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CLINICAL ARTICLE

HIV vulnerabilities of sex-trafficked Indian women and girls

Jhumka Gupta [a,*], Anita Raj [b], Michele R. Decker [c], Elizabeth Reed [d], Jay G. Silverman [c]

[a] Yale School of Public Health and Yale University Center for Interdisciplinary Research on AIDS, New Haven, CT, USA
[b] Boston University School of Public Health, Department of Social and Behavioral Sciences and Boston University School of Medicine Boston, MA USA
[c] Harvard School of Public Health, Department of Society, Human Development, and Health, Boston, MA, USA
[d] Duke University, Duke Global Health Institute, Durham, NC, USA

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ABSTRACT

Objective: To qualitatively explore potential mechanisms that may confer heightened risk for HIV infection among survivors of sex trafficking in India. *Methods:* Case narratives of 61 repatriated women and girls who reported being trafficked into sex work and were receiving services at an NGO in Mysore, India, were reviewed. Narratives were analyzed to examine potential sources of HIV risk related to sex trafficking. *Results:* Participants were aged 14–30 years. Among the 48 women and girls tested for HIV, 45.8% were HIV positive. Narratives described very low levels of autonomy, with control exacted by brothel managers and traffickers. Lack of control appeared to heighten trafficked women and girls' vulnerability to HIV infection in the following ways: use of violent rape as a means of coercing initiation into sex work, inability to refuse sex, inability to use condoms or negotiate use, substance use as a coping strategy, and inadequate access to health care. *Conclusion:* Sex trafficked women and girls lack autonomy and are rendered vulnerable to HIV infection through several means. Development of HIV prevention strategies specifically designed to deal with lack of autonomy and reach sex-trafficked women and girls is imperative.

1. Introduction

According to the UN Protocol to Prevent, Suppress, and Punish Trafficking in Persons, sex trafficking is "…the recruitment, transfer, harboring, or receipt of persons via threat, force, coercion, abduction, fraud, or deception and/or for the purpose of sexual exploitation, including prostitution" [1]. Among the deleterious health consequences affecting women and girls subjected to sex trafficking (e.g. post traumatic stress disorder, sexually transmitted infections [STIs], gynecological infections, tuberculosis [2–5]), the threat of HIV infection is of tremendous public health importance in India. This country is currently grappling with one of the largest HIV epidemics in the world [6], and is also believed to be the destination for some 150 000 women and girls who are trafficked across South Asia each year [7]. While research regarding HIV among sex-trafficked populations is in its early phases, multiple investigations focused on South Asia have documented that 22% to 38% of sex-trafficked women may be HIV positive [3,8,9]. These seroprevalence figures fall within the higher range of the HIV prevalence estimates among female sex workers (FSWs) recently documented in India which ranged from 3.1% to 40.0% [10]. These data suggest heightened vulnerability to HIV among trafficked women and underscore the critical need for research to examine factors that may confer such elevated risk.

Sex trafficking is a dire human rights violation and represents one of the most extreme forms of female sex work. Thus, factors that are likely to increase the threat of HIV infection among all FSWs are believed to be more extreme among women and girls who have been sex trafficked [8,9]. Specifically, sex-trafficked women and girls have been shown to experience alarmingly high rates of physical and sexual violence. Recent data indicate that women and girls who entered sex work via trafficking were over 7 times more likely to report experiencing violence in brothels than FSWs who were not identified as trafficked [11]. Other research has documented the prevalence of violence during both the trafficking process and while in sex work to be as high as 95% [2]. Such experiences of violence are believed to diminish possibilities for condom use and increase the potential for injuries (e.g. vaginal trauma or laceration) that may facilitate HIV acquisition [8,9,12,13]. Younger age may also contribute to HIV vulnerability: half of all trafficked women are believed to be under 18 years old [14] and prior research has documented higher HIV infection among younger survivors of sex trafficking [8,9]. To date, however, there has been limited public health research directly investigating such theorized mechanisms.

The purpose of the present study was to explore the existence and operation of mechanisms by which risk for HIV infection is heightened among sex-trafficked women and girls in India.

* Corresponding author. 60 College Street, Room 420, New Haven, CT 06520, USA.
E-mail address: Jhumka.gupta@yale.edu (J. Gupta).

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2. Materials and methods

All de-identified case records obtained from survivors of sex trafficking presenting to Odanadi Seva Trust (Mysore, Karnataka, India; Fig. 1) between February 2002 and April 2006 were collected by the US-based investigative team in March 2007 (n = 71). Odanadi is a nongovernmental organization (NGO) providing shelter and care to vulnerable women and girls from the South Indian state of Karnataka. Odanadi is also part of a larger network of NGOs throughout South Asia (namely India, Nepal, Bangladesh) whose activities focus on service provision (e.g. counseling, general health care, job training) for survivors of sex trafficking. As women and girls exit sex work (often through release efforts coordinated by such NGOs and police), they are placed within the care of network member NGOs who operate near the trafficking destination for short-term care. The local NGOs then work to repatriate survivors of sex trafficking to longer-term facilities within their regions of origin. For example, Odanadi provides longer-term assistance to those trafficked from Karnataka; it also provides services to women and children who have been abandoned, face mental illness, or experience family violence.

The study involved a retrospective qualitative analysis of information collected through a routine intake interview at Odanadi. Intake interviews are conducted upon initial entry into care by trained counselors working as case managers. Interviews seek to obtain information regarding basic demographics, trafficking history, and experience of forced prostitution (i.e. entering sex work via trafficking) as part of an overall assessment to determine service needs. Case managers record all testimony into case records. As the interviews were conducted as part of routine assessment of service needs (i.e. not for research purposes), the case managers did not receive training in qualitative research methodology, and no specific "research instrument" or guide was used. All case managers took detailed notes (in Kannada) during interviews; these notes comprised the case narratives, which were then analyzed by the US-based investigative team. Because of the service-based nature of Odanadi, the case narratives do not always include verbatim accounts of interviews, and may also include summaries as noted by case managers.

As part of the regular service provision at Odanadi, all survivors of sex trafficking undergo an HIV test conducted by one of Odanadi's partner hospitals in Mysore. All case managers obtain verbal consent from the individuals prior to arranging an HIV test. HIV serological testing is conducted via enzyme-linked immunosorbent assay (ELISA) or Western Blot; results of laboratory testing were recorded in the case records.

Of the 71 case records obtained by the US-based investigative team, 10 were excluded because these individuals were receiving services at Odanadi for reasons other than sex trafficking. The sample was restricted to women and girls who were documented as being trafficked into sex work by either the police in the trafficking destination city (as indicated in their case record) or by Odanadi case managers (n = 61).

Narratives recorded by case managers in Kannada, the main language spoken in the South Indian state of Karnataka, were translated into English by case managers. Codes were developed through an iterative process, using a grounded theory approach [15]. All case record narratives were reviewed and coded separately by the first and senior authors (JG and JS). Coding occurred until saturation was reached regarding themes related to HIV risk. The first author finalized the coding in cases involving interpretation differences. Coded case narratives were then discussed with the larger investigative team to further refine identified themes.

The study did not involve direct contact with human subjects. All study protocols were approved by the Harvard School of Public Health Human Subjects Committee.

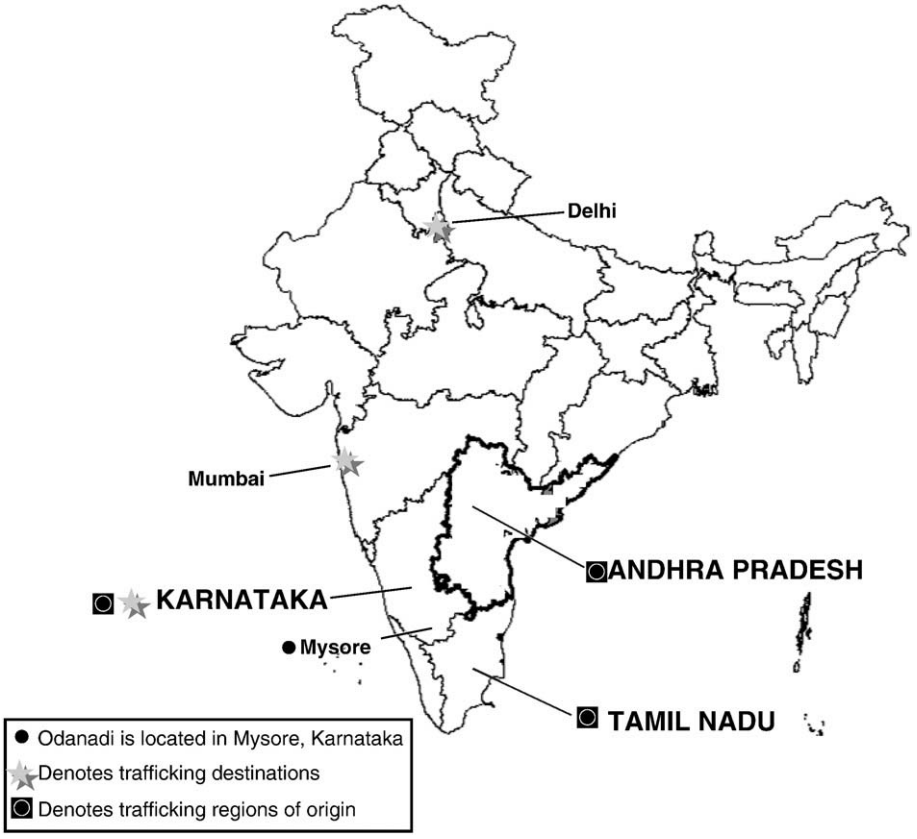

Fig. 1. Map of India highlighting Odanadi, regions of origin, and trafficking destinations.