

The ethical implications of culture: challenges in the care of female sex workers in India

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Abstract

Cultural considerations call into question the frameworks of traditional ethical judgments. In India, cultural female sex worker communities depend on women for economic gain, but also justify their practices as “tradition”. The care of these patients is complex, particularly because of limited interactions with the health-care system, and poor negotiation power for the prevention of sexually transmitted infections. In this commentary, I confront a woman from the Perna community, a sex worker tribe in Northern India where wives are pimped by their husbands and mothers-in-law. As a physician treating Salma, you diagnose her as HIV-positive, but disclosure of her status will likely result in her death from her family. However, as a female sex worker, she is at high risk of transmitting HIV to other members of the local public, a number of whom are also your patients. How do we as clinicians navigate a challenging ethical situation as it pertains to the safety of an individual patient, the threat to public health of a community, and the need to understand the cultural challenges of unique but oppressive systems that are in place in countries around the world?

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Cultural traditions are among the few instances in which ethical boundaries can be significantly shifted. The way in which we may judge a situation in the United States may likely have different social connotations in another setting which force us to reconsider our judgments. But what about traditions which are so viscerally disheartening that they demand universal change? Among those that have garnered such considerations include female genital mutilation, common in parts of Africa, Asia, and the Middle East. Less publicized but equally worthy of serious thought is cultural sex work, found in many parts of India.

In 2011, I began working in the Perna community outside of New Delhi, India. The Pernas are a group that has long practiced sex work according to elders in their village, dating back into the 1800s (1). At the time, many of India's nomadic tribes held different social roles that revolved around the Maharajas (Kings) of the

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regions in which they dwelled. For the Pernas, this primarily entailed herding sheep and cattle. However, with the British Criminal Tribes Act in 1871, a number of tribal groups, including Perna, were criminalized for their traditional work (1). This was largely because some, though certainly not all, of these groups were also involved in theft and criminal activity. Members of the Perna claim that this was the launching point for their entry into sex work, largely as a result of economic destitution.

As a physician studying the Perna from a medical, anthropological, and sociological lens, I sought to understand the social dynamics present in the communities. A Perna daughter is married only within the Perna group, and once she has her first child, is subsequently expected to begin sex work, with her mother-in-law and husband serving as analogous to a brothel-madam and a pimp, respectively. Her in-laws pay a bride price for her, as opposed to a dowry, which is traditionally given in Indian culture from the bride's family to the groom's. While many Perna women will recite that this is their *dharma* or "duty", a number of younger girls and NGO staff workers were quick to share that physical and communal force is used to ensure that girls enter this work. In cases where there is too much resistance, the girl will be divorced and outlawed from the community. This can happen with more than just refusing to participate, however. Sexually transmitted diseases in this group are heavily scrutinized as they are bad for business. Given these circumstances, there are a number of important and challenging medical ethics dilemmas that arise in providing care for women in the Perna tribe.

CASE

Imagine you are a primary care physician working in New Delhi, India when a young woman, Salma, comes to your clinic. She appears rushed as she sits down, and you can infer from her clothing and her manner of speech that she is from a rural area. Your nurse walks in and whispers to you that Salma is a sex worker from the Perna community.

Salma confides that she has had unprotected sexual intercourse and has been feeling unwell, including tactile fevers, body aches, and headaches. Her physical exam is generally unremarkable and she has no other medical history that she can recall given that she very rarely sees doctors. You work her up for a panel of sexually transmitted infections, including HIV and plan for her to return to clinic within one week for her lab results. You offer her condoms, but she explains that she won't earn as much if she uses condoms with clients. Also, many clients refuse to negotiate for condom usage and become violent at times.

Her lab results are notable for HIV antibodies. Upon returning to see you, she is shocked to find out her results as she has heard about HIV, but was unaware of how it was transmitted. She notes that there was a rumor that one of her recent clients was HIV positive, but she couldn't convince him to use a condom. She pleads with you not to disclose to other patients and community members that there is HIV in her community as she is worried that it could threaten her life. She explains that she could be killed by her family or other community members, who will see it as a threat to their community's livelihood and income. Given that so few women see physicians, they will be suspicious of her as some of her neighbors found out that she went to the doctor recently.

ANALYSIS

The aforementioned case is one that has been reported by the Perna community as having occurred previously during my interactions working in these villages. Central to the ethical dilemma is a familiar but essential conflict between the privacy and safety of the individual, versus the threat to public health from transmissible and highly infectious diseases, in this case HIV. Furthermore, given that organized sex work is illegal in India, how do we reconcile that this is a communal tradition that Salma practices and has confided in you? Given that our patient, Salma, is a female sex worker, her risk of exposure to others is very high as she has frequent sexual contact with multiple partners. From what she has told us, and from well-cited research, negotiation of condom usage is very difficult for female sex workers, especially given the fi-

nancial incentive for performing unprotected sexual acts (2). Thus, it is very important that we consider the potential for local epidemics to begin around sex worker communities, particularly once a woman is infected. However, aside from solely the risk of HIV, what duty do we have as physicians to give our patients information regarding health risks that are likely relevant for them to know? Condoms are not 100% effective against sexually transmitted infections, and have the risk of breaking during intercourse. In addition, many oral sexual encounters are unprotected and pose a threat of transmission if there are any open lesions in the oral cavity. Given that many of your patients are potentially customers and could be exposed to HIV from this community, there is a sense of responsibility to protect your patients from a known harm. However, Salma should not be defined by her potential risk to others; first and foremost, she herself is your patient and demands the right to be treated as an individual suffering from disease, as well as structural violence.

However, Salma's situation is quite unique for a number of reasons which are fundamental to the physician-patient relationship, as well as to our commitment as physicians toward the human rights of our patients. As mentioned in the case, Salma is from a female sex worker community, one of many in India, that sees her sexual exploitation as "tradition". Other communities facing similar challenges include the Devadasi, Nat, Bedia, and Kanjars (1, 3, 4). As a member of this community, Salma is subjected to severe societal stigma from both the public as well as from health care providers, a problem faced by female sex workers globally (5). This makes it extremely difficult for Salma and women like her to access basic medical care, including education on disease transmission, which may have helped Salma prevent contracting HIV. Still, as Salma explained, negotiation of condom use as a female sex worker can be dangerous from the threat of a client, or could result in violence from her husband (who serves an analogous role to a "pimp") given that she would make less money for protected sex (6). Like female sex workers around the world, the combination of societal stigma, low health literacy, poor understanding of HIV, and lack of access to trusted providers all contributed to the marginalization of Salma's health (7).

Is it possible to both protect Salma, while also addressing the important public health implications of HIV in sex worker communities? Can this be done without worsening societal stigma and further criminalizing women who are already being exploited by oppressive and misogynistic systems? Furthermore, is there a role for the physician to assume in preventing HIV transmission to other sex workers in the Perna community? This requires thoughtful and tactful effort by the clinician, who must become both a doctor for the individual, and the community.

For Salma's safety and her trust in the physician-patient relationship, it must be emphasized to her that her personal medical accounts are completely confidential. In the United States, physicians in several states have a legal obligation to disclose infectious public health threats to the public health department (8). Furthermore, in HIV cases, physicians can disclose the status of the patient to their partners without their consent if reasonable attempts have been made to convince the HIV infected individual to voluntarily disclose, and if the physicians feels that the partners is at risk of contracting the disease as a result (9). However, Indian law does not currently have strict guidelines on the disclosure of HIV status when such disclosure is likely to result in harm to the patient. In the Perna community, there are high rates of domestic violence, and harm to Salma would certainly result from disclosure to her husband (1). It is important to explain to Salma that HIV transmission occurs through unprotected sexual intercourse, including the possibility of oral, anal, and vaginal sex. Furthermore, Salma should be transitioned into regular visits with an infectious disease clinic to monitor her HIV.

Given the sexual health burden of the community, a practitioner may consider advocating for general sexual education outreach efforts in conjunction with distribution of condoms in Salma's community. Furthermore, the promotion of medical camps in the community for regular STI checks will be of immense public health importance.

With regards to the protection of the health of the public and your patients, it will be essential to reiterate modes of HIV transmission, while warning them of high-risk groups, one of which

is female sex workers. By addressing the need for condom use as a self-protecting measure for patients who may well also be clients, we can protect people who are not yet infected, and can slow the spread of HIV. Furthermore, it will be important to inform the public health department of known HIV prevalence in a sex worker community without needing to identify an individual.

CONCLUSIONS

Immense challenges remain, particularly as they relate to Salma's return to community sex work in which she suffers from many health risks aside from HIV, including physical and mental violence, substance abuse, and malnutrition. These require further work from medical anthropologists, mental health professionals, obstetricians/gynecologists, law-makers, local police, and politicians to begin addressing the criminal sex work systems. Furthermore, the use of "tradition" as a means of justifying oppressive systems that exploit women for economic gain must be challenged. These women are suffering, and their example truly calls into question the value of culture when it inherently devalues an entire gender. As physicians, we must protect the health of our society's most vulnerable, as well as the health of our society – but we must ensure that in doing so, we also do no harm.

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REFERENCES

- 1 Karan A. Understanding cultural female sex work in India and why tradition must be challenged. The Lancet Global Health Blog. December 2016. Available: <http://globalhealth.thelancet.com/2016/12/09/understanding-cultural-female-sex-work-india-and-why-tradition-must-be-challenged>. Accessed: 12 February 2018.
- 2 Elmes J, Nhongo K, Ward H, Hallett T, Nyamukapa C, White PJ, et al. The price of sex: condom use and the determinants of the price of sex among female sex workers in eastern Zimbabwe. *J Infect Dis*. 2014;210 Suppl 2:S569–78. PubMed <https://doi.org/10.1093/infdis/jiu493>
- 3 Karan A. Women in India's Cultural Sex Trade Need Healthcare. Huffington Post. January 2017. Available: http://www.huffingtonpost.com/entry/why-healthcare-is-essential-to-overcoming-the-cultural_us_58791a1ce4b03e071c14fca4. Accessed: 12 February 2018.
- 4 O'Neil J, Orchard T, Swarankar RC, Blanchard JF, Gurav K, Moses S. Dhandha, dharma and disease: traditional sex work and HIV/AIDS in rural India. *Soc Sci Med*. 2004;59:851–60. PubMed <https://doi.org/10.1016/j.socscimed.2003.11.032>
- 5 Scorgie F, Nakato D, Harper E, Richter M, Maseko S, Nare P, et al. "We are despised in the hospitals": sex workers' experiences of accessing health care in four African countries. *Cult Health Sex*. 2013;15:450–65. PubMed <https://doi.org/10.1080/13691058.2012.763187>
- 6 Jie W, Xiaolan Z, Ciyong L, Moyer E, Hui W, Lingyao H, et al. A qualitative exploration of barriers to condom use among female sex workers in China. *PLoS One*. 2012;7:e46786. PubMed <https://doi.org/10.1371/journal.pone.0046786>
- 7 Lafort Y, Lessitala F, Candrinho B, Greener L, Greener R, Beksinska M, et al. Barriers to HIV and sexual and reproductive health care for female sex workers in Tete, Mozambique: results from a cross-sectional survey and focus group discussions. *BMC Public Health*. 2016;16:608. PubMed <https://doi.org/10.1186/s12889-016-3305-5>
- 8 Center for Disease Control. State Statutes Explicitly Related to Sexually Transmitted Diseases in the United States. June 2014. Available: <https://www.cdc.gov/std/program/final-std-statute-sall-states-5june-2014.pdf>. Accessed: 12 February 2018.
- 9 HIV.gov. Limits on Confidentiality. Available: <https://www.hiv.gov/hiv-basics/living-well-with-hiv/your-legal-rights/limits-on-confidentiality> Accessed: 12 February 2018.