Sex work and HIV/STI prevention in the Pacific region, including analysis of the needs of, and lessons learnt from, programs in four selected countries

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Sex work and HIV/STI prevention in the Pacific region, including analysis of the needs of, and lessons learnt from, programs in four selected countries

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This report is based on a review of the literature on sex work in the Pacific and of the international literature on sex work and HIV prevention, key informant interviews with past and current HIV/STI Section staff and HIV/STI/ Sexual Reproductive Health Advisors in regional agencies including UNFPA Pacific and UNAIDS Pacific, with local stakeholders, service providers and program implementers in Fiji, Vanuatu, Kiribati and Chuuk State (Federated States of Micronesia). Commissioned by the Secretariat of the Pacific Community (SPC), Public Health Division, the report is intended as a resource document to inform the development of effective HIV and STI prevention programming for sex workers in the Pacific region.

For the purposes of this report, 'sex worker' is very broadly defined and refers to those who, consensually, sell or exchange sex for cash or for any other goods and services, and includes those who do not identify themselves sex workers.

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The views expressed in this document are those of the author, and do not necessarily represent the views of the Secretariat of the Pacific Community or the Pacific Islands HIV and STI Response Fund.

Contents

Executive summary

International and Pacific experience has shown that:

- access to condom and lubricant, accurate risk reduction information and STI/HIV testing and treatment services are the most basic components of HIV/STI prevention programs for sex workers;
- an enabling environment fostered through public and service provider attitudes, policing and the operation of the justice system, policy and the law, is essential to uptake of core HIV/STI prevention;
- peer educator involvement is a key element of HIV prevention programs for sex workers;
- ongoing investment in peer educators is critical to ensure that skills are adequate and messages are up to date and accurate. Peer educators also need training in a range of other skills such as problem-solving;
- outreach is a crucial element of service delivery. Condoms and lubricant need to be available on the streets and in bars and other sites where sex work occurs;
- HIV/STI testing services are less stigmatising and more attractive when they are provided as part of a package with other health and/or welfare services;
- HIV/STI prevention services for sex workers must be confidential and safe, as well as free;
- sex worker organisations and networks will mobilise around HIV/STI prevention activities if they are supported to do so;
- sex worker organisations are key to a community empowerment approach, which has proven to be central to effective HIV/STI prevention, internationally; and
- the sustainability of HIV prevention programs for sex workers are underwritten by the capacity of, and resources available to, the implementing organisations.

However,

- in the Pacific, sex work takes a range of forms, and the conditions under which it is undertaken vary significantly between PICTs, and sometimes even within a country (e.g. Papua New Guinea);
- in some PICTs sex workers will typically not be prepared to collectivise, or to publically identify as a sex worker;
- not all of those who sell sex in the Pacific identify as a sex worker, even when it is their only source of income;
- motivations and major concerns are often different for transgender sex workers than they are for women sex workers, and the nature of dominant concerns often also differs between ethnicities. Transgender sex workers are more concerned with stigma and discrimination, and female sex workers are more concerned with being able to safely earn an adequate income. While violence and abuse is a risk for both women and transgender, women appear to be more vulnerable to violence from family than from clients. Nothing is known about male sex work in PICTs; and
- reliable research is necessary to debunk any myths about who is involved in sex work, and the conditions under which it occurs, in order that responses can be based on evidence rather than prejudice and conjecture.

Some wider issues are common to all PICTs.

- Christianity exerts a powerful authority in all PICTs. This means that, in the case of sex work, many policy makers perceive public health imperatives to be in conflict with public notions of morality.
- PICTs are small societies; the leadership of individuals and those who champion the need for services for, and rights of, sex workers is crucial. Effective champions might come from outside the community of sex workers as well as from inside.

- PICTs are, to varying degrees, low resource countries with struggling health and welfare infrastructures. Local resources must be taken into account when designing and costing programs, so that implementation is sustainable.
- Funder policy and service provider organisation decisions are often made in response to international, rather than local, agendas.

The most immediate and pressing needs for HIV/STI prevention for sex workers in the Pacific region are for the regular and reliable provision of the most basic HIV/STI prevention services. Steps must be taken to ensure that core services are sustained and ongoing. Fiji has a substantive history of HIV/STI prevention activities for sex workers. Yet the gaps in provision of basic prevention resources are growing. Core HIV/STI prevention service provision must be ongoing; ensuring provision of these services will have little lasting impact as a 'one-off' project, or as a first step to be followed by alternate income generation/retraining or other efforts to divert people from sex work.

Similarly, while increasing capacity for advocacy is an essential long-term strategy, it cannot address immediate needs. The findings of this report show that the following needs are current and immediate:

- more extensive, regular and reliable condom/personal lubricant and information outreach services;
- accurate information about, and access to, safe, non-judgemental and confidential sexual health services; and
- investment in, and ongoing training and support for, peer educators.

There is also a need to include sex workers in processes of decision making and problem solving at a range of levels: from program design and implementation, to public policy and legal debates affecting sex work.

Structural factors creating vulnerability must also be broached, and this requires a long-term program of interventions and the enlistment of a range of local agents in order to confront stigma and discrimination against sex workers, prevent abuse and violence against sex workers, and promote an enabling environment for HIV prevention activities.

1. Context and characteristics of sex work in the region: a review of the literature

Pacific Island countries and territories (PICTs) are diverse; political regimes, cultural norms and languages vary widely. The forms of sex work undertaken across the Pacific are as diverse as the social, economic and political contexts in which they are situated. Reliable information on sex work in PICTs is fragmented and incomplete. However, characteristic forms of sex work include: paid sex with seafarers, women boarding boats, and the provision of sex to affluent locals, tourists, business travellers or migrant workers. Sex work typically occurs around ports and transit hubs, in development or construction enclaves and near military installations. Most sex work is informally organised and sex workers operate independently, although in Guam and Palau sex work is managed from within other entertainment establishments. Significant levels of sex work have been documented in Port Moresby, Honiara, Suva, Guam and Saipan (Connell and Negin 2010:30), but various forms of sex work take place throughout the region. Seafarers have reported that sex workers were easily available in Fiji, French Polynesia, Guam, Nauru, New Caledonia, Papua New Guinea, Samoa, and Tonga (Peteru 2002).

Sex work in PICTs is largely driven by economic need, but boredom, lack of opportunity and a limited long-term outlook, alienation and marginalisation are also factors (McMillan and Worth 2010a & b; Sladden and Vulavou 2008; UNICEF 2010; Toatu 2007). Along with financial support, engagement in sex work may also supply a sense of community, a means of distraction and escape (McMillan and Worth 2010a & b; Sladden and Vulavou 2008). Sex work is often coupled with alcohol or other intoxicants, heightening the risks of unsafe sex. Other documented motivations for sex work include a desire for independence or an expression of resistance and revenge (Wardlow 2002; McMillan and Worth 2010b & 2011).

Sex work undertaken in Pacific countries is mostly independent, with workers arranging their own business. However, in a few PICTs – mainly US affiliated –sex work is more organised and based in karaoke bars, massage parlours and strip clubs, some of which provide for sex on the premises or arrange for escort services. A significant amount of informal, casual or opportunistic sex work also takes place across the Pacific. Sex exchanged for food, transport or other resources, though less visible, is assumed to be more widespread than sex for cash (Commission on AIDS in the Pacific 2009). In some countries, women engaged in paid sex do not necessarily identify themselves as sex workers, even when they support themselves and their children by selling sex (Commission on AIDS in the Pacific 2009; McMillan and Worth 2011; Chuuk Resource Centre 2011).

There are reports of a growing presence of migrant, mainly Asian, sex workers, but there is no specific behavioural or other data on Chinese and other Asian sex workers in the Pacific (Connell and Negrin 2010). Chinese and Koreans have been brought in by Asian businesses to work from clubs in Majuro (Jenkins 2005), and the migration of sex workers is said to be of some significance in Northern Marianas and Marshall Islands (Connell and Negin 2010). Asian sex workers are heavily stigmatised and subject to discriminatory attitudes from both officials and the wider local community. Migrant sex workers are at a particular disadvantage compared to local sex workers, as their access to services is restricted by their illegal migration status and language barriers, and other constraints may arise from conditions of employment (Cwikel et al. 2006; Hansen, McMillan and Worth 2012).

According to anecdotal evidence, the number of people engaging in sex work is increasing across the Pacific. Structural drivers of sex work in the region include pressures of unemployment, unequal distribution of resources, forces of development, and the transition to consumerist monetarist societies, along with the effects of integration into and reliance on a global economy. The continuance of these economic factors, along with the social and cultural underpinnings of gendered inequalities, will ensure that sex work continues to be undertaken

by many as a means of participating in an increasingly consumption-oriented social life, creating opportunity, or simply putting food on the table.

In many PICTs, official and public discourses on sex work focus on migrant sex work, and demonise an immigrant Asian community in particular. This approach tends to elide sex work as sex trafficking, disavowing the engagement of local woman in sex work and also diverting attention from important local drivers and issues.

Prevention is a cornerstone of the Pacific response to HIV and sex workers are a target group. The predominant means of reported HIV transmission in the Pacific is unprotected sex (Commission on AIDS in the Pacific 2009:2). Hopes for 'treatment as prevention' are unrealistic in a region with limited capacity for ART coverage. To be effective, HIV and STI prevention must ensure that primary prevention activities are ongoing in the Pacific and, as there is little injecting drug use in most PICTs, access to and use of condoms and lubricant are core elements of prevention. Programs aimed at increasing the use of condoms and lubricant during paid sex will be crucial to HIV prevention efforts in the Pacific. These programs, and the behaviours promoted therein, must also be supported through the generation of an enabling environment for HIV prevention.

1.1 Sex work in Fiji

The Melanesian Republic of Fiji is a transit and economic hub in the Pacific. Despite new repressive anti-prostitution and anti-trafficking laws and recent crackdowns on sex work, local sex workers operate in all the main centres. There is also a significant number of transient migrant sex workers in Suva (McMillan and Worth 2011a; Windybank 2008) about whom very little is known.

In Fiji, sex work is predominantly the domain of female and male-to-female transgender, although a small number of male sex workers have also been reported. Ethnic Fijian (I-Taukei) sex workers are better networked and more easily accessible through outreach and other services than are Indo-Fijian sex workers (McMillan and Worth 2011a). Similarly, transgender sex workers are more publically visible and prominent in sex worker organisations than are female sex workers.

Migrant Chinese sex workers are based in Suva, and tend to arrive on non-work visas. They may arrive in groups with travel and visa organised by a tour company, but they work independently and make their own arrangements with clients. While migrant Chinese sex workers in Suva form a distinct community of their own – working from the same clubs, servicing a specific clientele (Asian seafarers and business men) and often sharing accommodation – these workers seldom speak more than rudimentary English and no Fijian, are not engaged in local networks, nor do they access local HIV and STI prevention resources.

Two key studies of sex work in Fiji, one qualitative and one quantitative (UNAIDS forthcoming) concur over the following findings.

- Around half of all sex workers in Fiji are in their twenties, but may be up to 50 years of age.
- The majority of sex workers take up sex work before they are 20 years old, but few start before the age of 16.
- Transgender sex workers start at a younger age, and Indo-Fijian women take up sex work at an older age.
- Indo-Fijian and female sex workers most commonly engage in sex work to support their children or family.
- Sex workers often move in and out of sex work, depending on other circumstances.
- Female sex workers, female Indo- Fijian sex workers in particular, are less happy with engagement in sex work than are transgender sex workers.
- (see McMillan and Worth 2010a, and UNAIDS forthcoming).

A 2011 IBBS of men who have sex with men (MSM)[1] (Rawstorne 2012) also captured some data on sex work as it found that 44% of the total sample of MSM had been paid to have sex. Many MSM are likely to be both clients and providers of paid sex, given that over a third of the sample had been involved in both providing and receiving money or goods in exchange for sex. Compared to men, transgender sex workers had more male transactional sex partners, both as a client as well as a recipient of goods (Rawstorne 2012).

While all sex work in Fiji is overridingly driven by financial need, there are marked distinctions in the motivations to sex work between women and transgender sex workers (McMillan and Worth 2010a; UNAIDS forthcoming). Nothing is known about male sex workers.

Clients come from all ethnic and income groups and include local men, foreign businessmen, tourists and seafarers (McMillan and Worth 2010a). Indo-Fijian men tend to engage Indo-Fijian sex workers, and migrant Chinese sex workers in Suva almost exclusively service the predominantly Asian crew of foreign vessels.

Sex work is independent in Fiji, there is no managed sector, and referrals are by word of mouth or direct solicitation. Most local sex workers are mobile; they may work from and operate from a variety of venues and travel between towns. Clients are predominantly met in the streets or in bars, restaurants or nightclubs. Increasingly, sex work is arranged over the phone and clients are met in private homes or motel rooms, although this has long been the dominant practice in Labasa, where there is little street solicitation (McMillan and Worth 2010a and 2011a).

Both informal and formal sex worker networks are extensive and numerous in Fiji, especially among transgender and I-Taukei Fijian sex workers. Indo–Fijian women and male sex workers are less well networked and Indo-Fijian women prefer anonymity.

Migrant sex workers also operate independently. There is no evidence of sex trafficking, despite much speculation in US Trafficking in Persons (TIP) reports. Recent increases in penalties and criminalisation of an expanded range of activities related to sex work resulted in a upgrading of Fiji's TIP status (McMillan 2012). Unfortunately, at the same time as it has hindered HIV prevention efforts, those same law changes have created an environment in which third person involvement makes sex work more discreet (McMillan and Worth 2011a), thus increasing the opportunities for acts of trafficking developing over time.

Recent studies have indicated the need for better information and HIV/STI prevention knowledge and resources. Unsafe practices reported include the use of two condoms – and anecdotal evidence of some women's belief that when no condom is available, anal sex is cleaner and safer than unprotected vaginal or oral sex.

Recent studies have indicated the need for better information and HIV/STI prevention knowledge and resources.

While condoms are reasonably accessible, lubricant is far less available. Night time/street condom distribution and outreach services are the most effective way to ensure sex worker access to condoms (McMillan and Worth 2010a).

Sex workers have other partnerships and non-commercial sexual relationships, and are less likely to use condoms with those non-paying partners than with their clients (Hammar 2012; McMillan and Worth 2010a). This is

[1] The author notes that MSM is a problematic term, and does not adequately reflect the diversity of male sexualities that it is used here to encompass – especially as MSM is used to also include male to female transgender women.

consistent with international literature (e.g. Pickering et al. 1993; Nguyen et al. 2005) suggesting that intimacy and emotional ties affect the condom use practices of sex workers.
In the Fijian context, sexuality is more complex and fluid than can be captured by standard gay/lesbian/bisexual/transgender categories. Recent surveys in Fiji have shown that the sex of an intimate partner cannot be predicted by the gender of the sex worker, and male and transgender sex workers may have male and/or female partners (Rawstorne 2012).

Previous research in Fiji has identified a need to reach Indo- Fijjan sex workers and has also noted the exclusion of Chinese migrant sex workers from data collection as well as from local sex worker networks and local HIV prevention funding (see McMillan and Worth 2010a). The impact of the legal environment and the culture of policing on HIV prevention and sex work has also been highlighted (McMillan and Worth 2010a; McMillan and Worth 2011a).

Despite some gaps in knowledge about migrant sex workers, rural sex work, male sex work, and to a lesser extent Indo-Fijian female sex workers, two recent studies, one qualitative and one quantitative, have provided much up-to-date data on sex work in Fiji.

Key points

- There is a significant sex worker population in Fiji.
- Clients come from all ethnic and socio-economic groups in Fiji.
- Sex work is largely driven by economic need and is underpinned by structural forces.
- Motivations and major issues of concern are different for female and transgender sex workers.
- Strong, well established networks exist and numerous sex worker organisations operate.
- Sex worker advocacy skills have been well developed through participation in regional networks.
- Indo-Fijian female sex workers are harder to reach and less well networked than I-Taukei and transgender sex workers.
- There are no prevention services targeting Chinese or migrant sex workers.
- Night-time/street condom distribution and outreach services are the most effective.
- Not enough lubricant is currently provided.
- There is a need for better and more up-to-date information for sex workers and outreach educators, and also service provider staff.
- Punitive laws and policing culture have a negative impact on HIV prevention.

1.2 Sex work in Vanuatu

An increase in sex work in Vanuatu has variously been considered in the context of urbanisation, tourism, development, high unemployment, changing gender relations, family violence, kava and alcohol use (Bulu et al 2007; McMillan and Worth 2011; McMillan 2011a). Forms of sex work in Port Vila have been shaped by a recent period of social and economic change, and are strongly tied to urban social life (McMillan 2011a). Vanuatu has experienced a rapid period of urbanisation and integration into the global economy that has dramatically affected the shape of Ni-Vanuatu social life, on Efate in particular. Before independence (1980) Ni-Vanuatu were restricted to rural village life and largely excluded from the town of Port Vila. Sex work appears to be a response to the challenges of change by those who have been excluded from the consumer economy and from opportunities to participate in town life because of unemployment, and also a response to the impact of social and economic change on gender relationships.

In Port Vila, selling sex is closely linked with going to town. In a recent interview-based study of selling sex in Port Vila, sex workers expressed this link both figuratively and literally; many sex workers said that they started selling sex when they moved to the town of Port Vila, but they also described *going to town* in search of clients when they needed money (McMillan 2011a).

Sex work is largely informal, independent, street, kava bar and club-based (Bulu et al 2007; McMillan and Worth 2011). In past years, Port Vila news media have reported that the casino is a sex work 'hub', but to date this has not been evident in studies.

While it is considered to be somewhat shameful and is practised covertly, selling sex is a common practice in Port Vila, according to those who engage in it. Sex workers either work alone, meeting clients on the streets during the day and making arrangements to rendezvous later, or they operate with small groups of friends, finding clients from *nakamals*, bars and nightclubs. In this latter style of sex work, social and monetary motivations tend to converge (McMillan and Worth 2011).

In Port Vila, sex workers are local women and men and also girls and youth (McMillan and Worth 2011; McMillan 2010; UNICEF 2010). Sex work is often taken up at a young age. In one study, most of the interviewees were less than 16 when they took up sex work and some were as young as 11 years old (McMillan and Worth 2011). A recent youth survey found that young males were also involved in sex work (UNICEF 2010). Male sex workers may have sexual relationships with both female and male partners (UNICEF 2010). Of more concern, not only were there low rates of condom use among youth involved in sex work, but condom use was actually lower among young people who had paid sex than among those who did not (UNICEF 2010).

In Port Vila, there were low rates of condom use among youth involved in sex work, and condom use was actually lower among young people who had paid sex than among those who did not.

In Port Vila, clients include local men of all occupational classes, male tourists, expatriate businessmen and also older local and tourist women. Sex workers commonly adopt a sliding scale of charging according to income. Sometimes small offerings and inexpensive gifts are accepted from clients who have little means. On the other hand, women may receive the equivalent of a month's salary for spending the night with a wealthy tourist (McMillan and Worth 2011).

Among female sex workers, sex work is often taken up as a way to overcome problems of a lack of, or inadequate, employment and of unsatisfactory or abusive intimate or family relationships (McMillan and Worth 2011). Often sex workers consider their engagement in sex work to be an interim situation only; a temporary response to, or way out of, adverse circumstances, a way to solve money problems, or create other opportunities (McMillan 2011a). While money earned from sex work is frequently spent on non-essential items, these earnings afford the workers some degree of independence and autonomy – a way to take control of their lives (McMillan 2011a).

Pledges to renounce sex work, given by sex workers to church or health service providers, often result in a more covert approach to sex work. Sex workers become less inclined to access services and condoms because it might expose their activities. It also makes them harder to reach by peers who may have been witness to the pledge (McMillan 2011a). Because of this, HIV prevention programs that appeal to sex workers' desires to look after themselves and take control of their lives offer a more effective HIV prevention strategy than attempts to discourage them from sex work (McMillan 2011a).

Few of those who sell sex in Port Vila identify as sex workers, and this has implications for the targeting of HIV prevention programs and services. While organic networks of sex workers do exist, these are informal, loose arrangements of friends that may sometimes work together. These networks are not extensive, as most sex workers are reluctant to let more than a small number of friends know of their engagement in paid sex (McMillan and Worth 2011).

Sex workers expressed a preference for condom use but were inconsistent in their use of condoms with clients (McMillan and Worth 2011). Condoms need to be free and at hand to maximise uptake. While the quality of condoms was raised as an issue, most sex workers spoken with in research said that they would not pay for condoms. Conditions of privacy and confidentiality were also a very important factor in determining whether or not sex workers would pick up free condoms. Moreover, privacy and confidentiality are not merely a matter of shame but may have implications for the personal safety of sex workers (McMillan and Worth 2011).

Sex workers hold many misconceptions about condoms and have a poor understanding of the role they play in preventing STIs and HIV transmission. Some sex workers, and some clients, did not know how to put a condom on a man. Clients' wishes usually determined whether or not condoms were used. Local clients are particularly averse to condom use. Sex workers in the 2011 study were not confident or competent enough negotiators to convince a reluctant client to use a condom. However those sex workers who had accurate information about the role and efficacy of condoms in preventing HIV and STI transmission did actively encourage clients to use condoms (McMillan and Worth 2011).

A frequent combination of alcohol, kava and sex work may exacerbate the HIV/STI transmission risk, as intoxication compromises intentions to use condoms. Drinking alcohol was also reported to be associated with lowered inhibitions and more adventurous sex than usual. As kava and alcohol drinking and sex work were often intertwined (McMillan and Worth 2010, see also Bulu et al. 2007), intoxication has to be taken into account when designing any HIV prevention programs and strategies for sex workers.

A frequent combination of alcohol, kava and sex work may exacerbate HIV/STI transmission risk as intoxication compromises intentions to use condoms.

An IBBS of female sex workers in Port Vila was conducted in 2011. A report on that survey is not yet available but, according to the research team, no cases of HIV were detected among the sample. While rates of other STIs were fairly high, they were not inconsistent with rates among the general population (pers. comm. Siula Bulu).

Little is known about sex work outside of Port Vila. Sex work does occur in Luganville and is assumed to be similar but on a smaller scale than in Port Vila.
Nothing is known about the outer islands, but youth transactional sex is known to take place on numerous islands.

Key points

- Many women who sell sex in Port Vila do not identify as a sex worker.
- Sex work is informal, independent and often opportunistic.
- Clients are local and foreigners.
- Sex work is imbricated in nightlife and urbanised social life.
- Many girls start selling sex at a young age.
- Young males as well as females engage in sex work.
- Condom use during paid sex is low.
- Sex workers need better/more accurate HIV prevention information.
- There are no active sex worker networks.

1.3 Sex work in Chuuk

Unemployment and poverty are strong drivers of sex work in Chuuk (Sladden and Vulavou 2008; Chuuk Resource Centre 2011). There has been much conjecture about young women being taken out to visiting fishing vessels on speedboats and offered to crew members in exchange for fish or money. However, a 2010 behavioural survey of 70 women who exchange sex for goods and services (Chuuk Resource Centre 2011), found that 40% of participant women involved in sex work met their most recent client on the street. A further 16% said their most recent client came through a friend or other client, and 13% said it was at a private house. The most common location for having paid sex was at a private house (54%), followed by hotel (17.5%). [It is possible, however, that, as in Tarawa in Kiribati (see McMillan and Worth 2010b), sex workers who operate on shore are a distinct group from those who go out to boats]. For the Chuuk Resource Centre study participants, the last client was Micronesian in nearly all cases, with about one third (36.5%) being youth, followed by government worker (20.6%), and businessman (14.3%).

In the Chuuk survey, respondent ages ranged from 15 to 40 years, but 80% of respondents were aged between 15 and 24 years old. The survey (2011) indicates that most women sold sex for economic reasons. Chuuk sex workers said they engaged in sex work to make money (66%) and because they enjoyed it (23%). Only a small proportion (14.5%) had any other paid work. The average number of partners on the last day of sex was two (although the responses ranged from 1-9).

In addition, Chuukese sex workers reported significant experience of forced sex, most often perpetrated by neighbours or an intimate partner rather than a client.

Most of the women in the survey (73.5%) knew where to go to get an HIV test, and just over half (58.5%) demonstrated correct knowledge of HIV prevention. However, more than two thirds (71%) did not use a condom with their last client, and almost all of those (94.9%) did not use a condom because none was readily available. Sex work in Chuuk involved high risk behaviours, including anal sex, multiple sexual partners, low condom use and low levels of testing and treatment for all STIs. Even where the women had good knowledge of HIV prevention, there was a mismatch between high knowledge of protective behaviours and low condom use. This was often due to lack of condom availability.

The Chuuk Resource Centre research findings show the need to increase availability and ensure access to condoms.

The report recommended a range of strategies to promote HIV prevention among the target group: the establishment of a sex worker support network, a reorientation of the peer educator training to a problem-solving approach, and more STI recognition and treatment information. The report also suggests the provision of alternative income generation schemes.

Key points

- In Chuuk, sex work takes place on shore.
- Chuuk sex workers operate independently and are not managed.
- Clients are usually locals.
- Sex work is underwritten by economic need but also by lack of opportunity and perhaps by boredom.
- Sex work in Chuuk involves high risk behaviours.
- Sex workers experience significant rates of forced sex (not perpetrated by clients) However, it is unclear whether this experience is related to sex work or limited to sex workers.
- HIV prevention information and knowledge has not translated into low risk behaviours.
- Accessibility of condoms is problematic.

1.4 Sex work in Kiribati

In South Tarawa, the crews of foreign fishing vessels interact with local i-Kiribati women in bars and clubs seeking sexual services (Toatu 2007; McMillan and Worth 2010b). *Ainen matawa* is the name for local women who board foreign vessels to sell sex. While the HIV diagnoses that Kiribati has experienced to date have been among *local* seafarers and their families, not *ainen matawa,* there are concerns about vulnerabilities to HIV for *ainen matawa* due to their sexual relationships with foreign seafarers who may originate from, and also pass through, areas with significantly higher rates of HIV than Kiribati. In addition, sexual health surveys of *ainen matawa* find consistently high levels of STIs among the women. *Ainen matawa* are motivated by money and goods they receive in return for sex, but also by the social life, relatively luxurious conditions and the safety of onboard life.

Paid sex is also apparent on Kiritimati Island near Hawaii, where clients are said to include US tourists and some local crew, as well as foreign seafarers (Sladden and Vulavou 2008). The primary driver of sex work in Kiribati is lack of paid jobs for young women, leading to economic hardship and boredom, and dissatisfaction with the treatment of women by local men ashore (Sladden and Vulavou 2008; Toatu 2007; McMillan and Worth 2010b). Sex work in Kiribati is overridingly conducted by women, although a 2009 survey of vulnerable youth found that some young men also engaged in sex work (UNICEF 2009).

The primary driver of sex work in Kiribati is lack of paid jobs for young women, leading to economic hardship and boredom, and dissatisfaction with the treatment of women by local men ashore.

I-Kiribati sex workers operate independently and make arrangements for themselves. There is little practical distinction between cash and goods as payment for sex, as most young people who exchange sex for cash also exchange sex for non-cash goods (UNICEF 2009), and women who board boats will accept goods as well as cash (McMillan and Worth 2010b). While much paid sex takes place onboard ships, it also takes place ashore; one survey found that nearly half of paid sex occurred in houses, hotels, clubs and outdoor areas such as the bush or beach (UNICEF 2009). This is consistent with claims by *ainen matawa* that there are many more covert sex workers in Betio who do not board boats (McMillan and Worth 2010b).

In 2010 it was estimated that there were about 80 young women on Tarawa who regularly boarded boats and another 40 on Kiritimati (pers com. Komera Otea). In Tarawa, the young women who board boats are typically aged between aged 18 and 25 years, although a few are as young as 16 years (McMillan and Worth 2010b). There are no figures or other data on onshore sex workers or on male sex work.

A small survey in Kiribati (Toatu 2007) found high rates of STIs among local i-Kiribati sex workers who board fishing vessels. A 2008 survey of young people found that condom rates in paid sex were low, and that less than half of the young people involved in paid sex used a condom at last sexual encounter (UNICEF 2009). Qualitative research in 2010 found that women who boarded boats used condoms with paying partners initially, but that condom use ceased with familiarity and trust (McMillan and Worth 2010b). That study also highlighted the need for protection from violence perpetrated by police and others to reduce women's vulnerability to HIV.

A qualitative investigation of the HIV prevention needs and capacities of i-Kiribati women who board foreign fishing vessels (McMillan and Worth 2010b) shows that relationships between seafarers and i-Kiribati sex workers do not conform to typical models of sex worker-client relationships as they may last weeks or months

and often take the form of serial, rather than multiple concurrent, sexual relationships. This has ramifications for the type of information on condom use and negotiation needed. Specific condom use considerations, for *ainen matawa* are akin to those of the wives and girlfriends of local seafarers, as there are similar issues around sustaining condom use over time and with reconciling HIV prevention and conception.

Women who board boats are identifiable to the wider community as *ainen matawa,* both because of their attire and because they will inevitably be seen on-board or travelling to the vessels. This results in marginalisation and estrangement from family, and leaves them vulnerable to discrimination and sexual and physical abuse from locals, including police. Fear of punishment, discriminatory treatment and shame deters them from accessing sexual health services or seeking help when they are subject to violence and abuse.

Some studies have reported growing levels of 'organisation' among *ainen matawa* in tones of dismay (see UNICEF report), yet it is not necessary to view this as a negative development. Socialising and spending extended periods of time together living on vessels, along with a shared experience of exclusion, generates a strong sense of group identity among the women, and the resultant community provides an excellent opportunity for delivery of resources and information (McMillan and Worth 2010b). Collectivisation is a necessary co-requisite of community mobilisation, and fundamental to effective HIV/STI prevention based on community empowerment.

In Tarawa, *ainen matawa* have engaged enthusiastically in previous sex worker-specific HIV prevention projects, providing peer condom distribution, information and outreach services.

Other risks related to sex work in Kiribati include the consistent association of sex work with heavy alcohol use and intoxication, and the vulnerability of sex workers to sexual abuse and violence (predominantly perpetrated by non-clients and also by the police) as a result of intoxication and also of identification as a sex worker.

Key points

- Sex work in Kiribati is driven by lack of economic and social opportunity and also by dissatisfaction with local relationship norms and abuse of women.
- Clients are predominantly foreign seafarers.
- Women who board foreign vessels work independently and are not coerced.
- Heavy alcohol use is deeply imbricated in sex work and heightens risk.
- Police and local men pose a risk to women who board boats.
- Women who board boats form a community providing an excellent site for HIV prevention.
- There are distinct types of sex work in Kiribati, ship-based and land-based, and also distinct sex worker populations.
- The conditions and dominant issues particular to sex work that occurs on Kiritimati Island are likely to differ from those of *ainen matawa* on Tarawa.

1.5 Legal environments

With good reason, attention has been increasingly directed to the impact of legislation on the human rights of sex workers and on sex workers' ability to reduce the risk of HIV and STI transmission during paid sex.

However, a consideration of the legal environment should extend beyond the letter of the law to include the wider justice system, such as the attitudes and behaviours of law enforcement agents and the judiciary, the

working of the courts, and access to legal advice. Local cultures of policing and law enforcement can be even more relevant to sex worker rights and to possibilities for HIV prevention activities than the law itself (see e.g. McMillan and Worth 2011a).

Only New Zealand and the state of New South Wales in Australia have models that come close to a full decriminalisation of sex work. Sex work legislation in other Pacific island countries falls into two categories:
(i) countries influenced by USA laws, where both sex work and activities associated with sex work are illegal (American Samoa, Marshall Islands, Palau, Northern Mariana Islands, Chuuk and Kosrae states of Federated States of Micronesia);
(ii) former British colonies, where the act of sex work is not illegal, but associated activities such as keeping a brothel, soliciting, or living on the earnings of sex work are offences (e.g. Samoa, Solomon Islands, Cook Islands, Kiribati) (Godwin 2012).

While many countries have laws that criminalise brothels, most Pacific Island countries have no history of brothel-based sex work (Godwin 2012).

Criminalisation, punitive practices of law enforcement, and other legal oppression of sex work create structural barriers to HIV/STI prevention and have a negative effect on community empowerment-based HIV programming. In Fiji, the 2010 introduction of heavier penalties for people associated with the sex industry had a deleterious impact on HIV responses (McMillan and Worth 2011a).

Criminalisation, punitive practices of law enforcement, and other legal oppression of sex work create structural barriers to HIV/STI prevention and have a negative impact on community empowerment-based HIV programming.

Active debate about sex work law reform and decriminalisation is increasing in both Papua New Guinea (Godwin 2012) and, most recently, in Fiji. In both countries advocacy from local sex worker organisations (supported by international and regional networks and also by UNAIDS) has played a central role in getting sex work law reform onto the agenda.

However, decriminalisation is not a black and white matter, and may come with an array of problematic regulatory conditions. In 1999, the Fiji Law Reform Commission recommended decriminalisation of sex work with regulation. Internationally, regulation is most effective where sex work is organised and brothel-based, but tends to further marginalise and exclude street-based sex workers. In most Pacific countries, sex work is independent and predominantly street-based.

Guam is one of the few countries with a brothel-based sex industry and is also the only PICT to have introduced regulations aimed at addressing STIs and HIV in the sex industry. Those regulations require certification of massage parlour workers and regular HIV and STI testing. However, international experience has shown that compulsory testing approaches are stigmatising. Compulsory testing is also unlikely to be effective in HIV prevention – given the window period between infection and developing HIV antibodies. Moreover, it is during this 'window' period that a newly infected person is him/herself most infectious. In addition, testing of sex workers does nothing to reduce the risk of sex workers themselves becoming infected, and certification of sex workers may engender a false sense of security and lead to greater risk taking (Godwin 2012). This false sense of security is particularly problematic where clients are already reluctant to use condoms, and where warnings about HIV and STIs are a key means by which sex workers encourage clients to use condoms (as they do for instance in Fiji – see McMillan and Worth 2010a).

Furthermore, regulation diverts valuable health resource funding to unnecessary surveillance, and this is a particular drawback in countries where funding and infrastructure are already inadequate.

The Australian Federation of AIDS Organisations (AFAO) has outlined a set of *Principles for model sex industry legislation.* These principles refer to decriminalisation of the sex industry and recognition of sex work as legitimate employment. They hold that decriminalisation should apply to all sectors of the sex industry and that all laws criminalising the sex industry should be removed. AFAO contends that sex industry businesses should be treated like other commercial enterprises and sex work should be regulated only through the usual business, planning and industrial codes/laws. Legal businesses are more open to scrutiny and more accessible (to risk reduction interventions) than are illegal and clandestine operations. The creation of red-light zones (as suggested in Guam) creates poorly lit, under-resourced and unsafe work areas.

AFAO accepts that specific sex industry regulations may be required to ensure the occupational health and safety and rights of sex workers. Ensuring sex worker access to confidential health services is a core principle, but these services must be voluntary.

The AFAO principles have been developed as a result of the experience of sex work within the range of legislative frameworks that are in place across Australia. In countries where occupational protection cannot be guaranteed for workers, and where female employees in particular are regularly subject to exploitative labour conditions (e.g. garment industry workers in Fiji), a reliance on usual business codes is likely to be a less effective means of minimising risk for sex workers than it is in Australia.

In addition, although it is clear that criminalisation gives license to discriminatory and punitive attitudes, decriminalisation is not in itself a magic bullet that will end the marginalisation, discrimination and harassment of sex workers. Research from New Zealand indicates that the police may use other laws such as vagrancy and public nuisance to continue the harassment of sex workers (Andrae 2010) and in some instances local bylaws are used to outlaw sex work.

Legal frameworks must be tackled at both community and structural levels, and advocacy for law reform will be most effective when it occurs at both regional and country levels. However, decriminalisation is a more immediate and pressing issue for some PICTs than for others and, similarly, law reform is a more imminently viable proposition in some places than in others. The matter of law enforcement and the culture of policing are perhaps more crucial, and certainly more immediately approachable, issues in many PICTs.

The matter of law enforcement and the culture of policing are crucial and immediately approachable issues in many PICTs.

Key Points

- Criminalisation of sex work and punitive practices of law enforcement create structural barriers to HIV/STI prevention.
- Factors salient to the legal environment include not just the law itself but attitudes of the police and the judiciary, as well as access to legal representations and information about the law.
- While PICTs are variously situated in respect of the potential and immediate need for a shift to decriminalisation, attitudes to law enforcement are both relevant and immediately approachable issues in most PICTs.
- Regulation of the sex work industry is highly problematic, and inappropriate where sex work is not brothel-based.
- Compulsory testing does not prevent transmission of HIV in sex work, it is also marginalising and a drain on resources.

2. Sex worker HIV prevention programs in four PICTS (past five years)

While HIV /STI prevention programs for sex workers are not highly developed in any PICT, the history and experience of projects range from that of Fiji with a fairly extensive background (by regional comparisons), to that of Chuuk State in the Federated States of Micronesia, where the sex worker project, and indeed a recognition of the existence of local sex work, is very recent.

In all cases, sex worker projects began by attending to core HIV prevention activities, embracing the concepts of outreach, condom distribution, peer education, network building and, to varying degrees, confronting stigma and discrimination. However, sustainability of services has been an issue in every country. The one exception is, perhaps, that of services provided in Port Vila by Wan Smol Bag. However, even there it has not yet been possible to expand coverage to other areas, despite a need, and it could be contended that the sex worker projects have been sustainable only because the implementing organisation has been able to draw on resources from other arms of its operations.

An earlier project in Tarawa ultimately failed, not due to the nature of the program but rather due to frailties of the implementing organisation. Experience since then has shown that generalised youth services will not be adequate to include sex workers, and that continuity is important to retain the services of even committed peers.

Recognising that behavioural interventions and clinical services alone will not be effective without community empowerment and an enabling environment, and in response to an understanding that poverty is a major driver of sex work, projects in Fiji and Chuuk have been redirecting their efforts towards retraining and alternative income-generation schemes and to (mentoring) sex worker advocacy. Core prevention services and particularly peer education are sacrificed in this refocusing.

There is little that is uniform about sex work as it takes place in the four PICTs under consideration. The projects have had to respond to different forms of sex work, which are amenable, or not, to somewhat different efforts. Where sex work is most covert and informal, such as in Chuuk and Vanuatu, it is difficult to mobilise a network of sex workers who prefer to remain anonymous. Categories of transactional /commercial, casual/ professional will have less bearing on HIV and STI prevention needs at any site than whether or not those who sell sex identify as a sex worker, how much control they have over the conditions of the sexual transaction, the sites where sex work occurs, and the risks associated with being publically outed as a sex worker.

Outreach and peer education workers have been absolutely key to condom and information distribution, as well as to reaching, engaging with, and understanding sex workers.

In all four countries, despite differing forms of sex work, outreach and peer education workers have been absolutely key to condom and information distribution, as well as to reaching, engaging with, and understanding sex workers. Furthermore, experience from all four countries has shown that the capacity of the implementing organisation is crucial to the quality and sustainability of sex worker projects.

2.1 Previous and current programs in Fiji

Fiji has a substantive history of HIV awareness programs, NGO involvement, and both qualitative and quantitative research on sex work. Much good work has been undertaken through past education and awareness programs in Fiji, and this legacy has enabled the development of networks and advocacy to date. However, core HIV/STI prevention activities – such as ensuring that sex workers have access to condoms and lubricant and also to HIV prevention education and information – are not the focus of current, or recently funded, programs. Core activities have been displaced in a redirection of resources to alternative income generation and work skills /retraining programs.

Current needs in Fiji

While good headway has been made in the generation of debate – within both the government and the church – including proposals for the decriminalisation of sex work, there are serious gaps in basic HIV/STI prevention programs for sex workers in Fiji. These gaps appear to be worsening in the absence of peer education training, regular outreach and condom distribution activities. There is not only a consistent shortage of lubricant, but also an apparent lack of understanding of its importance. Current needs in Fiji are:

- investment in cond
- om and lubricant distribution pathways;
- more highly developed peer education programs;
- reintegration of (currently informal) peer educators into monitored programs, for information updating and further training;
- improved information and updated STI/HIV education and resourcing for both sex workers and service providers; and
- fostering and supporting internal networking in Fiji among sex worker organisations and other government and NGO service providers in the country, especially to develop partnerships through which programs can be implemented.

2.1.1 Community empowerment approaches

Early HIV prevention funding supported workshops focused on HIV knowledge and awareness, and on providing peer education and outreach skills. Most of the current volunteers and community advocates were trained during these early workshops. In 2007, UNFPA supported an emerging sex worker network, Sex Worker Advocacy Network (SWAN), to conduct a series of sex worker advocacy and peer education workshops. SWAN no longer exists. Similarly the closely related NGO (AIDS Task Force Fiji) that accommodated SWAN and was central to the early delivery of peer education and sex worker focused HIV/STI prevention has been defunct for at least 4 years.

A later round of funding focused on network building. In 2008, Pacific Counselling and Social Services (PCASS), with funding from the Pacific Islands HIV and STI Response Fund, facilitated sex worker support groups in Lautoka and Labasa as part of the Sekoula Project, providing safe space for weekly meetings at a drop-in centre, running HIV prevention and other workshops, and overseeing condom and lubricant outreach distribution. The Sekoula project also facilitated sex worker access to social support and legal services and to HIV/STI testing services at the hub centres. The project benefitted from being embedded in a well-run and structurally robust organisation, and was able to draw on the administrative, technical and managerial capacities of that NGO.

The social and community activities undertaken by the Sekoula network demonstrated the value of building good relationships between sex worker groups and police and local health service providers, and generating a positive profile for sex workers in the community.

However, the vulnerability of sex worker programs to political/legal change was demonstrated by the sudden withdrawal of important sex worker outreach activities. Condom distribution and weekly education sessions provided by Sekoula ceased abruptly following law change in Fiji (see McMillan and Worth 2011a; PCASS Annual Report 2012). These core HIV/STI prevention services were replaced by education, health and welfare services made available to sex workers through mainstream programs.

The Sekoula project has been revived in name, but the network itself has been detached, renamed and made 'independent' from PCASS, reoriented towards the provision of alternative income generation programs and work skills training, and also to the capacity building of an independent sex worker advocacy group: Pacific Rainbow$ Advocacy, a fledgling sex worker network with a focus on advocacy.

Pacific Rainbow$ does not have funded core HIV/STI prevention activities to mobilise around. While it has been mentored by PCASS staff, it has few resources available, and the organisation building process is based on (and to a certain extent stalled in) the imperative that a few leaders quickly acquire administrative and organisational skills. While huge strides have been made with regard to these skills, condom distribution and outreach activities are minimal and connection with and relevance to many within the sex work community is diminishing. While it is early days yet, this organisation seems to be following in the footsteps of an older network, one which has highly experienced advocates and leaders with good regional connections, but diminishing community relationships.

The Australian sex worker network, Scarlet Alliance, worked to formally establish a national sex worker advocacy network (Survival Advocacy Network (SAN)), which was formalised in Fiji in 2009. Advocacy training for SAN leadership has continued through the Asia-Pacific Sex Worker Networks (APSWN) mentoring of SAN leaders. Consequently, advocacy skills of some individuals are highly sophisticated, and human rights-based advocacy has been enhanced by the high visibility of transgender sex workers at public events and celebrations. APSWN is based in Thailand, recognised by UN bodies and plays a strong advocacy role. However, despite leaders regularly representing Fijian sex workers on an international stage, SAN is lacking local capacity to engage in HIV/STI prevention. It conducts no ongoing regular core activities for its membership, such as condom distribution or peer outreach.

A third sex worker network also exists – Rainbow Women's Network (RWN) – a grass roots group that has developed locally with no outside support. The agenda of the RWN sex worker group is driven by the local community. RWN has sourced a little in the way of small grants from local community funders to pay for workshops but has otherwise no external funding and the group is dependent on the energy of a few committed individuals. Thus regular HIV/STI outreach sex worker interventions can seldom be sustained, and activities such as HIV/STI prevention workshops and street condom distribution are largely ad hoc.

In 2010 a first Fijian sex worker network forum was organised in response to the recommendations of an APSWN meeting in Pattaya. UNFPA funded a 'Research to Action' meeting, focused on the findings of recent UNSW research into HIV prevention needs of sex workers in Fiji. Recommendations from this meeting included a board-style council of sex worker groups, but there was no funding for follow-up meetings to progress these decisions.

2.1.2 Core HIV/STI prevention activities

Currently in Fiji, core HIV/STI prevention activities (ensuring access to condoms and lubricant and to HIV prevention education and information) are dependent on the motivation, time availability, personal capacity of, and relationships between, a number of unpaid and largely unsupported individuals.

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Condom and lubricant outreach is conducted and organised predominantly by various informal assemblages of individuals. Informal arrangements enable a supply of UNFPA resources to reach sex workers in Nadi and Lautoka as well as around the streets and bars of Suva. The supply chains include individuals from other (non-sex work targeted) NGOs with a mandate for STI/HIV prevention, volunteer peer outreach efforts, and the opportunistic services of supportive friends travelling to Nadi, as well as various boutique sales assistants, BBQ stand workers and nightclub bar staff. While penetration into the communities requiring condoms and lubricant is very effective, the supply of crucial resources is irregular at best. Lubricant is constantly in short supply.

Local UNFPA staff responsiveness to need and opportunity, and flexibility in relationships with individuals and a variety of other organisations is currently a centrally important facilitator of condom availability. However, it does make accurate reporting difficult, and places a heavy burden on those same staff.

NGOs who provide condoms for pick up often do not understand the importance of also providing lubricant and only make up one in five 'packs' with lubricant included. This occurs even where their clients are predominantly transgender.

STI and HIV testing and treatment services are variously provided by private NGO and government clinics. Few sex workers will disclose their work to service providers, so it is difficult for clinicians to understand the situation, their specific vulnerabilities, or the risks that their sex worker clients take. Many sex workers, especially Indo–Fijian women, prefer to pay for private doctors when they can afford it. Some doctors provide services to their sex worker clients free of charge.

Historically, the provider most popular with sex workers was a Marie Stopes International (MSI) clinic. It was popular because it was considered confidential and safe, and also because it was conveniently located in the middle of downtown Suva. The closure of this clinic was a response to MSI's international, rather than local, agendas.

Part of early UNFPA funding assisted in the establishment of a part time sexual health clinic targeting sex workers. This clinic operated from a community NGO office. Very popular with some sex workers, others expressed concern about lack of confidentiality. The clinic closed when the Australian volunteer nurse reluctantly resigned over concerns about clinic management, storage of samples and the overall safety of the clinic. While there are many advantages of sex worker-only services, such a service does not necessarily overcome confidentiality problems. Indeed, these may be exacerbated. Furthermore, it is crucial that all clinics are professionally managed and secure and that clinical best practices can be followed.

In Suva, a new NGO clinic, Medical Services Pacific, has recently emerged, specifically targeting marginalised women, and transgender and women sex workers, as well as youth. They are currently in dialogue with one of

the Suva female sex worker groups about appropriate service provision, and have also approached the national organisation of sex workers, but at the time of writing had not had a response.

Until recently, government clinics have been considered discriminatory and marginalising and have been unpopular with sex workers. Increasingly, sexual health hub clinics in the three main centres have made efforts to try to ensure that sex workers are not deterred from using their services – with variable results. While these efforts should certainly continue, small NGO clinics, such as Medical Services Pacific in Suva, are more strongly motivated and better placed to be responsive to sex worker specific needs, as well as being more understanding of the issues involved.

HIV knowledge and risk reduction education

No one is currently conducting HIV and STI prevention education for sex workers in Fiji. Studies show higher rates of condom use in paid sex than in unpaid sex and there appears to be an assumption that levels of information are also good. However a recent UNAIDS survey identified a high demand among sex workers for information on HIV/STI risk reduction. Other indications that risk related knowledge is poor include the use of anal sex and douching to reduce risk.

In addition, information about where to obtain services is often poor and out of date – not only among volunteer peer educators but also among some NGOs that regularly provide information or referrals to sex workers. Similarly, many service provider staff may need more education, as some seem unaware of the role or importance of lubricant.

The sex work community needs more sex work specific information, and the peer educators who are still active need to be upskilled and supported. Most peers were trained a long time ago. Their methods and messages have never been audited. NGOs and other service providers must also ensure that their sources and referral practices are accurate and up to date.

2.1.3 Alternative income generation

It is well recognised that sex work, especially among women, is driven by economic need and this is exacerbated by gendered economic inequalities in Fiji. Alternative income generation programs appear to provide means of escaping sex work. However, such outcomes appear unrealistic in a country where many sex workers are already also seamstresses, hairdressers or run BBQ stands, and cannot earn enough to support themselves and their families on those earnings alone.

To date, Sekoula's experiences of micro-financing show that alternative income generation schemes are expensive and demand extensive staff training and resourcing to implement.

Key factors as identified by the Sekoula experience

- Micro-financing systems need to be responsive.
- Accurate assessment of client repayment capability is essential, and repayment schedules also need to be flexible.
- Financing programs require ongoing and close monitoring and mentoring of recipients: when follow up stops, then repayments stop too.

- Communication and maintaining contact with recipients can be difficult, and this usually hinges on the existence of, engagement with, and buy-in of local sex worker networks.
- Micro-financing/micro-credit programs will fail if they are provided in isolation from other support, such as access to social work; social, legal and financial services; and health services, as well as business and basic work skills.
- Application processes must be transparent and applicants need to be told clearly and early when they are declined. Assessment staff need to be sensitised and understanding.
- Capacity building is necessary not only for recipients, but also for service provider staff.

Micro-financing into small businesses may prove successful for a select few, but will generate debt for others. Similarly, unless work training is extensive, it will restrict sex workers to the low-paid labour opportunities they have previously found inadequate. Real education opportunities will be feasible and appropriate for only a small number of candidates and are expensive to provide.

Although expensive and very staff intensive, alternative income-generation projects and micro-financing may be a viable additional strategy, when core HIV/STI prevention activities are in place and sustained. However, with regard to STI/HIV prevention, alternative income generation is no substitute for core activities.

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2.1.4 Sex worker networks

There are currently three distinct formal sex worker organisations in Fiji, although in actuality the membership of the networks overlaps to a large degree. These groups have emerged as a result of both local and regional drivers, and are driven by different agendas. While this difference in focus should be conducive to working together, cooperation is sometimes undermined and relationships between the groups can fraught due to perceived competition (mostly for funding and resources, but also ability to gatekeep). These problems are often exacerbated by competition for involvement in regional or international fora, or for other opportunities associated with research. However, the existence of a number of sex worker groups appears to be necessary in order to include and represent the diversity of sex workers and their primary concerns. A council approach to dialogue between the different groups is likely to be more appropriate and productive than a hierarchy.

Transgender sex workers are prominent in the leadership, governance and management structures of Fiji's sex worker advocacy networks. Transgender sex workers are vulnerable in different ways to female sex workers, and are less able to remain anonymous in society. Transgender sex worker advocacy also overlaps with MSM issues of vulnerability to sexual abuse, marginalisation and discrimination on the basis of sexuality, as well as sex work.

Divergences of experience and differing priority issues are the rationale behind the women-only membership of one network. While acknowledging that a form of discrimination is being practised by a women-only policy, the membership holds that other networks effectively represent transgender issues and that female sex worker concerns are different, a little more mundane, and often silenced.

Female sex workers, especially Indo-Fijian women, tend to be preoccupied by immediate concerns, such as access to condoms, so they can safely earn money to put food on the table. They feel alienated from groups whose focus is on decriminalisation and marginalisation, and shy away from a public profile. None of the current organisations has been very successful at including Indo–Fijian women. But where they have been recruited and involved, success has been attributed to home visits by outreach peer volunteers.

2.1.5 Lessons from the Fijian experience

- Nascient networks will actualise and mobilise around core HIV/STI prevention activities, if supported.
- Conversely, organisations become inactive and atrophy if the grass- roots constituents are not involved and do not take ownership through involvement in core activities.
- Networks of sex workers are resilient and endure, even when NGO service providers and formal organisations may not. Informal networks have an organic existence and will remain an important resource for STI/HIV prevention efforts.
- International agendas and regional priorities are not necessarily local priorities. To remain relevant to local sex workers and consolidate organisations, the agendas of sex worker groups should first be driven by local constituents and local needs, rather than by regional issues.
- The establishment of sophisticated sex worker advocacy networks is not enough in itself to ensure that HIV prevention activities take place.
- Regular core HIV prevention activities cease when they are not specifically funded. Funding and support for basic HIV prevention activities must be ongoing.
- Funding conditions should permit service providers to respond to changing needs and opportunities, and /or improved understanding of sex worker needs and circumstances.
- Outreach efforts and home visits are the key to greater inclusion of Indo-Fijian women in support networks and delivery of HIV/STI prevention resources.
- While politically more palatable, alternative income schemes aimed at diversion from sex work can be delivered only to a very small number, are expensive and time consuming, require extensive monitoring and staff training, and divert important resources away from core HIV prevention activities.
- There is a tendency for mainstream service providers to sacrifice services targeted at sex workers if continuance is perceived as a potential threat to the reputation, or to the sustainability of other mainstream programs and/or funding.
- Police crackdowns and punitive law enforcement practices are detrimental to HIV prevention.

2.2 Previous and current programs in Vanuatu

Current needs in Vanuatu

- Understanding of circumstances and conditions of paid sex on islands other than Efate.
- Increased capacity to expand services beyond Port Vila.

The central agent in sex worker research and HIV/STI prevention resourcing and service provision in Vanuatu is WanSmolBag (WSB). WSB sex worker peer educators conduct condom distribution and outreach, and recruit sex workers for education workshops.

The WSB sex worker program is embedded in a high profile and very popular and well established organisation that also engages very effectively in general community education and raises awareness through edutainment. The sex worker peer education service has arisen out of a successful youth peer education program and provides access to clinical services.

WSB has multiple programs all aimed at dealing with social issues. The resultant synergies are evidenced in the way that the presentation of a sex worker character in the popular TV edutainment program 'Love Patrol' has encouraged sex workers to use the WSB sexual health clinic. The show's sex worker characterisation also appears to be challenging many marginalising and stigmatising stereotypes about the nature and motivations of sex workers (Drysdale 2012).

The characteristics of the organisation are important to the success of the programs. Not only is WSB well-known and popular among youth and the wider community, it can also provide a high level of technical capacity and administrative acumen – especially with regard to reporting. The financial capability of WSB has also been important to the continuity of STI/HIV prevention services provided to sex workers, as the organisation is in a position to carry over funds to continue programs, instead of being forced to cease activities during funding interims. Peer educators in the WSB program are paid for several hours a week, and this is important to the retention of their services and the regularity and reliability of outreach activities.

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Those who sell sex in Port Vila do not necessarily identify as sex workers and are reluctant for their engagement in paid sex to be known to others. This limits the possibilities for the development of sex worker organisations. WSB has modified the approach to workshop planning and delivery in acknowledgement of the reality of sex worker patterns of participation.

WSB's previous approach to sex worker programs was modelled on network consolidation and aimed to work with a group of around 15–20 female sex workers who had been identified through a young people's peer outreach program. It was envisaged that a series of regular meetings would develop HIV/STI preventions skills and knowledge, and build a core group of peer conduits who would enhance the access of the wider sex work community to resources through the development of a peer network.

However, although the meetings were popular and well attended, the attendees varied from meeting to meeting. And while some sex worker peer educators were recruited through this program, overall membership of the group was too fluid for the meetings to operate as planned – which was a course development, with one session building on the next.

As a result, the current approach is to conduct stand-alone workshops, with the particular focus being decided by those who attend on the day. Most meeting attendees do return, but only sporadically, and first engagement with the program is usually motivated by a desire to get a suspected STI professionally examined and treated.

While WSB also supports a stable MSM group in Port Vila, a similar organisation of sex workers has not been possible. Interestingly, the MSM network emerged from young males involved in early sex worker programs. While the female sex workers felt no need for a support or advocacy network, and in most cases were resistant to any involvement that risked their being publically identifiable as a sex worker, the young men found a lot of

value in their new network as a support group. The MSM network did not coalesce instantly, however, and took time to consolidate.

WSB sex work programs are limited to Port Vila. Some HIV/STI interventions covering other parts of Vanuatu have attempted to include sex workers. Save the Children youth peer activities and condom social marketing have previously tried to include sex workers in both Port Vila and Luganville, with little evidence of success. Condom social marketing has been effective and appropriate for youth, but less so for sex workers. Condom social marketing may, however, impact on client attitudes to condom use. The Ministry of Youth Development and Sports supported a condom social marketing program targeted at youth in the outer islands with the aim of also addressing transactional sex. As yet, there are no evaluations or reports on that program. Church and other programs that encourage sex workers to give up sex work result in concealment and reluctance to ask for condoms.

2.2.1 Lessons from the Vanuatu experience

- Campaigns effective for youth in general will not necessarily be effective for sex workers.
- Not all sex workers are prepared to be part of a formal organisation.
- Payment for peer educators is effective.
- Access to clinical services attracts sex workers to STI/HIV education activities.
- It is important that programs can be responsive to the realities of the situation, accepting and adapting, when sex workers do not engage as expected.
- It takes time to build new networks and support groups, and to gain the trust of and to motivate those with stigmatised and marginalised identities.
- The capacity and skills of the service provider organisation is important to the success of the program.
- A holistic approach is very effective.

2.3 Previous and current programs in Chuuk State, FSM

Current needs in Chuuk

- Continuity of funding that will ensure the continuance of core HIV/STI prevention outreach activities.
- Further investment in peer educator development.
- A deeper understanding of the specific local forms and conditions of sex work in Weno and the outer islands, and of related vulnerabilities to STI/HIV.

A 2007/8 UNFPA-funded HIV/STI program conducted an HIV and STI prevention workshop with young women. The participants were given peer educator training to conduct outreach on Weno and other islands in Chuuk lagoon where paid sex takes occurs. In 2009/10 the Chuuk Resource Centre (CRC) conducted a behavioural survey with female sex workers. The results of the survey surprised many stakeholders, and challenged the predominant belief that sex work was centred on foreign fishing vessels. This CRC survey and its findings led directly to the development of an outreach based HIV/STI prevention program, targeting sex workers on Weno.

Recommendations from the survey hinged on upskilling and improved training of peer educators and on reviewing the approaches used in the peer education program. Consistent with this were recommendations that

the sex worker network be actively involved in a problem-solving approach to adapting messages and developing strategies more appropriate to the circumstances and conditions of local forms of sex work.

The current sex worker HIV/STI education program is supported by the Chuuk Women's Council (CWC), and funded by the Pacific Island HIV and STI Response Fund. The program engages two peer educators, and provides access to condom pick-up and sexual health clinic and counseling services. The peer educators conduct outreach education, referrals to the sexual health and STI testing services available at CWC, and condom distribution.

Initially, the sex worker project arranged for special opening hours at the government sexual health clinic in Weno in order to improve access to testing and treatment services. However, whenever the demands of providing general population services became too great, these special hours would be cancelled. In order to ensure that clinical services for sex workers are available and prioritised, CWC now has a room set up as a clinic. An overseas volunteer program has enabled the engagement of a nurse to provide regular and reliable clinical services to sex workers.

The NGO and the project are heavily reliant on volunteer time and resources, and both the existence and the success of the project are underwritten by the long-standing collaboration between the government health department and the NGO – a collaboration largely made possible by personal relationships and the community standing of the NGO.

The CWC sex worker education project funding will end in June 2013. The next project planned is an alternative income generation project, targeted at young mothers more generally and aims at preventing sex work uptake. Donations of sewing machines have already been received.

However the initial sex work and HIV prevention project has exposed only the tip of an iceberg and it is crucial that the primary activities of peer outreach, condom provision, HIV/STI education and clinical testing and treatment services are continued, and that recent inroads to engagement with a previously hidden population are not lost. In addition, there is a need for the continued education and upskilling of peer educators who are highly motivated but still relatively new and inexperienced and in need of support and development.

CWC has been reliant on WHO provision for condoms and will seek US funds to continue the sex work program. However, any such application will require a very creative description of the target group, as US funding excludes sex workers.

As in Port Vila, networks of sex workers in Weno are very small (consisting of several friends) and are only very loosely connected. The women involved are frightened of being identifiable as a sex worker, and of family and others knowing that they receive payment for sex. The peer educators are still making new connections with sex workers, and covering new territory. It is a slow process, as sex work is hidden and trust must first be gained.

The Chuuk sex worker HIV prevention project turns on peer educators, and support for peer educators is the area of greatest need. The peer educators are volunteers with few administrative or financial resources to draw on; they also need the backing of institutional resources and ongoing training /upskilling /inclusion in planning and decision making. Peer educators have few resources and in order to retain their services it is necessary to find some way to provide some, even if small, payment.

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In addition, peer educators need training in order to adequately document their activities. However, project administrators must themselves first be trained. Reporting to funders is a challenge for the service provider, and a considerable drain on the resources of an NGO that relies heavily on volunteer skills and time. Training support has been necessary to rescue funding for the program after funding was set to be withdrawn due to reporting inadequacies.

2.3.1 Lessons from the Chuuk experience

- Research may show that previous assumptions about the nature of sex work are incorrect.
- Research can seed networks.
- Good working relationships, partnerships and cooperation between NGO and government agents is valuable.
- Leadership from outside the sex worker population can also be extremely important. Having respected community figures to champion sex worker programs may be essential where there is no effective sex worker community, or where sex workers choose to remain anonymous.

2.4 Previous and current programs in Kiribati

Current needs in Kiribati

- Condom distribution in the clubs and bars of Betio – a district with high need for HIV and STI prevention services, especially for sex workers.
- The reactivation of a peer educator-based, sex worker-specific, STI/HIV prevention project on Tarawa.
- Further investment in peer educators' knowledge and skills development, especially problem-solving skills.
- Genuine inclusion of, and engagement with, sex workers so that they can workshop issues and develop strategies.

In 2007, UNFPA supported three STI/HIV prevention workshops, two in Tarawa and one in Kiritimati Island. One South Tarawa workshop included youth educators from the Kiribati Adolescent Health and Development (AHD) Program and the other two included women who have been boarding foreign ships *(ainen matawa).* Twenty-four participants took part in the first sex worker workshop on Tarawa. Attendance at the second Tarawa workshop in 2008 was compromised by the presence of a Korean fishing vessel in port, as many of the women were on board and could not be located. Only half the original number of participants attended the 2008 workshop (Sladden and Vulavou 2008).

A UNFPA report (2008) on the workshop program recommended that sex worker workshops be repeated to reinforce and maintain women's motivation and resolve and to conduct safe sex. It also recommended extending the workshops to other relevant atolls, such as Kiritimati Island, and to provide a range of resources to sex worker peer educators who had already been trained.

While few of those recommendations were picked up, a sex work peer education network was seeded as a result of these early workshops. It was supported by funding provided to a local Bairiki based organisation, the Kiribati Association of NGOs (KANGO), through SPC. The project pivoted on a group of peer educators who would conduct condom distribution and HIV education outreach. The program was very effective in that it regularly distributed male and female condoms and the peer educators had access to others on board the boats. The sex

workers were beginning to organise themselves and mobilise around risk reduction issues. The sex workers' relationship with the project leader was a positive and productive one, based on mutual trust.

On Tarawa, peer services are absolutely key to the delivery of condoms and other resources to sex workers. Conclusions from a qualitative investigation into HIV prevention needs of *ainen matawa* highlighted the ways in which the sex workers themselves provide very special opportunities for the development and delivery of HIV interventions. The women who board boats on Tarawa are already a community – they know each other, they stay on boats together and share many resources. The sex worker peer educators proved to be committed and motivated peer workers when they were supported through a sex worker-specific project, regularly delivering condoms around the bars and clubs on land, despite the derision and abuse they often faced from the wider community.

While the peer educators were very committed, the project needed more investment in peer educator development if activities were to effectively extend beyond condom distribution and community building. Peer educators were poorly resourced, their risk information was basic at best, and they had few skills with which to creatively approach and develop strategies for locally specific issues – of which there are many. While the sex worker project was far from fully developed, it was extremely valuable and had great potential. Unfortunately, the host organisation was very fragile and had limited capacity. Funding for the project was discontinued and, soon after that, the NGO itself also folded.

Currently, there is no HIV/STI prevention project specifically for sex workers on Tarawa. HIV prevention activities in Kiribati have been primarily directed at seafarers and their wives, and at youth. The way responsibility is divided up, along with funding, tends to encourage competition between NGOs. Other NGO stakeholders engaged in HIV prevention peer education with youth have tried to include sex workers. The peer education outreach data from these various youth projects do not provide data on numbers of sex workers reached. What the coordinators of those projects do know, however, is how difficult it is to engage and retain sex workers in an HIV prevention program.

While youth programs on Tarawa have had increasing successes with MSM groups, they have had little success at retaining sex workers in their programs, even where they have been able to make contact or hold workshops. The few inroads made to engagement with sex workers were possible only where some original KANGO program members were willing to assist. While contact and some meetings were achieved, no ongoing relationships were managed. This situation highlights the need for continuity, and the time it takes to develop trusting relationships – relationships that will not necessarily be transferred along with funding. Personnel changes in particular are a deterrent to sex workers (and other vulnerable groups such as HIV+ people) for whom trust is both essential and hard won.

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Effective sex worker programs are more expensive than generalised youth programs, as services must be outreach. Transport to and from Betio is a specific need on Tarawa, as local minivan services over the causeway are irregular and unreliable (due to the causeway being a toll road). Peer educators also need to be compensated for outreach-related expenses. This amount may be small but it must be regular.

Despite clearly identifying sex workers, along with seafarers and their families, as the most at risk group in Kiribati, the latest draft of the National Plan still buries sex workers within young people more generally, with

outputs referring to 'young people, including most at risk and vulnerable'. Not only are there currently no sex worker-specific services or projects, but at the time of consultation (January 2013) there were no condom distribution activities taking place in Betio (the area of highest population density, site of bars and nightclubs and of local interaction with foreign seafarers and access to foreign fishing vessels).

A mainstream approach of including sex workers in youth programs has failed to engage sex workers in Tarawa; only a sex worker-specific programme has ever managed to attract and retain sex workers in peer education and condom distribution. That sex worker project was only a first step, and held the potential for the development of more extensive and effective HIV prevention services for this group.

2.4.1 Lessons from the Tarawa experience

- Mainstream efforts fail to effectively include sex workers.
- Sex workers are essential to the delivery of HIV/STI prevention resources on board boats where sex work occurs.
- Sex workers are committed and motivated peer educators when engaged.
- Sex worker networks continue to exist outside of formal organisations and are a crucial resource.
- Continuity is important for service provision as trust takes time to develop and relationships of trust are crucial.

2.5 Sex work projects in other PICTs

HIV prevention in sex work programs has also been funded in Palau, Pohnpei, the Republic of the Marshall Islands (RMI) and Papua New Guinea (PNG). Although there is little data on sex work in French Polynesia, at least one local agency is known to have been working with street sex workers in Papeete.

Palau: Despite sex work being illegal in the Micronesian Republic of Palau, many female migrant workers from the People's Republic of China, Taipei, Indonesia and the Philippines employed in karaoke bars and nightclubs as hostesses and waitresses also engage in sex work. Young local Palauan girls are also reported to engage in casual sex work (pers. com. Philomen Temegil[2]), but there are no actual data on this.

A 'Ladies in the Entertainment Business Program' project, undertaking HIV/STI prevention activities for karaoke bar staff, has been funded by the Response Fund. The project office is based at the Palau Ministry of Health and the project has delivered condoms and provided in-house HIV/STI information and education sessions to the staff of karaoke bars.

In Palau, HIV prevention strategies directed by sex workers themselves are problematic.

There are many barriers to engaging the indirect sex workers who work in karaoke bars and clubs in Palau. Conditions of karaoke bar employment, marginalisation and social isolation, migrant status and the illegality of sex work in Palau – all make the identification and engagement of hostesses engaging in sex work very difficult, as well as increasing their vulnerability to HIV/STIs. These factors, combined with a high turnover of hostess staff, render HIV prevention strategies directed by the workers themselves problematic.

[2] Previously coordinator of the Ladies in the Entertainment Business Program.

Much time and repeated contact is necessary to build trust and good relationships with the mama-sans (floor managers) and the management. These relationships are essential to gain access to the workers, but there is a regular turnover of floor staff. Since the resignation of the original coordinator of the Ladies in the Entertainment Business project, its activities have effectively ceased and the program appears to be in some sort of hiatus or reconfiguration, in accordance with the precepts of the incumbent project officer.

Papua New Guinea: In contrast to Palau, where sex work is mostly based in entertainment establishments, workers here are predominantly migrants, and conditions are relatively uniform. The most striking characteristic of paid sex in Papua New Guinea is its diversity. The literature problematises simple categorisations of sex work, describing a range of forms, conditions and drivers of paid sex in the country (see, for example, Jenkins 1996; Hammar 1999; Jenkins 2000; Wardlow 2002; Mgone et al. 2002; Gare et al. 2005; Maibani-Michie et al. 2007 and Kelly et al. 2012).

Overall, however, sex work is informal and independent in Papua New Guinea and there are few, if any, organised brothels. Sex work also enables mobility and access to services for women who have no access to cash. Direct sex work clusters around, but is not limited to mines, gas fields, logging camps, ports and the town of Port Moresby. There is now increasing evidence that sex work is an important driver of the epidemic (see e.g. Kelly et al. 2012). The nature and context of paid sex has been influenced by increased mobility; the development of mines, ports and logging camps; growing urban populations; changes in access to cash income; and the gendered differentials of that access. Large-scale economic transitions have also effected changes in social and cultural roles for men and women. Forms of sex work may still be changing.

Despite a lengthy history of sex work, HIV/STI prevention projects in Papua New Guinea have been fraught and coverage has been piecemeal. From 1996 to 1998 the Transex Project was funded by AusAID in cooperation with the country's Department of Health to promote HIV prevention among sex workers and their clients in the transport and security industries. Building rapport with sex workers proved to be a long and delicate process, seriously hindered by police harassment and arrest of sex workers, including many sex workers involved in the project (Jenkins 2000). The Transex Project was originally intended to be implemented through an urban, community-based NGO, but the stigma, security and legal problems involved in working with sex workers meant no NGO was prepared to take on the project, despite the funding attached (Jenkins 2000).

Save the Children in Papua New Guinea (SCiPNG) has also worked with sex workers to prevent HIV, mainly through its Poro Sapot Project. SCiPING runs 'drop-in' centres for sex workers in Port Moresby and Goroka, and provides condoms, information on HIV and AIDS, and basic training for peer educators. The Poro Sapot project faced difficulties as a result of the illegal status of sex work and the punitive response of law enforcement. The Three-Mile Guesthouse raid provides a highly publicised illustration (see Stewart 2006).

Since about 2002, Hope Worldwide ran HIV prevention / awareness activities and condom distribution in the Three Mile area, and Anglicare also provided care, treatment and prevention in Port Moresby. Aside from these and a couple of small initiatives in Hagen and Madang, there was little in the way of sex worker projects until Papua New Guinea Friends Frangipani emerged from a national meeting of sex workers held in Goroka in 2006. In 2007 the network established a base in a Port Moresby office. Friends Frangipani is a sex worker advocacy group, whose stated aims include the provision of safe sex information and materials. Friends Frangipani has been receiving capacity building support from the Australian sex worker organisation Scarlet Alliance, funded by The Consortium.

The UN's focus in Papua New Guinea as relates to sex work is primarily around law reform, organisational capacity development, and strengthening of equitable service provision (pers. com. Stuart Watson[3]). UNAIDS PNG is currently working with Friends Frangipani, Kapul Champions (the MSM network), and Igat Hope (the PLHIV network) on legal literacy projects, including rights awareness and access to support services and emergency contacts.

Currently, AusAID HIV and Health Program-funded civil service organisations and NGO service providers are being encouraged to adapt their programs, giving them a much greater focus on targeting most at risk populations (MARP). It is as yet unclear whether this means that to retain funding, HIV/STI treatment prevention and care service providers will need to change their focus completely – from holistic services for whole communities to services for MARPs – or whether they should incorporate MARP groups into the existing services they provide. There is also a growing emphasis on head counting and size estimations, which does not sit easily with a more holistic approach to service provision. The funder decisions have been made without input from current program implementers.

Due to the diversity of forms of sex work, especially in rural areas, a range of approaches to HIV prevention service provision for sex workers is necessary. Outside the Port Moresby and development enclaves, it could be argued that those engaging in paid sex are better served by local providers who have good knowledge of specific local conditions than by any universal models of service provision.

Due to the diversity of forms of sex work, especially in rural PNG, a range of approaches to HIV prevention service provision for sex workers is necessary.

Increasingly also, HIV and STI treatment and prevention services in Papua New Guinea are being devolved to gas and mining companies and other international agents of resource extraction as part of their responsibilities to staff and the community. While this relieves the government budget, it also constitutes an abrogation of state responsibility for citizen health to private enterprise. Commentators have argued that this is a dangerous precedent (see Worth 2012).

Solomon Islands: In nearby Solomon Islands, as in many other PICTs, HIV and STI prevention activities are primarily implemented by civil society stakeholders (GARPR 2012: 7). A 2008 UNFPA report concluded that considerable capacity building was required before appropriate local agencies in Solomon Islands would be able to run HIV/STI prevention workshops for sex workers. In addition, a better grasp of factors influencing sex work and identification of key local NGO partners for delivering interventions in appropriate locations needed to occur before programs could be designed and implemented (Sladden and Vulavou 2008).

For a short period, condom social marketing was undertaken by Marie Stopes International. This predominantly targeted youth, but also MSM and sex workers where possible, and attempted to increase accessibility of condoms through taxi drivers, hotels and entertainment sites. These activities ceased with the project funding.

Pohnpei: In Pohnpei in 2011, the National Adolescent Health Development Program (AHDP) and HIV & STI Program initiated a community education and outreach program working with commercial sex workers and sailors.

[3] UNAIDS PNG

The three key strategies of the project are:

- provision of information materials on the transmission and prevention of HIV & STIs;
- provision of condoms and lubricants accompanying the materials and in key locations such as hotels (in the rooms as well as at reception), port and security offices;
- referrals to testing.

Initially, project staff conducted home visits to sex workers in shared households, offering testing and education services. Later outreach was also conducted in a local bar where sex workers operate most evenings.

The program works with a group of 25–30 women, ranging in age from 17 to 35 years, although many are still teenagers. Most of the women are locals. Sex is usually exchanged for money, but sometimes food or alcohol is also exchanged. Clients are primarily foreign seafarers – fishermen from Indonesia and other parts of Asia.

The Pohnpei program began by engaging the support of the one or two sex workers who attended the Public Health clinic, then expanded through the involvement of peer educators. The program workers visit key sites, such as the port, hotels, and sex workers' residences. To maintain confidentiality, HIV and STI testing can also be conducted at the workers' homes.

The program relies on the support of police, port security staff and hotels. A baseline of current sailors' and sex workers' knowledge and behaviours is yet to be determined. This is the next phase in an evolving program. Information provided by sex workers will help guide that evolution.

Republic of the Marshall Islands: In 2007/8, UNFPA funded a local NGO – Youth to Youth in Health (YTYIH) – to run peer education workshops, and these included workshops with local women known to engage in commercial sex. Youth to Youth in Health in Majuro and Ebeye are the only groups to have worked specifically with sex workers in Marshall Islands.

In 2008, YTYIH attempted a behavioural surveillance survey of sex workers. However, sex work is illegal and the process of the survey drew unwanted attention to the sex workers, with some subsequently being deported and others disappearing to avoid prosecution. As a result, YTYIH instead ran a number of focus groups with their network of sex workers to identify issues and develop a program. The resulting report recommended ongoing training and support for peer educators, as well as outreach to ensure the availability of condoms, STI testing and treatment, and provision of drop-in centres for social support (Alfred 2008).

YTYIH is currently funded through the Response Fund to provide sex workers with education and awareness programs, as well as access to testing and counselling. YTYIH reports show interactions with approximately 50 sex workers over a three month period. No evaluation data are available (RMI GARPR 2012).

Given that previous sex work projects resulted in a crackdown by the government on illegal immigration, and scared a lot of women into silence, women in Marshall Islands are understandably reluctant to be identified as sex workers. YTYIH has, however, been able to work with 'young women' without specifically discussing their sex work. Sex work is often attributed to Chinese women, and while migrant sex work does exist, there is clear evidence of the involvement of Marshallese women. Moreover, transactional sex – for drinks, gifts, and transport – is likely to be more common than is discussed, especially among young Marshallese.

Guam: Guam has an active sex industry comprised of street workers and workers operating from entertainment establishments, such as massage parlours, karaoke clubs and strip bars. The Guam Department of Public Health has worked with community-based organisations to implement a 100% CUP among massage parlour workers, but HIV/STI prevention efforts are predominantly done by regulation. Quarterly screening of massage parlour workers is required by the Massage Parlour Regulations which require parlour managers to ensure that workers are certified to be free of STIs and HIV. Compliance with regulations is reportedly poor. In addition, the Public Health Department has found that regulation makes sex workers difficult to reach, due to fear of prosecution.

In Guam, regulation makes sex workers difficult to reach, due to fear of prosecution.

French Polynesia: In French Polynesia two associations work on HIV prevention: 'Action contre le sida' (ACS) - action against AIDS – which has a general population focus, and 'Le club de prévention' which conducts outreach on the streets of Papeete and is familiar with the local sex workers. Unfortunately, there is currently no collaboration between them and the government agency.

3. International literature on sex work and HIV prevention

Internationally, sex workers bear a disproportionately high burden of HIV (Baral et al. 2012), indicating an urgent need to scale up access to quality HIV prevention programs. In addition, as stigma, discrimination, and violence against sex workers adversely impact on HIV prevention efforts, the wider policy – legal and law enforcement environments underwriting these phenomena – must also be addressed if efforts are to be effective (Baral et al. 2012).

Thus programs need to address both risk and vulnerability. Efforts should be two-pronged, with interventions implemented at the individual sex-worker level to reduce risk of infection, and also at the structural level to foster environments that enable safer sex practices and reduce vulnerability.

Economic analysis has shown that returns on investments in HIV prevention programs for sex workers will be substantial in a broad range of country scenarios (Kerrigan 2013). Yet 'the allocation of national prevention funding is frequently grossly mismatched to the distribution of new infections that could be averted, and the cost effectiveness of the interventions – and this is especially true for sex workers' (Kerrigan et al. 2013). Empowerment-based comprehensive HIV prevention among sex workers is cost-effective; labour costs are the major expense (Kerrigan 2013).

3.1 Addressing proximate risk factors

The most basic components of individual level HIV prevention interventions are those of risk reduction education, ensuring access to condoms and lubricant, and STI treatment. Access to voluntary counseling and testing (VCT) and to treatment care and support for those who test positive are also essential to reduce transmission risk in sex work.

The promotion and provision of condoms and improved access to STI treatment for sex workers are effective in reducing HIV transmission (Laga et al. 1994; Levine et al. 1998; Steen et al. 2000; Ghys et al. 2001 & 2002, Alary et al. 2002, Wi et al. 2006) and are the most rudimentary of risk reduction services. Use of water-based lubricants reduces condom breakage (Voeller et al. 1989; de Graaf et al. 1993; Rojanapithayakorn and Goedken 1995; Smith et al. 1998). While lubricant use is essential for male and transgender sex workers, it is also desirable for female sex workers, particularly during anal sex.

Global experience indicates specific elements of HIV prevention programs that are common to effective implementation of sex-worker interventions. Peer involvement in HIV risk reduction information and condom/lube outreach distribution is essential for success. Peer educators are central to the acceptance of HIV prevention information among sex workers. Sex worker peer educators must truly be peers, not simply age group peers for instance, and thus must have worked as sex workers or be still actively involved in sex work (Rekart, 2005). Sex worker peers are best placed to deliver condoms and risk reduction education, and they should also be engaged in the design of messages as they are knowledgeable about local beliefs and practices and conditions that influence local sex work practices. Advice given by peers on risk reduction practices is more acceptable to sex workers, and peers have better access to other sex workers than non-sex workers do. In some programs, peer educators also accompany sex workers to medical appointments (UNAIDS 2006).

Despite the fact that peer educators are usually voluntary workers receiving minimal amounts for reimbursement, a peer education program requires significant investment in personnel with adequate training, ongoing support and regular supervision (Brussa 1998). Peer educators are more likely to be retained when they receive payment.

The provision of other health, welfare and social services, skills training and workshops will also increase program acceptability and uptake. HIV/STI is improved and stigma is reduced when other sexual health and primary health-care services are available along with HIV and STI testing (Vuylsteke et al. 2004; pers. com. Philomen Temengil 2012). Prevention services need to involve significant sex worker input into design and implementation in order to attend to structural barriers to safe sex. Where 'sex worker organizations have partnered with government actors, the response to HIV among sex workers has been particularly effective and sustainable' (Kerrigan 2013).

3.2 Addressing distal factors creating vulnerability

While individual level activities are crucial, many circumstances impacting on HIV and STI risk are beyond the control of individual sex workers. Sex workers who have the most control over their working conditions are the least vulnerable to violence, STIs and other health risks (Whittaker and Hart 1996).

Environmental and structural level interventions are necessary for effective HIV prevention (Sweat and Denison 1995 and 2006; Blankenship et al. 2000; Kerrigan et al. 2006). In the context of sex work, key environmental and structural level interventions are those that attend to community empowerment and mobilisation, policies and legislation, and related third parties such as police, employers and bar owners, clients and non-paying partners, as well as key service providers.

Sex worker organisation and mobilisation is important to collective action, resource sharing, sex worker self-determination and advocacy. Collectives may provide referrals to a range of services from condom and lubricant access; support groups; clinical, welfare, legal and financial services; human rights and law reform advocacy. Project evaluations in India have found collectivisation to be positively associated with HIV/STI risk reduction knowledge and increased rates condom use (Population Council 2002; Halli et al. 2006).

Sex worker leadership plays a crucial role in promoting human rights of sex workers and reducing the burden of and risks for HIV infection. 'Where sex worker organizations have partnered with government actors, the response to HIV among sex workers has been particularly effective and sustainable' (Kerrigan 2013). A community empowerment-based approach to comprehensive HIV prevention intervention among sex workers, and early uptake of ART by positive sex workers can significantly reduce HIV incidence among sex workers and the general population (Kerrigan 2013). Early initiation of ART is, of course, dependent on access to and uptake of HIV testing and treatment.

The actions of other parties also determine the wider context of sex work and risk. Interventions addressing the environment include those aimed at the police and other agents of law enforcement, clients and bar or club owners and management (see e.g. Lowndes et al. 2000; The Synergy Project, 2000). There are numerous benefits from liaison between police and sex-work projects. Sensitisation and advocacy work with police may promote tolerance, discourage violent treatment and abuses of sex workers, and prevent the harassment or arrest of project staff (see e.g. Jenkins, 1997). Recent modeling exercises show that, more generally, reducing violence against sex workers averts new infections (Kerrigan et al 2013).

Policy and social context shape both HIV risk and the response to risk, and also influence provision and coverage of services. Legislative frameworks and policy are central to the promotion and creation of enabling environments. A recent case-study analysis of eight countries has found that criminalisation of sex work hinders the response to HIV, and prevention, treatment and care are also limited by stigma, discrimination and violence against sex workers. However, '[i]n settings where sex work is recognized as an occupation an enabling environment is created whereby stigma and discrimination against sex workers can be directly addressed and access to HIV prevention and treatment services facilitated' (Kerrigan et al. 2013; see also Section 1.5 Legal Environment above).

Even condom use policies within individual sex work establishments are effective (Morisky et al. 2002). However, the case of Thailand shows that political commitment at governmental level enables multi-sectoral cooperation and is capable of reducing rates of STIs as well as HIV prevalence nationally (Hanenberg and Rojanapithayakorn 1996; Rojanapithayakorn 2003).

Some studies have indicated that government regulation and licensing of sex work can reduce STIs and risk behaviours among female sex workers (Siotin et al. 2010). However, much of those data pertain to the regulation of brothels. Licensing is a much less effective approach to HIV prevention among marginalised and street-based sex workers (Shahmanesh, Patel, Mabey, & Cowan 2008; Siotin et al. 2010). Sex work in the Pacific is independent and often informal and in most PICTs there is little evidence to date of the involvement of middlemen or of formal brothels. Government regulation has also been criticised for human rights violations through forced STI testing and for the diversion of scarce resources from other important healthcare needs of sex workers, such as violence prevention (Wolffers & van Beelen 2003).

When sex work is criminalised or heavily sanctioned and testing is enforced, sex workers are pushed outside the public health system (Shannon et al. 2010; Nhurod et al. 2010). Moreover, compulsory testing may deter condom use by engendering a false sense of security in clients.

3.3 Service providers

Sex workers have specific needs regarding STI case management, prevention messages and condom promotion. Conventional healthcare facilities may fail to meet these needs for several reasons, including a prejudicial attitude of health-care providers and ignorance about sex workers' problems. Specialised health services or 'sex-worker only' clinics offer better opportunities for targeted educational sessions and health promotion, but potential coverage may be limited and expense may make such clinics unsustainable (Vuylsteke et al. 2004). An alternative and significantly less expensive model is the integration of a specialised package of services for sex workers into an otherwise mainstream service.

It is possible to provide accessible, acceptable and good-quality sexual health care for sex workers, either through exclusive sex-worker clinics or at integrated clinics. Key characteristics of a clinic suitable for sex workers include: location, opening times, cost, confidentiality, and staff attitude (Nyamuryekung'e et al. 1997; Vuylsteke et al. 2004). The requirement to make appointments, long waiting times, fear of discrimination and judgmental treatment from staff, and the attitudes of other patients are all barriers to clinic use by sex workers (Jeal and Salisbury 2004).

NGOs have traditionally provided services to marginalised communities, and are often best placed to help support outreach, peer education and condom promotion. However, few NGOs have the managerial and

technical capacity necessary for effective implementation and expansion of sex-worker interventions, and capacity building of the implementing NGO agencies is often necessary in order to achieve good quality, sustainable sex-worker services (Steen et al. 2006). Initial capacity building requires training of staff at service centres, community workers and peer educators. Other necessary capacity building will involve increasing the organisational and managerial skills of service provider organisations, as well as their monitoring and evaluation capacities.

If requirements for sex worker medical services widen to include HIV care, then partnerships with government health sectors become essential.

3.4 International models of sex worker projects

The usefulness of international literature on model programs is somewhat limited in its application to the Pacific region in that it comes from areas with significant epidemics and a history of successful small scale interventions. Thus the international trend is currently advocating the upscaling and integration of services (see Baral et al.). However, upscaling will be less appropriate where prevalence is low, ART coverage is poor, primary HIV prevention is still the central objective, and where only a few fledgling networks and services exist.

The Indian Sonagachi project has developed over 20 years. While it now encompasses a full range of services designed to offer alternatives to sex work, community support and advocacy, as well as core HIV prevention services, the project began by mobilising a community around those core services. In the Pacific region, sex work projects, where they exist, are still very new and undeveloped, and need to ensure that the groundwork of those core services is maintained. The Avahan project utilises partnerships between sectors to enable the most effective program implementation and service delivery.

The European Transnational AIDS/STD Prevention Among Migrant Prostitutes in Europe Project (TAMPEP) experience highlights the importance of continued investment in peer educators. It also points to the need for organisational autonomy, and the importance of being able to adapt.

PSI's TOP model focuses on behavioural methodologies, including condom distribution and peer intervention, addresses structural factors, such as stigma and discrimination, and promotes an enabling environment for HIV prevention.

In the Pacific region, Population Services International's (PSI) Targeted Outreach Program (TOP) model is worth considering for adaptation because of its dual focus on behavioural methodologies, including condom distribution and peer intervention, and on addressing structural factors, such as stigma and discrimination, and the promotion of an enabling environment for HIV prevention. Important to its success, the TOP project's practice is based on taking account of the everyday realities of sex worker lives and including sex workers in decision making.

3.4.1 India's Sonagachi Project

The Indian Sonagachi and Avahan models, both multipronged strategies led by sex workers, are the best documented structural HIV interventions.

The Sonagachi Project began in 1992 in a red-light district of Calcutta as a health promotion project to inform sex workers about HIV and AIDS, promote condom use and provide clinical STI services. The project evolved into an empowerment model with strategies that include community mobilisation, rights-based framing, advocacy and micro-finance (Population Council, 2002; Basu et al. 2004).

The project achieved markedly increased rates of consistent condom use with clients, and the prevalence of syphilis has been dramatically reduced (Population Council 2002). Trials of the Sonagachi model demonstrated significant condom use increases among female sex workers, compared to a control community receiving standard care of STD clinic, condom promotion, and peer education (Basu et al. 2004). The Sonagachi model also significantly: 1) improved HIV and STI risk reduction knowledge; 2) instilled a hopeful future orientation, reflected in a desire for more education or training; 3) improved skills in sexual and workplace negotiations, reflected in increased refusal and condom decision making; 4) built social support by increasing social interactions outside work, social function participation, and helping other sex workers; and 5) addressed environmental barriers of economic vulnerabilities by increasing savings and alternative income. It did not, however, increase members' ability to take leave or to shift location, nor did it reduce loan-taking.

Another highly respected Indian program, the Avahan project, works through state level and NGO partners, which in turn contract with local NGOs to organise peer outreach, community mobilisation and dedicated clinics for sex workers (Steen et al. 2006).

3.4.2 TAMPEP, a European project with migrant sex workers

In Austria, Germany, Italy and the Netherlands, the Transnational AIDS/STD Prevention Among Migrant Prostitutes in Europe Project (TAMPEP) works with female and transgender sex workers who have migrated from Africa, Eastern Europe, Latin America and South-east Asia.

TAMPEP uses cultural mediators and peer educators, and also offers seminars and workshops aimed at empowering sex workers and creating an environment that supports safer sex behaviour. Because sex workers migrate, new peer educators are continuously trained. The most successful peer educators are leaders of their target group; exhibit some knowledge of health; have educational talents; have excellent communication skills; and are highly ambitious and motivated.

TAMPEP spends 2–3 months selecting, training and following up peer educators. Peer educators receive a small fee while undergoing training, and they participate in course design. The peer educators receive a certificate on completion of the course.

Cultural mediators conduct follow-up by supporting the peer educators, providing additional information and materials, and facilitating contacts with public health personnel.

Lessons learned during the program's first five years reveal that peer education programs should:
(1) be part of a broader effort to improve conditions for migrant sex workers;
(2) be conducted by autonomous community-based organisations; and
(3) continuously adapt to change (Brussa 1998) .

3.4.3 P.S.I.'s Targeted Outreach Program, Burma.

P.S.I.'s Targeted Outreach Program (TOP) began in 2004 and conducts HIV prevention programs with female sex workers in 19 cities in Burma. TOP uses a peer-based approach to distribute male and female condoms and lubricant, and provides sexual and reproductive health-focused health care.

TOP faces numerous impediments to HIV prevention efforts; Burma is large, infrastructure is poor and there is a lack of skilled personnel. In addition, political conflict is intermittent and persistent. PSI has reported a decline in HIV prevalence among female sex workers who participate in TOP, from 33.5% in 2006 to 11.2% in 2009. PSI has estimated that around 70% of female sex workers in Burma were reached by TOP during this period and that the program contributed to the decline in HIV prevalence among sex workers nationally (TOP, PSI Myanmar and USAID 2011).

It is impossible to change behaviour and achieve results on this scale with only a single, or sporadic, contact with participants; extensive coverage, repeat contact, and reiteration of HIV prevention messages were all essential to the success of the project. The project started in one city and coverage was gradually extended, expanding throughout the country. In 2010, TOP made repeated contact with 47,215 individual sex workers a total of 196,500 times, about quarterly on average (TOP, PSI Myanmar and USAID 2011).

In addition to providing direct services, TOP addresses social drivers of HIV, broaching stigma and discrimination, promoting community mobilisation and adopting an advocacy role for sustained positive effects on health.

TOP's integrated approach includes clinical services, confidential VCT, treatment for tuberculosis, reproductive health services, STI treatment and antiretroviral therapy. Peer outreach activities include education and communication, resource distribution, and community building. Peer outreach workers also invite potential clients to TOP's drop-in centres, which offer a safe place for sex workers to meet, fostering community building, support groups, training and educational activities, entertainment, and self-care, including bathing and sleeping. These centres are vital to TOP's program (TOP, PSI Myanmar and USAID 2011).

Health care provider training and sensitisation to stigmatisation and discrimination are another key element of the TOP program success, as these ensure that sex workers are not alienated and deterred from using STI/HIV testing and treatment and other essential health services.

TOP's experience shows that achieving a high level of coverage and good quality services is dependent on the organisation's understanding of the wider context of sex workers' lives, and this is achieved by the participation of sex workers in both the design and implementation of the programs. Hiring sex workers as project staff is a key means of ensuring inclusion, and also improves chances of reaching the more covert and hidden sex worker populations.

3.5 Universal principles

Overall, the international experience shows that structural interventions, such as policy change and sex-work collectivisation, can significantly impact a broader range of factors to reduce vulnerability to HIV and STIs than can clinical and prevention services. Thus a multipronged approach will have more effect than behavioural interventions alone (Shamanesh et al. 2008; Swendeman et al. 2009). A combined model of peer-driven, empowerment-focused behavioural interventions, and free HIV and STI testing for all sex workers, and mobile outreach to the most marginalised sex workers may help promote HIV prevention in resource-limited settings

(Siotin 2010). Confronting marginalisation and discrimination and reducing violence against sex workers are key to fostering an environment in which effective HIV prevention for sex workers is possible.

While there is no single universally appropriate model, a set of universal principles have been proposed by WHO, UNAIDS and APSWN. These include:

- a non-judgmental approach;
- ensuring interventions do no harm;
- ensuring privacy, confidentiality and anonymity;
- according human rights and basic dignity;
- valuing sex workers' views, knowledge, and life experiences;
- inclusion of sex workers in development and implementation of interventions;
- conceptualizing sex workers as highly motivated to improve their health and well-being as part of the solution;
- building capacity and leadership among sex workers to facilitate effective participation and community ownership;
- recognising the role of clients and third parties and the environment in HIV transmission; and
- responding to the diversity of sex work settings and of sex workers.
  (See WHO 2004).

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