International Journal of Gynecology and Obstetrics 114 (2011) 101–105

Contents lists available at ScienceDirect

International Journal of Gynecology and Obstetrics

journal homepage: www.elsevier.com/locate/ijgo

CLINICAL ARTICLE

History of sex trafficking, recent experiences of violence, and HIV vulnerability among female sex workers in coastal Andhra Pradesh, India

Jhumka Gupta [a,*], Elizabeth Reed [b], Trace Kershaw [a], Kim M. Blankenship [c]

[a] Yale School of Public Health and Center for Interdisciplinary Research on AIDS, New Haven, USA
[b] George Washington University, Washington, USA
[c] American University, Washington, USA

ARTICLE INFO

Article history:
Received 2 December 2010
Received in revised form 3 March 2011
Accepted 15 April 2011

Keywords:
HIV
Sex trafficking
Sex work
South Asia
Violence

ABSTRACT

Objectives: To estimate the prevalence of sex trafficking as a mode of entry into sex work, and to examine associations between sex trafficking and recent violence experiences and HIV vulnerability among female sex workers (FSWs). *Methods:* In a cross-sectional study in 2006 in coastal Andhra Pradesh, India, 812 FSWs were recruited via respondent-driven sampling to take part in an oral survey of their experiences in sex work. *Results:* One in 5 (19.3%) FSWs met the UN definition of sex trafficking. Women trafficked into sex work were more likely than other FSWs to report recent violence experiences (adjusted odds ratio [AOR], 1.93; 95% confidence interval [CI], 1.32–2.81), more clients per week (AOR, 1.63; 95% CI, 1.11–2.41), and more days of sex work per week (AOR, 1.76; 95% CI, 1.18–2.63), and were less likely to report use of FSW-focused services (AOR, 0.60; 95% CI, 0.42–0.86). No significant differences emerged regarding HIV knowledge or consistent condom use. *Conclusion:* There was a high prevalence of sex trafficking. A history of sex trafficking was associated with a greater vulnerability to recent violence and HIV risk behaviors, underscoring the need for increased attention to the public health needs of trafficked populations.

1. Introduction

The sexual exploitation of women and girls is a major human rights violation. Sex trafficking is defined by the United Nations (UN) as "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…or being in sex work while under age 18" [1]. One annual estimate of sex trafficking of women and girls across south Asia is approximated at 150 000 [2].

Vulnerability to HIV infection among women and girls affected by sex trafficking is of concern in India, where some 2.5 million people have HIV [3]. Data from 287 Nepalese women and girls released from sex trafficking in India showed a seroprevalence of 38%, a value that lies within the higher spectrum of HIV prevalence estimates noted among female sex workers (FSWs) in the high-prevalence Indian states of Maharashtra, Andhra Pradesh, Tamil Nadu, and Karnataka (2%–38%) [4,5]. These factors highlight the need to examine what exacerbates HIV vulnerability in this understudied population.

Qualitative work in India indicates that the vulnerability of sex-trafficked women and girls to HIV infection is exacerbated by several mechanisms, including forced unprotected sex, mobility restrictions that preclude access to healthcare and other services, violence upon sex work initiation, and limited autonomy [6]. Interference with access to healthcare and other social services, especially services specifically targeting FSWs, is of particular concern owing to missed opportunities for provision of education, treatment, and related services. Both violence and low autonomy within the sex work environment are thought to heighten risk, owing to reduced ability to negotiate condom use and to control the nature of sex work (e.g. frequency of sex work) [6]. Moreover, by definition, sex-trafficked FSWs are more likely than other FSWs to be minors (<18 years), and thus might face greater demand from male clients for unprotected sex and have diminished ability to negotiate condom use [4,7].

Research on sex trafficking and HIV in India has overwhelmingly focused on NGO-based samples of sex-trafficked women and girls after release from sex work in brothels. To our knowledge, only 1 Indian study (of brothel-based FSWs in West Bengal, India) has specifically examined how experiences might differ between women who entered sex work via trafficking and those who entered for other reasons (e.g. for economic prospects devoid of coercion or force) [8]. That study found that trafficked women had a higher HIV prevalence and experienced more violence upon sex work initiation than other FSWs [8]. The extent to which these findings apply in other Indian geographical contexts or non-brothel (e.g. street- or home-based) settings remains unclear. Such information is needed,

* Corresponding author at: Yale School of Public Health, 60 College Street, Suite 400, New Haven, CT 06510, USA. Tel.: +1 203 737 4656; fax: +1 203 785 6279.
E-mail address: jhumka.gupta@yale.edu (J. Gupta).

0020-7292/$ – see front matter
doi:10.1016/j.ijgo.2011.03.005

given the relatively higher prevalence of HIV in "harder hit" southern states (e.g. Andhra Pradesh) [9], the higher number of non-brothel-based FSWs in these regions [10], and the growing concern about trafficking within non-brothel settings [11].

The aims of the present study were to estimate the prevalence of trafficking as a mode of entry into sex work among a sample of FSWs in Andhra Pradesh, India, and to examine potential differences in sources of HIV risk (including use/non-use of FSW-focused services) between women who entered sex work via trafficking and those who did not.

2. Materials and methods

Data were collected from April 1, 2006, to June 29, 2006, as part of the baseline survey for Project Parivartan, a community-based HIV study in Rajahmundry in the East Godavari District of Andhra Pradesh, India. Eligible women were 18 years or older, reported having had sex in exchange for money in the previous year, and were capable of providing informed consent. Recruitment was via respondent-driven sampling [12,13]. Trained female Telugu-speaking research assistants orally administered the 90–120-minute quantitative survey in the Parivartan field office. After qualitative field work, consultation of existing studies with FSWs in India, and feedback from local NGO staff, surveys were developed in English, translated into Telugu (by Telugu-speaking research assistants), and back-translated into English (by Telugu-speaking researchers not linked to the study). All study materials had been piloted with FSWs.

Participants received compensation for their time and transportation, and were provided with the option for referral and accompaniment to local FSW services if distress was detected. Yale University Human Investigation Committee, Duke University Medical School's Institutional Review Board, and VHS-YRG Care Medical Centre Institutional Review Board in Chennai approved the study.

Demographic data and sex work characteristics, including current age, education, religion, and sex work venue (i.e. the setting where sex work took place) were assessed via single items. Consistent with the UN definition of sex trafficking [1], women who reported being lured, cheated, or forced into sex work, or who entered sex work when younger than 18 years were considered to have been trafficked into sex work.

The reason for entry into sex work was assessed via a single item. Participants were asked: "Did you start doing sex work because (1) you had to provide for yourself and family; (2) you were advised by a friend/relative; (3) you are a traditional sex worker; (4) you were lured, cheated or forced into the business; (5) you were abandoned or kicked out by family or husband; or (6) you were beaten by husband?" Age of entry into sex work was obtained via a single item that asked participants to report their age when they first began sex work. Years of sex work was calculated by subtracting age of entry from current age.

Recent violence experiences were assessed via 3 items modified from Conflict Tactics Scale 2 [14]. Participants were asked: "In the past 6 months, how many times would you say someone has (1) beaten (e.g. hit, slapped, pushed, kicked, punched, choked, or burned) you (physical violence); (2) threatened you with a knife or gun or used a weapon against you (severe violence); or (3) forced you to have vaginal, anal, or oral sex against your will (sexual violence)?" Three dichotomous variables were created: (1) any violence (yes to any type of violence versus no to all items); (2) any sexual or physical violence (yes to physical or sexual violence items versus no to both); and (3) any threats of severe violence (yes versus no).

Sources of HIV risk were assessed via 5 variables. (1) Number of clients: participants were asked to report the number of male clients that they had sex with in the past 7 days. Responses were dichotomized as less than 10 versus 10 or more. (2) Number of days of sex work: responses to the question of the number of days engaged in sex work during the past week were dichotomized as 3 or less versus 4 or more. (3) HIV knowledge: a 7-item scale was used to assess participants' knowledge about HIV prevention, including transmission. Responses were dichotomized as high knowledge (above the mean) versus low knowledge (below the mean). Each of these items was developed to be consistent with a large-scale survey of at-risk populations in India, including FSWs [15]. (4) Consistent condom use with regular or occasional clients: as previously shown to yield a conservative assessment of self-reported condom use [16], 2 separate items were combined to create the "consistent condom use" variable. First, women were asked whether they used a condom the last time they had sex in the past 7 days. Next, a 5-point Likert scale, ranging from "always" to "never" was used to assess how often FSWs used condoms with clients in the past 7 days. Responses were then dichotomized. Consistent condom use was recorded if the answers were "always" in the past 7 days and "yes" in the past 7 days. All other responses were recorded as inconsistent. (5) We used an item created specifically for the survey to assess the use of FSW targeted services. Women were asked whether they had visited an NGO-affiliated sexually transmitted infection (STI) clinic targeting FSWs (providing treatment) or drop-in center (providing a safe place where FSWs could relax, take classes, or socialize) in the preceding 6 months. Responses were coded as yes versus no.

To estimate the prevalence of sex trafficking, we calculated the percentage of FSWs who reported either entering sex work when younger than 18 years or being lured, forced, or cheated into sex work. We then calculated prevalence estimates for recent violence experiences, number of clients, and days of sex work in the past 7 days, and consistent condom use, HIV knowledge, and use of FSW-focused services, both by the total sample and by trafficking status. Crude and adjusted regression models (containing duration in sex work, education, and current age) were used to assess whether outcomes differed by trafficking status. Adjusted odds ratios and 95% confidence intervals were used to assess significance at $P<0.05$ in logistic regression models. All analyses were conducted using SAS version.9.1 (SAS Institute, Cary, NC, USA).

3. Results

In total, 812 FSWs took part in the study. Nearly 1 in 5 (n = 157, 19.3%) women met the UN definition of being trafficked into sex work (Fig. 1). As compared with other FSWs, those entering via trafficking were in sex work longer, were younger, had entered sex work at a younger age, and had less education; no other significant differences emerged (Table 1).

In the 6 months preceding the survey, women who originally entered sex work via trafficking were almost twice as likely as other FSW to report experiencing any form of violence (53.5% versus 39.1%; adjusted odds ratio [AOR], 1.93; 95% confidence interval [CI], 1.32–2.81); physical or sexual violence (53.5% versus 38.4%; AOR, 1.99; 95% CI, 1.36–2.90); and threats of severe violence (11.5% versus 6.1%; AOR; 1.85; 95% CI, 0.99–3.50) (Table 2).

In the week preceding the survey, FSWs who had entered sex work via trafficking were more likely than other FSWs to report having sex with 10 or more clients (41.0% versus 27.0%; AOR, 1.63; 95% CI, 1.11–2.41), and to report engaging in sex work for 4 or more days (71.2% versus 53.3%; AOR, 1.76; 95% CI, 1.18–2.63). FSWs who entered sex work via trafficking were also less likely to report use of FSW-targeted services in the preceding 6 months (44.6% versus 59.1%; AOR, 0.60; 95% CI, 0.42–0.86) (Table 3). Although higher consistent condom use was observed among trafficked FSWs, (50.0% versus 37.9%), the difference was not significant in the adjusted analysis (AOR, 1.20; 95% CI, 0.88–1.92). No significant differences in HIV knowledge were observed.

The aim of the present study was to examine how selected sources of HIV vulnerability varied among FSWs who originally entered sex work via trafficking (based on the UN definition). However, post hoc