

Combating human trafficking in the sex trade: can sex workers do it better?

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ABSTRACT

Background The dominant anti-trafficking paradigm conflates trafficking and sex work, denying evidence that most sex workers choose their profession and justifying police actions that disrupt communities, drive sex workers underground and increase vulnerability.

Methods We review an alternative response to combating human trafficking and child prostitution in the sex trade, the self-regulatory board (SRB) developed by Durbar Mahila Samanwaya Committee (DMSC, Sonagachi).

Results DMSC-led interventions to remove minors and unwilling women from sex work account for over 80% of successful 'rescues' reported in West Bengal. From 2009 through 2011, 2195 women and girls were screened by SRBs: 170 (7.7%) minors and 45 (2.1%) unwilling adult women were assisted and followed up. The remaining 90.2% received counselling, health care and the option to join savings schemes and other community programmes designed to reduce sex worker vulnerability. Between 1992 and 2011 the proportion of minors in sex work in Sonagachi declined from 25 to 2%.

Conclusions With its universal surveillance of sex workers entering the profession, attention to rapid and confidential intervention and case management, and primary prevention of trafficking—including microcredit and educational programmes for children of sex workers—the SRB approach stands as a new model of success in anti-trafficking work.

Keywords population-based and preventative services, social determinants, work environment

Background

Sex work, migration and human trafficking

Sex work exists in some form in all societies. The conditions surrounding sex work, the social and legal status of the profession and the position of sex workers themselves vary widely across time and place. Despite differences, sex work nearly everywhere entails risk.¹ Understanding those risks is a prerequisite for identifying opportunities to improve conditions of sex workers' lives.²

Many of the risks associated with sex work—from disease transmission to human rights violations and violence—stem from 'structural' conditions of sex work, and the frequently marginalized social status of sex workers. Migration and mobility exacerbate vulnerability and create opportunities for exploitation and abuse.³ Migration of labour has increased

rapidly over recent decades due to economic liberalization and globalization. Where male workers—including migrant labourers, transporters and uniformed services—move, there is increased demand for paid sexual services. This demand is often readily met, especially where poverty is pervasive and women have few viable economic options.⁴ Women also migrate for work. Some move to areas where sex work is known to be lucrative, seeking a way out of poverty. Others set out looking for other work, and may end up in sex work,

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either out of choice or through deception. Sex work can thus be voluntary or involuntary—while many sex workers choose to enter the profession, others are induced under false pretences or otherwise coerced.⁵

The problem of human trafficking is related but much broader, involving coercion in the economic exploitation of men, women or children.^{5,6} Most trafficking of persons involves other sectors and types of labour, including agriculture, construction and domestic work. In these areas, differentiation is generally made between the majority of workers who migrate voluntarily and those who are trafficked.

Where the sex trade is concerned, however, distinctions between consensual and coerced work are often blurred.^{5–7} Evidence suggests that trafficking accounts for a minority of those entering sex work—1 in 5–10 by recent estimates from Andhra Pradesh, India and Thailand^{8,9} Nevertheless, anti-trafficking organizations frequently cast a wide net, conflating all sex work with trafficking.^{10,11} Seeking to ‘rescue’ trafficking ‘victims’ in sex work areas, ‘raid and rescue’ operations fail to distinguish between voluntary adult workers and those who are trafficked or underage. The effects of such actions have been damaging—communities disrupted, social and health services interrupted and sex workers taken into custody, abused or driven underground, increasing rather than reducing their vulnerability.^{4,12–14} Nonetheless, the methods, outcomes and impact of anti-trafficking interventions have received little critical examination in the literature.¹⁵

In this paper, we review an alternative response to human trafficking, including child prostitution, where sex workers themselves—organized collectively as Durbar Mahila Samanwaya Committee (DMSC)—address the related problems of coerced and underaged sex work.

DMSC and self-regulatory boards

In 1992, the World Health Organization helped local doctors to assess HIV transmission risks in the Sonagachi red light district in Kolkata (Calcutta), West Bengal and helped design an STI and HIV Intervention Project. The success of the intervention in preventing a major HIV epidemic in West Bengal, through progressive and active involvement of sex workers themselves, is internationally recognized.^{16,17} The experience and confidence gained in organizing an effective HIV prevention effort led the sex worker community to take on a range of other health and social problems affecting them, from violence and discrimination to the limited educational opportunities available to their children.

In 1995, DMSC was formed as a community-based organization of Sonagachi sex workers, currently representing >65 000 members in 49 branch committees covering an

estimated 85% of sex workers in West Bengal. DMSC operates 51 clinics, 33 self-regulatory boards (SRBs) and 32 educational activities including homes and schools for children of sex workers. They also have a number of community development projects, including a cooperative saving scheme, to reduce dependence on sex work and create security for those who choose to practice the profession.

There have been significant changes in STI/HIV risk among sex workers and their clients in DMSC project areas since 1992. Reported condom use has increased from <3% in 1992 to 87% in 2007. Syphilis prevalence has declined from 25–30% to <1% during the same period. HIV prevalence remains stable at 5% among Kolkata sex workers, compared with rates surpassing 50% in other major Indian cities.¹⁸

In 1997, DMSC decided to address the problems of underaged and coerced women in sex work settings. Community members who had themselves been trafficked at some point in time proposed policies and strategies that were discussed among DMSC members. A multi-stage response based on the concept of SRBs and community vigilance (see Fig. 1) was developed to regulate entry into sex work, identify abuses and respond comprehensively where coercion or underaged sex work was suspected. Each SRB is composed of 10 members, including 6 from the sex worker community, a local ward counsellor and representatives from health, social welfare and labour sectors. More detail on SRB operations is provided in Supplementary data.

SRB operate in 8 sex work communities in Kolkata and 25 other communities in West Bengal. The concept of SRB was developed based on the understanding that sex workers themselves can take charge of their living and working conditions in partnership with other civil society members. As a professional group they aspire to live and work in dignified and violence-free environments, where sex workers exercise autonomy over their lives and manage systems of their own to prevent entry of minors and trafficked women into the sex trade. To this end, DMSC systematically documents each aspect and stage of SRB work. Careful documentation provides a record of all identified entrants into the area and the decisions, management and follow-up of all cases. These records are used to monitor and improve outcomes, from identification and case management to career building, reintegration and follow-up.

Methods

A review of 15 years of SRB project data was conducted, supplemented by interviews with SRB members, police, anti-trafficking units, other government officials and civil society groups involved in anti-trafficking and women’s rights.

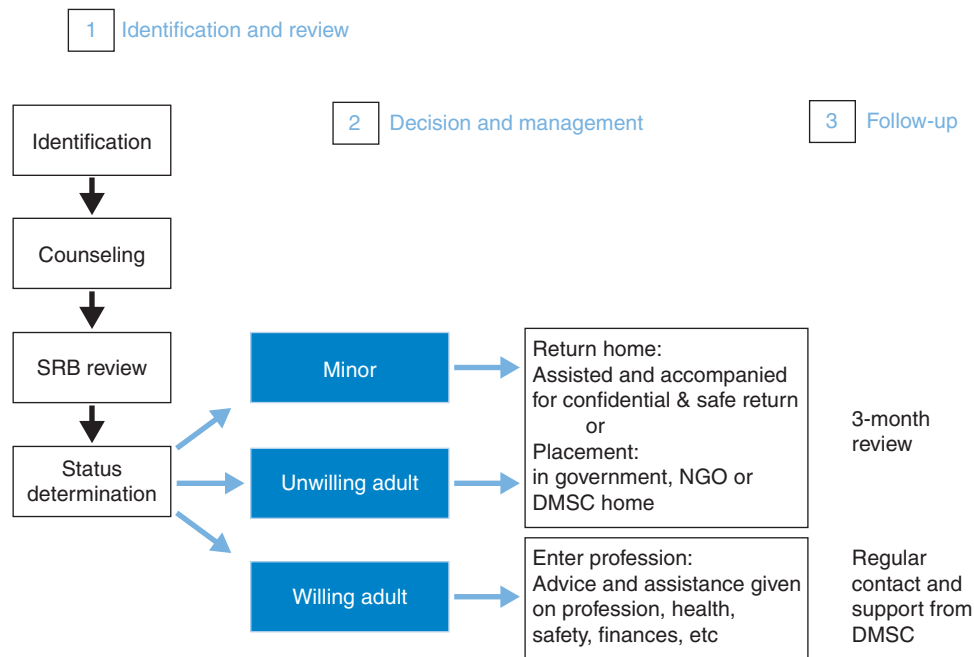


Fig. 1 Overview of steps of SRB review (DMSC). (1) The first step—*identification and review*—is made possible by promoting a high level of community vigilance. Each day, peer educators, who have responsibility for 60 sex workers, visit houses in the red light areas where newcomers are easily identified. During the day, the peer educator or malkin accompanies the new girl or woman to the clinic or drop-in centre where a space is available for SRB meetings. At night, identified newcomers are brought to a short-stay home where they can safely spend the night prior to SRB review the next day. To begin the review, a clinic counsellor explains the process and completes an SRB intake form that becomes the official record of the process. Within one to several hours, an SRB meeting is convened to review the case and develop a plan of action to help the girl or woman choose from among several options. The SRB secretary takes detailed notes in a register while other SRB members ask probing questions to determine the girl's circumstances and motivation for entering the profession. If answers are not consistent and credible, additional information or verification is sought. (2) The goal of the review—*decision and management*—is to determine whether the girl is a minor, or if an adult, whether she is informed and willing to enter the profession. Where the age of a girl is in question, an appointment for bone X-ray is made. Once the SRB has decided on a course of action with the girl, steps are taken to facilitate the process and ensure optimal outcomes. By taking care to ensure privacy and confidentiality, Durbar has recorded better outcomes and fewer outright rejections when returning girls and women to their families and communities. Reintegration involves a number of steps designed to facilitate return of the girl or woman to her family and community. One or more community members will accompany minors or adult women who choose to return home. The community members assess the family and community circumstances and take steps to facilitate the girl's return. When circumstances at home are deemed to be abusive or otherwise not conducive for the woman or girl to return, placement is arranged at a government or government-supported private home. For a woman over 18 years of age who convinces the SRB that she is making her own decision to enter the profession willingly, advice and assistance are offered. For women entering the profession, regular follow-up is ensured through DMSC's network of peer educators. (3) SRB members conduct *follow-up* visits 3 months after return or placement to verify the person's security, to assess conditions and to intervene if needed to improve arrangements. In conducting regular follow-up visits, SRBs have developed an informed view of the situations facing women and girls on return or placement, and use that information to conduct advocacy at multiple levels to ameliorate conditions. A more detailed description of SRB composition and operation is provided in Supplementary data.

In-depth interviews were conducted with 10 women and girls screened by SRBs. We also reviewed over 5 years of project data of Ashodaya Samithi, a sex worker organization in another state of India, which adapted the SRB approach to different conditions.

We use DMSC's working definition of trafficking within the sex trade, which includes (i) minors <18 years of age and (ii) adult women in sex work against their will. These are consistent with Indian laws, including the Immoral Traffic Prevention Act (ITPA), which address sex work and trafficking, and the recently amended Indian Penal Code (IPC 370, 370A) on violence

against women, including sexual assault and trafficking. While a signatory to UN anti-trafficking conventions, India has not revised its legislation to include broad and controversial definitions of human trafficking.^{6,7}

Results

Short-term programme outcomes

From 1996 through 2011, the number of SRBs run by DMSC in West Bengal increased from 3 to 33. During that time, a total of 828 cases reviewed by SRBs were found to be

either minors, or adult women who were unwillingly brought to sex work. Figure 2 shows the number of minors and unwilling women identified by year. Of those screened between 2001 and 2011, 668 were judged to be minors and 151 were adults unwilling to join the profession. Each of these girls and women received assistance with reintegration—to return home or find alternative placement.

These ‘cases’—the minors and unwilling women who are assisted to leave sex work areas—are clear *direct* beneficiaries of DMSC’s anti-trafficking work. They are only part of the story, however. A much larger number of women willingly enter the red light areas to seek work in the profession. Through daily ‘surveillance’ of the red light areas by peer educators and other community members, DMSC does not haphazardly identify isolated ‘trafficked cases’ but systematically screens all newcomers to red light areas, reporting both the *numerators* (minors and unwilling adults) and *denominators* (all newcomers) in the trafficking equation. It thus gives a more complete picture of the extent of trafficking in sex work and of SRB outcomes.

From 2009 through 2011, 2195 women and girls were seen by SRBs across West Bengal (Fig. 3). Of these, 215 (9.8%) were judged to be either minors (170 girls, 7.7%) or unwilling adults (45 women, 2.1%). The remaining 90.2% were women

documented to be at least 18 years old who, following counselling and SRB review, convinced the SRB that they were willingly choosing to enter the profession. Since these women receive counselling and are offered advice, health care and the option to join saving schemes and other community programmes, they can easily avoid many of the initial risks and harms faced by voluntary entrants to sex work in other settings. These women can thus be seen as *indirect* beneficiaries of the anti-trafficking work carried out by SRBs.

Vulnerability reduction and primary prevention

Knowing well that conditions of poverty and lack of economic options for women facilitate the work of trafficking networks, DMSC also runs a number of programmes that can be considered *primary prevention* of trafficking. By increasing educational and economic options for sex workers and their children, such programmes reduce vulnerability and increase choices.

DMSC works on several levels against debt bondage and unfair interest rates. Most importantly, the community promotes savings among its members and offers credit on fair terms. Usha Multipurpose Co-operative Society Ltd. (USHA) is a self-banking initiative of and by the sex workers community in Kolkata, set up in 1995 in response to the difficulties sex workers were facing in trying to open individual savings accounts at local banks. With 16 400 members, USHA now has an annual turnover of over \$2.5 million USD and invests capital in community projects.¹⁹ To encourage sex workers to save, a convenient collection system was established. A team of community members with training in basic accounting makes daily rounds to collect deposits. Each member carries a savings book in which deposits are recorded by the collector.

From the beginning when sex workers in Sonagachi began organizing for their rights and better working conditions, the health and welfare of their children were priorities. DMSC now actively promotes and facilitates school attendance through its educational programmes. USHA cooperative bought land and constructed a boarding school in the country where sex workers can send their children. As a result of these initiatives, school attendance and literacy among the children has increased markedly.

Long-term outcomes

Long-term outcomes are monitored project wide using survey data to capture population changes in DMSC areas. For the Sonagachi area since 1992, these include a decline of over 90% in the proportion of minors (age < 18 years) and an increase in the median age of sex workers from 22 to 28 years (Fig. 4).

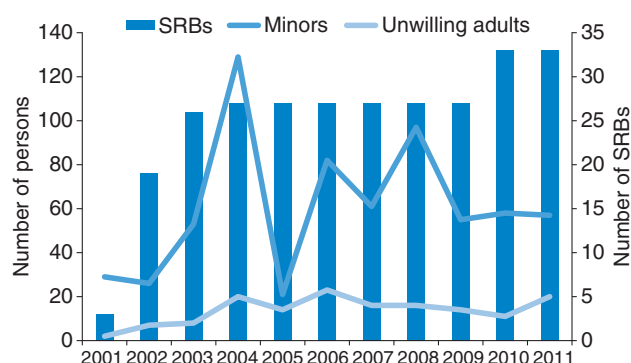


Fig. 2 Number of minors and unwilling adults identified by SRBs, 2001–11.

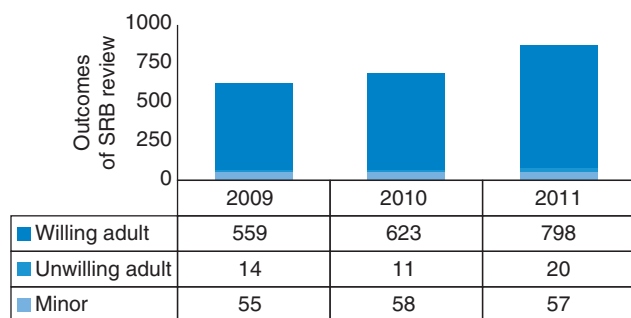


Fig. 3 SRB screening, 2009–11: minors, unwilling adults and willing adults.

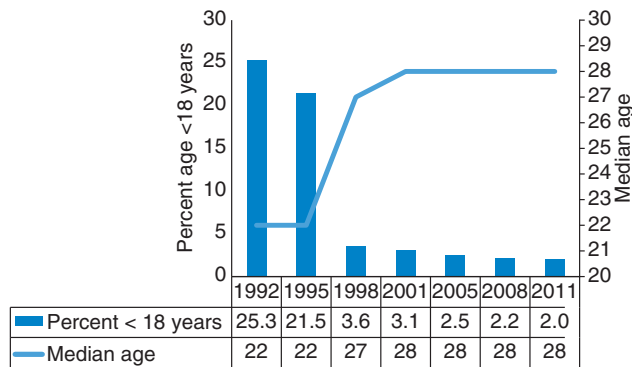


Fig. 4 Proportion of minor girls and median age of sex workers in Sonagachi.

Replicability

DMSC's response to trafficking has been shown to be replicable in diverse settings, from urban red light areas to rural and border districts of West Bengal and rural districts of South India. The experience of Ashodaya Samithi in Mysore and surrounding districts of Karnataka to prevent HIV transmission, violence and trafficking has been described.^{20,21} The SRB approach has been adapted to Mysore conditions where 89% of sex workers solicit in public places and entertain clients at nearby hotels or lodges, rather than working from brothels. Through community vigilance and peer educators, ~2–300 new entrants to sex work are identified each year. Since 2004, <4% of these newcomers have been found to be either minors or adults coerced into sex work. Ashodaya's SRB collaborates actively with local protection agencies to facilitate reintegration of these women and girls.

Discussion

Main findings of this study

Through mobilization of community and extensive coverage, DMSC has achieved notable successes in preventing human trafficking and child prostitution in sex work areas. Initial successes in addressing HIV and other STIs increased community participation and confidence to take on other problems that contributed to high vulnerability.^{16–18} Savings and credit schemes have reduced dependency on sex work, and SRBs effectively address a range of abuses from trafficking to child prostitution. Building on strong peer interventions and involving women who had themselves been trafficked, SRBs developed effective solutions to tenacious problems confronting anti-trafficking groups—how to identify trafficked women and girls in the first place, then how to intervene, manage cases and conduct follow-up to ensure optimal outcomes. By

the late 1990s, DMSC was replicating similar interventions across the state of West Bengal, subsequently extending coverage to an estimated 85% of sex workers.

What is already known on this topic

Organizations that work against human trafficking face a daunting array of challenges. Figure 5 depicts a common cycle of trafficking in the sex trade and identifies key constraints facing interventions (outside circle). While these multiple constraints—from underlying poverty in source communities through anonymity and insecurity in transit, difficult detection in destination areas and a paucity of reintegration or alternative placement options—have been reported in the literature, few effective solutions have been described.

What this study adds

DMSC's collaborative intervention approach systematically addresses these constraints, also illustrated in Fig. 5 (inside circle). Despite similar challenges and ongoing collaboration with other agencies, DMSC's approach to preventing human trafficking in the sex trade differs fundamentally from others in several ways:

- (i) As a community-led strategy compared with top-down law enforcement approaches.
- (ii) In clearly separating 'trafficking' from consensual adult participation in sex work.
- (iii) In its universal 'surveillance' and rapid response to identifying newcomers to sex work areas, intended to reduce harms early.
- (iv) In its attention to holistic responses to trafficking, from source and destination communities to reintegration.
- (v) In safeguarding the confidentiality of individuals during all phases of the response.

DMSC's SRB interventions assist almost three times as many women and girls than other anti-trafficking efforts combined. During the 3 years from 2007 to 2009, DMSC reported 259 cases of underaged girls and unwilling women removed from sex work settings (Fig. 2). Police reports for West Bengal for the same period include 90 women and girls rescued under the ITPA and related statutes. This difference is not surprising. According to local, municipal and state police and anti-trafficking units, police respond to complaints or information volunteered by informants. Few cases are lodged compared with the estimated size of the problem, however. In contrast, SRBs actively screen every newcomer to the profession in red light areas.

Despite differences in approach, DMSC makes every effort to work with law enforcement and social welfare agencies to

4 Challenges faced by DMSC and others

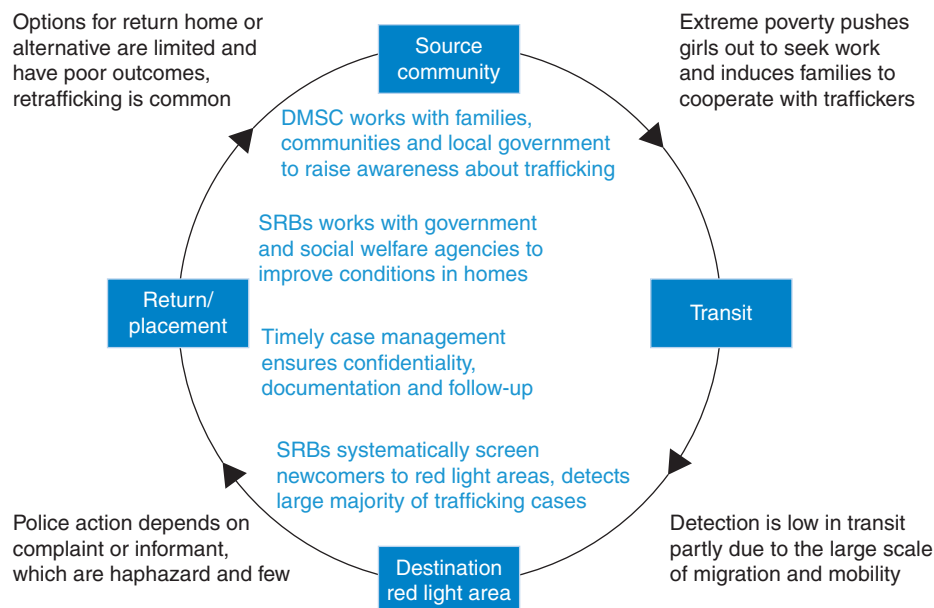


Fig. 5 A cycle of trafficking.

promote more comprehensive approaches to human trafficking in the sex trade and to strengthen the combined response. Interviews with a range of public and private sector officials with experience in anti-trafficking work put high value on existing collaboration. While some of those interviewed were not in full agreement with all of DMSC's positions—regarding sex work as legitimate work, for example—such differences have not prevented their working together. All recognized the positive contribution of DMSC to overall anti-trafficking efforts, and most were actively collaborating in at least some areas. Strong collaboration was most evident on common platforms of human rights and the rights of children.

Case management continues to present challenges. Once a girl or woman has been removed from sex work, DMSC and other anti-trafficking groups face similar obstacles—rejection by families, limited and often inadequate options for reintegration or alternative placement, cross-border repatriation. DMSC thus collaborates actively with police, social welfare and NGOs in managing cases and in advocating for better services. One important aspect of DMSC's work is its insistence on the need to preserve the girl/woman's confidentiality. This is frequently not the case during rescue missions organized by police and others, where publicity exposes those 'rescued', further undermining chances for reintegration into their communities.

DMSC's efforts to reduce vulnerability for particularly marginalized populations can also be considered effective

primary prevention of human trafficking. By increasing awareness and options for women and girls living in extreme poverty, it is reasoned, they will be less susceptible to traffickers.

Limitations of this study

The issues of human trafficking in the sex trade, and the related crime of child prostitution, are complex, and opportunities to circumvent control still exist. DMSC has systematically analysed the dynamics of trafficking in West Bengal and designed interventions to limit abuses, and programme data provide strong evidence of improvement in a number of areas. Yet, traffickers adapt to changing conditions and likely divert their activities to areas with less control. In addition, significant problems remain. Key informants, DMSC and Ashodaya project staff all pointed to several problematic areas:

- (i) Laws are flawed, do not distinguish victims from perpetrators, and deal only with trafficking in the sex trade.
- (ii) Despite laws, conviction rates of traffickers are low. Where successful, it is usually low-level operatives not the kingpins who run the networks.
- (iii) Reintegration and alternative placements often fail due to weak programmes and inadequate resources.
- (iv) Unless something is done to improve conditions in source communities and to ensure the safety of migrating women, trafficking will continue.

In conclusion, SRBs appear to have several important advantages over narrow law enforcement approaches for preventing trafficking related to sex work and mitigating adverse consequences. Systematic identification and screening of newcomers into sex work areas allows for a high detection rate of trafficked girls and women. Emphasis on rapid and confidential reintegration likely also improves outcomes, while primary prevention efforts reduce vulnerability and harms. Beyond such clear benefits to individuals, these results likely discourage perpetrators and networks from attempting to traffic women into areas where SRBs operate.

Supplementary data

Supplementary data are available at the *Journal of Public Health* online.

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