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Me, My Intimate Partner, and HIV:
Fijian self-assessments of transmission risks

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USP Library Cataloguing-in-Publication Data

Me, my intimate partner, and HIV : Fijian self-assessments of transmission risks / Lawrence Hammar… [et al.]. – Suva, Fiji : United Nations Development Programme Pacific Centre, 2011.

90 p. : col. ill ; 26 cm.

ISBN 978-982-304-041-7

1. AIDS (Disease)—Fiji 2. AIDS (Disease)—Fiji—Prevention 3. HIV infections—Fiji—Prevention
I. Hammar, Lawrence II. UNDP Pacific Centre.

RA643.86.F5M45 2011 362.1969792

Content

Acknowledgments

Special thanks go to the 74 study respondents and the 21 Key Informants who gave so generously of their time, thoughts and lives.

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Organizational support
Fiji Ministry of Health (Dr. Josaia Samuela), Fiji National Health Research Ethics Committee, Fiji Network of People living with HIV (FJN+), UNAIDS and AIDS Team (Pacific), Pacific Islands AIDS Foundation and UNDP.

Funding support
Programme Acceleration Fund (PAF) through UNAIDS and UN Theme Group.

Project Management and report production (UNDP)
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Photograph credits
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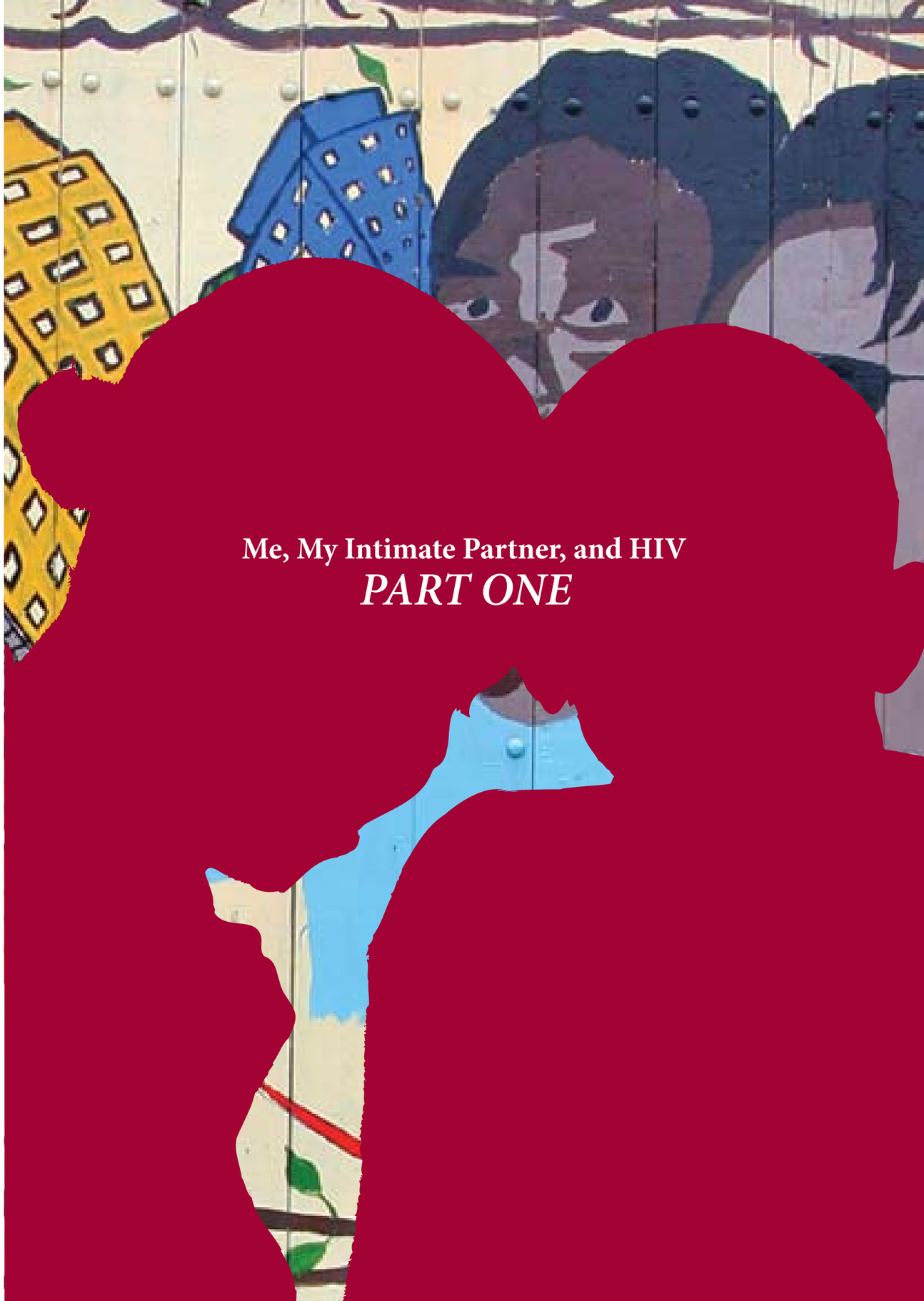
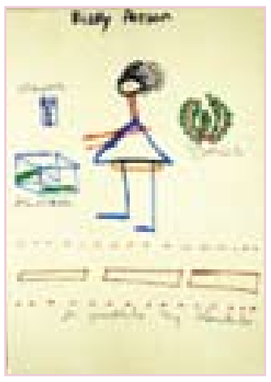


Précis: "Intimate Partner Transmission of HIV in Fiji"

This report is designed to strengthen Fiji's response to HIV and AIDS. The aim of our study was to provide useful data about how Fijians think of and manage their risks of sexual transmission of HIV. We used multiple research methods and instruments to investigate the cultural, cognitive, and behavioral factors that shape HIV and STI transmission risks in Fiji. For the sake of brevity, we did not include here research protocols and instruments, letters of introduction and research clearance, statements of informed consent, and the like, but they can be obtained upon request to UNDP.

Part One contains an Executive Summary of the data we collected in Suva in July, August and September of 2010. We also discuss the five-weeks-long workshop in qualitative research methods that was led by Lawrence Hammar, the Principal Investigator (PI), a cultural-medical anthropologist who has ties of longstanding to and in the insular Pacific. The workshop was attended by eight Fijians: Tura Lewai, Tuberi Cati, Vilisi Gadolo, Jone Gucake, Verenaisi Turagaiviu, Sesenieli Bui, Rachana Kumari, and Elenani Naikini Sotia. Their general and specific accomplishments show what a bright future there is for qualitative research in Fiji.



Part Two presents the findings that emerged from research we conducted with members of six "target groups"—1) gays, lesbians, and transgenders; 2) taxi-cab drivers; 3) health care workers; 4) university students; 5) Christian pastors; and 6) people in sex work—and their Intimate Partners. We conducted 14 focus group interviews, with a total of 74 participants; 73 of those 74 took part in one-on-one, in-depth, individual interviews. All 74 also engaged individually and in group settings in concept-mapping (drawing) exercises that depicted their self-assessments of HIV transmission risks. The drawing that graces the title page of this report, for example, depicts a participant's response to our request of everyone that they draw "Me, My Intimate Partner, and HIV." We also asked participants privately to draw "How I Try to Prevent HIV Transmission" and in a focus group setting to draw "Risky Persons," "Risky Behaviours," and "Risky Settings." We also conducted 21 Key Informant interviews with Suva-based Fijian experts in these issues.

In Part Three we discuss our findings in greater detail. We digitally recorded formal interviews and we continue to transcribe, code and analyze the transcriptions we made of them. We used multiple data points and sources to summarize the contours of 37 intimate relationships. We have condensed those into summaries of intimate relationships, Target Group-by-Target Group. We coded and analyzed and discuss here the various concept maps our respondents drew. We also present in less structured, narrative form the statements our respondents made about their knowledge of STI signs and symptoms and the beliefs they hold regarding the ability of non-standard practices and substances ("herbal medicine," prayer, etc.) to prevent if not also cure HIV infection.

Our focus was consistently upon finding evidence of factors that might heighten risk of transmission of HIV and STIs in the context especially of intimate relationships. Those included ongoing, untreated STIs; patterns of sexual networking and frequencies of "relationship infidelities"; knowledge of STI signs and symptoms; inconsistent or altogether absent condom use; and beliefs and practices regarding treatment of HIV infection.

We found that our 74 Fijian respondents have internalized and easily express public health messages about abstaining from sex, being "faithful" sexually, and getting tested for HIV antibody (HIVab). Nevertheless, they also and accordingly externalize their own HIV transmission risks, away from Self and Intimate Partner toward Other, especially strangers and sex workers. Moreover, they exaggerated the risks of HIV transmission via renegade men wielding syringes (as pictured below), sports injuries, and blood transfusion and donation. This example is one of many, many that could be cited.

In the final sections we discuss why and how it is that we think that our respondents did not exhibit much specific knowledge of the signs and symptoms of STIs or match their considerable expression of rhetoric about condom use with their actual use. Specific knowledge of causes, signs and symptoms of STIs was limited to instances of discharge, captured by the "covering term" in the Fijian lexicon: tona. Many participants believe in the power of faith and prayer to treat or cure HIV infection. Various forms of "Fijian medicine" and faith healing were resorted to instead of or to augment pharmaceutical cures for STIs or treatments for HIV. Instead of perceiving the HIV and STI transmission risks of sexual intercourse per se (and avoiding sex or using condoms accordingly), respondents constructed risk in terms of renegade syringe injectors, blood transfusions, accidental blood contact, tattoo needles, and sex with strangers and especially sex workers. Even the Intimate Partners of sex workers located risk in the persons and actions of sex workers but denied their own risks accordingly. Just like other respondents, and instead of using condoms, the Intimate Partners stressed the importance of "sticking to one partner," of "trust," and of "being faithful." Of course, neither they nor their sex worker wives and girlfriends do or can do any of those things. Moreover, three of those Intimate Partners reported higher numbers of sexual partners in the past 12 months than did their sex worker wives and girlfriends.

In summary, we are convinced that Fijians currently face a terrible dilemma without benefit of critical, open discussion of the individual and public health consequences of sexual ethics. Fijians can avoid infections by having sex that is better protected (by condoms), and perhaps even with a larger number of persons, with consent, communication, and mutuality of pleasure, or they can adhere to cultural and religious rules to have sex only with a legal spouse of the opposite sex but without condoms. The first option is safer in terms of HIV and STI transmission risks, but the risks of social and religious approbation are higher, especially so if she be a female. The second option heightens transmissive risks because social and religious codes are adhered to, and those codes tend to protect (heterosexual) male privilege. Accordingly, the gender-neutral tenor of public health campaigns and messages, we feel, thus needs to change. "Stay Faithful," "Stick to One Partner," "Wait Until Marriage," and the like, don't seem to match the realities of sexual desire and sexual practice in Fiji. Only five of our 74 respondents were virgins at marriage (none being Christian pastors or their spouses). Several spoke of the non-consensual conditions under which they lost their virginity.

Abbreviations and Acronyms Used

AIDS	Acquired Immunodeficiency Syndrome, or AIDS, is a surveillance definition that means a syndrome of opportunistic infections and diseases that can develop as immunosuppression deepens along the continuum of HIV infection from primary infection to death. Often greatly misunderstood and contested, it is collection of signs (such as prolonged weight and hair loss), markers (lowered CD4 cell counts, HIVab sero-reactivity), and symptoms (productive cough, persistent diarrhea). "AIDS diagnoses" are highly correlated with these symptoms and usually (but not always) an HIVab+ blood-test result.
ART	Antiretroviral therapies. The term ART has replaced the former HAART, or Highly Active Antiretroviral Therapy. Either way, a pharmaceutical regimen that combines several drugs (usually two nucleoside reverse transcriptase inhibitors and a protease inhibitor) to attempt to slow or thwart viral replication and bring the viral load in a person who is HIVab+ to a low, hopefully undetectable level.
ARV	Antiretroviral/s. Refers to drugs used to treat infections caused by retroviruses (primarily HIV).
ANC	Antenatal Clinic.
FJN+	Fijian Network for People Living with HIV/AIDS, a Suva, Fiji-based organization for ethnic Fijians who have tested HIVab+ and that provides training, referrals, counseling and support, in addition to testing services.
GDDs	Genital Discharge Diseases, such as chlamydia and gonorrhea. These would appear to be referred to locally in the Fijian language as tona, but that term may also function as a covering term for all STIs.
GUDs	Genital Ulcer Diseases, such as syphilis and Herpes Simplex Virus-Type II (genital herpes). There appears to be little specific local knowledge in Fiji of them (and no terms in Fijian or Hindi language) beyond mentions of syphilis.
HIV	Human Immunodeficiency Virus. "HIV" is split into two main types (HIV-1 and HIV-2), the first of which is split further into three major Groups—M[ain] , N, and O—Type C of the first of which is common in sub-Saharan Africa and in Papua New Guinea, which comprises 95%+ of all HIV infections in the insular Pacific.
HIVab	HIV antibody, what our blood can produce following sufficient exposure to HIV.
HIVab-	HIV antibody-negative, a test result suggesting non-exposure to HIV.
HIVab+	HIV antibody-positive, resulting from a testing algorithm that finds "Initial" and "Repeat" Reactives that must be "confirmed" by additional and/or different tests.
KIT	Koninklijk Instituut voor de Tropen (Royal Tropical Institute).
NACA	National Advisory Committee on AIDS, located in the nation's capital of Suva.
NGO/ INGO/ FBO/ CBO	Non-Government, International Non-Government, Faith-Based and Community-Based Organizations; each has aided Fiji's response to HIV and AIDS.

PMTCT	Prevention of Mother-to-Child Transmission, now changed to PPTCT: Prevention of Parent-to-Child Transmission, meant to include and instill a greater sense of male involvement and responsibility.
STIs	Sexually Transmitted Infections, such as gonorrhea, syphilis and chlamydia.
SPC	Secretariat of the Pacific Community.
UNDAW	United Nations Division for the Advancement of Women.
UNGASS	United Nations general Assembly Special Session [on HIV and AIDS].
UNAIDS	United Nations Joint Programme on AIDS.
UNDP	United Nations Development Programme
VCCT	Voluntary Confidential Counseling and Testing, which has been promoted as an indirect method of prevention. Five "hub centres" throughout Fiji provide the bulk of testing and counseling, although many other organizations sponsor projects in which counseling, testing, and treatment for STIs are provided.
WHO	World Health Organization.

Executive Summary

Training

- between June 23rd and July 28th, 2010, the Principal Investigator (PI), Lawrence Hammar, led a training workshop in Suva, Fiji
- eight Fijians were taught qualitative research methods, skills, perspectives, and findings
- attendees deepened their knowledge base regarding HIV and AIDS in the Pacific
- attendees strengthened local research capacity and lessened dependence on foreign donors
- five of the eight graduates completed the data-collection phase

Sampling

- 74 members of six target groups (and their Intimate Partners) were enrolled using personal contacts, cold-calling, and convenience sampling procedures; they were then assigned color-coded, alphanumeric identifiers (e.g., Green004B)
- target group members and their Intimate Partners were contacted separately; each had to agree to provide informed consent, separately, for either to be enrolled in the study
- Christian pastors and the Intimate Partners of taxi-cab drivers were the hardest to enroll
- the sample was thus: **Orange (gays, lesbians and transgendered persons): 6+6=12; Green (taxi-cab drivers): 7+7=14; Blue (sex workers): 6+6=12; Purple (university students): 8+8=16; Black (health care workers): 5+5=10; Red (Christian pastors): 5+5=10**
- each person participated first in a focus group discussion, then engaged in two concept-mapping exercises, and then in an individual interview (one did not sit for this interview)
- respondents were not interviewed by the interviewer of their Intimate Partner
- participants were compensated for their time and transportation
- no untoward events or feelings related to the raising of sensitive topics were reported
- participants many times reported positively upon their participation in the study

Sociodemographic findings

- 33 (45%) lived "downtown," 36 (49%) in urban settlements, and four (5%) in rural villages
- 55 (75%) were ethnic Fijian, eight (11%) Indo-Fijian, seven (10%) Fijian-other Pacific islander, and one (1%) Fijian-European
- six (8%) were educated through primary school, 43 (58%), through high school, 16 (14%), through tertiary/vocational/technical school, and eight (11%), through university
- 69 (95%) professed Christianity; three (4%), Hinduism; and one (1%), Islam
- 34 (47%) earned pay-checks; 11 (15%) were unemployed, looking for work; 16 (22%) were housewives or students, six (8%) were sex workers; five (4%) were subsistence farmers; and five (4%) were street-vendors
- 24 (33%) were single, never married; 29 (40%) were married, only once; nine (12%) were in a "de facto" marriage; five (7%) were married more than once; four (3%) were divorced; two (2%) were widowed
- six (8%) had spent time in prison, the lengthiest sentence having been seven years; none reported any sexual behavior whatsoever while in prison

Findings about HIV and STI signs and symptoms

- **note:** not all the "health workers" in our overall sample were in the health worker Target Group; not all of the gay, lesbian and transgendered persons were in that Target Group
- **five reported being (or were reported by their Intimate Partners to be) HIVab+**
- **at least two, maybe three had not disclosed their status to the Intimate Partner**
- **no HIVab+ respondent used condoms consistently;** one wife did not use them with her HIVab+ husband, but did use them with her boyfriend; an HIVab+ husband used "Fiji medicine" instead of condoms to prevent transmission; the wife of an HIVab+ man "trusted in the Lord to prevent HIV to me"
- when asked about signs and symptoms suggesting STIs, 24 (33%) reported having **in the past** suffered pain during sexual intercourse; 19 (26%), pain on urination; 18 (25%), lower abdominal pain that doesn't go away; 10 (14%), genital itchiness, 10 (14%), genital/anal discharge; seven (11%), a genital/anal sore; and seven (11%), problems suggesting infertility
- 23 symptoms probably of STI were reportedly suffered once; nine, twice; five, "many times"
- 10 respondents (14%) reported **currently** suffering genital/anal discharge; seven (10%), pain during sexual intercourse; four (5%), pain on urination; nine (11%), lower abdominal pain that doesn't go away; two (2%), genital itchiness; two (2%), genital/anal sore; one (1%), an ongoing problem suggesting infertility
- 23 respondents who reported suffering the apparent signs and symptoms of STIs sought treatment at a health facility (one through a private doctor); eight self-treated; six went to a traditional healer; five did nothing; 14 continued to have sex prior to seeking treatment
- **none of the five HIVab+ mentioned symptoms thereof or taking any HIV medications**
- **four HIVab+ respondents (and/or their Intimate Partners) report taking "Fiji medicine," "herbal medicine," and "water cures"**

Findings about sexual activity

- **respondents highlighted the importance of abstinence, but only five were virgins at marriage**
- 11/45 "singles" (24%) reported having had extra sexual partners in the past 12 months
- 11/28 "marrieds" (39%) reported having had extra sexual partners in the past 12 months
- of those reporting extra sexual partners in the past 12 months, the mean number thereof was 6.6; six respondents reported two additional partners; seven reported three, three reported four, four reported five, one reported eight, one reported 11, one reported 15, two reported 34 (one being a policeman, one being a health care worker), and one (a shoe-shine "boy" and security guard) estimated having "50+" sexual partners in the past 12 months
- **52/73 (71%) reported ever having given or received anything directly for sex** (multiple answers were possible); 25/52 (48%) had given or received money; 19 (37%), alcohol/other drugs; 17 (36%), clothing; 12 (23%), food; 10 (20%), rides; four (8%), yaqona
- **51/73 (70%) reported having experienced oral sex (this is probably an underestimation insofar as it included those who identified as gay males and who didn't report engaging in anal sex);** the youngest age at which oral sex was experienced was seven years of age; the oldest (to date) was 22 years of age; the mean age of first experience was 15.8 years
- **70/73 (96%) had experienced vaginal sex (the three exceptions being gay males);** the mean age at first experience thereof was **16.21 years**

- **9/73 (12%) reported having engaged in anal sex;** the mean age of first experience thereof was **19.2 years;** the youngest age at which it was reported to have been first experienced was at age 11; we suspect that this, too, is an underestimation: no sex worker or Intimate Partner thereof nor several gay males reported engaging in anal sex
- two respondents (a male and a female) were five and six years old when they lost their virginity; one each was 10, 11, and 12; two were 13; three were 14 or 15; 10 were 16
- 23/73 (32%) said they had been "forced" into sex; several were men who said that girlfriends or wives had "forced" them or that "senior boys" had "forced" them into, for example, engaging in "convoy" sex; several women said that they had "forced themselves" to have sex in order to please partners
- **10/73 (14%) had forced others to have sex;** a few women said they had forced men into it
- **13/73 (18%, 11 being males) had engaged in "group sex" including "convoy,"** which several men did not consider to be "forced" sex, even when rape charges were later brought
- **4/73 (5%) had their first sexual experience with a relative,** including a six year-old girl who was raped by her uncle; three females had been raped by (male) relatives
- many respondents said incest (usually but not always forced) was common and increasing

Findings about sexual hygiene and genital practices

- sexual lubricants used included saliva, coconut/soybean/baby/vegetable oil, shampoo, body lotion, hair/shaving gel, Vaseline, egg-whites, commercial lubricants
- one male (an ex-prisoner) reported having inserted marbles into his penis, but 42/73 (58%) knew of such; 9/42 (21%) mentioned ball-bearing/glass pieces/toothbrush tip insertions; 6/6 sex workers and several gay and transsexual males had seen them in male sex partners
- vaginal and anal douching prior to sexual intercourse were commonly reported
- most females knew other females who had used lemon leaves or juice, saltwater baths, steam baths, alum powder, Colgate toothpaste, ginger pieces or juice, and Detol and commercial douching preparations to "cleanse" and "tighten" the vagina; "Fijian herbal medicine" was several times mentioned as being used to heal cuts and lesions in the vagina

Condom use behaviors

- **18/73 (25%) reported having used a condom at last sex,** with anyone; Self initiated condom use 12 times; Partner, four times; both, twice
- **university students exhibited the highest rates of condom use at last sex (81%);** only five of the remaining 57 respondents (9%) had used them at last sex
- 25% had used a condom at last sex, but 62% depicted condom use on their concept maps
- of those who had **not** used condoms, 34 (62%) cited "faithfulness" as their reason; 11 (20%) said they "didn't like the feeling"; eight (15%) said "their partner didn't like the feeling"; nine (16%) said condoms were "too expensive or unavailable"; two said condoms were "against their religion" (multiple answers were possible)
- of those who **had** used condoms, "prevention of STIs and/or HIV" was mentioned 18 times; "family planning," four times; "not knowing their partners," two times
- 39/73 (53%) had traveled away from Suva in the past 12 months; seven had engaged in sex while traveling, but condom use away from home was inconsistent

Cognitive structuring of HIV and STI transmission risk

- **Only 11/73 (15%) felt themselves to be at "high risk," but 54/73 (74%) and 52/73 (73%), respectively, wanted to be tested for HIVab and STIs**
- of the 62/73 (85%) who said they were at "low risk," most seemed unaware of their partner's infidelities and of their own or their partner's current infections (including of HIV)
- there was **almost no specific knowledge of the properties of STI and HIVab testing,** including in health workers and their Intimate Partners; some believed tests to be methods of prevention; others believed them to be unnecessary insofar as they had been tested previously; yet others believed HIV to be remarkably easier to transmit sexually than STIs; still others wanted an HIVab but not STI test—or vice-versa—or that there was a singular "STI test"
- specific knowledge of causes/names/signs of STIs was minimal, including in health workers
- **many, including health workers, believe HIV infection can be cured by faith and prayer**
- **only four (all females) stated transmission risks to emanate from Intimate Partner**
- frank discussion of sex, condoms, desire, and STI and HIV transmission routes **is rare**
- **unsafe sex is normative** in non-commercial sexual encounters
- taxi-cab drivers facilitate a lot of casual and commercial sexual networking
- there is a lot of talk of love of and communication with sexual partners, but little evidence of them

Me, My Intimate Partner, and HIV
PART TWO

Introduction

"Umm . . . the [drawing] titled "Be Faithful," what I meant here is me and my wife, the one that I'm legally married to. Be faithful to each other, in the sense that you spend more time, valuable time together by knowing each other's needs and wants. Nowadays, many married couple never spend time together" (husband of a health worker).

Roughly 837,000 people live in Fiji, mostly on Viti Levu or Vanua Levu, two of the 100 or so inhabited islands. About one-fifth of them live in the nation's capital of Suva. About (54%) of all Fijians are ethnic Fijians, also called "i-Taukei," and most of those profess Christianity. Fijians of Ethnic Indian descent (Indo-Fijians), most of whom are Hindu or Muslim, comprise another 39%. The remaining 7% or so of Fijians are other Pacific islanders, for example, from the Solomon and Cook Islands, and expatriates from various European and Asian countries (WHO 2006: 30). In US$, Fijian Gross Domestic Product per capita ($3,514) is greater than twice the figure for Vanuatu and more than five times greater than the figures for Papua New Guinea and the Solomons (Schoeffel 2009: 4, Table 1). In terms of the number of live births in hospitals, the average life expectancy, the number of health facilities and people's access to them, Fijians are a healthy, vibrant population, especially by comparison to other countries in the Pacific, for example, Papua New Guinea (Hammar 2010a).

Unfortunately, the incidence (new cases of) and prevalence (existing caseload) of sexually transmitted infections (STIs), whether genital ulcer diseases (GUDs) such as genital herpes and syphilis, or genital discharge diseases (GDD) such as chlamydia and gonorrhea, pose serious and growing health problems in Fijians and other insular Pacific islanders. The prevalence of genital herpes and other STIs in females attending antenatal clinics (ANC) in Vanuatu, for example, is extremely high in itself (Haddow et al. 2007; Zenner and Russell 2005), but infection with such also heightens the risks of sexual transmission of HIV (and other STIs). A 1986 study employing routine testing of 440 antenatal clinic-attending females (257 ethnic Fijians, 183 Indo-Fijians) found that 14.2% of the former and 1.7% of the latter tested positive for syphilis, and that half of the ethnic Fijian females and more than one-third of the Indo-Fijian females were also infected with chlamydia (Gyaneshwar, Nsanze, Singh, Pillay, and Seruvatu 1987). Indeed, the burden of infection with chlamydia that is shouldered by pregnant females in the Pacific is among the heaviest in the entire world (SPC 2010). Fijian females were reported by the Ministry of Health in September of 2010 to "top the list" in the Pacific (Rina 2010). The WHO-sponsored Second Generation Survey (SGS) conducted in 2004-2005 and again in 2008 in Fiji and five other Pacific countries found that 29% of a large cohort of antenatal clinic (ANC) attendees had been infected with chlamydia, another 1.7% with gonorrhea, and another 2.6% with syphilis (UNGASS 2010). Chlamydia prevalence in Fiji's ANC attendees **even who reported that they had had only a single sexual partner in the previous 12 months** was still greater than one in five (29/134—21.6%; UNGASS 2010: 7). Chlamydia prevalence in those 25 years of age or younger was 37.5% (Fiji Ministry of Health 2010: 5), suggesting that this STI is hyperendemic.

Researchers of all stripes now accept that HIV and STI transmission risks are also about gender relations and gender-based violence, however, not just the properties of viruses, parasites and bacteria (see Lepani 2004; Hammar 2010a, b, c; Sladden 2005). Although it has taken two decades or more for many organizations to recognize the consistent findings of social scientists along these lines, virtually all of them now affirm the centrality of gender relations in HIV and STI transmission, prevention and treatment (cf. UNAIDS 1999, 2000a, b, c; UNAIDS and KIT 2005; UNDAW 2004; WHO 2001, 2003, 2004a, b, 2010).

In Fiji as elsewhere throughout the Pacific (Schoeffel 2009), rape, wife-bashing, incest, sexual molestation, and other forms of sexual violence are common and underreported (Chaudhary 2003-2004; George 2008; Kaitani 2003; Tora 2006). A research study conducted by the Fiji Women's Crisis Centre (located in Suva) involving 1,575 Fijians sampled randomly and interviewed by scheduled interview found that 80% had witnessed domestic violence in their homes. About 95% of the cases had been perpetrated by males against females, and male family members were the perpetrators "most of the time." Nevertheless, regarding rape and incest, a remarkably small fraction of even the cases reported to the police or in the pages of the Fiji Times were reported to them (only 420 cases in 25 years; see http://www.fijiwomen.com). "Convoy" sex, known euphemistically as "serial sexual intercourse" and known in Papua New Guinea as lainap or singol fael, is in Fiji, according to Kaitani (2003: 226), "a common practice of young men [although boys] do not see it as rape." The text box recounts two of the instances thereof that our respondents related (see above).

Text box 1:

Interviewer: "Have you ever taken part in group sex?"

Fijian male: "Yes, in boarding school one weekend, several girls came, and one girl, she had sex with 50+ boys. No condoms were available. You weren't allowed to do that [use condoms] in school. The girl got pregnant, she complained to the police that she was raped, but it was willing" (23 year-old Fijian male university student).

Fijian male: "I went to an all-boys school. When I was 17 years old, towards the end of school term we had a social and we brought a girl to the dorm and hid her for three days. We drank home brew, 13 of us, and we had convoy sex, unprotected. In the beginning, I didn't want to, but I was threatened by the senior prefects that if I didn't participate, I would be beaten up" (22 year-old Fijian male university student).

In some ways, the coming of HIV and AIDS to Fiji has heightened interest in other, related, public health matters and sharpened the focus upon gender relations. Manual search of every issue and the turning of every page of the Fiji Times newspaper for 2000-2009 showed that media coverage in Fiji of these problems has increased public awareness of (and outcry against) them. Increasing HIV prevalence is often linked to the growing prevalence of untreated STIs. Those are often associated with if not blamed on declining "tradition," the "breakdown of the family," the increasing sexualization of particularly female youth, and

Text box 2:

"I am often asked whether there will ever be a cure for HIV/AIDS, and my answer is that there is already a cure. It lies in the strength of women, families and communities who support and empower each other to break the silence around AIDS and take control of their sexual lives" (quoted in Epstein 2007: 167).

the influx of Western-derived music, pornography, Hollywood, Bollywood, the Internet, cell phones, and social networking sites.

Such discussions of cultural and specifically religious taboos are surely increasing. Other conversations are taking place in Fiji about widespread changes that have occurred to patterns and outcomes of sexual networking and the transmission of STIs and HIV. As never before, Fijians are now saying "no" to sexual violence, questioning heterosexual male privilege, and beginning to confront the longstanding cultural and religious taboos that prevent open, frank discussion of these and other sexual matters (Sturrock 2007; Tora 2006). The quote in the text box above (text box 2) represents similar conclusions to which Ugandan women came when faced with the steady increase in deaths of friends and loved ones.

Even though Fiji remains a "low prevalence" country, high levels of movement, literacy shortfalls, proximity to countries that have high HIV prevalence, and high rates of STI transmission mean that this is not the time in Fiji to remain complacent, as Tim Sladden wisely reminded us (2005). The Burnet Institute concluded in 2009 that "Fiji's location and function as a regional hub, together with anecdotal reports of STIs being acquired in Fiji by nationals of neighbouring [Pacific Island Countries and Territories] and subsequently imported to their countries of origin, suggest that control of HIV in Fiji may have a considerable impact on controlling spread in the wider Pacific" (Coghlan et al. 2009: 61). The cumulative number HIV cases, the increasing recognition that STIs are endemic in Fiji, the ongoing problems related to commercial sexual networking, and the increasing sexualization of Fijian culture have led some to conclude that Fijian communities are "at great risk for the introduction and rapid spread of HIV infection" (Cliffe, Wang and Sullivan 2006: 28). HIV infection trend data in Fiji suggest, say McMillan and Worth (2010: 4), "the potential for a rapid spread and negative social and economic impacts, should numbers of HIV infections reach a critical mass."

Whatever "critical mass" may mean, it took 15 years (from 1989 to 2004) for the first 182 HIVab+ cases to be reported to the Fiji Ministry of Health, but only six years (2005-2010) for the next 182 to be reported. Most (87%) of those 364 cases involve ethnic Fijians, and only one case each has been attributed to intravenous drug use and blood transfusion. While males still account for 53% of the total since 1989, the male:female ratio was reported in 2009 to be 45:55 (Fiji Ministry of Health 2010: 3). These shifts appear to be following trends reported elsewhere in the Pacific (Hammar 2010a), leading many to talk of the "feminizing" of the epidemic.

But what to make of even this seeming trend, much less the seeming trend of increasing HIV transmission, is far from clear. In Fiji as elsewhere, most HIVab testing is done on pregnant females, there is no equivalent male clinic population matched for age and relationship status, and females who attend ANC have by definition been having unprotected sexual intercourse. Because qualitative sexuality and health services research are not yet well developed in Fiji, it is difficult to say how representative those figures are. Given the low number of HIVab tests conducted since 1989 and their non-random character (most tests are done in ANC or in STI clinics), there aren't sufficient data yet to define the epidemiology of HIV clearly.

What is clearer, however, is that when national HIV and AIDS responses are not guided by sufficient empirical data and social-scientific principles, those responses suffer. This has been demonstrated in Thailand (Fordham 2005), Nepal (Pigg 2001), Indonesia (Butt, Munro and Wong 2004), and South Africa (Epstein 2007), to mention just a few examples. Hammar (2007, 2008, 2010a, b), Lepani (2004), Reid (2009) and many others have critiqued the questionable assumptions that have blunted the efficacy of the response in Papua New Guinea to HIV and AIDS.

The primary aim of this report is to recount key findings from qualitative, exploratory research that the Principal Investigator (PI), Lawrence Hammar, conducted with Fijian co-researchers in Suva. The research focused on 1) what Fijians do and don't know about STI signs and symptoms; 2) how they assess their own HIV transmission risks; 3) how they think they can treat or cure HIV; and 4) what they think about condom use and with whom they think they ought to use them.

The research crew used multiple methods in multiple settings to collect and interpret multiple kinds of data from members of multiple Target Groups and their Intimate Partners. As for the research methods and instruments, in-depth, one-on-one style interviews were conducted. Respondents were engaged in concept-mapping exercises. The team conducted focus group discussions about topics including community, sexual and reproductive health and wrote fieldnotes based upon the participant-observation in which team members engaged around town.

In the pages below we explore cognitive patterns and behavioral dynamics that emerged from the study. Many data points and sources suggest a great degree of cognitive dissonance in Fijian self-assessments of HIV and STI transmission risk. We found that Fijians have internalized public health messages to "abstain from sex" or, failing that, to "stick to one partner" or, failing that, to use condoms, but that are contradicted by their actual sexual practices. Each of the text box 3 quotes (below) about abstinence and fidelity, for example, comes from the mouths of people who are sexually active with many, many more than their Intimate Partners; the first is someone who recounted 34 in the past year, the next two are from men who are the frequent clients of sex workers, and the final five are from five sex workers.

Text box 3:

"One way to prevent HIV is not to have sex, is . . . to wait for the right person and . . . and stick to one partner."

"Okay . . . I have to stop myself from being a sex pervert. Here in Suva . . . we have women but may be men, too, who sell themselves for sex . . . and these I have try to avoid, try to avoid from going to this group know[n] as prostitute."

"Secondly, you should have . . . one sex partner, only one sex partner . . . You'll see that I've drawn a church. You and your partner should become a devoted Christian and be faithful in believing in God. Secondly, you should go to the hospital for check up every month."

Sex Worker #1: "Being faithful for your whole life"; Sex Worker #2: "Be faithful"; Sex Worker #3: "By having only one partner"; Sex Worker #4: "Saying no to sex"; Sex Worker #5: "Um, always use condom . . . and stick to one partner. I [am] faithful to all my partners."

Indeed, we discuss in greater detail below the fact that the 74 respondents about whose risk assessments we learned projected HIV and STI transmission risk in markedly but complexly contradictory fashion. For example, risk was projected onto sex workers, even if the respondent was one herself or married to or had sex with one himself (or herself). Many respondents who were not involved in commercial sexual transactions still felt their risks to lie there. Many respondents singled out the special risks of attending night-clubs and of consuming alcohol even if they frequently did just that (and never used condoms) or if they abstained from both (and so weren't thereby at risk). The text box 4 quote here captures these cognitive dynamics nicely. This 29 year-old taxi-cab driver is afraid of "foreigners" but yet is in a long-term (13 years) relationship with one and doesn't use condoms with him. Like virtually every other respondent, this one completely ignored the transmissive risks that their Intimate Partners posed to them or that they themselves posed to others.

Text box 4:

Taxi-cab driver: "In Fiji, like, plenty kinds of people from Asia, like plenty people . . . are from different places. So, we don't know where they bring the AIDS from. While they live [in] Fiji so they can spread each other. So [HIV transmission is] from other peoples, too, from other places . . . I am a taxi driver, so I carry many kinds of people. I'm scared of them . . . Because we don't know, because sometimes they . . . don't want to use condoms. And like, they'll leave deaths in Fiji [by infecting people with HIV] and they'll go, and we . . . gonna suffer."

Interviewer: "Okay. You've got a boyfriend but he lives in another country and you don't get to see him very much. And so when he comes here and you have this [intimate] kind of relationship, is that very safe in terms of HIV?"

Taxi-cab driver: "I been worried . . . but normally I can't blame him . . . 'cause normally then we talk [to] each other then he'll tell me to trust [him]: [he says] 'I'm married, and I'm just having sex with my wife'" (29 year-old Indian cab driver whose first sexual partner was this foreign boyfriend).

The Training Workshop

"If we've been together almost three weeks and still can't be really honest to each other, how can we expect our future respondents to draw what they really think?" (Rachana Kumari, co-investigator)

The project was conceived as being a two-part, two-phase undertaking. The first part was the HIV social research methods training workshop held in Suva, Fiji from 23 June to 28 July, 2010. Training modules were designed with several goals in mind:

- to introduce workshop participants in a fun but rigorous way to qualitative research
- to build a sense of themselves as colleagues and future researchers
- to sharpen their analytical skills regarding social science findings about HIV and AIDS
- to develop their writing skills sufficient to get published in professional journals
- to enable them to apply their skills practically, to conduct and to plan further research
- to strengthen local research capacity and thus lessen dependence on foreign donors

The eight Fijians who were eventually recruited and hired were paid F$60.00 daily and provided with morning tea, equipment, stationeries, a flash drive, four photocopy reading packets, and a transportation allowance. The five who were retained through the data-collection phase were then paid $F70.00 daily, and three were retained later to help in audiotape transcription.

During the training workshop, each day was broken into two morning and two afternoon sessions. Attendees read about and then eventually put into practice their knowledge of 1) HIV, AIDS, and STIs in the insular Pacific; 2) sexual behaviours and transmission risks; and 3) specific research methods. Attendees made compelling observations, interviewed people, and wrote detailed fieldnotes. On one occasion workshop attendees jumped into taxi-cabs in dyads and interviewed cab drivers who, after providing their informed consent, spoke of the sexual encounters they facilitated and/or participated in.

Methods and Rationale

"I will not want to come to town knowing that HIV is mostly transmitted only in town. I believe by eating good food and being physically engaged in activities such as gardening and so on will prevent me from getting HIV" (Fijian taxi-cab driver).

The project was designed to help strengthen Fiji's response to HIV and AIDS and respond to a methodological problem that frequently affects HIV research. Usually only one side of the sexual ledger is studied. Studies of prostitution usually ignore customers, and studies that employ methods of sexual diary-keeping typically record only the sexual acts of the keepers, not of the keepers' partners. For example, Ghuman et al.'s (2006) study of changing sexual networking styles in Vietnam notes that tallies of sexual activities engaged in by girlfriends and wives ought to tally with those of the boyfriends and husbands (but don't), that memories of ease of reaching orgasm or types and outcomes of use of family planning methods ought to square (but rarely do so). They found (2006: 172) that Vietnamese women "were about half as likely as men to report that they had had sex with their future spouse before marriage," that Vietnamese men were 50% more likely "to report having had sex with their spouse before marriage" and that Vietnamese women considerably underreported their own premarital sexual activities.

We proposed therefore to use multiple methods with both Intimate Partners so as to be able to assemble truer, more contextual understanding of people's self-assessments of HIV and STI transmission risks. The initial contact we had with study participants was at the outset of the focus group interviews we conducted at three different venues. Many were held at Our Place, where FJN+ is housed, but four focus group interviews were held in the private flat of the PI and at another venue rented by the project owing to the better acoustics and closer proximity to respondents they afforded.

All focus group interviews were digitally recorded for later transcription, coding and analysis. Facilitators conducted the interviews that followed the reading and discussion of the informed consent form. Process Observers met and greeted the arriving participants, handled supplies, took notes on non-verbal communications, and provided compensation. Following conduct of the focus group interviews, appropriate field staff used a standardized interview schedule usually within 48 hours to inquire of 1) sociodemographic variables and issues regarding age and sex, education and work; 2) knowledge of HIV and AIDS; 3) past and present genital health and sexual hygiene; 4) sexual practice, consensual and not; and 5) personal risk assessments. Those data were entered into a FileMaker Pro database (Version 11). Qualitative data were collected also from coding and analysis of two concept-mapping exercises. The lengthy passages in the text boxes, for example, depict the kinds of cognitive factors that often emerge from more engaged, qualitative interviewing. Use of multiple means of data collection have allowed us to probe more deeply the attitudes and norms and the factors of religion and gender that structure risk. Data from application of these and other research methods will continue to be coded for later analysis and write-up.

Sample

"If the couple wants to be HIV-free they have to live a life like husband, love your wife just as Christ to her holy and cleansing her by washing through the water by word. The reason why I noted it down in my drawing [is this is a] way of fostering togetherness in a marriage life. If come a time when one of the couple get infected with HIV, say, for example, the woman, they will still show compassionate love towards each because they are devoted Christians" (wife of a taxi-cab driver).

This study was designed to be small, inductive and above all, exploratory, and so a sample of 70 or so respondents was thought to be sufficient. Additionally, instead of sampling only from what are usually considered "Most at Risk Populations" (gay males and sex workers), we proposed to include university students, health care workers, Christian pastors and taxi-cab drivers—and their Intimate Partners, whether boyfriend, wife, girlfriend or husband. Our eventual 74-person sample reflects considerable diversity even though we were unsuccessful in recruiting more Indo-Fijians and expatriate Caucasian and Asian participants. Several previously planned focus group discussions collapsed because either the target group members (Christian pastors) or their intimate partners (of taxi-cab drivers and of gays, lesbians and transgenders) got cold feet and failed to show up.

Text box 5:

Sex Worker: "Okay, this is a condom. Have to use condoms always . . . And this is a boy and a girl, like, they are partners, like, having one partner . . . And avoid going to pubs . . . And then this is a needle; you do not have to exchange needles when you do tattoos . . . And this is alcohol, you have to avoid alcohol . . . And do not have, do not do group sex, like having two or three partners to have sex. . . And say 'no' to sex with anyone you don't know, because you don't know that that person doesn't have HIV . . . And then this is oral sex, and you have to use a condom during oral sex . . . And you have to be faithful, to each partner, by using condoms. If you have a sexual relationship from, apart from your Intimate Partner, you have to use condoms . . . And you have to have regular check-ups, from the clinic, if you have sex apart from your Intimate Partner . . ."

Interviewer: "Now, can you relate that drawing to me? It says that you have to be faithful to each other."

Sex Worker: "You have to be faithful to each other, and, umm, be faithful to each other by using condoms . . . you have to trust each other, like being faithful to each other, so you must use condoms."

Interviewer: "Do you use the condom with your husband?"

Sex Worker: "Ahhhh, no, he loves me and I am trusting him."

(29 year-old Fijian female sex worker).

The procedure we followed involved, first, the design of a focus group discussion protocol, an in-depth interview schedule, a Key Informant interview protocol, and two sets of directions for concept-mapping exercises that would aid in conduct of the methodology that the PI designed previously. Second, the team pre-tested them on themselves, friends and family members, and then edited and revised them accordingly. Third, the team met with and had the research instruments and protocols approved by the National Health Research Ethics Committee. Fourth, the team followed a recruitment algorithm, beginning with providing a Letter of Introduction to potential recruits and obtaining their fully informed consent. The team made sure that potential recruits were contacted anonymously and that Intimate Partners were recruited by someone else, thus maximizing anonymity and confidentiality; both had separately to provide informed consent for either to be able to take part.

Text box 6:

"[Me and my boyfriend are] just walking past the hospital just showing that we hadn't really, uh, uh, we don't really think of HIV that much, like, it's just a subject that we hardly ever talk about, like, we know it's there in society, but we don't, uh, really think of it from day-to-day basis . . . like, we never really took the topic of HIV seriously until we came to this, um, we had that [focus group discussion facilitated by Rachana and Lawrence], so it's been an eye-opener for both me and my partner, so I think we will, yeah, we've taken into consideration going and getting checked and stuff, mmm."

(female University student describing her drawing on "Me, My Intimate Partner and HIV" and commenting on her experience of participating to the study)

Recruitment was time-consuming and in some cases difficult; the several dozen phone calls we made, for example, to Christian churches and to an agency for women's advocacy did not result in a single study recruit, and neither did attendance at a Rescue Mission-sponsored workshop for Christian pastors despite the eagerness they stated initially. Nevertheless, on balance, we encountered relatively few setbacks related to recruitment.

Text box 7:

"[Preventing HIV transmission means] no sex unsafe outside, say, no oral sex, and avoid contact with sexual organs of another partner . . .
I spend most of my time at home. I think it's the man who should be abstaining, the reason being, they are the ones that goes around to a lot of places due to work commitment . . . To me, married life should mean a happy, never-ending love episode. But in most situations, it is not true. We can be living a perfect love life without knowing one partner is having an affair."

Of our eventual 74 study participants, only one did not show up for an in-depth interview, so the participation rate was near 100%. Additionally, the team took heart from the kind and insightful words that many respondents shared about their experience of participation, for example, in the text box 6 quote above.

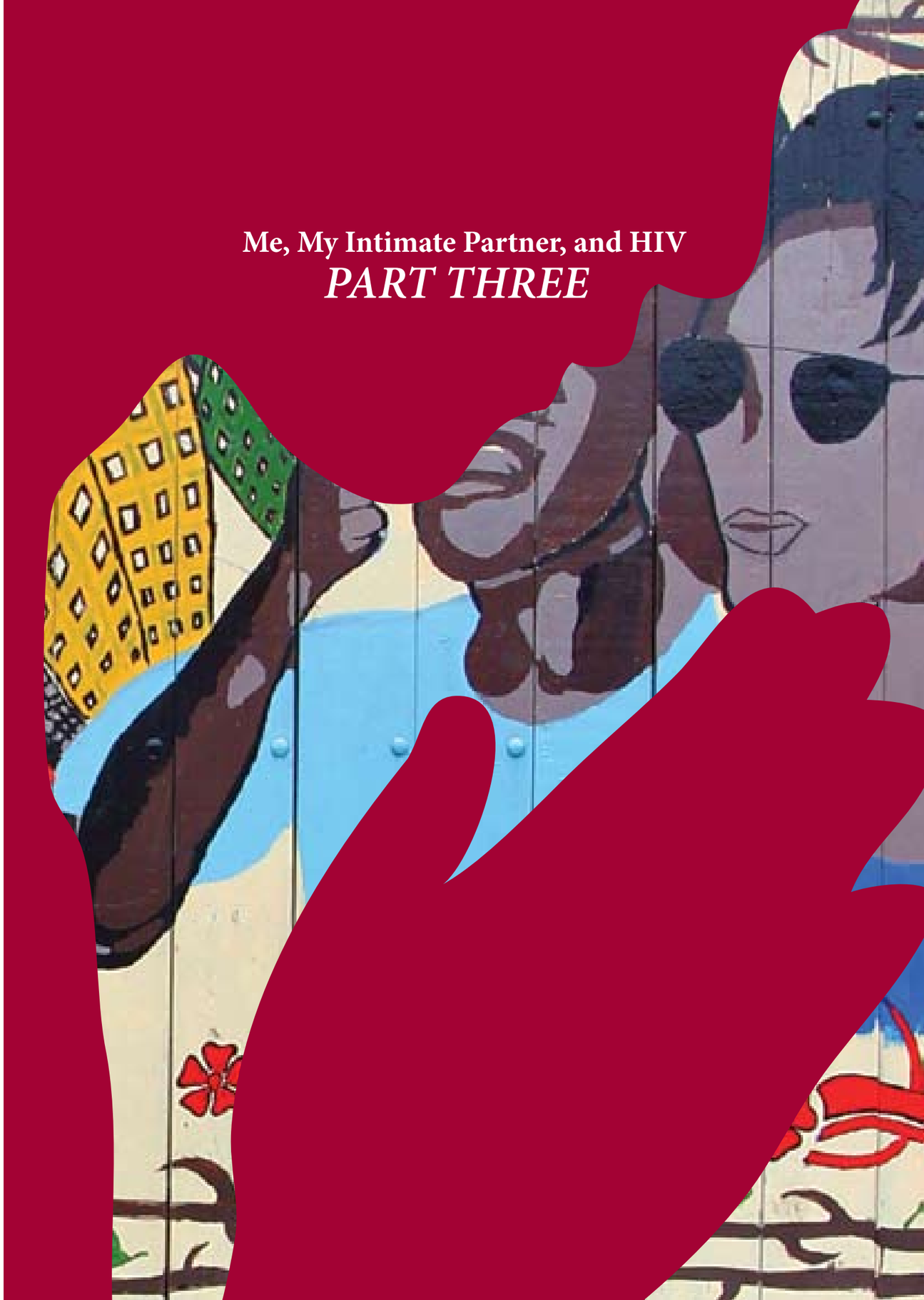
The topics of investigation were sensitive, the politics of representation are not always so straightforward, and some people stated their fears of participation based on experience in previous, quantitative, survey-style research. Nevertheless, the team did not feel overly constrained by gender relations and dynamics in the interviewing setting; men were many times interviewed by women and women, by men. The text-box quote about marriage not necessarily being a "happy, never-ending love episode" is from a 40 year-old Fijian wife of a taxi-cab driver and security guard, and she was interviewed by a man.

Table 1 below depicts the overall composition of our sample. In sections below we discuss salient cognitive factors and relationship dynamics, target group-by-target group.

Table #1: Overall Sample Composition

Target Group	# Participants	Comments
Gays, lesbians, transgenders (and their Intimate Partners)	Orange/6+6=12	one Intimate Partner did not show up for his interview; this group included sex workers and health care workers, too
Taxi-cab drivers (and their Intimate Partners)	Green/7+7=14	four focus groups were recruited and scheduled, but only two were held, as none of the eight wives in the first two scheduled groups would agree to participate
Sex workers (and their Intimate Partners)	Blue/6+6=12	this was the easiest group to interview and recruit, but their Intimate Partners were shy and unforthcoming; two recruits were non-heterosexual
University students (and their Intimate Partners)	Purple/8+8=16	these cohort members were extremely easy to recruit and interview
Health care workers (and their Intimate Partners)	Black/5+5=10	two recruits told us that Fiji School of Medicine staff had been warned away from participation; our eventual recruits were most helpful and interesting
Christian pastors (and their Intimate Partners)	Red/5+5=10	Christian pastors were difficult to recruit, but their focus group discussion was surprisingly candid and racy; their spouses were very shy but eventually quite forthcoming about their special risks

Me, My Intimate Partner, and HIV
PART THREE



Risk and Intimacy in Fiji: 37 relationships, summarized

"HIV, um when I was 18, I start to know about HIV. And HIV is like, uh, it's, uh, curable, eh, HIV, but AIDS is not, am I right?"

Interviewer: "I'm asking you. Whatever you say is the right answer."

"Okay. In the community, if you are found with condoms you are, straightaway, you are known as a, a sex worker, a person who has more than one partner.

So, it's almost like when you are seen with, one in my community from where I am at now, when you are seen with condoms, you're known straightaway that you are a person who is a sex-worker" *(Intimate Partner of a sex worker).*

Findings from studies conducted around the world have demonstrated clearly and fairly consistently the HIV and STI transmission risks of companionate relationships (see Clark 2004; Moodie 2000; Carpenter et al. 1999; Schoepf 2003; Hammar 1998, 2004b, c, 2006a, b, 2008, 2010a, b; Wardlow 2002, 2004, 2007, 2008; Hughes 2002). Whether or not the relationship is between heterosexuals, whether it is in marriage or on the way to it, a long and growing list of qualitative and quantitative studies demonstrates the operation of important cognitive factors and behavioral dynamics at work that imperil people sexually in their intimate relationships. Intimate partnerships can heighten HIV and STI transmission risk because the frequency of unprotected intercourse tends to go up as condom use goes out the window. "Customers" turn into "boyfriends" (and boyfriends into husbands) by the foregoing of condom use. Couples desire children, too, and that requires unprotected sex. Moreover, HIVab prevalence is often higher in the older men who are more likely to become the husbands of younger females than in the younger males who might otherwise have become their boyfriends. Telescoping the perspectives and findings of the studies cited above and many score more (e.g., Bolton 1992; Hammar 1999a, b, 2006), the truism for especially heterosexual women is that HIV and STI transmission risks can go up as number of sexual partners and frequency of sexual partner change go down. This is due primarily to decreased levels of condom usage between Intimate Partners and the high prevalence of infection therein.

The opposite, of course, is communicated to people by means of public health and other, religious and secular messages, that marriage is (relatively) safe. The salience of these messages for Fijians could not be clearer, and it emerged no matter what research instrument was used on which Target Group member. For example, an Indo-Fijian health worker concluded: "as we all know that AIDS or HIV, there is no barrier, anyone can get it, which means they should screen themselves and then be, stay faithful to one partner and not have multiple partners." An Indo-Fijian husband commented: "I would be faithful to my wife, that, only my partner for the life, same thing as having sex with my wife only." An ethnic Fijian male health care worker summarized it this way: "Okay . . . when I look at it as myself, as how I try to prevent HIV transmission, is being faithful to my wife, meaning only one sex partner, eh?, not to commit adultery and not to have any other sexual partner apart from my wife." A Fijian gay male explained his drawing this way: "[What] I noted down is being faithful; I believe if people be faithful then they don't need to worry about anything, not even HIV . . . because they know they are being faithful to his partner or her partner."

The Indo-Fijian wife of an Indo-Fijian taxi-cab driver explained a comment that she drew on her panel, "Say No to the Polygamous Society," by saying, "like, married with multiple partners; through this kind of marriage the disease is transmitted to and fro."

For brevity's sake, we have here summarized and analyzed relationships, target group-by-target group, beginning with the Orange group—gays, lesbians, and transgender persons—and their Intimate Partners. Almost without exception, our data suggest the complete externalization of risk, a projection outward and away from Self and Intimate Partner toward Other and toward other settings, behaviors and persons. For example, none of the 36 drawings from members of the Orange group depict any gays, lesbians and transgender persons per se.

Gays, lesbians, transgenders (and their Intimate Partners): 6+6=12 (1 refused in-depth interview)	
ethnicity:	10 Fijian, 1 Fijian-European, 1 Fijian-Other Pacific islander
marital status:	2 de facto, 3 divorced, 7 single/never married
current STI symptoms:	6/11
condom use at last sex:	4/11
mean age 1st oral sex:	17.2 (5/11) (surely, this is an underestimate)
mean age 1st vaginal sex:	18.33 (6/11)
mean age 1st anal sex:	16.75 (4/11) (Note: 5/9 gay males report no anal sex)
virgin at marriage:	0/12
"low" risk assessment:	9/11
want STI Test:	9/11
want HIVab Test:	9/11

This cohort consisted of six intimate partnerships involving men, women, and transgendered persons. They ranged in age from their early 20s to their early 50s. One participant took part in a focus group discussion but not in the in-depth interview. Seven of the 12 self-identified as single, never married, and three said they had been married previously and divorced. Two said they were in de facto marriages although the two who said so were not intimate with each other. It is not legally possible in Fiji for men to marry men, and women, women, so it is not surprising that inconsistencies emerged as respondents attempted to configure their relationship status. None of the 12 was (or will be) a virgin at marriage. Six of the 11 are suffering from STIs. Four of the 11 had used a condom at last sex.

For many and no doubt complicated reasons, a number of inconsistencies emerged when respondents attempted to recount sexual activities and self-assess their HIV and STI transmission risks. For example, nine of the 11 self-assessed their HIV and STI transmission risks as "low," but nine of 11 also wanted to have an STI and an HIVab test because of fear, curiosity, and anxiety. Neither half of one couple reported ever having had sex with a female, but their drawings of persons and settings they considered risky to them are filled with depictions of (presumably) heterosexual females flagging down drivers, enticing men sexually with tight clothing and then being raped by a group of men. One person who claims to be a transgender female claims never to have had had vaginal intercourse. Another person says that he lost his virginity to an older male, a "same-sex" male, but claims also never to have had oral or anal sex. The drawing here is by a lesbian who says that she's in a monogamous relationship but she is currently suffering from several signs and symptoms of STIs. She depicts her risk as pertaining to heterosexuals cavorting on a beach. In a relationship between two self-identified gay males, one of them is HIVab+ **but has probably not yet disclosed his status to his Intimate Partner.** In several settings the issue came up awkwardly insofar as they don't always use condoms (or with each other). When they don't with each other, the other partner says, it's because they are "faithful" to each other, even though he recounted at least four other sexual partners in the past year and even though he claims also never to have had oral or anal sex. He says he's at "high-risk" because he doesn't always know his sexual partners personally. His HIVab+ partner, however, says he's at "low risk" of HIV transmission because he "believes so much in condoms every time I have sex."

In terms of sexual practices and risks, similar inconsistencies were reported. For example, the transgendered health care worker who is married to a woman but who enrolled in the study alongside his Intimate Partner, a single, unemployed, bisexual male, asked at the outset of the interview, "Can HIV spread by having sex with a member of the same sex?" That respondent then reported 34 non-intimate sexual partners in the last 12 months, while the Intimate Partner reported three non-intimate sexual partners in the last 12 months and no condom use with any sexual partners. Two gay males intimately involved with each other both self-assessed their STI and HIV risk as "low" even though they are frequently tested for STIs and wish now also to be treated again (because they don't always use condoms). One's "Risky Person" drawing was not of another gay male or himself or his own Intimate Partner, but rather, of an infected woman who is a stranger, "the person that you don't know . . . You don't know they are HIV-positive."

As with members of the other Target Groups, knowledge of the signs and symptoms of STIs was sub-optimal. For example, in an intimate relationship between two bisexual males, one chalked up his afflictions to his bisexuality, to the fact that his partners are much younger or much older, and to the wearing of "warm pants." Both men were 16 when they had vaginal sex for the first time, one, with an older female relative. Both had engaged in group sex, one with another male and another female, consensually, and then also in groups of men under the influence of alcohol, and the other, in situations of village-based "convoy" sex but with a girl who, he said, consented. In a relationship between two gay males, both had suffered from the same STI signs and symptoms; one attributed them to "unprotected sex," having "multiple partner," and "sitting down" on "cold cement slab." One reports 11 total sex partners in the past year and inconsistent condom use, and his partner, five, two of whom are "steady partners." Both had been forced into sex the first time they had it, one by an older "stranger," a "family friend," and the other, by a cousin at a party. In another relationship one male believes he got his multiple STI signs and symptoms from "the cold" and from "having multiple partners" and from women whose vaginas are "dry." He's had five different sexual partners in the past year, only one of which is "steady, regular," he says, but with whom he has sex just as frequently as with his Intimate Partner. He says he "always" uses condoms with all his partners (all of whom are single, unmarried males), including at last sex, so as to prevent STIs and HIV. Nevertheless, he assesses his STI and HIV risk as "high" and says that he wants to be tested for STIs to "know my status," and for HIV, because he is frequently drunken and passed out while having sex.

Taxi-cab drivers (and their Intimate Partners): 7+7=14	
ethnicity:	9 Fijian, 4 Indo-Fijian, 1 Fijian-Other Pacific Islander
marital status:	1 de facto, 10 married, 2 married >once, 1 widowed
current STI symptoms:	1/14 (maybe 3/14)
condom use at last sex:	1/14
mean age 1st oral sex:	19.16 (6/14)
mean age 1st vaginal sex:	17.57 (14/14)
mean age 1st anal sex:	N/A (0/14)
virgin at marriage:	1/14
"low" risk assessment:	13/14
want STI Test:	10/14
want HIVab Test:	10/14

This cohort of taxi-cab drivers and their Intimate Partners comprises 14 respondents in seven marriages, one being de facto. They range in age from the low-30s to the mid-50s. One lost his virginity at age 27 when he married (the only male virgin at marriage in the entire sample), while his wife lost hers at 15, though not to him. Another cab driver has another wife about whom the wife who enrolled with him does not know.

None of these respondents claim currently to be suffering from signs and symptoms of STIs, although several had in the past, one because he "had sex with a woman inside my taxi," though he claims also never to have paid or given anything for sex. Another says that he once suffered from discharge he got from "having sex with an infected girl," and went both to a hospital and to a traditional healer to be treated. Yet another attributed his problems to "taking a lot of yaqona and 'the cold'" and wearing "warm clothes." His wife has suffered once each from discharge, a vaginal sore, pain on urination, pain during sex, and genital itchiness, but attributed each symptom to unprotected sex with her boyfriend 13-14 years ago.

Condom use by members of this cohort was rare and it was reported inconsistently, but it was probably underestimated. Only one respondent (not two!) claimed to have used a condom at last sex. An Indo-Fijian couple claims to have been faithful to each other during the past 12 months, but while the husband says they don't use condoms because "they are faithful," the wife says they use them "always" and as a family planning method. One wife who claims that she'd been faithful to her husband says that they sometimes use condoms. He says he and his wife "never" use condoms because "we are faithful to each other," but also recounted several extramarital encounters in the past year. Another cab driver says he uses condoms "sometimes" with his wife and "sometimes" also with his second and third partners. He, too, admits to having paid for sex, and all three of his drawings suggest great familiarity with commercial sex. Another cab driver said he has paid money, food and clothing and transportation (rides) in exchange for sex.

Indeed, many of the drawings of the taxi-cab drivers and some of their Intimate Partners featured sex workers and sex-working locales. A man who was married previously and a woman in her first marriage both said they have sex once each week, "never" use condoms, and are at "low risk" because they're both faithful (though they want to be tested for both STIs and HIVab). The husband drew a series of public settings where drinking and glue-sniffing and taxi-cab driving and commercial sexual networking occur; he drew "prostitutes" and "gays" as "Risky Persons" and sex atop a bed in a motel room as constituting a "Risky Setting." His wife drew a sick-looking person about to ride a Ferris Wheel, a park-bench at the sea wall, and a couple drinking beer in a night-club. Another taxi-cab-driver said he'd used condoms each of the times he had sex in Nadi, Rakiraki and Lautoka with sex workers (as did other cab drivers report having had sex on the road), though previously he denied their use. He also initially denied the marital infidelities in the past 12 months that came out graphically on his "Three Drawings." His "Risky Setting" depicts "all ladies stopping vehicles," a boat, a seawall, a street, and lots of sex workers. "Risky Behavior" (depicted here) depicts "husband using money to pay girls for sex," while the "wife stay quiet [at] home." Both he and his wife, however, say that they are at "low risk," she because "I don't have any other sex partner apart from my husband," but he because I am "taking HIV and STI medicine, Fijian medicine, pure spring water and deep seawater, drink[ing] it four times a month and it helps me by preventing me from bacterial or any viral diseases." He doesn't want to be tested for STIs or HIV because "[I] already know my status [HIVab+] and trust what I take to protect me." His wife wants to be tested again for HIVab to find out whether her medicine is removing HIV from her body.

The reported rates of marital infidelity in the past 12 months are probably underestimates. One cab driver has had several affairs recently, two being also with a "steady, regular partner." Two of his additional partners are divorced/separated/widowed civil servants, and a third partner is married. He says that "when I'm drunk I usually ring up one of my regular partners and force them [to have sex] even though they say 'no.'" When asked to describe the contents of his drawings, another cab driver says that a "Risky Setting," even though "sex happens anywhere," is the motel, "where most casual sex partners would prefer to go . . . [I]t is because you don't take your wife there but . . . a new woman, so you can do whatever style of sex you want to do . . . I can only take girlfriend there and not the wife to motel. I can do whatever style of sex I want to do and in most cases protective issues is non-negotiable, but many times, because I've been too drunk, I forget to use the condom."

Personal risk assessments of HIV and STI transmission were inconsistent. Both halves of an Indo-Fijian couple say that they are "low risk." She "trusts" her partner is not having affairs (even though he is), and because "my husband gives me good money," "that means he's working and not going around with girls." Both, however, want to be tested, she "to confirm" whether or not she's infected, he "so I can know about myself if I'm safe." Another wife says that she's at "low risk" because "I am faithful to my husband and I have only one sex partner," yet both say they want to be tested; he wants to know that his "system, blood and sexual organ are clean." Another married couple both say that they are at "low risk," but whereas she says that it is because she is faithful, he says he "has to protect myself with the prostitute girls and to have sex with only one partner" (even though he doesn't) and "visit hospital every month." The wife of another cab driver wants an STI test, but doesn't want an HIVab test "unless if I have other sex partners." Her husband doesn't want to be tested because, he says, "I know my best partner," and because "I know my partner and I track my partner every month, so I [don't] need a test." In another couple, both husband and wife say they are at "low risk," he because "I'm faithful to one partner," and she because "My partner and I both don't go out. I trust him and [that he] never has affairs." He does not want to be tested, but she says that now, "because of what I've learnt today—it has made me frightened," she wants to be tested for both. Her husband's three drawings depicted an individual, forlorn-looking female in each, in different settings of street-corners, bush areas, and seawall. His wife is the only one among the 14 to locate risk in the body of her Intimate Partner, who is dubbed "Taxi Driver." In the Indo-Fijian couple, the cab driver husband mentions that oil is used by lots of Indian men (instead of the condom) "to prevent skin-to-skin contact." He says he's at low risk of STI and HIV transmission, and doesn't need tests thereof. She, however, doesn't trust her husband, and says she's at "high risk" and wants to be tested because she's having unprotected sex with him.

Sex workers (and their Intimate Partners): 6+6=12	
ethnicity:	10 Fijian, 1 Indo-Fijian, 1 Tongan
marital status:	5 de facto, 1 married, 1 married >once, 4 single, 1 widowed
current STI symptoms:	6/12
condom use at last sex:	4/12
mean age 1st oral sex:	16.71 (7/12)
mean age 1st vaginal sex:	14.25 (12/12)
mean age 1st anal sex:	N/A (0/12) (Note: this is exceedingly unlikely)
virgin at marriage:	1/12
"low" risk assessment:	9/12
want STI Test:	7/12
want HIVab Test:	8/12

This cohort of six sex workers and their husbands and boyfriends reported interestingly inconsistent self-assessments of sexual behaviors, relationship status, and transmission risks. Several Intimate Partners of each other did not agree as to whether they were single or married and whether or not their partners had other Intimate Partners. Two Intimate Partners of the sex workers were shoe-shine "boys" and another two had been or were members of the disciplinary forces. The average age at loss of virginity for the male members of this cohort was lower than that of their wives and girlfriends. One man was six years old when he lost his virginity to a "much older woman," another was 11, still another was 13 (with an older female cousin, "while watching blue movies with her"), and yet another was 10 (again, with a grown woman). All 12 claimed never to have engaged in anal intercourse.

Six of the 12 were suffering from STI signs and symptoms, but it required application of several research methods to establish so. Both halves of a lesbian couple reported former and current, multiple symptoms of an STI. In another couple, the husband reports no STI symptoms, but the wife reports several. In yet another relationship the wife reports having suffered several bouts of several symptoms that she attributes to "having multiple partners," to clients who have "big dick," and to clients who have inserted marbles into their penes. Her shoe-shine "boy" husband reports several STI symptoms that he blames on a loss of semen and poor sexual hygiene. Another sex worker has suffered vaginal sores, pain during urination, pain during intercourse, lower abdominal pain that does not go away, and problems with pregnancy, and she currently experiences genital itchiness. Yet another couple has suffered from and continues to suffer several STI signs and symptoms but are mostly self-treating them.

This cohort's members varied greatly in their reporting of sexual behaviors. For completely understandable reasons, some sex workers and their Intimate Partners underestimated sexual behaviors (as did members of other Target Groups) and at least two Intimate Partners overestimated them. One sex worker claimed 15 partners in the past 12 months (but more, elsewhere), while her husband, a member of the disciplinary forces, said his number was "uncountable" but then settled on "50+." They have sex several times each week with each other, unprotected. Another sex worker states that she has had eight sexual contacts in the last 12 months, and her Intimate Partner has had two; they have sex with each other "several times each week," unprotected. A lesbian sex worker reports having sex once a week with her Intimate Partner and several times a week with another contact, allegedly her only commercial partner. Another sex worker had five sexual partners within the past year, and has sex with her Intimate Partner, unprotected, "several times each week." A fourth sex worker says that she has sex with her Intimate Partner "several times each week" (though he says "once a week"); he has sex "once each week" with another regular partner and has had several other partners but with neither of them has he used condoms. Through several means it was established that a sixth couple greatly and obviously undercounted their sexual contacts in the past 12 months.

As did members of other Target Groups, but perhaps more spectacularly so, sex workers and their Intimate Partners exhibited extreme cognitive dissonance about their HIV and STI transmission risks and in their patterns of condom use. In this regard our findings square with those of Van Buuren Inoke and Sharma (1997), who found relatively high rates of condom use between sex worker and client but not between sex worker and Intimate Partner. Compared to other Target Groups, a lower but still high fraction (9/12) of this cohort perceived their HIV and STI transmission risks to be "low," despite the demonstrated risks of being a sex worker or being the Intimate Partner of one. Nevertheless, 7/12 and 8/12 wanted to be tested for STIs and for HIV, respectively. One sex worker says that she is at "high-risk" for STI and HIV transmission owing to her lack of certainty about the fidelity of her husband. He says that he is at "low risk" because "I have only one partner" (which isn't true), albeit a sex worker; he confessed: "I don't know a lot about my partner, whether she is honest to me or not." One sex worker says that she's at "low risk" because she was just tested last year, but still wants an STI test and an HIVab test "to know myself if I'm clean or not," to "know if I don't have HIV." Her Intimate Partner says he's at "high-risk" owing to the extent of his unprotected sexual encounters (but not those with his Intimate Partner). Another sex worker states that she is at "low risk" because she is "faithful" to her partner, and he, too, says that he is "low risk," also because he is "steady with my partner, been faithful to her, and she is the only one." She, of course, is a sex worker, so she can't be "steady" with anyone, and the PI later found the husband attempting to solicit Asian fishermen customers for her. Neither husband nor wife in this relationship wants to be tested for STIs or HIV. In another couple, the wife "gets tested on a quarterly basis," and the husband wants to be tested but "knows" that he is "clean." Another husband spent seven years in prison, during which time he inserted marbles into his penis, and says he is at "high risk" "'cuz I'm addicted to sex." He wants to have an HIVab test to "know if I'm safe," but doesn't feel the need for an STI test "'cuz I'm having a faithful partner" (even though she is a sex worker and he has extensive extramarital sexual contacts). A fifth sex worker says she is at "low risk" "because at the moment my partner has only me," even though that is false, but wants both an HIV antibody and an STI test "to know my status and for my health."

Text box 8:

"it's the police [to laughter] because they are policemen, and most of us trust them, and some of the policemen fix the girls, they want to escort [sex workers] to the bush . . . and they have sex with them, because we trust the police, eh? Not us, but the small girls, some small girls . . . Some, they want to have blow jobs with us, some they want to have sex with the pooftahs. [Interviewer: How do they get away with that?] They will just say a threat and, and they will come and have sex with you: 'I can take you under the law'" (Fijian i-Taukei sex worker explaining who is a "Risky Person")

Condom use patterns in this cohort are similarly inconsistent. One sex worker "always" uses condoms with her clients but not with her Intimate Partner because they are "faithful" to each another (even though neither is); he claims to have used a condom the last time he had sex, but she says she didn't. Another husband says they only "sometimes" use condoms, and didn't at last sex because "we are faithful to each other" (even though neither is). A sex worker says that her husband "never" uses condoms, because he "doesn't like the feeling," but she "always" uses them with at least two of her other sexual contacts. Another sex worker says that she and her Intimate Partner "always" use condoms during sex, but he says that they "never" do so, because they are "faithful to each other" (though neither is). The "Risky Setting" drawn by one sex worker is of a client in a car but with whom she is adamant about using condoms; her husband, however, who is exceedingly active sexually, doesn't figure in either of her

three drawings. He drew "Risky Person" in an interesting way, a woman soliciting a customer, and then explained it by saying, "actually, it came to my mind that it's like a prostitute standing on the road, by the roadside"; that is, he draws "prostitute" (i.e., his wife) as Risk Incarnate, but he doesn't use condoms with her. The lesbian sex worker reports "always" using a condom, and her partner, "never," but the sex worker claims to "always" use them with her Intimate Partner, too, even though they're lesbians and "are faithful to each other" (even though they aren't). The Intimate Partner is one of several who drew or told stories about men around town and in nightclubs who harass women with oversized, erect penises and menace them with syringes filled with blood. She explained one of her drawings by saying, "this is a boy, he always show his dick around, to anyone he sees," to which several assented. She then explained that a "man from Nausori" who is HIVab+ has begun to attend night-clubs and dances and inject women with HIV-tainted blood, an explanation with which others in attendance agreed. "He's gonna take it and inject the girl," she said, explaining her drawing in great detail. "That's what they do in the club; they inject that person in the club, night-clubs . . . There's a person that goes around in the club and take injections, HIV injections, and injects them. Yeah, it's true. He lives somewhere in Nausori. Maybe he wants everyone to have HIV with him."

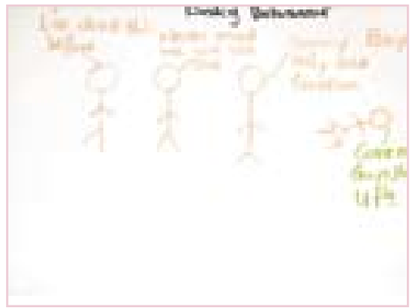
Several of the sex workers told compelling, horrible stories of having experienced sexual molestation when younger and sexual violence and harassment while on the job, whether by policemen or religious officials or politicians or customers. One sex worker said that her mother used to send her to a shop and "this guy" used to force her to have sex and that she felt "helpless"; she is still in great pain over her experiences. Another's grim story of suffering of incest (perpetrated by a grandfather) came out during a concept-mapping exercise. The story in the text-box quote told by a sex worker about police harassment was confirmed in duplicate by other sex workers.

This cohort was recruited in two waves and, like the taxi-cab drivers, were interviewed in four, not two focus group discussions. Two respondents were married to each other, the remaining self-identified as single. Two couples were difficult to enroll regarding a participation criterion. The female in one initially adamantly proclaimed her virginity, but it eventually came out that, because of the trouble she'd experienced in the relationship, she had been engaging in anal intercourse with her Intimate Partner, without protection of condoms, so as to protect her "virginity." Her Intimate Partner initially said that he has never forced anyone into sex, but by study's end she showed up with a huge knot over her eyebrow, where he had head-butted her, she said, because she had refused to have sex with him. The female half of another couple said initially that she was at "low" risk for HIV and STI transmission because she's "not having sex," but then indicated in several other ways later that she was.

Only one respondent seemed currently to be suffering from an STI, but others spoke of past suffering. A 20 year-old Fijian female recounted her grandmother's explanation of her many maladies suffered several times, which was that it was "because of the cold," because of "sitting on the cement." She had sex "more than five times" prior to being treated. She also self-treats the discharge from which she claims she frequently suffers by douching vaginally with a ginger/kura fruit juice solution that she boils and uses with a single-use syringe. Her method is "to flush it inside and after that, wear pad because of all the dirt (mucus, sticky yellow discharge)." Her Intimate Partner adds that this makes her vagina tighter and "cleaner." A 20 year-old male university student reports several STI-related problems; he attributes the painful urination to "too much drinking" and the genital itchiness to "not bathing," and he self-treated by bathing. A 22 year-old man attributed the bloody urinary discharge and swollen testicles he

University students (and their Intimate Partners): 8+8=16	
ethnicity:	15 Fijian, 1 Fijian-Other Pacific Islander
marital status:	2 married, 14 single/never married
current STI symptoms:	1/16
condom use at last sex:	13/16 **Note**: this is the highest rate thereof in the sample)
mean age 1st oral sex:	18.43 (16/16**)**
mean age 1st vaginal sex:	18.37 (16/16)
mean age 1st anal sex:	21.25 (4/16)
virgin at marriage:	0/16
"low" risk assessment:	13/16
want STI Test:	12/16
want HIVab Test:	13/16

suffered previously to having been injured during a rugby match by an opponent who squeezed his testicles too hard. He didn't get this treated. A 21 year-old Fijian female university student complains of painful intercourse but doesn't know how to explain it; her 22 year-old Fijian student boyfriend attributes all of his symptoms to having gotten drunk and had unprotected sex with an infected girl, but he says that he went immediately to a hospital for treatment.



This cohort exhibited high but inconsistent rates of condom use. The married couple has "never" used condoms and don't plan to do so soon. A couple who seemingly have a healthy relationship say they have sex about once per week but never with a condom, since he says he "doesn't like the feeling," and she says they're "too expensive." The couple above in the troubled relationship aren't using condoms at all; she says that they never think of using condoms since "we are having anal sex and oral sex," not vaginal. Her anxiety and insecurity is captured neatly here in the text-box quote. Only one couple, in this case, a 20 year-old Fijian male university student and his 22 year-old girlfriend, use condoms as a family planning method. The female half of another couple reports "sometimes" using condoms with her boyfriend but who says that he "never uses them at all" with her, and not with any of his other sexual partners, either. She lost her virginity at age 19 and is the only female in the entire sample to have used a condom when first she had sex (with her boyfriend). Another young man continues to be unfaithful to his girlfriend several times each week with a single female and "always" uses condoms with her, but "never" with his Intimate Partner. She has protected sex irregularly each month with two additional partners.

Text box 9:

"it really made me think [the assignment] and I thought of chocolate because we both like chocolate and when he wants something, he buys me chocolate, 'cuz I love chocolate. So . . . well, like chocolate, we both like chocolate but you don't really know how good it is until you taste it and then you know it's bad, or is it still good? So, us, it's like that. When my Intimate Partner comes sometimes he looks so good I want to eat, but then I don't really know how good he is for me [long pause] unless, uh, yeah, I taste him [another pause] or he gets tested [voice audibly dropping off] and, you know, if he have a HIV or an STI, then I'll know it." (Fijian female university student explaining her drawing of a chocolate bar to represent "Me, My Intimate Partner, and HIV")

Regarding sexual practices and frequencies, none of the 16 was or will be virgins at marriage. All 16 respondents self-identified as heterosexual and had engaged in oral and vaginal intercourse. The average age at loss of virginity was just over 18 years. Four said they had engaged in anal intercourse, on average engaging in it for the first time at age 21. Two male respondents reported having taken part in a "convoy session," one involving "50+" males in his school dorm. The female in question got pregnant and even pressed rape charges against the boys, but he says that the female had sex "willingly." Another male student says he was "forced" into bringing a girl into his school dorm room by senior boys who would have beaten him otherwise; he and 12 other male students had unprotected "convoy" sex with her. The drawing of "Risky Behavior" of one of the two who reported having engaged in "convoy" sex depicted a "willing" girl/woman but the presence of only one condom, so the others have to forgo their use. His "Risky Setting" drawing also depicts a group setting, but of multiple men and women: one woman is HIVab+ but who hasn't told others ("None of them know I have HIV"), and another woman is a "whore."

Many members of this cohort had had additional partners in the past year. In two relationships, the boyfriend reported a single sexual partner in addition to his Intimate Partner. One female university student doesn't know that her boyfriend has another girlfriend with whom he is still having sex and who is pregnant with his child. Nor does she know that he's had four other sexual partners in this past year in addition to her, two of whom are currently, by his account, "steady." She claims fidelity and sex with him "several times a week," but he reports sex with her only "just sometimes," sex with his ex-girlfriend "once in a month," and sex "once in a fortnight" with another partner. A 23 year-old Fijian (i-Taukei) male student says that even though he's had four additional partners in the past 12 months, which he says was "an accident," he's still "faithful" to his partner. He was seven years old when he had oral sex for the first time with a relative, and 14 when he had vaginal intercourse, in this case, with a closely related female cousin.

Members of this cohort drew the most colorful, complete and detailed drawings. In a three-panel representation, a married 20 year-old Fijian male drew 1) four HIVab+ people (three women and one man) who are standing outside a night-club waiting to get in and who will later infect the patrons they take home later; 2) an HIVab+ woman who is soliciting two men on a street-corner, and two more women who are HIVab+ (each with a red dot over their heads) who are waiting outside a club to get inside and infect two unsuspecting men; and 3) a four-part story in which a man asks his "Bro" to "fix him a gal" and who does, introducing "Sarah" to him, whereupon they meet, hook-up, and in the dead of night, are depicted as having sex on a bed indoors. She consents to sex but is then represented as holding back by saying "Okay, but . . . ," but then infects him with HIV. The female student who had been head-butted by her boyfriend depicted risky settings, persons and behaviors, respectively, as sex without condoms (even though she doesn't use them), drinking (in which she doesn't engage), having multiple partners (which doesn't apply to her), night-clubs (which she doesn't attend), and sex in motels (which she hasn't had); she doesn't associate HIV and STI risk with her actual Intimate Partner. Another several male respondents' depictions of "Risky Person," "Risky Setting" and "Risky Behavior" were of luridly drawn sex workers soliciting and attempting to hitch-hike, of cheap motels, of "dirty night-clubs," and the like. The drawings of their female Intimate Partners also depicted the dangers of drinking sessions, of having sex with sex workers, and of night-clubs and other locales at which sex workers ply their trade. The "Risky Person" in this cohort is most often a well-built, garishly put-together, often red dress-wearing sex worker soliciting men, always with a smile on her face, and usually standing on a street-corner or cavorting outside a club or laying down on a bed in a motel.

Not surprisingly, self-assessments of HIV and STI transmission risks were as inconsistent as they were interesting. Thirteen of the 16 said their risks were

"low," but 12/16 wished to be tested for STIs, and 13/16 for HIVab. A male university student corrected his earlier claim of fidelity in the past 12 months by saying that he is at "high-risk" because "I have sex with other women/girls without condom." His girlfriend says that she's at "low risk" because she's "only having one partner," but yet wants to get tested for STIs because of the pain on urination she suffers, almost unbearable at times, and the genital itchiness that the douching solution she applies doesn't cure. The female student who had recently lost her vaginal virginity concludes that she's at "high-risk" because of her unfaithful boyfriend and who refuses to get tested. She wants to be tested for STIs but also for HIVab "because it has no symptoms." He says he's at "low risk" because he "knows his partner really well" and has known her for "nine months," but does, however, also want to be tested, if only to mollify her. Another couple both think they're at "low risk" because they've been faithful for three years, but he wants to be tested as "there is no harm . . . even though I know I don't need to," and she doesn't want to because she is frightened at the possible results. Another young man does not want to be tested for STIs but does for HIVab because he "just get[s] drunk and ha[s] sex, so I'd like to know my status." She wants to be tested for both STIs and HIV because she "might be infected, for example, from hospitals by needles." Another young man wants to be tested for both STIs and HIV; his girlfriend does not want to get tested for STIs but does want to be tested for HIV because she wants to find out whether he has been faithful to her (he hasn't). Both partners in another relationship say they are at "low risk" but want to be tested, she, "so I can know my status" and so that she doesn't spread it to her partner, and he, "just for security," "just to be safe." In another relationship, the woman says she's at "high-risk" because, even though she has many partners, she's using condoms with them, and so is at risk from her Intimate Partner, with whom she doesn't use condoms, even though "I trust him and we are open to each other." She does not want an STI or HIVab test, however, because she is "afraid to find out—what if I have it?" He says he's at "low risk" because "we've been having unprotected sex but nothing has happened," but he wants to be tested anyway. In his "Three Drawings," he locates risk in the body of a sex worker, at the seawall with couples making out, a carton of beer on the bench, with the young woman saying "if you love me, u can prove it by having sex with me." Only one respondent drew herself into a "Risky Setting," in this case, as she was walking home past a sugar plantation. As with other Target Groups, no drawings implicate Intimate Partners in HIV and STI transmission risk per se.

Health care workers (and their Intimate Partners): 5+5=10	
ethnicity:	6 Fijian, 4 Indo-Fijian
marital status:	9 married, 1 married more than once
current STI symptoms:	2/10, and at least one is being treated for HIV infection
condom use at last sex:	2/10
mean age 1st oral sex:	17.5 (4/10)
mean age 1st vaginal sex:	13.88 (9/10)
mean age 1st anal sex:	0/10 **(Note**: on various grounds we disbelieve this number)
virgin at marriage:	2/10
"low" risk assessment:	8/10
want STI Test:	7/10
want HIVab Test:	7/10

All 10 health workers and their Intimate Partners (some of whom were also health care workers) were married, four being Indo-Fijian, and six being ethnic Fijian (i-Taukei). Based on nine responses, the mean age at which they lost their virginity was just under 14 years. One had sex first with a family member at age 13 while bathing together and watching pornographic videos. As with other Target Group members, condom use rates were low and inconsistent, there was for understandable reasons underreporting of past and present sexual behaviors. Self-assessments of "low" HIV and STI transmission risk were also high. Many believed that faith in God and practice of fervent prayer could prevent HIV transmission and cure HIV infection.

Two of the 10 seem currently to be suffering from STI signs and symptoms, both halves of one couple experiencing pain while urinating, lower abdominal pain, and in the wife's case, ongoing problems trying to conceive, which she attributes to missing her menstrual period and being overweight. The unemployed wife of an Indo-Fijian health worker indicates having experienced genital itching but not having sought formal treatment. One of the 10 is HIVab+, though no signs or symptoms or problems thereof were reported.

Condom use rates were low. In one couple the husband states "occasional" condom use, while the wife states they "never" use them, but both agreed that they did not use them during last sexual intercourse. Both halves of another couple said they use condoms "sometimes," but they disagreed as to whether or not they used a condom the last time they had sex; the husband said they had because of an infection he had gotten "due to personal hygiene." In another couple the HIVab+ spouse reported an additional sex partner within the past 12 months and having had sex only "sometimes" with that person, while the spouse claims to have been faithful during that period and also to have had sex only "sometimes" with the HIVab+ spouse. Condoms are used only "sometimes" between these two intimate couples. The serodiscordant couple disagrees about their use at last sex, but the HIVab+ spouse reports being forced into having sex so as to allay accusations by the spouse of infidelity. Another health care worker wife says that she and her husband use the "withdrawal method," which she says is the most

effective way to prevent HIV and STI transmission; both spouses claim to have been faithful in the past 12 months, that they have sex "several times a week," and that they "never" use condoms.

Eight of the 10 cohort members perceived their STI and HIV transmission risks to be "low," but seven of 10 wanted to be tested for either STIs or HIVab or both. A female health worker doesn't wish to be tested, stating that she knows she is "negative" at the moment, while her husband wants to be tested to let her know he is not infected. Both attribute HIV and STI transmission risks to drinking and having multiple sex partners and smoking marijuana and cigarettes. He drew "Risky Settings" as including night-clubs, wharves, hotels, motels, pregnancy (a fetus inside an HIV-infected mother), and a person smoking. Both are suffering from signs and symptoms of STIs, but they claim mutual fidelity and deny any risk whatsoever. Both halves of another couple say they are "low risk" because they are "faithful," even though both wanted to be tested for STIs and HIVab as a "health precaution." As did those of other members of their cohort, their "Risky Setting" and "Risky Behavior" depicted blood transfusions and tattooing practices, travelling and village locales. Another husband depicted "Risky Behavior" as a married male engaging with a single female, having sex with an HIVab+ male, having multiple partners, and having unprotected sex. His wife depicted an HIVab+ woman, a confused and uneducated woman, infecting another and thus initiating a chain of infection. Another husband drew what was drawn by the person next to him, namely, "having multiple partners," "travelling to a village," "being bisexual," "getting drunk," and "attending nightclubs." His wife drew the same "confused, uneducated woman" as was drawn next to her. Her "Risky Person" couldn't recite the alphabet or her numbers correctly, but her other drawings featured beer-drinking, having multiple sexual partners, and experiencing rape, one drawing "depicting a female being raped with many males standing in the background watching." The husband admitted elsewhere to have raped a woman with eight friends and also to having been in jail for six years. Nevertheless, her "Risky Setting" is not constituted in and by sexual risks, but rather, by breast-feeding and attempting to stop and give aid to a victim of a car accident. Both halves of the fifth couple self-assessed their STI and HIV transmission risk as "low," but both wanted to be tested anyway, to "know their status"; having been tested for both just 60 days previously, the wife depicted "Risky Behavior" as sexual behavior and/with rugby players, and the husband drew a male with two female partners and two other females cavorting nearby. The HIVab+ spouse acknowledges being so, and therefore doesn't feel the need to be tested again, but the spouse (perhaps because condom use is inconsistent?) wants to be tested to "know my status." The PI and other researchers felt uneasy as to how slightly prevention methods were being taken in a serodiscordant relationship.

Christian pastors (and their Intimate Partners): 5+5=10	
ethnicity:	7 Fijian, 1 Fijian-Other PI, 2 Fijian-Rotuman
marital status:	1 de facto, 7 married, 2 married more than once
current STI symptoms:	2/10 (Note: one is being treated for an STI, one for HIV)
condom use at last sex:	2/10
mean age 1st oral sex:	17.6 (5/10)
mean age 1st vaginal sex:	17.8 (10/10)
mean age 1st anal sex:	21 (1/10)
virgin at marriage:	0/10
"low" risk assessment:	9/10
want STI Test:	6/10
want HIVab Test:	5/10

This cohort of five Christian pastors and their Intimate Partners (spouses, in each case) was extremely difficult to enroll and in some ways difficult also to interview. In other ways, however, they were insightful and helpful, and the focus group discussion involving pastors was surprisingly raucous and funny. All 10 cohort members had already engaged in vaginal intercourse, but none of them were virgins when they married. Their self-assessment of "low" risk of STI and HIV transmission, as with other Target Group members, was high (9/10), but compared to members of other Target Groups, relatively few wanted to be tested for STIs (6/10) and HIVab (5/10).

Only one of the 10 reported any signs and symptoms of STIs. A wife complained of previously having suffered pain while urinating and during intercourse accompanied by genital itchiness and persistent lower abdominal pain, and she still suffers serious pain during sex and persistent lower abdominal pain. She attributes both to having had a Caesarian section and to "the cold" and "sitting on the cement slab." She says that she has used alum powder to make her vagina tighter but "didn't like it," and has also used ginger pieces and ginger juice douching preparations to effect the same thing. Having recently learned that her husband might be HIVab+ (though he did not disclose his status to her, she learned what the medicines were that he was taking: "anti-retroviral drugs") she reported then and later that they don't use condoms. During her in-depth interview she stated that she doesn't want or need to be tested as "my faith alone will save me from contracting HIV from my husband who's positive. Plus, he's taking anti-retroviral drugs." During his in-depth interview the husband claimed that he wants to be tested to "know my status." The wife is currently in an extra-marital sexual relationship and "always" uses condoms with that partner, whereas with her husband, she "never" uses them.

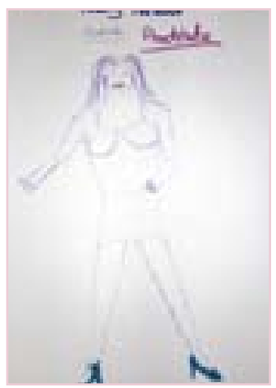
Members of this cohort self-assessed their HIV and STI transmission risks in ways that were particularly dissociated from Self, from Intimate Partner, and from actual sexual intercourse. This drawing of a "Risky Person" by one pastor depicts a school graduate's cap, a globe, and a heart that is dripping, seemingly, blood. The concept map drawn later by the same pastor contained the same stylized drawing of a heart, tanoa (kava bowls), of the smoking of marijuana, and of the drinking of alcohol. The spouse's concept maps and other drawings were the most spare of all 74 respondents. The only "sexual act" depicted was of a sexual "thought," which was considered to be "risky." This couple believes that STI and HIV transmission risks are global and ubiquitous—everywhere and nowhere at the same time—but not specifically sexual; their drawings are busy with hearts, love, bibles, hand-holding, crosses, and education. The wife self-assessed her STI and HIV risk as both "low" and "high": "low" "because of my religious beliefs" and her own marital fidelity, but "high" owing to her husband's possible infidelity. One can "get" STIs easily, she says, because they are "all around us," "through tattoo or blood transfusion." She wants to get an HIVab test for "peace of mind," to "know her status," and because "I visit hospitals for transfusion." Another husband perceives himself to be at "low risk" "because I trust my wife" and because "God the almighty is with us all the time," but yet he wants an STI and an HIVab test "to check my health" and "to know my health concerning AIDS," respectively. She, too, trusts in God and in her husband's fidelity, but yet wants both STI and an HIVab test "just to know my status."

Condom use rates were inconsistent, and many contradictions emerged about relationship and sexual behavioral dynamics. A couple exhibiting a considerable age difference both claim fidelity in the past year; the husband states their sexual frequency as "sometimes," while she indicates "several times a week"; he says they "never" use condoms because "we are faithful," while she states it's because he wants to have a child. He indicates never having engaged in oral or anal intercourse, but she says she's engaged in both just in her first year of married life. Another wife said the relationship was de facto only and that they had eloped, whereas the husband said that they had married formally in a church. In a third relationship, the husband first engaged in vaginal sex at age 13 and then oral sex at 14; she lost her virginity at age 15 to a boyfriend who was also her cousin; though she says he raped her, she says that she also was in love with him. Her husband disclosed having once engaged in group sex with a group of friends, and data suggest it was consensual homosexual sex. In another relationship the wife indicates that she has sex "several times a week," while the husband says "once a month." The wife had been sexually molested by an uncle who plied her with gifts, clothing, jewelry and money. Both self-assess as being at "low risk." He wants to get both an STI and an HIVab test, neither of which he's had before; she, however, wants an STI test "to know whether I'm okay," but does not want an HIVab test, not because she thinks she isn't infected, but because she is afraid that she is. In another relationship, the husband states that they have sex "several times a week," while she indicates "once a month." He indicates using condoms "sometimes," and at last sexual encounter, while she indicates she has "never" used one. Yet another couple says that each is at "low risk" of getting HIV or an STI, she because "I trust my partner; he doesn't sleep with others," and that they've been faithful, and he says the same thing. When asked if they want to be tested for STIs and HIVab, she says "yes" because she "needs to know if I have an STI," and adds that if she tests positive for HIVab, "I'll blame it to my husband." His "Three Drawings" project HIV and STI risks outwards, however, away from his wife, toward scenes of drinking and dancing, a woman who is seemingly suffering from AIDS, with boils on her body, and tattooing practices. His wife drew a series of night-club, motel, play-ground and street settings, and two figures seem to be suffering from AIDS. "Pories" (prostitutes) feature heavily in the "Risky Setting," and they are "All lady's [ladies] stopping veichiles [vehicles]." Her "Risky Person" includes three "gays" and persons engaged in commercial prostitution on a popular road.

"How I Try Not to Think About Preventing HIV Transmission": concept maps of Self, Intimate Partner, and Other

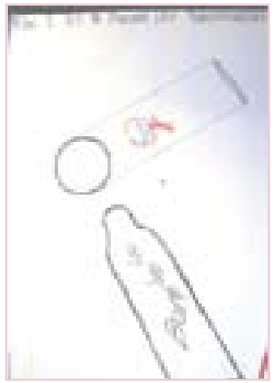
"Uh, if I remember there's a condom in my bag and to spike up the sex just before we have sex, I'll say 'there's a condom in my bag, can you bring it out to spike up our sex?' But halfway through he'll take it off again. Um, it doesn't feel nice; when he's my partner for 13 years and we normally go natural. It'll feel, it feels funny" (Fijian sex worker).

Brief mentions were made above of themes depicted by various Target Group members and their Intimate Partners while engaged in various concept-mapping exercises. At the conclusion of each focus group discussion we served participants light snacks and refreshments and allowed them to catch their breath, stretch their legs, and retrieve telephone messages. When we reassembled the participants they were each provided with three A4 cards and some markers to draw with and asked to think about HIV transmission risks and then draw 1) a Risky Person; 2) a Risky Behaviour; and 3) a Risky Setting, again, all in terms of HIV transmission. They were told that after they are done they will explain their drawings in their own words. After they completed their drawings the team recorded their explanations by digital recorder. As these drawings suggest, and as we detail below, most participants imagined "pros," "prostitutes," "hookers," "pories," "sex workers" and social and sexual intercourse with them in various settings to be Risk Personified. We discuss those findings below and also how we coded and analyzed the data.



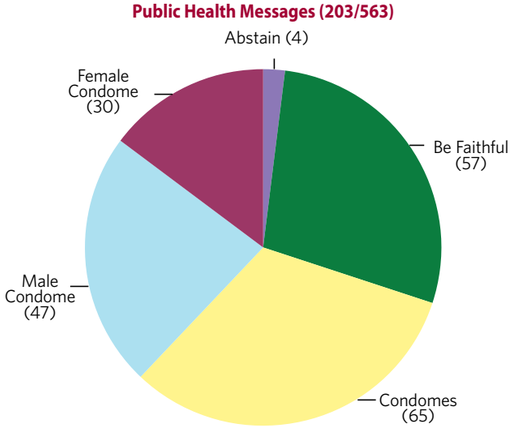
We then used the same technique to get our respondents to self-assess their own HIV transmission risk. At the conclusion of the focus group discussions the research team told the participants to think now about their life, their own body, their Intimate Partner and the character of their intimate relationship(s) and draw on one paper, "How I Try to Prevent HIV Transmission," and then on another, "Me, My Intimate Partner and HIV." After they were done they were asked to explain their drawings to the research team. The research team was firm and repeatedly so regarding the content of the exercise and insisted that they draw their own sense of their HIV transmission risks, not just what they thought the research team would like to hear. They were told to depict the actual methods of HIV transmission prevention they use, not just what they had been told is good or that would be good for someone else. They were asked to represent how they and their Intimate Partners together think about and deal with HIV, not just what they read on a pamphlet. One or two days later the research team then interviewed them again.

We discuss those findings below in greater detail, but we will note here that only a very few—like the one from a transgender male who drew "Up ya bum!"—described HIV transmission prevention methods that people actually use. Instead, most depicted opinions, acts, messages, behaviors and contexts that had nothing to do with the respondent himself or herself. Sex workers and their husbands and boyfriends stated the imperative to "Be Faithful" when of course they can not and are not. Health care worker and Christian pastor wife drawings supported the use of condoms, but they themselves did not use them. A taxi-cab driver depicted villagers growing healthy food, fishermen catching fish, and students playing rugby. Yet others took the opportunity almost to deliver a lecture, as with this example from a university student. In real life, however, the artist hasn't been tested for STIs and HIVab, has been unfaithful to an Intimate Partner several times, does not use condoms consistently, has not "wait[ed] until marriage" to lose virginity, has never been counseled regarding sexual matters, and sufficiently distrusts her Intimate Partner as to be frightened about the likely outcome of test results. She is one of only few who depicted herself, in this case, while attempting to get home from the bus-stop.



The PI devised the following method to analyze and code the concept maps. Each concept-map was posted on the wall in a university classroom, color code-by-color code, Target Group member-by-Target Group Member, and Intimate Partner-by-Intimate Partner. Thus, for example, on one wall hung all of the Red color code drawings, those of the Christian pastors hanging atop, while those of their Intimate Partners hanging underneath. Two research assistants were assigned to each color. Manual counts were made of each message, object, person, act, and setting depicted. Those totals were affirmed by each dyad and confirmed by the PI.

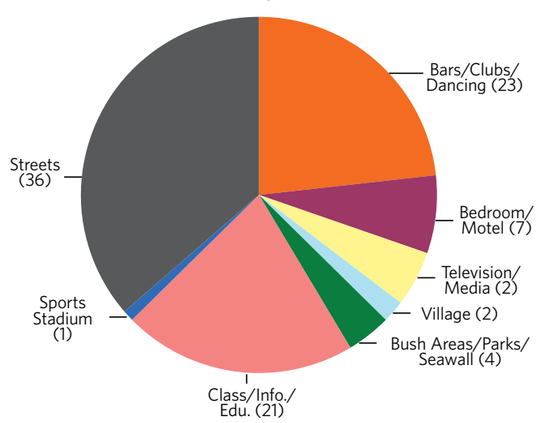
Public Health Messages (203/563)



We counted 563 depictions and settled upon the following themes and categories that we discuss below. Public Health Messages were depicted 203 times out of 563 (36% of the overall total). People Depicted constituted 108 of the total (19%). Social Settings were drawn 99 times (18%). Relationship Figures and Symbols were rendered 52 times (9%). Healthcare Settings and Symbols were represented 41 times (7%). HIV Treatments and Cures were mentioned 19 times (3%). Various Objects and Practices were drawn 40 times (7%). Religious Figures and Symbols were depicted 42 times (7%). Various Sex Acts were drawn 27 times (5%).

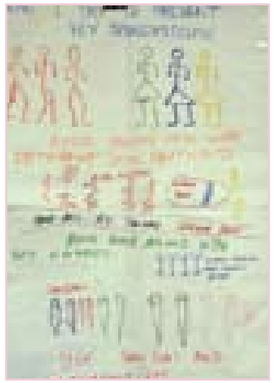
We will discuss first the Public Health Messages that our participants drew. Those 203 drawings featured permutations of the "ABC" message. Only four depictions were of the "A" in "ABC": "abstinence," but because each and every respondent was sexually active, that probably makes sense. The "B" in "Be Faithful"—"Be Faithful," "Stick to One Partner," and the like—were depicted far more frequently (57/203). Few respondents have ever used a female condom, but they were mentioned 30 times. Male condoms were depicted 47 times, and condoms generally, 65 times. **Although only 25% of our respondents had used a condom at last sexual intercourse (13 of those 18 respondents being university students), 62% depicted them.**

Social Settings (99/563)

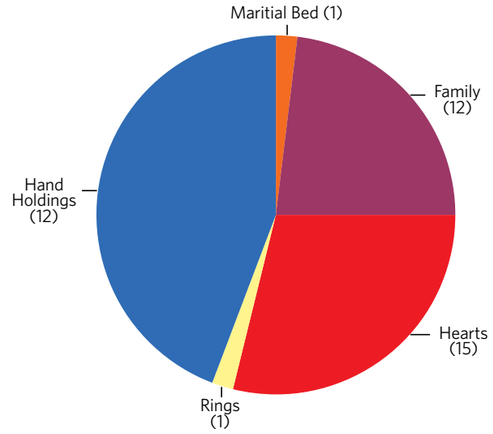


Social Settings were depicted 99 times (18% of the total), as follows: "streets" (bus-stops, street-corners, busy roadways), 36%; bars, night-clubs, music and dancing, 23%; settings of knowledge and learning, 21%; bedrooms and motels, 7%; television and other media, 5%; bush areas, parks and the seawall, 4%; village, 2%; and sports stadiums, 1%. These data generally associate (66/99: 66%) HIV transmission risk with commercial sexual networking, sites where it is negotiated and takes place, and settings of alcohol purchase and use. "Villages" and "sports stadiums" were mentioned more frequently in context of "Risky Behavior" and "Risky Setting." This map drawn by a Fijian taxi-cab driver lays out Suva's geography in terms of casual and commercial sexual networking, including seawall, Colo-i-Suva park, night-club and motel. The drawings, however, are of other people's sexual cavorting. At the seawall, it says, "after the drinks, they can be having sex and the HIV spreads."

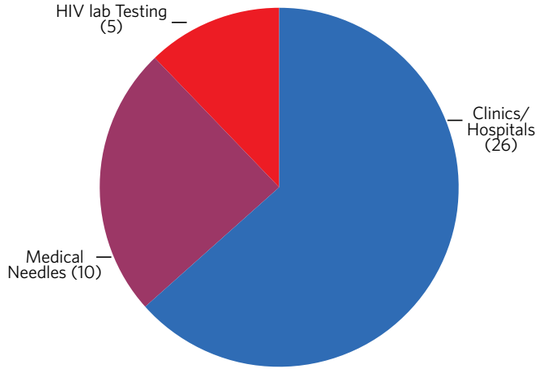
A large number (52/563) of "Relationship Figures and Symbols" were drawn, as follows: hand-holding, 42%; hearts, symbolizing love and relationship commitment, 29%; family, 23%; rings, once, and sexual intercourse, once.
The pie chart of People Depicted (108/563 total depictions) shows even more clearly how Fijians construct HIV transmission risks. Only 18 respondents depicted Self (17%); Intimate Partner, by contrast, was depicted 47%; and Other Partner, 14%. Sex Worker and Sex Worker client were drawn 11% and 6%, respectively, and taxi-cab drivers, 6%. This concept map was drawn by a 45 year-old taxi-cab driver who has at least three regular sexual partners. He prevents HIV transmission by avoiding "going around with sex workers," and elsewhere that "I choose the partner very carefully, not the type that you can pick in a night-club." He was one of three taxi-cab drivers who declaimed the efficacy of "Fiji medicine," in this case depicted as "plants and herbs."



Relationship Figures and Symbols (52/563)

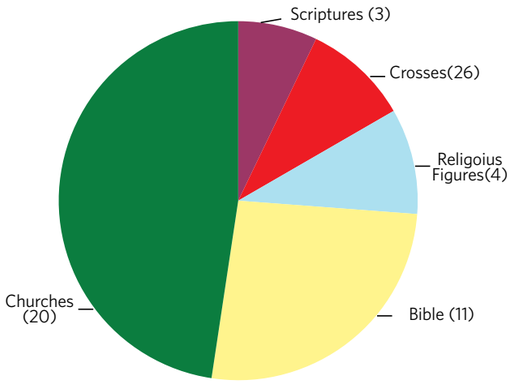


Healthcare Settings and Symbols (41/563)



Healthcare Settings and Symbols were depicted 41 times (7% of the total), but there were only three kinds of them: clinics and hospitals, 26 times; medical needles, 10 times; and HIVab testing, five times. A taxi-cab driver, for example, depicted use of a condom and avoidance of bush areas and tainted medical equipment.

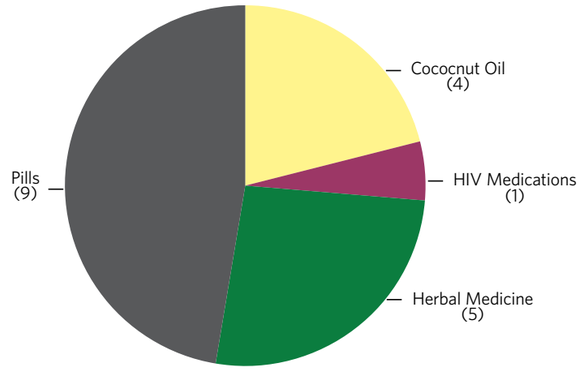
Religious Figures and Symbols (42/563)



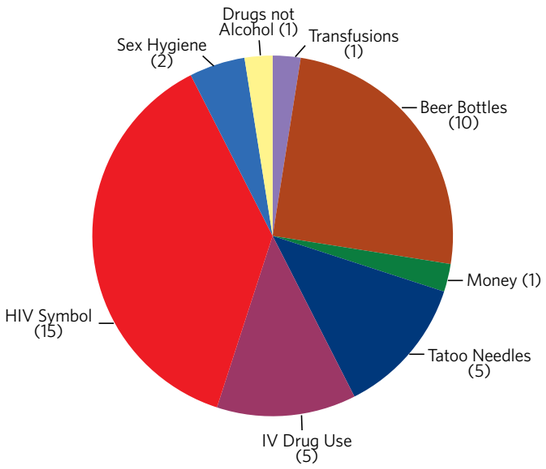
"Religious Figures and Symbols" were drawn 42 times, or 7% of the total. Depictions of churches constituted 20% of those mentions (48%); Bibles, another 26%; crosses and religious figures, 10% each; and Scripture, 7%.

There were very few mentions of HIV Treatments and Cures (19 overall, or 3%), as might be expected. Nine of those 19 were of "Pills," and five and four depictions, respectively, were of "Herbal Medicine" and "Coconut Oil." None of the "Pills," however, were of actual HIV medications, but rather, of birth control pills and aspirin tablets. There was only one mention of actual HIV medications, despite that at least five respondents were HIVab+. Of the four who depicted coconut oil as a treatment and/or cure, one was the Intimate Partner of a sex worker, one was a taxi-cab driver, and two were the Intimate Partners of taxi-cab drivers. Of the five who depicted herbal medicines, one was the Intimate Partner of a sex worker, two were a taxi-cab driver/wife couple (he was taking them), and then an HIVab+ health care worker. Beliefs in the power of coconut oil to cure HIV infection are not shared only by lay-persons.

HIV Treatments and Cures (19/563)



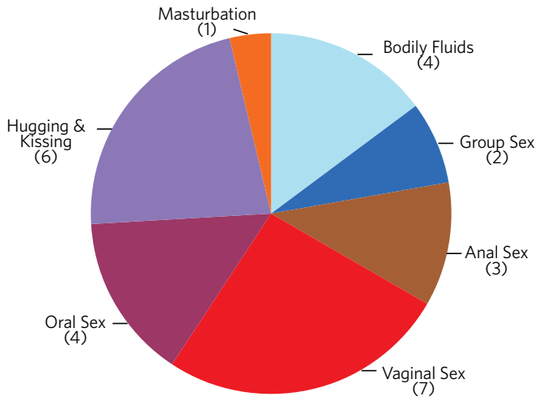
Objects and Practices (40/563)

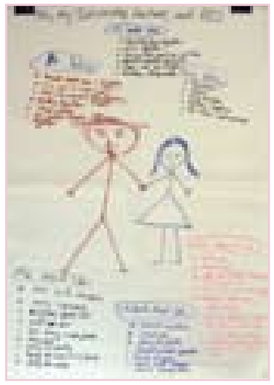


Another 40 mentions out of 563 (7%) were made of what are called here "Objects and Practices," including Drugs, not Alcohol, one; Sexual Hygiene, two; Blood Transfusions, one; and Money, one. Five mentions each were made of IV Drug Use and Tattoo Needles; 10 of Beer Bottles; and 15 of HIV Symbol.

Only a few representations (27/563, or 5% of the total) were of actual sexual acts and practices. Seven of those 27 were of vaginal intercourse; four were of oral sex and bodily fluids; six were of hugging and kissing; three were of anal intercourse; and two were of group sex. Even though it is an effective means of preventing HIV transmission, masturbation was mentioned only once. The concept map drawn here by a male health care worker is the stirring exception and lists both positives and negatives. "On good mood," it says; "adventurous sex," "hardcore sex," "oral sex," and "sleep naked" were depicted. He says he doesn't like anal sex, doesn't like using condoms, doesn't like using lubricants, and "dirty remarks." He says that she doesn't like oral sex or anal sex or sex without condoms during the "unsafe period." Both reported never having engaged in anal sex.

Sex Acts (27/563)





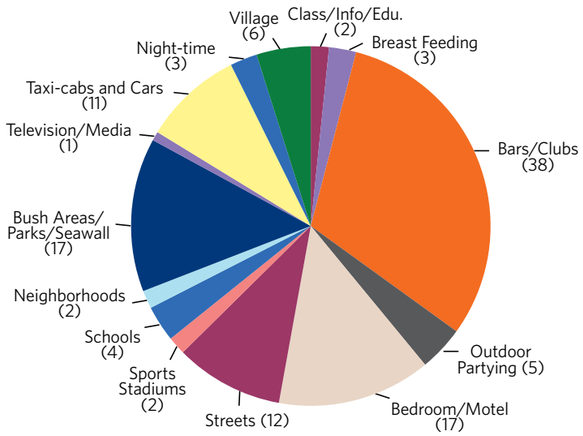
Drawing Attention: person, setting and behavior in Fijian assessments of risk

Interviewer: "Okay, but if I'm hearing you correctly, you are worried not about your boyfriends or husband, you are worried about getting it from a client?
SW#1: "Yes"; SW#2: "Um, can be"; SW#3: "Um, yes."
SW#1: "Uh, well, from a client, because a client could be coming in from a foreign land."
SW#2: "And, um, like, um, with a partner you have a trust, you have your trust with a partner."
SW#3: "And like with me, why I have my trust with my partner is,
I've been with him for 13 years and we have three children"

Unlike the assignment that asked them specifically to locate themselves in their concept maps ("How I Try to Prevent HIV Transmission," "Me, My Intimate Partner, and HIV Transmission") our second application of the concept mapping technique didn't require them to do so. Respondents had only to draw **Risky Person**, **Risky Setting**, and **Risky Behavior.** Either way, these drawings also had little to do with the artists themselves. The boyfriends and husbands of sex workers often depicted sex workers as Risky Person, but didn't draw their own wife or girlfriend as such or draw themselves having sex with them as constituting a "Risky Behavior." Many other respondents depicted absence of condoms as a "Risky Behavior," but yet themselves didn't report condom use. The three men who counted 34, 34, and "at least 50" sexual contacts in the past year did not depict themselves as "Risky Persons," either.

The "Three Drawings" were analyzed and coded the same way as were the two concept maps Manual counts were made of each message, object, person, act, and setting. There were 437 depictions in 215 drawings overall (some of the 74 respondents did not draw all three drawings). We kept the five themes and categories as previously, but we did not need to tabulate Public Health Messages, Relationship Figures and Symbols, and Religious Figures and Symbols for obvious reasons—condom use, hearts, rings, hand-holding, bibles and crosses are not risky.

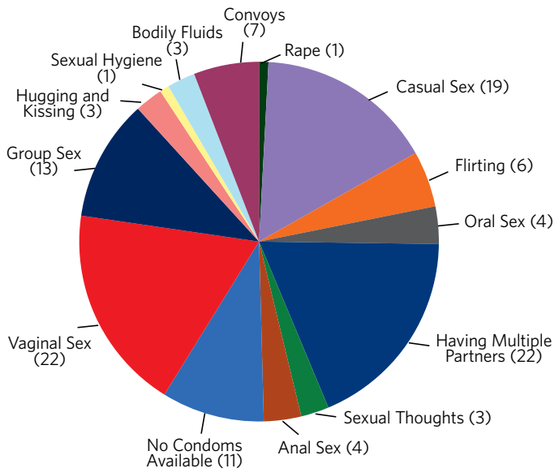
Social Settings (123/437)



Ranked in order of most to least frequently depicted, **Social Settings** were drawn 123/437 (28%); **Sex Acts,** 119/437 (27%); **People Depicted,** 98/437 (22%); **Objects and Practices,** 79/437 (18%); and **Healthcare Settings and Symbols,** 18/437 (4%).

Of the 123 "Social Settings" depictions, 38 of them (31%) were of bars and night-clubs. This representation of "Risky Behavior" was drawn by a gay male, who projects risk onto a seeming heterosexual couple enjoying "party time" in a bar, and then later, between them, "about to have sex both drunk, don't know each other, and on top of that, no condoms!" Another drawing by the same gay male, titled "having a sexual session without a condom on the beach," depicts another seemingly heterosexual couple. Seventeen drawings (14%) depicted sexual acts taking place in a bedroom and/or motel, often one and the same. Another 17 drawings depicted bush areas, the seawall, and parks; often times the drawings were of clusters of men and women, but sometimes of groups of men and a single woman, smoking and drinking. We categorized "Outdoor Partying" separately, which was depicted five times (4%); street corners, bus-stops, and road-ways were depicted 12 times (10%); taxi-cabs and cars featured 11 times (9%); villages, another six times; schools, four times; breast-feeding and "night-time," three times each; classrooms, neighborhoods, and sports stadiums, twice each; and television and media, once.

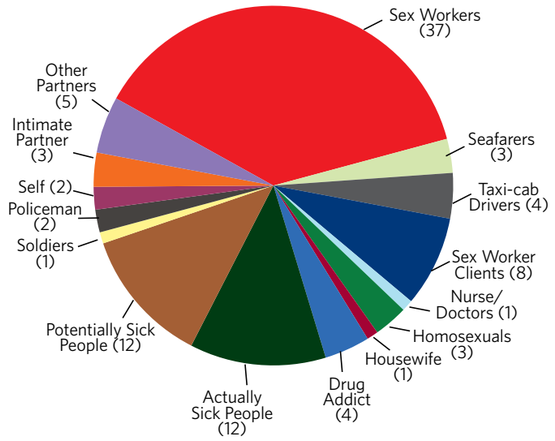
Sex Acts (119/437)



Next most frequently depicted were "Sex Acts" (28%). Of those depicted, "Vaginal Sex" and "Having Multiple Partners" were each depicted 22 times (18%). "Group Sex (11%) was coded separate from "Convoy" (6%) because female agency was so clearly absent in the latter. The unavailability of condoms was represented 11 times (9%), flirting (5%), anal sex and oral sex both four times (3%), and then hugging and kissing and sexual thoughts both three times (2%). **None of the 215 drawings, not even those by gays, lesbians and transgendered persons, were of lesbian- and gay-themed places and settings.**

Of the "Risky Persons" depicted, "Sex Workers" were by a long stretch the most frequently depicted kinds of persons, 37/98 (38%). "PSP" (Potentially Sick People) and "ASP" (Actually Sick People) were each drawn 12 times (12%). The latter were people suffering visibly from boils and rashes and swellings and weight loss, the former as appearing healthy, wearing bula shirts, and being handsome or pretty, but still "harboring" a "silent" infection. The clients of sex workers were drawn eight times (8%), Other Partners (meaning, not one's Intimate Partner) were drawn five times (5%), and a smattering of other kinds of "Risky Persons" were drawn, too, including drug addicts, homosexuals, policemen, seafarers, and, in one case each, soldiers and housewives. Once again, the boyfriends and husbands of sex workers depicted sex workers, but not their own wives and girlfriends. Sex workers themselves only once depicted a client. Sex workers never depicted

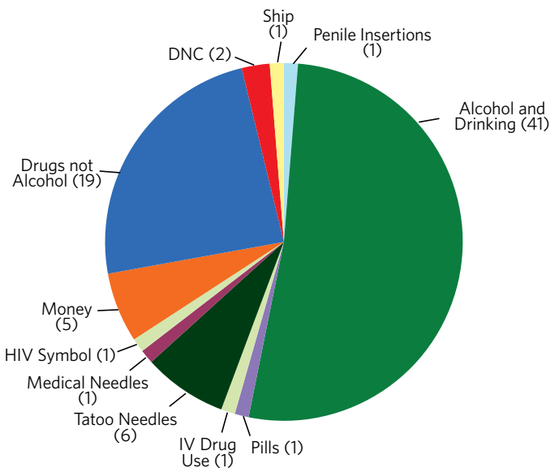
People Depicted (98/437)

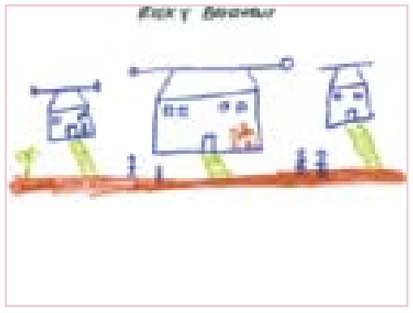


their own Intimate Partners, but they did depict others whom they know intimately: male relatives who had molested them and policemen who had harassed them. One woman was six years old when she was raped by a male relative. Her drawing of "Risky Behaviour" is set in a house in a village, and she describes it thusly: "this is a man, with a grand-daughter, trying to, trying to fix his grand-daughter, trying to rape her, and the grand-daughter didn't know that the grand-father has HIV. It's happening in the village." Her "Risky Person" drawing is also of an obviously older man, "50+," who is "trying to fix that small girl there," a "girl like 14." Even though her parents didn't believe that she had been raped, her rapist-uncle had to splash water on her to revive her; since then, she has felt fear and is "sometimes traumatized when I think about it."

"Objects and Practices" constituted 79 of the 437 depictions, 41 of them (52%) depicting scenes of alcohol and drinking. Drugs but not alcohol constituted another 21 mentions (27%), but if alcohol were added, the two combined (76%) comprise over three-quarters of all depictions. Tattoo needles (six), money (five), ships (one) and penile implants (one) were also depicted. The "Risky Person" drawn by the wife of a health care worker is sufficiently drunk that she can't remember her numbers, and her friends, all female, are represented as being risky, too. Another female health worker drew a drunken woman who can't remember her alphabet or numbers. Perhaps this means that such artists had gleaned perspectives from a past workshop or seminar.

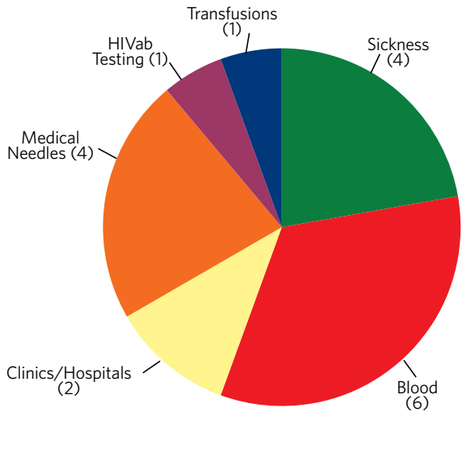
Objetcs and Practices (79/437)





Very few Healthcare Settings and Symbols were depicted (4% of the overall total). Of those 18 depictions, six were of blood; medical needles and sickness garnered four each; clinics and hospitals comprised another two; and blood transfusions and HIVab testing were depicted once each. This drawing of a "Risky Setting" depicts both a tattoo needle, presumably contaminated with someone else's blood, and the setting of a blood transfusion. Many respondents seem worried of the dangers of blood donation, not just blood receipt (transfusion). Yet others seem inordinately worried about breast-feeding and tending to the victims of car crashes. The health worker artist notes the imperative to use gloves "when you help a person got accident."

Healthcare Settings and Symbols (18/437)



Tona! Tona! Tona!: Fijian understandings of STI signs and symptoms

tona: gonorrhea
gonorrhoea: tona
(Capell 1991[1941]: 237, 339)

These entries in Arthur Capell's A New Fijian Dictionary said it all in 1941, again in 1991, and if the quotes in the text-box are any indication, yet again in 2011. There are no words in the Fijian lexicon for syphilis, Donovanosis, genital herpes, chlamydia, trichomonas, or any of the 30 other STIs. Vidikoso ("scrofulous ulcer") tantalizes (could vidi be recent and mean "VD?"), but no participant mentioned it. Because genital ulcer diseases (GUDs) and genital discharge diseases (GDDs) are new in the Pacific (Hammar 1998) we should not expect knowledge about them in Fiji to be highly developed. There are no words in the Fijian lexicon for their **causes** (bacteria, viruses, protozoa, fungi), **signs and symptoms** (lesions, discharges, swellings, pain, secondary infertility), **treatment modes** (antibiotics and antiretrovirals), or **transmission dynamics** (in terms of exposures required, routes of entry, modes of transmission, and sizes of inoculates). We would not therefore expect to find evidence of lots of accurate knowledge about HIV, AIDS and STIs (see also Kaitani 2003: 16; Chaudhary 2003-2004: 35, 29; Coghlan 2009; Schoeffel 2009).

Text box 10:

Interviewer: "How many STIs can you name?"

Respondent #1: "Gonorrhea, syphilis."

Respondent #2: "Syphilis."

Respondent #3: "Tona. Tona. Tona."

Respondent #2: "That's it, tona. That's the Fijian word for it" [lots of nervous laughter and chatter].

Respondent #4: "Myself, I can't really explain anything because I don't know what it is all about"

(four Christian pastors).

Researchers have theorized why specific knowledge of these problems has not deepened and broadened upon the introduction to Fiji of STIs. Miliakere Kaitani (2003: 16) isolates "cultural expectations" such that such matters are not to be spoken of in public. There is a "lack of information and knowledge of reproductive and sexual health," she notes. Fijian men are supposed to know the answers already. They are "expected to know the healthy and accepted reproductive and sexual health behaviour," even though the information is absent or lacking and even though its dissemination is frowned upon (2003: 16). Fabienne Labbé (2010) asked HIVab+ Fijians about these matters, amassed similar findings, and concluded that they were flip sides to the same coin. First, there are the social and linguistic tabu not to breach. Rules "govern discussion or reference to sexuality among indigenous Fijians. Talking about sexuality or alluding to sex is indeed highly regulated in the indigenous Fijian community" (2010: 15). Second, specific rules prevent improper speech and behavior between specific kinds of people. Reference to "sexuality or to anything that might remind one of it (alluding to sexual parts or underwear, for example) is strictly prohibited amongst other categories of people" (2010: 15). (For what it's worth, two members of our research team are aunt/niece, and they could not ask or answer such questions of each other while practicing interviewing strategies.) Carmen White worked in Fijian secondary schools on the intersections of race, gender, class, and nationalism (especially 2005) and points to several gender-specific outcomes of these dynamics. "[N]otions of Fijian authenticity intersect with gender," she notes, "to the extent that compliance with standards in behavior marked as authentically Fijian is bifurcated by distinctions between what is normative for Fijian males and Fijian females" (2005: 317). She discusses especially the different ways that male versus female movement is linked to social ideals of proper gender behaviors. "Fijian girls who roam the streets in recreational pursuits akin to male groups," she notes, "may have aspersions cast on their sexual virtue" (2005: 318). In several publications, Nicole George (especially 2008) has theorized the fact in Fiji that talk about sensitive matters (whether they are about sexual health, masculinity, or women's status) predictably results in great hue and cry, a backlash perhaps against speaking publicly about what ought to be "private" matters. She notes, for example, that public discussions about the legal status of gay males and lesbians "have provoked a volatile and frequently hysterical style of public debate that, ironically, appears to have intensified homophobic sentiment rather than promoted tolerance of homosexuality in Fiji" (2008: 166). Even the Family Planning Association of Fiji expressed homophobic sentiments in trying to explain fast-rising levels of STIs in Fiji (Fiji Times 1996a, b). Perhaps talking about sex (as opposed to having it or doing it) takes all the fun out of it (Schoeffel 2009: 17).

Given this cultural backdrop, it is hardly surprising that discussion of sexual matters relevant to addressing STIs forthrightly is brought to a standstill. In addition, there is a lot of misinformation and disinformation about STIs and HIV. During several years' relevant clinical work, Arvin Chaudhary (2003-2004: 35) encountered strong belief amongst Fijians in a set of myths about HIV that are relevant to our discussion below of Fijian understandings of STI and HIV transmission and risk factors. We mention and respond briefly to each of them.

- "Only gays and prostitutes have HIV."

Probably no one would agree with the only, but yet most of our respondents did externalize their HIV transmission risks and often singled out women in prostitution and gay males in doing so.

- "Insects like mosquitoes may transmit HIV."

We encountered this only once. During a focus group discussion with taxi-cab driver wives, one said that she had attended a workshop and "asked about the mosquito bites, because I have children and I was worry about them. But when they say it is not, then I felt relieved again."

- "Condoms leak and are unsafe to prevent HIV transmission."

While there is lots of misinformation about condoms (for example, several said that two or three condoms should be used at once), the more important issue is the cognitive dissonance regarding with whom one should or does not need to use them. Fijians don't appear to be misinformed about the tensile strength of condoms so much as about that of their intimate relationships.

- "HIV and AIDS [are] same thing."

Yes, there is considerable confusion among our respondents, but if Fijians believe this, it is partly only because public health authorities, politicians, researchers, NGO representatives and newspaper editors use phrases such as "HIV/AIDS," "HIV/AIDS virus," "HIV/AIDS infection," "AIDS transmission," and the like, all the time. The Burnet Institute report, for example, collates figures obtained from studies in which members of allegedly "high-risk" citizens of five insular Pacific countries were ranked and ordered in terms of "No incorrect beliefs about AIDS transmission" (2009: 81, Table 33 of Appendix 1). The phrase, of course, is nonsensical: it is physically impossible for a disease syndrome to be transmitted. Hundreds more examples could be amassed from the titles and content of the sources in the bibliography of the present report.

- "One can tell by looking at someone who has HIV."

Quite a few claim, and rightly, to be able to do this, but perhaps it would be better phrased in the negative: "one cannot necessarily tell by looking that someone has HIV."

- "Everyday contact can transmit the virus."

We found that respondents exaggerate the HIV transmission risks of car crashes, breast-feeding, rugby matches, blood-giving and blood-receiving, and many believe that sex with "strangers" and those in prostitution are more unsafe per se than is sex with one's Intimate Partner.

- "Pretty/Cute and clean looking people are safe."

This is the same as assuming that one's Intimate Partner is by definition safe.

- "Ejaculating outside (after unprotected penetrative anal or vaginal intercourse) will not transmit HIV."

Several respondents had been "taught" that "withdrawal" is "the safest method" of HIV prevention. Others believe that injections of vitamin-C, faith, consumption of cold-pressed, extra-virgin coconut oil, and fervent prayer can cure HIV. Only two respondents (both gay males) reported their knowledge of the existence of pre-ejaculate. No one mentioned viral load.

Now that we have discussed some of the ideas that Chaudhary encountered throughout Fiji and during clinical practice, we want in the section below to present data from the focus group interviews we conducted about what respondents seem to know about STIs. The text-box quotes at the outset of this section from Christian pastors suggest that knowledge of STIs seems to begin and end with tona, meaning, usually, discharge, probably gonorrhea. When we asked the spouses of taxi-cab drivers the same question, and even though we conducted the discussion slowly, gently, and in Fijian, only one answered, by saying, "Tona . . . Yeah, definitely, tona waice is 'dripping water' [laughing] . . . [and] umm, syphilis [laughing] . . . Um, samuna [skin rash]. That's the only name I know. Yes, and samuna." These two groups of respondents mentioned only discharge as "the" signs and symptoms of STIs. Their answers to questions about the causes (in the strict sense) of STIs included mentions of unprotected sex per se, but the bulk of their attributions were to immorality and alleged promiscuity, on being the kind of person who would have multiple partners.

Groups of university students mentioned a few more names:

> Interviewer: Thank you . . . Um, we'll begin with how many STIs you can name, sexually transmitted infections.
>
> Respondent #6: Syphilis.
>
> Respondent #7: Syphilis.
>
> Respondent #6: Gonorrhea.
>
> Respondent #7: Herpes.
>
> Respondent #4: Warts.
>
> Respondent #6: Tona.
>
> Respondent #6: Yeah. The pus when you urinate, the pus comes out.

Respondent #6 was the only of 74 respondents to mention publicly having suffered from an STI.

When we conducted a focus group interview with the Intimate Partners of university students (several of whom were themselves university students), we elicited essentially the same responses: Respondent #1: "Gonorrhea . . . AIDS"; Respondent #2: "Syphilis . . . HIV"; Respondent #3: "Herpes." Neither they nor the university students themselves mentioned any specific knowledge about the various causes of STIs, mentioned only discharge in terms of signs and symptoms, and didn't know specifically how they could be treated.

The boyfriends and husbands of sex workers were confused about these and other matters:

> Interviewer: So, how is syphilis related to HIV, and how is HIV related to AIDS?
>
> Respondent #1: I think that's where you are not taking any more precaution onto it, like, uh, you're not using condom, you know, you [have] syphilis, and you're still having sex without condoms, to my understanding//

Interviewer://How many, how many STIs are common here in Fiji that you people know?

Respondent #3: Gonorrhea, syphilis, AIDS.

Respondent #2: Gonorrhea is same as syphilis, eh?

Respondent #4: What is tona?

Respondent #1: HIV.

When we interviewed sex workers themselves, two of the six mentioned gonorrhea, one mentioned Hepatitis B, two mentioned that the "cause" was "unprotected sex," and that symptoms included "discharge of yellowish fluid." One said "Oh, I've seen it in one of my ex-boyfriends. I found, uh, his underwear but the pus was like in his underwear. Yellowish. Yellowish and like white and [it] stinks. He came to the STI clinic; they gave him some pills, green pills, STI clinic."

Some respondents conflated gonorrhea and syphilis, and both with HIV:

Interviewer: What [about] gonorrhea and syphilis?

Respondent #1: They are the same.

Respondent #2: [Gonorrhea is] Stage 1.

Respondent #1: And Stage 2 is syphilis. [Gonorrhea and syphilis] are the same. Stage 1.

Respondent #2: And then you go onto the STI and then into the HIV.

Respondent #1: It goes stage by stage, that whole.

Respondent #3: Well, gonorrhea, if you don't treat it, from the syphilis stage, then it's going to turn into HIV.

Respondent #1: It gets more infected in your system and you go for check up.

Respondent #2: Well, like, tona is like//

Respondent #1: //Refers to the whole, whole. And when someone says tona, you'll just know straightaway the person is referring to something on a person, to deal with these, uh, diseases, so straightaway you'll know, "oh, it's either syphilis or gonorrhoea or sores, or what," so.

Interviewer: So, is that gonorrhoea, is it tona, would you refer to that as tona?

Respondent #2: Syphilis.

Respondent #3: It refers to all of that, yes.

Gays, lesbians and transgendered persons also expressed little specific knowledge of STIs and again conflated gonorrhea with syphilis.

Interviewer: How many STIs can you name?

Respondent #1: Gonorrhea, syphilis, um, those are the main ones I know [to knowing laughs!]. HIV, that's the main one.

Respondent #3: Infection of the sexual organs. Education, from what we learned, what we cover, only, facial, the eyes.

Respondent #4: What are the symptoms? [really long pause] Sores around the genital area, and if they go for urination, there is pain.

In a focus group composed of the Intimate Partners of health care workers (several of whom were themselves health care workers), we asked them the same questions:

Interviewer: Okay, let's see how many STIs can you name.

Respondent #1: Four: chlamydia, trichomonas, syphilis, gonorrhoea.

Interviewer: How about you sir, do you know any STIs, the name of any STIs?

Respondent #2: No.

Interviewer: And you ma'am?

Respondent #3: No.

Interviewer: And you?

Respondent #4: No.

Respondent #5: I've heard of them [only].

Health care workers themselves had a little bit more to say, but again, discussion was terse and tentative; our impression was that some wished not to appear to "know too much," but that others felt ashamed that they apparently knew so little. Only two respondents had anything to say:

Interviewer: What kinds of STIs (or Sexually Transmitted Infections) do you know about?

Respondent #1: Syphilis and gonorrhea. Those are the two main ones.

Respondent #2: HIV and AIDS. Genital warts.

Respondent #1: Uh, genital warts.

Respondent #2: Gonorrhea.

Respondent #1: Herpes.

Intimate Partners of university students hinted at perhaps female-specific STI symptoms:

> Interviewer: Okay, so [in males], that's like a discharge? Do females get tona?
>
> Respondent #2: They are unaware of it. For males, they will be aware of it because they have only one channel for//
>
> Respondent #1: //Sexual intercourse.
>
> Respondent #2: Yeah, intercourse, and for using it to pee, like that, but for females, they won't be aware of it because of the double lane.
>
> Interviewer: Because they have both the vagina and the urethra.
>
> Respondent #2: Yeah.
>
> Respondent #1: It's just that . . . they experience unpleasant smell from their vagina.
>
> Interviewer: Okay, so do you ladies suffer from waica, if that's how you pronounce it?
>
> Respondent #2: They do but they are not aware of it, because it's not painful.
>
> Respondent #1: They probably oblivious, eh?, to it. Like, they oblivious to it; they just wash themselves, they don't really go and get checked. So it's there, but they don't know.

Text box 11:

Interviewer: How many STIs or sexually transmitted infections [do] you know about, and their names, in Fijian or English?

Respondent #2: You mean, the disease like "tona"?

Respondent #4: Dogoa? Is that right [checking with her peers]?

Respondent #2: No, these are diseases; this is like STIs, tona.

Respondent #3: //These diseases [are] transmitted through sexual intercourse, like AIDS. HIV.

Respondent #1: No, AIDS is different from STIs.

The wives of four taxi-cab drivers also had little specific information to share, as is evident in these text-box quotes.

With these data in mind, we will support our contentions in another way. As is shown in Table 2 below, 21 respondents seemed to be suffering from currently or had in the past suffered from STIs. For any "yes" answer they gave to our questions about pain on urination they may have faced, sores in their genital regions, lower abdominal pain that didn't go away, and so on, we asked several follow-up questions, including how they think they became afflicted.

The results were extremely interesting. The 21 respondents made a total of 60 attributions. Males made 31 of those, females made 24, and a transgender person made five more. Of those 60 attributions, only 12 were specifically to sex. Eight of them were made to sitting on "cold" cement or being infected by "the cold" or draft. Females mentioned causes that males in general didn't, for example, menses, childbirth, rape, and drinking hot liquids, and others that heterosexual males specifically didn't: penises that were over-large or that had had marbles inserted in them (see Norton 1993; Patel, Ali and Taoi 2009). Males cited the wearing of warm clothes, drinking too much alcohol or yaqona, dehydration, and several other reasons. (To clarify, interviewers stressed lower abdominal pains that didn't go away; reports of genitals traumatized by childbirth didn't qualify as an STI.)

Table #2: STI Symptom Attributions to Sex, not-Sex, Suva (N=21)

Attributions	males (12)	females (8)	t-gender (1)
	#	#	#
"I don't know"		1	
"the cold,""sitting on cement"	3	4	1
"sex"	5	6	1
"hospital medicines/operations"		1	
"warm clothes"	2		
"drinking too much alcohol"	4		1
"drinking too much yaqona"	2		
"poor sexual hygiene"	3		
"having multiple partners"	3		
"loss of body fluid"	2		
"poor nutrition"	2		
"tense/muscle withdraw"	3		
"dry vagina"	1		
"rugby injury"	1		
"penile modifications/marbles"		3	
"menses"		4	
"birth"		1	
"drinking hot liquids"		1	
"large penis"		3	1
"rape"			1
Total # non-sex attributions	25	18	
Total # of attributions	31	24	4

To repeat, because the table is comprised of attributions made by people who reported symptoms, there is likely under-counting. For example, none of the five HIVab+ respondents reported any symptoms, nor was any mention made of genital herpes, chlamydia, syphilis, or venereal warts. The 2008 incarnation of the Second Generation Study of STI prevalence of ANC attendees in Fiji showed a prevalence of chlamydia in pregnant females 25 years older or younger of 37.5% (Fiji Ministry of Health 2010: 5); nevertheless, probably most of them will not have been aware of their infections with chlamydia owing to their asymptomatic presentation (see also Hotchin et al. 1996). Increases in the number of cases of congenital syphilis have been reported, too (Fiji Ministry of Health 2010: 30).

To summarize: many respondents seemed to think that all sexually transmitted infections were variously gonorrhea or tona or that gonorrhea was syphilis. Some believed that either could "turn into" HIV, and the latter, into AIDS. Whether or not they know more than what they reported in focus groups, none of the 74 respondents stated specific causes of STIs, specific treatments for them, or that STIs heighten HIV transmission risks in terms of abraded skin and lowered immune response. Only one respondent (a Fijian male university student) mentioned the specific diagnosis (of gonorrhea) he had received.

The Boundaries of Belief: faith and faith healing in the light of HIV discourse

"In the case of STIs, from what I know, it can only be transmitted when you have sexual intercourse with an infected woman, can be my female cousin [!!!] or other woman long as she is infected with STIs, and if I'm not protected, surely I'll get it . . .
STIs are only common in women. I'll use the condom and also if I get infected with STIs (tona) I'll drink Fijian medicine" (taxi-cab driver).

Religious beliefs and discourses are a fundamental part of the social, cultural, economic and political landscape in Fiji. Since 1989, when HIV was first reported in Fiji, Christian churches in Fiji have provided spiritual support to those infected with HIV and/or diagnosed with AIDS, just as they have in Papua New Guinea (Hammar 2009b). Christian churches and officials in Fiji have helped to mobilize people and communities and strengthen Fiji's national response to HIV and AIDS. Ministry of Education representatives and initiatives, for example, have had to rely upon church leaders and members to deliver messages of a sexual nature insofar as sexual matters are difficult to discuss openly and in public. Chaudhary (2003-2004: 56) noted that a huge shift had occurred quickly; "Five years back the churches would not tolerate any issue on HIV or sex to be discusse[d] in their congregations," he notes, though now "it has somehow opened its doors for the followers to learn about HIV issues by holding discussions in the churches and youth forums with the help of medical staff." To its great credit, the Methodist Church of Fiji now observes National not World AIDS Day on the first Sunday of December, not on the first day of December overall.

In Fiji, religious settings, figures and practices are the lenses through which matters of sexual health and behavior are understood and acted upon. Some Fijians adhere to religious dictates (or say they believe in them), for example, in stressing the A or the B of ABC. Some Fijians specifically oppose them (or say they do so), for example, in being lesbian or having sex as a man with another man or supporting gay-, lesbian-, and transgender-friendly causes. Some Fijians profess belief systems that mandate one thing while their actual behaviors are otherwise. Many devout Catholics yet use condoms to prevent pregnancies or STI transmission. In any event, introduced religious edicts and pre-European contact mores guide (sexual) morality in Fiji. Nevertheless, those same edicts and mores are also highly flammable zones of contestation (Kaitani 2003; Tora 2006; George 2008; White 2005).

For these and other reasons, relationships between religion and AIDS, religious beliefs and HIV transmission, and faithful and empirical treatment of HIV infection are extremely tangled. Moreover, HIV and AIDS and neo-Pentecostal movements around the world have each emerged and spread in the same settings and contexts, for example, of globalization, poverty, women's oppression, and structural adjustment policies (see Dilger 2007: 64). Religious discourses can fan the flames of transmission and stigma instead of putting them out (Takyi 2003). Roura

et al. (2010) showed that one-third of all Tanzanians believe that prayer can cure HIV because its transmission was "the work of Satan." Many studies conducted in African countries found that local populations believed fervently that HIV transmission was a form of punishment from God, expressed a high degree of fatalism about its prevention, indicated that fervent prayer and strong faith can cure HIV infection, and accounted for transmission in terms of beliefs in demonic forces and sin (for a partial sampling, see Zou et al. 2009; Wanyama et al. 2007; Lagard et al. 2000; Deribe et al. 2008; Mshana et al. 2006; Hess and McKinney 2007; Dilger 2007; Adogame 2007; Adogame 2007; Roura et al. 2010; Odimegwu 2005; Nweneka 2007; Wilkens 2009). Religious figures and discourses have been shown in many studies conducted in the Pacific to enable unprotected sex, to misinform and disinform about prevention methods, to induce stigma, and to reinscribe masculine authority in the home and as regards sexual practice (Hammar 1998, 2007, 2008, 2010b, c; Wardlow 2008; McPherson 2008; Eves 2008, 2010).

In Fiji, gays, lesbians and transgendered persons are stigmatized for their non-heterosexual identities and behaviors. Some fundamentalist Christian interpretations of sexual identities and comportment have demonized same-sex relationships "as the perceived harbinger of HIV-AIDS. Fijian Methodist leaders exert considerable influence and voice strong denunciations of homosexuality, identifying it as a violation of a preordained relationship between a man and a woman sanctioned by God, with HIV-AIDS constituting punishment for this 'sin'" (White 2005: 321). More progressive moments have been recorded in the Pacific, too, of Christian hearts and minds being changed over questions of HIV, AIDS, sexuality and condoms (Dundon 2007; Eves 2010; Wilde 2007; Hammar 2009b, 2010a; Gibbs and Mondu 2010). Those extend to questions of adherence to regimes of ARV. Kelly et al. (2009: 25) found that "acceptance of Christian causes of illness is not always straightforward and does not exclude other healing strategies."

Given these prefatory remarks, it is now time to examine some of our data. Of our respondents who voiced opinions on the matter, most expressed belief that most other Fijians believe in the efficacy of religious faith, herbal medicines, laying on of hands, Christian prayer and other means of treating if not also curing HIV.

During our focus group discussions with health care workers, for example, we asked them "Are people going in for faith healing or prayer [to cure HIV]?" and three respondents said "Yes!" in unison. One of them said "Yes, I came across a pastor who prayed, uh, I mean, uh, a patient, and then later found out that the patient became negative. And he was a positive case and then after, chain prayers and groups praying for him, you know, praying for him, it disappeared." Another told a very personal story: "I gave birth to my son in 2004, 2003, eh, and he was tested positive. Uh, we prayed for him, we fast for him. Uh, they have a final blood test for him that's, uh, one year, six months, 18 months, so for first six months he was tested positive and we kept on praying for him. Turns out he was negative." When we asked for other, seemingly specific examples, a health care worker reported that "At home, I mean, at the church, we are Seven Days [Seventh Day Adventists]. We had one youth, uh, he's a positive, like, uh, every two weeks, every two Sundays, we have to prayer, make a special chain prayer for this [HIVab+ person]." When we asked whether or not it cured the person, the speaker indicated that such prayer worked to the extent to which the person attended church. "Sometimes, sometimes he doesn't attend church," said one health care worker, while another one added "It's basically, the principle is, as a Christian, people believe that, by the stripe of Jesus Christ we are healed. There is a scripture quotation." Yet another two health workers agreed with the earlier story of prayer having led to the seroconversion of an HIVab+ infant: "Just adding on to your sister, over here, I think medical miracles will happen, but it will only happen if you are identified at early stage, [faith cures of HIV], so from my point of view, in this case, those two people were identified very early stages"; "I would disagree with that [i.e., prayer can cure HIV at any "stage"], because [the man] who got it in '98 was a bit towards the end of it. So, it was just a miracle thing that happened that day. Because even the relative couldn't go close to him, because he was getting, you know, smelling, smell, which, sores, on his body which didn't heal, and then, but the pastor kept on going.

These health care workers, despite our repeated probing, did not, however, believe that coconut oil, "Fiji medicine," and Noni juice could cure HIV (although others did). When we asked about the purported curing of an HIVab+ person by the Greece-born, U.S.-based televangelist Benny Hinn, in Suva, in 2008, they were adamant that, as one put it, "They have to have faith." When asked whether cures of the non-believing could be effected, they replied, in unison, "No," and then one added: "For, to have, to be effective in prayer, if the patient is on the wheel chair, he has to have faith, if it's, if that's going to happen. It's not only the pastor." When we asked, hypothetically, "Okay, and let's say if all seven of us in this room are HIV+ and we go and we have 110% faith, trust that this is going to work . . . ," again, in unison, they answered "Yes."

Taxi-cab drivers and their Intimate Partners expressed many of the same opinions in both focus group and individual interviews. The wife of a taxi-cab driver [whose HIVab+ status was revealed previously] said the following:

> Secondly, in my next drawing is about the coconut or virgin oil as a cure. I read about the virgin oil from a book on herbal medicine and it talks about virgin oil as a cure of HIV. It is mandatory that, one has to follow the "Eight Laws of Health" as noted down in my drawing in English and also in Fijian. For example, nutrition, exercise, water, sunshine, mental health, fresh air, stress free and spiritual wellbeing. Like, [what] a close friend did, was by drinking virgin oil and [he] strictly followed the "Eight Laws of Health" and he was actually cured of her disease [she was speaking here of her own husband] . . . [Another couple] they were completely cured, including their child. They take just as I've noted in my drawing: three table-spoons of virgin oil three times a day . . . Yeah, virgin oil is different. It's very similar to that of baby oil sold in major supermarkets. You know, with a milky, colourless nature. You can buy it from Morris Supermarket and I have a bottle at home.

During a focus group interview with taxi-cab driver wives, one said:

> Many have turn to faith healing and traditional healers to cure for their sickness. As I speak to you now, many people have been cured of their sickness through the power of prayer. I believe it is time that we worship our God in a way that will protect us from all types of infirmity . . . You know, nowadays there's so many new diseases and we have lost hope that it can be cured medically or by traditional healers. My only hope is in the Divine Intervention [said with emphasis] and that's why I chose religion as that best option for me, because, I've witness how one of my relative get healed in Levuka [the prior capital of Fiji]. He was diagnosed with HIV some years ago and after taking medicine for sometimes, her condition deteriorated and he decided to become a devoted Christian [and] from then, he became well and till today he is free from HIV.

During his concept map interview conducted a few days later, this woman's husband, a taxi-cab driver, clarified that "HIV is transmitted through sexual intercourse, but if you drink a lot of herbal medicine you can protect yourself from it," and that he was currently taking it: "Yes, I have tried it myself; [it cures] all kinds of diseases . . . Yes. HIV and any other sickness." One of his compatriots said during his interview, "Also, as we may have heard or known about traditional medicine, Fijian medicine, that is, plants and herbs, like, many have used as a cure [emphasized] and it has also been proven to be an effective method of prevention. Because many people believe that, when they drink, it cures [emphasized] their sexually transmitted infections completely." A third taxi-cab driver said "and also try drinking a lot of traditional medicine or Fijian medicine because there's plenty around and it's available in abundance," but also, to prevent infection in the first place, "try, be, stay at home and have only one partner . . . He should go to the hospital first for the sake of confirming his/her HIV status. Once confirmed positive, then [he] should go to church for faith healing, and only if person believe from his heart that he could be healed from HIV through the power of God [will he be healed]."

One spouse of a Christian pastor, a woman who learned that her husband was taking HIV medications [though he had not disclosed such to her], said "In some cases, spiritually, healers [gasping], if you have that HIV and he seek spiritually for priest and if you, if you have the, if you fully, fully have faith, in God, it will definitely cure, yeah. I've heard that case, I've seen it and I believe in it, too. Yeah." Her compatriot then added, "If you have faith in God, [then] obviously you can be cured." When we asked then about any other treatments for HIV she knew, one wife said "there are some traditional medical healers," those who use Noni juice to treat HIV: "Noni, in Fijian that's kura. The fruit from the tree, you squash it and then you boil it and then you strain it and you drink the juice, from that Noni juice." Another participant, gesturing in the direction of the first speaker whose husband was on HIV medications, also said "They are using [Noni juice] for other things, but that's what she said about her husband."

We then asked the wives specifically about the efficacy of prayer and faith healing in treating HIV.

> Interviewer: What do you think of prayer and faith healing in terms of HIV?
>
> Respondent #4: Yes, I hear that we are to go to church and believe in Christ. We should love each other. Even if we know that my partner is infected we should prayer for him and love him unconditionally. [Emphasis added] Yes, for me personally, prayers do work miraculously in my family. I saw it in a DVD, and it happened in Nausori. I think, yeah. It was a gay, homosexual, and he had that HIV, so there was a praying session going on, he went up. He really believed in himself that God will cure his disease, and it happened.
>
> Interviewer: How do you know it happens? I'm just curious//
>
> Respondent #4: //Curious. He went up and test, testimony, testify that, he got cured by the priest, because he really believe that God cured him, so it's like, it came out like boils//
>
> Interviewer: //So he said.
>
> Respondent #4: yeah, and the next time, he went and got tested, there was no HIV.
>
> Respondent #2: If you have faith in God, [then] obviously you can be cured.

At least two sex workers also believe in the power of prayer to cure HIV: "Yes, you have faith in it and you will heal," "Believe in God and it will heal," but a third said, "Well, I would say 'no' to all of those, because, uh, I know of, uh, uh, a AIDS victim who went through a lot of prayers, encouraged him to have faith that he would stay alive. But he eventually died; it ate him away." A lively discussion ensued, however, as we probed a bit further: "Um, hum, okay, okay. Is there any kind of faith healing or any kind of prayer healing for HIV here in Fiji?" "Prayer healing," said one, and another said "We've heard of some, but, uh, I don't think it's working." They mentioned private sessions engaged in at the pastor's house, where the person is prayed over. When they were asked whether they thought it worked or didn't, one said "Uh, in, in soul, in the soul but, uh, body, no I don't think so," but another said "Yeah, yes, you have faith in it and you will heal, believe in God and it will heal." This sex worker claims to know a friend who was HIVab+, "but he always go and, to a Pastor, and go to church, now he's in church, so he's well, he look well now." She was then asked whether the friend had had another blood test, and the respondent said "I don't know about that."

Our discussions with gays, lesbians and transgenders sparked some lively conversations on this point. One young gay male said "Ummm, yeah, I heard about it, but it doesn't make any sense. It doesn't make sense it can prevent itself from HIV." Nevertheless, during another focus group discussion, another young gay male said "But when we got HIV all we want[ed to do was] to go to church, want to change our lives, want to change, because nowadays [because of our faith in God] we don't have, uh, uh, HIV, it is a virus, eh? But it got, it don't have a cure . . . [but if you go to church, cures are] faith-based . . . Yes, because every day, some people got HIV, they got AIDS, but it's have no cure . . . but they, they, they, when they got faith, faith by them, they go to church, then they healed by going, listen to God's word . . . and they got a, got a, pray, got blessed by the priest, got a, but, uh, me and my boyfriend, we have both, both believe that only God will help cure all the things." Interestingly and tellingly, and despite the use of "we," none of this was conveyed to his partner, whom he says is also HIVab+ but who did not disclose his status, either.

Our focus group discussions with university students didn't elicit such strong feelings or at least not those that were shared so frequently. When the interviewer asked, for example, "Is there faith healing with regards to treatment, faith healing like church?" a male student answered "Yeah. I heard about, I believe that some people are being cured, saraga, with church, eh? They have being praying and they being cured they healed." His female cohort added "It can happen if you really have faith in it, believing in yourself that you can. It's the person himself that has the disease, [he] has to have that inner faith that, once you [are] prayed upon, he will be or she will be cured. It's a miracle." When we asked for evidence, three students answered "I have heard about that AIDS is being cured by faith healing"; "I just heard about it"; "I don't know anyone."

The Intimate Partners of these students sounded a bit unsure about cures of HIV, but when we asked them about the ability of faith healers to heal other illnesses, they answered as followed:

> Respondent #4: Maybe.
>
> Respondent #5: Not specifically HIV/AIDS, but any kind of sickness. Pastors will pray over and they get healed . . . Cancer . . . Stroke . . . Blind[ness], visual healing.
>
> Interviewer: Okay, but not HIV?
>
> Respondent #5: Haven't heard of.
>
> Respondent #4: We don't really hear specifically of someone getting healed of HIV/AIDS, but as Christians we just believe if you have faith and you do believe that you have HIV and it will go after you [are] prayed over, then it will. But I haven't heard of any person or someone being healed of HIV.

The Intimate Partners of sex workers didn't seem to have clearly formed opinions on the matter. The lesbian partner of a sex worker, for example, when asked about faith healing said, "If you have, uh, this disease, for example, you have a disease with you, just pray, just, uh, change not to be sin again. Like they regret it. They regret because they have, uh, this, uh, disease. They feel guilty. Yeah, they feel guilty, so we don't see them in church. So, we see them in church, they go to church, they pray. They ask God for forgiveness." The husband of a sex worker mentioned an herbal medicine that was "famous around Fiji and around the world. It's, it's, uh, very hot product around the world now at the moment. But it's [curative]; it's like a herbal thing, too," in whose properties to cure diseases he believed. Another husband then mentioned a concentrated form of "grog" (yaqona) that, when drunk in this concentrated form, could cure just about anything, including the symptoms of AIDS, but not HIV itself: "It will cure the disease but we do not know the virus is still inside." It can also be used to treat tona, he said.

Summary discussion of important contextual issues

"To me, whenever one of the partner cross the fence and have extramarital sex with another partner he or she can get infected with the disease HIV, can further developed into AIDS and following that is death. As the Bible said that the wage of sin is death, so his/her punishment is to die" (wife of a taxi-cab driver).

The kind of exploratory study as we conducted and whose findings we have begun to report here is relatively new to the Pacific (but see Buchanan-Aruwafu and Maebiru 2008; Butt 2008; Butt and Eves 2008; Dundon 2007; Hammar 1996a, b; Lepani 2007; NSRRT and Jenkins 1994; Wardlow 2008). Qualitative research into HIV and AIDS and sexual health and behavior is not yet well developed in Fiji. We hope that the present work, alongside the works of Kaitani (2003), White (2005), George (2008), McMillan and Worth (2010) and others will increase interest among public health officials, policy planners, and donor country representatives in the promise and rewards of qualitative research. Exploration of Fijian self-assessments of transmission risks and the knowledge bases they build about the signs and symptoms of STIs are sensitive issues, and they have clear public health implications.

Our findings, in the main, square with those of Chaudhary (2003-2004), Kaitani (2003), van Buuren Inoke and Sharma (1997), McMillan and Worth (2010), and others. In various ways they have noted that Fijians, pretty much just like everyone else, **externalize their HIV and STI transmission risks, exhibit sub-optimal understandings of STI signs and symptoms, and use condoms inconsistently.** Knowledge of Fijians about these matters, says Kaitani (2003: 3) is "limited because they have a narrow range of sources of information on sexuality and they are misinformed about this taboo topic. The end result is a high incidence of teenage pregnancy and high incidence of STIs among the indigenous Fijian population." Kaitani argued that Fijian men are aware of condoms and of the pressing threats of HIV and AIDS, but because condom misinformation is rife and because religious opposition to their use is strong, they believe them to be ineffective. Our findings support those of Kaitani. They bring into sharper relief the point that the problem isn't so much with false beliefs about the physical properties of condoms, as with false beliefs about the safety of their intimate relationships. The models of HIV and STI risk they have developed, including ideas about with whom they should and with whom they do not need to use condoms, have become so deeply internalized as to be almost invisible.

Our study found that Fijian self-assessments of HIV and STI transmission risks are externalized, away from intimate partners and encounters, such that boyfriends don't for the most part think they need to use condoms with girlfriends, nor husbands with wives. Wives and girlfriends may want to use condoms, and they seem more suspicious of their husbands and boyfriends than are their husbands and boyfriends suspicious about them. Nevertheless, they tend to hold back from pressing for safer sex and greater communication about these issues in favor of relying on "trust" and "love" and "faith" in a partner's fidelity and uninfectedness. Sex workers showed no lesser desire to attempt to promote and project intimacy by non-use of condoms with Intimate Partners than did Christian pastors. University students appear to believe in the efficacy of trust and love and hand-holding in much

the same way as do the wives of taxi-cab drivers. The boyfriends and husbands of sex workers—even in the face of contrary evidence, lots of it—want just as badly to believe in the fidelity of their sex worker girlfriends and wives as do the boyfriends of other gay males—again, despite evidence to the contrary.

Kaitani found also that Fijian male youths had received poor sexual health education, but we found the same deficits at work amongst Fijian women and girls, too. Her finding that Christian male youths commenced their sexual lives earlier than had non-believers and that they exhibited greater numbers of sexual partners, lifetime, and a higher frequency of sexual partner change, too, than non-believers (2003: 183) may strike some as counter-intuitive. Our study shows that, whatever "traditional" ideals of masculinity and femininity may be and have been (see especially White 2005; George 2008; Kaitani 2003), Intimate Partner transmission of HIV is in Fiji as elsewhere a real and perhaps growing risk. **Fijians have obviously, deeply, and sincerely internalized mainstream public health messages—**including the tenets of the ABC platform**—just as surely as they have externalized their STI and HIV transmission risks.**

We conclude from our various experiences and preliminary analysis of our data that "awareness" campaigns and public health messages and workshop and seminar participation has not led to the deep and nuanced self-assessments of HIV and STI transmission risk that are grounded in the cognitive and behavioral realities of intimate partnerships. Our (quite reasonable) prediction prior to beginning the field research component of the project was that Fijians, just like Americans, have not been led more deeply and critically to develop their knowledge bases beyond the level of posters and pamphlets, slogans and catch-phrases. The internalized message seems to be that if one can avoid sex with strangers, avoid having multiple partners, can "trust" in one's partner, can have faith in God, and so on, one will prevent HIV transmission. Moreover, even if per chance HIV transmission should occur, a large number of our respondents believe deeply that there are many faith, herbal, aqueous and other medicines available.

Recommendations

1. **Fijians can and must be challenged not to externalize their HIV and STI transmission risks, away from Self, away from Intimate Partner, away even from one's family, faith, and community.** This requires earnest and meaningful revamping of public health posters, policies, and messages that do not yet include the relational terms of wife and husband, boyfriend and girlfriend. We believe that great benefit would ensue were special posters to be designed and disseminated that said, in effect, "This is your husband. He is the one most likely to infect you if you have sex without condoms or if he is forcing you to have sex" or "this sex worker, because she uses condoms with her client, is lowering the risk of transmission; it's too bad that she doesn't use them with her husband."

2. **Condom use must be constructed as an effective means of preventing unwanted pregnancies and HIV and STI, not as something that one uses only in a commercial sexual encounter or with a stranger.** Given the realities of public health problems in Fiji, especially the high caseload of untreated STIs, public health and other officials must strongly and consistently say the obvious: **intimacy carries risks.** Unprotected sexual intercourse is the enemy here, if we have one—not condoms, not strangers, not sexual desire, and certainly sexual enjoyment.

3. As is the case in Thailand (Fordham 2005) and Papua New Guinea (Hammar 2006, 2010a), there is a sincere desire among Fijians that non-standard HIV medications can be shown to "work," that herbal medicines, faith healing, Kura juice, prayer, injections of Vitamin C, coconut oil, "deep seawater," taking "treatment breaks," and the like, will work in preventing HIV transmission and curing HIV infection. Belief in the efficacy of such was shared by the HIVab- and the HIVab+ alike. The Fiji Ministry of Health recognized that even members of some HIV advocacy organizations share these beliefs. We think this is not just a "one off problem that has since been addressed" (2010: 27), but is instead a real problem that is likely to become the more so. **We recommend that the Fiji Ministry of Health take the leading role in monitoring and responding quickly and firmly if it appears that such beliefs are delaying or blunting the effectiveness of HIV medications and their roll-out.** Because the "Hub Centres" seem to be spoken of quite highly in terms of access, services, and personnel, we think that they make natural allies in this fight, but to do so, the work will need to be done also outside the clinic, not just in it. Additionally, formative research might be undertaken in those clinics and other healthcare settings, with those clinicians and other health professionals, regarding their beliefs and belief systems. Considerable research efforts in Papua New Guinea, to take just one country in the Pacific (e.g., Hammar 2010a; Dundon 2007; Wardlow 2008), shows that there really aren't (m)any purely secular, "scientific" settings of healthcare provision.

4. **We recommend that HIV social research be expanded in Fiji, beginning with exploration of this very issue.** "Fiji medicine," prayer, and extra-virgin, cold-pressed coconut oil will undoubtedly become even more preferable to Fijians as treatment or prophylaxis. They afford relative anonymity. They cost relatively little. Most Fijians have easy access to them. Qualitative research is needed to explore whether Fijians desire "Fiji medicine," "Pure Spring Water" and "deep seawater" because they are created in Fiji by Fijians. Graham Fordham

notes that Thai people prefer Thai "bush medicines" for their reputed authenticity (2005: 112-117). The new "traditional healers" in Papua New Guinea, too, claim similarly to have found the source of their bush medicines "deep in the forest," and this appeals to Papua New Guineans. "Deep seawater," "pure Fiji spring water," "Fiji medicine," and the like, are lauded in Suva for probably some of the same reasons, and so are claims made by faith healers about the efficacy of prayer and laying on of hands. Public health authorities and religious leaders alike, lay persons no less than specialists, should take these emerging issues extremely seriously. They will surely hamper a more effective roll-out of antiretroviral medications should such soon become necessary. In doing so, they should look for guidance to the extraordinarily well developed qualitative, ethnographic literature about these topics.

5. We recommend **strengthening the national capacity in qualitative HIV social research.** This project has proved that it is cost-effective and life affirming to engage "non-specialist" community members in such endeavor. We suggest that the training workshop we have developed should be extended in several directions and that each such holding of a workshop must be linked to specific, relevant and feasible, if modest, research studies. The holding of such workshops would build research capacities in said organizations, thus lessening dependence on foreign dollars, sponsors and consultants. Also, and perhaps more importantly, it would increase the likelihood of the uptake of such qualitative findings as emerge in ways that benefit those organizations.

6. In order to strengthen Fiji's national response to HIV and AIDS, **we suggest several lines of inquiry** among the many others that could be mentioned: i) vulnerability of youth in Fiji; Fiji has not conducted a youth survey since 1996; all indications are that Fijian youth are sexually active, use condoms inconsistently, and face new and added pressures to become and remain sexually active; ii) practices of sexual health and hygiene; exploratory research should be trained upon use of condoms, sexual lubricants, foreign object insertions into the penis, and vaginal and anal douching practices; iii) knowledge of STI signs and symptoms and relevant treatment modes; possible differences between members of ethnic Fijian and Indo-Fijian communities should be explored, as should be inter-faith and interdenominational differences; iv) sexual networking locales and patterns involving in-migrating Chinese females; v) non-standard treatments for STIs and HIV, whether by faith or herbal medicine.

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Endnotes

[1] In this report, "Fijians" means "Fijian citizens," and where relevant, the terms "ethnic Fijian" and "Indo-Fijian" will be used.

[2] One regrettably disappeared. Another two were terminated for unprofessional conduct.

[3] After extensive deliberation and in keeping with the mandate of the Research Ethics Committee request (whom we again thank for their good work in helping to clarify research aims and goals), we decided upon $10 for participation in each leg of the study, and then also $5 (more in some cases) for those who needed to take a taxi to us. No one complained at the amount of the reimbursement and there is no evidence of anyone feeling overly coerced to participate.

[4] Fabienne Labbé noted that most of her HIVab+ key informants were indigenous Fijians and that "Not one of Indo-Fijians living with HIV was available to participate in the study" (2010: 5). Her sample consisted of 25/28 ethnic Fijians and three persons of "mixed" origins, including one who was "part European" and two who traced ancestry also to the Solomon islands (2010: 8).

[5] Labbé's report (2010) also notes that two of 10 men learned of their Intimate Partner's HIVab+ serostatus as a result of that partner's pregnancy, their partners themselves learning of their serostatus as a result of receiving antenatal services. Thirteen people found out about their seroconversion after they or their partner had begun to experience signs and symptoms of HIV infection. This is to say that people may learn of their serostatus relatively late but not necessarily because their partner is/partners are purposely choosing not to disclose such to them. From her special vantage point as Research Officer of the Pacific Islands AIDS Foundation (PIAF), Hilary Gorman noted (in a personal communication) that PIAF has started to conduct "Rights and Responsibilities" workshops for both people living with HIV and AIDS and those who provide HIVab testing and counseling services. Rumor has it that their programs will shortly be offered to Fiji School of Medicine students. The researchers who carried out the TOMS (Three or More Study) study of Australian gay male engagement in group sex encounters (Prestage et al. 2008: 26) found that most of the groups devoted to group sex encounters didn't have a rule of disclosure of HIV status; only one quarter "indicated the rule was that they either must disclose their status to everyone or to those who asked."

[6] In the section entitled "Wai ni AIDS" of her report (2010: 32-34), Labbé shows intriguingly that many of her HIVab+ informants, especially those who had been diagnosed well prior to the coming to Fiji of antiretroviral therapies, had had recourse to these and many other kinds of medicines. These medicines are administered in multiple ways, including having been prayed over. Labbé says that such medicines used allegedly to cure HIV are "of two types," that is, "Fijian" herbs, liquid, tree bark and other plant materials, and then "hybrids," which combine these "Fijian" substances and concoctions with spiritual prayer, for example, "coconut oil on which words of blessing are uttered and which is afterwards drunk according to Fijian medicine conventions" (2010: 33).

[7] Yaqona is the Fijian name for Piper methysticum, also known as kava. It is primary a crop cultivated and consumed in many Pacific Islands cultures. The roots of the plant are pounded or ground and mixed with water to produce a drink with mild anaesthetic and sedative properties.

[8] According to the 2007 census cited by the Fiji Islands Bureau of Statistics (consulted online): 837, 271. http://www.statsfiji.gov.fj/Social/popn_summary.htm .

[9] Stewart, Mulipola-Lui, and Laidlaw's study of Fijian concepts of "trustworthiness" (1980) might be relevant here; they concluded that, when compared to Indo-Fijian and European adolescents, there was a marked tendency of Fijian adolescents to trust people perceived as being close to them (mostly extended family members and co-villagers).

[10] Although each of the females self-identified as "sex workers," it is also possible that neither they nor their Intimate Partners identified them as "prostitutes." Labbé made this good point (in a private communication with the author): it is possible that these Fijian females see themselves as "sex workers" but the Indo-Fijian females who solicit from in front of the post office and artifact and curio malls identify themselves as "prostitutes." It is possible, also, that our boyfriend and husband informants draw this distinction, however real or false it may be empirically. It is worth noting that the UNAIDS guide to proper terminology to use in writing documents for UNAIDS sponsors warns against using "prostitute" (unless in case of juveniles being involved) and enjoins the use of "sex worker" instead (2008: 5).

[11] Reading a preliminary draft of this report, Labbé recounted (in a private communication) having heard versions of this story "over and over again, the 'injector' usually being a woman" and including versions in which Suva market-sellers who were HIVab+ were thought purposely to be infecting juices sold thereat. She added further that many of her HIVab+ informants appeared to believe in the truth of these stories, confirming what the author has many, many times heard also in Papua New Guinea.

[12] In a private communication, Labbé has suggested a different interpretation altogether, however, in essence, that respondents were not so much parroting public health admonitions regarding HIV transmission risk amplification as echoing the social truth that "alcohol consumption is considered to be the only circumstance in which women can lose sight of their social obligation to confine sexuality to the context of marital bonds." Labbé's female HIVab+ respondents "all said they had sex because they were drunk," perhaps, she suggests, because females do not yet feel comfortable expressing their own sexual desire per se. There is much merit in Labbé's argument here, although the stylized nature of three of the drawings (done in isolation in each case) warrants perhaps an additional explanation, for example, in terms of what respondents had "learned" in workshop settings.

[13] Katherine Lepani's work in the Trobriand Islands of Papua New Guinea on the culture-bound syndrome there known as sovasova (2007) is instructive here. Trobriand islanders believe that sovasova is a form of chronic illness whose signs and symptoms include nausea, lassitude, and weight loss. It is caused, they say, when people breach taboos on having sexual intercourse with a fellow matrilineal clan member. Just as tona functions in the Fijian

lexicon as a covering term for seemingly all sexually transmitted afflictions, whether genital discharge disease or not, sovasova influences Trobriand comprehension of HIV and AIDS. Sovasova "underscores cultural ideations about the importance of social exchange and the corporeal mixing of difference in sexual relationships," she says (2007: 12).

[14] His sources were a Fijian peer educator and a Fijian Officer-in-Charge at an STI clinic.

[15] The distinct differences between syphilis and gonorrhea weren't nailed down in European countries or the U.S. until well into the 19th century.

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