Determinants of Risk Behaviour of Sex-workers in Jamaica

A Qualitative Approach

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ABSTRACT

The practice of evidence-based medicine is well established and research is a key element. Evidence-based approaches require an understanding of the complexities of the interactions and dynamics that influence decision-making. Qualitative research methods are increasingly being used to complement the findings of the traditional quantitative methods. A qualitative study which examines the sexual choices of commercial sex-workers is described to demonstrate the usefulness of this type of study. Focus group discussions give the reasons for the non-regular use of condoms and identify other factors needing intervention. These include low self-esteem and poor job satisfaction as well as problems with violence and drug use. It provides vital information for HIV/AIDS prevention activities for commercial sex-workers.

La Investigación Cualitativa: Una Herramienta útil en la Investigación. Caso de Estudio: Determinantes del Comportamiento de Riesgo de las Trabajadoras Sexuales en Jamaica

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RESUMEN

La medicina basada en evidencias es ya una práctica bien establecida y la investigación es un elemento clave al respecto. Los enfoques basados en evidencias requieren que se comprendan tanto las complejidades de las interacciones así como la dinámica, que influyen en la toma de decisiones. Los métodos de investigación cualitativa se emplean cada vez más para complementar los hallazgos de los métodos cuantitativos tradicionales. A fin de demostrar la utilidad de este tipo de estudio, se describe un estudio cualitativo que examina las elecciones sexuales de las trabajadoras del comercio del sexo. Las discusiones de los grupos focales dan las razones para el uso no regular de condones así como para identificar otros factores que requieren intervención. Estas incluyen la autoestima baja, pobre satisfacción en el trabajo, así como problemas con la violencia y el uso de drogas. El estudio ofrece información vital en relación con las actividades de prevención del VIH/SIDA, para las trabajadoras del comercio sexual.

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INTRODUCTION

Medical research has traditionally relied on quantitative methods which produce factual, reliable, generalizable data. There is increasingly more debate on the role and use of qualitative research as part of medical research. Qualitative research is defined as research involving detailed verbal descriptions of characteristics, cases and settings (1). It is a body of research techniques which seeks insights through loosely structured, mainly verbal data rather than through measurements (2). It involves an in-depth understanding of human behaviour and what governs and influences decision-making with regard to behaviours.

Qualitative research is a useful tool as it often provides details about numerical findings and is increasingly being recognized as important to understanding healthcare (3). It is extensively used in social science research and was first used in medical research in clinical studies on schizophrenics (4). With the increasing recognition of the role of lifestyle choices in the development of disease, studies which give insights into understanding behaviours are most needed (5). Moreso, behavioural models of interventions which are so important in chronic disease prevention, rely on qualitative methods (6).

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Quantitative methods provide numbers while qualitative methods examine the why and how of decision-making (7). It is increasingly being noted that when used in combination, quantitative and qualitative data yield a more complete picture [Fig. 1] (8).

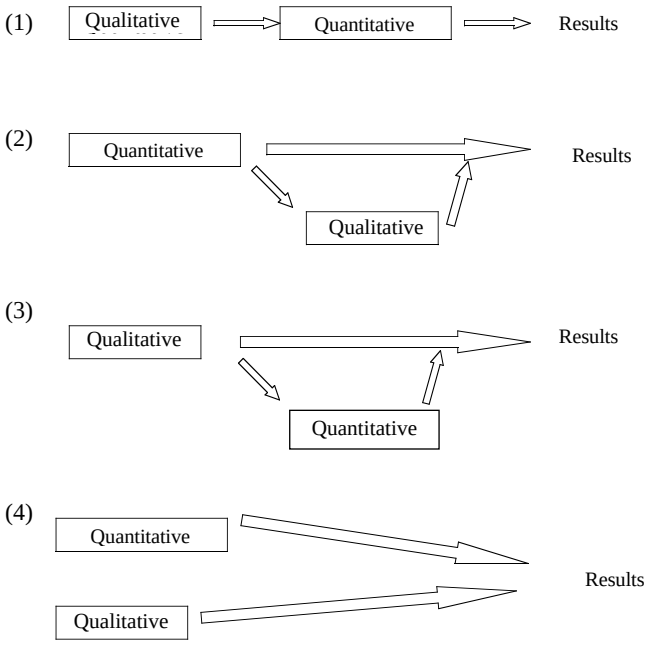

Figure: Possible ways qualitative and quantitative can be integrated.

Public health practitioners are increasingly using mixed methods in areas involving behaviour such as smoking cessation, HIV and sexually transmitted infections (STIs) (9). Qualitative methods are also being used more in areas such as health service research and health technology assessment (10).

It is becoming increasingly important for clinical researchers to recognize the role of qualitative methods in medical research and this paper describes how qualitative research was used to provide additional information about a topic. It is based on the HIV/AIDS problem on which there is quantitative information (11) and the need for high risk behaviour reduction through an effective health promotion programme (12).

BACKGROUND TO STUDY

Sex-work is illegal in Jamaica and other parts of the Caribbean. Despite its stigmatized status it is highly entrenched and is practised in both rural and urban areas.

From quantitative studies, there are several known facts on the sex-worker industry (13). There are an estimated 2500 persons, both male and female, involved in the sex industry in Jamaica (13, 14). The industry encompasses heterosexuals, bisexuals and homosexuals in different categories including exotic dancers, 'beach boys', 'rent-a-dread' and child prostitutes. Six per cent of males between 15–24 years and 15% of males 25–49 years admit to engaging in commercial sex (15). Thirty-one per cent of persons with AIDS report that they have had sex with a sex-worker. Forty-six per cent of HIV-infected sex-workers reported that they were infected through unprotected sex with their main partners while 24% reported that they were infected by clients. The rate of HIV infection among the general population in Jamaica is less than 2% with an estimated 22 000 persons living with HIV at the end of 2005. The rate of HIV infection among sex-workers was 9% at the end of the same period (15, 16).

The need for effective health behaviour modification strategies in STI/HIV prevention is clearly documented (17) especially since studies are reporting an increase in condom use overall but not among high risk groups (14). The higher HIV rate among sex-workers confirms the need in the area. At the 2006 International AIDS conference, it was reported that preventive services were only reaching 16% of sex-workers (18) compared to 34.7% of the adult population 15–45 years old (14).

In considering HIV/AIDS and STIs, sex-workers in all populations are regarded as a "primary risk group." This is because they have a high rate of partner change and typically record HIV/STI infection rates that are much higher than the national levels (14, 19).

Both male and female sex-workers usually enter the trade as adolescents or in their very early twenties. They are usually unskilled with a low level of education and a weak family support system. Many commercial sex-workers (CSWs) do not identify themselves as such and are usually highly mobile. The clientele of sex-workers is quite varied and includes just about anyone with a need for sex who is willing to pay for it.

Quantitative research has identified the problem and need for action (5,11,12). This qualitative study provides an understanding of factors contributing to the behaviour and provides the basis for interventions. The aim of the study was to identify, examine and provide some understanding of the determinants of high risk behaviours among sex-workers that may lead to HIV infection.

SUBJECTS AND METHODS

Qualitative techniques of focus group discussions and key informant interviews were used to meet the objectives of the study. A list of settings and situations where sex-workers operate was obtained from key informants including health-workers and sex-workers. From this list of sites, it was established that sex-work took place in almost every main town in Jamaica. Kingston, Portmore, Ocho Rios, Montego Bay and Negril were the geographic locations named most frequently as having numerous sex-work sites; however these types of operations seemed to span a wide cross-section of locations including rural districts and occupational based sites such as fishing villages. This list revealed that there is an established

industry and a broad based network of these locations across Jamaica.

The 'snowball' method was used to recruit participants for the focus group discussions. A healthcare worker was asked to identify one or two members of each category of sex-worker and they in turn were asked to invite their colleagues to the sessions. Eight focus groups were conducted with sex-workers from each of the following categories (two groups per category):

- Male sex-workers
- Female sex-workers operating on the streets
- Go-go dancers
- Sex-workers who operate in tourist resorts

Each focus group consisted of a minimum of 8 and a maximum of 12 persons and was conducted by someone trained in focus group moderating. The main criteria for participation in each group were similarity in place of operation and being involved in sex-work. For some groups, this meant that there were as much as 10-year differences in ages among the participants.

The discussions were held in private settings on neutral grounds determined by the sex-workers. All groups declined being audiotaped but each session had a recording secretary who took detailed notes. The participants were offered refreshments and a small monetary incentive for their participation. Participants signed consent forms to indicate their willingness to participate.

A list of themes was developed and used with all four groups who participated enthusiastically (Table 1). Follow-up questions were added to the basic theme items where probing was necessary. The biggest challenge of the focus group discussions (FGDs) was to get the participants to talk in turn.

Table: Focus group discussion themes for sex-workers

1.	Knowledge of HIV/STI information
2.	Assessment of risk and vulnerability
3.	How participants feel about sex work
4.	How participants feel about condoms (when they feel they should be used and with whom and how they arrive at such a decision)
5.	The nature of their relationships with their clients
6.	Attitudes of clients to condom use
7.	Attitudes of clients to the sex-worker
8.	Explore sex work and drug use/abuse
9.	Explore drug use among clients during business
10.	Explore the extent of the sex industry *ie* age of the SW, recruitment, foreign connections, retirement
11.	Relationship with law enforcement, club management
12.	Relationships with main partners (do they feel condoms belong in their main relationships)
13.	Explore issues of fidelity among main partners
14.	Have they been adequately targeted/reached by the NAP
15.	What are gaps in targeting sex-workers

The participants had strong opinions on some of the issues and were often not tolerant of others who did not share their point of view. This was very challenging for the facilitator who was constantly forced into the role of referee and also for the note-taker to capture the responses. By the second FGD, a decision was taken to use more than one note-taker. It may be beneficial to use smaller groups with this population.

ANALYSIS

The constant comparative technique first articulated by Glaser and Strauss in 1967 but subsequently refined by Lincoln and Guba in 1985 [Wimmer and Dominick, 2003] (20) was used to analyze the responses. The following key steps were adopted:

- Thorough examination of the data collected (field notes and transcripts)
- The systematic search for common responses and themes
- Elaboration and refinement of categories
- Search for relationships and themes among categories
- Simplifying and integrating data into a meaningful understanding of the people and events being studied.

The researcher attempted to remove or at least become aware of prejudices, viewpoints or assumptions that might interfere with the analysis, by using the standard technique of having more than one person analyze the data, by submitting the unedited transcripts for review by a non-governmental organization (NGO) representative, a Ministry of Health (MOH) representative and a colleague with limited knowledge of the issues. The results identified and conclusions drawn by the researcher were also submitted for critical feedback. Adjustments were made based on the responses.

RESULTS

Some results and focus group discussions with the four categories of sex-workers are presented.

Places of Operation

Names and locations have been omitted to protect confidentiality

Sex-workers revealed that "business" is conducted in a variety of locations and settings and is also associated with various sectors of the entertainment industry. Sex-workers operate from bars, go-go clubs, night clubs, hotels, brothels and massage parlours (although no participant admitted to working from a massage parlour). They also solicit on the streets, on beaches and at cruise ship ports. Mostly male sex-workers operate through formal or informal escort services or work as 'rent-a-dreads' to mainly white female tourists. Sex-workers in Kingston also claimed to visit off-shore locations such as Pedro Keys fishing village. Some sex-workers had plied their trade abroad mainly in other Caribbean islands including Antigua, St Maarten and the Bahamas.

Sex-workers in tourist resorts reported that most of their customers were foreign tourists but they also had regular customers who were the crew of cruise ships. They claimed that white men treated them better and paid more

than blacks. Almost all would only do business with a local if they were desperate. This demonstrates the multiple diverse nature of sex-partners in the business.

Street based sex-workers in Kingston operated in specific parts of the city including some high profile locations but also numerous other less high profile locations. Two persons had been deported from the countries where they reportedly had not practised their current trade but resorted to it after being unable to find a job in Jamaica.

Male sex-workers generally seemed to have better job satisfaction than their female counterparts. All male sex-worker participants sold sex to men. Most did not solicit from the streets but depended on a telephone network or personalized "links". Some had both male and female customers and claimed to provide escort services to lesbians who wanted to portray a heterosexual image. Some male sex-workers worked in places where they could set up liaisons with business and vacation tourists as well as local "*big men*". The few who solicited from the streets went for customers in "*high profile*" vehicles and stayed away from men they would be likely to meet again in normal day-to-day activities.

Knowledge of HIV/STI and Risk Assessment

All the categories of sex-workers knew that condoms protected from HIV and other STIs; however they also had a lot of misinformation about HIV/STIs. The male sex-workers seemed generally more correctly informed about HIV and other STIs than the females.

Sex-workers' Perception of Sex-work

Apart from some of the male sex-workers, all other groups of sex-workers thought that their kind of business was morally wrong or degrading.

"Is not a nice work but is good, quick money."

"I do it because of financial need, it makes me feel guilty but I have my children to look after."

It was undoubtedly fraught with serious drawbacks such as violence, inconsistent earnings, high level of competition and dishonest clients who would either demand their money back or stole it. There was not much in place for retirement from sex-work and in general there was poor job satisfaction; everyone would rather be doing something else.

Main or Regular Partners

Most CSWs had a main partner and a number of regular customers. They referred to sexual relations with these persons as "feel-good-sex". For quite a few female sex-workers and one male this regular partner was female. In "feel-good-sex" no fee is charged; but, if the sex partner was not a main partner, the person was expected to do favours or provide gifts. The most significant thing about "feel-good-sex" is that condom use is inconsistent or not used at all.

Some worker's main partners knew of the kind of business they conducted but others were in the dark. There was no mention of a pimp or similar controlling relationship although there were persons who helped to facilitate linking with customers but this was seen as a favour or, at most, a kind of partnership.

Condoms

Almost all the sex-workers, male and female felt that condoms were their best "business partner". They described condom use as being essential to survival.

"Condom is my man, it looks after me"

Everyone swore to condom use for new or "one off" customers but probing led to admission of lapses in use when with regular customers. Young male and female prostitutes seemed most naive about condom use with regular partners. They made claims of regular partners using condoms consistently except with them. The more experienced sex-workers acknowledged the risk of infection from main partners when condoms were not used but still admitted to inconsistent use.

Customer resistance to condom use was very common. There were reports of being offered more money for "bare-back" or being threatened or forced through the use of weapons to provide sex without a condom. Customers were reported to have frequent and numerous complaints of side effects of condom use including itching, bad smell and rashes.

Female condoms were not widely used. Most females either had never seen or used one or felt that it was hideous and likely to be uncomfortable. Some complained of the high cost. A few admitted that it was useful when clients were resistant to the use of male condoms.

Drug Use

Drug use especially alcohol was reportedly quite common. Clients and CSWs share drugs and the drugs of choice included alcohol, ganja, crack cocaine and 'ecstasy'. Ganja and alcohol were the most widely used drugs but 'ecstasy' was referred to by the dancers as the "*dancers sweetie*." Dancers claimed that it helped them perform better on stage.

A number of CSWs perceived that the clients were easier to manipulate when they were "*high*". They also admitted that some customers became unmanageable under the influence.

Violence

An important risk factor that emerged and one that is not addressed consistently in CSW interventions is the issue of violence and its effect on the sex-workers ability to practise safer sex. There were many horror stories of being kidnapped, abused, beaten, stabbed, robbed, gang raped and deserted in remote places at ungodly hours of the night and early morning.

Expectations of the Ministry of Health

The findings with regard to their expectations from health services supported their stated interest in HIV prevention.

The sex-workers were generally pleased with the MOHs interest in them although there were some who perceived that they were being blamed for the spread of HIV. The men who have sex with men (MSMs) were really impressed and felt that this interest gave them some status. Sex-workers wanted the Ministry of Health to continue to provide condoms. They felt that this was especially important since if they could not afford condoms, they might be tempted to go without.

The HIV/STI prevention information and condom negotiation skills provided by the MOH staff were also highly valued. Helping to stave off police harassment and teaching new-comers to the industry condom negotiation skills were frequently mentioned tasks for the MOH and yet they did not use condoms consistently as advised.

Some sex-workers wanted more testing opportunities and the provision of counselling and support groups. There was also some mention of job training, provision of investment opportunities or money management skills. The male sex-workers wanted some health workers to be more objective about their sexual preference.

The research has identified a number of facts that a quantitative study could not and by extension provides the following information for risk reduction:

Specific Challenges of Risk Behaviours

- Sex-workers intention to use condoms with clients is strong but condom use with regular clients and main partner is much lower than with other clients. In these cases, this intention is weakened by the subjective norm which comes largely from a desire for "feel-good-sex" and the related need to satisfy the "significant other".
- Most sex-workers fully intend to use condoms in business transactions but there is however strong resistance to condom use among clients. For a number of reasons especially awareness of HIV and STIs, sex-workers do turn down offers of more money for unprotected sex. It is very clear that sex-workers who are drug addicts will seldom turn down offers of more money for no condom use. They also are reported to sell condoms distributed freely to purchase their drug of choice.
- Another instance of actual behavioural control outweighing intention is in the instance of violence. Sex-workers point to many instances of forced sex where clients use weapons to prevent the sex-worker from using condoms. Those who are not brothel based (the majority) depend on the client to provide a venue or offer their wares in dark and unpopulated places where no help or means of escape may be available.

Barriers to Risk Reduction Interventions

1. Poor self-perception: many CSWs express a feeling of being blamed for the HIV epidemic. This is based on the attention they receive through public health interventions and media reports. There were also many claims of being "targeted" by HIV positive clients whose intention was to infect as many persons as possible. Interventions for CSWs must therefore address self-esteem.
2. Commercial sex workers are often highly mobile and do not stay in a location for very long. This makes it difficult to have multiple contacts with them over a period of time.
3. Sex-work is illegal and stigmatized in Jamaica and other parts of the Caribbean. When sex-work is illegal, it is driven deeper underground and prevention efforts become more difficult. This is especially so in the case of male sex-workers who sell sex to men, given the stigma related to this in Jamaica. One strength of the current MOH programme is the attempt to work with the "gate keepers" at many of the CSW sites. Illegal status and stigma also prevent the penetration of prevention programmes into certain types of operations as there is denial about this activity as in the case of massage parlours and perhaps in the "call girl" network.
4. Many CSWs do not identify as such and are in denial of their activities.

DISCUSSION

The need to control and contain the HIV/AIDS disease is well documented and it is yet another disease that needs behaviour modification. In this way, it behaves similarly to a chronic disease and the significance of risk reduction in reducing the mortality/morbidity of chronic diseases has been documented as well as the difficulty in effecting behaviour modification and change (21). As this reported study suggests, the qualitative findings further describe the quantitative findings and supports the importance of using a combination of methods in research efforts to improve the completeness of information. It is able to describe the why, how and context of the chosen behaviour, in this case sexual practices, and to suggest possible interventions. For example, this study reported poor job satisfaction suggesting a possible non-sexually related intervention that is alternative employment opportunities. It is a method which can be used to understand aspects of other diseases. Understanding the why can be lifesaving (23). In a follow-up qualitative study on myocardial infarction, survivors identified the why for failure of the rehabilitation programme and reported that persons felt that survival and "return to normal" in six weeks indicated to the persons that the event was not serious so rehabilitation was not needed.

The information on condom use again demonstrates the complementary nature of the two research methods. From quantitative studies it is known that persons only use condoms sometimes even though belonging to a high risk group. This qualitative study provides additional information about

the why not and when not. Such information suggests the need to have targeted health messages for the vulnerable group and what the message could include.

The criterion used in making the decision of whether or not to include a qualitative component, is no less rigorous than for quantitative studies (23, 24). It includes describing the problem to be addressed; in this case, how can the high risk behaviours in a specific group of persons be identified with a view to designing an intervention. If the topic cannot be defined clearly then it cannot be studied. Similarly, the qualitative methods need to be appropriate and the analysis very detailed. As for quantitative studies, quality control (that is validity) is critical.

CONCLUSION

It is clear that the factors that influence behaviour and act as barriers to the adoption of safer sex practices among sex-workers include:

- Drug and alcohol use that cause poor risk perception or lack of behavioural control.
- "Feel-good-sex" with main partners and regular clients which is related to gender roles as well as self-perception.
- Violence which leads to lack of actual behavioural control as the sex-workers' choice is taken away.

These are three main factors contributing to the non-use of condoms among sex-workers. The study report described the why of an important behaviour and presents an alternative research strategy. Clinical practitioners have traditionally regarded numerical, statistically significant data as the only way to describe a problem. It is increasingly being recognized in the medical literature that in clinical care and service delivery, quantitative data cannot provide all the answers. The increasing importance of behaviour modification in reducing disease has reinforced the need for additional research tools and qualitative research is one such tool. It will never replace quantitative research but can be used to complement it and the two methods can be used to inform each other.

Qualitative research has been referred to as "soft" but if properly and rigorously done is a useful complementary tool to quantitative research.

What is important is that one should adhere to the principles of good research whatever research method is used.

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