Commentary: Categorizing risks for HIV among female sex workers: the importance of context

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Preventing infection among those at particularly high risk has long been a central plank of HIV intervention efforts globally. Special emphasis has been placed on this approach to control the HIV epidemic in regions where the infection has not become ‘generalized’, or widespread in the general population. India falls into this category, with the National AIDS Control Organization (NACO) describing the situation nationally as a ‘concentrated epidemic’: prevalence rates in the general population are relatively low (0.34%, age-adjusted prevalence among antenatal clinic attendees of 0.48%), but are markedly higher among ‘high-risk groups’. This includes injecting drug users (7.2%), men who have sex with men (7.4%), female sex workers (5.1%) and attendees at sexually transmitted disease clinics (3.6%).1 Ever since the first National AIDS Control Programme (NACP-I) was launched in 1992, mapping of ‘high-risk behaviour’ and identification of socio-demographic and other characteristics associated with heightened risk have been deemed essential to the design and effective targeting of interventions.2 The current programme (NACP-III), which runs from 2007 to 2012, aims at achieving saturation coverage of high-risk populations with targeted interventions (from a current estimated 55% coverage in the case of sex workers); and it is here that further detailed work on the profiles and categorization of particular vulnerable populations may have special relevance.

As we have learnt more about sex work in the subcontinent, researchers have developed a number of classifications or typologies that attempt to describe types of sex worker according to various criteria (such as economic status, place of work or mode of organization). The assumption is that such criteria will help predict vulnerability to infection and hence can be used to inform intervention targeting. Currently NACO recommends categorizing sex workers solely on the basis of their place of solicitation, as a proxy for level of HIV risk, to target intervention efforts. In this issue, Buzdugan et al.3 argue that this approach may conceal important variations in the extent to which different sex workers are actually vulnerable to infection. Using a novel methodological approach, they demonstrate that combining ‘site of solicitation’ with ‘site of sex’ reveals
significant variations in HIV prevalence among those who solicit on the street, identifying those who then take their clients to lodges as having substantially higher prevalence rates than those who service their clients elsewhere. The fact that these women and brothel-based sex workers are the two groups identified as having the highest HIV prevalence rates in Karnataka, may of course indicate some common underlying feature, e.g. relating to the use of commercial establishments as sites for sex, which renders these sex workers relatively more vulnerable than others. The importance of this study is to demonstrate that criteria other than those most commonly used—and most easily observed and measured—may be of greater importance in determining such vulnerability. This has implications both for the kinds of preliminary observational and survey work that tends to be undertaken before the launch of a targeted intervention and, subsequently, for the kinds of interventions most likely to be effective in reducing risk.

Despite the existence of innumerable targeted interventions for sex workers worldwide, establishing the effectiveness or otherwise of different approaches remains highly problematic. A recent systematic review of preventative interventions among sex workers concluded that there was reasonably reliable evidence to demonstrate the effectiveness of condom promotion and risk-reduction counselling in reducing HIV incidence, as well as some evidence for structural approaches that focus on empowering sex workers, but very little evidence that treatment for sexually transmitted infections (STI) has any additional benefit in preventing HIV infections. The detailed delineation of setting-specific predictors of risk as found in this issue’s article has most immediately obvious programmatic value in better targeting conventional, biomedical approaches of condom promotion and STI treatment; community empowerment would arguably not be best served by dividing sex workers into differing priority groups according to whether they take their clients into a hotel (‘street to lodge’) or behind one (‘street to street’). In India as elsewhere, implementation of most targeted interventions has long been in the hands of locally based Non-Governmental Organizations and, in recent years, increasing attention has been given to approaches that tackle the structural sources of vulnerability together with activities aimed at empowering communities through ownership of intervention projects. Influential in prompting this shift has been the ‘Sonagachi project’, a self-empowerment programme among sex workers in Kolkata that has come to be regarded as a model for such approaches globally. What is often overlooked in the application of experience from particular interventions, however, is the extent to which success is dependent on detailed knowledge of and appropriate adaptation to local contexts. One element in the Sonagachi project’s success was its precise and detailed attentiveness over time to the characteristics of the local sex trade. The finding that including ‘site of sex’ as well as ‘site of solicitation’ provides a more accurate indication of HIV risk may seem to be a tiny part of the complex weave of elements that could be pertinent to intervention design. On the other hand, just this sort of attention to the specifics of local variability may make the difference between an intervention that succeeds in protecting vulnerable women and one that fails.

Conflict of interest: None declared.

References