## Protecting female migrants from forced sex and HIV infection

We thank Nyovani Janet Madise and Bernard Onyango for their comments[1] on our Article.[2] They question our insufficient elaboration on poverty as an underlying cause of forced sex in relation to HIV for migrant women. However, our study characterised, with an innovative life-course approach, the adverse living conditions faced by migrant women when they are subjected to forced sex after migration. We showed that administrative and housing insecurity are specific forms of poverty faced by migrant women.[2] These insecurities, observed in large cities in Europe, result from European immigration policies and structural inequalities.

We agree with Madise and Onyango that our study would benefit from a stronger framework on the link between gender and HIV, but one developed in relation to the context of migration. Our research is based on a structural approach of the gendered determinants of HIV in the specific context of migration from sub-Saharan Africa to Europe. Our study questions the relation between structural forms of violence against migrants and sexual violence against migrant women as a gendered determinant of HIV infection.[2] The results show that policies denying access to human rights entail gendered insecurities by making women dependent upon transactional sex and multiple sexual partnerships to access basic survival needs. Transactional relationships increase the risk of forced sex.[2] Women's dependence upon men, including intimate partners, acquaintances, and family members, strengthens the appropriation of women's bodies by men,[3] making women more likely to be exploited or abused in domestic work, sexual services with sexual harassment, and forced sex. Control over women and intimate partner violence increase risk of incident HIV infection[4].

Madise and Onyango point out legal and social barriers to access to care as one of our Article's understated powerful messages. However, in France, unlike some other European countries, access to the health-care system, whether regular or irregular, is relatively effective for migrants. Nevertheless, this is not enough to stop the spread of HIV infection, which requires an additional strong social and political response.

The strength of our study is the identification of women who were infected with HIV after migration using a combination of life-event and clinical data. The individual-level estimate is as high as 30% for women. As noted by Madise and Onyango, another study[5] has revealed a high level of HIV infection among migrant women once in Europe, but contrary to our estimate, this is not derived from a representative sample.

We declare no competing interests.



*Julie Pannetier, Andrainolo Ravalihasy, Nathalie Lydié, France Lert, Annabel Desgrées du Loû*
**julie.pannetier@ceped.org**

CEPED, IRD, Université Paris Descartes, Inserm, équipe SAGESUD, Paris, France (JP, AR, FL, ADdL); and Santé publique France, Saint-Maurice, Paris, France (NL)

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