Sex Trafficking and STI/HIV in Southeast Asia:

Connections between Sexual Exploitation, Violence and Sexual Risk

JAPAN
Official Development Assistance

UNDP

Published in July 2009

UNDP Regional Centre in Colombo
23, Independence Avenue,
Colombo 7, Sri Lanka.
Tel: +94 11 4526400
Fax: +94 11 4526410
rcc@undp.org
www.undprcc.lk

ISBN 978-955-1031-19-0

Layout and design by A&D Advertising

A Regional Assessment of Sex Trafficking and STI/HIV in Southeast Asia: Connections between Sexual Exploitation, Violence and Sexual Risk

Jay G. Silverman, PhD
Michele R. Decker, ScD
Heather L. McCauley, MS
Katelyn P. Mack

[1] Harvard School of Public Health (Boston, MA USA)

ACKNOWLEDGEMENTS

This quantitative research study on the issue of sex trafficking and HIV in Southeast Asia was undertaken by UNDP Regional HIV and Development Programme, together with the Harvard School of Public Health. The study was commissioned to the principal researchers and authors Dr. Jay Silverman and Dr. Michele Decker from the Harvard School of Public Health and covers three countries in the Southeast Asian Region, namely Cambodia, Indonesia and Thailand.

The publication benefited immensely from technical reviews and inputs from Asia Pacific country offices, UNDP headquarters, Regional UN agencies and the UNDP Regional Centre in Colombo. In particular, we would like to acknowledge the contributions of: Katherine Moriarty and Rany Pen (UNDP Cambodia), Susana Fried (BDP, NY), Matt Friedman (UNIAP Thailand), Gary Lewis, Martin Fowke, Anne Bergenstrom and the regional team (UNODC Regional Centre, Thailand), and Azrul Mohd Khalib (UNAIDS and UNDP Malaysia).

We are grateful to each of the researchers, who conducted the country studies and analysis, which constitute the basis for this publication: Dr. Jay Silverman, Dr. Michele Decker, Heather L. McCauley MS, and Katelyn P. Mack of Harvard University. Our special thanks are extended to Dr Jay Silverman, who led the research team, and authored the written work for this publication with the help of his team.

The final report was prepared under the overall guidance and supervision of Caitlin Wiesen with substantial contributions from Kazuyuki Uji, Pramod Kumar, Marta Vallejo, Revati Chawla, Nashida Sattar, Mini John, Tiruni Yasaratne, and Kishanthani Paramjothy. We wish to thank Yumiko Yamamoto from the Trade & Investment team within the Regional Centre Colombo, who provided valuable peer review comments. We gratefully acknowledge the leadership support provided by Nicholas Rosellini and Omar Noman for undertaking the study.

We would like to acknowledge with gratitude the Government of Japan for their financial assistance which made this study possible as well as their commitment to addressing the issues of trafficking and HIV in the region.

The views and conclusions expressed in this report are those of its authors and do not necessarily reflect positions of UNDP, its member governments, or other collaborating or sponsoring institutions.

It is our hope that this study will contribute to greater dialogue on issues of sex trafficking and HIV and more effective responses that address the health, well being and safety of sex-trafficked women and girls.

Caitlin Wiesen-Antin

Caitlin Wiesen-Antin
Regional HIV/AIDS Practice Leader & Programme Coordinator, Asia & Pacific
UNDP Regional Centre
Colombo, Sri Lanka

FOREWORD

The lack of evidence has been one of the critical missing links to discuss, explore and act upon the nexus between HIV and human trafficking. Heightened HIV risk of girls and women trafficked for sexual exploitation is often intuitively perceived. However, the paucity of systematic research and evidence on the linkage has deterred informed discussions on the subject. It may have also contributed to the absence of coordination and sometimes even the development of dissociation among stakeholders working on HIV prevention, human trafficking and the empowerment of sex workers, both at policy and programmatic levels.

In an effort to strengthen Asia's knowledge base on the subject for initiating dialogue and collective action, UNDP Regional HIV and Development Programme for Asia and the Pacific commissioned this Southeast Asian multi-country research. It is built upon a series of South Asian studies on HIV vulnerability of sex trafficked girls and women conducted by Dr. Jay Silverman and Dr. Michele Decker of Harvard University, who are also the leading authors of this Southeast Asian multi-country research. The South Asian studies have paved the way for bringing together various HIV and anti-trafficking stakeholders and basing their dialogue on evidence rather than differing ideological standpoints.

This Southeast Asian multi-country study on HIV vulnerability of sex trafficked girls and women is the first of such systematic research ever undertaken in the Southeast Asia region. The findings and lessons from the study including limitations and need for more investigations can provide us with powerful evidence and impetus to further explore this unexplored field. In this context, the study has taken us a step closer towards more comprehensive and integrated approach to prevent human trafficking and HIV infection in the region.

The current global economic crisis, the resulting cut-back on formal employment opportunities and the narrowing of former migration channels may lead to an increase in unsafe migration and trafficking of girls and women for sexual exploitation. I hope this publication will serve not just as a reference but also as a stimulus for examining and acting upon potential risks faced by vulnerable girls and women across the region at uncertain times.

Mr Nicholas Rosellini

Deputy Assistant Administrator and
Deputy Regional Director
Regional Bureau for Asia and the Pacific, UNDP

CONTENTS

1 EXECUTIVE SUMMARY and KEY FINDINGS

1.1 Background for the Regional Study

Trafficking in persons is currently defined by the United Nations as the forced, coerced, fraudulent or deceitful entry into labor including prostitution, entry by abduction, or entry into such work under age 18 years.[1]Trafficking in persons for purposes of sexual exploitation, termed 'sex trafficking' in this report, is considered to pose tremendous risk for health consequences ranging from trauma and poor mental health to sexually transmitted infection (STI), including HIV. Moreover, sex trafficking is thought to pose a number of unique and qualitatively different forms of STI/HIV risk,[2] while at the same time posing significant barriers in accesssing HIV reduction education and related programming.[3] However, little empirical data exist to describe 1) women and girls' experiences of sex trafficking, 2) sexual risk encountered in this context or, importantly, 3) STI/HIV outcomes among women and girls trafficked into sex work. The need is particularly great regarding data that allow comparison of trafficked to non-trafficked women in sex work for more direct estimation of the effects of trafficking on STI/HIV risk and outcomes. Assessment of the links between trafficking for sexual exploitation and STI/HIV is conspicuously absent for the Southeast Asia region.

[NOTE: It is important to recognize that whether trafficking victims should include those under 18 regardless of quality of entry, and whether movement of persons is required for trafficking are both the subject of continuing international debate. However, as no official revision of this definition has taken place to date, we have conformed to the 2000 definition for purposes of this report, with a test of this potential revision included in one country-specific report.]

Sex trafficking is a serious public health and human rights concern in Southeast Asia, with an estimated 200,000-250,000 women and children trafficked within the region each year.[4] Cambodia, Indonesia and Thailand provide important contexts for this problem, serving as source, transit and destination countries for sex trafficked women and girls, many of whom are under the age of 18.[4-8] But each country is also distinct with regard to their roles within the region; within Cambodia, trafficking activity is typically confined within the national borders,[9] with women and girls from rural areas trafficked to urban destinations such as Phnom Penh. Indonesia is characterized by both domestic and international human trafficking,[10] with destinations including Malaysia and other Southeast Asian, East Asian and Middle Eastern destinations.[8, 10] Thailand is considered a leading destination country for trafficking for the purposes of sexual exploitation within the Southeast Asia region.[11] Bangkok and, secondarily, Chiang Mai, are considered the main hubs of sex trafficking, drawing internally from communities in northern and rural Thailand as well as other major source countries including Myanmar, Yunnan province of China, Cambodia, and Laos.[4]

Given the prevalence of sex trafficking across Southeast Asia and the high degree of both domestic and international implications for the health and human rights of victims of this crime, particularly as it relates to the HIV epidemic, researchers from the Harvard School of Public Health collaborated with the United Nations Development Programme Asia-Pacific Regional Centre in Colombo to launch a multi-country investigation of sex trafficking and STI/HIV within Southeast Asia. Sources of data on women and girls trafficked for sexual exploitation were identified and studied in each of three countries: Thailand, Cambodia and Indonesia.

1.2 Study Methods

In each case, most representative data of highest quality were sought. Data on the issue of trafficking among women and girls involved in sex work and their STI/HIV risk is scarce for the following reasons: As the topic has been recognized only relatively recently, it is criminal in nature; it involves an extremely vulnerable and 'hidden' population; it has been historically excluded from programs, surveillance or research regarding HIV and sexual risk among sex workers; and it has not been included in ongoing state-sponsored surveillance. After an extensive search, three national samples were identified involving the efforts of academic, country-level NGO and global NGO partners. Samples from Cambodia and Indonesia were comprised of sex trafficking survivors served via post-trafficking NGO services across these countries. In contrast, the data utilized in the report on Thailand is a national survey of female sex workers, some of whom reported having been trafficked. In this case, comparisons between trafficked female sex workers (FSWs) and non-trafficked FSWs were completed to determine whether experiences were qualitatively different based on trafficking status, allowing comparisons between experiences of sex work based on trafficking. All analyses attempted to characterize the experiences of trafficking survivors, related not only directly to STI/HIV, but also to the context for such risk and infection, i.e., workplace violence and maltreatment, deprivation of basic human rights such as denial of food and water, health care access and freedom of movement.

Summary findings specific to each country study are listed below:

1.3 Key Findings

1.3.1 Cambodia

- The majority (52.2%) of female sex trafficking survivors identified via this national network of rehabilitation NGOs were under the age of 17 at the time of trafficking
- 3 out of 4 (74.1%) survivors were trafficked internally within Cambodia
- Sexual violence was prevalent, with 1 in 4 (25.0%) reporting forced sex acts in the context of trafficking and sex work
- A similar majority (73.4%) of survivors tested positive for sexually transmitted infection
- Contrary to previous findings in this area, duration of exploitation was related to STI along a "U" shaped curve;
    - 90% of survivors exploited for 2 months or less were STI infected, suggesting tremendous risk for acquisition in the initial phases of sexual exploitation
    - Among victims that were exploited for longer than 2 months, the risk of STI infection decreased and then increased over time, with 100% of those exploited for over one year infected.
- No cases of HIV infection were detected among this sample of trafficking survivors; given the high levels of STI detected (i.e., evidence of substantial levels of sexual risk and consequent exposure to infection), this finding suggests that either:
    - a) very little HIV infection is currently circulating among the men with whom these women and girls were made to have sex,
    - b) diagnostic detection of HIV among the NGOs participating in this surveillance system is inadequate, or

- c) reporting of cases of HIV detected at the NGO-level to the surveillance system is inadequate.

1.3.2 Indonesia

- The prevalence of HIV among trafficking survivors was 5.7%, rising to 19.4% among those trafficked for sexual exploitation one year or more.
- 1 in 7 (14%) trafficking survivors tested for at least one of 4 sexually transmitted infections, including HIV, were infected.
- The prevalence of HIV among those trafficked within Indonesia was found to be 5.4%.
- Slightly less than half (46.5%) of sex trafficking survivors were exploited under the age of 18 years; notably a substantial number experienced trafficking for sexual exploitation at very young ages, with approximately one-quarter (24.5%) of survivors trafficked under 15 years of age.
- Most women and girls were trafficked within Indonesia (61.4%), with Malaysia being the destination for the majority of those trafficked across national borders (32.7%).
- Conditions and treatment were oppressive; most (76.6%) survivors were denied all movement, and many were forced to use drugs or alcohol (24.8% and 36.4%, respectively).
- Exposure to multiple forms of abuse was common; psychological abuse was reported by nearly 80% of women; 44% experienced physical abuse, and 75% of trafficked women and girls experienced sexual violence.
- Several factors were significantly related to STI/HIV or HIV among sex trafficking survivors:
  - Duration in forced sex work of greater than one year
  - Being forced to drink alcohol or use drugs in the context of sex work
  - Greater average number of male clients per day
  - Imprisonment within sex work settings
  - Factors including violence victimization, and other experiences of maltreatment in sex work also appear to be meaningfully related to STI/HIV risk among sex trafficking victims.

1.3.3 Thailand

- Approximately one in ten (10.4%) FSWs in the sample indicated they met the criteria for sex trafficking used in this report (i.e., began sex work under the age of 18 years, or entered via mechanisms of force, fraud, or deception).
- Sex trafficked FSWs were younger in age as compared with non-trafficked FSWs and were also found to have been involved in sex work for longer periods of time as compared with non-trafficked FSWs.
- Trafficked FSWs reported significantly greater numbers of male clients, reporting an average of 33.4 vaginal sex episodes with clients in the past month as compared with only 24.6 such acts among those non-trafficked ($p=0.03$).
- Anal sex, which represents a relatively high level of HIV risk, was three times as common among sex trafficked FSWs (8.2% vs. 2.6%; $p<0.01$).

- Trafficked FSWs faced greater difficulties regarding condom use; 22.4% of trafficked women reporting recent condom failure compared to 12.4% of non-trafficked FSWs.
- Recent condom non-use was far more prevalent among trafficked FSWs compared to non-trafficked FSWs (8.2% vs. 3.1%; p=0.02).
- Women who reported having been trafficked were far less knowledgeable regarding HIV transmission.
- Trafficked women were three times as likely to experience violence at initiation to sex work as compared to non-trafficked women and girls, as well as being more likely to report recent violence or mistreatment in the context of sex work.

1.4 Conclusions

In sum, the findings of this multi-country regional study for Southeast Asia provide consistent evidence that trafficking of women and girls for sexual exploitation places such individuals at high risk for HIV/STI infection. Trafficking victims appear to suffer qualitatively and quantitatively different and greater levels of sexual risk and STI/HIV infection, and are less likely to be reached by HIV prevention programs. Critically, consistent across the studies in this regional analysis is the use of physical and sexual violence and other forms of maltreatment against trafficked women and girls in the context of sex work. Thus, a key message of this regional study is the denial of the most basic elements of human dignity, health and wellbeing associated with the trafficking of women and girls for sexual exploitation. Beyond the human rights costs of such maltreatment, this abuse appears to play a central role in placing women and girls at extremely high risk for STI/HIV. Hence, in addition to the primary prevention of trafficking, consideration of trafficking within HIV harm reduction and other prevention efforts among female sex workers should be prioritized.

Such integration of trafficking and HIV may be challenging given the differing perspectives and priorities of partners involved in the prevention of HIV and of trafficking. Existing HIV harm reduction approaches are challenged by their structure and incentives that are in opposition to identifying and assisting trafficked individuals, combined with the often violent disempowerment of individuals inherent to trafficking. Current anti-trafficking programs and policies also face major obstacles in consideration of HIV prevention. Police involvement in identification and removal of underage or unwilling sex workers is criticized as resulting in the re-victimization and mistreatment of both trafficked and non-trafficked sex workers. Rescue operations involving police and others have in instances led to sex workers being less willing to cooperate in HIV education and harm reduction based on the increased vulnerability of sex work operations to being shut down and prosecuted related to contact with external agents of any kind. Although all of these concerns are valid, the choice between 1) providing HIV prevention services to this extremely vulnerable population, or 2) assisting children or others forced into sexual exploitation is not acceptable from either a public health or human rights perspective. We must move beyond to establish common ground, and begin a sincere dialogue leading to the development of programs and policies that provide desperately needed HIV prevention to sex workers, yet also assist those trafficked into sexual slavery.

2 INTRODUCTION

2.1 Sex Trafficking

Human trafficking is a major and widespread human rights concern, with conservative estimates of victims in the hundreds of thousands annually, the greatest concentration of such victimization occurring within South and Southeast Asia.[12] The majority of trafficking victims are thought to be women and girls,[10] with large numbers trafficked for the purposes of sexual exploitation (e.g. sex trafficking). According to the United Nations, human trafficking is the forced, coerced, fraudulent or deceitful entry in to sex work or other labor, including entry by abduction or entry into such work under age 18.[1] As noted previously, this definition is the subject of much debate, with many more recently arguing for the narrowing of this definition to exclude minors who report entering voluntarily, as well as those individuals who are not transported in the course of their exploitation. No official revision of the 2000 definition has taken place to date.

Young women who are trafficked are often lured with false promises of economic opportunities, travel, or marriage, unwittingly placing themselves under the control of traffickers who subsequently exploit and sell them - in the case of sex trafficking, into sexual bondage. Abduction via use of drugs and force is also common in this context.[2] The current and recent studies of this issue indicate that between 10 and 33% of current female sex workers (FSWs) have been trafficked into sex work.[13, 14] Studies conducted among women served by post-trafficking victim services have also found an overwhelming prevalence of both physical and sexual violence during trafficking,[15] further indicating the involuntary and violent nature of trafficking experiences.

Southeast Asia is a leading source, transit and destination region for trafficking of women and girls for sexual exploitation.[10] Within the region, Cambodia has been identified as both a high-risk source and destination country.[16] The overwhelming majority of sex trafficking incidents in Cambodia occur internally, drawing on women and girls from rural areas of the country as well as Vietnam.[9, 11] Indonesia similarly experiences internal trafficking from rural to urban areas.[8, 10] However, most often the country is a source[10] for destinations such as Malaysia, Japan, Saudi Arabia, among other locations primarily in Southeast and East Asia and the Middle East.[17] Thailand is considered a leading destination country for trafficking for the purposes of sexual exploitation within the region,[11] often drawing internally from communities in northern and rural Thailand as well as other major source countries including Myanmar, Yunnan province of China, Cambodia, and Laos.[4]

2.2 STI/HIV in Southeast Asia

The HIV/AIDS epidemics in Southeast Asia are widespread, but differ in prevalence and impact across nations. For the year 2007, approximately 75,000 people in Cambodia were living with HIV, with an estimated 7,000 deaths per year based on such infection. In Thailand, 610,000 people were estimated to being living with HIV by 2007, with 31,000 deaths due to AIDS in that same year.[18] Within Indonesia, 270,000 people are reported to be living with HIV, with approximately 9,000 AIDS-related deaths per year. Trends in population prevalence are also disparate. In Indonesia, for example, prevalence is described as rapidly increasing; although the population prevalence is currently estimated at 0.2%, increasing numbers

of new infections in this populous nation have led to this being described as one of the fastest growing HIV epidemics in Asia.[18] In contrast, Cambodia and Thailand demonstrate decreasing trends among the general population having earlier suffered high HIV prevalence,[18] with the most recent prevalence estimates at 0.9% and 1.7%, respectively.[18] This decrease is reported to be based on the implementation of the 100% Condom Use Campaign starting in the 1990's.[19-21]

2.3 Sex Trafficking and STI/HIV

Recent findings from South Asia illustrate the high prevalence of HIV among sex trafficking victims, across studies focused exclusively on trafficking victims [2, 22] as well as recent data indicating greater levels of HIV infection among trafficking victims as compared with their non-trafficked counterparts.[13, 23] Far less is known concerning relations of trafficking to STI/HIV in other nations facing epidemics of trafficking and STI/HIV, including Cambodia or Indonesia.

While sex work is widely acknowledged as a primary context for STI/HIV risk,[19] sex trafficking is thought to pose a number of unique and qualitatively different forms of STI/HIV risk. Sex trafficking may be a particularly salient STI/HIV risk context given immature reproductive tracts of younger women, which can facilitate STI/HIV acquisition;[24] limited power among trafficked victims to refuse unprotected sex or negotiate condom use;[3, 25] restrictions on mobility and limited access to preventive health services including STI/HIV prevention messages and treatment;[15, 25, 26] limited knowledge of STI/HIV transmission and prevention, particularly among those trafficked at young ages;[25] and extensive physical and sexual violence victimization[13, 15] which may serve to both facilitate HIV transmission as well as compromise sexual negotiation and condom use.

Beyond the STI/HIV-related consequences for individual sex trafficking victims, trafficking likely facilitates the continued spread of the HIV epidemic from high prevalence to low prevalence settings. Specifically, sex trafficking may be a critical factor in the spread of the HIV epidemic as young girls are trafficked from lower incidence areas to epicenters of the epidemic, consequently infected with HIV, and then return to lower incidence regions-of-origin.[2, 27] Also, these most vulnerable women and girls are less likely to be represented in sentinel surveillance efforts or, as presently demonstrated, in HIV prevention programs, or among those sex workers seeking medical care. Thus, the epidemic may be maintained among trafficking victims, although it may not be visible to authorities, even after substantial reductions are achieved among other populations. Hence, clarification of the extent of trafficking, STI and HIV among trafficking victims, and how experiences of such individuals relate to STI/HIV risk is critical in order for the public health and human rights communities to progress in prevention of both HIV and trafficking for sexual exploitation across Southeast Asia.

3 CAMBODIA: STUDY METHODS and RESULTS

3.1 Study Methods

Data were collected through the NGO Joint Statistics Project on CSE Trafficking 2005-2006 with funding support from the ANESVAD Foundation, led by ECPAT-Cambodia in collaboration with a national network of non-governmental organizations (NGOs) in Cambodia. The Project collected information from 25 NGOs representing 63 shelters, referral agencies and legal aid NGOs in 17 Provinces. The collaboration of these NGOs represent the myriad of services available to victims of trafficking for the purposes of sexual exploitation, including but not limited to temporary housing, health care (e.g. STI and HIV testing), counseling services, and legal aid. Many of these NGOs additionally provide support for victims of other forms of violence and exploitation (e.g., domestic violence and sexual assault), rendering them comprehensive in serving victims from a variety of forms of gender-based violence. Reflective of this design, comparisons with other forms of trafficking (e.g., trafficking for labor exploitation) were not possible.

In conjunction with participating NGOs, ECPAT-Cambodia developed a 66-item tool used to collect information on client records of trafficked women and girls receiving services at these organizations. Demographic characteristics, characteristics of the trafficking experience (e.g., destination, violence and disempowerment), health outcomes including STI and HIV, as well as aspects of service provision and criminal prosecution were collected. The data collection tool was also used to eliminate double-counting in the database. Given the large number of shelters operating independently, the significant number of referrals made between NGOs, the possibility that a woman/girl could be trafficked and rescued more than once, and the general mobility of the population, identification of duplicate records was critical. ECPAT-Cambodia conducted training to familiarize staff at each participating NGO with the data collection tool. Staff then reviewed the case and medical records kept at their NGO, and used the data collection tool to complete a standardized description of each trafficking case seen by their NGO during the relevant time period. The ECPAT-Cambodia data management team provided ongoing technical assistance during this process, and collected completed records sheets submitted by each NGO and entered the data into the ECPAT Cambodia system.

The current investigation consists of secondary analysis of data collected by ECPAT Cambodia via the procedures described above. Data were analyzed and compiled by researchers at the Harvard School of Public Health. For the purpose of the current analyses and consistent with the UN definition of human trafficking, trafficking victims were defined as those exposed to sex work who entered below the age of 18, or were forced or coerced into sexual exploitation. Of the 450 records collected within the ECPAT system for 2005-2006, the majority could not be classified as meeting criteria for sex trafficking, most often due to lack of confirmatory data such as age at trafficking or context of entry to sex work. Thus, the final sample for the current analyses included 136 individuals (i.e., 30.2% of the entire sample) meeting criteria for having been trafficked for sexual exploitation.

3.2 Results

3.2.1 Sex Trafficking Survivor Characteristics

Over half of the sample (52.2%) was age of 17 or younger at the time they were trafficked. Approximately one in three (32.4%) were between the ages of 18 to 21, while a smaller percentage (15.4%) were ages 22 and older at the time of trafficking. A majority (83.1%) of the sex trafficking survivors in the sample (N=136) were Cambodian and 16.9% were of Vietnamese decent. Primary education was reported by half the sample (54.6%) with almost a third of the sample (31.1%) reporting no formal education. While a small portion of the survivors were married or widowed, the vast majority were never married (86.1%). Consistent with recent trends in the region that demonstrate within-country trafficking as a primary mechanism,[9] 75.4% were trafficked to or within Cambodia. Other destination countries included Thailand (11.9%) and Malaysia (11.1%) with less than 2% being trafficked to Vietnam or China.

Table 3.2.1a Demographics characteristics of sex trafficking survivors (n=136)

	%
Age at trafficking	
<18 years	52.2
18-21	32.4
22 and over	15.4
Nationality	
Cambodian	83.1
Vietnamese	16.9
Education	
None	31.1
Primary only	54.6
Secondary or higher	14.3
Marital status	
Never married	86.1
Married/informal marriage	8.5
Widowed	5.4
Trafficked to	
Cambodia	75.4
Thailand	11.9
Malaysia	11.1
Other	1.6

Of the 136 women sampled, 14 were intercepted during trafficking and thus were removed from further analyses describing the nature of experiences during sexual exploitation and their relation to sexual health. Among the remaining 122 women, almost one in three women (30.0%) remained in sex work for greater than one year, with 18.6% remaining for 6 months to 1 year, 24.3% remaining for 2 months to 6 months, and 27.1% remaining for less than 2 months.

Notably, approximately 1 in 5 survivors reported that they worked with other trafficking victims during their sexual exploitation. These data suggest that some establishments may be relatively reliant on trafficked women and girls for sexual exploitation, while in other settings, victims are either isolated from other victims of trafficking or perceive themselves to be the only victim of trafficking. It is currently unclear as to whether these workplaces reliant on a greater portion of trafficked sex workers may be qualitatively riskier regarding STI acquisition. Given evidence from other regions and patterns noted in Cambodia, however, it may be hypothesized that such establishments may be known for younger or trafficked female sex workers and, consequently, perceived by male clients as allowing greater opportunity for condom non-use and/or sexual violence. However, further data are needed to test these hypotheses.

Being resold after having been trafficked was also common, with 16.8% of victims facing this experience. Frequent shuttling amongst work settings has been noted elsewhere, including India[2] and Thailand,[23] and is thought to maintain the anonymity of trafficked victims as well as maximizing client interest via repeated presentation of girls as 'new'. High mobility of sex workers has also been noted in countries such as Indonesia;[28] however, the shuttling experienced by trafficked sex workers is thought to be for the purpose of avoiding police detection. Moreover, as a consequence of the deception involved, trafficked women may experience disempowerment above and beyond what is experienced in other highly mobile populations. Exposure to new pools of clients and difficulty in identifying an opportunity to leave and/or access available health and social services are thought to pose additional risk for STI/HIV. Unfortunately due to missing data regarding STI for those reporting being resold, analyses regarding these hypotheses were not possible with the current dataset.

Table 3.2.1b Working conditions of sex trafficking survivors

	N=122
Duration of exploitation	
<= 2 months	27.1
2 months- 6 months	24.3
6 months-1 year	18.6
Greater than one year	30.0
Worked with other trafficking victims	
Yes	19.2
No	80.8
Was the victim resold	
Yes	16.8
No	83.2

3.2.2 STI/HIV Testing Coverage among Sex Trafficking Survivors

Of the 122 sex trafficking survivors, STI information was provided for 64 (52%), and HIV information was available for 63 (52%). The database did not provide information regarding method of STI and HIV testing, and these methods may have varied across NGOs participating in the ECPAT-Cambodia data collection effort. For example, STI/HIV testing may have been conducted onsite at some NGOs, with others contracting such services to local medical providers. Notably, both HIV and STI testing varied across the sample with respect to age at trafficking and destination of trafficking. Young women under the age of 17 were more likely to be tested for STI and HIV compared to their older counterparts.

Figure 3.2.2a Percentage of STI testing by the age at trafficking

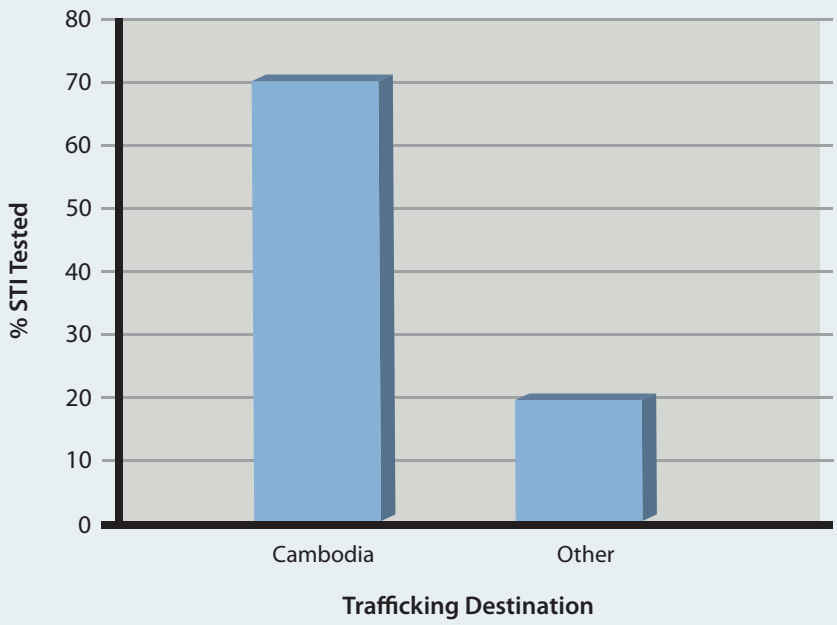
Similarly, those trafficked to/within Cambodia were more likely to be tested for STI and HIV compared to those trafficked to other countries, including Thailand, Malaysia, Vietnam and China. These findings may reflect differences in the availability of STI/HIV testing in Cambodia which has been scaled up in recent years,[29] differences across NGOs that primarily serve specific populations (e.g., younger victims or internally trafficked victims), or biases within NGOs regarding those at greatest risk and, thus, tested. Given the significant STI and HIV risks demonstrated among sex trafficking survivors, routine STI/HIV screening and treatment must be considered a critical component of comprehensive care for trafficking survivors; programs and services serving this population must be supported in implementing universal screening and subsequent testing based on informed consent. This appears to be a particularly urgent need in the Cambodian context.

3.2.3 HIV Prevalence

No cases of HIV were reported among the sample of those identified as victims of sex trafficking. Within the larger sample of 450 records assembled by ECPAT, there were 2 cases of HIV detected among those cases that could not be classified as meeting criteria for sex trafficking (i.e., under 18 years at time of entry to sexual exploitation, or evidence of force, fraud or coercion), although it is unclear whether infection occurred prior to or during trafficking. These individuals were 23 and 24 years old at the time that they were offered and accepted work as sex workers. There was no evidence that these individuals were tricked or forced into such experiences.

The very low number of HIV cases detected among this broader sample, as well as the absence of HIV cases detected among those identified as sex trafficking victims, is a surprising contrast with both previously identified high levels of HIV among sex trafficking survivors in other regions,[2, 13, 30] as well as evidence of HIV within the Cambodian population of sex workers [30-32] suggesting that this finding should be considered with caution. The decline of HIV within Cambodia's sex work context since its peak in the

Figure 3.2.2b Percentage of STI testing by trafficking destination



mid-1990's,[33] making exposure to sex work less risky with regards to HIV, may in part explain the very low number of HIV cases detected. The prevalence of such STI, however, clearly indicates the existence of unprotected sex and other risk behavior among this group. The low levels of HIV testing within the current sample are also of concern, and suggest that infected individuals may not have been detected. The need to support NGOs serving trafficking victims who have experienced sexual exploitation in their efforts to monitor HIV is paramount to protecting the health of these individuals as well as the broader public health interest. Finally, given the sensitivities surrounding disclosure of HIV status, it is also possible that NGOs participating in the NGO Joint Statistics Project were reluctant to report such information on behalf of their clients based on confidentiality concerns. Further research is needed to determine if the current findings accurately reflect the HIV prevalence among Cambodian women and girls trafficked into sex work, or is a biased underestimate based on patterns in HIV testing coverage and reporting.

3.2.4 STI Prevalence and Associations with Sex Trafficking Survivor Characteristics

Across the subsample of those tested for STI, 73.4% of trafficking survivors were STI-infected. STI status varied, although not significantly, based on age at trafficking, with those ages 22 and older reporting STI most often (88.9%). However, 76.3% of survivors trafficked under the age of 17 (a group that comprised over two thirds of the sample), and 58.8% of women trafficked at ages 18-21 reported STI, suggesting that infection is a major concern for all trafficked FSWs. Differences were also found based on nationality; 75.4% of trafficked women from Cambodia were STI infected, as compared to 57.1% of trafficked women from Vietnam. This result may reflect qualitative differences in cross-border trafficking experiences or work settings once trafficked into Cambodia. Further work is needed to understand differences in STI risk experiences based on national origin.

Figure 3.2.4a STI prevalence by the age at trafficking

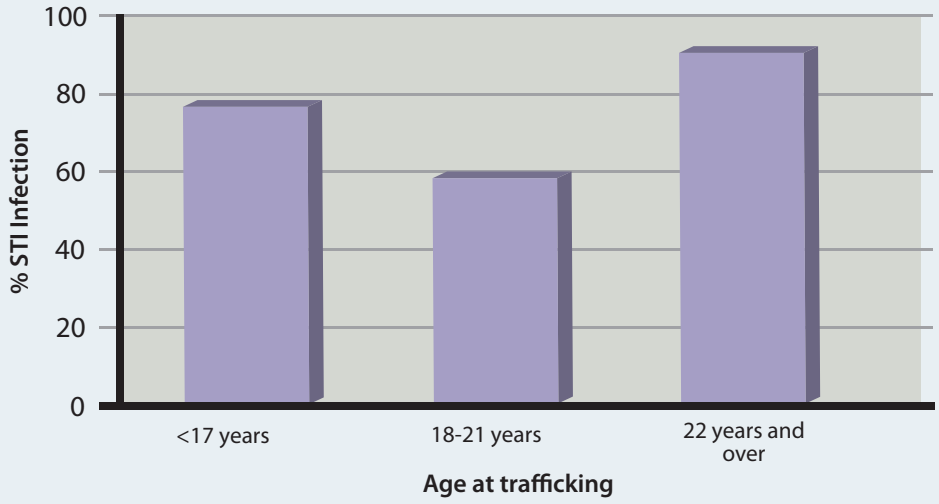
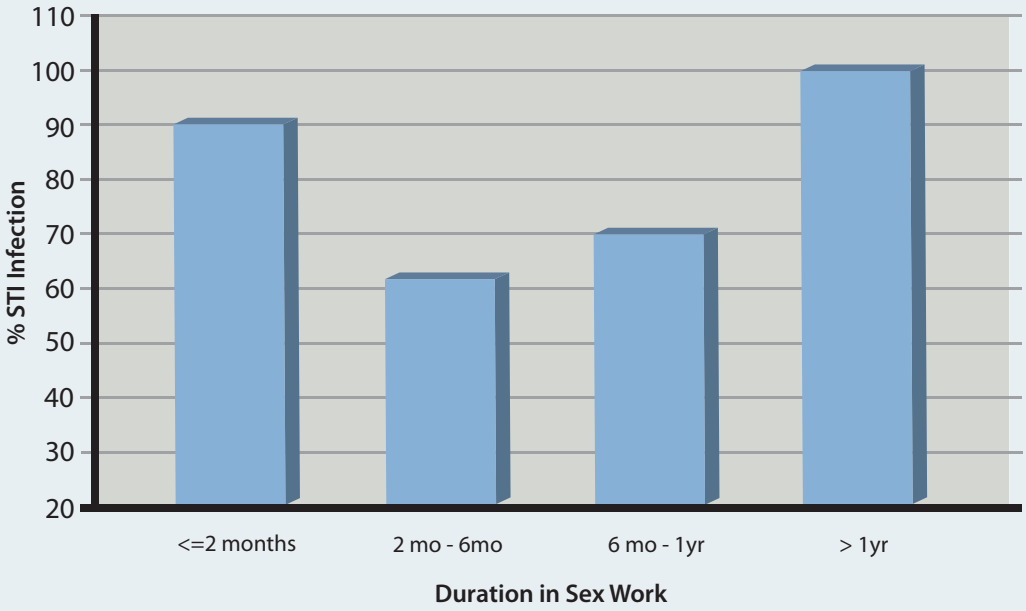


Figure 3.2.4b STI prevalence by the duration in sex work



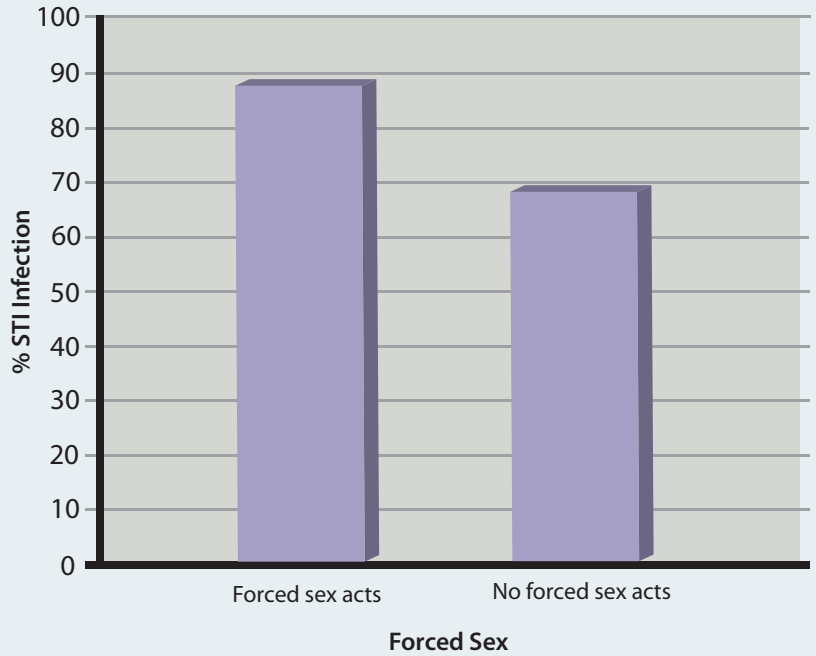
A clear yet complex relationship between duration of sexual exploitation and STI was identified (p=0.039). As illustrated in the graph below, those most recently initiated into sex work (e.g. those working less than 2 months) reported relatively higher rates of infection (90%). This is consistent with recent investigations from Cambodia[34] and South Asia,[13] indicating tremendous risk for STI in the early phases of sex work, potentially reflecting experiences of forced sex or forced unprotected sex. While not specifically tested in this investigation, research from India has highlighted the violent nature of initiation into sex work that trafficked women experience.[13] This violent and, thus, risky initiation is a likely contributor to the current findings as 15% of this group reported forced sex and 20% reported sexual abuse. However, among those trafficked into sex work for longer than 2 months, the prevalence of STI infection increased with duration. This trend has been found in prior investigations of sex trafficked women that demonstrate

increased levels of HIV with longer duration in sex work.[22] The U-shaped trend found here suggests that those who avoid infection upon entry into sex work face a higher risk for infection with increasing duration of their exploitation. Findings provide support for primary prevention of sex trafficking as likely the only means of avoiding the high levels of STI (and perhaps HIV, as found in earlier work) suffered based on extreme levels of sexual risk faced during the period of initiation to sex work. Efforts to identify and assist victims as early as possible should also be supported in order to reduce the risk of STI that increases with the length of their exploitation. Efforts to prevent sex trafficking and efforts to prevent STI should work in tandem.

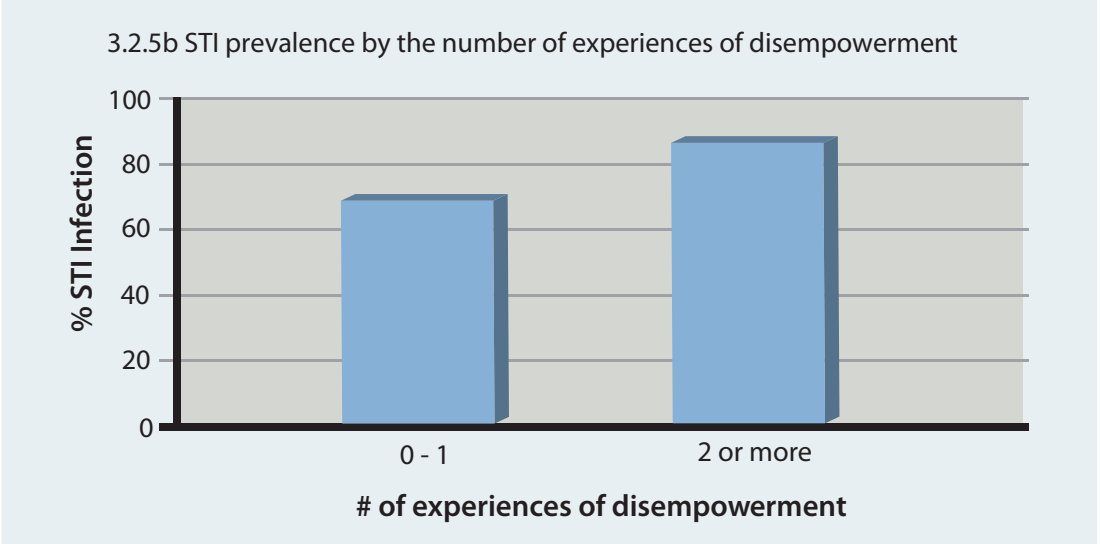
3.2.5 Violence, Mistreatment and STI

Sexual violence was prevalent among this sample of sex trafficking survivors. One in four survivors (25.0%) reported being forced to complete unwanted sex acts, while an even greater number (28.1%) reported sexual abuse in the context of trafficking and sexual exploitation. STI was common among sexual violence survivors in the sample. The experience of forced sex acts demonstrated a trend, though not statistically significant, towards elevated STI risk with 87.5% of those victimized STI infected as compared with 68.8% of their non-abused counterparts (p=0.145). Sexual violence may pose direct STI risk via forced sex and resulting lesions that may facilitate infection in the presence of STI exposure. Violence may also affect STI risk via indirect mechanisms, including compromised ability to refuse unwanted sex or negotiate condom use following experiences of sexual violence.

3.2.5a STI prevalence by the experience of forced sex acts



In addition to sexual violence, sex trafficking victims often face less obvious forms of maltreatment or disempowerment.[35] An index of disempowerment experiences was assembled to capture a range of forms of maltreatment including being deprived of food, detained when not working, not being paid or paid less than promised, not being allowed to leave the sex work venue, and the withholding of identity documents by the manager. One in four survivors (25.0%) experienced 2 or more forms of maltreatment. Such experiences were also related to elevated STI risk but, again not at a level that reached statistical significance.



These results highlight the vulnerability created by sexual violence as well as non-violent forms of maltreatment. Further research is needed to better understand the mechanisms potentially responsible for the observed patterns; for example, while beyond the scope of the currently available data, establishments within which women and girls are treated extremely poorly may also be environments in which condoms are less likely to be used or trafficked individuals are exposed to greater numbers of clients, or clients more likely to be infected.

4 INDONESIA: STUDY METHODS and RESULTS

4.1 Study Methods

The International Organization for Migration (IOM) operates a global network of shelters to provide rehabilitation and repatriation services to identified victims of trafficking. IOM monitors assistance and collects information on the trafficking survivors it assists. The IOM global human trafficking database is considered the world's largest database of primary data on registered victims of trafficking (VoTs), containing primary data on 12,500 registered victims of more than 80 different nationalities trafficked to more than 90 destination countries. The scope of data monitored varies extensively across countries, with the highest quality and quantity of data currently available via the Jakarta, Indonesia IOM Mission. The Jakarta IOM Mission has been using this standardized anti-trafficking data-management tool since 2002 to facilitate management of IOM direct assistance through a centrally managed system as well as mapping the survivor's trafficking experience. The Indonesia IOM Mission database includes data for survivors receiving services at four recovery centers (Jakarta, Pontianak, Surabaya, Makassar) based in Indonesia.

On arrival, each trafficking survivor receives a comprehensive medical evaluation and completes an in-take interview; the database is constructed based on data obtained via these mechanisms. The database includes quantitative data on demographic characteristics of trafficking survivors (e.g., age at trafficking, marital status), trafficking experiences (e.g., destination country, escape mechanism), workplace conditions and violence victimization therein, and STI and HIV laboratory testing results. Analyses were conducted to describe characteristics of trafficking survivors and trafficking experiences, and evaluate factors related to a) infection of any STI, including HIV, and b) HIV alone. The current analyses are limited to 509 female survivors of sex trafficking documented by IOM Indonesia from January 2005 through November 2008. Data were provided to the research team at the Harvard School of Public Health in a form that did not include any personal identifiers based on a Memorandum of Understanding between the IOM and the Harvard School of Public Health. The process also follows the IOM Data Protection principles governing the collection, processing, storage and transfer of data.

4.2 Results

4.2.1 Demographics of Sex Trafficking Survivors

The majority of women and girls who had been trafficked for sexual exploitation reported never being married (67.4%), with smaller numbers being married (11.6%) or divorced/separated (17.0%) prior to having been trafficked. The somewhat higher number of divorced/separated vs. married trafficking victims may, if this pattern is distinct from other migrant populations, support reports that young girls who are married in childhood and divorce early may be particularly vulnerable to exploitation into sex work. Nearly all of the women were of Indonesian nationality (99.1%).

The majority of women (52.0%) escaped from sexual exploitation with help from the police. A notable 30% of girls and women left on their own. These data suggest that 1) police may play an important role in

identifying and removing victims of sex trafficking, supporting the need for continuing support for such efforts, but only so long as human rights considerations of both sex workers and trafficking survivors are strictly ensured; and 2) the contexts in which trafficking victims may leave sex work on their own must be explored so as to enhance such opportunities.

Table 4.2.1 Demographic characteristics of sex trafficking survivors

	Total Sample N=509 %
Marital status	
Never married	67.4
Married	11.6
Divorced or separated	17.0
Widowed	4.0
How escaped	
Police	52.0
On own	30.7
NGO	8.2
Customer/Friend/Other/Employer	9.1

4.2.2 STI/HIV Prevalence

Table 4.2.2 shows the prevalence of STI/HIV infection among the total tested for each form of infection. The sample size was diminished slightly due to small amounts of missing data concerning STI/HIV test results, thus the total number tested has been provided for each STI/HIV outcome.

Table 4.2.2 STI/HIV prevalence among sex trafficking survivors

	% (n/N tested)
HIV	5.7 (19/331)
Syphilis	6.1 (20/326)
Gonorrhea	4.3 (21/487)
Trichomoniasis	5.1 (25/487)
Any STI and/or HIV	14.0 (68/487)

We found that 5.7% of the trafficked women and girls tested for HIV were infected. Although this is far higher than the prevalence of HIV infection in the Indonesian general population (estimated at 0.2%), it is slightly lower than the national HIV prevalence estimated for FSWs in Indonesia (9.5%).[18] Notably, the age of FSWs included in studies of sex work in Indonesia is consistently far older than that of the trafficking survivors in the present study; previous studies in which age was assessed involved FSWs

of mean age 27-31 years[36, 37] as compared to a mean age of 20 years among this sample of trafficked women and girls. Age of FSWs has related positively to greater likelihood of infection in previous work involving FSW samples. Further, mean duration of sexual exploitation among the current sample was 5 months, as compared to 13 months in the only FSW study where this information was reported. In fact, 7 out of 8 trafficking survivors in the current study faced less than one year of such exploitation. Notably, among those enduring more than one year in prostitution, the prevalence of HIV currently observed was far higher – 19.4%. Thus, given that previous studies if STI/HIV among FSW samples involved older participants enduring sexual exploitation for longer periods of time, comparisons of HIV and STI among younger and less 'experienced' women and girls in the current sample to other HIV estimation efforts is likely inappropriate. In fact, if we limit consideration to those trafficked for sexual exploitation for a period of greater than one year, a perhaps more comparable group based on duration in sex work documented elsewhere, we find that HIV prevalence among trafficking survivors appears to be significantly greater than that reported for FSWs not identified as trafficked.

Another critical concern in considering the relative risk of HIV among these women and girls as compared to other FSWs involves the lack of any comparable data for FSWs in Malaysia. The most recent data for HIV among sex workers in Malaysia were collected in 2000 and involved a convenience sample that was mostly comprised of transsexual individuals.[38] Given that almost one third of the current sample of trafficked women and girls were exploited in Malaysia, such data are needed to further consider whether trafficking presents additional risk for HIV infection among FSWs in this national setting.

Regarding the prevalence of other STIs, estimates for syphilis, gonorrhea, and Trichomoniasis ranged from 4.3-6.1%. These estimates are, similar to present findings for HIV prevalence, somewhat lower than those found among other samples of FSWs, e.g., prevalence of syphilis among FSWs in two earlier studies was 7.5-13.0%.[36, 37, 39] Overall, 14% of sex trafficking survivors tested had at least one STI (syphilis, gonorrhea, or Trichomoniasis, or HIV). However, as with HIV, the prevalence of STI/HIV infection was far greater among those women and girls enduring sex work for more than one year (23.1% vs. 11.7%; Table 4.2.2). Given that the current sample is far younger and likely endured sex work for far shorter periods than samples included in previous FSW studies of STI, such comparisons may not be informative in advancing our understanding of STI/HIV risk based on trafficking. Studies are urgently needed that involve sampling of FSWs in which trafficking history may be assessed so as to allow for true comparisons of HIV/STI risk among trafficked and non-trafficked women and girls while taking into consideration potential differences in age and duration of exposure.

4.2.3 Demographic and Trafficking Characteristics and STI/HIV Infection

Table 4.2.3 describes the demographic and trafficking characteristics of sex trafficking survivors and examines their association with STI/HIV infection among those with STI/HIV test results (n= 487). Nearly 50% of women were trafficked prior to age 18. Moreover, a significant portion were trafficked at very young ages, with 1 in 4 (24.5%) trafficked prior to age 15. Slightly more than 1 in 3 (37.4%) were trafficked between the ages of 18 and 24 years. In contrast with prior work in other settings,[2, 40] age at trafficking was not significantly related to STI/HIV infection.

The majority of women and girls were trafficked within Indonesia (61.4%), with the Malaysia constituting the second most common destination (32.7%). Approximately 5% were trafficked to Japan; and other countries to which victims were trafficked include Taiwan, Hong Kong, East Timor, and Saudi Arabia. Women and girls trafficked to countries outside of Indonesia demonstrated similar risk for STI/HIV infection compared with those who remained in Indonesia (16.0-17.0% vs. 12.0%).

Although the vast majority (87.5%) were trafficked for one year or less, those who were trafficked for more than 1 year had significantly greater risk for both HIV alone and STI/HIV infection (19.4% vs. 3.4%, p<.01[1]; and 23.1 vs. 11.7; p=.02). The observed increased risk for STI/HIV as length of time spent in sex work increases likely reflects more opportunities for STI/HIV infection, for example, due to greater number of sexual partners. Further, recent examinations of STI/HIV risk among trafficked vs. non-trafficked FSWs suggest that risk exposures are not only more likely among those trafficked, but that these higher risk exposures continue throughout the entire period of sex work.[23]

Notably, the median duration of trafficking experience was 5 months across the sample, which also serves to contextualize the prevalence of STI/HIV and HIV presently identified relative to that of other samples. For example, in a study by Ford et al.,[39] the sample of Indonesian sex workers reported a mean time in sex work was 13 months. Further work is needed to determine if, given similar levels of exposure, trafficking victims may be more likely to become infected with HIV and other STIs.

Table 4.2.3. Demographic and trafficking characteristics related to STI/HIV among sex trafficking survivors

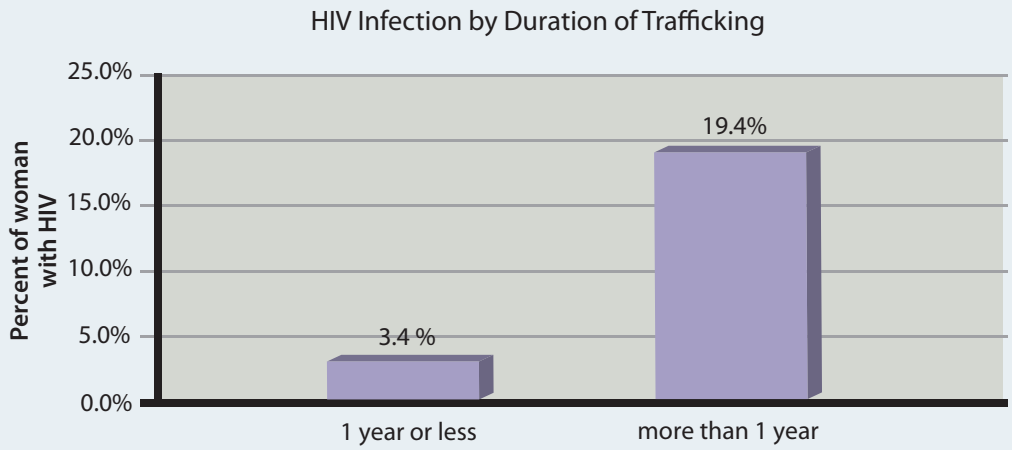
	Total Sample n=487 %	STI/HIV infected %	P value
Age at trafficking			0.616
<15 years	24.5	14.1	
16-17 years	22.0	9.0	
18 -24 years	37.4	13.9	
25 years and over	16.1	15.4	
Trafficked to			0.330**
Indonesia	61.4	12.0	
Malaysia	32.7	17.0	
Japan	5.1	16.0	
Other*	0.8	--	
Duration of Exploitation			0.024
<= 1 year	87.1	11.7	
More than one year	12.9	23.1	

**Note: Women trafficked to 'Other' locations include: Saudi Arabia, East Timor, Taiwan, and Singapore.*
***For comparison of being trafficked to Indonesia vs. Malaysia, p=.144.*

Characteristics examined above were also considered as risk factors for HIV infection alone. Similar to the pattern identified with STI/HIV, the risk of HIV infection was elevated based on having been exposed to sex work for longer than one year (3.4% vs. 19.4%; Figure 4.2.1). Also similar to results for the broader grouping of STI, HIV infection did not differ based on destination country (p=0.144), with 5.4% of those trafficked within Indonesia infected with HIV as compared with 5.0% of those trafficked to Malaysia. Very small numbers of women and girls trafficked to Japan and other destinations precluded meaningful

comparisons. Notably, 8 of the 10 HIV cases detected among sex trafficking survivors in Indonesia occurred among those trafficked to Riau and Kepulauan Riau provinces, perhaps reflecting qualitative differences in experiences among those trafficked to this area, or differences in HIV prevalence among the male client populations in this setting.

Figure 4.2.1 Percentage of HIV infection by duration of exposure



4.2.4 Working conditions: Mobility, Forced Substance Use, Deprivation, Wage Withholding

Although conditions and treatment within the context of sexual exploitation varied among sex trafficking survivors, most experienced multiple forms of abuse and maltreatment (shown in Table 4.2.4). In fact, 82.5% reported enduring 7 or more such exposures.

The majority were made to have sex with multiple male clients per day, with 1 in 8 (13.1%) reporting having been made to serve more than 6 per day. Most women and girls who had been sex trafficked reported having all mobility denied (76.6%). Forced substance use was also common, with 36.4% of women reporting having been forced to drink alcohol, and nearly a quarter (24.8%) being forced into drug use. Forced alcohol use was significantly associated with greater likelihood of having an STI/HIV (19.1% vs. 11.2%; p=.02), with forced drug use demonstrating a similar pattern with a trend towards elevated infection risk. Forced substance use may represent an extremely 'toxic' environment, likely resulting in victims' reduced ability to negotiate condom use, and perhaps involving male clients more likely to be infected based on their own drug use.

Other major forms of mistreatment included deprivation of food and water (45.7%), deprivation of needed health care (67.7%), enduring psychological abuse (79.7%), and being imprisoned in the context of sex work (34.8%). Nearly three-quarters of women (72.9%) were fully deprived of wages and 84.3% reported being forced to work excessive hours.

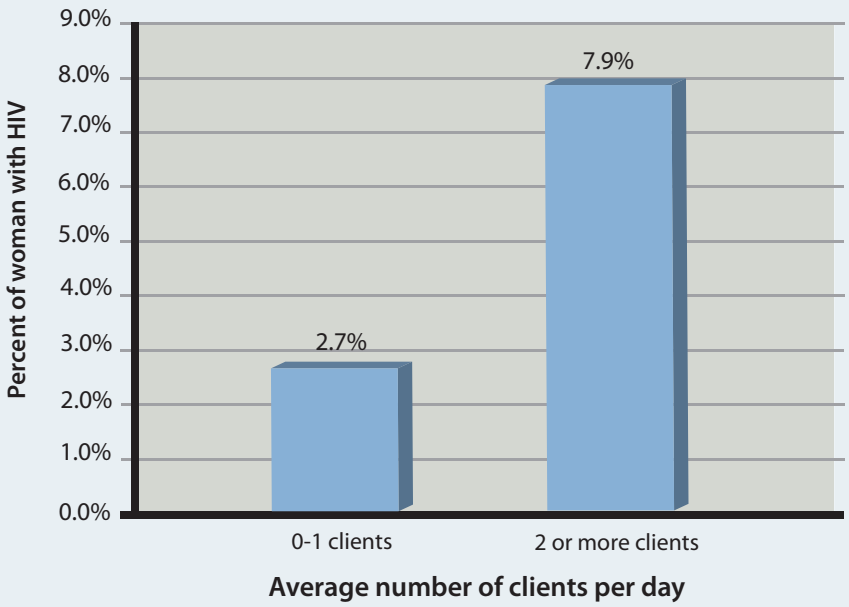
Trafficking survivors reported imprisonment during exploitation demonstrating a trend towards elevated STI/HIV infection with 17.9% of women reporting imprisonment having an STI/HIV compared to 11.9% of women not reporting imprisonment within sex work (p=0.075). Imprisonment may increase HIV/STI risk via accompanying forms of violence or maltreatment, reduced ability to negotiate condom use, or reduced access to health care services or health education programs. More information is needed to better understand how imprisonment within sex work may make sex trafficked women and girls vulnerable to STI/HIV.

Table 4.2.4 Conditions/treatment in the sex work context and STI/HIV among sex trafficking survivors

	Total Sample n = 487 %	STI/HIV infected n = 68 %	P value
Customers per day (average)			0.761
0-1	40.8	12.6	
2 -5	46.1	14.7	
6 or more	13.1	16.1	
Denied movement			0.616
Totally denied	76.6	13.2	
Partially denied	18.7	17.2	
No restriction imposed	4.7	13.6	
Traded across employers			0.197
Yes	16.3	18.7	
No	83.6	13.0	
Forced alcohol use			0.020
Yes	36.4	19.1	
No	63.6	11.2	
Forced drug use			0.085
Yes	24.8	19.1	
No	75.2	12.6	
Poor sanitation			0.268
Yes	42.3	11.8	
No	57.7	15.4	
Deprived food and water			0.932
Yes	45.7	13.9	
No	54.3	13.6	
Deprived healthcare			0.565
Yes	67.7	13.1	
No	32.3	15.0	
Psychological abuse			0.603
Yes	79.7	13.4	
No	20.3	15.5	
Ideological pressure			0.756
Yes	30.9	13.3	
No	69.1	14.4	
Imprisoned			0.075
Yes	34.8	17.9	
No	65.2	11.9	
Fully deprived of wages			0.375
Yes	72.9	12.5	
No	27.1	15.6	
Forced into excessive working hours			0.697
Yes	84.3	13.9	
No	15.7	12.2	
Exposure to any workplace disempowerment and/or violence			0.245
Less than 7 of the above factors	17.5	8.3	
7 or more of the above factors	82.5	15.9	

Characteristics examined above were also considered as risk factors for HIV infection alone; the sole factor identified as related to HIV was number of clients per day (see Figure 4.2.2 Percent HIV Infected by Number of Clients). Larger number of clients was associated with a trend towards increased HIV infection prevalence, as 2.7% of those with 0-1 clients per day on average were HIV infected as compared with 7.9% of those seeing 2 or more clients per day (p=0.066).

Figure 4.2.4 HIV infection by average number of clients per day



4.2.5 Violence Victimization and STI/HIV Infection

Experiences of physical and sexual violence were found to be very common among sex trafficking survivors; 81.1% reported being physically or sexually abused in the context of trafficking and sexual exploitation.

Table 4.2.5 Violence victimization among sex trafficking survivors tested for STI/HIV (n=487)

	Total Sample n = 487 %	STI/HIV infected n = 68 %	P value
Physical abuse			0.759
Yes	42.7	13.3	
No	57.4	14.3	
Sexual abuse			0.263
Yes	74.7	14.9	
No	25.3	10.8	
Physical or Sexual abuse			0.878
Yes	81.1	14.0	
No	18.9	13.3	

STI/HIV infection was found to be more common among sex trafficking survivors reporting sexual abuse than those who did not, but this difference does not reach statistical significant (14.9% vs. 10.8%; p=0.26). The ability to detect differences in STI/HIV infection based on experiences of sexual violence may be compromised by variation in experiences of violence victimization within the three quarters of sex trafficking survivors who indicated such experiences. For example, STI/HIV risk may vary based on qualities of violence victimization within trafficking for sexual exploitation not fully captured within the current study, e.g., the relative severity and frequency of abuse.

Nonetheless, the high prevalence of physical and sexual violence victimization identified is notable, and demonstrates consistency with prior work conducted among sex workers with and without attention to trafficking.[13, 41-43] Violence is thought to pose STI/HIV risk via direct mechanisms (e.g., lesions associated with forced sex that may facilitate transmission) as well as indirectly (e.g., via compromising victims' future ability to refuse sex or negotiate condom use for fear of violent repercussions). Notably, while not fully captured within the current study, women and girls who have been sex trafficked likely face physical and sexual violence victimization from a number of different perpetrators, ranging from traffickers themselves to clients, brothel managers and even police;[44] further work is needed to better understand experiences of violence among victims of sex trafficking and others in sex work, as well as mechanisms by which such experiences may pose STI/HIV risk.

4.2.6. Multivariate analyses predicting HIV and STI/HIV

Statistical models to simultaneously consider the associations of forced alcohol use, forced drug use, imprisonment, customers per day, and duration of exposure to sex work were constructed in an attempt to clarify the relative role of these factors in STI/HIV infection. The only statistically significant predictor of HIV infection was duration of exploitation for longer than one year (AOR 4.70, 95% CI 1.61, 13.73). A similar trend towards elevated STI/HIV risk was identified based on duration of exploitation greater than one year (AOR 1.98, 95% CI 0.96, 4.08). One likely explanation of these findings is that longer duration may represent greater opportunity for exposure or accumulated exposure to sexual risks that are indicated by other factors. To better understand the individual roles and temporal ordering of these risk exposures, longitudinal studies are typically called for; however, such efforts are clearly unethical in this context. Although valid concerns exist regarding recall bias, clarity on these and related issues may be achieved via retrospective data collection involving detailed reporting on succeeding periods of exposure.

5 THAILAND: STUDY METHODS and RESULTS

5.1 Study Methods

Data were collected between February and March of 2007 by the Institute for Population and Social Research (IPSR) at Mahidol University (Bangkok, Thailand), in collaboration with local non-governmental organizations (NGOs) in Bangkok, Chonburi, Chiang Mai and Songkhla, Thailand. The sample was constructed to approximate the proportional number of sex workers in each province as reported by the STI Division, Ministry of Public Health of Thailand. Local NGO staff within each province developed maps of sex work establishments to facilitate recruitment and understanding of the distribution of sex workers and the types of sex work venues (i.e. massage parlors, brothels, karaoke bars, etc). Within each province, venues were stratified based on factors such as type of establishment, price range, and number of sex workers prior to being randomly selected based on the maps developed. Female sex workers (FSWs) working in these establishments were invited to participate in the study; sampling of FSWs was proportional to establishment size such that establishments employing larger numbers of FSWs had greater numbers enrolled. Of 301 invited, 202 establishments agreed, for a venue participation rate of 67.6%. At each participating establishment, FSWs were approached for recruitment by the research team; sampling was proportional to establishment size such that establishments employing larger numbers of FSWs had great numbers enrolled. Of the 1,025 participants recruited, 815 consented to participate for a response rate of 79.5%. The survey was administered by trained interviewers in Thai in a private location within the establishment. Two items were used to assess trafficking status among FSWs; FWS were characterized as having been trafficked if they were under the age of 18 at their first paid sexual encounter, or if they entered sex work via force, fraud or deception. Single items were used to assess demographic characteristics as well as forms of STI risk. HIV knowledge was assessed via a seven-item scale (e.g., "can a person get HIV by sharing a meal with someone who is infected?"); responses were summed and tertiled for analysis. Resulting data were analyzed by researchers at the Harvard School of Public Health in consultation with both IPSR and NGO representatives.

5.2 Results

5.2.1. Sex trafficking and FSW characteristics

Approximately one in ten (10.4%) FSWs in the sample indicated they met the criteria for sex trafficking (i.e., began sex work under the age of 18 years, or entered via mechanisms of force, fraud, or deception). Sex trafficked FSWs were younger in age as compared with non-trafficked FSWs (as would be expected based on the definition of trafficking utilized), and were also found to have been involved in sex work for longer periods of time as compared with non-trafficked FSWs; this finding of longer duration of servitude among young trafficking victims is consistent with an earlier study of trafficked Nepalese girls.[2]

Table 5.2.1 Characteristics of sex workers (n=815)

	Total Sample n = 815 %	Trafficked n = 85 %	Non trafficked n = 730 %
Age at entry*			
17 years or under	9.4	89.4	0
18 to 21 years	26.8	3.5	29.5
22 years or older	63.7	7.1	70.4
Current Age*			
14 to 23 years	30.6	60.0	27.1
24 to 30 years	36.3	21.2	38.1
31 or older	33.1	18.8	34.8
Duration*			
< 1 year	30.5	10.6	32.8
1 year	18.2	7.1	19.5
2 years	10.8	9.4	11.0
3 years	40.5	72.9	36.7
Setting			
Karaoke	17.4	21.2	17.0
Massage Parlor	11.4	8.2	11.8
Beer Bar	26.4	12.9	28.0
Freelance	18.2	27.1	17.1
Brothel	16.3	21.2	15.8
Other	10.3	9.4	10.4

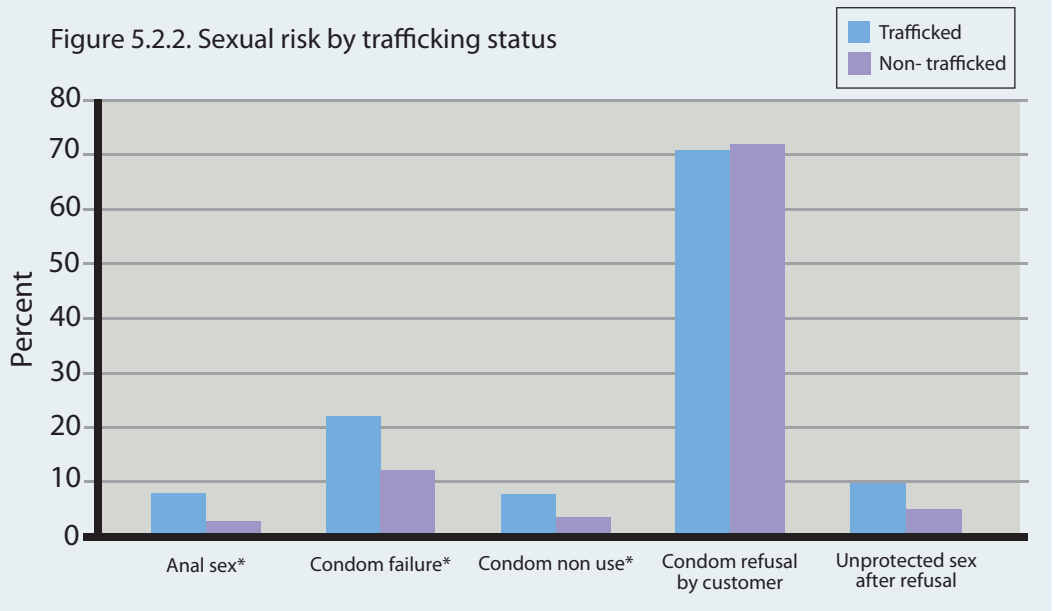
** indicates statistical significance at p<0.05*

Sex work setting varied based on trafficking status, with trafficked FSWs more likely to work in freelance settings (27.1% vs. 17.1%) and brothels (21.2% vs. 15.8%), and less likely to work in beer bars (12.9% vs. 28.0%%). These particular findings should be considered with caution; while it is likely that trafficking status does influence the types of establishments in which FSWs work, it is also possible that these findings reflect differences in the ability of the research team to access trafficked FSWs in certain settings. Further research is needed to confirm this finding. No differences in ethnicity or recruitment region were detected based on trafficking status.

5.2.2. Sexual Risk

Sex trafficked FSWs were found to face greater STI/HIV risks in a number of different ways. Trafficked FSWs experienced greater levels of sexual exposure, reporting an average of 33.4 vaginal sex episodes with clients in the past month as compared with only 24.6 such acts among those non-trafficked ($p=0.03$). Anal sex, which represents a relatively high level of HIV risk, was three times as common among sex trafficked FSWs (8.2% vs. 2.6%; $p<0.01$). These higher levels of sexual exposure (i.e., exposure to STI/HIV) may reflect greater client demand for younger, trafficked women, limited negotiation capacity to refuse sex, and/or greater pressure to have sex with higher numbers of clients. Trafficked FSWs also faced greater difficulties in negotiating proper condom use, with 22.4% of trafficked women reporting recent condom failure compared to 12.4% of non-trafficked FSWs. This roughly doubling of condom failure may reflect limitations in knowledge about correct condom use, perhaps due to limited access to condoms, or male clients' lack of attention to correct condom use with these most vulnerable individuals. Recent condom non-use (past 5 vaginal sex acts) was also far more prevalent among trafficked FSWs compared to non-trafficked FSWs, with trafficked women reporting 3 times the number of incidents in which a condom was not used (8.2% vs. 3.1%; $p=0.02$). These indicators of reduced condom use among sex trafficked FSWs are particularly concerning in light of their higher levels of sexual exposure described above. Lifetime experience of client condom refusal was common among the total sample (71.5%); no differences were detected based on trafficking status. However, proceeding to having unprotected sex after a client refused to use a condom was twice as common among trafficked vs. non-trafficked FSWs (10.0% vs. 5.2%; not statistically significantly different based on small numbers of reports). This potential difference in trafficked women's capacity to refuse unprotected sex may reflect clients seeking out those younger and more vulnerable FSWs. While not available within the current study, understanding of the frequency and recency of experiences of client condom refusal is needed to add additional clarity regarding differences in related sex risk based on sex trafficking status.

Figure 5.2.2. Sexual risk by trafficking status



5.2.3. Violence

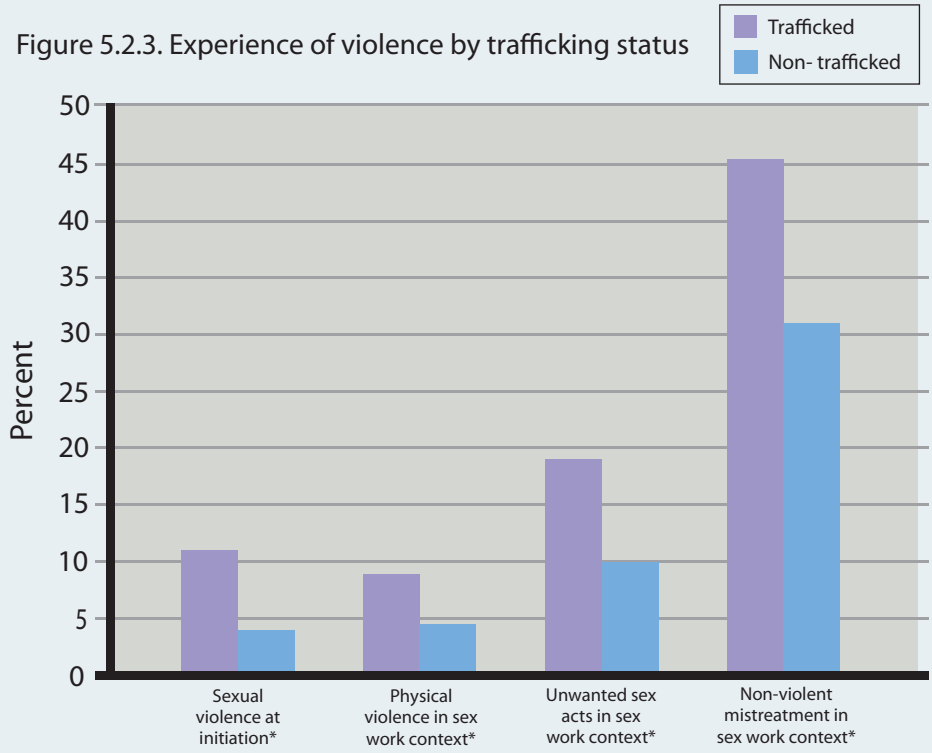
As compared with their non-trafficked counterparts, sex trafficked FSWs were approximately three times as likely to have experienced sexual violence at initiation to sex work; 11.8% of trafficked FSWs reported this compared to 3.6% of non-trafficked FSWs ($p<0.01$). As discussed earlier, such sexual violence may

well provide the critical and early opportunity for infection explaining higher levels of HIV among the youngest FSWs in earlier studies.[2, 45]

While an estimated one third (36.6%) of the sample had experienced recent non-violent mistreatment (e.g., being yelled at, not being paid or paid less than agreed, or made to do other unwanted acts), those entering sex work via trafficking were approximately 50% more likely to report such experiences (51.8% vs. 34.8%; p<0.01). Of note, a higher prevalence of reported unwanted sex acts in the context of sex work was also reported by trafficked FSWs (18.6% among trafficked vs. 10.7% among non-trafficked, p<.01), again indicating limited ability to negotiate sex or sexual protection.

The greater levels of violence victimization combined with greater levels of sexual risk faced by trafficked FSWs clearly demonstrate a lack of power or control over their lives and bodies as compared to other FSWs. To maintain control over an individual in any situation of forced labor, violence and the threat of violence are critical tools; perhaps the most vivid and disturbing example is the violent sexual initiation of trafficking victims in order to force them to comply with demands to have sex with male clients. As reported in earlier work,[22] those trafficked into sex work who do not comply willingly with such demands, likely set the stage for this sexual brutality to overcome initial resistance. Further, such resistance as well as trafficked FSWs likely relatively low status among FSWs overall may make it more likely that multiple forms of violence will continue beyond the period of initiation, as currently demonstrated.

Figure 5.2.3. Experience of violence by trafficking status



* Indicates statistical significance at p<0.05

Beyond the broader mental and physical health consequences of sexual violence, sexual violence at initiation to sex work and beyond poses a number of risks for HIV infection. Such physical trauma to the genital tract, particularly in the cases of younger girls, may directly facilitate HIV infection. Beyond the initial assault, such women and girls may be forced or coerced to have sex with additional men prior to healing of wounds from the violence, thus extending their heightened vulnerability to HIV. Finally, early sexual violence victimization may also disempower trafficked FSWs regarding future sexual or condom negotiations with clients. These findings indicate that existing HIV prevention and education efforts

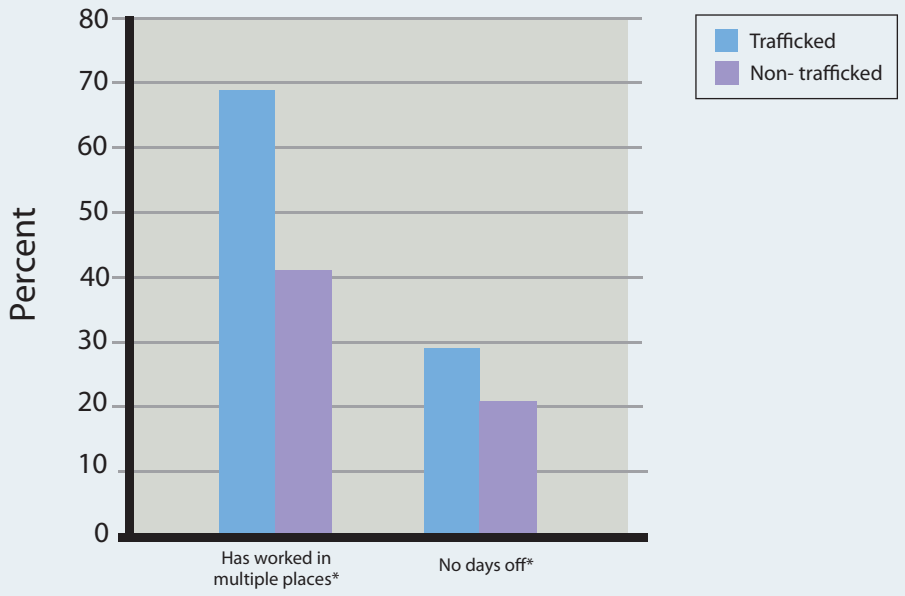
targeting FSWs may face a significant limitation in that FSWs, particularly trafficked women and girls, are at high risk of becoming infected prior to having any opportunity to access such programs.

As discussed earlier, the greater prevalence of recent violence victimization (for this sample, long after initiation) among trafficked FSWs suggests that being trafficked into sex work may pose ongoing vulnerability throughout the time that they participate in sex work. This continuing violence likely leads to extreme disempowerment, may manifest in reduced sexual decision-making or condom negotiation power, and may explain findings of greater condom non-use and condom failure found among trafficking victims, both within brothel establishments and other indoor settings as well as amongst free-lance FSWs. Further research is needed to disentangle the role of pimps and other types of managers in controlling condom use and perpetrating violence against FSWs across this range of settings.

5.2.4. Working conditions: Mobility and Days Permitted without Sex Work

As illustrated below, having worked in multiple locations was also more prevalent among trafficked FSWs than non-trafficked women (69.4% vs. 41.2%; $p<0.01$).

Figure 5.2.4 Working conditions by trafficking status



* Indicates statistical significance at p<0.05

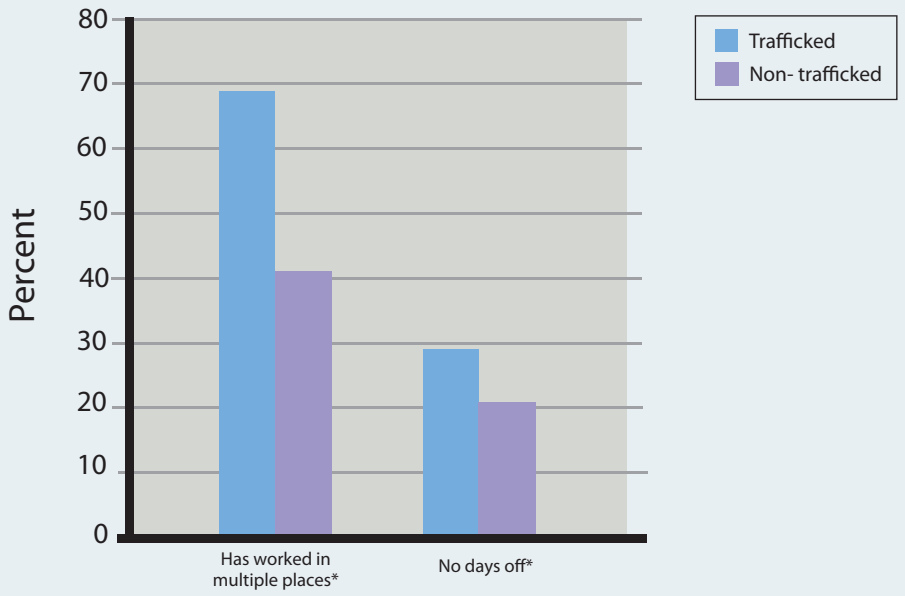
This finding is consistent with prior research from South Asia[2] and supports contentions that these victims may be shuttled between workplaces to avoid police and/or NGO detection,[46] as well as to be presented as new/virginal to a new community of male clients; previous work has demonstrated that men will pay far higher prices for sexual access with younger girls and those perceived to be virgins.[46] Such mobility also likely poses a critical barrier to the ability of sex trafficking victims to access help and health care,[47] and may both prolong their victimization and increase their risk of developing serious health concerns.

Though not statistically significant, trafficked FSWs also were more likely than those not trafficked to report that they do not have any days during which they are permitted not to participate in sex work (29.4% vs. 21.4%), further adding to our understanding of the qualitatively different experiences of sex work among trafficked FSWs reflective of their lower status and lack of control over their lives and participating in sex work.

5.2.5. STI/HIV Knowledge, Testing, and Access to Information

Approximately two thirds (67.3%) of the sample had ever received an STI test, and 83% reported having received an HIV test. These outcomes were not found to vary based on sex trafficking status. Such results suggest that education and access to STI/HIV services represent continuing unmet needs among the population of Thai FSWs overall, in addition to the needs specific to sex trafficked FSWs. While unavailable within the current data, future research to clarify the sources of HIV and STI testing for both trafficked and non-trafficked FSWs is needed to understand the types of services utilized by these groups and identify potential settings for intervention for trafficked FSWs.

Figure 5.2.4 Working conditions by trafficking status

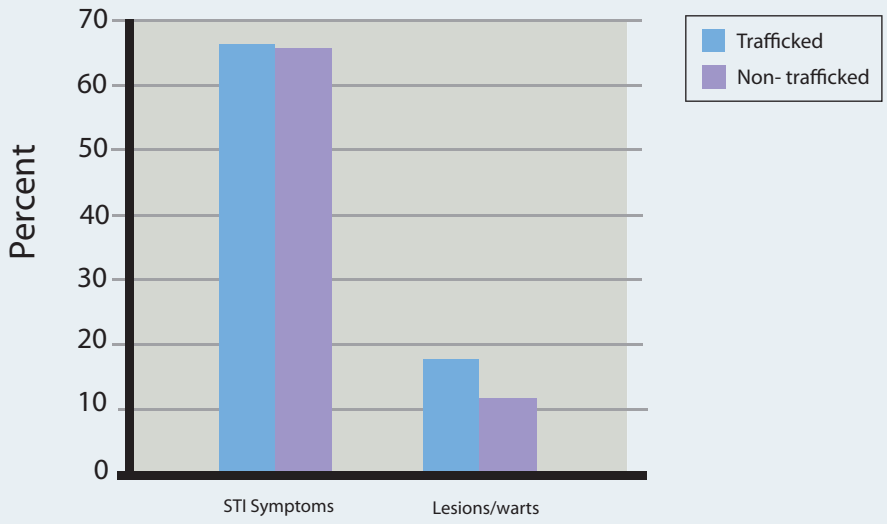


Unlike STI/HIV testing outcomes, HIV knowledge did vary based on trafficking status. Sex trafficked FSWs demonstrated lower levels of HIV knowledge relative to non-trafficked FSWs (p=0.04), consistent with concerns that those trafficked into sex work at early ages may have less access to such information. This lack of access may well reflect difficulties of HIV prevention programs in reaching sex-trafficked FSWs based on their greater isolation from health care and other assistance,[47] concerns among those controlling sex trafficking victims that the presence of those presenting as underage or being there against their will lead to sanctions by HIV educational agencies, or unwillingness of the part of HIV educational agencies to operate in settings involving younger FSWs in order to avoid the ethical issues that might arise. Such concerns are often described as being based on the reduced access to all FSWs that may result from HIV education agents acting against those responsible for allowing such agents to work in these settings.

5.2.6. Sexually Transmitted Infection (STI) Outcomes

Recent STI symptoms (i.e., lesions, warts, itchiness, lower abdominal pain, pain when urinating) were common across the sample, with approximately two thirds reporting any such symptom during the past four months. Report of grouped recent STI symptoms was not found to vary based on sex trafficking status. However, trafficked women and girls were somewhat more likely to report lesions or warts as compared to other FSWs (17.9% vs. 11.8%; p=0.11).

Figure 5.2.6. STI symptoms by trafficking status



The syndromic approach to STI assessment, though recommended for settings which lack diagnostic facilities,[48] is limited in its specificity. Further investigation of STI/HIV outcomes among FSWs based on their trafficking status is needed, particularly given clear evidence of elevated sexual risk among trafficking victims. A trend towards elevated risk for lesions or warts for trafficked FSWs may reflect higher prevalence of ulcerative STI and suggests elevated risk for further transmission of infection including HIV. Further, lesions may reflect recent or prior genital injury, indicating both experiences of sexual violence and greater vulnerability to STI/HIV.

5.2.7. Demographics, Sexual Risk and STI among Sex-trafficked FSWs

Restricting our analyses to those FSWs meeting criteria for sex trafficking (n=85), several demographic and sexual risk factors were related to STI infection. Among those reporting anal sex in the past month, 100% were STI infected ($p<0.05$). A trend toward increased STI risk based on multiple work locations was also detected; 71.2% of trafficked victims who worked in multiple settings were STI infected as compared with only 53.9% of those who stayed in one location. Among those reporting recent physical violence, 100% were STI infected as compared with 62.8% of those not exposed to such violence ($p<0.05$). A trend towards increased STI risk was also detected based on exposure to recent unwanted sex acts; 87.5% of trafficked victims violated in this way were STI infected relative to only 60.9% of those not victimized in this way. Notably, non-violent maltreatment also related to STI infection, with those experiencing non-violent forms of maltreatment such as verbal abuse or being made to do unwanted acts not involving sex observed to be over four times as likely to be infected as compared with their non-mistreated counterparts. Taken together, these findings illustrate the dual roles of sexual risk and disempowerment as represented by violence and maltreatment in posing STI risk to sex-trafficked FSWs.

Table 5.2.7. Demographic, sexual risk and STI among sex-trafficked FSWs

	STI Infected	OR (95% CI)
Age at entry		
14 years or under	71.4	1.08 (0.34, 3.42)
15-16 years	52.4	0.48 (0.16, 1.40)
17 years or older	69.8	-ref-
Duration		
< 1 year	66.7	1.25 (0.21, 7.62)
1-2 years	71.4	0.91 (0.21, 4.00)
3 years	64.5	-ref-
Vaginal sex without a condom		
Yes	85.7	3.36 (0.38, 29.33)
No	64.1	-ref-
Condom failure		
Yes	82.4	2.98 (0.77, 11.53)
No	61.0	-ref-
Anal sex in past month		*p<0.05
Yes	100.0	
No	62.8	
Multiple work locations		
Yes	71.2	2.12 (0.82, 5.50)
No	53.9	-ref-
HIV knowledge		
Low	72.7	1.33 (0.43, 4.18)
Medium	57.1	0.67 (0.22, 2.07)
High	66.7	-ref-
Physical violence in past week		*p<0.05
Yes	100.0	
No	62.8	
Unwanted sex acts in past week		
Yes	87.5	4.50 (0.95, 21.38)
No	60.9	-ref-
Non-violent maltreatment in past week		
Yes	82.1	4.19 (1.54, 11.41)
No	52.2	-ref-

* *Odds ratio not supported due to empty cells; p value based on chi-square analysis*

5.2.8. Empirical Consideration of Alternate Definitions of Trafficking to Assess Consistency of Results

While the current report defines sex trafficking as the forced, fraudulent or deceitful entry into sex work, entry by abduction, or entry into such work under age 18, based on the UN Palermo Protocol,[1] as discussed earlier, the ongoing debate concerning the definition of sex trafficking must be acknowledged. The elements of force, fraud, and deceit are generally agreed on components of sex trafficking, but elements such as the age criteria (e.g., under age 18 at entry) are considered arbitrary by some. While there can be no doubt of the harm caused to children by involvement in sex work, the question remains as to whether this should be considered child sexual exploitation, or commercial sexual exploitation of children, for example, rather than part of the definition of sex trafficking. Others have argued that trafficking must by definition include travel or transport, either within or across geographic boundaries, to reflect the forced migration element common amongst trafficking victims.

To inform this debate, post-hoc analyses were conducted of the current sample to consider an alternate definition of sex trafficking; specifically forced, fraudulent, or deceitful entry into sex work only (i.e., without consideration of the under age 18 component of the definition). For these post-hoc analyses, FSWs indicating that their entry to FSW was under conditions of force, fraud, or deceit, including violent sexual initiation as an element of force, were considered to have been sex trafficked, with those not reporting such elements defined as not sex trafficked. Given current and prior evidence that early age at entry to sex work confers negative health consequences as well as sexual risk, post-hoc analyses were limited to those individuals that entered FSW at or over the age of 18 years, to avoid the introduction of confounding.

Among FSWs who began sex work at or over the age of 18 years, 4.8% met criteria for the alternate definition of trafficking (i.e., entry via force, fraud or deceit, including sexual violence at initiation). The relatively small number of those meeting criteria for trafficking limited statistical power to compare differences in HIV risk behaviors based on trafficking; however, several trends towards elevated sexual risk were noted, demonstrating consistency with findings presented earlier within the report. Specifically, trafficked FSWs were more likely to experience recent condom failure (18.2% vs. 12.8%, $p=0.366$); work in multiple locations (48.6% vs. 41.2%, $p=0.386$), face violence or mistreatment in the workplace (42.9% vs. 34.8%, $p=0.331$), and have had recent unprotected sex (5.7% vs. 2.9%, $p=0.346$). While not statistically significant at the $p<0.05$ level in part due to small cell sizes, these findings echo those presented earlier and suggest elevated sexual risk among trafficking victims classified by the alternate definition.

Further research aided by larger sample sizes is needed to extend and confirm these findings, both in Thailand and elsewhere. Investigation of extent and role of force, fraud or deception is strongly indicated; recent findings from a small sample of FSWs in Nicaragua demonstrated that an estimated 2 in 5 FSWs entered via force, coercion or deception,[49] suggesting that this element of trafficking may be prevalent in some national and regional settings. The current investigation was not able to assess other elements of alternate sex trafficking definitions that may be under consideration, e.g., transport; however, further research into these distinct components of potential trafficking definitions is recommended to best clarify the most relevant elements of this concept, and ultimately inform policy and programmatic efforts to assist those victimized.

Nonetheless, when considering either the definition indicated by the UN Palermo protocol (i.e., age<18 at the time of entry or entry via force, fraud or deception), or an alternative definition consisting only of the force, fraud, or deception elements (i.e., that used in the post-hoc analyses), trafficked FSWs appear to

demonstrate greater sexual risk for the contraction of STI/HIV. Should the age criteria for sex trafficking be dropped, prior evidence of the harm to those entering FSW prior to age 18 (e.g., Silverman et al., 2008)[40] strongly indicates that children in FSW be prioritized as a population in need of assistance regardless of whether they are deemed to have been trafficked and/or victims of child sexual exploitation.

6 RECOMMENDATIONS and CONCLUSIONS

Across all three country studies, our findings consistently indicate that trafficking for sexual exploitation relates to high risk for STI/HIV among women and girls, with victimized women and girls facing high levels of exposure to conditions and experiences within the sex work context that have placed them at risk for such infection. Further, in direct comparisons of trafficked to non-trafficked sex workers, trafficked women experienced significantly higher rates of STI/HIV risk factors as well as actual infection. It is also critical to observe that across all of the studies in this regional analysis, physical and sexual violence as well as other forms of maltreatment were used against trafficked women and girls in the context of sex work. Such abuse may well make trafficking victims further vulnerable to STI/HIV by making resistance to unsafe sex and negotiation of condom use less likely. These findings also demonstrate the tremendous costs of sex trafficking in terms of the loss of human dignity, health and wellbeing for women and girls. Taken together, this evidence clearly supports the need to consider trafficking for sexual exploitation as a key concern within regional efforts to reduce and prevent HIV.

Increasing understanding of the sources of risk for being trafficked among vulnerable populations and how these vulnerabilities may be reduced is urgently needed, as primary prevention of trafficking may well represent a critical, yet missing, component of HIV prevention within Southeast Asia. As important, these results point to the need for the careful integration of trafficking prevention efforts with HIV prevention programs among FSWs and greater consideration of STI/HIV vulnerability in efforts to identify and assist sex trafficked women and girls in the context of sex work. All such efforts should be evidence-based and supported by a comprehensive research agenda on both trafficking prevention and the implications of trafficking for HIV, with the current report and other initial investigations viewed as a starting point, not conclusion, in this process.

An initial step in considering mechanisms by which to integrate these dual concerns is evaluating existing HIV prevention programs in the context of sex work. One major component of current HIV prevention efforts is harm reduction via female sex worker 'regulatory boards' or 'unions' (e.g., The Durbar Mahila Samanwaya Committee(DMSC) in the Sonagachi District of Kolkata). The Sonagachi model, for example, has been demonstrated to be effective in improving condom use, empowerment of sex workers, and preventing HIV infection among sex workers and their clients. Some have criticized this model for the lack of attention to adolescents; however, it has not been assessed for its impact on adolescent sex workers. Regarding trafficking, a critically relevant element of this model involves sex workers actively working to eliminate the presence of minor girls as well as trafficked women. Although a major potential advance in counter-trafficking strategy, success of such efforts may be challenged by competing economic incentives for those involved in sex work operations to maintain the presence of trafficked individuals (i.e., the relatively high profits derived from the prostitution of adolescent sex workers). Thus, evaluation of these aspects of the model is critical. And if found to be effective, the Sonagachi model should be optimized and considered for broader implementation based on its ability to empower sex workers and their collectives to play a proactive role in reducing both HIV and trafficking.

Elements of anti-trafficking efforts and policies have also drawn significant criticism. Most concerning are rescue operations involving police. Police raids on brothels have been reported to involve violence and sexual abuse of FSWs, and to have forced sex work operations underground where regulation and health services access is further restricted, and where even greater vulnerability to violence may be experienced by both trafficked and non-trafficked FSWs. However, few alternatives currently exists to bring trafficking

victims out of such sexual bondage, and the current research indicates that this is, indeed, by far the most common vehicle by which trafficking victims escape from involuntary prostitution. Another possible approach, although still limited in scope and needs a thorough evaluation, is the Sonagachi approach in which a collective of sex workers themselves assist in the identification and removal of trafficked women and girls from sex work settings. This approach could minimise the risk of harmful consequences of rescue operations by the police. Greater involvement of human rights entities, within and outside of government, in overseeing the actions of police regarding trafficking victims, evaluation of anti-trafficking elements of sex worker empowerment models (e.g., the Sonagachi model), and development of avenues of assistance not involving the criminal justice system (e.g., the health sector) are critical to improving responses to the presence of trafficking victims in sex work settings.

Although there are valid and serious concerns from both anti-trafficking and HIV risk reduction leaders regarding current approaches (i.e., the neglect of trafficking victims by HIV prevention efforts and the abuse of FSWs and disruption of HIV prevention programs in the context of removal of trafficking victims by police), these concerns must not lead us to embrace the artificial choice between 1) providing HIV prevention services to this extremely vulnerable population, or 2) assisting children or others forced into sexual exploitation ; this is clearly unacceptable from both a public health and human rights perspective. Thus, we must move beyond this debate, establish common ground, and begin a sincere dialogue leading to the development of programs and policies that provide desperately needed HIV prevention to female sex workers, yet also assist those trafficked into sexual slavery.

Clearly, integration of anti-trafficking and HIV prevention efforts targeting FSWs poses unique challenges. As illustrated by the multiple perspectives described above, the HIV and anti-trafficking communities are simultaneously reasonable and disparate in their approaches to resolving the intertwined problems of young women and girls trafficked into forced prostitution and the resulting potential for HIV infection. However, given current and previous findings that between 1 in 10 and 1 in 3 FSWs meet current criteria for trafficking, coupled with the starkly elevated sexual risk observed among those trafficked, concerted action is strongly indicated. Dialogue amongst state actors, advocates, practitioners and researchers representing both HIV prevention and trafficking prevention efforts is a critical starting point. These experts must come together to overcome the limitations of existing HIV prevention efforts in preventing transmission to trafficked victims while simultaneously developing effective means of reducing trafficking of women and girls into forced prostitution in which financial and other incentives align with, rather than compete with, the overarching goal of reducing such sexual exploitation. The UN system may play a pivotal role in supporting such dialogue which brings together sex worker organizations, police, judges, leaders in public health efforts to prevent HIV, as well as NGOs working to either empower sex workers or to prevent trafficking to develop and assess effective responses that either simultaneously or in a complementary fashion address the intertwined issues of HIV and sex trafficking.

The current findings also indicate that the 100% Condom Campaign, a large-scale and otherwise successful HIV prevention effort, may fall short of meeting the needs of those trafficked into sex work. A clear example of this is the significantly reduced ability to use condoms and reduced access to HIV-related information among trafficked vs. non-trafficked FSWs in Thailand. Such efforts may well be stymied by the limited access to necessary knowledge concerning condoms, as well as the reduced power that trafficked women and girls have to negotiate condom use and refuse sex without a condom. The high prevalence of violence and other mistreatment among trafficked FSWs also likely leads to reduced ability to negotiate condom use or otherwise protect themselves sexually. Moreover, HIV prevention efforts targeting those involved in sex work typically fail to assist individuals until after the initiation period, a time during which trafficked FSWs face tremendous risk for contracting HIV based on their often violent initiation into sex work.

As discussed earlier, primary prevention of trafficking may be a critical component of HIV prevention. Evidence-based efforts in this area should address and reduce the integrated social and economic vulnerabilities that are responsible for creating a climate supportive of sex trafficking. While economic realities such as poverty and limited education and employment opportunities certainly contribute to trafficking in all forms, these factors render women disproportionately vulnerable given social realities of limited status of women, gender discrimination, and a climate of objectification and commodification of women.

As important as targeting vulnerability of women and girls is reduction of demand for trafficking victims by men – the true root cause of trafficking for sexual exploitation. Reducing such demand requires engaging men and boys in shifting deeply engrained gender-based social norms, attitudes and behaviors regarding male rights to sexual access and control of women and girls; it is the persistence of such norms that maintains trafficking of women and girls for sexual exploitation as well as other horrific forms of gender-based violence. Paying for sexual access to very young women and girls must be made a highly stigmatized behavior that incurs both significant social costs and results in prosecution. Efforts to better understand the context and motivations for such demand are necessary to develop such interventions and policies and require working across a broad spectrum of gender networks and movements.

NOTE: Given the documented risk for HIV infection among women trafficked for sexual exploitation, agencies caring for trafficked girls and women and health care providers either connected with agencies, as well as those who work in settings in which sex work is prevalent, must be aware of HIV-related diagnostic and treatment resources available in their communities.[50] Although trafficked women and girls face multiple barriers to health care access, based on awareness of possible indicators of trafficking (trauma symptoms, recurring STI, apparent fear of accompanying individuals), providers should be aware of voluntary counseling, testing and treatment protocols and resources available to the general population. An educational approach is suggested if a provider suspects a woman or girls may be trafficked, rather than direct rescue efforts unless the provider is knowledgeable regarding the available systems of assistance for trafficking victims. Further, in asking patients about having been trafficked, safety must be the highest priority; e.g., do not ask accompanying people to interpret, and only ask such questions when privacy from accompanying persons is assured. A comprehensive guide to caring for the health of trafficked individuals has been published by the IOM (Caring for Trafficked Persons: Guidance for Health Providers 2009; Geneva: International Organization for Migration).

6.5 Conclusion

In sum, findings of this multi-country regional study consistently indicate that trafficking for sexual exploitation places women and girls at high risk for HIV/STI infection. Trafficking victims appear to suffer qualitatively and quantitatively different levels of sexual risk, and are less likely to be reached by HIV prevention programs. Thus, sex trafficking may be a critical factor in the persistence of the Southeast Asian HIV epidemic. In addition to the primary prevention of trafficking and reduction of male demand for sex with trafficked individuals, consideration of trafficking within HIV harm reduction and other prevention efforts among female sex workers must be prioritized and accomplished. To achieve this goal, greater dialogue is required across the spectrum of responses to sex trafficking and HIV within sex work, including advocates for the rights of both sex workers and children, advocates for the prevention of trafficking, law enforcement policy-makers and practitioners, as well as those leading public health efforts to reduce HIV in the context of sex work. Only through such efforts we may develop effective and sustainable solutions to address the health, well-being and human dignity of sex-trafficked women and girls.

REFERENCES

1. United Nations. United Nations Protocol to Prevent, Suppress, and Punish Trafficking in persons, especially women and children, supplementing the United Nations Convention against Transnational Organized Crime. *Article 3 (a-d), G.A. res. 55/25, annex II, 55 U.S. (GAOR Supp. (No. 49) at 60, U.N. Doc. A/45/49 (Vol. I));* 2000.

2. Silverman JG, Decker MR, Gupta J, Maheshwari A, Willis BM, Raj A. HIV prevalence and predictors of infection in sex-trafficked Nepalese girls and women. *JAMA*. 2007;298(5):536-542.

3. Huda S. Sex trafficking in South Asia. *International Journal of Gynecology & Obstetrics.* 2006;94(3):374-381.

4. Burke A, Ducci S. *Trafficking in Minors for Commercial Sexual Exploitation: Thailand*. Torino, Italy: Action Programme against Trafficking in Minors for Sexual Purposes: UNICRI; 2005.

5. UNICEF. Cambodia: Statistics. http://www.unicef.org/infobycountry/cambodia_statistics.html. Accessed March 1, 2009.

6. Wawer MJ, Podhisita C, Kanungsukkasem U, Pramualratana A, McNamara R. Origins and working conditions of female sex workers in urban Thailand: Consequences of social context for HIV transmission. *Social Science & Medicine*. 1996;42(3):453-462.

7. Limpakarnjanarat K, Mastro T, Saisorn S, et al. HIV-1 and other sexually transmitted infections in a cohort of female sex workers in Chiang Rai, Thailand. Sex Transm Infect. February 1, 1999 1999;75(1):30-35.

8. UNODC. Global Report on Trafficking in Persons. Geneva: United Nations Office on Drugs and Crime; 2009.

9. Derks A, Henke R, Vanna L. Review of a Decade of Research On Trafficking in Persons, Cambodia. Phnom Penh: The Asia Foundation; 2006.

10. US Department of State. Trafficking in Persons Report. Washington, D.C.: US Department of State; 2008.

11. US Department of State. Trafficking in Persons Report. Washington, D.C.: US Department of State; 2005.

12. Congressional Research Service. Trafficking in Women and Children: The U.S. and International Response. Washington, DC: Library of Congress; 2001.

13. Sarkar K, Bal, Mukherjee R, et al. Sex-trafficking, Violence, Negotiating Skill, and HIV Infection in Brothel-based Sex Workers of Eastern, India, Adjoining Nepal, Bhutan, and Bangladesh. J Health Popul Nutr. 2008;26(2):223-231.

14. Silverman J, Decker M, McCauley H, Mack K. The Connections between Sex Trafficking and STI/HIV in Southeast Asia: A Regional Assessment: UNDP; 2009 In Progress.

15. Zimmerman C, Hossain M, al. e. The Health of Trafficked Women: A Survey of Women Entering Posttrafficking Services in Europe. American J Public Health. 2008;98(1):55-59.

16. UNODC. Trafficking in Persons: Global Patterns. Geneva: United Nations Office on Drugs and Crime; 2006.

17. US Department of State. 2008 Human Rights Report: Indonesia. Washington, D.C.: US Department of State; February 25, 2009.

18. UNAIDS. Report on the Global AIDS Epidemic. Geneva: UNAIDS; 2008.

19. Ruxrungtham K, Brown T, Phanuphak P. HIV/AIDS in Asia. Lancet. 2004;364(9428):69-82.

20. Rojanapithayakorn W. The 100% Condom Use Programme in Asia. Reproductive Health Matters. 2006;14(28):41-52.

21. Saphonn V, Sopheab H, Sun LP, et al. Current HIV/AIDS Epidemic: Intervention Programs in Cambodia, 1993-2003. AIDS Education and Prevention. 2004;16(Suppl A):64-77.

22. Silverman JG, Decker MR, Gupta J, Maheshwari A, Patel V, Raj A. HIV prevalence and predictors among rescued sex-trafficked women and girls in Mumbai, India. J Acquir Immune Defic Syndr. 2006;43(5):588-593.

23. Decker MR, McCauley HL, Phuengsamran D, Janyam S, Silverman JG. Sex trafficking and HIV/STI Risk among Female Sex Workers in Thailand UNDP; 2009 In Progress.

24. Lee V, Tobin JM, Foley E. Relationship of Cervical Ectopy to Chlamydia Infection in Young Women. J Fam Plann Reproductive Health Care. 2006;32(2):104-106.

25. UNGIFT. An introduction to Human Trafficking: Vulnerability, Impact and Action. Vienna: United Nations Office on Drugs and Crime; 2008.

26. Beyrer C, Stachowiak J. Health consequences of the Trafficking of Women and Girls in Southeast Asia. Brown Rev World Affairs. 2003;10(1):105-119.

27. Singh S, Millis E, Honeyman S, al. e. HIV in Nepal: Is the violence conflict fueling the epidemic? PLoS Med. 2005;2(8):e216.

28. Ford K, Wirawan DN, al. e. The Bali STD/AIDS Study: Evaluation of an Intervention for Sex Workers. Sex Transm Dis. 2002;29(1):50-58.

29. NCHADS. Annual Report: 2008. Phnom Penh: National Center for HIV/AIDS, Dermatology and STD; 2009.

30. Sopheab H, Gorbach PM, Gloyd S, Leng HB. Rural sex work in Cambodia: work characteristics, risk behaviours, HIV, and syphilis. Sex Transm Infect. August 1, 2003 2003;79(4):335-.

31. Kim A, Sun LP, Chhorvann C, et al. High Prevalence of HIV and Sexually Transmitted Infections Among Indirect Sex Workers in Cambodia. Sexually Transmitted Diseases. 2005;32(12):745-751.

32. Mills E, Singh S, Orbinski J, Burrows D. The HIV/AIDS epidemic in Cambodia. Lancet Infect Dis. 2005;5(10):596-597.

33. Saphonn V, Parekh B, Dobbs T, et al. Trends of HIV-1 seroincidence among HIV-1 sentinel surveillance groups in Cambodia, 1999-2002. J Acquir Immune Defic Syndr. 2005;39(5):587-592.

34. Sopheab H, Morineau G, Neal JJ, Saphonn V, Fylkesnes K. Sustained high prevalence of sexually transmitted infections among female sex workers in Cambodia: high turnover seriously challenges the 100% condom use programme. BMC Infectious Diseases. 2008;8(167):epub ahead of print.

35. Cwikel J, Ilan K, Chudakov B. Women brothel workers and occupational health risks. J Epidemiol Community Health. October 1, 2003 2003;57(10):809-815.

36. Sugihantono A, Slidell M, Syaifudin A, al. e. Syphilis and Hiv prevalence among Commercial Sex Workers in Central Java, Indonesia: Risk taking behavior and attitudes that potentiate a wider epidemic. AIDS Patient Care and STDs. 2003;17(11):595-600.

37. Davies SC, Taylor JA, Sedyaningsih-Mamahit ER, al. e. Prevalence and Risk Factors for Herpes Simplex Virus Type 2 Antibodies among Low- and High-Risk Populations in Indonesia. Sex Trans Diseases. 2007;34(3):132-138.

38. UNGASS. UNGASS Country Progress Report: Malaysia: UNAIDS; 2008.

39. Ford K, Reed BD, Wirawan DN, al. e. The Bali STD/AIDS Study: Human papillomavirus infection among female sex workers. International J of STD AIDS. 2003;14:681-687.

40. Silverman JG, Decker MR, Gupta J, Dharmadhikari A, Seage Iii GR, Raj A. Syphilis and Hepatitis B Co-infection among HIV-Infected, Sex-Trafficked Women and Girls, Nepal. Emerging Infectious Diseases. 06 2008;14(6):932-934.

41. Choi SY, Holroyd E. The influence of power, poverty, and agency in the negotiation of condom use for female sex workers in mainland China. Cult Health Sex. 2007;9(5):489-503.

42. Farley M, Barkan H. Prostitution, violence, and posttraumatic stress disorder. Women Health. 1998;27(3):37-49.

43. MAP/UNAIDS. AIDS in Asia: Face the Facts: UNAIDS; 2004.

44. USAID. Violence and exposure to HIV among sex workers in Phnom Penh, Cambodia. Washington, D.C.: Bureau of Democracy, Human Rights, and Labor; 2006.

45. Sarkar S, Bal B, Mukherjee R, al. e. Young age is a risk factor for HIV among female sex workers - an experience from India. J Infect. 2006;53(4):255-259.

46. Nair PM. A report on trafficking of women and children in India: 2002-2003. Volume I. New Delhi: UNIFEM, ISS, NHRC; 2004.

47. Cwikel J, Chudakov B, Paikin M, Agmon K, Belmaker RH. Trafficked female sex workers awaiting deportation: comparison with brothel workers. Arch Womens Ment Health. Oct 2004;7(4):243-249.

48. Mayaud P, Mabey D. Approaches to the control of sexually transmitted infections in developing countries: old problems and modern challenges. Sex Transm Infect. 2004;80(3):174-182.

49. Decker M, Mack K, Barrows J, Silverman J. Trafficking, violence victimization, and condom non-use among prostituted women in Nicaragua. IJGO. In press.

50. IOM. Caring for Trafficked Persons: Guidance for Health Providers. Geneva: International Organization for Migration; 2009.

UNDP is the UN's global development network, advocating for change and connecting countries to knowledge, experience and resources to help people build a better life.

UNDP Regional Centre for Asia Pacific, Colombo Office
23, Independence Avenue,
Colombo 07, Sri Lanka

Telephone: +94 11 4526 400
Fax: +94 11 4526 400
Email: rcc@undp.org
Web: www.undprcc.lk