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Living with HIV in Fiji: Highlights from a qualitative study (Part 1)

by Fabienne Labbé, PhD Candidate, Center for Research and Documentation on Oceania

This two-part article presents selected findings from the research report entitled *Living with HIV and AIDS: Perspectives of women and men in Fiji* (2011). Prepared for the National Health Research Committee of the Ministry of Health of Fiji, the report aimed to expose, in simple language supplemented with extracts from interviews, the results of a qualitative study of the experience of people living with HIV, which I conducted as part of my doctoral degree in anthropology at the School for Advanced Studies in Social Sciences (*École des Hautes Études en Sciences Sociales*).

Part 1 of the article describes the objectives, methods and sample of the research before turning to the contexts of HIV acquisition and diagnosis reported by the participants of this study. Part 2 examines the health care practices of HIV positive people, experiences of HIV disclosure, the impacts of the infection on spirituality and the benefits of joining an association of people living with HIV. So watch out for your next PASA issue!

Research objectives and methods

Fieldwork for this study was conducted between November 2007 and December 2008. The research objectives were 1) to collect the perspectives of HIV positive people on the realities that contribute to an increased risk of transmission of the virus in Fiji, 2) to understand the ways these individuals make sense of the infection, 3) to document their therapeutic trajectories and 4) to delineate the continuities and changes brought about by HIV in their life.

In collaboration with the Reproductive Health Clinics of Suva, Lautoka and Labasa and the Fiji Network for People Living with HIV and AIDS (FJN+), 17 women and 11 men were recruited and interviewed. Thirteen people were interviewed once while 15 were met on more than one occasion (total=43 interviews). The interviews, of an average length of one hour 25 minutes, were recorded on an electronic device. The respondents had given their informed consent to participate in the research and to be recorded prior to the interview. A compensation of 15 FJD, plus a variable, small reimbursement for transport, was given to the research participants.

The interviews were transcribed and analysed using the thematic analysis method.

Sociodemographic characteristics of the sample

Consistent with national figures on HIV, the 17 women and 11 men who took part in this study were mostly indigenous Fijians (25/28). The respondents ranged in age from 21 to 45

(median=30.5).¹ A large majority was living in urban areas (23/28), with the bulk in the region of the capital city (19/28). At the time of the study, five women had no stable place to stay.

When interviewed, half the respondents were in a relationship (nine married and five in a de facto union) and four were single. Many were widowed (4/28) or were separated or divorced (6/28), frequently as a result of their positive status. On average, the interviewees had 1.4 children. Four respondents had lost a child to AIDS.

Half the research participants had completed Form 5 or less at school, junior secondary (Form 1 to 4) being the level most commonly attained by the interviewees (10/28). At the time of interview, the majority was unemployed (18/28) while two were studying. Eight people were engaged in salaried work, six of them being employed in HIV-related jobs. Among those who were unemployed, thirteen (13/18) had never had waged work or had only been employed in occasional and unstable jobs. Two women reported having ever been involved in sex work.

Contexts of HIV diagnosis and knowledge about the infection

The research participants had been living with a diagnosis of HIV for periods varying from two weeks to approximately eight years (median=3 years, n=27). They estimated the time lapse between their contraction and their diagnosis of the infection to be from three months to four years.

Almost half the interviewees received their diagnosis after they (9), their partners (2) or their children (2) had experienced HIV-related symptoms (n=27). Seven people learned about their HIV seropositivity in the context of a pregnancy (theirs (5) or their partner's (2)). Only three reported having been diagnosed with HIV following self-initiated testing for the infection in the absence of symptoms. In the three cases, the HIV positive status of their sexual partner was clearly known or strongly suspected.

Most of the people interviewed reported limited and unspecific knowledge about HIV prior to diagnosis. Five said they were well informed about the infection. Two even reported having been involved in awareness activities. Regardless of their level of knowledge, all the research participants mentioned they had not been concerned by the infection. Some women alluded to the allegedly "at risk groups" (homosexuals and sex workers) and said that they had felt safe because they did not belong to these groups. Nonetheless, it seems as though the risk of HIV had simply not been part of the picture.

HIV acquisition and social risks

Almost all the people interviewed reported having contracted HIV through heterosexual sex (27/28). However, cases of homosexual acquisition could have been under-reported due to the condemnation and stigmatization of same-sex desire and sexuality in Fiji.

¹ Where more than one interview was conducted with a same research participant, the first interview was used as reference for sociodemographic characterization.

The life stories of the research participants show that the risk of HIV is strikingly gendered in the indigenous Fijian community. Realities that contribute to an increased risk of exposure to the virus among men include: 1) labour mobility and migration, which require the separation of couples and increase the likelihood of extramarital sex; 2) the prevailing culture of masculinity, which constructs as normal for men to have more than one sexual partner; 3) the pressure to adopt normative male behaviour, including the practice of seducing women, that exists in a society organized along gender lines and where male friendship is fundamental.

Realities that impact the risk of HIV among women include: 1) their difficult access to economic resources, which lead some to marry men that they do not know or to resort to exchanging sex for money/gifts in order to make a living; 2) the gender ideology which assigns women to a subordinate position in the couple, prevents them from challenging their partners' infidelities and exposes many to violence; 3) the double sexual standard which makes it hard for women, but less so for men, to flee a relationship when sexual intercourse is assumed to have taken place (for example in case of elopement).

All the respondents considered the cultural and religious rules that make sexuality a subject inappropriate for public discussion responsible for a lack of information about sexual and reproductive health among indigenous Fijians and at the origin of an increased risk of HIV in this community.

All the interviewees perceived alcohol to be strongly linked to sexuality and to the risk of HIV in Fiji. Several of the research participants themselves reported they had had sex, and contracted HIV, while under the influence of alcohol.

The people interviewed said condoms were seldom or not systematically used by indigenous Fijians. Reasons advanced included problems of accessibility, the shame associated with condom procurement, preferring the feeling of "skin-to-skin" sex, a lack of knowledge on condom use and the difficulty of using one after alcohol consumption. More importantly, condoms seemed to be considered incompatible with intimacy.

For more details or for a copy of the full research report, please contact Fabienne Labbé, PhD Candidate, School for Advanced Studies in Social Sciences, Centre for Research and Documentation on Oceania, Email: fabiennelabbe@gmail.com