i mas yusim kondom olgeta taim bilong abrusim HIV.

### **Wei bilong skelim kondom long olgeta**

Wok painimaut i soim olsem Poro Sapot em i nambawan lain tru bilong skelim kondom long ol. Dispela ol kondom i no bilong baim – em bilong kisim nating. Dispela pasin bilong Poro Sapot i mas go het yet na i mas go bikpela. I mas i gat wei bilong kisim kondom long ol klinik na haus pasindia na hotel nabaut. Na tu ol i mas putim gen ol dispela masin bilong skelim kondom long ol ples we ol manmeri i save mekim wok long kisim mani o narapela samting long wok koap, olsem long viles o setelmen.

### **Ol toktok bilong HIV**

Wok painimaut i soim olsem pasin bilong kisim gupela save long ol narapela wanwok nabaut, em i gupela tasol namba bilong ol wanwok husat em yet i save gut na ken skulim narapela, em i sot. Em bai i gupela tru long skulim gut planti lain moa, husat ol inap skulim gen ol wanwok na poro. Dispela lain i ken skelim kondom long ol wanwok, tasol tu, ol yet mas i gat gupela na strepela save, bai ol inap givim gupela na strepela save bilong HIV long narapela.

### **Ol lain husat i save kamap long ol klinik nabaut**

Wok painimaut i soim klia stret – planti man i no save go kamap long ol klinik nabaut bilong lukim wokman bilong helt na painimaut sapos ol i gat sik, o bilong kisim save long rot bilong lukautim ol yet. Bilong stretim dispela, i mas i gat planti ol nupela klinik bilong ol man yet, bai ol man inap pilim orait long go kamap long klinik. Dispela ol klinik i mas bilong man tasol na ol woklain bilong klinik tu i mas man tasol.

### **Sapos ol i save olsem ol i gat HIV pinis o nogat, dispela mas strongim tingting long yusim kondom olgeta taim.**

I mas i gat ol gupela ples bilong sekim blut long HIV – i mas i gat planti bilong ol dispela ples bilong ol lain husat i save mekim wok long kisim mani long wok koap. Ol mas inap i go i kam long ol dispela hap long laik bilong ol yet.

### **Ples bilong kisim ART**

Ol lain husat i save mekim wok long kisim mani o narapela samting long wok koap, ol i mas i gat gupela rot long kisim ART, sapos ol i painim HIV pinis.

### **Namba bilong ol lain husat i kisim pinis HIV**

Ol lain husat i save mekim wok long kisim mani o narapela samting long wok koap, em HIV i save painim ol isi tru. I mas i gat ol program na halivim na moa wok painimaut wei em i luksave long wei bilong halivim ol. Tasol taim dispela wok i kirap, yumi mas lukluk gut long yumi i no sutim tok long ol, olsem ol yet i as bilong HIV i kirap bikpela long PNG.

### **Nupela wok painimaut**

Taim bilong wokim sampela nupela wok painimaut gen, ol i mas lukluk gut long:

- ol lain yangpela tru husat i save mekim wok long kisim mani o narapela samting long wok koap
- ol lain husat i gat HIV na tu ol i mekim wok long kisim mani o narapela samting long wok koap
- ol man husat i save mekim wok long kisim mani o narapela samting long wok koap

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