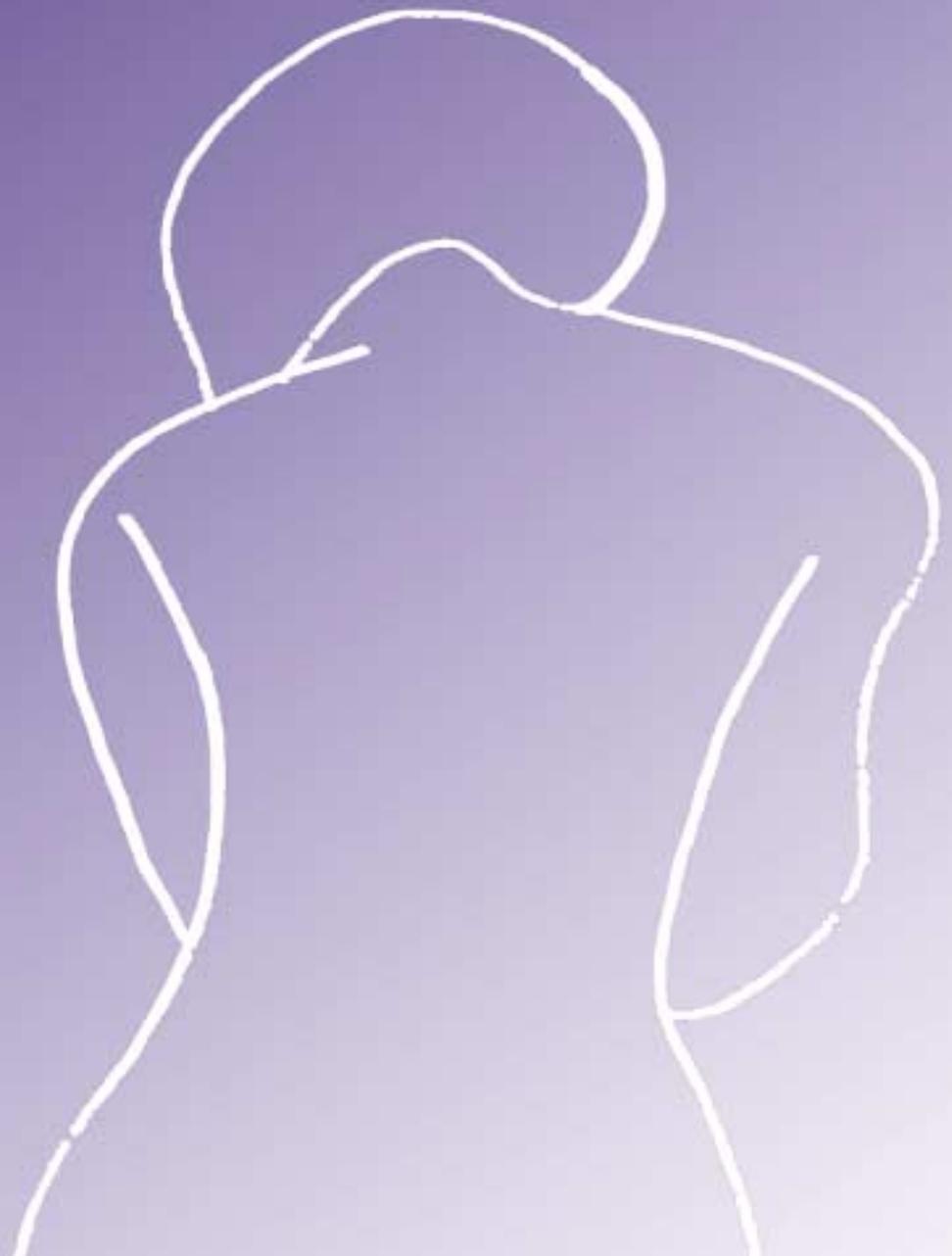


The Health Risks and Consequences of Trafficking in Women and Adolescents

Findings from a European Study

including:
Human Rights Analysis of Health and Trafficking and
Principles for Promoting the Health Rights of Trafficked Women



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The health risks and consequences of trafficking in women and adolescents findings from a european study

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Trafficked Women Defining Trafficking

What comes to your mind when you hear the term “trafficking in women?”

Oh-oh-oh! Terrible, serious problem.

I think about pain, loneliness. It is very painful, for me, to think about this.

I know what it means, it had just happened to me. I was being sold as though I was cattle. I was being captured and stripped of all my dignity and self-control.

Disgust and hate for all those people. It is a nightmare, I'd never have thought that so many girls get in such situations.

Something horrible, the most terrible experience a woman could face.

It upsets me. It is a nightmare. I'd never have thought that so many girls get in such situation.

It reminds me of my life and that of my colleagues. It's like slavery.

It hurts because I live through it myself. I've been trafficked. I feel bad. It's disgusting. I feel bad for the girls, and the pimps are disgusting the way they treat them.

Very bad. Terrible, serious problem. Because there is unemployment.

I think about the girls working as prostitutes as I did. I want to help them, but I don't know what to do.

Anyway, I am a woman. I feel sorry for the girls and sorry that I cannot help them.

I remember my story. Police are combating it, but not very successfully.

I don't like this term.

I want to put in jail all the people who are guilty in trafficking. I'd like to kill them. Too many people deal in trafficking of people.



Summary of findings and general recommendations

Overview of study

This report represents the findings of a two-year multi-country study on women's health and trafficking to the European Union. It is an initial inquiry into an area about which little research has previously been conducted. Interviews were conducted by researchers in Albania, Italy, the Netherlands, Thailand, and the United Kingdom with women who had been trafficked, health care and other service providers, NGOs working against trafficking, law enforcement officials, and policy-makers.

Summary findings

Conceptualising health and trafficking

- The health risks, consequences, and barriers to services for trafficked women are similar to those experienced by other marginalised groups, including:
 1. migrant women;
 2. women experiencing sexual abuse, domestic violence, or torture;
 3. women sex workers; and
 4. exploited women labourers.
- Trafficking often has a profound impact on the health and well-being of women. The forms of abuse and risks that women experience include physical, sexual and psychological abuse, the forced or coerced use of drugs and alcohol, social restrictions and manipulation, economic exploitation and debt bondage, legal insecurity, abusive working and living conditions, and a range of risks associated with being a migrant and/or marginalised. These abuses and risks impact women's physical, reproductive, and mental health, may lead to the misuse of drugs or alcohol, diminish women's social and economic well-being, and limit their access to health and other support services.
- The range of health needs of trafficked women, and the different opportunities to provide services are best understood by considering each stage of the trafficking process, including:
 1. pre-departure;
 2. travel and transit;
 3. destination;
 4. detention, deportation, and criminal evidence; and
 5. integration and re-integration.

Pre-departure stage

Women's health status and knowledge about health prior to leaving home affects their health throughout a trafficking experience.

- There are a number of common factors that make women vulnerable to trafficking and exploitation. Factors influencing trafficked women's decision to migrate included poverty, single parenthood, a history of interpersonal violence, and coming from a disrupted household.
- Women who were trafficked often had limited information and many misconceptions about key aspects of their own health – for example, only one of 23 trafficked women interviewed during the study felt well-informed about sexually transmitted infections or HIV before leaving home. This lack of knowledge has implications for women's later health and health seeking behaviour.

Travel and transit stage

During the travel and transit stage of the trafficking process women were faced with the risk of arrest, illness, injury, and death from dangerous modes of transport, high-risk border crossings, and violence.

- Before starting work in a destination setting, nearly half of the 23 trafficked women interviewed had been confined, raped, or beaten during the journey.
- During the travel and transit stage women may experience an "initial trauma" that is usually acute, and triggers survival responses that engender symptoms of extreme anxiety that can inhibit later memory and recall. The impact that trauma can have on memory may have significant effects later when women are questioned by law enforcement officials, asked to provide criminal evidence, or participate in trial proceedings.
- Women who are trafficked often blame themselves for having failed to recognise the deceptive or violent recruitment tactics used by traffickers, or for not having escaped the exploitative situation in which they are placed. These feelings of guilt may later contribute to women's low self-esteem, and make them wary of trusting others.
- Women interviewed for this study rarely had access to health information or care while in transit.

Destination stage

The extreme violence and psychological stress women experienced during the destination stage pervaded their

work and personal lives, and had a major impact on their health.

Physical health

- Twenty-five of 28 women reported having been “intentionally hurt” since they left home. The majority of reported injuries and illness were the result of abuse.
- Women reported broken bones, contusions, pain, loss of consciousness, headaches, high fevers, gastrointestinal problems, undiagnosed pelvic pain, complications from abortions, dermatological problems (e.g., rashes, scabies, and lice), unhealthy weight loss, and dental and oral health problems.
- Women were deprived of food, human contact, valued activities and items, and held in solitary confinement.

Sexual and reproductive health

- All women reported having been sexually abused and coerced into involuntary sexual acts, including rape, forced anal and oral sex, forced unprotected sex, and gang rape.
- Six of thirteen women reported having unprotected anal sex.
- Gynaecological complications were the most commonly reported health problems.
- Only four of twenty women knew where to go for medical care in the destination country.
- Of twenty-two respondents, nearly one-quarter reported having had at least one unintended pregnancy and a subsequent termination of pregnancy in the destination country. For one woman, an illegal abortion resulted in near-fatal complications.
- Most women who worked as sex workers reported having 10 to 25 clients per night, while some had as many as 40 to 50 per night.
- Nearly one-quarter of the women reported not using condoms regularly or at all for vaginal sex with clients, and more than half did not use them with intimate partners or pimps.

Mental health

- Psychological control tactics used by traffickers to manipulate women and create dependency included, intimidation and threats, lies and deception,

emotional manipulation, and the imposition of unsafe and unpredictable events. These tactics served to keep women intimidated, uncertain of their immediate and long-term future, and therefore obliged to obey the demands of the traffickers.

- Eight of twelve women reported having at least half of 21 negative mental health symptoms during the time they were in the destination stage and under the control of the trafficker. Of these, four reported 15 or more symptoms.
- The most common reported symptoms were: *feeling easily tired; crying more than usual; experiencing frequent headaches, frequently feeling unhappy or sad; and feeling as though they were not as good as other people or permanently damaged.*
- Six of nine women who responded to questions about suicide, reported having thought about committing suicide.

Substance abuse and misuse

- Women explained how traffickers forced or coerced them to use drugs or alcohol to encourage them to take on more clients, work longer hours, or perform acts they might otherwise find objectionable or too risky.
- Some women chose to use drugs, alcohol or cigarettes to cope with their situation.
- Women related their use of alcohol to the trafficking situation – none of the women who reported drinking while working had consumed alcohol in their home country.

Social well-being

- While in the trafficked situation women were isolated as a result of:
 1. restricted movement, time, and activities;
 2. absence of social support; and
 3. linguistic cultural, and social barriers.
- None of the women reported feeling free to do as they liked. Some were physically confined, others were under regular surveillance.
- The majority of women had little to no contact with family members.

Economic-related well-being

- Women were subjected to debt-bondage and other usurious financial arrangements that pushed them to

The health risks and consequences of trafficking in women and adolescents. findings from a european study.

- take risks, withstand long hours, and serve more clients.
- Twenty-two of thirty women reported keeping little (8) to none (14) of their earnings. Fifteen said they were unable to buy basic necessities. This severely limited their ability to maintain acceptable levels of hygiene, and to care for their physical and psychological health.

Legal security

- None of the women arranged their own travel documents or work permits. Few maintained possession of their identity papers.
- Women were commonly insecure about their immigration status and legal rights, which made them hesitant to use health or other formal services, and reluctant to seek outside help.

Occupational and environmental health

- Nearly all respondents worked seven days per week, described the working conditions as “bad” or “terrible,” and were forced to perform acts that were a danger to their health and for which they expressed a personal loathing.
- Half the respondents lived in the same place they worked. Two slept in the same bed in which they worked.

Health service uptake and delivery

- Despite the severe health effects of trafficking, women’s access to health information and medical care was extremely limited. This lack of access resulted because of the traffickers’ restrictions on women’s movements, women’s lack of knowledge about available care options, and because of women’s fear of local authorities.
- There are many barriers to providing health services to trafficked women in destination countries. Most contact is likely to be made through “outreach programs” or mobile services directed at women in sex work, or women working in other labour sectors that are known to employ trafficked women.
- Key challenges related to providing services to trafficked women include:
 1. meeting women’s multi-dimensional service needs;
 2. accessing women in safe and appropriate ways;
 3. overcoming language and cultural barriers;
 4. gaining trust and offering support; and

5. developing strategies to address women’s lack of security and frequent mobility.

- Services are most likely to foster women’s overall well-being if care is holistic in nature, and integrates health promotion and service delivery with other practical forms of assistance (e.g., legal, social service, language).

Detention, deportation, and criminal evidence stage

During the detention, deportation, and criminal evidence stage women were rarely offered opportunities to address their health needs, and their health was often negatively affected by the multiple stresses related to this time period. Findings related to the detention, deportation, and criminal evidence stage are based primarily on interviews with law enforcement officials, trafficked women who came into contact with law enforcement authorities, and several service providers.

- Immigration and police authorities interviewed in Italy, United Kingdom, and Ukraine acknowledged that they do not have victim-sensitive procedures to determine, or to meet the health needs of trafficked women.
- Trafficked women rarely view law enforcement officials as a source of assistance. Only one of twenty-eight respondents actively sought the help of authorities with the belief that she was a victim of a crime.
- When in the custody of authorities, women reported that conditions ranged from “horrible” (for the majority), to good, (for the minority).
- Deportation procedures rarely include systematic inquiry into whether women have pressing health needs or safety concerns.
- Service providers and police suggest that a “reflection period” has significant benefits to women’s physical and mental health and well-being, and police interviewed in destination settings stated that this time period can foster women’s capacity to participate in criminal proceedings.
- The experience of testifying takes a significant toll on women’s physical and mental health, which can, in turn, negatively affect the outcome of the criminal proceeding.

Integration and reintegration stage

The integration and reintegration stage can have both positive and negative health effects that are often

directly related to the amount and quality of support a woman receives. Findings related to integration and reintegration are based on interviews with women who had escaped the trafficking situation, and with providers who assist with the integration and reintegration of trafficked women.

- Although the integration and reintegration process is a time of physical recovery and psychological and social reorientation, only the smallest minority of trafficked women receives adequate physical health care and psychological support after a trafficking experience. The experience of providing services to trafficked women highlights that women react differently to individual experiences of abuse and exploitation. Many sustain serious and enduring physical and mental health complications. However, many do not fit the image of a destroyed victim.

Access to health services during the integration and reintegration period

- The integration and reintegration process poses numerous health concerns similar to those faced by refugees, recent immigrants, and returnees.
- Women returning home generally found access to health services to be difficult and expensive, services to be of poor quality, and mainstream practitioners to vary greatly in their level of information and sensitivity. As women's access was often dependent on their ability to pay, most were not able to afford the full range of care that they needed. Lack of confidentiality was a significant concern in many settings, with women fearing that stigmatising personal details would not remain confidential
- Women remaining in destination countries generally perceived health services to be of good quality. However, their access to health and other services was often dependent on their willingness to cooperate in criminal proceedings against traffickers.

Overview of the process: meeting women's needs

Based on interviews with service providers who assist women during the integration and reintegration stage, the process of service provision was commonly divided into three stages:

Stage one: crisis intervention, and meeting practical needs

- Issues often addressed during the initial encounters between a provider and client included:
 1. meeting a woman's practical needs,

2. ensuring personal security;
3. assisting with documentation;
4. arranging shelter, housing; and
5. multi-sector service coordination.

- Care providers tried to earn women's trust by offering tangible assistance, approaching women and sensitive subjects slowly and in non-judgemental ways, and maintaining continuity of care.
- Women in both integration and reintegration settings expressed concerns about their personal safety, and reprisals of traffickers.
- Legal and funding restrictions often limit the availability and duration of service provision, emergency shelter, and longer term housing for trafficked women.
- Service providers working with trafficked women often coordinate with providers from different sectors such as, medical, legal aid, social service, education, occupational training, and in some cases, law enforcement.

Stage two: meeting medical needs, setting personal and tangible goals

- The second stage of care generally involves medical assessment, and treatment of women's physical, sexual and reproductive, and mental health needs.
- Women were treated for STIs, respiratory infections, external injuries, dermatological problems, and reproductive health complications (including pregnancy and terminations).
- Groups assisting trafficked women try to accompany women to outside medical care facilities and other appointments to offer practical assistance and emotional support throughout what are often unfamiliar and intimidating procedures.
- Psychological sequelae are often the most persistent and complex health outcomes.
- Care providers work to address women's mental health needs by:
 1. assuaging women's guilt and shame;
 2. building trust;
 3. understanding women's external aggression;
 4. identifying ways to work effectively with interpreters; and
 5. offering socially and culturally competent care.
- Some women find it difficult to recalibrate their

responses for non-violent, non-exploitative settings. Survival and coping mechanisms that are no longer necessary may detrimentally affect the way women relate to others.

- Support can come in many forms, and is often dependent on the available resources, customs and culture of each setting. Where possible, women's most important source of support is family and friends.

Stage three: recognising longer term mental health issues, and helping women to look towards the future

- The third stage of care provision is generally when providers focus on preparing women for an independent and self-sufficient future.
- For women living outside their home country, language, cultural, and social orientation are the first building blocks to their independence.
- For both women remaining in destination countries, and women returning home, employment is a critical bridge between the debilitating memories of past and a self-sufficient future.
- For women returning to their family, groups try to aid the reunification process by contacting a woman's family members and emphasising her need for emotional support.
- The longer-term support that is important to addressing women's enduring psychological reactions is rarely accessible for most women.
- While recognisable patterns of need exist and can be prepared for, there is no blueprint for the process of integration or reintegration, as every woman has unique needs that require individual responses.

Support for support workers

- Assisting victims of trafficking can be stressful, and emotionally exhausting work. Staff can benefit from regular support from management and colleagues.

General recommendations

1. Recognise trafficking as a health issue.
2. Recognise trafficked women's rights to health and health services as primary and fundamental elements of their legal and human rights.
3. States should adopt the UN Palermo Protocol.¹ States and donors should increase their commitment and financial support in order to implement provisions proposed in Article 6.² Specifically, States should increase the priority and funding accorded trafficked women's health and protection to a level commensurate with the severe harm caused by trafficking and take appropriate action to make gender and culturally appropriate provision for the physical, psychological and social recovery of female victims of trafficking, including medical, psychological and material assistance, appropriate housing, counselling, legal information, and employment and training opportunities.
4. Develop health-related prevention and intervention strategies for trafficking based on existing models of good practice established for other forms of violence against women (e.g., domestic violence, rape and sexual abuse) and models established for integration of immigrants and reintegration of returnees. Models should include gender- and culture-specific strategies developed for medical care, social service practices, health education, public awareness, and protocols and training for law enforcement response.
5. Increase awareness of health risks and consequences of trafficking among government, key policy-makers, public health officials, health care providers, law enforcement agencies, and relevant non-governmental and international organisations, and donors.
6. Fund, develop, and implement training and education programs for health care providers in relevant sectors that include, but are not limited to: information on trafficking, physical, sexual, reproductive, social, and mental health consequences, and culturally competent treatment approaches.
7. Reduce the political, social, legal, and financial barriers that impede measures that promote the well-being of women at risk of being trafficked, and that hinder the provision of adequate health interventions for who are trafficked.
8. Fund and promote health outreach services to vulnerable migrant women in sectors known to

Summary of findings and general recommendations

employ trafficked women in destination countries, and ensure that care is offered in appropriate languages.

9. Fund the development of victim-sensitive procedures for use by law enforcement officials to identify, interview, and assist trafficked women.

10. Promote the development of a European Union and/or World Health Organization document to be distributed to migrant and travelling women from known countries of origin (produced in various languages) that includes:

- summaries of primary health risks and consequences related to migration and trafficking;
- definitions and descriptions of symptoms of common and severe illnesses among migrant and trafficked women, and related treatment options;
- definitions of trafficking, various forms of gender-based violence, and forms of exploitation, including descriptions of the health implications; and
- translation of key health words and phrases in relevant languages.

11. Respect and apply the principles set forth in the European Council on Refugees & Exiles' (ECRE) "Good Practice Guide on the Integration of Refugees in the European Union",³ integrating measures to meet the special needs of trafficked women. Specifically, implement measures to adhere to the principles outlined for "health," including recognition that:

- "...lack of adequate and health reception conditions during the initial stage of arrival can seriously undermine refugee long-term health and integration prospects."
- "...specialised refugee services should form a permanent part of mainstream health provision and benefit from long-term public support. They should act as "...bridges" to mainstream provision and focus on specific care and treatment needs resulting from experiences in the country of origin and during a refugee's flight to safety."
- "...key priority should also be given to the establishment of interpreting and mediation services as well as the promotion of health education and prevention programmes."

12. Fund and carry out research on:

- Effective mechanisms for disseminating health-related information to migrant women, including a review of currently available

information targeted at migrant women.

- Appropriate models of multi-sectoral service provision working with migrant women at risk, including a review of outreach practices.
- Short and longer-term psychological outcomes of victims of trafficking.
- The range of health outcomes among trafficked women.
- Social well-being and the process of integration and reintegration among trafficked women.
- Models of service provision for integration and reintegration.
- Health-related services for victims of other forms of gender violence (i.e., intimate partner violence, sexual assault) to compare to existing practices and the advancement of support services for victims of trafficking.
- Good practice procedures and guidelines used by law enforcement officials, health care providers and NGOs to assist victims of sexual assault and domestic violence in order to develop an appropriate model for trafficked women.

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References

¹ United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing The United Nations Convention Against Transnational Organized Crime.

² Section II, Article 6 Assistance to and protection of victims of trafficking in persons:

“3. Each State Party shall consider implementing measures to provide for the physical, psychological and social recovery of victims of trafficking in persons, including, in appropriate cases, in cooperation with non-governmental organizations and other relevant organizations and other elements of civil society, and, in particular, the provision of:

- a) Appropriate housing;
- b) Counselling and information, in particular as regards their legal rights, in a language that the victims of trafficking in persons can understand;
- c) Medical, psychological and material assistance; and;
- d) Employment, educational and training opportunities.

4. Each State Party shall take into account, in applying the provisions of this article, the age, gender and special needs of victims of trafficking in persons, in particular, the special needs of children, including appropriate housing, education and care.

5. Each State Party shall endeavor to provide for the physical safety of victims of trafficking in persons while they are within its territory. Each State Party shall ensure that its domestic legal system contains measures that offer victims of trafficking in persons the possibility of obtaining compensation for damages suffered.”

³ The European Council on Refugees & Exiles (ECRE), ECRE Task Force, Gaunt, S. et. al. (eds.) “Good Practice Guide on the Integration of Refugees in the European Union”: http://www.ecre.org/erfproject/good_practice/intro.pdf.

Terms and Definitions

Health:

“A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.¹

Trafficking:

“The recruitment, transportation, transfer, harbouring or receipt of persons by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power, or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at minimum, the exploitation of prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.”²

Trafficker:

“Person responsible for, or knowingly participating in the trafficking of women. In this report, perpetrators of trafficking include recruiters, agents, pimps, madames, pimp-boyfriends, employers, or owners of venues that exploit trafficked women.

Violence against women:

“Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life.”³

Trafficked woman:

“A woman who is in a trafficking situation or who has survived a trafficking experience. For the purpose of this report, the term “woman” also includes adolescents.”⁴

Pre-departure stage:

“The period before a woman enters the trafficking situation.”

Travel and transit stage:

“The travel and transit stage begins at the time of recruitment when a woman agrees to, or is forced to depart with a trafficker (whether she is aware that she is being trafficked or not). This stage ends when she arrives at her work destination. It includes travel between work destinations and often involves one or numerous transit points.”

Destination stage:

“The period that a woman is in the location where she is put to work and subjected to coercion, violence, exploitation of her labour, debt-bondage or other forms of abuse associated with trafficking.”

Detention, deportation, and criminal evidence stage:

“The period when a woman is in the custody of police or immigration authorities for alleged violation of criminal or immigration law, or co-operating, voluntarily or under threat of prosecution or deportation, in legal proceedings against a trafficker, pimp or madame, exploitative employer or other abuser.”

Integration and re-integration stage:

“The period that consists of a long-term and multi-faceted process that is not completed until the individual becomes an active member of the economic, cultural and civil and political life of a country and perceives that she has oriented and is accepted.”⁵

References

¹ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

² United Nations. (2000). 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.N. GAOR Supp. (No. 49) at 60, U.N. Doc. A/45/49 (Vol. I).

³ United Nations General Assembly. (1993). Declaration on the elimination of violence against women. Proceedings of the 85th Plenary Meeting, Geneva, Dec. 20, 1993, United Nations General Assembly.

⁴ An adolescent is between the ages of 11 and 19, according to WHO Department of Child and Adolescent Health. See: WHO Dept. of Child and Adolescent Health and Development. (n.d.) *Overview of Child and Adolescent Health*. [Webpage] URL www.who.int/child-adolescent-health/over.htm

⁵ Adapted from The European Council on Refugees & Exiles (ECRE) ECRE Task Force, Gaunt, S. et. al. (eds.) (1999) Good Practice Guide on the Integration of Refugees in the European Union: http://www.ecre.org/erfproject/good_practice/intro.pdf.

Aims and methodology

Aims

This report represents the findings of a two-year study on women's health and trafficking in the European Union. The study is an initial inquiry into an area for which little research has previously been conducted. The overarching aims of the study were to highlight the many health risks and consequences of trafficking in women, and to provide information on women's health needs for use by care providers, social services agencies, law enforcement and immigration officials, and policy makers.

Specific objectives

1. Develop appropriate frameworks to conceptualise the health risks and consequences to women and adolescents (hereafter referred to as "women") of being trafficked.
2. Describe the range of health risks and consequences to women of being trafficked.
3. Identify and discuss obstacles and opportunities for health care provision during different stages of the trafficking process.
4. Make recommendations for strategies to improve health-related responses to trafficked women.
5. Develop a set of ethical and safety recommendations for interviewing trafficked women.
6. Develop a legal and human rights analysis of health and trafficking that can be used to guide the development of rights based standards for use by organisations providing assistance to trafficked women, and by law enforcement and immigration officials dealing with cases of trafficking in women.

Study partners and participants

The study was conducted by:

London School of Hygiene & Tropical
Medicine (LSHTM), United Kingdom

University of Padova, Department of
Sociology, Italy

La Strada, Ukraine

International Catholic Migration
Committee, Albania (ICMC)

Global Alliance Against Trafficking in
Women, Thailand (GAATW)

STV, Foundation for Women, Netherlands

London Metropolitan University, Child and Woman
Abuse Studies Unit (CWASU), UK

The London School of Hygiene & Tropical Medicine

(LSHTM) took overall responsibility for the study design, coordination, and drafting of the findings.

Methods

A variety of qualitative methods were used to compile information from a range of sources. The paucity of existing information on this topic made it necessary to draw extensively from different key informants (including trafficked women and service providers), and from the body of literature on health, migration, violence, law and human rights. Gender and action-based research approaches,^{1,2} influenced the design and implementation of the study, including the development of the ethical recommendations, interview techniques, the interpretation of data, and the recommendations.

Overview of the study methodology

1. Literature review.
2. Development of conceptual frameworks.
3. Development of *World Health Organization (WHO) Ethical and Safety Recommendations for Interviewing Trafficked Women*³ in collaboration with the Department of Gender and Women's Health, World Health Organization, and an input and review process with an international panel of experts on trafficking in women.
4. Legal and human rights analysis of trafficking and health, draft *Principles Promoting the Health Rights of Trafficked Women*.
5. Development of study instruments by LSHTM and review and testing by study partners.
6. Interviews with a total of 28 trafficked women and adolescents in Italy, United Kingdom, the Netherlands, Ukraine, Albania, and Thailand.
7. Interviews with a total of 107 key informants in eight countries from the health, law enforcement, government, and NGO sectors.
8. Data analysis, report drafting, and review of report by partners.

1. Literature review

A comprehensive review of health and trafficking literature was conducted to a) inform the development of the conceptual framework; b) inform the development of the study tools; and c) supplement the qualitative data collected during the study. For this, published and unpublished literature in the following subject areas was reviewed:

1. Trafficking information
 - general;
 - regional; and
 - country-specific .
2. Health and
 - interpersonal and other forms of violence against women;

- torture and organised violence;
 - sex work;
 - women's health (e.g., general, sexual, reproductive, mental, social health);
 - migrant domestic labour, other forms of exploited labour; and
 - migration, refugee and migrant populations;
 - human rights and legal rights.
3. Country-specific health-related data, descriptions, case examples, and analyses.
 4. Ethics, biomedical ethics, women's rights, and human rights.
 5. Relevant international and European instruments, policies, and legislation on related subjects, i.e., trafficking, health care, health and care for migrant populations, HIV/AIDS, and human rights.

2. Development of conceptual frameworks

As health has not been a central theme of trafficking-related research, three frameworks were developed to help conceptualise the health risks, consequences, and issues in service provision related to trafficking:

Framework 1: Stages of the trafficking process

Framework 2: Spheres of marginalisation and vulnerability

Framework 3: Health risks abuse and consequences

Because trafficked women are sexually and economically exploited, experience physical and other forms of violence, are part of a migrant population, and often work in the sex industry, frameworks were developed based on existing conceptual models that examine health in the subject areas of migration, intimate partner violence, sexual abuse, labour exploitation, and sex work. The frameworks, research strategy, interview tools and data analysis draw on each of these perspectives. Framework 1 forms the basis for the report's structure.

3. Development of *World Health Organization Ethical and Safety Recommendations for Interviewing Trafficked Women*

Interviewing a woman who has been trafficked raises a number of ethical questions and safety concerns for the victim, others close to her, and for the interviewer. In the process of gathering information there is the danger that the safety and individual needs of victims may not be adequately addressed. Having a sound understanding of the risks, ethical considerations, and the practical realities related to trafficking can help minimise the danger to both the woman and the interviewer. Adopting an ethics-based approach can also increase the likelihood that a woman will disclose relevant and accurate information.

These guidelines were drafted in consultation with a group of experts on trafficking and violence against

women, most of whom have worked directly with women who have been trafficked. These guidelines have taken as a starting point, the *World Health Organisation (WHO) Putting Women's Safety First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women*⁴ and incorporated elements of the *Human Rights Standards for the Treatment of Trafficked Persons*,⁵ *International Principles and Guidelines on Human Rights and Human Trafficking*,⁶ *VIP Guide. Vision, Innovation and Professionalism in Policing Violence Against Women and Children*,⁷ *International Ethical Guidelines for Biomedical Research Involving Human Subjects*⁸ and reporting guidelines for media and journalists.⁹

The *WHO Ethical and Safety Recommendations for Interviewing Trafficked Women* (see Appendix A) were sent out for input, review and comments three times to selected experts on trafficking in women and to all study partners. The fourth and final review was carried out by LSHTM's study team, and WHO's Department of Gender and Women's Health. The study methodology was approved by the LSHTM ethical committee.

4. Legal and human rights analysis of trafficking and health

A review and analysis of health-related provisions of international and regional human rights instruments and standards was carried out with the aim of clearly establishing trafficked women's legal and human rights to health and well-being, and concomitant State obligations to ensure that these rights are protected. This analysis serves as the basis for the draft *Principles Promoting the Health Rights of Trafficked Women* (see Appendix B).

5. Development, review and testing of study instruments

Five semi-structured qualitative questionnaires were developed to conduct in-depth interviews with:

- trafficked women;
- health and medical care providers;
- non-health-specific service providers and NGOs; (i.e., trafficking, women's groups, social services, refugee agencies);
- law enforcement officials (i.e., immigration and police); and
- policy-makers (e.g. donors, health care, law enforcement).

The structure of the questionnaire relied heavily on framework 1, with questions generally clustered around the stages of the trafficking process: pre-departure; travel and transit; destination; detention, deportation and criminal evidence; and integration and reintegration. Questions were framed to gather respondents' perceptions of the range of health risks directly and

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indirectly related to the trafficking experience (see *Conceptual framework 3*), health consequences, and intervention opportunities and obstacles. The questionnaire for interviewing trafficked women was designed to begin with less sensitive questions, moving gradually to more difficult issues.

Draft instruments were developed by LSHTM and were reviewed and revised collaboratively at the three-day "Fieldwork Preparation Workshop" that took place from 2-4 August 2001 in London. Six different, but coordinated questionnaires were developed to interview various key informants and trafficked women. Each questionnaire offered two sets of questions, reflecting whether the interview was being carried out in a European Union country or a non-EU country. The chart below outlines the different questionnaires by respondent, and highlights key themes of the interviews.

Question-information category	Trafficked women	Health care worker	NGO staff	Law enforcement, immigration officials	Policy makers, donors
Service provision, actual and perceived needs	Services received, perception of, experience with services in country of origin, services desired	Services available, requested, required, desired, multi-sector coordination, obstacles	Services available, requested, required, desired, multi-sector coordination, obstacles	Services available, requested, required, multi-sector coordination, obstacles	Activities addressed or funded, mission/philosophy
Past and current physical, sexual and mental health	Perceived health problems pre-departure, throughout stages, at present	Health problems encountered, treated	Health problems, perceived, encountered, referrals made	Health problems encountered	Health areas addressed or funded
Work	Work conditions, hours, violence, health risks, income	Perception, case examples of women's work conditions, health risks, etc.	Perception, case examples of women's work conditions, health risks, etc.	Perception, case examples of, records of women's work conditions, health risks, etc.	Perception of women's work conditions
Personal and social life	Living conditions, intimate partner, friends, contact with family, violence, freedom, personal expenditures	Perceptions of conditions of women's personal life and effects on health	Perceptions of conditions of women's personal life and effects on health	Perceptions of conditions of women's personal life and effects on health	Perceptions of conditions of women's personal life
Detention	Encounters with authorities, treatment by authorities	Referral by or contact with authorities	Referral by or contact with authorities	Health assessments capacity, health care available, multi-sector coordination	Policies or activities related to or funded in the area of law enforcement, immigration
Travel	Health hazards, problems during travel	Perceptions, case example of journey hazards	Perceptions, case examples of journey hazards	Perceptions, case examples of journey hazards	
Home and Return	Family, feelings about return, violence	Perception of women's return, activities related to prevention and return	Perception of women's return, activities related to prevention and return	Perception of women's return, activities related to deportation, return	Policies or activities related to prevention and return

Interviewers were encouraged to use the questionnaires liberally and to follow the respondent’s lead, listening for and pursuing subjects the respondent wanted to talk about. Probing words or questions were included in the questionnaire to help interviewers obtain more detailed information. Responses were documented. None of the interviews with trafficked women were recorded on audio tape. In some cases interviews with key informants were recorded on audio tape. Translation of materials from Ukraine, Thailand, Albania and the Netherlands was carried out by the interviewers who were all bi-lingual. Translations of Italian interview documentation were carried out by outside translators familiar with the subject of trafficking or health.

6. Interviews with trafficked women and adolescents

One of the greatest challenges associated with the study was to ensure that the findings reflected the perspectives of women who had been trafficked. Given the highly sensitive nature of the study topic and the potential dangers associated with trying to interview women who were in a trafficking situation, the study focused on interviewing women who had left the trafficking situation, who were in a position of relative safety, and who had access to support. For this reason the study sought to interview participants through relevant support organizations both in the EU partner countries and in three countries of origin. A total of 28 women who had been trafficked were interviewed for this study: 4 in Albania, 5 in Italy, 3 in the Netherlands¹⁰, 2 in Thailand¹¹, 4 in the United Kingdom and 10 in Ukraine. All of the respondents were contacted through a local support organisation with whom they had already developed a relationship. Women were interviewed in private by a member of the research team. In Albania, the Netherlands and Ukraine, the support organisation was also the study partner. In Thailand, the study partner was the sister organisation to the service provider. All interview case files were coded (no real names were used) and the files were stored in secure facilities.

Due to time limitations and the in-depth and qualitative interview format, women were not always able to respond to each question. For this reason, throughout the report, the number of women responding to different questions varies.

Overview of respondents

The demographic characteristics of the 28 respondents are described below. Study participants came primarily from Eastern Europe, with only two women coming from South East Asia (Laos). Women interviewed had mainly been trafficked from Central or Eastern Europe. All women interviewed were under 30, with a third being under twenty-one, and five were under eighteen. The youngest respondent was eleven years old at the time she was trafficked. Nine women had children, and seven were single parents.

Number of respondents by country of origin	Number of respondents by country of destination*	Number of respondents by age at time of interview
Ukraine -12	Italy - 11	ages 13-17: 5
Albania - 7	United Kingdom - 4	ages 18-21: 5
Romania - 3	Netherlands - 3	ages 22-25: 8
Kosovo - 2	Yugoslavia - 3	ages 26-28: 10
Laos - 2	Belgium - 2	
Lithuania - 1	Kosovo - 2	
Togo - 1	Thailand - 2	
	UAE - 1	
	Turkey - 1	
	Greece - 1	
	Albania - 1	

* Several women were trafficked to and worked in more than one country. Two women were trafficked to Kosovo and Yugoslavia, one woman worked in Italy and the UK, and one worked in Greece and Italy.

Of the 28 women interviewed, 25 had been trafficked into sex work, and three into domestic labour (where they were raped and abused). Most women reported being physically assaulted at some time during the trafficking process, and all reported being sexually abused and coerced. All women reported that they had physical and sexual ill-health effects resulting from the trafficking.

Characteristic	Number interviewed
Primary type of labour exploitation	25 sex work 3 domestic labour
Respondents reporting having experienced interpersonal violence before departure	7 of 20
Respondents reporting having experienced physical violence, (not including sexual violence) during trafficking experience	25 of 28
Respondents having experienced sexual abuse and coercion during trafficking experience	28 of 28
Respondents reporting physical, sexual or mental ill-health after trafficking experience	28 of 28

Women’s reported physical, sexual and mental health symptoms were based on women's own perceptions of their condition. No clinical examinations were conducted for this study.

7. Interviews with key informants

A total of 107 key informants were interviewed. A break down of the areas covered is given below:

Key informant by sector	Number interviewed
Medical, health services	38
Non-health specific organisations	39
Law enforcement and immigration	17
Policy makers	12
Madam	1

Medical and health-specific services:

A total of thirty-eight key informants from all countries, were interviewed. These included, family planning, reproductive health, gynaecological and obstetrics services; termination of pregnancy (TOP) services, refugee and immigrant health centres; sexual health outreach teams; sexual health clinicians treating sex workers; referral services for victims of trafficking; and mental health professionals working with refugees, victims of domestic and interpersonal violence and other forms of violence against women (i.e. sexual assault), victims of organised violence and torture, and victims of trafficking.

Non-health-specific organisations:

A total of thirty-nine key informants from all countries were interviewed from NGOs and international organisations. These included organisations providing shelter and other direct services to victims of trafficking; NGOs conducting prevention, education, legislative lobbying and law-related projects, and other anti-trafficking or sensitisation programs; immigrant and refugee services, sex-worker rights projects and cultural mediators.

Law enforcement and immigration:

Seventeen key informants from the United Kingdom, Italy, and Ukraine were interviewed from law enforcement, including police and immigration officials, and special police forces on trafficking.

Policy makers and donors:

Twelve key informants were interviewed, from government justice offices, international and multi-lateral donors in the United Kingdom, Italy, and

Ukraine, and the Uzbekistan embassy in Thailand. The project also benefited enormously from the participation of a member of the Italian research team, Professor Franca Bimbi (of the University of Padova), who is currently a Member of Parliament. In addition to her sociological perspective, Professor Bimbi offered invaluable political insights and analyses of government policy.

Madam:

One madam was interviewed in Ukraine.

8. Data analysis, report drafting, and “Partner Review Meeting”

Interview data were entered and coded using NVIVO NUD*IST for qualitative research analysis. Data were analysed using a multi-layered approach that considered the entirety of each woman’s individual experience in conjunction with patterns and themes identified throughout the group, and the perceptions and experiences of key informants. Data were examined, for example, for comparisons between women's and key informants’ perceptions of health needs, priorities, and experiences with treatment (service uptake and delivery) and reviewed within the overall context of women’s detailed case histories. Research and discourse from related subject areas (i.e., other forms of violence against women, vulnerable groups and health care provision to marginalised populations) assisted in the interpretation of findings.

A draft report was developed by LSHTM and reviewed at the “Study Partner Review Meeting” in November 2002. During this three-day working meeting, study findings were discussed and evaluated, study partners jointly drafted a set of “general” and “stage-related” recommendations, and discussed plans for distribution and public release of the report. *The WHO Ethical and Safety Recommendations for Interviewing Trafficked Women* were reviewed and finalised.

Study limitations

When reading the report it is important to recognise that the study has several limitations.

One of the first limitations emerged as the study team tried to develop questionnaires that would cover the diverse and complex phenomenon of trafficking. Trafficking involves a broad spectrum of experiences and assorted individual victim and survivor profiles. It involves a range of trafficker tactics, intervention strategies, and country settings. Developing questionnaires to explore this range of contexts is extremely challenging. As such, for some women and key informants certain questions were irrelevant, while for others the same questions accurately captured their background and experiences. This means, for example, that questions about risks and dangers during the voyage

were less relevant for women who traveled by a conventional means of transport (by train, air) than for women who traveled on foot through mountains or malaria-endemic jungles.

The second limitation was in trying to access women who had been trafficked into forms of exploitation other than sex work. In the end, with the exception of three women who worked as domestic servants, all 25 other respondents had been trafficked into prostitution. Although other forms of trafficking-related exploitation (e.g., domestic labour, factory labour, agricultural labour, begging, marriage) have numerous different health risks and consequences, it is also true that many are similar to those experienced by women trafficked into sex work. For this reason, it is anticipated that the findings may be generalised to represent many of the risks and consequences experienced by women exploited in other forms of labour, as well. Research on health and other forms of trafficking-related exploitation is urgently needed.

Similarly, as this study was on trafficking to the European Union, international trafficking was the focus. No information was gathered on the health implications of being trafficked within national borders. While many of the health risks and consequences may be similar, further research is needed on internal trafficking.

A third, and certainly not small difficulty in doing research on trafficking, is the political and sociological debate surrounding “trafficking.” The discourse on trafficking, prostitution, immigration, and human rights remains controversial. To isolate and examine the health needs of women who have been trafficked poses a number of complications. In highlighting the health of women trafficked into sex work, it was important to make certain that the discussion did not suggest that sex work is equivalent to forced prostitution, sexual exploitation or trafficking. Conversely, by promoting the health needs of women trafficked into sex work, there is a risk that sex workers who are not “trafficked,” but who may suffer equivalent exploitation and health complications may be erroneously implicated as less worthy of care.

Similarly, by focussing on the health needs of trafficked women, there were concerns that the health needs of other migrant women who are exploited in various forms of labour, but do not fit neatly under the legal definition of “trafficking” are marginalised or neglected. As pointed out by Anderson and O’Connell-Davidson:

“It is extremely difficult to come up with a universal yardstick by which “exploitation” can be measured” or “just how deceived a worker has to be about the nature and terms of the employment prior

to migrating before s/he can properly be described as a “victim of trafficking.”¹²

Not least, was the concern that in the current anti-immigrant climate that pervades the discussion of trafficking, this study would somehow be used to draw a solid but erroneous line dividing victims of trafficking from “others” who are perceived as “simply taking advantage of the system.” The difference between smuggled and trafficked has not yet been clarified in practice. Again, O’Connell and Anderson explain, “The trafficking/smuggling distinction represents a gaping hole in any safety net for those whose human rights are violated in the process of migration.”¹³

Findings in this study, while identifying the health risks and consequences associated with trafficking, are simultaneously suggestive of the dangers posed to similarly vulnerable and marginalised groups exposed to violence, exploitation and discrimination (e.g., migrant women, exploited labourers, sex workers) that need and deserve attention and care.

A fourth concern was that health and trafficking, viewed from a migration perspective, is broad enough that each stage could theoretically demand a separate study and a full set of study questions. For this research, however, we were able to offer only an initial exploration of most stages, giving the most attention to the health implications of the destination stage. It is our hope that by identifying the gaps for the other stages, and highlighting the importance of this information to improved service provision, further research will be funded to explore the health risks and intervention opportunities for each stage of the trafficking process.

A final challenge was in gathering information about the treatment of trafficked women by authorities. While most police and immigration officials were co-operative during interviews, there are very few countries that have developed and implemented victim-sensitive procedures for women who have been trafficked. Because so little is in place to address women’s needs once they are under the auspices of police or immigration offices, the responses of authorities during interviews were either based on a very limited number of experiences addressing women’s health needs or were speculative.

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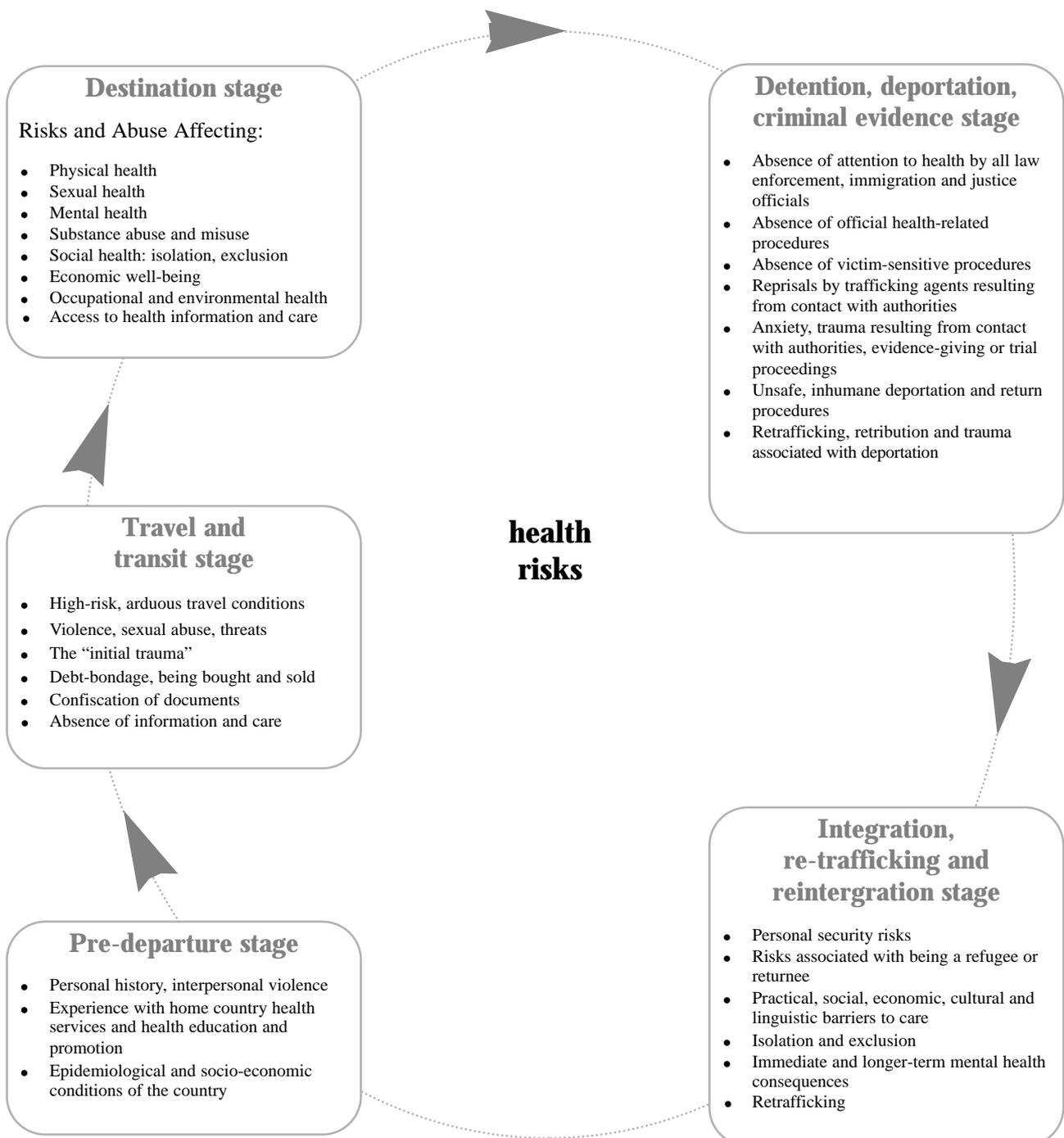
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- ¹¹ Two additional interviews were carried out with migrant women from Uzbekistan who worked in sex work in Bangkok and, at the time of the interview, were being held in the Immigration Detention Centre (IDC) in Thailand. These women are not represented at any time as trafficked women and, as such, not included in numbers representing respondents. Where relevant, their experiences in the IDC are related in the text. The two other women were from Laos trafficked to Thailand and their experiences are represented in the text.
- ¹² Anderson B. & O'Connell-Davidson J. (2002). *Trafficking - A Demand Led Problem? Part I: Review of Evidence and Debates*. Stockholm: Save the Children, Sweden.
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Conceptual frameworks

Introduction

The relationship between public health and violence against women is increasingly being recognised.¹ In the case of trafficking in women, however, health has not been a central theme of research. To gain a fuller appreciation of the health risks and challenges of service provision to women who have been trafficked, three frameworks that illustrate some of the risk and health dimensions have been developed for this study. The frameworks draw on larger bodies of work in related areas, such as migration, violence against women, and service delivery to marginalised and vulnerable groups. The research strategy and analysis of the study findings incorporate concepts from each of these frameworks. The first framework forms the basis for the report’s structure.

Conceptual framework 1: Stages of the trafficking process



Framework 1 presents an overarching perspective of women’s health needs throughout five primary stages of the trafficking process. These are:

- Pre-departure stage;
- Travel and transit stage;
- Destination stage;
- Detention, deportation and criminal evidence stage; and
- Integration and re-integration stage.

This framework draws on literature and models developed to examine health and migration.² It presents the different stages of the trafficking process in order to highlight the health risks, service needs, and opportunities and challenges for intervention at each stage.

In addition, by breaking down the trafficking process into chronological stages, the framework helps to emphasise the need to take into account the risks and abuses associated with each stage, from pre-departure through integration or reintegration, in order to address women’s health needs. The pre-departure stage, for example, may include specific experiences of violence and abuse that affect a woman’s immediate health, ability to avert later risk, and potential future resilience. Likewise, there are individual experiences and factors associated with each of the other phases that impact a woman’s health and well-being.

Similarly, each stage of the trafficking process offers different opportunities and challenges for health interventions. For example, it is possible to improve women’s knowledge about health and health service delivery while a woman is still in her home country by

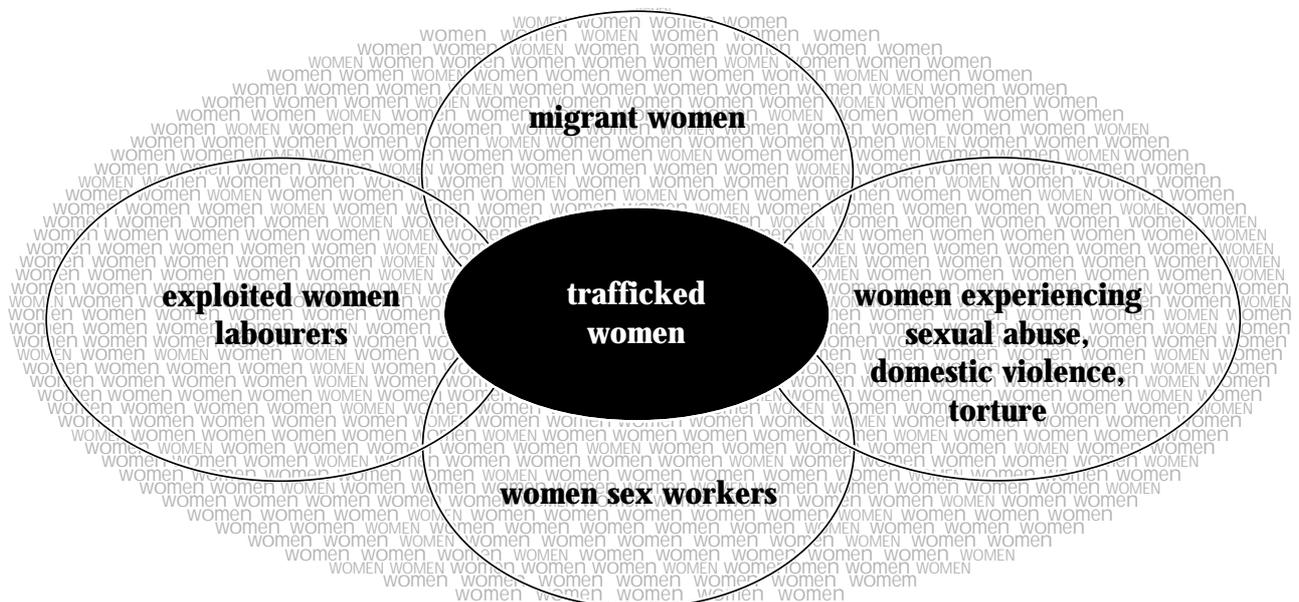
increasing health promotion campaigns and offering targeted information on health and migration. This type of information may enable women to better defend their health when they need to.

This chronological perspective also corresponds to public health models of prevention that delineate primary, secondary, and tertiary levels of intervention:

1. Primary prevention: aimed to address the problem before it begins.
2. Secondary prevention: aimed to respond to early signs of the problem.
3. Tertiary prevention: aimed to respond once the problem is evident and already causing harm.³

In the case of trafficking, *primary prevention* comprises those interventions implemented during the earliest stages of a woman’s journey, in the pre-departure and transit stages. These interventions might include, for example, public health promotion strategies aimed at providing information on reproductive and sexual health, symptoms associated with infectious diseases, mental health and related symptoms, or health risks associated with migration, including trafficking and legal rights to health services in other countries. *Secondary prevention* takes place later during the destination stage where women might be offered screening for infections, treatment for newly emerging health problems, and referral to assistance or information that may help avert further harm. Finally, *tertiary prevention* represents interventions implemented during the integration and reintegration stage, when, for the majority of women, physical, sexual and psychological problems have manifested and they require significant care and support.

Conceptual framework 2: Spheres of marginalisation and vulnerability



The second conceptual model (above) recognises that women trafficked into sex work share the vulnerabilities of several marginalised or socially excluded populations:

- migrant women
- women experiencing sexual abuse, domestic violence, torture
- women sex workers
- exploited women labourers

Thus, although there is limited data on trafficking and health, reviewing the health literature on immigrants and refugees, exploited labourers, sex workers, and women who have experienced gender-based violence can help to illustrate many of the health implications for women who have been trafficked.

Women who have been trafficked are liable to suffer types of abuse, stress, depression and somatic consequences similar to those experienced by female victims of violence; the alienation, disorientation felt by migrant women; and the physical, psychological and sexual work-related risks of exploited labourers and exploited sex workers. Placing trafficked women at the centre of the four overlapping spheres that represent these vulnerable populations serves to emphasise the multiplicity and complexity of their needs.

The literature on service provision for these groups also highlights the range of barriers to health care and suggests potential lessons for service delivery. Obstacles to service delivery for these groups include high mobility, linguistic and cultural differences, clandestine or highly marginalised existence, social and economic inequity, legal restrictions, funding restrictions, stigma, and political and social discrimination (including by health care providers). Lessons learned indicate that for vulnerable and marginalised groups, providers must develop strategies that incorporate outreach activities that do not rely on individuals being able to access mainstream clinic or hospital-based services. In addition, effective service delivery needs to incorporate linguistically appropriate and socially and culturally sensitive approaches to health care. Sound program planning and implementation of services takes account of the range of risks, potential abuses, and multi-dimensional health needs of these populations.

It must be noted that it is with the greatest of caution that we associate the situation of migrant sex workers with that of trafficked women. It is in no way meant to indicate that all migrant sex workers are trafficked. Nor is it meant to downplay the risks, vulnerabilities and exploitation faced by non-trafficked migrant sex workers – or for that matter, by non-migrant sex workers.

Conceptual framework 3: (see overleaf) Health risks, abuse and consequences

The risks and abuses faced by trafficked women are rarely singular in nature. They are often combined in a calculated manner to instil fear and ensure compliance with the demands of the traffickers, pimps and employers. Women are physically beaten to force them to have sex, raped as a psychological tactic to intimidate them into future submission, isolated to disable them psychologically, and economically deprived to create a reliance on traffickers. Women who try to rebel or reclaim portions of their independence are beaten or financially penalised – and sometimes both. In addition to health complications caused directly by violence and intimidation, trafficked women also face health risks associated with their social, legal, and gender marginalisation, i.e., high risk labour sectors, barriers to service, discrimination. These risks parallel those experienced by the groups represented in framework 2.

The third framework was conceived to delineate this range of health risks and consequences faced by women who have been trafficked.

The forms of risk and abuse and the corresponding health consequences associated with trafficking include:

1. physical abuse → physical health;
2. sexual abuse → sexual and reproductive health;
3. psychological abuse → mental health;
4. forced, coerced use of drugs and alcohol → substance abuse and misuse;
5. social restrictions and manipulation → social well-being;
6. economic exploitation and debt bondage → economic-related well-being;
7. legal insecurity → legal security;
8. abusive working and living conditions → occupational and environmental well-being; and
9. risks associated with marginalisation → health service uptake and delivery (framework 3).

Each of the nine categories represents a spectrum of danger and severity of health consequences. In this report, Framework 3 has been used specifically to analyse the risks, abuse and consequences occurring during the destination stage. For most women this is the period when the full range of risks appears or culminates.

What is difficult to capture in a framework, however, is the repetition and persistence of the abuse and trauma associated with trafficking. What differentiates trafficking and its consequences from the effects of singular traumatic events (disaster, a rape) is that trafficking involves prolonged and repeated trauma, or "chronic trauma."⁴ This framework provides an overview of the

range of risks and abuse for which the health impacts of any one can be devastating. When they occur in combination and repeatedly, these abuses result in symptomatology similar to that observed in victims of other types of chronic abuse and trauma, such as domestic violence and torture.^{5,6}

It is also important to note that the health risks are multiple, and the consequences overlapping and often reciprocal in nature. For example, physical risks cause negative psychological responses, which in turn may result in additional physical health problems (e.g., frequent headaches, digestive disorders). Most of the categories of risk have mental health implications that are discussed in the text of the report (but not repeatedly represented in Framework 3).

Health outcomes largely depend on the degree and duration of the coercion, and the individual’s capacity to cope (which is often strongly influenced by the quality of support available).

The various forms of abuse and coercion intersect numerous times in different ways to create an inextricable labyrinth of physical and psychological risk. Trapped in such a maze, most survivors develop coping mechanisms that help them anticipate and avert the most ominous dangers, manage imminent risks, and endure the negative consequences. Yet, in the longer term, once out of the threatening environment, these survival responses can inhibit an individual’s resilience and normal functioning.

Conceptual framework 3: Health risks, abuse and consequences

Forms of risk and abuse	Potential health consequences
<p>Physical abuse</p> <ul style="list-style-type: none"> ● Murder ● Physical attacks (beating with or without an object, kicking, knifing, whipping, and gunshots) ● Torture (ice-baths, cigarette burns, suspension, salt in wounds) ● Physical deprivation (sleep, food, light, basic necessities) ● Physical restraint (ropes, cuffs, chains) and confinement ● Withholding medical or other essential care 	<p>Physical health</p> <ul style="list-style-type: none"> ● Death ● Acute and chronic physical injuries (contusions, lacerations, head trauma, concussion, scarring) ● Acute and chronic physical disabilities, (nerve, muscle or bone damage; sensory damage, dental problems) ● Fatigue, exhaustion ● Poor nutrition, malnutrition, starvation ● Deterioration of pre-existing conditions leading to disability or death
<p>Sexual abuse</p> <ul style="list-style-type: none"> ● Forced vaginal, oral or anal sex; gang rape; degrading sexual acts ● Forced prostitution, inability to control number or acceptance of clients ● Forced unprotected sex and sex without lubricants ● Unwanted pregnancy, forced abortion, unsafe abortion ● Sexual humiliation, forced nakedness ● Coerced misuse of oral contraceptives or other contraceptive methods 	<p>Sexual and reproductive health</p> <ul style="list-style-type: none"> ● HIV/AIDS ● Sexually transmitted infections (STI) and related complications, including pelvic inflammatory disease (PID), urinary tract infections (UTI), cystitis, cervical cancer, and infertility ● Amenorrhea and dysmenorrhea ● Acute or chronic pain during sex; tearing and other damage to vaginal tract ● Negative outcomes of unsafe abortion, including, cervical incontinence, septic shock, unwanted birth ● Irritable bowel syndrome, stress-related syndromes ● Inability to negotiate sexual encounters

Forms of risk and abuse	Potential health consequences
<p>Psychological abuse</p> <ul style="list-style-type: none"> ● Intimidation of and threats to women and their loved ones ● Lies, deception, and blackmail to coerce women, to discourage women from seeking help from authorities or others, lies about authorities, local situation, legal status, family members ● Emotional manipulation by boyfriend-perpetrator ● Unpredictable and uncontrollable events and environment ● Isolation and forced dependency (see "social restrictions and manipulation" below) 	<p>Mental health</p> <ul style="list-style-type: none"> ● Suicidal thoughts, self-harm, suicide ● Chronic anxiety, sleep disturbances, frequent nightmares, chronic fatigue, diminished coping capacity ● Memory loss, memory defects, dissociation ● Somatic complaints (e.g. chronic headache, stomach pain, or trembling) and immune suppression ● Depression, frequent crying, withdrawal, difficulty concentrating ● Aggressiveness, violent outbursts, violence against others ● Substance misuse, addiction ● Loss of trust in others or self, problems with or changes in identity and self-esteem, guilt, shame, difficulty developing and maintaining intimate relationships
<p>Forced and coerced use of drugs and alcohol</p> <ul style="list-style-type: none"> ● Non-consensual administration and coercive use of alcohol or drugs in order to: <ul style="list-style-type: none"> - Abduct, rape, or prostitute women - Control activities, coerce compliance, impose long work hours or coerce women to engage in degrading or dangerous acts - Decrease self-protective defences, increase compliance - Prevent women from leaving or escaping 	<p>Substance abuse and misuse</p> <ul style="list-style-type: none"> ● Overdose, self-harm, death, suicide ● Participation in unwanted sexual acts, unprotected and high risk sexual acts, high risk activities, violence, crime ● Addiction ● Brain or liver damage, including pre-cancerous conditions ● Needle-introduced infection, including HIV and hepatitis C ● Dependence on drugs, alcohol, or cigarettes to cope with abuse, stress, anxiety, and fear, work, long hours, pain, and personal disgust, cold and physical deprivation, insomnia and fatigue
<p>Social restrictions and manipulation</p> <ul style="list-style-type: none"> ● Restrictions on movement, time, and activities; confinement, surveillance, and manipulative scheduling in order to restrict contact with others and formation of helping relationships ● Frequent relocation ● Absence of social support, denial or loss of contact with family, friends, and ethnic and local community ● Emotional manipulation by boyfriends-perpetrators ● Favouritism or perquisites with the goal of causing divisiveness between co-workers and discouraging formation of friendships ● Denial of or control over access to health and other services ● Denial of privacy, or control over privacy 	<p>Social well-being</p> <ul style="list-style-type: none"> ● Feelings of isolation, loneliness and exclusion ● Inability to establish and maintain helping or supportive relationships, mistrust of others, social withdrawal, personal insecurity ● Poor overall health from lack of exercise, healthy socialising, and health-promoting activities ● Vulnerability to infection from lack of information, deteriorating conditions from restricted health screening and lack of treatment ● Vulnerability to infection and abuse due to restricted access to work advice from peers ● Difficulty with (re)integration, difficulty developing healthy relationships, feelings of loneliness, alienation, helplessness, aggressiveness ● Shunned, rejected by family, community, society, or boyfriends ● Re-trafficked, re-entry into high-risk labour and relationships

Forms of risk and abuse	Potential health consequences
<p>Economic exploitation and debt bondage</p> <ul style="list-style-type: none"> ● Indentured servitude resulting from inflated debt ● Usurious charges for travel documents, housing, food, clothing, condoms, health care, other basic necessities ● Usurious and deceptive accounting practices, control over and confiscation of earnings ● Resale of women and renewal of debts ● Turning women over to immigration or police to prevent them from collecting wages ● Forced or coerced acceptance of long hours, large numbers of clients, and sexual risks in order to meet financial demands 	<p>Economic related well-being</p> <ul style="list-style-type: none"> ● Inability to afford: <ul style="list-style-type: none"> ● Basic hygiene, nutrition, safe housing ● Condoms, contraception, lubricants ● Gloves, protective gear for factory work or domestic service ● Pharmaceuticals (over the counter or prescription) ● General health care, reproductive health care, pre-natal care, safe termination of pregnancy (TOP) ● Heightened vulnerability to STIs, infections, work-related injuries from high-risk work practices ● Potentially dangerous self-medication or foregoing of medication ● Punishment (e.g. physical abuse, financial penalties) for not earning enough or for withholding tips or earnings ● Physical or economic retribution for trying to escape, e.g., abduction of other female family members to pay off debts ● Rejection by family for not sending money or returning home without money
<p>Legal insecurity</p> <ul style="list-style-type: none"> ● Restrictive laws limiting routes of legal migration and independent employment ● Confiscation by traffickers or employers of travel documents, passports, tickets and other vital documents ● Threats by traffickers or employers to expose women to authorities in order to coerce women to perform dangerous or high-risk activities ● Concealment of women’s legal status from the women themselves ● Health providers requiring identity documents 	<p>Legal security</p> <ul style="list-style-type: none"> ● Acceptance of dangerous travel conditions, dependency on traffickers and employers during travel and work relationships ● Arrest, detention, long periods in immigration detention centres or prisons; unhygienic, unsafe detention conditions ● Inability or difficulty obtaining treatment from public clinics and other medical services ● Anxiety or trauma as a result of interrogation, cross-examination, or participation in a criminal investigation or trial ● Deportation to unsafe, insecure locations, risk of re-trafficking and retribution ● Ill-health or deterioration of health problems as a result of reluctance to use health and other support services
<p>High risk, abusive working and living conditions</p> <ul style="list-style-type: none"> ● Abusive work hours, practices ● Dangerous work and living conditions (including unsafe, unhygienic, over-crowded, or poorly ventilated spaces) ● Work-related penalties and punishment ● Abusive employer-employee relationships, lack of personal safety ● Abusive interpersonal social and co-worker relationships ● Non-consensual marketing, sale, and exploitation of women 	<p>Occupational and environmental health</p> <ul style="list-style-type: none"> ● Vulnerability to infection, parasites (lice, scabies) and communicable diseases ● Exhaustion and poor nutrition ● Injuries and anxiety as a result of exploitation by employers, risky and dangerous work conditions ● Injuries and anxiety as a result of domestic or boyfriend-pimp abuse

Forms of risk and abuse	Potential health consequences
<p>Risks associated with marginalisation</p> <ul style="list-style-type: none"> ● Cultural and social exclusion, including limited adaptation to social and cultural norms, language limitations ● Limited access to public services and resources, including health care services ● Limited quality of care due to discrimination, language and cultural differences ● Public discrimination and stigmatisation related to gender, ethnicity, social position, form of labour ● Reduced income, weak negotiating power and financial hardship resulting from immigrant status and language limitations ● Clandestine movements and high mobility ● Limited access to potential sources of assistance (e.g., law enforcement, public officials, national representatives) ● Fear of law enforcement and other authorities 	<p>Health service uptake and delivery</p> <ul style="list-style-type: none"> ● Deterioration of health and existing health problems ● Poor preventative care and treatment ● Alienation from available health services ● Lack of continuity of health care and social support ● Potentially dangerous self-medication ● Inability to afford health promoting products and activities ● Increased physical and psychological dependence on abusers or exploitative employers ● Reluctance to leave or report abusers or exploitative employers ● Loneliness and other negative mental health outcomes ● Adoption of unhealthy coping strategies, such as use of addictive substances (cigarettes, drugs, alcohol) to cope with distress, mental health outcomes

Concluding remarks

In laying out the numerous elements of and issues associated with the trafficking process, the frameworks help to illustrate the complex and interdependent nature of the health needs of trafficked women. Although trafficking in women is in many ways unique – particularly in the level of exploitation and violence – the frameworks highlight that important lessons can be learned from existing research and service provision to other similarly at-risk groups. Later chapters draw upon published literature about these other populations to help illustrate the ways trafficking affects women’s health, and the potential opportunities and barriers for preventive and curative health service provision.

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1. Pre-departure stage

When I was 16 my parents and only brother were killed in a car accident. I watched my mother die in the hospital. When I was 22 I was shot in the shoulder. Then, someone broke my windows and set fire to my door. I think it was because I am ethnic Moldovan. I became so anxious and depressed that I quit my job at the university. My girlfriend proposed I contact her friend who would help me leave Ukraine.

Katerina,
Ukraine to UK

The pre-departure stage¹ encompasses the time before a woman enters the trafficking situation. This stage influences a woman's vulnerability to trafficking, reflects her mental and physical health characteristics at departure, impacts her health and health-seeking behaviour throughout the trafficking process, and affects her care and resilience once she is out of the trafficking situation.

This chapter discusses the health factors that characterise the pre-departure stage, including:

1. a woman's personal history (particularly as it relates to violence or sexual abuse);
2. the quality of a woman's home country's health services and health promotion; and
3. epidemiological and socio-economic conditions in the home country.

Although many health risk and protection factors will have been established prior to departure, these will ultimately be affected, and often superseded, by the degree of coercion a woman experiences once in the hands of traffickers. Any knowledge of her own health needs or the way to use care services is rendered meaningless if she is unable to exercise her options. Yet, to the degree that she can make decisions, the more information a woman has about caring for herself and locating services, the more likely it is that she can protect her health within a trafficking situation.

1.1 Personal history

1.1.1 Why she left home

I am 13 years old. Before I left Romania, I was living at an orphanage since the age of seven. My mother was on her third marriage. She didn't want me to live with her and her husband. What I

want the most is to live with my mother. This is one of the reasons why I left the orphanage in the first place. Then, I went with my friend on a tourist trip to Yugoslavia.

Laura,
Romania to Albania

In making the decision to migrate, women are often influenced by their past and present circumstances (e.g., poverty, experiences of violence, family breakdown, medical needs), as well as larger socio-economic factors (e.g., unemployment, social unrest). Women are driven from their homes by poverty, economic crisis, interpersonal violence, war, ethnic cleansing and environmental destruction. The resulting loss of resources force women, in particular, to accept risks and uncertainties that they might otherwise reject in order to support themselves and their families.

From a socio-economic perspective, trafficking of women and female migration can be considered a matter of human "supply" and "demand."² From an individual perspective, women's reasons for leaving their home country are usually complex and multiple. Some experts have described it as the convergence of "push factors" (i.e., poor home conditions) and "pull factors" (i.e., the promise of better situations elsewhere and increase in migration opportunities).³ For most women, it is some combination of all of these, but the final factor that clinches the decision is the timing and apparent quality of the offer to depart, as with Olena:

For a long time I was looking for a job, but I couldn't find anything. Once in a bar my friend told me that a lot of our citizens go abroad, settle there very well and work there. Sometimes girls marry foreigners and then a fairy tale life comes true. She said she could acquaint me with a man who could help me to depart. When I met with Mr. P he told me that I could go to Italy and work there as waiter in the restaurant with the payment US \$2000 per month. His speech was so considerate and nice. When I said I had no money for documents or travel, he said not to worry, he would arrange everything.

Olena,
Ukraine to Yugoslavia and Kosovo

For this study women were asked the reason they left home. Seventeen of 28 respondents cited earning money as the primary reason for migrating.

Primary reason for leaving country of origin	Number
Earn money	17
Abducted	2
Fleeing danger/abuse	2
Marriage promise/love	2
“Don’t know”	2
Seeking an interesting experience	1
Promise of tourist holiday	1
Study abroad	1
Total respondents	28

All but one of the twenty-eight respondents reported having been tricked or deceived by bogus employment opportunities (e.g., housekeeping, restaurant work), by false promises made by an alleged lover or fiancé, or abducted. Two were kidnapped in their country of origin. Only one woman knowingly accepted work as a sex worker for one year in order to help support her family, but, she was nonetheless lied to about the terms and conditions of the work (she is listed above as one of the 17 who left to “earn money”).

One respondent, Alma, was only thirteen when she was lured by a promise of marriage from a refugee camp in Albania:

I had to leave my home in Kosovo together with my family in 1998. In the refugee camp I fell in love with a man who, after only two weeks, promised to marry me. I ran away with him to Italy without telling anyone.

Alma,
Kosovo to Italy

Alma was later sold/forced by her “fiancé” into sex work.

Two women could not explain why they left home. One simply said,

It’s the million-dollar-question. I don’t know. I just decided to leave and I left.

Valbona,
Albania to Italy

Thirteen of the respondents reported that they chose to accept job offers abroad because of unemployment,

poverty, and the need to support children, siblings or parents. Tetyana, who was promised a job as a nurse by a friend of her mother, recounted her reasons for leaving home:

I have a small daughter, Katya. Katya burnt herself with boiling water. She was in the hospital for a long time. Burns were on 60% of her body. I needed to earn a lot of money for my daughter’s treatment. I didn’t want to go, I wanted to stay with my ill child, but I had no other way out. I proposed that my husband go abroad and work as a builder, but he refused.

Tetyana,
Ukraine to Italy

Of the seventeen women stating “money” was the reason they left, nine had children. Seven of the nine were single parents. Of the two others, one said her husband was unemployed, and the other said that her husband would soon be laid off from a low-wage factory job. Information from victim support services around the world suggests that a significant proportion of women who are trafficked are single mothers. IOM data on women assisted in Kosovo between February 2000 and February 2001 showed that 47 of the 57 women who reported having children were raising them alone.⁴

Two respondents stated that their primary reason for leaving home was violence or abuse. Two women reported that they were kidnapped by traffickers. One was sold by acquaintances and abducted from a local café. The other explained that she was drugged when at the train station in the capital city, Kiev, on the way to the hospital for follow-up treatment for a tumour.

It has been suggested that young women and girls from dysfunctional families easily fall prey to traffickers.⁵ The two youngest respondents (ages 11 and 13) had both lived in orphanages before being trafficked. One had been shunned by her mother when she remarried, and the other had been taken from her parents by child protection authorities. Other studies have found that many trafficked women come from single female-headed households.^{6,7,8}

Only one woman reported a serious health problem prior to departure. While it is unlikely that a woman who is ill will choose to migrate for work, there are circumstances where, for example, a stigmatising health problem, such as HIV, may push a woman to leave her community. In Thailand, a woman who was raped by a soldier and contracted HIV was rejected by her parents and stigmatised in her village. No longer able to make a life in her community, she sought the services of a smuggler and was subsequently trafficked to Japan.⁹

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In some settings, traffickers recruit women who are in ill-health or disabled. In Cambodia, for example, amputees and persons disfigured by landmines, persons disabled by polio, and elderly women are trafficked to Thailand to work as beggars. In a case in Ukraine, traffickers targeted and recruited two mentally disabled women for work in Italy.¹⁰

Although none of the respondents in this study reported having been sold by their parents, in some areas parents or other relatives knowingly sell young women and girls to traffickers.

Trafficked women are often portrayed as passive victims. However, the decision to migrate frequently reflects initiative, courage and strength of character to seek a better future. Later, these dreams of a better life fall victim to criminal gangs and the perpetrators of labour exploitation. It is then that women's personal fortitude and intelligence often help them to survive the ensuing abuse.

1.1.2 History of violence and abuse

I was just 15 when I left Romania. When I was 12 my mother died, my father became an alcoholic and would beat me and my brother. A cousin said he would get me out of this situation and into a 'normal' life. He sold me like a slave.

Caroline,
Romania to UK

It is common for women who have been trafficked to report a history of violence or abuse.^{11,12} For many, abuse by family members or authority figures, assaults related to civil unrest or armed conflict, or witnessing violence not only affects their health and well-being, but is the driving force that propels them into the hands of traffickers.

Of the 20 women responding to the question, "Did anyone ever hurt you while you were living in your home country," seven responded affirmatively. Two women reported being abused by their spouse, four by their father, or "parents," and one by classmates. For these women, this was among the most sensitive subjects and the one they least wanted to discuss.

Although only two of seven women reporting abuse said it was the primary reason for leaving, for all seven it was a contributing factor in their decision to leave. In these cases poverty may have been the primary motivation, but it is likely that experiences of violence tipped the balance. Hotline workers at La Strada in Ukraine quoted callers saying, "Well, better to be a prostitute abroad than to be raped and abused by my husband."¹³

Ten of the twenty-eight respondents were under the age of 18 when they were recruited or abducted by

traffickers. Although this study did not collect case histories of childhood abuse, other research suggests that sexual abuse among pre-adolescent girls is associated with low self-esteem, feelings of shame, vulnerability, and unworthiness,¹⁴ and that young girls who come from poor, dysfunctional or abusive families are extremely vulnerable to traffickers' offers.¹⁵ Client data collected by Animus Association Foundation of Bulgaria, a non-governmental organisation operating a Rehabilitation Center for victims of trafficking, also indicate that the groups most at risk of being trafficked are adolescents and women with past traumatic experiences.¹⁶ This included victims of domestic violence, sexual assault, children from orphanages, and children with a large number of siblings and only one parent.¹⁷ Moreover, traffickers reportedly target girls who they perceive to be distressed or who reveal family problems.¹⁸

Violence and abuse at home not only push women to seek a way out, but can negatively impact their health throughout the trafficking process. Women who have experienced childhood sexual abuse,^{19,20} and those who have endured trauma and violence are more likely to suffer long-term physical and mental health consequences and engage in future risk-taking behaviour than those who have never experienced abuse.²¹ Behavioural and physiological changes that occur in response to high-risk, threatening events can have negative impacts on health even after violent episodes cease,^{22,23,24,25} including physical sequelae (e.g., chronic pain, gastrointestinal symptoms and negative health behaviours)²⁶ and psychological reactions (e.g., anxiety, depression, aggression and self-harm).²⁷ This would suggest that trafficked women who have been victims of prior violence are likely to be exceptionally vulnerable to illness and prone to high-risk behaviour, particularly if put in a highly stressful situation (e.g., forced sex or labour, being an undocumented migrant).

A psychotherapist who has worked extensively with trafficked women interpreted the ways past violence increases women's vulnerability:

Because many women have experienced violence prior to being trafficked, they often have developed an identity of a victim. This makes them more vulnerable to traffickers who use it to psychologically manipulate and control the women, who think that they deserve the bad treatment and don't deserve help. In addition, the women are vulnerable because they haven't had experience communicating without violence, so to a certain extent violent experiences are "normalized."

Nadia Kojuharova,
Animus Association Foundation, Bulgaria

While this study did not focus on situations of armed conflict or refugee settings, women who are in or fleeing situations of civil unrest or residing in refugee centres are vulnerable to trafficking. Reports from organisations working with refugees,²⁸ for example, indicate a high incidence of sexual abuse of women in refugee camps, and an increasing number of women being recruited from refugee centres by traffickers.^{29,30} Having experienced violence (including sexual violence), witnessed violence (including abuse, disappearance, and murder of family members), or suffered the disruption, dangers and trauma of displacement, women have obvious motives for seeking more secure situations elsewhere—even if it means accepting risks that they would otherwise refuse.

1.1.3 Recruitment: trust and deception

[I left] because I was naïve and was hoping for a better life.

Laura,
Romania to Albania

All but one respondent who accepted the offer of a trafficker were recruited by someone they knew, such as a friend, cousin, neighbour, boyfriend or fiancé, or by an individual recommended to them by someone they trusted. Four women were deceived by promises of love or marriage. One of the four was from Romania and three were from Albania, where a common *modus operandi* of traffickers is to lure young women away with proposals of love or marriage.³¹ Women wooed by a prospective lover explained that this man eventually sold them or became their pimp.

Ultimately, the betrayal by the person who trafficked them—and women’s sense of self-blame for having believed them—cause many women to reproach themselves for their “stupidity” or gullibility. The culpability women feel for this ruinous decision feeds into the trafficker’s control. However contorted the logic, both the trafficker and the woman construe that by having agreed to depart (perhaps even knowing that elements of her immigration were illegal), she has, to a certain degree, been complicit in her own enslavement. Her shame at her “error,” compounded by her humiliation at the violations in which she participates (willingly or unwillingly), further contributes to her entrapment.

These deceptive recruitment practices cause women to lose faith in others and themselves. This has both physical and emotional safety consequences that play themselves out in destructive ways throughout a woman’s journey. A woman’s inability to trust others may, for example, discourage her from seeking outside help. Her loss of confidence in her decisions leaves her more likely to obey the directions of whoever is closest

to her—in the case, of trafficked women, this person is usually the same person who is exploiting her.

When a woman believes that there is a love relationship with her trafficker-pimp, the effects of his breach of trust are multiplied and not dissimilar to those identified with domestic or intimate partner violence (i.e., a woman is harmed by the person that she is supposed to trust most). In trafficking situations, the man who professes to love the woman is also the one who puts her up for sale and collects the profits. Caught in this dichotomy of alleged love and abuse and expendability, some women negatively re-adjust their self-perception and express their devotion and dependency by continuing in the sex work demanded of them. It is only later that women often begin to understand the incongruity of the love and exploitation. As expressed by a woman twice trafficked by the same man, “If he loved me that much, he wouldn’t have let me do this” [Ellen, Albania to UK].

As will be discussed in later chapters, the inability to trust others may also reappear in counter-productive ways when women are interviewed by law enforcement officials or enter the care of social support workers (see *Detention, deportation and criminal evidence stage* and *Integration and reintegration stage*). Longer term, this emotional contradiction can make it difficult for women to develop healthy relationships (see *Integration and reintegration stage*).³²

Conversely, for some women, the scepticism gained early on from this experience may have a protective effect in the future and prevent women from relinquishing responsibility for their safety to others. This hard-won vigilance may minimise the degree to which women are repeatedly emotionally seduced and victimised.

1.2 Home country health services and health promotion

In considering the health situation of trafficked women, it is important to recognise how the extent and nature of the country’s health care system, the effectiveness of public health education programs, and a woman’s individual experience with the health sector in her home context may influence whether and how she seeks care later.

Few women have any information on services in the destination setting prior to leaving or while in the destination setting. Many women’s preconceptions about health are based on their experience with services in their home country. These can influence their understanding of the availability, quality, and cost of services elsewhere. Where women have access to health education (such as, information on reproductive health, sexually transmitted infections (STIs), and

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contraception) they can, if afforded the opportunity, be better able to protect themselves from illness and infection.

1.2.1 Experience and opinion of care in home country

At home you have to be rich to have proper care.

Ellen,
Albania to UK

Women were asked about their experience with the medical sector in their home country. Of the eighteen women who responded to questions about accessibility, eleven complained about having to pay for services. One woman from Ukraine lamented the loss of socialised medicine, “Now there is no free medicine in Ukraine. I have to pay even for an ambulance” [Tamara, Ukraine]. Two others specifically cited having to pay for “gloves and medication.” Two women said the services were “easier” in their country because they knew what to do, while in the destination country one needs to know the rules.

Asked about quality of care, four women said the service was “good” in their country, though two of these women added that it depended on one’s ability to pay or noted that, “If you were not connected, you could not get medical attention” [Valbona, Albania to Italy]. One woman disliked the “bad service” and the “bad attitude of doctors” in her country.

In Italy, Belgium, and Britain, like many other Western European countries, sexual health services are available free of charge to non-residents, as are accident and emergency services. However, respondents who had not been clients of outreach services or integration programs in destination countries stated they did not know or did not believe there were any free health services available in the destination country. Similarly, they reported that they didn’t know what documents would be needed to access health care. Women interviewed in Ukraine and Albania who were trafficked to Italy, Belgium, and Turkey did not know whether the destination country offered any free services.

1.2.2 Health promotion and women’s knowledge

Although health promotion, particularly campaigns related to sexual and reproductive health and HIV/AIDS, are increasing in many middle and lower income countries, sexual education, including knowledge and use of modern forms of contraception and awareness of STIs still remains limited.^{33,34,35,36}

In many eastern European countries, in particular, levels of modern contraceptive use are low and abortion is a

common method of addressing unwanted pregnancy. For example, in Ukraine the national programme of family planning commenced in 1995. In 1996 only 5% of women of reproductive age used oral contraceptives.³⁹ In 2002 abortion remained the main form of contraception and abortion rates in Ukraine were among the highest rates in the world, along with Moldova and Romania. In Russia, a 1998 government study showed that 7% of women under the care of a physician had ever used an oral contraceptive. Accessing the contraceptive pill depends on cost, (in Russia oral contraceptives can consume 10-15% of a woman’s monthly salary⁴⁰), on the availability, and on the health service provider’s familiarity with oral contraceptives.

Treatment for STIs in many eastern European countries is also limited. In Albania, for example, treatment is only provided in one-third of the country’s hospitals and basic antibiotics for treatment are often lacking (syphilis testing is not available at all).⁴¹

The sexual health knowledge reported by respondents in this study appeared quite limited (time limitations for interviews meant that questions about health knowledge focussed primarily on sexual and reproductive health).

When asked, “What did you know about sexually transmitted illnesses or HIV/AIDS before you left home,” 11 of 23 women stated that they had no knowledge or poor knowledge, and 11 said they had a general sense or basic knowledge. Only one woman stated that she felt well-informed.

When asked whether they knew more after their experience of trafficking, 20 respondents stated they know “more now,” while three reported that their knowledge was the same—and that they still did not know much.

When women were asked how they learned to use condoms, only one woman said that she had learned from sex education in her home country. Ten of 20 women reported they learned during the time they were trafficked, “on the job, from mypimp/madam/boyfriend, or from my friends/colleagues/other girls.” Six women stated: “everyone knows.” Two women explained that they learned by themselves, and one said from television.

Seven women said they were using the contraceptive pill. Two explained that they had learned of this method from health practitioners in the destination country after an abortion, and one learned from her doctor in the destination country.

1.3 Epidemiological and socio-economic conditions of a woman's home country

While use of broad health indicators from a woman's home country alone are not indicative of any individual's health status, an individual's overall health profile often reflects aspects of the larger public health environment and socio-economic conditions.⁴² Although an analysis of the relationship between trafficking and the epidemiological and socio-economic conditions of various locations is beyond the scope of this report, it is worth highlighting one issue that stands out above most others: poverty.

The physical and psychological effects of poverty on health cannot be overstated. Studies have repeatedly shown that inequity and low socio-economic conditions are associated with poor health indicators and risk-taking behaviours.^{43,44} Anxiety and depression are also positively associated with environmental stressors, specifically poverty.⁴⁵ Women who are trafficked represent the sum of the effects of poverty, both in their health and well-being and in their decisions about and means of migration.

In a time of increasing anti-immigrant sentiment, it is worth recalling that most women would prefer to remain in their own peaceful and stable country, near healthy, happy family members, work in jobs with sufficient income to pay for housing, and be able to afford education for their children and health care for their parents. However, as the UNDP development indicators show each year, middle and low income countries are severely limited in their capacity to provide healthy and sustainable living conditions for many of their citizens, especially females. The 2002 UNDP "Gender Development Index" rankings for the countries included in this study suggest, in the broadest sense, that women coming from low-ranking countries, (Thailand 60, Ukraine 66, and Albania 74) have found reasons for emigrating to countries in which women have greater opportunities, rights, and freedoms, (Netherlands 8, United Kingdom 12, and Italy 74.)⁴⁶

Concluding remarks

From a health perspective, individual and socio-economic conditions preceding a woman's departure are critical. They are important as factors that influence a woman's decision to leave, the quality of her health while she is travelling and working, and her later recovery. From a prevention perspective, this information is essential to implementing effective development plans and deterrent measures. For the health practitioner assisting women who have been trafficked, these factors are not simply peripheral background patient data, but vital

components to understanding a woman's current health status and treatment needs. The individual, social and environmental health risks and resources in a woman's home country deserve great consideration by law makers considering legislation and decisions regarding deportation, return, and asylum.

Are there any measures that can be taken during the pre-departure period to help women who may fall victim to a trafficker better protect their health? Prevention campaigns are important to inform women of the dangers of trafficking. Development efforts that aim to improve local conditions and opportunities for women are critical to make it unnecessary for women to seek to leave. Nonetheless, given the state of global economic and social affairs, trafficking of women is unlikely to abate in the near future. Women are likely to continue to look for opportunities to improve their lives and that of their family, and criminal gangs will remain in business to lure and exploit them.

For this reason, it is important for health policy makers, non-governmental organisations, and international agencies to work to make certain women are as informed as they can be about all aspects of their health, including, sexual, reproductive, and mental health, before they leave home. One important strategy would be for public health authorities and NGOs to offer general health information to women planning to migrate, information about available (and free) health resources in destination countries, and useful contacts in destination countries for safety and security.

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2. Travel and transit stage

The most difficult part of the journey was getting shot at while crossing the “night zone” on the way to Kosovo.

Olena,
Ukraine to Yugoslavia and Kosovo

The travel and transit stage begins when a woman agrees to or is forced to depart with a trafficker (whether she is aware that she is being trafficked or not). This stage ends when she arrives at her work destination. It includes travel between work destinations and often involves one or numerous transit points. A woman can have several periods of travel and transit, such as when she is sold from one work destination and “re-trafficked” to another.

The travel and transit stage is generally the time when illegal activities and movements begin. Crimes include abduction, use of forged documents, facilitation of illegal border crossings, harbouring and employing undocumented persons, rape, and other forms of violence.¹

Trafficking and illegal migration is a risky business for both traffickers and trafficked persons—and the greater the risk for the traffickers, the more dangerous, even fatal, it can be for trafficked women. While most traffickers and their agents benefit from delivering their passengers to the planned destination, their primary concern is avoiding arrest. Traffickers are willing to subject women to life-threatening modes of transportation, arduous travel, and employ threats and violence, even murder, to elude authorities. Events that occur during this period can pose serious danger, cause extreme stress, and establish a woman’s vulnerability to later risk and ill-health. This time represents the beginning of the cycle of harm to come.

This chapter discusses the risks associated with the travel and transit stage, describes the impact that the violence and dangers of this stage can have on women’s physical and mental health, and suggests how this experience increases the risk and likelihood of future ill-health for trafficked women.

Although this study does not address internal trafficking (trafficking within a woman’s own country), it is important to recognise that women who are trafficked within their national borders are often no more able to assert themselves or access resources than women trafficked internationally. Threats, violence, and forced captivity are widely reported by women traded and sold within their own countries.^{2,3} Indeed, in this study one of the respondents who suffered some of the most serious sexual abuse during the travel and transit stage was raped, beaten, and held captive in Tirana, the city where she lived.

2.1 Anxiety and the “initial trauma”

When I got out of the lorry we all went over to the park nearby where we were to wait for another truck. From here I could see many, many police in the distance...I started feeling very worried and changed my mind about going on. I wanted to go home, I thought I had made a stupid decision. I started crying. I told Sascha I wanted to go home. He slapped me hard across the face and told me that I must go on and that he could kill me. It shocked me. He stayed very angry. It was too dark and I had no idea where I was or how to go home. And there were so many police. I was afraid they would arrest me. At that time, I was thinking, “out.” I wanted out. Now I understood that I was in big trouble and could end up in prison. Never in my life did I have this kind of trouble. Better to go home than end up in jail. I was so sorry that I had agreed—that I was this stupid.

Natasha,
Ukraine to UK

2.1.1 Departure and anxiety

While departure from home can be a time of hope, it can also be a time of great stress. For many women, this was the first time they had left home. They were leaving family and loved ones behind and headed towards a new and uncertain future—a future that depended on the promises and good-will of others.

For most respondents, the travel and transit period was the point at which they realised that they had been horribly misled and their future would be bleak.

Once we arrived in Vlora town I saw my fiancé meeting some young men who called him “Boss” and showing high respect to him. I also noticed he was promising to three foreign women to arrange for their trip to Italy, as well, which looked very strange to me, so I refused to follow him to this trip to Italy, but the answer I got from him was that there was no other possibility left for me, and that he would not allow me to return to my family.

Alma,
Kosovo to Italy

By the time women have submitted themselves to the care of a trafficker and learned that they are in serious danger, most are rendered virtually powerless by threats, violence, or practical barriers (especially once they have travelled beyond their country's borders). The rapid pace of the travel, illegal status, fear of the authorities, inability to speak the language, and the logistical barriers compound women's entrapment. For many women, planning for escape was secondary to thoughts of survival. Women who discovered that they had been tricked and were not in safe hands felt overwhelming stress and anxiety. This anxiety rarely subsided, but instead increased as violence and dangers emerged.

Many of the respondents stated that at the point when they discovered the truth about the trafficker, they wanted to turn back but were unable. While most women understood that by that time there was no way out, they nevertheless later felt that they *should* have done something to reverse their fate.

2.1.2 The "initial trauma" and memory

As the travel and transit stage is the time when women first learn they are in mortal danger, it can be considered the point of the "initial trauma."⁴ Whether introduced by a violent act or experienced as shock from having learned their fate, this first trauma establishes the context of danger that is now the woman's reality. According to experts on mental health and violence against women, this initial trauma is usually acute, generally engenders symptoms of extreme anxiety, and can inhibit memory and recall.⁵

When crossing this mental boundary from the relative safety of her past to the extreme danger posed by the present, a woman may dissociate herself from the present as a form of denial, and in order to be prepared for upcoming threats.

Moreover, the way a woman processes this traumatic moment can impact upon her ability to later recall these events. Physiologically, when confronted with danger, the "fight or flight response" takes over.⁶ Research has shown that in response to this stress, chemicals are released by the brain that inhibit "selective attention," or one's ability to filter perceptions.⁷ During a traumatic episode, the woman no longer concentrates or observes, but instead becomes hypervigilant to all stimuli in order to react quickly to the next threat.

To the degree that a woman's ability to absorb information is inhibited, her capacity to recall details is diminished. The physiological response of the autonomic nervous system combined with women's guilt-dissociation may help explain why, when women are later asked by police, immigration officials or social workers to recall the circumstances surrounding their

trafficking, they are frequently unable to offer precise details or coherent recollections of events.

2.2 Transport conditions

Two men escorted us. We were fed only bread and water. We crossed through Poland, Germany, and Holland. At the border with Poland we crossed without any problems, but at the border with Germany we were told to leave the bus and cross the border on foot late at night.

Nadia,
Ukraine to Belgium

Women were asked about a number of factors related to the conditions of the journey to their initial destination, including the mode of transport, length of time in transit, route, dangers, sleep and food, and whether anyone accompanied them.

2.2.1 Routes, modes of transport, and dangers

Women reported travelling by car, mini-bus, boat, train, plane, on foot, and concealed in trucks. Albanian women travelling to Italy reported travelling by rubber dinghy, speedboat, and ferry. Respondents from Ukraine reported travelling by car, bus and mini-van to destinations including, Italy, Belgium, Turkey and Kosovo, and by plane to the United Arab Emirates.

For 12 of the respondents, the journey time was from one to two days. Five women spent between one week and two months in transit.⁸

Illicit travel poses many dangers, particularly when trafficking agents aim to make maximum profit from each trip. Women were asked, "Were there any dangerous or difficult passages?" Eleven of 17 women replied affirmatively. Women said they were "very afraid"; several said that "everything" about the trip was difficult, and that there were "lots of dangerous passages."

Three women crossed mountains by foot at night and one woman who ended up in Kosovo explained how she was shot at while crossing the "night zone." One other recounted:

I was sold from Serbia to Albania, from Albania to Macedonia, from Macedonia to Kosovo. Every time while crossing the border I was under the guard of a man with a gun. I should be silent and not to ask for help at the border.

Marina,
Ukraine to Yugoslavia and Kosovo

the health risks and consequences of trafficking in women and adolescents. findings from a european study.

Women are most likely to be forced to undertake dangerous routes at border crossings where immigration controls are strict, or when traffickers do not obtain visas or other travel documents for them. La Strada, Ukraine reported assisting women who had been forced to swim across rivers with fast running currents during the night. One client explained that her companion was unable to swim against the current and had drowned while trying to pass from Poland to Germany.⁹ It is not unusual for women to be forced to take circuitous routes through forests or mountains:

At the border with Yugoslavia, we crossed on foot. First we went through the woods at night, then we crossed the river by boat.

Anna,
Ukraine to Yugoslavia

Another woman who travelled from Moldova to Romania was forced to stretch out across fiberglass insulation in the ceiling of a train in order to avoid detection.¹⁰ Women caught by authorities not only risk being turned back, but being returned to a third country (such as the case of an Uzbek woman who was deported from Turkey to Ukraine).¹¹

Of the three women who travelled to the United Kingdom, two entered the UK via Eurostar from Belgium and France. The third respondent described how she was smuggled by refrigerated lorry out of Ukraine, then transferred to a second lorry (unbeknownst to the driver) to cross Europe and through the Channel Tunnel:

We travelled with 4 other girls and Sascha in a refrigerated lorry. It was very cold. We waited for a driver of a large lorry to go into the restaurant for a snack. An associate of Sascha's removed the bar from the door, we climbed in and the bar locking the door was replaced. This was a big lorry that was carrying big cardboard boxes, maybe refrigerators. It was very, very cold. It was pitch black and we could see nothing. No one talked. We travelled again in the big lorry and then onto a train, for maybe another three hours. When we stopped, Sascha began to bang very strongly on the side of the truck so the driver would come to look inside. The driver was very surprised and began to shout when he saw us.

Natasha,
Ukraine to UK

Trafficked women who travel by locked container or cargo quarters of a ship also risk suffocation. The above respondent arrived safely. However, in that same year 58 men and women from China suffocated in a refrigerated lorry while trying to reach the UK, despite knocking on the walls to alert the driver to release them.¹²

Those who travelled by rubber dinghy reported being transported clandestinely at night. All but one of the women who travelled by boat from Albania to Italy stated that the boat was overcrowded, and several said they feared capsizing and drowning:

I came by boat. I did not sleep, it was too crowded. I thought we would sink because there were too many of us. I was seasick. After landing in Italy, we walked all night.

Mirella,
Albania to Italy

Another woman who travelled by boat in December was forced to swim the last 200 metres to the shore and then walk to the hotel. Subsequently, she contracted a high fever and chills (for which she was offered no medication or medical assistance).

While there is currently no data on tropical and communicable diseases among trafficked women (e.g., malaria, tuberculosis), several reports on trafficked and smuggled migrants have indicated that long days of travel through malarial infested jungles, as well as travel and housing in unhygienic and cramped quarters, increase migrants' vulnerability to infectious diseases.^{13,14}

2.2.2 Sleep, food and exhaustion

Women reported periods of poor nutrition, little sleep, and exhaustion as they were moved from one place to the next.

Of the 17 women who answered questions about sleep during travel, 12 stated that they did not sleep or slept extremely little throughout the journey. For some women this meant that they did not sleep during the night of travel, while for others, it meant they had little or no sleep over a period of several days. In addition to the physical conditions of the journey, for many women the anxiety and anticipation of what was to come hindered their ability to sleep and eat.

Sleep deprivation not only affects women's ability to think clearly, it also decreases the body's natural protection mechanisms related to pain and the immune system.^{15,16}

Women who underwent longer journeys also reported not being fed regularly or being given food that was

not nutritious.

With little rest and sleep disturbances that frequently continue into the destination stage, women who have endured difficult journeys are more susceptible to illness and infection and likely to experience pain and discomfort more acutely.

2.2.3 Accompanied travel

Traffickers ensure that women arrive at the intended destination by making certain that they do not travel alone. Twenty-three of 28 women interviewed were accompanied throughout their travel by the trafficker or an agent in the smuggling chain. Of the women who were accompanied, eight stated they travelled with the trafficker in a group with other women.

For women who might consider returning home, trafficking agents are usually highly dissuasive. One woman from Ukraine, for example, reported how police complicit with the traffickers escorted her and two other women from the border of Yugoslavia to Belgrade.

The most ruthless traffickers make clear that the cost of fleeing or turning back would be too high, as explained by one Nigerian woman interviewed for another study.

The trip to get to Europe is very high risk and full of danger. You risk your life at every border because the ones who work at the borders can demand anything from you if you want to cross. And you are forced to do whatever they ask you if you want to go on, because going back would be worse. The Nigerian border is terrible, but I have faced the worst situation along Morocco's border. You have almost arrived in Spain and you would really do anything at that point. And, you also have to consider that if you try to run away, you will be killed. I have heard of girls who did not want to go on, but the ones who paid for the trip did not let them go back to Nigeria. They beat the girls. But the girls were really desperate, they did not want to go on. I heard that one of them was killed and her body was left in Nigeria.¹⁷

B,
Nigeria to Italy

Five women were provided with documents and travelled alone. These women were often accompanied to the departure point and met at the designated destination by the trafficker or a relative of the trafficker.

One woman, for example, travelled via Eurostar to the UK and was met at the station by the trafficker's cousin, who brought her to the trafficker. Often these women have not yet become aware of the exploitation that lies ahead.

2.3 Buying and selling women

I left my village to go to Timisoara, where I stayed about 3 days in a hotel, then entered Serbia through a big field, avoiding the border point. There, we met with two Serbian men, who took us to Belgrade, by car, to a house where I met some other Russian, Moldavian and Romanian women. During this period I saw pimps and smugglers from Serbia and elsewhere coming to see the girls and buy them! Girls weren't allowed to leave the house without being accompanied by their pimp, or their pimps' friends. Then, a Serbian bought me, as well, and took me by car to Trieste, Italy, transiting through Bosnia-Herzegovina.

Kiyemet,
Romania to Italy

Eleven respondents specifically reported having witnessed or been told of their "purchase." Five women stated they were sold multiple times. Respondents recounted sale prices ranging from for €700 to €15,975 (Euros).

The main financial transactions generally take place during this phase, as the woman is made aware of her debts and repayment obligations, or her "debts" are transferred to another trafficker or employer, and she is effectively "sold." One respondent, a 15 year-old from Romania en route to the United Kingdom, gave a detailed account of a journey that took her through Serbia, Macedonia, Albania, Italy, and Belgium, during which she was sold on three different occasions.

Three women reported having been "purchased" at auction-like settings,^{18,19} (e.g., at Arizona Market, outside Brcko in North-West Bosnia) where prospective pimps and agents came to select new "merchandise." This dehumanising process further disassembles a woman's sense of self and self-worth.

In the trafficking trade there are numerous ways in which financial transactions take place. It is beyond the scope of this report to review the range of trade arrangements made by traffickers. However, as will be discussed, what is important in the health context is the very act of women being bought and sold and the severe physical and psychological effects of this level of exploitation.

In a majority of trafficking cases, the arrangements for and process of travel are used to put women in a situation of “debt-bondage.” Debt bondage is associated with slavery and is characterised by the perpetual servicing of a debt through one’s personal services or labour.²⁰ After departure women are commonly informed that the sum initially agreed upon for travel and job placement is no longer sufficient. Under explicit or implicit threat, women are told that they are responsible for additional and previously unmentioned expenses, such as housing, food, bribes, work-related expenses, and costs related to their “purchase.” Women are informed that they are responsible for paying these debts off before they can leave their work and obtain their freedom. As discussed further in the *Destination stage* chapter, debts rarely decrease, making it difficult or impossible for women ever to be released from indentured servitude.

2.4 Violence and sexual abuse

They took me away to a flat [in Tirana] where they kept me for two months. I was guarded. I tried to escape once, but they followed me and forced me to return. The man who I think bought me wanted sex and if I refused he raped me. I was raped and beaten and abused by about six to seven men in this house. The man who bought me would rape me and when I would try to refuse, he would send another man down to beat me. He put a love bite on my neck to remind me. They were keeping me there while they arranged my passport and Schengen visa. I had a breakdown. I just wanted to hurt myself. I would cry a lot. I was scared and worried. I was bruised. The back of my neck was bleeding from being hit with the thick gold chain. They beat me and kicked me. They told me “Don’t scream or we will kill you.” They would. I kept quiet. I was a virgin before. I couldn’t sleep. I kept having dreams all about it. I became pregnant [while in the house]. I had an abortion, but they guarded me while I was [at the clinic] and I couldn’t talk to anyone.

Ellen,
Albania to UK

For nearly half the women interviewed the most serious threats to their health during this stage resulted from violence and sexual abuse. Fourteen women reported having been confined, raped, or beaten once or several times during this stage, before starting to work. Several specified that they were abused after having been told of their future work in prostitution and having refused.

Only two women reported receiving any medical attention during this stage following sexual abuse or violence (both required an abortion).

Nearly all respondents were reluctant to discuss details of the violence and sexual abuse during this stage. Interviewers did not press women to re-live these traumatic events.²¹

Women are vulnerable to abuse by any individual along the route, including trafficking agents, escorts, drivers, border officials, and anyone else who may be involved in her transport. Women quickly learn that obedience is the safest option. One respondent explained:

Sergey took me to his apartment in Milan, where I met another Albanian woman, Jacklin...She told me she was working in the streets of Milan as a prostitute and that this would be my work also for the future. I tried to leave from that place once I understood his intention, but he mentally, physically and sexually abused me in order to force me. As a result of such behaviour I was hospitalised for about 3 months, with Jacklin staying with me all the time to guard me.

Marja,
Albania to Italy

Traffickers are known to rape girls who are virgins at the time of their abduction or sale as a sexual initiation, and to ensure women’s co-operation with the first clients. Three respondents explained that they never had sexual intercourse prior to being raped.

These extreme and life-threatening forms of violence are meant to show women the price of disobedience. Based on these explicit power dynamics, women are forced to submit to the demands of traffickers in order to survive.

One of the most important consequences of a trafficker’s initial violence or threats is to make the woman accept her dependence. Forced dependence is a key feature of captor-captive relationships.

Discussing victims of torture, T. Miller, citing Farber, Harlow and West, explains:

...the captor-influence tactics induce in prisoners of war a state of debility resulting from pain, disease, fatigue and starvation. The anticipatory anxiety induced by unrelenting uncertainty and the threat of death, pain and non-release become most prominent. Because

captors control resources for alleviating this dreaded state, captives develop a dependency on their captors for relief. The result is clearly a negative impact on self esteem and lessened conscious efforts to retain pre-captivity identity, group support and initiate covert action against the captor.²²

The tactics used to inculcate dependence and submission are also described by Maria Tchomarova, a psychotherapist working with trafficked women for Animus Association Foundation/La Strada, Bulgaria. Tchomarova likens the stages of mental manipulation of women to those employed by totalitarian regimes. First, the woman is forced into “extreme survival conditions” during which the possibility of death is made real and the woman recognises that she no longer controls her safety – the trafficker does. The second stage involves “physical exhaustion.” Women are forced to work long hours and days, which gives owners significant control (and increased profits). Without time to rest, the woman is debilitated and unable to consider her options or contemplate self-defence strategies. Control and isolation are the final elements in ensuring women’s dependence.²³

In a captor-captive-like situation, where her only substantial contact is with the trafficker, a woman’s perceptions of the world and herself are reflected through his skewed construction of her universe. His rules are her rules. His needs are her needs. His fears are her fears.

Concluding remarks

The travel and transit period can be as unthreatening as a plane ride or short boat trip, or it can involve mortal dangers that can disable or kill a woman, such as crossing rapidly flowing rivers, war zones, or treacherous mountains under armed guard. For many women this period took an enormous toll physically, psychologically and emotionally.

The effects of traumatic events on memory and recall that occur during this time are important later when women are asked to recount people, places, and times of events for legal or other purposes, as well as for their psychological health. In particular, the consequences of this trauma should be recognised when police seek testimony from women who have been trafficked. Women may have difficulty offering details of their experience and may have inconsistencies in their statements and gaps where they are unable to describe what happened to them. It is not unusual for memory lapses to cause unwarranted doubts about a woman’s veracity.

The travel and transit stage is probably the period for which it is most challenging to develop intervention strategies. Women are often under close surveillance, regularly on the move, and may not yet recognise that they are in danger and need help. However, like the pre-departure period, the travel and transit period can offer opportunities to provide vital information to women. Ports of departure and entry used for immigration detection can also be places where health, safety and contact information in appropriate languages is provided to women. Embassies and consulates may serve the same purpose. Once a woman arrives at a work destination, she is usually much more isolated, possibly confined, making it more difficult for her to find essential, even potentially life-saving information that could be made available while she is in transit.

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3. Destination stage

Tania again proposed I go to the disco with a man. After I refused she called the guard who beat me. Even though my face was bloody, they still took me to the client to provide sexual services. So started my stay in Turkey, not knowing the language, not having documents or money.

Tamara,
Ukraine to Turkey

The destination stage is the period that a woman is put to work and her labour is exploited. The destination stage encompasses the forms of abuse associated with trafficking.¹ For most women in this study, danger and violence pervaded both their work and personal lives in this stage.

The forms of risk and abuse, on the one hand, and the corresponding range of health consequences, on the other hand, can be roughly divided into nine broad categories (Figure 3):

1. physical health;
2. sexual and reproductive health;
3. mental health;
4. substance abuse and misuse;
5. social well-being;
6. economic-related well-being;
7. legal security;
8. occupational and environmental well-being; and
9. health service uptake and delivery.

Each category is discussed below and draws upon information provided by women who had been trafficked.

During the destination stage most women encounter multiple forms of risk and abuse that reinforce and exacerbate each another in ways that increase morbidity. The medical and the social aspects of this panoply of risks and consequences must be taken into account, as well as their cultural meaning for women within and between cultures.² A woman's social and cultural framework influences how she contextualises abuse and the survival strategies she develops.

This chapter looks at the different forms of abuse, associated health risks and key aspects of health service delivery during the destination stage.

3.1 Physical health

3.1.1 Reported injuries and illness

They beat me and kicked me. They told me, 'Don't scream or we will kill you.' I kept quiet. I was a virgin before they raped me.

Ellen,
Albania to UK

Trafficked women were asked to describe health problems that they had experienced while in the destination country. Women reported broken bones, contusions, head and neck trauma, dental problems, loss of consciousness, headaches, high fevers, dermatological problems (e.g. rashes), scabies and lice, unhealthy weight loss, gastrointestinal problems, and complications from abortions.

The majority of injuries and illnesses reported by women were the result of physical and sexual abuse. As discussed below, women were beaten, raped, and deprived of sleep, food, and other basic necessities, leading to fatigue, weight loss, and vulnerability to infection.

Other reported health complications included pains and illnesses which were not a direct result of violence, such as dental pains, respiratory, and other infections from inadequate heating or hygiene. Violence, deprivation and lack of treatment often exacerbated these conditions. It was common for perpetrators to prevent women from accessing health care, and for women to rule out care for reasons of cost or legal documents. "I decided not to go to the doctor because I thought I would have to pay" [Katrina, Ukraine to UK]. When Katrina finally collapsed she was taken to an emergency service, where she learned that she was six months pregnant and had contracted syphilis.

Women who are trafficked are also injured trying to escape.^{3,4} For example, a Ukrainian woman fell two stories after having tied towels together to form a rope. She had a serious spinal injury, requiring two months of hospitalisation and leaving her with a permanent disability. Other women describe being beaten after asking clients for help to escape.

Finally, research on other forms of violence against women highlights that certain chronic pains and illnesses—such as idiopathic pelvic pain and irritable bowel syndrome—are associated with chronic stress and anxiety caused by abuse.^{6,7,8} The relationship between illness and abuse may be mediated by immune suppression resulting from chronic stress.^{9,10} This research strongly suggests that many of the respondents'

physical health problems—including gastrointestinal problems, pelvic pain, and dermatological complaints—are likely to be the indirect result of physical, sexual, or psychological abuse inflicted by traffickers, owners, and clients.

3.1.2 Physical violence

I was beaten in the abdomen and head, but never in the face because they didn't want to ruin the merchandise. Sometimes I was kicked in the stomach and in the legs.

Oskana,
Ukraine to Italy

Women were asked whether anyone had intentionally hurt them since they left home. Of the twenty-five women who responded to this question, twenty-three replied “yes.”

Of the respondents who were willing to offer more detailed descriptions of abuse, women reported having been hit, kicked, punched, struck with objects, burned, cut with knives, and raped. Women also described being deprived of food and held in solitary confinement as punishment. Two respondents specifically noted that beatings were carried out in such a way as to avoid making the injuries visible.

Over half the respondents associated headaches and other pains, such as pain in the legs and lower back with the violence they endured. One respondent, a domestic worker, was beaten about the head and neck with a wooden rod by her employer. As a result, she continues to have chronic headaches and loses consciousness one to two times daily.

Respondents explained that violence and punishments were inflicted as a response to perceived disobedience, to force them to have or sell sex, when they had not earned enough money, and when customers complained about them. After fleeing an abusive father, one woman trafficked to Belgrade explained, “We were beaten if we refused to work, and even if we didn't understand the language. If he found any tips, we were beaten and the money was taken away” [Anna, Ukraine to Yugoslavia].

Murder is not uncommon. In 2000 the Italian Ministry of Interior reported that 168 foreign prostitutes had been killed, the majority of whom were Albanian or Nigerians murdered by their pimps.¹¹ While it is not confirmed how many of these were cases of trafficking, these populations are commonly associated with trafficking in Italy.

In other accounts of extreme violence, law enforcement officials interviewed recounted cases of women who had been kept in cold baths for hours, burnt with cigarettes,

hanged from the ceiling, and had salt poured into their wounds. One officer cited a case of women who had been brutally beaten, and, so that the contusions would be less visible, the perpetrators then forced them to sit in an ice bath for hours.

In locations where law enforcement is weak and impunity rampant, reports of extreme violence and injuries are common. One young respondent from Laos trafficked to Thailand, explained, for example, “One girl, they burnt her face with a hot iron.” She spoke further of the violence she endured:

I was delivered to one of the houses near the forest. The employer told me that here I will have to sell my body. I was very scared and started crying. They confined me in a room for one week. Every day they beat me and forced me to accept the job. The second week I could not bear the pain any more and I agreed to accept the client. Anyway, after eight days of torture, I thought I will accept the job to save my life. I hoped that I might be able to seek help from the client. But every time when I told my story and asked for help the clients told the employer and I was beaten harder and harder. So I accepted my fate.

Ani,
Laos to Thailand

Perpetrators of abuse included trafficking agents, employers, boyfriend-pimps, and clients. Other research has noted cases of sexual and physical abuse by law enforcement officials,^{12,13} and members of the armed services, including peacekeepers.¹⁴ To date, very little has been written on the perpetrators of trafficking. One recent study looking at the “demand side” of the most common forms of exploitation of trafficked women and children proposes that those who exploit child labourers, domestic workers, or sex workers frequently “cloak what is an exploitative labour relation behind fictive kinship or some other form of paternalism.”¹⁵ Other reports on trafficking have recognised the business and economic motivations of perpetrators and the links to Mafia and organised crime.^{16,17} More research is needed on perpetrators of trafficking and trafficking-related violence.

3.1.3 Physical deprivation and punishment

The girls were beaten and not fed for every fault.

Alexandra,
Ukraine to Belgium

In addition to beatings and rape, perpetrators punished women by depriving them of basic elements of survival

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or being human, such as food, human contact or valued activities or items.

One respondent who physically collapsed from hunger and required hospitalisation explained:

I was not fed, was beaten and was locked in the bathroom till night...It lasted more than two weeks and when the ambulance driver came, he told the mistress that I lost consciousness due to starvation.

Tamara,
Ukraine to Turkey

Malnutrition and unhealthy weight loss were common problems caused, in part, by food deprivation and poor nutrition. Women explained that they were treated like animals, not given enough to eat and what they were given was not fresh or nutritious. Sixteen out of twenty-two women said that they were often hungry and lost significant amounts of weight. Three women reported losing between ten and twenty-three kilos.

One young girl from Laos who was beaten regularly explained:

We got a pack of instant noodles and a banana everyday. If they had any leftover rice, we could eat that with the noodles, but they often asked us to throw food away rather than giving it to us. Once I was slapped across the face with a shoe because I ate an orange that had been part of a spiritual offering and then thrown in the trash. That was the most painful experience and humiliating too.

Nipaphone,
Laos to Thailand

3.2 Sexual and reproductive health¹⁸

Everyday when his wife left for work he would come into my room and rape me. He would grab my arms so tightly they were bruised. When it was ordinary sex [vaginal] sometimes he would use a condom, sometimes not. I was always worried about getting pregnant. When he would take me from behind, he never used a condom.

Elena,
Ukraine to Italy

3.2.1 Forced sex, rape, and sexual assault

In the trafficking context, risks to reproductive and sexual health generally result from sexual abuse and coercion. All of the women in this study, including three domestic workers, reported having been sexually abused and coerced into involuntary sex acts. Sexual abuse and non-consensual sex acts included vaginal rape, forced anal or oral sex, forced unprotected sex, gang rape, sex without lubricants, sex during menstruation, and sex accompanied by violent or degrading rituals.

Women who were forced to sell sex reported having been raped by traffickers, pimps, acquaintances of traffickers and pimps, and clients. Two domestic workers employed as nannies and housekeepers, described being raped repeatedly by their employers and by other men. One was violently raped, anally raped, forced into unprotected sex, and subjected to other acts that she found degrading (but preferred not to discuss) by her employer. The second woman explained that when she was punished by the employer, she was brought down to the street or *strada*, where she was turned over to the pimps and made to work through the night, then returned to the employer.

One respondent escaped before traffickers could prostitute her, but was raped by her trafficker before fleeing. The rape resulted in a pregnancy and the birth of a daughter diagnosed with congenital syphilis. She described her rape:

I said, "no" [to prostitution] ...For me, I never did anything like this. Sascha said, tomorrow you must go to work... That night he raped me and hit me in the head and kicked me in the leg. He raped and beat me so that I would understand that I am just the same as all the rest. No better.

Katerina,
Ukraine to UK

It is common for perpetrators to use rape as a tactic to wear down women's defences to the point where they "agree" to sex work. One Metropolitan Police Detective in London described the case of a witness from Lithuania, "M. was raped at least once daily by L. Again and again he told her to work as a prostitute. She said that her 'will to resist was completely destroyed by the sexual abuse.' Eventually she submitted to working in a brothel" [Metropolitan Police, London].

Rape has also reportedly been used to extort money from women's families. A report from the Australian Institute of Criminology referred to reports of Chinese female migrants who, under the control of traffickers, were raped while family members were listening on the

phone, in order to persuade families to pay off debts.²⁰

Not surprisingly, of all the health problems reported, gynaecological complications were among the most common. As clinical examinations were not conducted for this study, the descriptions below reflect women's reports of symptoms or recollection of test results. Over half of the women reported symptoms commonly associated with sexually transmitted infections (STIs) and other signs of gynaecological ill-health, including unusual or heavy discharge, pelvic pain, pain or bleeding during intercourse, amenorrhoea, and heavy and irregular bleeding. Several women reported specific STIs including, Hepatitis B, Syphilis, and Human Papillomavirus (HPV or genital warts). Women also reported urinary tract infections, renal dysfunction, cervical dysplasia, ovarian inflammation, and complications from a botched abortion.

Rape, repetitive sexual abuse, and coerced sexual risk-taking can result in tearing of the vaginal tract and genitals, sexually transmitted infections, and unwanted pregnancy. Sexual abuse and rape are also linked to allergies, skin disorders, tension headaches, nausea, irritable bowel syndrome, chronic pelvic pain, dysmenorrhoea, depression, and poor overall individual health.^{21,22,23,24}

The importance of the link between sexual abuse, injuries and STIs has been increasingly recognised.^{25,26,27}

Women sold into sex work, women with multiple sexual partners, and in particular, women who have frequent or rough sex, are at risk of contracting STIs, as tears and trauma to the vaginal lining increases susceptibility to infection.²⁸ This vaginal/genital trauma can be extreme, as in the case of Trina, who explained; "I felt pain in my vagina and kidney when I was raped, and every time after sex I had bleeding" [Trina, Laos to Thailand]. The presence of STIs also makes women more vulnerable to HIV infection.

Moreover, the long term consequences of untreated STI's can include, pelvic inflammatory disease, lasting damage to the reproductive tract, kidney and bladder, infertility, miscarriage, infant morbidity and mortality, and cervical cancer.

The dimensions of coercion and violence within the trafficking situation also increase women's risk of infection limiting women's ability to negotiate how sex takes place and whether condoms are used.²⁹

Trafficked girls³⁰ are likely to suffer long-term health consequences from the sexual abuse they experience. Research on childhood sexual abuse suggests an association with depression and suicide, sexual dysfunction, an increased risk of contracting sexually

transmitted disease later in life, adulthood substance misuse, difficulty with intimate partner relations, and problems in the parental role.^{31,32,33,34}

3.2.2 Clients

*I was not happy at all the customers.
I thought: it has to stop.*

Ellen,
Albania to UK

Trafficked women working in prostitution rarely have control over the number or type of clients they accept, or the sexual acts they perform. Of the 18 respondents who estimated the number of clients that they served each night, seven stated that they had fewer than ten, while eleven women estimated between 10 and 25. Two women of the latter group reported serving as many as 40 to 50 on any given night. One woman expressed her repulsion, "After two or three clients, I felt tired and disgusted with myself" [Maria, Albania to Italy].

In order to earn enough money to buy their freedom, pay back a debt, or to respond to the demands of employers, women are frequently obliged to accept many more clients per day, often at a cheaper rate, than is generally the case for non-bonded and non-coerced sex workers.

3.2.3 Condom use

Trafficked women are at risk of STIs (including HIV) and unwanted pregnancies from unprotected sex with traffickers, owners, pimps, boyfriends, and from sex with clients. Condoms are the main method of protection against STIs. When asked about condom use with clients, 17 of 23 women reported regularly using condoms. Twelve reported ever using condoms with intimate partners (i.e., pimps, boyfriends).

When asked about condom protection for other sexual acts (oral sex, masturbation and anal penetration), 10 of 19 women reported using condoms for oral sex, 3 of 16 reported using condoms for masturbation or "hand jobs," and 6 of 13 reported having unprotected anal sex. One woman explained, "My owner ordered me not to use condom for oral sex. It was very rare when I used condoms for anal sex" [Anna, Ukraine to Yugoslavia].

Research on HIV highlights that the probability of HIV infection is highest with unprotected receptive anal intercourse, and very low for oral sex and masturbation.

Although some women were able to successfully negotiate condom use, there is reason to believe that respondents may over-report usage. This was suggested by health outreach workers, who said that women prefer to tell the outreach worker the "correct" answer—that is, she uses condoms regularly both in her work and with

her partner. In addition, in our interviews with women, a number of women who reported using condoms with clients and partners nevertheless also stated that at times they had unprotected sex, such as when clients pull it off during sex, when the condoms tore, or when clients refused.

For trafficked women, even when they are aware of the benefits of condoms, their use is commonly at the discretion of owner, pimp, or client. For example, Trina explained, “Some of them [customers] refused to use condom. Sometimes I insisted and said that I won’t provide service and ran from the room. The brothel owner talked to the man and some complied. But some clients refused and raped me” [Trina, Laos to Thailand]. Another woman from Ukraine stated, “My owner ordered me not to use condoms for oral sex” [Alexandra, Ukraine].

Some research on HIV among brothel sex workers suggests that women are most vulnerable to infection during the first six months of work when they have the least bargaining power, and have fewer customers who use condoms.³⁵

Significant influences in condom use also included difficulty in accessing condoms, and their cost. When asked about access to condoms, nine of thirteen women stated that pimps or owners were their sole source, “I worked without condoms unless clients requested them, then the owner gave me condoms. Normally, I had no condoms” [Oskana, Ukraine to Italy].

The cost of condoms, already expensive at pharmacies and markets, was further inflated by some owners who added the cost to a woman’s debt. One woman reported that she was charged US\$ 10 for each condom. To cover the costs of the condoms she was told to make clients buy alcoholic beverages at the bar. Even when condoms are given to brothel owners at no charge, such as from the UK sexual health projects, outreach workers were not confident that the condoms were always passed on to women without charge.

In some settings unprotected sex commands higher fees. Women facing the many financial pressures of the trafficking situation often agree to undertake high-risk acts in order to charge more. As one woman noted, “Girls without condoms make good money in one year, two years...” [Lucy, Kosovo to UK].

Although clients may comprise the majority of a sex worker’s sexual contact, studies and professionals working with sex workers suggest that clients are often not the main source of transmission of infection, and that women are commonly at greater risk of STI infection from their non-commercial sexual partnerships.^{36,37} As a sign of trust and love—or because they are given no

choice—women have unprotected sex with their partners. One woman explained her decision by saying, “when I use a condom with him I feel myself like I’m working with the client” [Ellen, Albania to UK]. The risk may be substantial as it is not unusual for partners of trafficked women to be involved in the sex trade and participate in high-risk activities such as sex with multiple partners working in prostitution or drug sales.

3.2.4 Other forms of contraception

Of the 17 women who answered the question about oral contraceptives eight reported using them. Several women began using them after an abortion and one started once she was released and in the care of an NGO. Aside from condoms, no other forms of contraception were reported.

The low levels of use of oral contraceptives may reflect that oral contraception has historically not been prescribed or used as an important form of contraception in many women’s home countries (see *Pre-departure stage*).

Misconceptions and concerns over side effects also affected women’s decision to use oral contraceptives. For example, one woman from Albania explained that even after two abortions she decided against oral contraception because of potential side effects, “I did not take the pill, I didn’t want to get fat, headaches, or have other side-effects” [Ellen, Albania to UK]. A gynaecologist in the UK highlighted that culturally-based beliefs may also dissuade women from using contraception, “In some cultures, women have problems taking contraception that alter their menstrual cycle and stops periods. There is the fear that the period builds up inside them.”³⁸

Other women were deterred by their inability to access medical care or the cost of oral contraceptives in countries where contraception was not free.

3.2.5 Douching and working through menstruation

I tried to clean myself as deeply as I could.

Irina,
Ukraine to Italy

Women believed that douching was important to their health and hygiene. Irina’s comment (above) was echoed by most women. More than half the respondents used either a feminine cleansing product purchased at a pharmacy, “syringed” with soda, or simply washed with soap and water. Two women also reported using disinfectants, such as Dettol (a skin disinfectant containing chloroxylenol and isopropyl alcohol).

Douching, even with standard soap and water, can decrease the vagina’s normal levels of lactobacillus.

This has adverse consequences for vulvovaginal health, affecting lubrication, the epithelium or vaginal lining, and the normal vaginal flora, which serve a protective function against potential pathogens.³⁹ There is some evidence that douching is also associated with increased risk of pelvic inflammatory disease (PID), although this may be attributable to the higher frequency of other high-risk sexual practices among women who report douching.⁴⁰ In some cultures where dryness and tightness of the vagina is highly valued or where virginity reaps higher prices, herbs or other mixtures may be inserted in the vagina to make it feel “tight” during intercourse.⁴¹

Seven women reported working through menses. All seven explained that they inserted a sponge for absorption. One 17-year-old who strongly disliked her pimp-boyfriend added that she used a sponge because she would rather be at work than at home, even during her period. Vaginal penetration during menstruation is associated with a higher self-reported rate of STIs.⁴²

3.2.6 Access to reproductive health information and services

Although women were at high risk of developing reproductive and sexual health problems, few trafficked women knew where to seek treatment for gynaecological complaints. Of twenty women asked whether they knew where women could go for treatment for sexually transmitted infections, only four could cite a treatment location. Each of the four mentioned outreach services or public clinics (*consultorio* in Italy). Eight women stated definitively that they “did not know,” while three women did not know but “guessed” that they would go to a doctor, hospital or gynaecologist. Two women explained that they would go to the owner, who would arrange a private physician. One woman working in Kosovo said that women “self-treat.”

Even women who knew where to go for treatment reported significant barriers to seeking care, such as, little freedom of movement, no money, and limited language skills. Many women were simply not permitted to leave their work venue, “I didn’t have any possibility of going to health centres or hospitals. My freedom was totally denied” [Laura, Romania to Albania].

Only six of 20 respondents reported having gynaecological exams while in the destination-work setting. Some exams were provided by NGOs and others were conducted at brothels or clubs. One woman noted, “When the doctor came to the brothels he only examined us externally” [Olga, Ukraine to Kososvo], indicating that the gynaecological care that she accessed was inadequate.

Inability to access health services not only deprived

women of care, but also denied them a meaningful source of information. A client survey conducted by one non-governmental organisation in Italy revealed that of the sexual health services provided, information on HIV and other sexually transmitted infections was most highly valued by migrant sex workers.⁴³ Interestingly, the only NGO activity more highly rated was “chatting,” perhaps suggestive of the isolation felt by many migrant sex workers.

3.2.7 Abortion, termination of pregnancy (TOP)

Out of 22 respondents, six women reported having had at least one unintended pregnancy in the destination country. One of these women carried the foetus to term, and the remaining five elected to have a termination of pregnancy (TOP). Of these five, one woman reported having undergone three terminations, and another reported two. Four women were treated by professionally recognised providers, and one received an illegal abortion.

Unintended pregnancies may occur for many reasons, including from rape, problems with contraception during sex work, or unsafe sex with intimate partners or pimps. One doctor in the UK explained, “Women tell me that their male partners beat them up and that is why they want a termination. They quite often have boyfriends who drink, take drugs and make these women have terminations” [Lead Clinician for termination of pregnancy services, London].

The preference for termination of unintended pregnancy was reiterated by respondents who had never been pregnant, the majority of whom stated that they would have sought an abortion had they become pregnant in the destination country. However, awareness of TOP services was generally low. Only two out of twelve respondents who had never been pregnant were able to identify an accessible TOP provider in their destination country.

Ignorance of abortion services, anti-abortion laws, and lack of free or affordable TOP services increase the likelihood that women will turn to illegal practitioners. While the safety and professionalism of illegal TOP services depends on the context (for example, in some countries where abortion is illegal, there are numerous safe illegal options), in most contexts the risk of having an unsafe abortion, with its attendant complications, rises when services are illegal.⁴⁴

In this study, women who received legal TOPs reported having few complications. The respondent who had an illegal abortion, however, suffered life-threatening complications. Elena was fourteen years-old when she underwent an illegal abortion in the United Arab Emirates:

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Abortion was forbidden because of the faith. I was past my fifth month, when the abortion was done. I didn't know I was pregnant. The abortion was done illegally in terrible unsanitary conditions. The operation was very difficult, so I was nearly dead. There was no anaesthetic. The doctor said he would inject soap water into the uterus and the foetus would go out. Then I was sent to the toilet and was told to wait. I paid 2500 drachmas for the abortion. After the abortion I felt very bad, like I would die and I was taken to the American hospital.

Elena,
Ukraine to UAE

Anecdotal evidence also suggests that unsafe TOP may be particularly common in cases where the employer arranges the termination. For example, a trafficked Laotian woman recounted, "One girl who was pregnant was beaten by the brothel owner severely. They gave her abortion pills. After she took the pills she was bleeding seriously" [Ani, Laos to Thailand].

In addition, much of what is known of the characteristics and profile of a trafficked woman parallel those of women who are most susceptible to undergoing an unsafe procedure – particularly in countries where abortion is illegal. Unsafe abortions are reported to be common among young women who:

1. have poor access to family planning information;
2. do not have strong social networks to access good health services; and
3. do not seek terminations until later stages of gestation.⁴⁵

In general, complications from unsafe abortion are common, and related to the abortion method used, the provider's skill, the length of gestation, and the accessibility and quality of medical facilities to treat complications if they occur.⁴⁶ Trafficked women are particularly vulnerable to post-procedure problems, such as incomplete abortion, sepsis, haemorrhage, and intra-abdominal injury. It is worth noting that in some locations, complications from unsafe abortions reportedly account for most maternal deaths.⁴⁷

Outreach workers assisting migrant sex workers in Italy and the UK report that abortion rates are extremely high, with some women having as many as twelve abortions.⁴⁸ It is not uncommon for women to be forced to return to work without sufficient time to recuperate, increasing the risk of post-procedure infection.

Some women, particularly women from Eastern Europe, may also have a pre-departure history of abortion, relying on termination as their main form of birth control. Statistics on abortion indicate that among the sub-regions of the world, Eastern Europe has the highest abortion rate (90 per 1000) compared with Western Europe, which has the lowest (11 per 1000).⁴⁹ In many former Soviet states, abortion has served as a primary form of birth control and retains importance in areas where awareness and availability of other forms of contraception are limited. In Ukraine, for example, a 2000 World Health Organization report on women's health states that "abortion remains the most common form of birth control....60% of women over the age of 35 have had abortions."⁵⁰

3.3 Mental health

Once I said something stupid and my owner took his gun and put it to my head. I heard the flick of the trigger mechanism. He warned me that the next time the gun would be loaded.

Anna,
Ukraine to Yugoslavia

Psychological coercion and abuse are hallmarks of violence against women and fundamental tactics used by perpetrators of trafficking. During the destination stage, a range of psychological abuse is used to manipulate women and to hold them hostage. In this way, women come to depend on the perpetrators of their bondage. Writing on the psychobiological effects of torture some experts have asserted, "One of the most pernicious effects of torture is that in their attempt to maintain attachment bonds, victims turn to the nearest source of hope to regain a state of psychologic and physiologic calm."⁵¹ Ultimately, the goal of control and corresponding dependency is achieved when a woman can no longer distinguish her independent personal and social self from the identity constructed through her exploitation.⁵² One respondent explained, "I felt really bad, I kept wondering what I was doing, if it was me or not. I could not recognise myself" [Ledja, Albania to Italy].

Psychological control tactics include:

1. intimidation and threats;
2. lies and deception;
3. emotional manipulation; and
4. unsafe, unpredictable and uncontrollable events.

This psychological abuse is generally persistent, commonly extreme, and frequently perpetrated in such a way as to destroy a woman's mental and physical defences. Negative mental health consequences are numerous and often long-term.

3.3.1 Intimidation and threats

Most women were made to understand early on, often during the travel and transit stage, the high price to be paid for disobedience. During the destination stage, respondents explained that warnings and subsequent punishment continued in the form of threats, physical violence, and sexual abuse. Women were also made aware of potential harm as they heard and witnessed the punishment of other women. One respondent from Ukraine who, upon learning that she had to work as a street prostitute, began to cry and refuse:

The Madam's partner, a big man from Yugoslavia threatened to hurt me or that he would make me 'disappear'. I believed them because I knew of cases where women were beaten and really did disappear.

Tanya,
Ukraine to Italy

Other women reported similar threats and beatings to warn them that non-compliance would not be tolerated. Nor would failure to earn enough, "She told me that if I didn't earn a lot of money that night, she would kill me". [Tamara, Ukraine to Turkey].

Threats against a woman's loved ones were particularly common, and an extremely effective mechanism of psychological control. Over one-third of the women interviewed reported that traffickers threatened to harm family members, and women in this study and others have frequently cited threats against family members among the primary reasons they felt immobilised or trapped in their situation.^{53,54} Traffickers are known to warn women that if they refuse or run away, a sibling will be taken in their place.

Even women whose families were not directly threatened frequently perceived their family to be at risk. For example, one woman explained, "No [we were never threatened], but I was very afraid of it" [Tamara, Ukraine to Turkey].

Traffickers also blackmail women into compliance by threatening to reveal compromising details to a woman's family. Several respondents reported that pimps threatened to inform their families about their work in prostitution, sometimes even using covertly taken photos of the woman at work.

Trafficked women fear being rejected and shunned by husbands, families, or their community. One Kosovan girl who was only thirteen years-old when she was recruited and forced into sex work in Italy, explained, "I am afraid to tell my family. I feel ashamed and worry that my father will not accept me" [Alma, Kosovo to Italy].

One woman, worried for her mother's health, asked the police not to contact her parents because her mother had a weak heart and if she learned that her daughter worked as prostitute, "it would kill her."⁵⁵

The threat of being resold or re-trafficked—with the implications of acquiring a new debt, a longer period of repayment, the potential for a worse situation and leaving any friends or acquaintances—was also used to control women. This fear was particularly common among women who had been in Kosovo and Yugoslavia.

Perpetrators also intimidated women by making examples of others, particularly in group settings (i.e., clubs or brothels).

3.3.2 Lies and deception

I told Sascha, "Look, if you let me go, I will go to the police, but I won't tell them anything about you." He told me, "if you go to the police, they will put you in prison."

Katerina,
Ukraine to United Kingdom

Traffickers frequently lead women to believe that whatever the miseries of their current situation, they will be far worse off should they appeal to others for help. Common ploys include telling women that if they are discovered without documents they will be imprisoned and forbidden to return home, or asserting that the local police are part of the Mafia and will abet traffickers by returning women or reselling them. Women, who may already be alienated from government authorities by cultural, social, or language barriers or past experiences with corruption, are further dissuaded from seeking help.

3.3.3 Emotional manipulation by boyfriend-pimps

I arrived without any documents, with a boyfriend that I thought loved me and wanted to marry me. He beat me repeatedly. First to force me to prostitute and again later when I tried to rebel.

Alma,
Kosovo to Italy

Seven women (from Albania, Romania and Kosovo) said that they were trafficked and/or pimped by a boyfriend, fiancé, or lover. These women were subjected to cycles of seduction, rejection, and abuse that is characteristic of intimate partner violence and noted for increasing their entrapment and diminishing their coping capacity.⁵⁶

While intimate partner violence, involves betrayal by a loved one, it is important to recall that in addition to

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betrayal, trafficking is also about being bought and sold and the meaning that this has. In cases where a woman's pimp also poses as her boyfriend, she suffers the damage to her self-worth of domestic violence and the alienation consequent of the merchandising associated with trafficking.

The emotional implications of being trafficked and pimped by an intimate partner are numerous and extremely complicated. While a thorough analysis of this contradictory circumstance is beyond the scope of this paper, women made it clear that they had difficulty coming to grips with this dichotomy. Many respondents struggled to come up with a term for their former "trafficker-boyfriend-pimp." One woman preferred "my man," another "my ex," and several consciously determined to use the word "pimp."

For many women in this situation, the negative aspects of dependence intermingle with positive ones related to care and support. As previously described, when a woman assesses that her well-being depends on her abuser, she often relinquishes important elements of self-determination.

Some experts, including researchers studying the physiological changes of exogenous depression, have referred to this 'giving up' as "learned helplessness."⁵⁷ However, critics of this theory contend that this places too much blame on the women by omitting consideration of the inadequate resources available to assist women, and the practical reality of a woman's common-sense assessment of the danger of opposing the abuser.⁵⁸ These critiques ring particularly true in the case of trafficking.

For some women, the relationship with the individual who they eventually referred to as their pimp involved moments of kindness and generosity, making it all the more difficult for them to accept that they were being exploited or to turn against these men. Women report promises of marriage, and acts of generosity, such as gifts of jewellery and clothing (albeit, bought with the woman's earnings). While in Italy, Caroline's new boyfriend promised to rescue her from prostitution and find her a "normal job" if she agreed to come to Britain with him. Once in Britain, however, he persuaded her that until he could find employment, she could make good money for them both by taking up sex work. After weeks of pressure, she relented and for nine months she continued working and turning over her earnings to the man who professed to love her, until she ultimately fled and agreed to testify against him.

These equivocal situations are not only problematic during the time a woman is in the exploited situation, but can also dissuade her from testifying or, if she decides to participate in a prosecution, may serve to

discredit her testimony (see *Detention, deportation and criminal evidence*).

3.3.4 Unsafe, unpredictable, and uncontrollable conditions

Women were asked whether they ever felt safe at work. None of the sixteen who responded stated they ever felt safe. Having worked in Serbia, Italy and the UK, one respondent asserted, "You never feel safe in places like that. They're horrible, cold, small rooms, no windows and a lot of girls" [Caroline, Romania to UK].

Traffickers benefit from keeping women perpetually "on edge" by creating an unpredictable and unsafe environment. Perpetrators of torture are known to employ similar tactics aimed at destabilising their victims and creating extreme uncertainty about the future.⁵⁹ In research on torture, two variables that dramatically effect whether certain stimuli will have deleterious health consequences are the degree of predictability and control that an individual has over an event.⁶⁰ Seen from this perspective, many of the women interviewed would likely have suffered the maximum effects of their volatile situations.

Relentless anxiety and insecurity has significant effects on mental health and overall well-being. Symptoms associated with this type of persistent stress include, psychosomatic symptoms (pains, nervousness, insomnia, nightmares, tremors, weakness, fainting, sweating, diarrhoea), behavioural changes (withdrawal, suspiciousness, irritability, aggressiveness, impulsiveness, suicide attempts, depression, fears, phobias) and cognitive impairment (confusion, disorientation, memory defects, loss of concentration).⁶¹ These may be mediated by immune suppression resulting from chronic stress.^{62,63}

3.3.5 Reported mental health symptoms while working

To obtain an overview of the range of psychological symptoms and symptom patterns experienced by respondents, a mental health screening tool was developed based on a World Health Organization (WHO) questionnaire (SRQ20) and the Composite International Diagnostic Interview 1.1 (CIDI),⁶⁴ also developed by the WHO. These instruments were designed to inquire about a range of recent symptoms associated with mental distress. The combination of reported symptoms reported gives an indication of whether the respondent is likely to be mentally distressed or not. Relevant questions were selected from these tools. The amended tool used for this study was not scientifically tested and so the data gathered in response to the questions selected do not provide quantitatively rigorous data. Nor do they offer definitive diagnoses of mental illness.⁶⁵ However, even

Destination stage

in the very small sample of women represented below, the collective responses illustrate the severity of women’s distress, highlight key symptoms, and suggest the impact on a wider group.

Twelve respondents were asked 22 yes-or-no questions about their feelings and behaviours (see appendix) over two different time periods:

1. while they were working, and
2. within the past four weeks.

Women were then scored according to the number of positive responses. The scores represent the number of symptoms reportedly experienced *during the work stage* of the journey.

Eight, or two-thirds of the women, responded positively for half or more of the symptoms (11+), strongly suggesting the need for mental health support. Four women had extremely high scores, responding positively to 15 to 18 of the 22 symptoms.

Certain symptoms were reported by nearly all respondents for the period while they were working.

Symptom	Number reporting	Total reporting
Easily tired or tired all the time	11	12
Crying more than usual	11	12
Frequent headaches	10	12
Frequently unhappy or sad	9	11
Had no interest in things	9	11
Felt tense, anxious all the time	11	12

Women were invited to elaborate on their answers, allowing more meaningful interpretation of these findings.

Describing the fatigue, Larisa told interviewers:

I was always sick, from the moment I went out to work, and I always felt tired. I felt really bad inside. I could not feel good. I was stressed, tired.

Larisa,
Albania to Italy

Talking about sadness, Laura, who was trafficked at age 13, said:

After all what was happening to me, I was more than unhappy, I was desperate all the time.

Laura,
Romania to Albania

Given the nature of the work, hours, conditions, and the menacing environment, it is not surprising that women regularly reported symptoms of exhaustion, stress, and anxiety. Moreover, each of these problems exacerbated the other. Laura, from Romania, highlighted the chain of physical and psychological reactions:

I was frequently afraid of my pimp beating me up — as they all used to do — and sexually abusing me. I was in a continual state of anxiety and worry so that sometimes I couldn’t sleep, also causing me headaches.

Laura,
Romania to Albania

When asked whether they “felt as if they weren’t as good as other people or permanently damaged,” 8 of 12 women answered “yes.” Like other forms of violence against women, trafficking degrades women’s self-esteem. One woman added, “When I was in the street and saw the other girls, “normal” ones, I used to think, ‘ Why can’t I be like them?’” [Maria, Albania to Italy] Another respondent said, “I used to feel like I am not a person” [Ellen, Albania to UK], and two women stated they felt “dirty” or “bad.” Under the extreme, often humiliating, life-style changes, women’s self-perception is shattered and identity often lost. No longer able to relate to who they were at home, at the same time, they are unable to identify who they have become.

Ten of twelve women suffered chronic headaches and several described migraine-like symptoms, such as nausea and vomiting when headaches were severe.

Four of 10 women said they had “heard voices when no one was there.” One, who was still living in fear of being found by her trafficker specified that she heard “ghosts” above her when she lived on the top floor. Two women said that they had always heard voices, and the fourth said that she heard her mother’s voice.

3.3.6 Suicide

When asked, “Have you ever thought of ending your life,” six of nine women who responded, answered “yes.” Two women who affirmed having had suicidal ideation said that these thoughts occurred “often.” One respondent explained, “I always felt anxiety and fear. Nothing

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interested me, and I felt I wanted to die” [Lola, Albania to Italy].

Research on domestic violence and suicide suggests that suicide attempts are provoked by women’s “entrapment” resulting from the perpetrator’s “coercive control,” and by being treated as “property.”⁶⁶ Stark and Filtcraft emphasise the role of the perpetrator in women’s suicide attempts. Their study findings highlight the impact of a perpetrator’s control over resources and decisions, and the social and institutional barriers that limit protective and assistance measures available to women. Undoubtedly, trafficked women feel as strong or a stronger sense of imprisonment, submission, and alienation from sources of support and assistance.

Describing one respondent, the researcher in Italy noted:

From what she says it appears that she suffered a great deal from her experience, and it seems she tried to cope with self-destructive behaviours (like cigarettes) or escaping in the dream of suicide. She also seems very aggressive and defensive as if she wanted to release her anger to the outside.

M. Treppete,
Researcher, Italy

One respondent from Laos explained that while she often considered suicide, her family obligations weighed heavier. “Many times I felt like ending my life but when I thought of my parents I couldn’t do that because I would like to go back and take care of my parents. As the youngest daughter that is my responsibility” [Ani, Laos to Thailand].

3.4 Substance abuse and misuse

Women who have been trafficked frequently encounter some form of substance abuse or misuse. “Abuse” in this case refers to the way perpetrators forced women to take drugs or alcohol. The term “misuse” refers to voluntary use at harmful levels.

Drugs and alcohol are another tool of power and control. Women under their influence are thought to be more pliant. Anaesthetised by narcotics or alcohol, women are made to take on more clients, work longer hours and perform acts they might otherwise find objectionable or too risky. In cases where use becomes dependency, women are further tied to their trafficker and work in order to support their addiction.

Even those who are not forced to drink or take drugs may choose to use drugs or alcohol to relieve stress. It is not uncommon for women who are victims of

violence to turn to drugs, alcohol or cigarettes as a coping mechanism and subsequently develop an addiction.^{67,68}

3.4.1 Drugs

In this study none of the women reported a current drug addiction. Three women reported using sedatives. One respondent reported taking two Diazepam tablets (anti-anxiety agent) daily. This same woman reported concurrently drinking 7-8 glasses of vodka and juice per night (contra-indicated with sedatives of this kind). One said she took sedatives, “when I would touch bottom ... only when I couldn’t bear it any longer” [Larisa, Albania to Italy].

While none of the respondents in this study reported having been drugged before being raped by traffickers or clients, other reports suggest that sedating women prior to sexual abuse is not an uncommon practice, particularly when women or girls are virgins at the time they are sold into prostitution.⁶⁹ Drugs are used to render young women defenceless for sex with their first clients.

One young Lao woman interviewed in Thailand related her fear over the employer’s use of non-prescription or traditional medication:

Every morning at 8 o'clock the employer gave us a spoonful of very bitter powder which we had to eat. During the first week, I could not eat any food because the bitter taste stayed with me. I asked them one day what it was. They shouted at me and said, "if you are lazy you have to take it!" I was forced to take it from the day I arrived. I often got very bad headaches, especially when I thought about my family. Sometimes I couldn't bear the pain. When I told them, they gave me a pack of "tunjai" [a cheap pain killer, popular among poor labourers, that can be addictive if used regularly].

Ani,
Laos to Thailand

Some women reported being drugged to facilitate their kidnapping or transit. One respondent reported that she slept throughout the journey because her pimp put something in her drink before their departure. Another reported that when she arrived at the central train station in Kiev, she remembered being, “stroked by something on my head and then somebody made an injection” [Natasha, Ukraine to Kosovo].

3.4.2 Alcohol

Yes, one to two bottles of 0.5 whiskey each night. It was a condition of our work.

Tamara, Ukraine to Turkey
and Alexandra to Belgrade

Four of nineteen women stated that while working, they drank significant amounts of alcohol (from seven glasses of vodka and juice to two bottles of .05 whiskey per day). Four others drank moderately. None of these eight respondents reported drinking while in their home country. None of those who reported drinking while in the work setting currently drink.

For many women, coerced alcohol consumption was part of a practice whereby women working in bars must make customers purchase drinks. Respondents from Ukraine referred to it as “consummation.”

One respondent, relying on her good relationship with the bartender, asked him to fill her glasses with juice instead of alcohol. She explained that there were times when clients tasted her drink, then complained to the bartender that they had been cheated of the alcohol.

The youngest respondent, who was trafficked to the UAE and experienced some of the worst abuse, stated that the worst part of her existence was when, “I was made to drink” [Elena, Ukraine to UAE].

The manager of one non-governmental organisation in Italy assisting sex workers suggested that in addition to using alcohol to distance themselves from their situation, women who work the streets drink in order to face the cold weather.

One respondent surmised that clients liked when women got drunk because it proved these were women of ill-repute, and thus unworthy of kindness or sympathy.

3.5 Social well-being

I never went to anyone for help because I had no opportunity to move. I worked at night with a Yugoslav only 15 feet away at all times. I was locked up in a room during the day. If I had had the chance, I would have tried to find the Red Cross for help.

Olga,
Ukraine to Kosovo

Much of trafficked women’s isolation is a direct result of a perpetrator’s actions, while other aspects are associated with their illegal status and the social exclusion similarly experienced by immigrant women⁷⁰

and female refugee populations.⁷¹

Specifically, women’s isolation and the negative impact it has on mental and physical health are a result of women’s:

1. restricted movement, time and activities;
2. absence of social support; and
3. linguistic, cultural, and social barriers.

Like other forms of risk and coercion, the various mechanisms used by traffickers to isolate a woman form a continuum. Some acts are quite severe, while others are much more subtle. There are reports of women who have been confined and shackled,⁷² while other women exist under the type of surveillance or hostile setting that effectively imprisons them.

3.5.1 Restricted movement, time, and activities

We talked about running away. But, we couldn’t see any possibility because we didn’t know where we could run to, how far from our home we were. We also worried that if they knew that we were planning to run away they would kill us, because they always said that they would kill us if we did not obey them. One girl, they burnt her face with a hot iron.

Ani,
Laos to Thailand

Women were asked: “Did you feel free to do what you want and go around where you want?” None perceived that they were truly free to do as they wished. Of 21 women responding to whether they were at liberty to do what they liked or go where they wanted, 19 stated a definitive “no” while two responded “yes and no.”

For many of the respondents, “not free” meant exactly that: they were physically confined to a space. Alexandra from Ukraine was only let out of her small room in the evenings to work the streets in Italy. Other women were monitored so closely that they were effectively imprisoned, such as the case of B, described by one Metropolitan Police Detective: “B worked in 3 different Soho flats. M took all her money. M always accompanied B to and from the flat. B said she felt she was a ‘total prisoner’” [Metropolitan Police, UK].

For others, especially those in an intimate partnership with their pimp, the lack of freedom was more complex. In relationships pervaded by violence, freedom is not simply a question of physical restraints. In situations where violence predominates, it is often about calculations and perceptions of risks and consequences. Free choice is related to what one perceives the

consequences of one's actions might be. Women who were interviewed understood that if they expressed a wish to go out, they would be accompanied. As Ellen, who lived with her pimp/boyfriend explained, "I was not free to go on my own. I wanted to go out, but he wouldn't let me. He would follow me" [Ellen to UK]. If they requested to go alone, they would be suspected of infidelity, or of trying to leave or escape. Women knew the price of voicing any preference might provoke anger, conflict, or violence. For most, exhausted from long and arduous work hours, it was simply not worth it. Caroline, from Romania, testified to this reality in a UK court when she stated that she never refused intercourse as it was always quicker and easier to consent, and refusal provoked abuse.

Women are also accompanied to health clinics and abortion services. Health workers report that pimps frequently escort women and wait for them. They also contend that women's inability to move freely and associate with persons of their choice severely constrains work of service providers. As noted by one provider in Italy, "It is very difficult to organise appointments with health services for Albanian girls because their condition is very close to slavery. They can't move alone" [Project Manager, Project Priscilla - Prostitution Street Worker Unit, LILA, Milan, Italy].

Even in the case where health workers go out to visit women at their work venue, information sessions with women are regularly interrupted by phone calls from pimps confirming women's whereabouts and their earnings.

Women were asked, "What did you do in your free time?" Of 20 respondents, 19 reported having no personal free time. Nearly all stated that when they were not working they stayed alone, slept, bathed, or were directed to clean the house or do other chores. For some who were confined, the options were minimal, "I slept, because I couldn't go anywhere" [Tamara, Ukraine to Turkey]. Others were made to do other work when they were not taking clients. Olga, from Ukraine explained, "I slept only few hours. I cleaned the room, worked at the bar, washed the pool, and cleaned the house" [Olga Ukraine to Belgrade, FRY]. Similarly, Caroline, who lived with her pimp-boyfriend, stated that during her free time; "I had to cook and clean, always" [Caroline, Romania to UK].

One respondent said that she went "window-shopping," but noted that she usually went with her boyfriend.

In limiting women's freedom, perpetrators also accorded them very little privacy. There was hardly any detail that pimps or employers did not know about their lives. One young Ukrainian woman trafficked to Belgrade explained, "We couldn't go anywhere, and we could talk

to each other only in a whisper and not long. All rooms were equipped with cameras and bugs." Another said, "...I could go to the city to make a call but only with the barman" [Anna, Ukraine to Yugoslavia]. Under regular surveillance, few women had any opportunity to discuss personal matters or establish supportive relationships.

As will be discussed below, employers are able to dictate virtually all aspects of a woman's personal life and daily existence—what and when she eats, when and how much she sleeps or bathes, what she wears, and how she cares for herself (or not).

3.5.2 Absence of social support

When I was working there wasn't anyone with whom I could talk. I wish I had a friend, but it was not possible with my situation.

Keti,
Albania to Italy

Social support has been deemed a critical component of coping with trauma among torture victims and for adaptation among migrants.^{73,74} The absence of emotional and social support has enormous implications for women's ability to withstand and cope with the stress of their situation. For many respondents, the lack of meaningful interpersonal contact left them feeling alone, and served to reinforce their belief that relief or escape was futile.

Traffickers can dictate and manipulate the terms and nature of a woman's contact with others. They can create situations that ensure she does not form bonds that decrease her feelings of isolation or her dependence on them.

Women reported having very little contact with their families. Fifteen of 21 women stated that they could not use a phone when they wanted. Of the fifteen, five reported having no contact with their families. Three stated that contact was very rare. Even for those who were able to call home, candid discussions were often not possible. "I called home once in two months, but the owners were listening" [Oskana, Ukraine to Italy].

A number of women explained that the loss of contact with their mother, in particular, was extremely difficult. One respondent asserted that this was among the most stressful parts of her experience.

Women were asked, "Who did you talk to most while you were there?" Most women (14 of 18) said that they either talked to their co-workers and/or their pimp-boyfriend. Several of these women also spoke with clients. Four women reported that they talked with no one. For those who were able to talk with individuals

other than boyfriend-pimps, conversations were frequently limited by time and context. Alexandra, who was forced to work the streets of Italy for nine months described, “Sometimes I could speak briefly with the other women in the van on the way to work, otherwise we were locked in separate rooms” [Alexandra, Ukraine to Italy]. Even those who reported having conversations with co-workers or others recognised the limitations of these relationships, “I did not have friends. I mean, real friends. I knew people in the “street” environment, but they were not real friends” [Keti, Albania to Italy].

Women were also asked about any contacts with local residents (outside of the work context). Fewer than half had any social contact with local residents. Those who did meet local residents, encountered them primarily through their work. One respondent, unable to think of any non-work social contact, explained, “Yes, once one client felt sorry for me, so he just talked to me and we had a dinner” [Tamara, Ukraine to Turkey].

When asked whether they had non-work-related contact with individuals from their (home) ethnic community, only three of 20 women reported any contact.

Further hindering the development of supportive relationships is the fact that traffickers frequently relocate women to avoid detection. In the case of health service provision, women’s transience is particularly problematic. Health outreach workers explain that they rarely see migrant sex workers more than once or twice. They highlight how care (e.g. vaccinations, follow-up clinic appointments) is seriously hampered by women’s mobility.⁷⁵

More insidious than the way perpetrators deny contact with others, is the manner in which they manipulate the nature of the relationships that women do have (colleagues, friends, and even family). For example, in some contexts, bar or brothel owners have been known to schedule women who speak the same language for different shifts. It is also not uncommon for owners to foster interpersonal dynamics that pit women against each other by creating internal hierarchies, competition to become the favoured one (or what one researcher referred to as the “queen bee”).⁷⁶ To accomplish this, the employer gives one or several women perquisites, allows them to serve fewer clients, or permits them extra freedom as a reward for their loyalty and complicity. The quid pro quo often is spying on and selling out colleagues. Mind games, such as subjective systems of rewards and punishments, discourage rebellion.

In one case reported by outreach workers in London, a woman in hiding from her boyfriend-pimp was identified by a former work colleague, and subsequently kidnapped in broad daylight by the boyfriend-pimp.⁷⁷

On the other hand, it must be noted that for many

trafficked women their co-workers are a loyal and vital source of support and friendship. Two respondents stated that they considered the friendships made while in the work setting the best part of their experience.

3.5.3 Linguistic, cultural, and social barriers

Once, I tried to explain to a client that I had been trafficked and needed help, but he couldn't understand me at all.

Oskana,
Ukraine to Italy

Trafficked women are also isolated by their inability to speak the language, navigate their surroundings, understand the social and cultural norms, local systems, and the new form of work required of them. This has enormous implications for women’s well-being, and for identifying health care options, communicating health problems, and comprehending treatment recommendations when they are available.

Only three of 26 respondents said that they could speak the language of the destination country. Eighteen reported they were not able to speak the local language at all, and five said that they were only able to speak a little.

Inability to speak the local language can affect women’s ability to negotiate services, and safe sex, in particular. Moreover, when women were unable to understand an employer’s or client’s demands it sometimes resulted in physical punishment. As noted by one respondent, “We were beaten if we refused to work, even if we didn’t understand the language” [Anna, Ukraine to Yugoslavia]. While working as a domestic worker, Olya had a similar experience, “[Language] was the problem, I had to stay near the disabled man and when he asked for something, and I didn’t understand, he would hit me with a pole” [Olya, Ukraine to Italy].

Not speaking the local language also makes it difficult, if not impossible, for women to seek a way out. Alexandra, who spoke Russian and Ukrainian, explained how she once tried to tell a client that she was being forced to prostitute against her will, but he simply shrugged, indicating he couldn’t understand her. One woman trafficked to the United Kingdom tried to call the emergency number, but was unable to explain her situation.⁷⁸

Language is but one factor contributing to women’s disabilities in a new location. Women are also hampered by their disorientation in a social and cultural context where they don’t know the rules or resources. Many are overwhelmed at the thought of navigating the logistics of a place they don’t know. Olya, who was employed as a domestic worker in Italy explained, “Sergio warned me that if I was out, I could be stopped by the police and could be put in jail.” Her social worker added that Olya

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was also intimidated to go out on her own because she was afraid she would get lost, she had no money, and didn't speak the language.

Women's social and cultural disorientation also meant that they were often completely unfamiliar with the avenues to access health services and information. Particularly for women trafficked from developing countries to richer countries, learning that free health services, for example, were available and truly 'free' (i.e., no bribes), was an alien concept.

Women were asked whether they knew of any free health services and what documentation they might need to access services. Eight stated that they knew of at least one free service. However, six were referring to the NGO services they received once they were out of the trafficking situation.

Similarly, thirteen of 20 women responding were unaware of the documentation necessary to receive free services. Five of the seven who knew which papers to present had learned this only after they were assisted by an NGO.

Women were asked, "Who would you have asked if you wanted advice about work?" Five women reported receiving work advice from "other girls," five stated that there was no one they would ask; four were instructed by the pimp or madam; three women, who were ultimately assisted by an NGO, cited the NGO; and two women stated that they did not need advice. Below are a sample of responses women gave:

Girls help each other, I would ask friends.

five women

To tell the truth, I didn't know what a condom was when I first came here. My ex's cousin's girlfriend showed me.

Ellen,
Albania to UK

I don't trust anybody.

Caroline,
Romania to UK

From the other side of the equation, health workers providing care to migrant sex workers stated that for them, language is the major obstacle hindering their ability to offer information and services to migrant women. (See *Health service uptake and delivery*).

3.6 Economic-related well-being

The owner made us work in the windows 12 hours a day. We had about 5 clients a day. We were not given any

money because, as we were told, we had to work off money spent on our documents and travel.

Elena,
Ukraine to Belgium

Even women who have successfully avoided physical violence are kept under the control of traffickers through various forms of economic exploitation that amount to debt bondage. As previously described (see *Travel and transit stage*), debt bondage renders a woman in perpetual service of a debt through her labour.

Women who are trafficked are not permitted to manage their income, and in some cases do not even know what they earn or how much more they owe, as indicated by one of the youngest respondents when asked how much she earned, "I don't know. I didn't get anything. Also I didn't understand their money system. I gave money to my owner" [Elena, Ukraine to UAE].

3.6.1 Debts

Respondents in this study reported owing or having been purchased for €700 to €15,975 (Euros) as described in *Travel and transit stage*. Traffickers oblige women not only to repay the alleged transport and document expenses, but also commonly charge them exorbitant fees for lodging, food, personal hygiene supplies, condoms, birth control, health care, and other work-related expenses. In addition, women frequently incur fines for many alleged infractions, such as tardiness, time off for illness, or other perceived misdemeanours or disobedience.

Traffickers have devised various schemes to extract the most work for the highest return from women. One respondent who worked as a house-keeper was informed upon arrival that she had to undergo a "three-month unpaid trial period." After three months, she was told that her services were considered unacceptable and she would have to accept a second unpaid trial period with a different employer.

The most common arrangement is for women to be informed that they must repay the trafficker's expenses, "It was £15,000 (€21,500) for the documents. He arranged everything, and invested all his money in me" [Caroline, Romania to UK].

Any accrued expenses, even health care, were added to a woman's debt. When asked about payment for the treatment of several sexually transmitted illnesses, Olga explained, "When I first came to the hospital, the owner cured me on credit, which was deducted from my salary" [Anna, Ukraine to Yugoslavia].

Pressures to earn and repay debts are fierce. In sex work,

Destination stage

financial demands push women to take risks, withstand long hours, or serve more clients to earn higher fees.

As noted, substance abuse can help women to endure the abuse on their bodies. Some women recognise the trade-offs:

I have never had or touched a customer without a condom, which doesn't really help you making money, but I guess this is your choice: whether you want the money or the health problems.

Caroline,
Romania to UK

Not all are able to choose.

To keep women uncertain of their remaining debt, cash and accounts are commonly kept by traffickers, employers or pimps. Women who do pay off their debts may also be re-sold, "I learned that I was sold to a pimp for 2200 DM (€ 955). The money he had spent on me I had to work off. When I worked the sum, the pimp sold me to Kosovo for 1750 DM (€ 735)" [Olena, Ukraine to Yugoslavia, Kosovo].

3.6.2 Money earned, money kept, money spent

I couldn't buy tampons. I ate once a day. Girls who are made to work have nothing.

Tania,
Ukraine to Italy

Respondents were asked a series of questions aimed at assessing how much cash they had in their pockets on a daily basis and their practical purchasing power. Economic abuse or deprivation is a recognised element of violence against women that affects women's health and well-being. Having access to cash is one of the many factors associated with women's psychological well-being, and their ability to care for themselves, i.e. purchase necessities, hygiene products, medications, health services, etc.

Women were first asked the amount of money they earned in a day. Of the 17 women who knew how much money they earned each night, they reported making between €45 to €1,200 per day. Five women did not have any idea how much money their work generated. Women were next asked how much of the money they were permitted to keep. Fourteen of 22 women said they were not able to keep any money at all. Eight stated that they were sometimes able to keep a little (e.g., "to buy cigarettes and coffee," or when they received tips).

For sex work, earnings and income structure vary from country to country and setting to setting. Women

working in apartments in the centre of London, for example, charge customers, on average, between GBP £20-45 (€28-63) per client for oral sex, hand masturbation or vaginal sex. However, before taking home any cash, women are required to pay GBP £250-300 (€352-422) working-flat rental per day (rent for housing is separate), and GBP £50 (€70) daily for the "maid" or flat manager (effectively the sex worker's boss). Women must serve, on average, 10 clients per day simply to break even.

Women were then asked what they did with the income they received. Most replied that they did "nothing" because they never saw any of it, or that they "gave it all to the pimp/madam/owner." Two women explained that they hid small amounts of money from pimps to send home to their families. One woman highlighted the risks of this practice, "If he found we had kept a tip, we were beaten and our money was taken away" [Anna, Ukraine to Yugoslavia].

One respondent worked seven days per week in the UK, making from the equivalent of €140 to €650, but was permitted to keep just €6 per day. Several other women cited similar arrangements.

One more financially fortunate respondent explained that she was given the equivalent of €43, sent home €65, and paid €217 per day to the owner to pay off her debt.

When asked whether they felt that they could buy basic necessities (e.g., food, tampons, shampoo, soap, aspirin, undergarments), 11 of 22 respondents stated that they could not. The other eleven women explained that the pimp, boyfriend or owner would supply these—from money taken from the women's earnings. Women were kept completely apart from the money they earned. "I have no idea how much a client paid. It was my pimp who used to bring me everything without even asking me what I needed" [Keti, Albania to Italy].

Women's financial dependence entrenches the subordination created by other forms of coercion. Her total reliance serves to crystallise her belief that she is like merchandise, powerless to control events in her life or to assert herself in any significant way. Psychologically, many women hold out hope that someday their debt will be paid off and they will earn these sums for themselves. As noted by Marina, "I was never paid by the second family, but continued to work in hopes that I would eventually get paid" [Marina, Ukraine to Italy].

Unable to afford the costs of medical care or inhibited from seeing a doctor, some women chose to self-medicate. This is particularly common in countries where antibiotics can be purchased over the counter. This practice can lead to a host of problems, not least, a

the health risks and consequences of trafficking in women and adolescents. Findings from a European study.

build-up of resistant strains of infection.

3.7 Legal security

The policeman took me to Belgrade where I was sold to the pimp who was given my passport.

Olena,
Ukraine to Yugoslavia, Kosovo

None of the respondents in this study arranged their own travel documents or work permits.

Six women reported having no documents at all. One was a 12 year-old respondent who travelled as a dependent, and never had her own papers. Another, aged 13, explained, "I never had any kind of documents except for my birth certificate. This year I should get my ID card" [Laura, Romania to Albania]. The four others crossed borders illicitly. Thirteen women reported travelling with passports, nine of whom stated the passport was counterfeit.

Nine women said the trafficker took their documents. In some cases where the traffickers arranged the travel documents, women never saw their papers at all, and thus never knew their legal status in the destination country.

For undocumented women, insecurity over their legal status pervades their existence and affects their decisions about health and safety, and whether or not to seek outside help.

It is common practice for traffickers to confiscate passports and identity papers, lie to women about their legal status, invent tales about the risks of walking the streets, contacting police, and to misinform and intimidate them about their rights.

Women who have been trafficked often fear police and immigration services more than they fear traffickers or their agents because of the risk of deportation or imprisonment. As summarised by Salt:

Irregular migrants using these services are exposed both to unscrupulous service providers and to the immigration and policing authorities, thereby generating a dependence on safeguards provided by the trafficking networks. Thus a symbiosis has developed between trafficker and trafficked.⁷⁹

Women's anxiety over uncertain or illegal status means that most fear contact with outsiders, including health service providers. As one respondent explained:

I was worried what [the outreach team] would ask. What [information] might go to friends, what papers were needed. I worried if my real name was in computers, then everybody would know.

Ledia,
Kosovo to UK

A health worker in Italy confirmed that even women who may be able to afford care don't often take the risk:

When deciding to seek medical care, money is not a relevant factor ... girls are very concerned with illegal status. Moreover, very often hospitals and others public services ask for documents (it seems that they have no knowledge of the law). In these cases, it is very important to have a cultural mediator taking the girls to the services.

Project Manager, Project Priscilla -
Prostitution Street Worker Unit,
LILA, Milan, Italy

Mainstream medical providers also are commonly unfamiliar with migrant women's rights to care. Moreover, discrimination against immigrants affects how women are treated. Findings from a study on domestic workers in the UK found that even in cases where women had a right to free health care, practitioners often imposed additional burdens of proof on migrant women. The report suggests that this "can result in the women failing to attend appointments or subsequently attempting to ignore serious health symptoms and further intimidate an already marginalised and vulnerable group."^{80,81}

Experts on migration suggest that restrictive immigration and labour laws limiting the legal options for individuals to travel and obtain documents independently have contributed to women's willingness to accept risks in job-seeking.^{82,83,84,85} Moreover, restrictive laws limiting the routes of legal migration and aggressive actions against undocumented migrants give perpetrators an important lever of power.

In the UK, for example, where the renewal of work permits for domestic workers depends on the employer, women's inability to independently apply for a visa can result in a power relationship that increases the risk that gross abuses go unreported. Similarly, immigration laws relating to sex work in the Netherlands are structured so that they exclude most legal avenues for migrant women to work independently. Of the dialogue on migration policies in Europe, some experts contend that, "existing policy-making is part of the problem, not the solution."⁸⁶

3.8 Occupational and environmental health

Reports from around the world indicate that women are trafficked into conditions that pose serious health and safety risks, conditions that are unhygienic, under-ventilated, unheated, overcrowded, and nearly always stress-filled.^{87,88}

Work and living conditions define, to a great extent, an individual's identity. They comprise the context within which people discern their self-worth and their value to others.

Women were asked a series of questions aimed at gaining an understanding of how they perceived the physical and psychological conditions of their workplace and living situation. This included inquiries about the physical environment, hours, safety, the aspects they perceived to be the most difficult, and those they most appreciated.

3.8.1 Work conditions

I would go work at 10 until 2:30 or 3 am, depending on business. I was always in the same place on the street. I would work 7 days a week, except for my period. You work all night, you wake up late, you are tired, you don't feel like doing anything. In the end, you just eat something and go back out to work.

Keti,
Albania to Italy

Seventeen out of 20 respondents stated they worked seven days per week. Women reported working punishing schedules, between 5 and 14 hours per day, most explaining that they began work in the evening and finished in the early morning, or when there were no more customers. Only two women specifically mentioned being permitted a break for dinner.

Most women described their work conditions as "bad" or "terrible." One woman recounted the conditions in a Yugoslav brothel,

We lived on the second floor, girls in one room. The bar was situated on the first floor. Our owner fed us with liver sausage, fish and bread. We didn't get money. They didn't buy us any clothes. If I refused to work they beat me.

Olena,
Ukraine to Kosovo

Another recalled conditions so unspeakable she could hardly tolerate the memory, "The conditions were awful. Too difficult to talk about, or to remember" [Oskana,

Ukraine to Italy].

Women in off-street prostitution described unhygienic, over-crowded work venues. Women working in the "windows" in the Netherlands and Belgium expressed their humiliation in this situation. Women walking the streets of Italy spoke of the long hours out in the cold winter nights. Health care providers report that women trafficked into streetwork come to them in "very poor health," [Ambulatorio per Stranieri, Trieste (Clinic for foreigners)].

When asked whether they felt safe in their workplace, none of the 20 respondents reported feeling safe.

In addition, women were forced to perform acts that were not only a danger to their health, but for which they felt a personal loathing, "I was disgusted by my job" [Jessica, Albania to Italy].

3.8.2 Difficult aspects of work

Women were asked which aspect of work they felt was most difficult. Several women said "everything" and "the work itself." Others spoke of the physical and emotional toll of the sex.

Other frequent complaints included exhaustion and the longing for family, "physical tiredness and being away from children" [Marja, Albania to Italy]. Punishing fatigue often predominates for women who are made to work the streets, like Tetyana who lamented how there was "no possibility even to sit for a while" [Tetyana, Ukraine to Italy].

"What do you think was the most difficult aspect of your work?"

Everything.

Keti,
Ukraine to Italy

To make myself do 'it.'

Tamara
Ukraine to Turkey

Oskana, who worked long and cold nights on the street and served between 20-25 clients per night in a parking lot, recalled with great emotion that for her; "the group sex" was the most difficult part. Laura, like other women abused by their pimps, felt that the abuse and accompanying health risks were most intolerable, "I was always forced to have sex with my pimp, and the clients, they never used any kind of protection, they also beat me up sometimes" [Laura, Romania to Albania].

The worst aspects most often reported by respondents were their fear of diseases, work without condoms,

the health risks and consequences of trafficking in women and adolescents. Findings from a European study.

being without documentation, being made to drink, fear of being re-sold, and fear of the police.

3.8.3 Living Conditions

“How was the place where you lived, slept?” “Did you live with anyone?”

[Conditions were] bad, terrible. There was one soap for everybody, one towel, the bed-clothes were washed very rarely.

Anna,
Ukraine to Yugoslavia

Ideally, one’s living-personal space is where an individual finds comfort and refuge, and is the place that defines her personal (vs. professional) self.

Half the respondents lived in the same place they worked. Two who worked in Yugoslavia and Kosovo said, “I lived and slept in the same bed as I worked”. For the rest, although they resided in a different location, their home environment was nonetheless filled with similar stresses and dangers. ‘Home’ was not a place to rest, recover, or feel safe.

Half the women described their living space as “bad” or “terrible.” Women described having to share beds with other women, or sleep on the floor. One young woman trafficked to the UAE described how she was locked in the bathroom and was forced to sleep on the floor. Another woman working the streets of Italy said that she was confined in her room each day when she was not working. Most of those trafficked to the UK, and a number in Italy described living in a “normal” apartment or house.

Ten felt the physical comfort of the living quarters was acceptable, but explained that residing with their pimps made their home life stressful, confining, and often violent.

3.8.4 Difficult aspects of life

“What do you think was the most difficult aspect of your life there?”

I felt like nothing could make it better. I felt like I was only a piece of meat with two eyes. I thought I will end up like nothing. There was no hope for me.

Caroline,
Romania to UK

Respondents were asked what they found most difficult about their lives in general during the period in which they were trafficked (other than work). Two women

specifically stated that what they found intolerable was to be treated as “a piece of meat,” valued according to the amount their body procured. One woman explained that worst was the “isolation,” and another said “relationships with people.” One cited what was most difficult was “finding a way out.” Another respondent flatly responded, “I was there against my will, being trafficked and forced to work as a prostitute. I didn’t have any freedom at all” [Laura, Romania to Albania]. Olena, trafficked from Ukraine to Yugoslavia and Kosovo, said, “When I was ill I got no help. It was very cold there.”

One Ukrainian woman said the “moral pressure” was what most distressed her. Similarly, a woman from Kosovo expressed her profound regret that as much as she wanted to go to church, she felt too dirty to cross the threshold. While no specific questions were posed about religious beliefs, many trafficked women working in the sex industry came from religious cultures where reconciling their faith with their work would be unimaginable.

3.8.5 Best aspects of work and life

“What was the best part of your work?”

No, nothing. No, no, really nothing.
Keti,
Albania to Italy

Women were asked about the aspects of their work they most appreciated. Nearly all of the respondents stated with certainty that there was “nothing” good about their work. Two women explained the best part was “when a client paid but didn’t touch me.” Two women mentioned the money, but explained that it was good because, “when I earned a lot of money my pimp didn’t beat me up” [Anna, Ukraine to Yugoslavia; Olena, Ukraine to Yugoslavia, Kosovo].

One woman cited, “friends who supported me” [Olena, Ukraine to Yugoslavia, Kosovo], and another trafficked from Ukraine to Italy said she appreciated the warm weather and the high standard of living.

3.9 Health service uptake and delivery

They are afraid to get sick since their body is the only “wealth” they have.
Public health clinic
 (“consutorio familiare”),
Mestre, Venice

Providing health care to women who are in a trafficking-work setting poses a number of challenges. Based primarily on interviews with groups and individuals working with sex workers and other marginalized

populations, a number of key issues emerged:

1. multi-dimensional service needs;
2. access to women;
3. language and culture;
4. gaining trust and offering support; and
5. women's mobility.

3.9.1 Multi-dimensional service needs

...the health agency has always been available, but the municipality was quite absent. Therefore, we entered the network of all social institutions in the area: charity organisations (Catholic and non), trade unions, education and training agencies.

Progetto Stella Polare, Committee for the Civil Rights of Prostitutes, Italy

Providers stressed that women's overall well-being depends on care that integrates health promotion and delivery with other practical forms of assistance aimed at strengthening women's self-determination (e.g., legal assistance, social services, language training).

Providers who worked with sex workers note that while many women's requests are gynaecological in nature, it is also common for women to ask for help with their legal status (i.e., "permit to remain") or employment. Several groups in Italy noticed that non-health requests have rapidly increased since 2000. Most groups assisting migrant women expressed how "destablising" it is for women to work clandestinely without documents. Service providers also explained that clients had reported violence and asked for assistance and shelter, they noted that these requests most often came later, once women felt a greater degree of trust.

In Italy, health services are offered based on a universal approach, and, based on this perspective, the previous immigration law (no. 40/1998) assures basic health care for irregular migrants. In practice, this means that health care is available from two categories of providers. The first include general public services, such as public hospitals, public clinics, family planning centres and anti-violence services. The second are dedicated services aimed at assisting migrant women or sex workers. In this second case, providing health services means assisting women to access to public services (for example, accompanying women to a hospital), and providing assistance to which irregular migrants are not normally entitled. When these organisations are not able to rely on providers who are willing to volunteer their services, they use money dedicated for anti-violence programmes, HIV/AIDS prevention projects, and projects for the integration of migrants and anti-trafficking programmes (Article 18 social protection

programmes). For the latter, law 40/1998 - which has recently undergone significant restructuring limiting the rights of migrants - provides groups opportunities to offer other services to irregular migrants once the women have applied for a "stay permit" for social protection.

In Britain, where trafficking has received relatively little public recognition, and there is currently only one limited pilot service project, groups providing health service outreach to sex workers and one organisation assisting migrant domestic workers are the most likely to come into contact with women who have been trafficked. Those providing health services to sex workers emphasised how difficult it is to even ask women about trafficking-related issues because they feel so limited in their ability to assist women or to refer them to other resources.

Most of the organisations that were interviewed for this study described how, in order to offer women the range of services they need, they have formed co-operative referral networks with other services (e.g. legal, refuge, social service).

3.9.2 Access to women

Flat owners/maids often invite service providers to new flats. Now we have a good working relationship with most owners/maids and are called when they open new flats.

Health outreach worker,
UK

The clandestine nature of trafficking, women's irregular status, and rapid mobility mean that service uptake often depends on the ability of the NGOs and health care professionals to reach out to women (i.e., versus women coming to them). Providers have demonstrated that service strategies that take account of the inhibitions and limitations of hidden and transient populations enable services to access some of the most vulnerable groups.⁸⁹

Word of mouth was reported as one of the most effective ways of reaching women according to most outreach workers. For women in sex work, for example, recommendations from co-workers provides the initial element of confidence that is not inherent in an unsolicited first visit by a previously unknown care provider.

Organisations working with migrant women also promote their services by offering free condoms, health information, free clinical services, pharmaceuticals, etc. This is a particularly effective outreach strategy in cases where employers, pimps, or madames restrict or monitor the women's activities. Generally, groups have found that when these individuals perceive there is some

the health risks and consequences of trafficking in women and adolescents. Findings from a European study.

benefit to the women that in turn profits them, they are likely to grant access. With this permission granted, women's fear of retribution for speaking to outsiders is decreased.

NGOs interviewed also reported reaching women through leaflets, and telephone help lines.

One group in Italy trying to reach migrant domestic workers creatively attempted to access women via the women's employers' doctors:

We thought that the women from Moldavia and Ukraine that are "badanti" (home carers) in Italy could contact us through general practitioners of the elderly or handicapped they take care of. Therefore, we sent information to all doctors of Mestre and Venice about our services for irregular immigrants. However, I am not sure this really worked as a way to communicate with immigrants. I think word of mouth ("passa parola") is more effective.

Consultorio familiare,
Mestre, Venice

Groups trying to contact migrant women reported that in addition to the practical difficulties of reaching women, health service uptake and delivery are hindered by restrictive legislation on migrants, insufficient funding, and the anti-migrant socio-political climate.

Health care professionals suggest that because of the many barriers that prevent women from making contact with the formal sector, service uptake is often dictated by the degree of a woman's physical discomfort or pain, or her inability to work. They explained that first-time patients, in particular, often do not seek services until pain becomes acute or the problem urgent.

When asked whether they require women to present any type of documentation, none of the providers interviewed in Italy or Britain required the women to present passports or other forms of identification for initial sexual health clinic visits or outreach sessions. "I never delve into their immigration status," said one clinician in London. However, it is worth recalling that interviews were conducted with groups that have regular contact with migrant or trafficked women. Other medical practitioners might be less sensitive regarding this line of questioning. London-based outreach workers consistently reported concerns about referring women on for other services for fear that women might be treated poorly or be told they are ineligible for care. Several stated, however, that in some cases (e.g. termination of pregnancy services) they have been able to identify avenues for women to access appropriate care. However, there is reason to believe that

restrictions on health services for undocumented persons are increasing.^{90,91,92}

In Italy, when women required further treatment, such as termination of pregnancy, scans, hospitalisation, or specialised treatment, providers were often able to arrange appropriate documentation or identification.

When asked about charges or fees, none of the providers interviewed in Italy or Britain required payment for services from migrant women. Health regulations in both countries allow for free care for sexually transmitted infections and other communicable diseases (except HIV/AIDS treatment) and free emergency care. In Italy, in principle, illegal migrants are entitled to register with the National Health Service (*Servizio Sanitario Nazionale*) for some basic assistance. They receive a card with a code number identifying them as foreigners that entitles them to specialist care, emergency, maternity, and hospital cover.⁹⁴

3.9.3 Language and culture

Language is the main barrier.

Numerous providers

Providers stated that differences in language and lack of available interpreting services were a significant hindrance with clients. In addition, providers acknowledged how women's differing cultural backgrounds can complicate diagnosis and care. A great deal has been written on the role that culture plays in interpreting symptoms and determining treatment. This literature highlights the need for a holistic approach that takes into account the individual's experiences, expressed needs, and the broader social context in which the individual is situated.^{95,96}

Nearly all those interviewed noted that while the number of migrant workers has risen dramatically over the past decade, services have often not been able to keep pace with the rapid change of client-base. Some organisations have, however, made great strides in accommodating a more diverse population, such as those employing cultural mediators. A cultural mediator is a go-between who understands the motivations, customs, and codes of both the migrant and dominant culture.⁹⁷

Two providers expressed their views on interpreting:

I think a cultural mediator is always essential in working with migrants. When the mediator was not there, I have tried working with an interpreter, e.g., an Italian that knew the language well, but it is not the same.

Progetto Stella Polare, Committee for the civil rights of prostitutes, Italy

We use a mediator or an interpreter. But still, there are problems. Mediation is a difficult means to use. When these women choose the “third” person themselves, it is much easier, because there is trust. There are useful questions to ask to establish a deeper relationship with them, but they do not answer certain questions with ease when external people are present.

Public health clinic
 (“consultorio familiare”), Italy

Concerns about the presence of outsiders are also shared, by clients. In some cases women are afraid to speak in presence of an interpreter, “I am ashamed, too shy to get an interpreter, to speak in front of people” [Lucia, Kosovo to UK]. Some women feel more embarrassed to talk about stigmatising subjects (e.g. sex work, sexual abuse) that are proscribed in their culture in front of an interpreter from the same culture and instilled with the same moral codes.⁹⁸ Women know exactly how poorly they will be judged according to those standards, whereas women may not anticipate the same disapprobation when speaking to an outsider. Moreover, in tight communities word travels fast, and it is understandable for women to be concerned about revealing stigmatising details to someone who may have contact with her local ethnic community, or her community in her home country.

Providers who did not employ cultural mediators or had limited access to interpreters (e.g., in the UK), reported relying on multi-lingual sexual health brochures from the organisation, Tampep (Transnational AIDS/STD Prevention among Migrant Prostitutes in Europe). For most of the groups interviewed in London, access to interpreting services is severely limited, at best. One group in London, whose client-base is approximately 80-90% migrant women has funds for only one Albanian interpreter for two outreach sessions per month. Inadequate support for interpreting means that providers risk misdiagnosing illnesses and mis-communicating treatment advice. It also means that they have little chance of understanding a woman’s mental health needs or when a woman wishes other forms of assistance.

Several providers in Italy and Britain explained that they worry about referring women to health service providers who may be discriminatory and treat migrant women poorly. One provider explained:

Sometimes it is difficult to convince them to get treated, not because they don’t want to, but because they want to avoid health workers who are filled with prejudices and judgements.

Progetto Stella Polare, Committee for the civil rights of prostitutes, Italy

Particularly in the case of trafficked women who are marginalised in multiple ways (as sex workers, migrants, because of low socio-economic status or gender), sensitive, non-judgemental care is essential to service uptake and delivery. Mainstream services often do not have the time or interest to provide unbiased, culturally appropriate care. As one cultural mediator in Italy observed, “Often they [mainstream health services] are racist and they do not like prostitutes very much.” Providers in both countries highlighted the importance of accompanying women to clinical and other appointments to help avoid some of these predictable problems.

When asked about mental health, several providers in Italy voiced concern over the misinterpretation of women’s behaviour because care-givers may view women through an ethno- and socio-centric lens. One mental health professional highlighted this issue by comparing cultural practices of Nigerian women to those of her own culture. She explained:

The different ways in expressing pain and emotion are always something to consider in order to avoid incorrect diagnoses. It is very easy, for example, to transform a religious behaviour into a delirium. The difference for Catholics [from Nigerians], for example, is that their belief entered the common mentality, therefore things like believing in miracles or praying to the virgin are accepted.

Centro di Salute Mentale,
Italy

Experienced providers have come to recognise the importance of culturally competent care and creative treatment strategies:

We were helping a Romanian woman who was convinced she was possessed by a demon ... we sought help from the formal (public) health services, in addition to consulting psychiatrists and ethno-psychiatrists. The possibility of referring her to an orthodox exorcist was not excluded.

Trans citt! e Prostituzione,
Italy

Providers also readily acknowledged that women experience the normal tensions of being a foreigner that can manifest as physical health problems. As one explained, “Often, it is not really a gynaecological pain, but the pain of women who just arrived in a country they do not know” [Public health clinic (Consutorio Familiare), Italy].

the health risks and consequences of trafficking in women and adolescents. Findings from a European study.

3.9.4 Gaining trust

To obtain trust from these women, it is necessary to introduce the service as health-related and not as a service that is investigating the trafficking organisation. It is always important to consider the situation of these women, which is different from woman to woman, to avoid impractical propositions.

Città e Prostituzione,
Italy

Individuals working with trafficked women explain that gaining a woman's confidence depends on the provider's ability to ensure her that the ' helper' will not cause harm (e.g., report them to the police or immigration, re-traffic them, betray them to a trafficker) and has something to offer. Until trust develops, women are reluctant to accept help, make follow-up appointments outside the outreach setting, or share personal information. Developing trust often takes time and several encounters, which for women who frequently move from place to place can range from the impractical to impossible.

Until trust has been established, providers strongly advise against asking women questions about their documentation, travel route, or other topics related to legal status. These are highly sensitive subjects, particularly because providers can be viewed as part of an authority structure the women are trying to avoid. Groups also state that they are reluctant to ask about boyfriends and women's personal lives. It is within this personal realm that for many women lies the danger. Until a provider gains a woman's trust, she will be reluctant to reveal information that may put her at risk yet may also be the key to assistance.

3.9.5 Women's mobility

Frequently we meet women with vaginal infections, or with discharges related to pregnancies. The problem is that the [trafficking] organisation does not allow the women to stay more than three months somewhere and this hampers the building of any treatment relation. When women are proposed a cycle of examinations or admission to hospital, they do accept, but later they will not come to the service since the organisation does not allow that.

Città e Prostituzione,
Venice

The nature of working illegally is characterised by mobility and invisibility. Providers assert that care is

hindered by their clients' movement, which does not allow time to establish trust, complete treatments, or schedule follow-up appointments.

Many regimens for preventative and curative care comprise an initial contact, with several follow-up visits. Vaccinations to prevent hepatitis B, for example, require an initial blood test and first vaccination, followed by a second vaccination one month later, and a third six months later. The investigation and treatment of sexually transmitted infections includes an initial examination with screening for infections, then follow up to ensure treatment has been successful and any relevant contacts traced. However, this group of women rarely remains in one place for very long, or has personal control over the time available for medical appointments. Nor do they have access to their medical records or know what diagnoses and treatments they have had in order to inform future providers. The frequent movement of trafficked women creates a particular service challenge that requires the development of creative outreach strategies.

Concluding remarks

This chapter highlights the aggregate nature of the health risks of the destination stage. These multiple forms of risk and abuse reinforce and exacerbate one another in ways that increase morbidity and, in some cases, mortality.

This chapter points out that many of the health-related risks are also the barriers that keep women from reaching out for services, and for service providers to reach the women. Trafficked women have very real reasons for not seeking care, even when confronted with pressing health complications. Service providers have practical, policy, and resource limitations that often impede them from accessing and meeting the needs of these hard-to-reach women in trafficking situations.

In addition to the practical barriers of care provision, there are also varying, and often competing, social and cultural factors inherent in providing care to a trafficked woman. A trafficked woman is situated within and between cultures. Her perception of the risks she faces, her own health, and potential health care services are based on the social and cultural meanings derived from her past (home), the culture and rules of her trafficking-work setting, and the cultural framework of the country and community in which she is residing. This can make it difficult for providers to develop appropriate strategies to meet women's needs, as healthcare providers' perceptions, particularly about medical care, are generally grounded solely in the local context and in their professional training.

Lessons from the experiences of the women and service

providers interviewed for this study suggest that health programs that incorporate mobile outreach strategies (vs. solely clinic-based programs) are the most likely to access these hidden and mobile women. Finally, those that incorporate informed and culturally sensitive care strategies are better able to provide the information and services required by this extremely diverse and vulnerable group.

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4. Detention, deportation, and criminal evidence stage

Generally, we try not to become involved with the welfare of people that we send back. I know that sounds terrible, but...

Immigration Official,
UK

The detention, deportation, and criminal evidence stage is the period when a woman is in the custody of police or immigration authorities for alleged violation of criminal or immigration law, or cooperating, voluntarily or under threat of prosecution or deportation in legal proceedings against a trafficker, pimp or madame, exploitative employer or other abuser.

This chapter focuses on the authorities' awareness of women's health needs and their preparedness to assess and address these needs during this stage. The following discussion is based primarily on interviews with officials whose mandate included work on trafficking or who had experience dealing with trafficked women. Immigration and police officials were asked about their experiences and official procedures related to the health and well-being of trafficked women. A limited amount of additional information was provided by women who had been held in detention.

The following section provides a brief overview of:

1. How authorities come into contact with women;
2. Officials' awareness of abuse and risks;
3. Officials' reported procedures related to health;
4. Detention conditions;
5. Deportation procedures;
6. Voluntary return;
7. Co-operating in a prosecution;
8. Trial and testimony; and
9. Asylum and leave to remain.

4.1 How authorities come into contact with women

I ordered a raid once because the women were not collaborating with the investigations regarding the killing of an Albanian prostitute.

Head of the section on
Organised Crime, Venice

Authorities come into contact with women in several ways. The most common sources of contact are through

non-governmental organisations or through police or immigration actions. Least common are cases in which trafficked women present themselves to authorities as a victim of a crime.

According to the individuals interviewed in Italy, women wishing to leave a trafficking situation and in need of police assistance are brought to the attention of authorities via non-governmental organisations. In the case of sex workers, clients often make requests for assistance to NGOs on a woman's behalf. For example, of approximately 400 calls to Caritas, help-line workers recall only five being from victims themselves; the others were mainly from clients, or from women's friends.¹ A similar pattern was reported by workers on the Italian government's national "hot line" (numero verde) for tackling trafficking for prostitution.²

A second common way women come into contact with officials is as a result of immigration raids or police actions, often initiated by units whose mandate includes prostitution. For instance, in Italy, actions by authorities are increasing as a result of growing anti-immigrant and anti-prostitution public policies. As noted by one public official in Italy, "Since September 2002 deportation procedures are being applied more rigorously than humanitarian provisions such as Article 18"^{3,4} [Article 18 provides a renewable six-month permit to stay to victims of severe exploitation who are considered in danger as a result of trying to escape their situation].

This is the case in many countries where government policy changes on immigration are resulting in more aggressive treatment of undocumented persons, which, in turn, reduces the priority given to health. Of those who are detained, some are questioned and released. Some are held for varying periods in immigration facilities ("reception" or deportation or refugee centre)⁵ or, depending on the country, they may be held in prison.⁶ For example, Galia, from Ukraine, was jailed in the United Arab Emirates, "Once, I was stopped by police while I was walking. The police took me to prison because I had no documents. I stayed in the prison for two months."

Italian police officials explained that in addition to standard actions, police have also undertaken actions in response to a woman's request for help in escaping a madame or brothel owner. The women believe that if the police are seen forcibly removing them from the premises, the women will appear to have been taken into custody unwillingly, and therefore will be safer from retribution.⁷

Women have also been known to be turned over to authorities by traffickers who wish to avoid having to pay the women what they are due, or when they are no longer of use to the trafficker. For example, one

immigration official in the United Kingdom explained how a 13-year-old Moldovan girl was dropped off at the Home Office by her pimp because she was in advanced stages of pregnancy and was therefore “no good to him anymore.” The trafficker reportedly told the girl to, “Go home and send your sister in your place.”⁸

In a limited number of cases, women come into contact with authorities when family members begin searching for them. Often this is done through NGOs, local authorities or embassies abroad. Two women trafficked from Ukraine to Belgium were freed as a result of an intervention initiated by one of their parents.

My parents appealed to the department dealing with trafficking in women. They noted the trafficker's details. He was called to the police. He denied that he had known the girls and had helped them to go abroad. Despite his denials, he nonetheless made a call to Belgium that very evening to the owner who was holding us and ordered him to give our passports back and let us go home.

Marina,
Ukraine to Belgium

My mother applied to the Ukrainian Embassy in Italy. Police came to that house and released me. IOM helped me return home.

Natasha,
Ukraine to Belgium

Based on the responses of both women and authorities, it is clear that the least common means of contact is for women to approach officials voluntarily and directly as victims of a crime. The deterrents to reporting to authorities are multi-fold. First, women fear the perpetrator will capture and punish them for fleeing. Second, dominant political and social pressures work against undocumented migrants and sex workers reporting abuse.^{9,10} Third, many trafficked women do not perceive themselves as “victims” of trafficking, but instead believe that their predicament is a result of their own mistakes, i.e., they entered into a bad contract, had bad judgement or were simply unfortunate.¹¹ Fourth, women believe that they have committed a crime (e.g., entering or residing illegally), and may be subject to arrest and imprisonment if they contact the authorities. Fifth, as noted by groups working with trafficked persons, women understand that contact with authorities will likely lead to deportation and, for many, they prefer to remain and receive a fair wage. Finally, women from areas where corruption is common suspect (sometimes correctly) that police are in collusion with traffickers and will return them to the traffickers or will re-traffic them.

4.2 Officials' awareness of risks and abuse

All law enforcement and immigration officials interviewed were able to describe abuses perpetrated against women by traffickers. Most were able to offer examples of violence and injuries. Law enforcement officials from both Italy and the United Kingdom related examples of women who had been burnt with cigarettes, hanged from the ceiling, or had salt poured into their wounds. One officer cited a case where women had been brutally beaten, and so that the contusions might be less visible, the perpetrators then put them into an ice bath for several hours.

Officials were also aware of the harsh conditions women endure and the extreme restrictions they face when under the control of traffickers, including their inability to take care of themselves and access health services.

In addition, authorities explained the risks a woman may face as a result of contacting an official. A woman who is thought to have spoken to police is likely to be suspected of betrayal. Therefore, instead of increasing their security, for many women encounters with authorities place them or their families at greater risk of violence. Police in Britain explained that after a woman is detained, a perpetrator would likely suspect her of having offered evidence against him, and have an incentive to take action to prevent her from cooperating further with the authorities. Moreover, as pointed out in a recent multi-country study on witness protection conducted by Anti-Slavery International, even when women agree to co-operate with authorities, protections are minimal:

Programmes and policies of many governmental, inter-governmental and non-governmental bodies recognise that, in order to have a comprehensive strategy to tackle trafficking in persons, it is necessary to regard the protection of victims' rights as intrinsic to the process of effectively prosecuting traffickers. However, in recent times it is victim protection per se rather than protection of victims' human rights that has dominated.¹²

4.3 Officials' reported procedures related to health

“What happens if a woman shows signs of severe anxiety, distress or trauma?”

Medical professionals would deal with

assessing mental health and whether she needed further help. It would be a very foolish officer who would interview a woman who was not sufficiently together to be interviewed.

Metropolitan Police,
UK

Although all officials interviewed were able to offer descriptions of the extreme abuse, illness, injuries, and trauma faced by trafficked women, they nonetheless also affirmed that women's health and well-being are not an official priority. Moreover, despite their recognition of women's need for medical attention, law enforcement officials explained that they currently have few procedures in place to: a) effectively determine if a woman needs medical attention; or, b) address any physical or psychological health needs.

As previously described, women may be brought in as either suspects or as victims of a crime. Different procedures and treatment will follow depending on how they are categorised, but there are no special measures to address the particular needs of trafficked women. Moreover, where a woman is suspected of having violated the law, there are currently few effective policies or procedures in place to determine whether, in fact, she has been trafficked, and thus, any health needs she may have related to trafficking, particularly those related to mental health (need for counselling, etc.) are generally not considered.

In the majority of cases when women are taken into custody they are required to submit to interviews, detained in prison or holding cells, or deported before their health needs are adequately assessed or addressed. Ketj from Albania, stated that after being picked up by Italian authorities, "They brought me in to the "Questura" and I think they ordered an administrative expulsion (*foglio di via*). They never offered me any help, I mean, medical care or something else. They were always quite cold."

Police and immigration officials were asked about policies and procedures related to women's physical and mental health. In Italy, officials reported that women suspected of having been exploited are referred to the municipality who deals with issues related to health or who will contact an NGO. In countries such as the Netherlands and Belgium, where officials have an explicit agreement with NGOs, representatives from designated groups are generally contacted soon after women are placed in custody. Through these organisations women are provided a range of services, including medical care and counselling.

Officials in the UK stated that there are no special procedures in place for women who are suspected of

having been trafficked, and that they simply apply the standard procedures used for other individuals taken into custody. Protocols followed will depend on whether the woman is considered a suspect or a victim. However, because many police actions are conducted jointly with immigration officers (and vice versa), most women come into contact with authorities as alleged violators of the law, not as victims of a crime. If a woman is brought in as a suspect, she will be asked the routine health disclosure questions posed to any suspect of a crime. Typically, she will be asked to complete a form requesting health information (e.g., current medications, chronic conditions). If she is thought to be a victim, police follow standard procedures for taking medical evidence, and if she reports a sexual assault, special procedures for sexual offences are applied.

When immigration officials were asked about the procedures applied to assess the health of women suspected of having been trafficked, those in the U.K. explained that all individuals in immigration custody are asked a broad standard health question, such as, "Are you fit and well?"

The manner in which women are currently asked about their health is unlikely to lead to disclosure of health concerns, or requests for examinations and care. Health inquiries are rarely made in private or by a health or medical professional. They are offered in what many women perceive as a hostile and high-pressure context. They appear to be offered merely as a necessary procedural formality rather than a genuine opportunity for women to disclose health concerns and request medical assistance. As one high-ranking police official put it, "This is clearly not a conducive environment for a woman to express her concerns."¹³ He added that there is a duty nurse on the premises, but her immediate participation could pose evidentiary problems, such as making it necessary for non-police personnel to be required to testify in court on a regular basis.

Women themselves reported that they were unwilling or afraid to ask for help and did not feel that the offers of assistance were genuine. When asked whether she was ever offered help or support, one woman replied, "Yes, but I never believed them and accepted" [Valbona, Albania to Italy].

Women also expressed concern over negative consequences resulting from requesting help. Ellen, from Albania, explained that she did not mention any of her health problems because, "I didn't want to cause any trouble" [Ellen, Albania to UK].

Some officials recognise women's reluctance to report any details about themselves:

She's been asked [about her health]. She doesn't want to talk about it. She just wants to go home. After what's happened to her earlier in the day [the arrest], she has no reason to believe that these are people who actually care, so you know we try to build a bridge.

Metropolitan Police,
UK

Women's position of vulnerability and the importance of building a relationship is reiterated in the UK "Crime Reduction Toolkit: Sexual Offences," citing a paper on reporting rape by Dr. J. Jordan:

"No matter what professional she is dealing with – police, doctors, counsellors – a woman who has been raped or sexually assaulted is looking to be heard, believed, to be respected and to regain a sense of safety and control over her life. All of the professionals who deal with her need to be adequately trained for the task, including having a clear understanding of both the effects of rape on her and the effects of rape myths on them."¹⁴

Because of the enormous gap in services, in the UK (where a pilot project for trafficked women has only just recently been launched) some officers of the Metropolitan Police often acted as social support workers for victims and witnesses. This labour- and time-intensive effort led to the establishment of strong bonds with a number of women. But, it also took away from the time that law enforcement could spend on investigation and prosecution. A better model is for trained social workers to be assigned to police teams working on trafficking.

Officials were also asked what their response would be in cases where a woman showed obvious signs of ill-health or who demonstrated serious symptoms of trauma. Police in both Britain and Italy explained that when women have visible injuries or signs of severe distress or, as in the case of rape, there is a need for medical evidence, they are immediately referred for emergency medical assistance. One UK immigration official, when asked about apparent symptoms of trauma, said that if a woman exhibited symptoms it would be up to the medical officer, "No interview would take place if the medical officer says 'no.'"

In Ukraine, when officials were asked about procedures related to health, most stated that they had no health services available and little ability to provide referral to care. However, two officials cited local NGOs as referral options or offered a government medical

facility as a possibility.

4.4 Detention conditions

Conditions were horrible. There was nothing, not even a blanket and they would not let you go to the bathroom. Even if I would spend only a night, it felt like a lifetime.

Marja,
Albania to Italy, held in police detention

Most of the women who responded to questions about detention had been in Italy and were speaking about police holding cells. They described the facilities where they were held after having been picked up during a police action as horrible or *bruttissime*. One Albanian woman added, "There were many of us, and the way they looked at us! I asked myself what I was doing there."

Ellen, who was twice trafficked into forced prostitution in the UK, was held in a detention centre where she awaited deportation. She said that the facility was adequate and remarked that it was "like a camp" where meals were provided from a canteen and she was able to smoke in the courtyard. However, while there, she was asked very little about her health needs, only requested to fill out forms about drinking and smoking habits.

As suggested by STV's description (below) of the temporary facility set up for women to be held after a police action, it is possible to be prepared to meet the special needs of women who have been trafficked:

[Conditions were] good because it was a well organised police action that had been planned for months based on thorough investigation. All victims detained were accommodated in a trailer park under police protection and surveillance. Social workers and medical staff were present to provide most basic and urgent support. Showers, food supplies were all taken care of. The victim's belongings were returned to them by the police.

STV,
Netherlands

Little is known about women who are trafficked, arrested and imprisoned. Information provided by a Ukrainian woman imprisoned in the United Arab Emirates suggests that the prison conditions in the UAE are abysmal. This woman was not given enough to eat and had to contact her mother in Ukraine to send money through the Ukraine Consul to pay for medication when she became ill.¹⁵

Two women from Uzbekistan who had been working in Thailand as sex workers were interviewed by GAATW in the Thai Immigration Detention Centre (IDC). While these women were not trafficked, the IDC is the same facility where trafficked women are held. The description below is revealing in the feelings of hopelessness and health concerns of women who are detained there:

Police sent me to jail and then to court and then I was sent to the Immigration Detention Centre [IDC]. I have been in the IDC for 10 months. When I was first arrested I had no idea about the charges and possible punishment. There was no explanation from the authorities. When I came to the IDC I met with other women. They explained to me and now I just accept my fate and hope that I can go back home some day.

In here I get more stressed than outside because here I feel like there is no future. I am just sitting and waiting for many months while doing nothing. I often get headaches and cannot sleep. I even have no cigarettes. I feel there is no way to release my stress. I told myself to accept that fate and wait. Food and water is very bad. I have to eat bad quality food all the time. There is no hot water here. Clothes are not enough, especially the underwear, they gave us 2 under pants each but we have to use them all the time. I also have problem with my womb, sometimes it is painful but I never got any medicine and no one arranged a check up by the doctor. I am very worried about it. Some times I ask for pain killer but I have to wait until the nurse comes up to the cell. Sometime they just ignore me. They may not think that it is serious pain.

“Do you get any clothes or toiletries?”

I have some clothes which I brought from outside but I do not have enough so sometimes when I wash them, they do not dry properly and I don't want to wear them, especially my underwear. I haven't get even one pair of pajamas, so I have to wear normal clothes at night. Sometime it is very hot.

Helen, voluntary travel
from Uzbekistan to Thailand

At present, there is very little research on women's experiences in detention, or on health-related procedures for women held in detention by authorities. However, reports on trafficking regularly suggest that services, where available, are usually inappropriate and inadequate to meet the specific health needs of trafficked females.^{16,17} It was beyond the scope of this study to gather systematic information on health and health procedures in detention settings. Research in this area is urgently needed.

4.5 Deportation procedures

Few care. To immigration they are just numbers.

Law enforcement official,
UK

Reports from around the world and interviews for this study suggest that despite various human rights, refugee and migrant conventions, laws on asylum and refugees, and the United Nations Palermo Convention, which recognises States' obligations to protect victims and address mental and physical health needs,^{18,19,20} women continue to be summarily hauled off during immigration raids and deported.^{21,22} Most trafficked women are not given the opportunity to say that they have been trafficked, access legal advice, gather belongings, contact friends or family, express health concerns, or request medical care.

Deportation is the most common outcome for women picked up by immigration authorities. In Italy, one police official explained:

When the police officers check the women, they ask for documentation and if the women do not have a permit to remain, the officers take them to the 'Questura' for the identification procedures. If the women are found twice without documentation they are sent to via Corelli (temporary reception centre).

Head of Organized Crime
Unit, Milan

In the United Kingdom, deportation generally occurs within 48 hours after a woman who is deemed to be in the country illegally is picked up. There is seldom any form of support for women when they return home. According to officials interviewed, it is only in the minority of cases that there is coordination between authorities in the destination country and assistance groups in the woman's home country.

The lack of a safe return procedure has significant personal security and health implications. First, upon

return, it is not uncommon for women to be met by individuals associated with their original exploitation. After collecting women at their port of return, traffickers often arrange for women to be re-trafficked, frequently adding relocation costs to the original debt. One woman from Albania explained that after her deportation from the UK her pimp-boyfriend arranged for his cousin to meet her at the airport in Tirana. Within a month she was returned to work in the UK.

Second, women's health is jeopardised by the fact that, without outside assistance, few have any way to pay for the many health services commonly needed upon return (see *Integration, reintegration stage*).

Third, poverty, outstanding debts to traffickers, and the lack of protection against a trafficker's reprisals make women extremely vulnerable to be re-trafficked or enter into other high-risk activities.

Finally, in some countries, such as Nigeria, women may be subject to medical screening and involuntary HIV testing. Moreover, as noted in a report by Anti-Slavery International, details of those who are HIV positive are given to the state office for social welfare; it is unclear whether anything is ever done with the results or whether women are notified of the results. No medical care is provided to those who test positive. The report highlights that this practice clearly violates the United Nations HIV/AIDS International Guidelines²³ that state that testing should only take place with the informed consent of the individual. It also points out the way that this practice discriminates against and stigmatises survivors and complicates reintegration.²⁴

This is another area in need of further research and in need of greater commitment from all governments to provide necessary services.

4.6 Assisted voluntary return

Increasingly, the network of offices of the International Organization for Migration (IOM) has been involved in arranging the voluntary return of women into the care of IOM offices in a woman's home country. Many IOM facilities are able to provide shelter, health services and other forms of assistance, including, in some locations, small sums of money from a victim's assistance fund. However, IOM does not have a presence in all countries. In some countries other NGOs are also involved. There is some concern that organisations with contracts for this work from governments may at times feel a conflict between keeping harmonious relations with governments and advocating strongly on behalf of trafficked women, such as in cases when it would be in the best interests of a woman to have a deportation order delayed or nullified in order for her to receive necessary medical care.

But in most cases there is no organisation providing repatriation services. The reality for the great majority of women is that they must fend for themselves.

4.7 Considerations related to cooperating in a prosecution

One woman staying at Payoke was preparing for a court case against the people who trafficked her when a phone call came from her daughter, who was still living in the woman's home country. Her daughter said that one of the trafficker's friends was holding a gun to her head and that her mother was not to testify. "Mama, don't testify." The woman ended up running away from the safe house. She left a note saying that she dared not testify, but that she could not go back to her home country. Under Belgian law she would have had to go back if she wouldn't testify.

case assisted by Payoke,
Belgium

To date, only a small number of the women who come into contact with authorities agree to participate in the prosecution of perpetrators. Yet, in most countries in Europe, assistance and support is contingent on a woman's agreement to cooperate (Italy is an exception: migrants in situations of abuse or severe exploitation have the formal right to stay without having to testify²⁵). Temporary residence permits are tied to a woman's agreement to cooperate in a prosecution against a trafficker.²⁶ Despite the potential to gain temporary residence, only a minute percentage of trafficked women have provided testimony to date.²⁷

Immediately after emerging from a coercive setting, women find themselves faced with the complicated and high-pressure decision of whether to participate in a prosecution. Their well-being may depend on their cooperation; it may equally depend on not cooperating. Law enforcement officials and other experts highlight a number of reasons that women decide not to participate in prosecutions.

First, many women are reluctant to press charges for fear of reprisals against them and, most especially, fear of harm to their families. As one experienced London Police Detective put it, "The girls are defeated. That's what makes the threat of reprisal so effective. They often have little remaining self-worth. All they have left is to protect their loved ones." Valbona, who believed she was once in love with the man who trafficked her, explained, "I am still afraid both for my safety and for

my family since my boyfriend-pimp (*protettore*) often threatened them and he is very powerful and has many friends in Albania.” [Valbona, Albania to Italy].

Women’s anxiety is not abated by State policies regarding witnesses. For a woman who agrees to testify, most States have no obligation to offer her residency beyond the conclusion of the trial – despite any danger to a woman or her family resulting from her testimony.

For women who have experienced the trauma of trafficking, the fear of unknown dangers cannot be overstated.

Second, women’s hesitance to come forward may also be attributed to conflicting emotions about testifying against a trafficker who was also a boyfriend or ‘ fiancé’.

Third, because of the illicit nature of the crime, women often do not know very much about the activities of the perpetrator. One Italian NGO manager working with migrant sex workers explained, “Sometimes it is a big problem when women have little to denounce simply because they do not know much. In these cases, the *magistratura* does not accept their denunciations and resends the women to the streets or repatriates them” [Stella Polare, Comitato per diritti civili delle prostitute, Italy].

Fourth, the lack of victim-sensitive procedures can greatly impact women’s decisions about giving evidence. This begins at the first contact. In most cases, police or immigration officials immediately resort to routine procedures for criminal suspects. This creates an adversarial context, pitting women who see themselves as victims against officials preoccupied with criminal law or immigration violations. Often, women’s need for privacy and security may not be sufficiently addressed, in the case of one woman, who while in the police station, was not seated in a location where she felt safe and she visibly winced every time a man walked by.²⁸

Even when women agree to cooperate with police or immigration officials, it is not uncommon for them to be unable to recall details of events, such as dates and locations. Often questions come too soon after the end of the trafficking situation for women to be prepared to answer. Officials often ask women to remember specific details around the time of the “initial trauma” or about the most profoundly disturbing events. As previously discussed (see *Travel and transit stage*), physiological and psychological responses that inhibit absorption and memory may prevent women from being able to provide accurate evidence. In these cases, it is not unusual for officials to believe that a woman is simply being untruthful or uncooperative.

4.7.1 “Reflection period”

In countries such as Belgium, the Netherlands and Italy, prosecution efforts have benefited from the cooperation between officials and NGOs able to provide a range of social services that often begin when a woman is granted temporary residency.

These countries have adopted trafficking policies that include a “reflection delay” or “reflection period,” a grant of temporary residency (often up to three months) that the State allows for a woman to decide whether she will participate in prosecuting her trafficker.

The reflection delay comes at a key point for a trafficked woman’s health. First, registering with the State entitles women to public services, including medical care. This temporary residency ensures that, in principle, she can immediately address pressing medical problems. Second, it permits women the time necessary to rest from an exhausting and traumatic experience before having to make many stress-filled decisions related to her future (e.g., assisting police and prosecutors to pursue her trafficker, returning home). Third, it provides the opportunity for a woman to develop relationships with individuals and organisations (such as NGOs) who can counsel her about her options, the risks and benefits of participating in a prosecution, and provide guidance in the many practical, legal, medical and emotional tasks she must undertake.

Italy is currently the only State in Europe that permits the right to remain without having to act as a witness. However, many contend that according to the law – and moreover, the practices – providing evidence to prosecute perpetrators of trafficking or exploitation is taken as an important, if not deciding factor in eligibility for social protection. Article 18 of the immigration law of 1998 permits temporary residence for victims of severe exploitation who are seen to be in danger. This article has not been invalidated by the new immigration law, although the Italian government has given less money to the organisations involved in these projects.

The UK government specifically opted out of the European Union Council Directive on short-term residence permits.²⁹ The Home Office explained,

We believe an automatic reflection period for victims of trafficking would undermine immigration control, hold up criminal proceedings and could provide an incentive for people to be trafficked to the UK.³⁰

In contrast, police suggest that such a delay, combined with coordination with an NGO providing counselling, would likely increase the number of women willing to

act as witnesses in cases of trafficking. As one detective with the Metropolitan Police explained:

The environment in a police station in the moments following a prostitution raid is not conducive to allowing women to make an informed decision about whether to participate in a prosecution.

Metropolitan Police,
UK

Another detective highlighted the stressful context of an interview with an Eastern European woman who declined to testify:

I feel she was really too scared, but it was her decision. Our offer was made in fairly hostile conditions, during a police interview. This is a case where three months "reflection" would be useful.

Metropolitan Police,
UK

Moreover, in the UK, police have no means of placing women in secure housing where social support is available. One officer describes the difficulty of ensuring the well-being of a potential witness:

For the first night, I organised a hotel in London. Eva phoned me soon after, terrified because the hotel was full of Albanians. A police chaperone was made available, but she was forced to stay two nights because there was nowhere to move her.

Metropolitan Police,
UK

Unlike many other European states, Britain currently has no specific legal provisions for trafficked women or State-sponsored services for trafficked persons. Trafficked women have no recourse to public funds or services unless they have submitted an application for asylum, or have been granted exceptional leave to remain. In neither case will a woman receive the type of secure accommodation and specialised care necessary for trafficked women.³¹ Women may, however, file for exceptional leave to remain, which will only be granted if they qualify under the UK asylum law. This does not entitle them to any special protection or care.

The absence of victim-sensitive procedures and facilities is compounded in many settings by the often conflicting mandates between the police and immigration services. While police may perceive a woman as an important witness in a crime, immigration officials see her as an illegal entrant. Women, many of

whom already have substantial scepticism of authorities, are not likely to quickly develop the trust necessary to reveal information that they believe may harm them. When asked whether special procedures might be instated to deal with cases of trafficking, one immigration official replied:

It's not like being victims of violence or anything. I would be very much against giving them a right to stay. If this becomes known, it will encourage people to say that they were trafficked. That would then open it to anyone who had been smuggled.

Immigration Officer,
Enforcement, UK

According to police officials interviewed in the UK, this is not an uncommon perception on the part of immigration officials, who either do not, or choose not to understand the link between trafficking and violence and other forms of mistreatment.

Police and others have, in a limited number of cases, expressed concerns about the veracity and authenticity of women claiming to have been trafficked. For example, there have been cases where women were suspected of being 'spies' or 'plants' placed in refuges or the social service system in order to inform traffickers about the actions of other women.^{32,33} An Italian police official explained:

When a woman decides to denounce, the project run by the Municipality of Venice starts. First the woman sees the manager for Town and Prostitution Service. They talk to understand what will happen, while the manager tries to verify her real intentions. This is a crucial phase since there is the risk that the organisation could infiltrate some women in the project in order to know where the protected structures are.

Questura di Venezia,
Italy

For this study, little information was gathered on prosecution in women's home countries. However, one Albanian woman who was re-trafficked from her home country was asked about the possibility of involving the local police and responded:

Maybe they [police in Albania] could have helped for a moment. But the men give money, corruption. They can put them in jail but then let them go in a week.

Ellen,
Albania to UK

4.8 Trial and testimony

Eva had to come to court over the course of 5 or 6 days. It was a jury trial. It is a defence tactic to make her wait, to unsettle the witness. When she took the stand, she was so traumatised she broke out in hives and collapsed. She was immediately seen by a doctor who prescribed a sedative...The testimony was extremely difficult for her. After the sexual violence, she told us that testifying was the worst experience of all.

Metropolitan Police,
UK

Testifying in court can take an enormous toll on a woman's physical and mental health. Conversely, a woman's physical and mental health can have significant effects on a trial.

Three cases in which women gave evidence in court were reviewed for this study. Two cases were reported by police detectives directly involved in the investigation. The UK researcher attended the trial of the third case.

In the first two cases, the trial was delayed or adjourned due to the women's extreme distress and inability to proceed. In one case, the woman physically collapsed on the stand. In the second, the trial was nearly called off because the woman was unable to gain enough composure to enter the courtroom. The third woman, a minor, was provided a screen and presented her evidence clearly and assuredly. She capably rebutted the attacks of the defence lawyer (mostly without translation).

What makes one individual more able to endure the stress of giving evidence than another is an important area for further study.

For a victim of trafficking, taking the stand means confronting the individual that abused and humiliated her. It often requires explaining what she may feel were equivocal circumstances in which the crimes occurred. It demands doing this all in public, in front of the defendant, a jury, friends of the defendant, and other onlookers, such as journalists. Women are rarely prepared for the trauma and stress created by this setting.

While a prosecution is intended to judge the actions of the alleged perpetrator, the proceedings and the verdict often also reflect on the witness. A Metropolitan Police detective explained how during one trial he tried to discourage the witness from appearing the day of the verdict because, as he put it, if the trafficker were not

convicted, he feared the young woman would feel the pain of having been judged to be a liar.

Defence lawyers tactics are aggressive. As suggested, they often attempt to put the victim-witness on trial. Their aim is to discredit the woman, or blame her for the circumstances in which the alleged crime occurred. During the trial of an Albanian trafficker, the defence accused 17-year-old Katerina of lying about her age, "trying to con the jury", and of having long ago plotted to come to the UK to take advantage of the social service system. He suggested that she saw Britain as "the goose that laid the golden egg." He further attempted to destroy her credibility by showing photos of her and her trafficker-pimp embracing at her 17th birthday party.

It is not unusual for a woman who has been involved in an abusive relationship to be faced with justifying how the relationship could have been simultaneously abusive and romantic – which is particularly difficult in a trial setting. Experts on domestic violence have commonly explained that abuse occurs in cycles in which tension and violence build, peak, and ebb.³⁴ The cycle recurs because perpetrators regain women's confidence by showing contrition. Moreover, even in cases where a woman never had, or no longer has romantic feelings, it is not uncommon for them, as a protective measure, to feign devotion in order to avert abuse.

While acting as a witness and victim of a crime, all three women were obliged to try to defend their actions and character. In one case, the woman testifying was accused by the perpetrator's defence lawyer of being money-crazed, while he portrayed the perpetrator as an innocent man who simply could not live up to this money-hungry woman's financial ambitions.³⁵

In places where trafficking laws are weak or non-existent, police and prosecutors often aim to charge a perpetrator with other related crimes, such as rape (as in Katerina's case). Testifying to rape is particularly difficult both because a woman must re-live the trauma and because of the non-supportive environment in which she must recount extremely personal and stigmatising events. In one of the three cases, the prosecution could not pursue a rape charge because, once having taken the stand, the woman was unable to talk about the rape. She was invited to write her description, but this was still too difficult for her.³⁶

Some of the difficulty in rape testimonies is attributable to the way legal practitioners neglect to recognise the context of a violent relationship. In one trial, the prosecution repeatedly asked the victim (witness for the prosecution) if she said "no" when the perpetrator wanted sex. She replied that she did not say "no", which seemed to her the obvious answer. For many women in abusive relationships, saying "no" was simply not an

option. Women with violent partners make well-calculated decisions. They understand that to refuse sex would lead to a conflict in which they would likely be abused. Women rarely choose this more dangerous of options, but instead assess that the undesired sex is less onerous than a violent episode. In these cases, the more appropriate question is, “Did you feel able to refuse?”

While taking the stand can be a highly traumatic experience that would be somewhat alleviated were the prosecution able to prepare the witness for this type of verbal aggression, legal constraints in some countries, (e.g., in the United Kingdom) disallow preparing the witness because of concerns over tainting or coaching a woman’s testimony.

4.9 Asylum and temporary residency

To date, there are few reports of victims of trafficking receiving witness protection or being granted asylum or temporary residency/leave to remain.³⁷ Moreover, in most countries, women are only offered these ‘ benefits’ if they agree to provide evidence against traffickers. What may be deemed unintentional coercion and re-victimisation by police, prosecutors and immigration officials is reportedly common. Pressures related to asylum and residency status have enormous consequences on mental health.³⁸ Much more research is needed on the relationship between mental and physical health, and asylum and residency.

Concluding remarks

Official attitudes and procedures on health in trafficking cases not only have an enormous impact on women’s well-being, but also on women’s ability and willingness to cooperate with authorities.

In the absence of appropriate care, time in a police holding cell, under the stress of an interrogation, or languishing in prison, a woman’s physical and psychological condition may deteriorate, and may result in irreversible damage. A woman in custody might, for example, be experiencing symptoms of post traumatic stress that turn from manageable to acute as a consequence of the added pressure of the circumstances. Or, a woman in detention carrying an unwanted pregnancy may, without medical attention, be forced to continue the pregnancy to term.

From the perspective of the police and other authorities eliciting information from a trafficked woman, illness and anxiety should be considered a liability. If a woman is feeling pain, discomfort, and anxiety, she is unlikely to provide full and useful information. It is to the benefit of all involved for a woman’s physical and psychological needs to be immediately addressed.

Inquiring about and treating physical and mental health concerns not only puts a woman at greater ease, but serves as a demonstration of good faith that her welfare is of concern. This alone can foster greater information sharing. Coordinating with a local NGO that can support and advise women in these highly stressful situations can serve to meet a woman’s needs and often assist officials in building the necessary trust and confidence with a potential victim-witness.

The health risks and consequences of trafficking in women and adolescents. findings from a european study.

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5. Integration and reintegration stage

It only takes a few days to break a woman, it takes many years to help her to rebuild her life. What we have learned is that life after trafficking is no less dangerous than life in trafficking.

AnimusAssociation
Foundation/La Strada, Bulgaria

5.1 Refuge and return

This chapter discusses the health factors associated with the integration and reintegration stage of the trafficking process. For the purposes of this study, we draw on the definition of integration and reintegration established in the *European Council on Refugees and Exiles' (ECRE) Good Practice Guide on the Integration of Refugees in the European Union*.¹ "Integration" is defined as the long-term and multi-dimensional process of either integrating into the destination country or reintegrating into one's own country. This process is not achieved until the individual becomes an active member of the economic, cultural, civil, and political life of a country, and perceives that she has oriented and is accepted.

The ECRE definition emphasises that this process must be "dynamic and two-way," placing "demands on both receiving societies and the individuals concerned." In other words, for both integration and reintegration the process involves adjustments on both the part of the individual who tries to orient to the destination country or reorient to her country of origin, and on the part of the destination country or country of origin that must respond to the needs of trafficked persons with appropriate policies and resources that enable individuals to live independent, productive, and healthy lives.

For health and well-being, the integration and reintegration process is a time of physical recovery and psychological and social reorientation. It is not uncommon for women who have experienced extreme or enduring violence to feel that the universe as they knew it no longer exists because their perspective has been irreversibly changed by their experiences. Women reconstruct their lives and relationships, for better and for worse, based on the assumptions, emotions, and contexts that now exist for them.

In considering the integration and reintegration process it is important to recall that different women react differently to experiences of abuse or exploitation. Not all trafficked women fit the image of a depressed and destroyed victim. Many women will not see themselves as victims or wish to be treated as such. Some women

emerge having developed personalities that reflect the strengths and independence that helped them navigate difficult times, while others are devastated by the experience. But the reality that all trafficked women face is that only a very few receive assistance following a trafficking experience.

The purpose of this chapter is to highlight some of the basic considerations and dilemmas related to women's health and service provision once women reach the integration and reintegration stage. This is not a guide to care provision, but rather an overview of the health risks, women's health needs (mental health, in particular), and key aspects of service provision during the integration and reintegration stage.² Where issues of integration and reintegration are very different, they will be discussed separately. Otherwise, discussions will refer to issues common to both. This chapter is based primarily on interviews with groups working with trafficked women in Italy, Ukraine, Albania, Belgium, the Netherlands, and Bulgaria.

5.2 General health

This section highlights some of the health issues specifically related to the integration and reintegration period. Although this can be a time when many health problems are addressed, this period can also pose new health concerns similar to those faced by many refugees, recent immigrants, and returnees. The health-related risks of this stage are likely to be exacerbated by, and exacerbate, the health problems developed during the other stages of the trafficking process.

5.2.1 General health: integration

There is a large and growing body of literature on health and immigration that presents factors related to risk, and service uptake and delivery for immigrants.^{3,4,5,6,7} It is worth highlighting some of the most prominent issues.

- The social exclusion and low socio-economic status of immigrants have significant and wide-ranging negative consequences on immigrants' health and use of services.^{8,9,10,11}
- Experts highlight the deleterious role of stress resulting from the rupture of previous social networks and coping with cultural differences. M. Eisenbruch, in his research with Cambodian refugees, referred to this loss as "cultural bereavement," or a mourning process through which the individual tries to come to terms with the loss of her former social structures, cultural values, and self-identity.¹²
- Poor access to health services and discrimination within the health care system compound an individual's social and cultural marginalisation and dependence.^{13,14,15}

- Immigrants, as aid recipients, are frequently cornered into a grateful, often subordinate or deferential role.¹⁶ This not only discourages women from actively participating (or taking the lead) in their diagnosis and treatment, but may also reinforce feelings of incapability.

These factors take their toll on women. For example, studies in Europe and the United States have shown that compared to non-immigrant women, immigrant women have a significantly greater number of negative reproductive health outcomes, including still-birth, premature delivery, and low birth weight.¹⁷

Though a woman who has been trafficked may have been residing in a destination location for months, even years, this does not mean she has begun to integrate in any meaningful way. She is likely to have many of the same needs and encounter the same difficulties as a newly arrived immigrant.

5.2.2 General health: reintegration

Women returning home also face numerous health risks and obstacles to services, although, many fewer studies have been conducted on health and the process of reintegration. Like immigrants newly residing in a destination country, women who return are likely to encounter different, but equally significant, feelings of isolation, alienation, and barriers to care.

While a returnee's experience has altered her in many and often invisible ways, she re-enters a family and community context that has not changed with her. In the eyes of her family, she may be perceived as essentially the same wife, daughter, or mother as before. For the woman, however, she has undergone life-defining events that may never be understood by those around her. Indeed, a number of respondents in this study chose not to reveal anything at all about the trafficking experience to close family members (particularly sexual abuse), anticipating that relatives would be unlikely to either comprehend or accept them. They thus lived alone with their memories and the physical and psychological aftermath.

Most women interviewed for this study who returned to their country of origin perceived that access to health services was generally difficult, unaffordable, and of poor quality. Many also felt that practitioners were uninformed and insensitive. Respondents and NGO staff in women's home countries expressed concerns that mainstream medical professionals who were not sensitised to issues related to trafficking could be judgmental and difficult to speak to about stigmatising health problems.

In these cases, the underlying cultural commonalities that

are often praised as beneficial elements of care provision did not work in favour of better treatment. Women from conservative communities found that cultural strictures fostered an environment that left them alienated and hesitant to seek help.

5.3 Access to services

5.3.1 Access and services: integration

Clients are referred by police, immigrant asylum centres, hospitals, and outreach groups. Police also circulate flyers in 30 languages offering: "if you are exploited...or if someone is making you do something you don't want to do..." and they give contact numbers for different groups that provide services for victims of trafficking.

Payoke,
Belgium

Groups in Italy, the Netherlands, and the United Kingdom providing services for women who have been trafficked reported that women came into contact with their services via police referral, word of mouth, immigration detention centres, help-line calls or referrals (mainly made by a client or friend), street outreach workers, and promotion materials. Means of contact varied by country and were related to the availability of trafficking-specific services. One health clinic that treats women reported:

The most significant source of contact with trafficking is through the telephone line linked to the detention centres. Direct use of the ambulatory [clinic] is extremely low, so are the contacts through the health outreach teams.

Ambulatory NAGA,
Milan

The health services available for victims of trafficking vary from country to country, as do women's legal rights to health care.¹⁸

Organisations offering integration services for trafficked persons in EU countries are often funded through national and local government sources. NGOs also rely heavily on women's access to public benefits to meet women's needs once temporary residence permits have been approved.

Many first-line services available to trafficked women are provided by non-governmental organisations that have augmented previously existing services for sex workers, victims of domestic violence and rape, asylum

seekers, and refugees.¹⁹ They bring to their work the experience, insights and strategies for overcoming the numerous challenges in working with traumatised and marginalised populations, and the challenges in dealing with public administrative procedures.

In the United Kingdom, at the time this report was written, no established services existed for trafficked women, although a pilot project has been launched.²⁰ To date, minimal assistance has been offered specifically for trafficked women, and it has been offered only on an ad hoc basis by local social service agencies in cases involving unaccompanied minors. For women who have agreed to testify, the Metropolitan Police, Charing Cross Clubs and Vice Unit, has been instrumental in assisting women to access health and other services, though this is not within their mandate, and often takes time away from investigations. The only groups in the UK that have regular contact with women who may have been trafficked are those offering sexual health outreach services (see *Destination stage*) and an NGO assisting domestic workers (i.e., Kalyann). None of these organisations are formally funded or have a mandate to provide trafficking-related assistance.

In contrast to the situation in the UK, in Italy, following the enactment of the social protection opportunities of Article 18 of Italy's previous immigration law and official funding sources, the Italian State has funded 49 projects aimed to assist victims of trafficking. These projects cover several areas, but are not equally distributed throughout the country. There is a significant concentration in the northern regions, where several NGOs, public services, and municipalities are involved in the assistance networks. The integration opportunities are not limited to persons who are trafficked for sexual exploitation; article 18 benefits are also open to those who are exploited by criminal organisations and work in other forms of labour. The projects funded by the state (Equal Opportunities Department) include shelter and social integration activities (for example, job training and language programmes) and offer beneficiaries the right to a permit to stay (first for social protection, and at the end of the programme for work or study). Many organisations are involved in these projects and apply a variety of conceptual approaches. Some of them base their work on a moral or religious approach (e.g., Catholic organisations). Others have developed a "citizenship" approach (considering prostitution a legitimate form of labour and therefore eligible for formal rights), while yet others take a gender approach.

Health care for trafficked persons in Italy is offered by sexual and reproductive health clinics, outreach services for sex workers and drug addicted populations, and assistance programmes for refugee, asylum seeking and migrant populations. Many of these providers are also the same groups that meet women while they are still in the

trafficking situation. This is an important advantage as this prior contact offers unique access to victims and an understanding of the circumstances from which women emerge.

Health services for undocumented populations in Italy are generally provided by NGOs and private providers. Municipalities and public services, such as the project *Città e Prostituzione* (City and Prostitution) run by the Municipality of Venice are also directly involved in some aspects of provision. Through *Città e Prostituzione*, undocumented populations may access public health services for urgent or emergency care, maternity and childbirth, sexual health, diseases affecting minors, and for persons over 65. NGOs often co-operate with a range of other providers, including family planning centres (*consultorio familiare*), paediatric clinics (*consulteri pediatrici*), mental health centres and various other professionals. In some cases, medical staff work on a voluntary basis.

The need for services has expanded rapidly in recent years. One family planning clinic in Mestre stated that it serves approximately 600-700 new patients each year, in addition to its existing patient base. Within the health rubric, several providers also noted that they employ social workers along with medically trained staff. Many agencies working with trafficked women in Italy employ cultural mediators.

In principle, irregular immigrants in Italy have a right to "basic assistance" from Regional Health Services. According to Italian government representatives (President of Republic and Ministry of Health), "basic assistance" is meant to include emergency care, essential care, maternity and childbirth, and diseases affecting minors and persons aged over 65. Law no. 40 of 6 March 1998 (Immigration and Provisions on the Condition of Foreigners) identifies two types of illegal migrants with different citizenship status: 1) illegal immigrants applying for stay permits who may temporarily register with the National Health Service; 2) illegal immigrants entitled to basic health protection. Both receive a card with a code number identifying them as foreigners temporarily present in Italy (*Straniero Temporaneamente Presente, STP*). With this card, they are entitled to specialist care and emergency, maternity, and hospital cover. Some providers even offer health related services without requiring this card.

In the Netherlands, integration services are primarily operated by NGOs and supported by government funding. Women who qualify under the B9 procedure, which provides temporary residence, are eligible to access social support for victims of trafficking.²¹ Integration services in the Netherlands, like other countries, are built on pre-existing programmes (e.g., harm reduction, outreach to sex workers, counselling,

social support and shelter for victims of domestic violence). According to STV (the Foundation Against Trafficking in Women), the lead agency officially designated to co-ordinate support services for trafficked women, there are 25 shelters for victims, which operate in ten regions of the Netherlands. Different agencies offer intensive counselling programmes for specific target groups, including trafficked women, as well as crisis intervention, group therapy and individual counselling, and practical help and guidance. For medical care and severe psychological needs, STV co-ordinates with public health agencies. According to STV, however, delays in access to insurance, medical facilities, and interpreting are common and can negatively impact the health of its clients.

In Belgium, integration services are offered by NGOs and are funded primarily through state funds, such as the National Lottery and the Federal Ministry of Employment and Equal Opportunities. The Centre for Equal Opportunities and Combating Racism, a government institution, has been given, by Royal Decree, core responsibility for the co-ordination of the three specialised centres for the assistance of victims of trafficking, Payoke in Antwerp, Pag-Asa in Brussels and Surya in Liège.

The three centres offer assistance to female and male victims of trafficking and smuggling on three levels: administrative, legal, and psychosocial. Under the framework of the 1994 and 1997 circulars, these centres are entitled to apply for residence documents for victims of trafficking and monitor their follow-up in close collaboration with the immigration office.

Legal assistance in Belgium aims to follow up on the initial declarations filed at law enforcement agencies. Victims of trafficking are offered pro bono lawyers to defend their interests through a project of the Flemish community. Victims of trafficking have full access to education and vocational training, employment, financial allowances, and mental and physical health care. These services are offered to promote the victim's further integration in society. Most of these services are arranged through referral, in collaboration with other regular providers. The centres offering shelter are often full and suffer from case overload.²²

5.3.2 Access to services: reintegration

So far, a lot of women have returned to prostitution, trafficking, or violent relationships. I believe that this is because they can't get the help they need and also because they can't find a caring and supportive environment. People either don't accept the women or don't understand their situation.

Animus Association Foundation/
La Strada, Bulgaria

Once returned to their home soil, access to care for most women depends on their ability to pay. Poverty proves a major health-seeking barrier. Nearly all the women interviewed who went home, returned without money or employment prospects. In many middle and low-income countries, medical care, though officially socialised, often is not actually free of charge (see *Pre-departure stage*). Services and medical tests and procedures often require private and/or illegal payments. In countries without a socialised medical system, services are almost wholly private and unaffordable for most residents.

Some women are able to access free services through local NGOs, but this often depends on NGO funding, their policies on fees (no fee or sliding scale), and their arrangements with medical care providers.

Most service organisations in women's home countries have been established specifically to address the problem of trafficking. They rarely receive support from the state. Funding generally comes from international donors and foreign aid programmes. Assistance to women is rarely dependent on their participation in criminal proceedings against traffickers. Access to services appears to be a random matter of timing.

In Ukraine, international organisations and local NGOs provide most of the re-integration-related assistance. There are approximately 25 local NGOs and three shelters offering services to trafficked women in Ukraine. Two are run by local NGOs in Odessa and in Kharkov. Both have arrangements with local government hospitals to provide medical assistance to victims. The third is operated by the IOM in Kiev and works out of the local hospital and has access to its medical facilities. A network of local NGOs offers various other services, such as counselling and occupational training. Women interviewed in Ukraine contacted local NGOs either through IOM, the La Strada network, overseas consuls or embassies, or on their own after seeing a public awareness campaign offering assistance.

In Albania, there are three main organisations offering shelter and assistance. Two international organisations are in Tirana (IOM, ICMC) and one local group is in Vlore (Women Hearth). Women in the International Catholic Migration Committee (ICMC) shelter (previously mainly assisting non-Albanians were primarily referred by local police. The Albanian Community Health Organisation (ACHO) is the main referral health care provider for both organisations in Tirana. Services are provided to women free of charge. Depending on the need, women may also be referred to private care or state maternal health care where payment will be made by the referring organisation.

5.4 Overview of the process: meeting women's needs

How would you describe the reintegration process for a woman who has been trafficked?

Generally, during the first and second week she is very traumatised and scared of everything. She spends the first month getting her bearings, thinking, readjusting, and visiting doctors. After three weeks to a month she may be ready to start making decisions about her future. She is also ready to start courses, skills training. After one to two months most women have finished psychotherapy. However, some need regular therapy for longer and it is common for all women to periodically revisit their therapists. After 6 months women often begin working, if everything else is ok. Some women go through this process faster or slower than others.

La Strada,
Ukraine

Providers were asked to discuss the general process and some of the major issues related to integration and reintegration, particularly as they relate to women's health. Below we have divided intervention practices into three very broad chronological stages in order to highlight patterns and common issues that emerged from interviews and literature by providers.^{23,24} A limited amount of information gathered from the women is also represented.

5.4.1 Stage one: crisis intervention and meeting practical needs

Meeting practical needs

In the first meetings with a trafficked woman, providers aim to address personal security issues and arrange appropriate housing, nutritious food, and rest. If the woman has any urgent medical needs, they are addressed at this time. Otherwise, health-related issues are usually attended to after practical needs are met.

NGOs working with trafficked women stressed the importance of offering practical information and demonstrating discernible results before asking a woman to recount her experience and reveal intimate personal details. One provider explained:

You have to take care of basic needs and by helping women with material

things you are indirectly addressing emotional and psychological needs by showing them that someone cares about them.

Payoke,
Belgium

Providers stated that actively involving a woman in accomplishing any number of the initial practical tasks can be an empowering process. This also begins building trust between the care provider and the trafficked woman (see *Building trust*).

Providers have also noted that for some women entering the integration and reintegration stage, the trafficking experience has made them strong and self-reliant. Having helped themselves through a treacherous time, they do not need or want to accept much of the assistance that NGOs may offer and resent being treated as helpless or victimised.

Some, however, may demonstrate an attitude of strength and independence, but the internal emotional reality and vulnerability may be quite different.

Ensuring personal security

I am afraid that my pimp could find me and I could be recycled into sexual services. I feel worried even for my sisters, also.

Alma,
Kosovo to Italy

Personal security is among the first concerns of a service organisation assisting women who have been trafficked. A woman in a destination country may express fear for her safety in the destination country or fear of the dangers of returning home. Similarly, a woman in her home country may fear immediate or imminent harm from traffickers. In a twelve-country study on witness protection, half the countries reported that witnesses experienced incidents of reprisals, and that reprisals were more likely to occur in a woman's home country, not least because local police are ill-equipped to protect women.²⁵

Four respondents interviewed for this study who did not return home were afraid of reprisals in the destination country. Seven were afraid for their safety in their home country. Tamara, who was severely abused in Turkey, stated, "I was looking forward to coming back, but I am still afraid of meeting the trafficker" [Tamara, Ukraine to Turkey]. Larissa, when asked what would most help her feel better, stated, "many things, especially security" [Larissa, Albania to Italy].

Women have very real reasons for feeling unsafe.

Women who return home not only worry about revenge by traffickers, but some also fear the interpersonal or other violence they had originally fled. Caroline, trafficked from Romania to the UK, explained, “I am afraid to return home because my father is an alcoholic who beat me.”

Addressing security issues is important to a woman’s mental health. If a woman is regularly looking over her shoulder to avoid those that may harm her, she is likely to remain in a state of hyper-vigilance that hinders her ability to reconstruct the necessary traits for living independently. As noted by S. Turner, a psychiatrist working with victims of torture, “...for some people only limited gains are possible. This is especially true for as long as the violence or the threat of further violence persists.”²⁶

Most NGOs interviewed stated that staff try to allay safety-related stress by immediately attending to practical security issues. As a staff member at Payoke explained, “Most women are in crisis in the beginning. They are insecure, feel unsafe and are afraid that the traffickers will find them again. They have problems eating and sleeping.”

Women’s anticipation of harm may be accompanied by flashbacks, nightmares, and re-experiencing events caused by trauma-induced neurobiological factors.²⁷ Research suggests that episodes of re-enactment may be triggered by perceptions of danger.

Nonetheless, the reality is that because so few women ever reach assistance organisations, most are left to deal with personal security concerns on their own. Katrina, from Ukraine, living alone with her child in Britain explained:

Now I sleep with a knife and my mobile under my pillow. I am afraid that Sergey might come to cut my throat. I’d be able to phone the police.

Katrina,
Ukraine to UK

Assisting with documentation

Assistance with preparing documents for immigration, social assistance, and other needs is one of the most pressing practical issues for women in destination countries. Administrative procedures are cumbersome, confusing, and rarely offered in translation. NGOs and legal assistance projects frequently assist women in filing the necessary papers that eventually entitle them to public support for services and to obtain legal status. Women in a foreign country without regularised status are vulnerable to re-trafficking or entering other exploitative situations. As one provider explained:

The most important aspects of service provision are getting the women social assistance from the Belgian government, because this frees them of the economic pressures to go back to an exploitative situation.

Payoke,
Belgium

Another provider maintained that legal residency and the stability that comes with it are fundamental to women’s resilience:

Trauma counselling is a long and painful process that only succeeds when the individual involved has social security and subsistence.

STV,
Netherlands

However, the same provider complained of the lag time before women receive the documents and funding:

It is difficult to find medical or health care when there is no funding or insurance. It takes some weeks before welfare benefits and medical insurance are realised. Before that, professional help organisations cooperate and/or pay the health care in advance.

STV,
Netherlands

Nearly all providers reiterated that legal limbo is among women’s greatest sources of anxiety. Support workers assert that even the process of applying to have one’s immigration status regularised appears to have mental health benefits by giving women a sense of legitimacy that alleviates feelings of guilt and criminality, and allays some anxiety over immediate deportation. Nonetheless, many women, like Annuska, continue to live with mixed emotions:

Even though things are rather safe by now, there is always fear and the threat of disturbance of the present life. There is no possibility to return home, to have a safe and human life there. At the same time there is still the threat of being expelled or deported. Some days are actually happy days.

Sometimes I am able to forget what happened and enjoy the present life.

Annuska,
Lithuania to the Netherlands

Arranging shelter, housing, and multi-sector service coordination

Arranging emergency shelter and longer term housing for trafficked women has proven problematic in both integration and reintegration contexts because of legal and/or funding constraints. Organisations may risk legal or funding penalties and be accused of harbouring illegal immigrants if they assist women who have not regularised their immigration status. In Italy, however, a public debate that took place a few years ago focused on the need to protect providers from these risks, resulting in Immigration Law n. 40/1998 10(2), which permits the provision of shelter and humanitarian care to irregular migrants. In addition, many shelter organisations depend on the provision of public assistance to women to pay for shelter-associated costs. Organisations assisting women returning home rely almost wholly on international donors.

There are differences of opinion about the best strategy for assisting and housing trafficked women. Some organisations provide emergency shelter in a central facility where many services can be provided in-house. Residency in such emergency shelters ranges from one to two days to five to six months. A number of organisations then assist women to arrange longer term housing. In cases where women wish to return home, groups help connect her to local a support agency, where possible.

Some organisations believe that housing women, even for short periods, in one central facility can put women and staff at risk, as there is greater likelihood the shelter location will become known to traffickers. These organisations prefer a more diverse system of housing and place women directly in apartments or group housing in different parts of a city, while maintaining regular contact to provide necessary services and information.

Some groups offer a range of shelters to suit the particular security and personal circumstances of the woman. The Italian NGO, Associazione On the Road, offers immediate accommodation in a “flight house” for very short periods. They also offer a second refuge with high security for longer periods, family placement, and independent housing.²⁸

Some NGOs suggest that group housing is beneficial to mental health as it offers greater opportunities for group therapy and for women to meet on a casual basis and discuss their experience with other victims. However, they also indicate that after a time a woman can come to feel she is reliving her experience through others, and that she is not moving beyond her identity as a trafficked person. In addition, women in closed shelters, or centres with high levels of security and numerous restrictions,

may begin to feel confined and controlled. Having just left a controlling setting, this is precisely the sort of prescriptive environment that may impede efforts to learn to live independently. Moreover, women often have too much free time to get lost in their thoughts or become overwhelmed by boredom.

Accommodation in a shelter home means no meaningful day activity. Combined with the stress of just having been trafficked, pressing charges, acting as a witness in the criminal procedures and dealing with the insecurity of the refugee procedures, my smoking has increased.

Annuska,
Lithuania to the Netherlands

Organisations providing care to women in destination settings explained that once housing and other practical issues are settled, women (who do not have security concerns) may begin to orient themselves by, for example, learning how to navigate local logistics (e.g., public transportation, public services), and undertake practical tasks (e.g., shopping, laundry, etc). These small steps are especially important for women who previously depended on traffickers as their go-between with the outside world. Negotiating the universe around them on their own serves as a further sign of their growing self-reliance.

5.4.2 Stage two: meeting medical needs, setting personal and tangible goals

Now my body does not feel the pain any more but I can feel the pain in my heart as if it is happening now. The bad memory sometimes comes back to me very clearly. I still remember the feeling of pain, and the picture of myself being raped by those clients still remains.

Keti,
Albania to Italy

Physical health

Organisations assisting trafficked women reported that nearly all clients have needed some level of medical care for physical health complications (e.g., musculo-skeletal, respiratory, and dermatological or dental problems). However, the most common problems were sexual and reproductive health problems (discussed below).

Payoke, a non-governmental organisation in Belgium assisting trafficked persons, stated:

We have seen women with black eyes, bruises, injuries from rape, and internal

bleeding, complications from botched abortions. Two-thirds have STDs and at one point ten of twelve women at the shelter had syphilis. Approximately 5-10% are HIV positive. Chlamydia is also a problem. Last year 3-4 had hepatitis B. A few women have fertility problems, not many but it does happen. We hear stories about women who eat very poorly while they are under the control of traffickers.

Payoke,
Belgium

Payoke also noted that of approximately 500 clients over the past four years there have been four or five cases of epilepsy.

La Strada, Ukraine, reported common physical health issues such as headaches and sinus infections, skin problems, such as lice and scabies, and dental problems.

Physical injuries are particularly severe among women who have tried to escape or flee a trafficker:

A woman escaped her trafficker by jumping out of a second floor window. She was bruised, fractured bones, unconscious, and had cuts and marks all over her body. She was transported to a hospital emergency room, where she received proper and most necessary treatment. Later she was transported to a rehabilitation centre for more specialised care.

STV,
Netherlands

Sexual and reproductive health

Sexual and reproductive health problems were reported by all the women interviewed for this study. All reported having been treated for sexually transmitted infections (STI). Most organisations assisting women trafficked for sexual exploitation provide testing and treatment in-house or regularly refer women to outside providers. Women commonly wish to address reproductive health problems immediately, both because of pain and irritation, and to prevent transmission to intimate partners at home.

Common sexual and reproductive health conditions noted by La Strada include pelvic inflammatory disease (PID), cervical erosion or inflammation, vaginal candidiasis, chlamydia, syphilis, gonorrhoea, and non-specific vaginitis.

GAATW in Thailand explained that Thai women who

had been given hormone medication to stop menstruation experienced irregular and heavy bleeding. GAATW's sister organisation, Foundation for Women, explained:

For women who were in construction, factory and fishery-related work, they would have problems related to the difficult work and malnutrition (lack of food). They would have pale skin, very dry hair and many scars. It is easier for us to detect health problems among these groups and they can share their health problems because their working experience is less stigmatising. However, some women might experience sexual harassment, therefore we must be aware and build trust so that they will share their problems and we can provide assistance.

Foundation for Women,
Thailand

HIV/AIDS has received some attention in trafficking discussions. To date, no prevalence data on HIV infection among trafficked women have been collected, but it is likely that prevalence follows regional patterns. In their research on health and safety in the sex industry, Ward, Day and Weber state, "Prostitutes are most at risk of HIV in situations of widespread heterosexual transmission, where control of other sexually transmitted infection is poor."²⁹ Other literature highlights the particular vulnerability of migrant sex workers, citing their limited access to information, support systems, essential services, and language barriers, which suggests that rates of infection might be at least as high or higher among trafficked women than other women in sex work in the country.³⁰

None of the women interviewed for this study reported having tested positive for HIV or AIDS.

The issue of HIV testing is complex. Testing should be voluntary and women who have been trafficked must be given the opportunity to weigh the benefits and potential implications of being tested. "Voluntary Counselling and Testing" (VCT) is the "process by which an individual undergoes counselling enabling him or her to make an informed choice about being tested for HIV."³¹ The emphasis of VCT is on the individual's right to choose whether or not to be tested.

A recent report on trafficking in southeastern Europe reports that for women in the care of the International Organization for Migration, HIV tests are available (except in Kosovo) on a voluntary basis and that the number of women accepting tests varies by country from 20%-80%.³² The report suggests that the variation in levels of testing may be because in some countries,

“shelter staff don’t encourage women to be tested as staff cannot guarantee the confidentiality of the results.”

Women’s reluctance to be tested may also be associated with their fear of the disease, of being stigmatised and outcast by their family or community, or the futility of ever affording treatment. Testing positive for HIV/AIDS can, in some settings, result in rejection by family, discrimination or violence by others, and suicide.^{34,35} Rather than face becoming an outcast, women may choose not to reveal their status (perhaps engaging in unprotected sex), or may choose to leave home (perhaps resubmitting themselves to traffickers).

Women in destination countries who have applied for legal status to remain reportedly decline HIV testing, believing that testing positive would be cause for refusal.^{36,37,38}

Like other persons living with HIV who face discrimination by insensitive and unformed care providers,³⁹ trafficked women who test positive are likely to encounter the prejudices related to their exploitation and the infection.

Medical care and referral

In both integration and reintegration settings, few groups interviewed were “one-stop shops.” Particularly for medical care, co-ordination between NGOs and health services is critical to ensuring that women receive the necessary range of care.

Most women receive testing for sexually transmitted infections and other transmissible illnesses, such as tuberculosis, as well as pregnancy tests.

On social support worker explained:

Together with her caseworker, a woman will decide what kind of medical care she needs – often gynaecological examinations or abortions – and about 90% of the women get an HIV test. Then La Strada will arrange for her to visit a hospital or clinic where she will be accompanied by her caseworker. La Strada tries to use the same hospitals or clinics, so that they know the staff and know that the staff will treat the women well.

La Strada,
Ukraine

However, in many countries, confidentiality, particularly as it pertains to sexual health services, reportedly remains a significant problem. Even in locations where

confidentiality standards may have improved, based on past practices, women continue to have concerns over privacy. For example, in Russia and other former Soviet states, previous practice dictated that individuals diagnosed with an STI could be ordered into in-patient care in specialised centres. Notification and contact tracing were compulsory and often involved the police.^{40,41} As recently as 2000, findings from Russia indicated that despite changes in law and practice, confidentiality and anonymity continue to be poorly understood by medical practitioners, are accorded little priority, and remain barriers to access.⁴²

While most organisations relied on outside services by different providers to supplement their own services, they stressed the importance of maintaining continuity of care by assigning one case manager to each woman who remains her regular point of contact. They also highlighted the benefits of accompanying women to medical facilities to offer practical assistance and emotional support through unfamiliar and often intimidating bureaucratic processes. This is particularly important in destination countries where women encounter language and cultural barriers. STV described one client’s situation:

She had to take a tuberculosis test as a condition of obtaining her B9-permission to remain, but no one could go with her. So, she had to go alone with only a form that said what she was coming for. She returned home without being tested, they did not understand her and she did not understand them.

STV,
Netherlands

A provider in Italy noted, “Staff consider accompanying women to take such examinations as a crucial moment for developing a relation of trust between the community and the woman” [Caritas, Italy].

Funding is an issue that directly affects the level of care that groups are able to offer, particularly local NGOs. International organisations generally have more resources to support medical care and other services. Local NGOs often refer and accompany women to care, but are rarely able to provide financial support.

Psychological reactions

The women who come here are strong. Their mental health problems are simply a reaction to certain situations. I think that overall they have a strong psychological equilibrium. The weakness is only on the surface, as a reaction, but they are really strong women.

Weakness was contextual versus from the inside. Apparent fragility is in part because they are foreigners and do not have the tools and are not in a position to begin on a path of self-determination because they feel lost. Our role is to understand these situations without transforming them into psychiatric illnesses when this is not the case. But, at the same time as these women are coping with so much, they can also place themselves in positions of submission, or in a relationship of exchange [with the service provider].

Centro di Salute Mentale
(Mental Health Centre), Italy

Trafficking commonly involves prolonged periods of repeated or “chronic trauma”,⁴³ that results in psychological sequelae that are often the most enduring and complex health outcomes among women who have been trafficked.

During the integration or reintegration stage, women appear to suffer symptoms often identified in survivors of other forms of chronic trauma (i.e., domestic violence, child sexual abuse, torture). Commonly recognised psychological reactions include sleep disturbances (including frequent nightmares), chronic anxiety, depression, feelings of aggression or self-harm, memory problems, dissociation, loss of concentration, and problems with identity.^{44,45,46,47}

In addition, many trafficked women feel stress related to the stigma that is associated with trafficking, forced prostitution, and sexual violence. The profound social and family disapprobation and personal humiliation that trafficking confers on many of its victims compounds the difficulties women have in dealing with their psychological reactions.

Although many reports on trafficking have attributed symptoms observed among trafficked women to post-traumatic stress disorder (PTSD)^{48,49} (or post-traumatic stress syndrome), many of the critics of PTSD have cautioned against pathologising or medicalising what may be normal, even constructive or existential reactions to extraordinary stress.⁵⁰ Although in some instances medical assessments are important to determining appropriate treatment strategies or to securing public resources, there is simultaneously a risk that women will be stigmatised by certain categorical diagnoses. Derek Summerfield, in his critique of post-traumatic stress disorder, contends:

The psychiatric sciences have sought to convert human misery and pain into technical problems that can be

understood in standardised ways and are amenable to technical interventions by experts. But human pain is a slippery thing, if it is a thing at all: how it is registered and measured depends on philosophical and socio-moral considerations that evolve over time and cannot simply be reduced to a technical matter.⁵¹

A woman’s resilience to trafficking-related trauma depends on a number of factors, including, the type, severity, and duration of the trauma, individual characteristics, such as age, personality, and social class, and the quality of support she receives – both professional and social (family, friends and religious or cultural affiliations).^{52,53}

To learn about some of the common mental health symptoms among the women interviewed for this study, respondents were asked about symptoms they experienced while working (see *Destination stage*), and those experienced within the past four weeks.⁵⁴ This set of questions was not used as a diagnostic tool, but merely as a way of looking at the some of the patterns of psychological distress among respondents.

As outlined in *Destination stage*, when twelve women were asked about symptoms they experienced while working, eight reported having experienced more than half of the 21 symptoms presented, and four experienced 15 to 18 symptoms. Women were then asked about the same symptoms for the past four weeks. Of eleven women responding, seven had experienced seven or fewer symptoms, and three reported 10 or more.

The following symptoms were those reported by the greatest number of women.

- *Easily tired or tired all the time.*
- *Crying more than usual.*
- *Frequent headaches.*
- *Frequently unhappy or sad.*
- *No interest in things.*
- *Feel tense, anxious all the time.*
- *Sudden unprovoked feelings of anxiety that did not immediately go away.*

Several respondents said that they felt improvements in their mental health since the time they were working, but noted that some of their negative feelings, such as anxiety and sadness, persisted:

Still now I always feel I am stressed, but it is different. Now I think that little by little, the situation will change.

Keti,
Albania to Italy

I still have some problems, but the most important is that I no longer work, and that's why I feel better.

Lola,
Albania to Italy

I feel much better now. I do not have any more pain in the abdomen as I used to. I also have a safe place where to stay. But I miss my family and I cannot return there.

Maria,
Albania to Italy

In contrast, two respondents, Katrina and Alma, reported the persistence of severe symptoms and suicidal thoughts. Katrina, from Ukraine, escaped her trafficker before being forced to work as a prostitute, but not before she was raped, contracted syphilis, became pregnant and gave birth as a result of the rape. She was given little social support following this experience. She reported experiencing nearly three-quarters of the symptoms discussed above and had regular thoughts of suicide.

Alma, who was 13 years-old when she was lured from a refugee camp by a false promise of marriage, reported continuing to experience nearly half of the symptoms even once she was out of the trafficking experience. When interviewed in a shelter in Albania, she said, "I feel more damaged than other girls with similar experience." She added, however, that sharing her experience with others "helped to relieve some of the stress."

Mental health support

Women who have spent less time abroad tend to recover more quickly, as do women who experienced less abusive treatment and women who have support from their friends or families. Generally, the women who have the hardest time recovering are those who are diagnosed as HIV positive and those rejected by their families.

La Strada,
Ukraine

Mental health support is a complex area because it can come in many forms and is often dependent on the resources available and the customs and culture of a setting. In some places formal or "professional" support may be provided by a psychiatrist or psychologist, social worker, counsellor, or therapist. In other settings (particularly those with limited resources) support can, for example, take the form of participation in a community development project or joining a women's cooperative. In one community in Thailand women returning from Japan are integrated into an income-

generating project that combines counselling and group discussions with other development activities aimed at empowering women. This has been called a more holistic approach, addressing women's practical and mental health needs simultaneously.⁵⁵ However, what the majority of women are able to access, and what most providers and experts agree best fosters a woman's recovery, is care and understanding from those who are closest to her, i.e., her family, friends and community.

Providers highlighted key issues elemental to women's mental health care that are discussed below.

Assuaging women's guilt and shame

I am ashamed to return home.

Alma,
Kosovo to Italy

Guilt and shame are emotions that psychologists and social support workers like to address quickly. Individuals providing psychological support highlighted the importance of immediately relieving a woman of self-recriminating emotions by emphasising that she was neither responsible for what happened to her nor to blame for not having escaped it. Support workers remind women to take pride in the strategies they adopted to avert further harm under such untenable circumstances. By reassuring a woman of her innocence, support workers simultaneously demonstrate that they do not judge or disapprove of her or her actions. The less afraid of disapprobation women are, the more willing they are to reveal difficult details of their experience. Support workers suggest that removing this barrier is a necessary first step to addressing other issues, such as trust and relationship-building.

Support workers try to boost women's self-esteem by helping them to look away from the past and its memories and start developing future goals, however small or short term. They believe that in setting realisable benchmarks a woman begins to recognise the future.

Nonetheless, for many the stigma of having been trafficked and what will be perceived by others as the woman's promiscuity can remain a barrier to support that sustains her sense of isolation and social separateness.

Building trust

The first person who meets a woman when she returns to Ukraine is the most important person. This person must make the woman feel safe and must build trust with the woman.

La Strada,
Ukraine

Providers in both integration and reintegration settings insist that trust is a fundamental and necessary element of the provider-client relationship. It is only once a support worker gains a woman's trust that the process of working through other debilitating problems can progress.

Many trafficked women have previously offered their trust to people who exploited them. This often leaves them with little reason to have faith in themselves or others. In the integration and reintegration stage, defence mechanisms developed in response to past threats can hinder a woman from trusting others.

Staff of NGOs explain that they try to earn women's trust by, for example, providing tangible assistance, approaching women and sensitive subjects slowly and in non-judgemental ways, and by maintaining continuity of care throughout which the worker regularly reaffirms her concern for the woman's practical and emotional needs.⁵⁶

The ways in which psychological functioning converges with social and other relationship dynamics is often referred to more broadly as "psycho-social" factors. R. Baker, in discussing refugees, explains that psychosocial considerations involve:

The complex interplay and the inextricable links between the inner world of feelings, values, assumptions and interpreted experiences and their effect on the external world of roles, relationships, ambitions and opinions.⁵⁷

For women who are reorienting outside the exploitation context, the process of coping and adapting is dynamic, as the effects of past traumas regularly intermingle with present tensions and practical social interactions. The ways that a woman's experience affects her sense of security, trust, and identity influences how she fills her role as parent, spouse, daughter, employee, and citizen.⁵⁸ In her book, *Trauma and Recovery*, Judith Herman explains:

People subjected to prolonged, repeated trauma develop an insidious, progressive form of post-traumatic stress disorder that invades and erodes the personality. While a victim of a single acute trauma may feel after the event that she is "not herself," the victim of chronic trauma may feel herself to be changed irrevocably, or she may lose the sense that she has any self at all.⁵⁹

The challenges and risks related to trust and relationship building are important both in a service context and in a woman's personal life. In both cases, a woman should have space to share her experiences, but not be forced or

pressured to reveal information about herself or her experiences. Women should be given the time and support to consider the implications of disclosure to those providing assistance, and to family members and other individuals close to them.

Understanding women's external aggression

It is not unusual for a woman who has been trafficked to display aggressive or hostile behaviour, feel short-tempered, or appear intolerant. This hostility may be directed at support persons or others close to the woman, including family members. These aggressive feelings, otherwise viewed as self-protective reactions, have become normalised in response to an environment that was filled with threats and danger. Women who have spent months or years strategizing to survive an external enemy may find it difficult to interact in a world without such threats. For some, when the enemy is not clear and present, they continue to create one.⁶⁰ They may become verbally or physically aggressive, or both. One woman trafficked to the UK described herself as having "a short fuse" and having "trouble keeping her temper."

When asked whether she continued to have suicidal thoughts, one respondent explained:

No, but I feel desperate. Sometimes, I feel like hitting someone else, but I did not want to kill myself.

Larissa,
Albania to Italy

Women may transfer their aggressive feelings to their support workers, family members, or acquaintances. Hostility may affect their ability to keep a job or maintain a relationship. For some, especially those who survived longer periods in a trafficking situation, it may mean that they return to prostitution, or to traffickers' services, because this is the setting and interpersonal dynamics for which their practical skills and survival mentality are now oriented.

Working with a language interpreter

Language differences can be a major barrier to mental health support. For many groups, finding and paying for an interpreter is difficult. Yet, even when an interpreter is available, the presence of a third person can hamper effective counselling.

First, identifying an appropriate interpreter is of immense importance. As previously mentioned, if the interpreter is from a different ethnic group or socio-economic background a woman may feel mistrust or judged, and therefore be reluctant to speak openly. If the interpreter harbours undisclosed prejudices that the provider does not pick up on, she or he may have

difficulty obtaining unbiased interpretations and will not be aware of any inaccuracies. One provider from the Netherlands noted, for example, the complications of having a Croatian mediator for a Serb woman in their program. It is important to identify ways to privately confirm with the woman that she is comfortable with the interpreter.

Second, filtering sensitive questions and profound emotions through a third party can inhibit the important personal connection between a support person and a woman.⁶¹

Third, establishing rules immediately about confidentiality is critical to working with an interpreter. This is particularly important if there is a chance that the interpreter is from the same community as the woman for whom she/he is interpreting. The rules against disclosure of case information hold true for communications and gossip outside the work setting and unauthorised information-sharing with other staff members.⁶²

Finally, but no less important, new or inexperienced interpreters often need to be sensitised to the issues they will hear about, trained to have supportive attitudes, and warned against judgmental attitudes.⁶³

Offering socially and culturally competent care

Providing care that is socially and culturally sensitive means not only the absence of discrimination, but the willingness to learn about, accept, and respond to differences.

For medical care, many organisations assisting trafficked women employ outside services or refer women to mainstream clinics or hospitals. Providers assisting trafficked and sexually exploited women reported that women who attend mainstream health services often face discrimination and blame. One non-practising doctor (now working for a donor organisation) interviewed for this study explained that she assumed most trafficked women voluntarily chose to migrate for sex work, and dismissed any harm that came to the women, as they themselves had made such a promiscuous choice.

Providers in destination countries also expressed concern that, as immigrants, their clients encounter racism and impatience from mainstream providers.⁶⁴

In one worrisome instance (but perhaps not uncommon), a female obstetrician-gynaecologist assigned to treat trafficked women in the Balkans, upon leaving the shelter said, “those people really scare me.”⁶⁵ At a time when women most need understanding and support, these types of responses may discourage women from seeking and following-up with care and may impair the

quality of the care provided.

Even where discrimination is not present, cultural differences between client and provider pose many challenges. Cultural aspects of mental health have been a topic of significant discussion in psychology literature.^{66,67,68} Both existing research and the providers interviewed for this study propose that the ways a woman interprets and reacts to her experiences depend greatly on how she integrates events into her religious, cultural, and personal context. Many contend that “Western models” of therapy risk misdiagnoses and inappropriate care when applied to individuals from different cultural backgrounds. It has been said that “psychiatric systems, like religions, kinship systems or political systems, are culturally constructed and mirror a culturally constructed reality.”⁶⁹ Women are likely to interpret and express distress, sadness, or anxiety in a way that reflects how these emotions are exhibited in their community. Individuals expect support or treatment that coincides with what is generally accepted as effective within their own culture.

By applying an ethnocentric perspective that relies primarily on a western model or a clinically-based psychiatric diagnoses to a culturally-based response, a provider risks treating an illness that the woman does not have, and simultaneously creating confusion in the woman’s mind about the significance of the medical encounter.

As noted by a provider in Italy:

Very often, one of the mistakes made by people working with immigrants is that of trying to make the others similar to us – [they believe that] the model to follow is ours and the others must adapt.

Stella Polare, Comitato per diritti civili delle prostitute,
Italy

Providers discussed women’s differing and often negative perceptions of Western-style counselling. Payoke explained:

We found that seeing a psychiatrist or psychologist was alarming for most migrant women. African women associated the therapists with wizards and juju and were wary of anyone trying to affect their minds.

Payoke,
Belgium

They added that formal counselling for women from Eastern Europe, for example, made them feel “insecure

and vulnerable” and was “stigmatising.” This is perhaps because psychiatry was historically associated with political persecution, severe disorders, and institutionalisation.^{70,71}

Several NGOs reported trying to identify ways of addressing cultural differences.

An individual might believe that the only way to undo a spell of black magic is to work with rituals to create a positive aura that protects the victim. Each working session between the worker and the victim therefore could start with a small ritual. For example, walk around the table, stand in front of the window and take a deep breath of positive energy.

STV,
Netherlands

HIV/AIDS also has varying society-based perceptions (often poor versus rich countries), as one provider explained:

Interventions may sometimes seem inadequate because of cultural differences. For instance, to explain to a migrant woman that she is HIV positive but she does not have AIDS is really difficult...we need to consider the meaning that that woman might attribute to being HIV positive. In Africa it means you are dying. But it is not the same here. This is difficult to explain without making a woman believe she is healthy. That also is not true.

Ambulatorio per Stranieri,
Italy

Viewing patients through a singular social and cultural lens raises the possibility of misunderstanding how an individual responds to trauma and what treatment strategy will be most effective. Alternatively, it may be said that sensitive care is related to a phenomenological approach to others’ expression of suffering and illness.⁷²

5.4.3 Stage three: recognising longer term mental health issues and helping women to look towards the future

Most women are in crisis in the beginning. They are insecure, feel unsafe, and are afraid that the traffickers will find them again. They have problems eating and sleeping. After a few weeks, most of these things are resolved. However, often about one

month after leaving the safe house - when women have work and a place to live so their basic needs are taken care of - most women start showing signs of more serious mental health problems. When everything is ok they “wake up” and start dealing with the past.

Payoke,
Belgium

The third stage varies greatly in time and scope depending on the woman and the circumstances. However, in general, this is the time when a provider begins to focus most on preparing a client for an independent and self-sufficient future. For women who are in a destination country, this means, among other things, identifying educational and training opportunities (e.g., skills training, language, cultural orientation). For women who will or have returned to their country of origin, providers try to identify local training, education, and support and, where appropriate, help prepare a woman (and her family) psychologically and emotionally for reintegration into national life or for her return.

Recognising longer term psychological reactions

Providers have begun to recognise that women’s psychological reactions change over time. They note that many of the more profound and enduring psychological effects appear later after a woman’s immediate practical needs have been met and she has had time to review her past and consider her future.

Psychological reactions may become chronic or more severe over time. One support worker suggests that between one to six months after first coming into contact with services, a woman’s deeper reactions to what she has experienced may appear. Problems that may increase at this point include amnesia, sleeping problems, symptoms associated with depression, and problems with interpersonal relationships.

Nadia Kozhouharova, a psychotherapist working with Animus Association Foundation, explained:

When women arrive they are in a mobilised state of mind and want to do something pro-active against trafficking, but later, the safer women feel, the more reality overwhelms them and their enthusiasm quickly turns to hopelessness. They fall into deep emotional crisis.

Animus Association
Foundation/La Strada, Bulgaria

Studies on the physiological responses to trauma suggest that chemical changes in the body (i.e., repeated depletion

of catecholamines, a neurotransmitter) resulting from prolonged extreme stress may contribute to an individual's reaction of avoidance or emotional numbing which is often accompanied by various forms of depression.⁷³

Psychologists have also pointed to "dissociation" as a common longer term reaction among women who have experienced violence. For some women, this may mean the inability to recall details or entire passages of past trauma. For others, it may manifest in more serious ways. In the aftermath of violence women may become physiologically less responsive to threats of harm to themselves, or may harbour feelings of aggression towards others or themselves. A support worker offered the following example:

A woman who had been exploited in the sex industry came to Payoke when she was pregnant. She noticed that in the past that when she was under stress she would do unusual things, like bite someone or walk through the streets bare-foot, and afterwards she would not remember doing these things.

Payoke,
Belgium

Assisting women to return home

I'm worried about my family's reaction when I get back home, and sad about what happened to me.

Laura,
Romania to Albania

For many women and their families, a woman's return home is an immensely emotional event. Providers noted that a valuable form of assistance during the reintegration process is facilitating a woman's reunion with her family. Many women fear shame and rejection if they tell the truth about what happened to them, and regret having returned home without the anticipated money. Four women specifically expressed concern for how their families would respond to their experience.

NGOs in Ukraine and Albania explained that they try to ease the reunification process by contacting family members prior to women's return to explain that the woman is not to blame for what happened to her, but was instead a victim of a common and serious crime. In addition, they try to prepare the family for the woman's mental distress and the ways this may affect her behaviour. They try to emphasise her need for unconditional acceptance and support. Where necessary, they also advise the family on security-related issues. One provider explained:

[The relatives] are prepared to meet the woman and are informed how her emotional state will affect her behaviour and personality. They are also prepared for their own reactions to her. Often, blame, shame, and resentment on the family's part will only surface months after a woman returns home, and we try to help them understand that this is normal, they can cope with it, and that it will pass. Family members are also briefed on keeping her safe.

Animus Association
Foundation/La Strada, Bulgaria

When women are returned to a capital city but are from other provinces, NGOs inform women about local services and support near her home (where available) that she may call if she wants further assistance, psychological support, or occupational training.

One social support worker from La Strada, Ukraine explained that over half the women she assists tell their parents or mother what happened to them and that it is uncommon for a woman's mother to reject her. However, she noted that while parents may accept their daughter initially, over time it becomes more difficult for them, and they may begin to blame or resent her.⁷⁴

According to providers working with women who have returned to their home country, many trafficked women do not tell their husband about forced prostitution or sexual abuse for fear that he will blame or leave her. For some women, reconciling their emotions can be made all the more difficult because they feel unable to reveal their experiences to their spouse. Several respondents for this study explained that they were certain that revealing what happened to them would destroy their marriage. Oskana, who continues to suffer serious reproductive health complications and extreme anxiety, described:

When I returned, I went immediately to the clinic to get treated for the diseases so I would not infect my husband. I can't tell him what happened to me. He wouldn't accept me after this.

Oskana,
Ukraine to Italy

Experts working with victims of sexual abuse suggest that by not disclosing the abuse, women maintain a sort of barrier or divide between the horror of the past and the 'normality' of the present⁷⁵ In revealing stigmatising events women risk destroying that which is normal in their lives – specifically, the other person's image of them. Providers suggested that a woman's need to conceal her emotions, her fear of exposure, and her

inability to seek support from intimate partners add greatly to her psychological burden.

Even when support workers succeed in encouraging a woman to invest in the counselling and support relationship and participate in group activities or self-help projects, this does not necessarily translate into an ability to develop and sustain personal relationships with men. One social support worker with Payoke reported that in the past two years only a few of her clients developed good, healthy relationships with men. Many have had problems combining sex and friendship.⁷⁶

Sexual exploitation and abuse can be so stigmatising that even if a woman is able to find a man who accepts her past, rejection by his family, or community pressure may ultimately defeat the relationship, as in the case of K:

K had an Albanian boyfriend, but when his parents found out that she worked as a prostitute the relationship broke down. K feels that any relationship she has will be damaged by her past and that alternatively, she will have no choice but to seek a relationship outside her cultural identity, which will leave her cut off and lead to isolation.

Poppy Project,
Eaves Housing, UK

Fostering occupational skills, language training, cultural orientation, and employment

Women who can't find a job or get training but are relying on social assistance for month after month have the most difficult time and are at risk of going back to sex work. It is very depressing for the women when they can't find work.

Payoke,
Belgium

Nearly all service providers asserted that for a woman to truly step beyond her past, mental health support should be accompanied by occupational skills training and employment. For women remaining in destination locations, language training and cultural orientation are essential.

Occupational skills training is important both for women who remain in a destination setting and for those returning home. Practical self-development activities can advance income prospects and foster self-confidence.

Acquiring the local language represents the beginning of the process of moving from practical and emotional isolation to inclusion. Providers suggest that language is

one of the first building blocks to women's belief that they can fend for themselves, interact within their new community, and eventually secure employment. This is the reason many integration programs in destination settings offer language training or connect women to outside language schools.

NGOs in destination settings explain that cultural orientation is also important. In Belgium, for example:

Women who plan on staying in Belgium can start taking a class, called "social orientation," that teaches the women about Belgium and about its laws. Classes are taught in the women's own language. Women who complete the class receive a diploma and can go on to enrol in Dutch language classes.

Payoke,
Belgium

According to most NGOs, employment is the ultimate and critical bridge between the past and its debilitating emotions, and a future of self-sufficiency. Employment represents the means to economic independence and reflects a woman's capacity to successfully participate in mainstream society. A case worker from a local Ukrainian NGO recounted the resilience of a woman trafficked into a Greek brothel offering sado-masochistic services:

After she returned to Ukraine, she tried to commit suicide. Her son stopped her. She underwent therapy and skills training. Now she is working as the office manager at a private firm and is functioning at a high level. This is the key to her continuing well-being.

Renaissance,
Ukraine

However, providers also agreed that finding jobs is challenging. Women returning home often face the same employment problems as when they left. Women remaining in destination settings encounter delays in obtaining appropriate immigration documentation permitting them to work, may have limited employable skills (including language), and often confront employer discrimination.

Moreover, for some women, persistent destabilising or destructive reactions to past and present events prevents them from fitting into a 'normal' lifestyle. Animus Association Foundation, Bulgaria explains:

Even when women have good jobs, they rarely stay long because of post-traumatic stress. So far, a lot of women

have returned to prostitution, trafficking, or violent relationships because they can't get the help they need and also because they can't find a caring and supportive environment. People either don't accept the women or don't understand their situation. Women need a combination of "practical" and "emotional" assistance if they are going to recover.

Animus Association
Foundation/La Strada, Bulgaria

Still troubled by her past, a woman may have disruptive emotions and display seemingly irrational behaviour that cause her to lose or leave a job. As most women do not reveal their personal history to employers, they may not be extended the necessary level of patience and understanding. The support of NGOs or family and friends can help mitigate some of the stress of re-entering the workplace.

Organisations providing integration and reintegration assistance agreed that this last stage is the most indefinite in time. As one suggested:

[The process is] long and painful. Some issues will most probably never be solved, recovered or redeemed, such as emotional damage and sometimes physical damage, but most of all, [damage] to the integrity of the women. Whatever help is given to them is at the end of the line. They have [already] become a victim and have to learn to cope with that. In most cases they will live an unprotected life, either from authorities or traffickers, in fear and social isolation.

STV,
Netherlands

Those groups assisting trafficked women pointed out that there is no blueprint for the processes of integration or reintegration. Although there are identifiable patterns of health needs that can be prepared for, individuals are affected differently and care must be responsive to each woman's unique needs.

5.5 Support for support workers

Western psychology and counselling always work towards something, usually a solution of some kind. In cases of trafficking of women, workers should learn and understand that, among other things, trafficking exceeds

our frame of reference... It destroys individuals' lives and there is no instant cure or redemption. Workers need to learn how to work with their own disillusionment and impotence.

STV,
Netherlands

Working with trafficked women, while rewarding, can also be disconcerting and stress-filled. Animus Association Foundation, Bulgaria, acknowledged the pressure on their staff. "Very often we feel at a dead-end. Helpless."⁷⁷

Some trafficked women benefit from treatment and assistance better than others. Providers are at risk of perceiving that they have somehow failed when women falter, leave the program, or do not meet their expectations. Individuals assisting trafficked women may find it difficult to accept that, despite their efforts, some women will not be able to re-adapt in ways the provider believes are healthy.

Not only may support persons misjudge the limitations of their assistance – and the limitations of victims to respond – but individuals who are overworked and heavily relied on may neglect to recognise their own need for psychological support in their work. Even the most seasoned professionals can experience intense feelings of hopelessness, disappointment, failure, anxiety, or anger from working with victims.⁷⁸ Clinical psychiatrist, Stuart Turner, notes that when providing support to survivors of torture:

...there are at least two people to consider. In addition to the needs of the patient...those of the health professional...must be taken into account... One of the most common difficulties occurs when the doctor or therapist is overwhelmed by the history of torture and the reaction of the survivor. There may be times when this tends to lead to a problematic, even damaging response.⁷⁹

He further outlines four common feelings that occur among therapists. The first is a sense of "hopelessness," or the overwhelming feeling that the individual simply has too many problems for the care-giver to help in any adequate way. This may, in turn, hinder the care-giver from addressing problems that may be treatable. Second is the feeling of "omnipotence" which may cause a care-giver to believe she must take on all of the woman's problems – this is sometimes fed by the victim's real and self-perceived dependency. Third, a care-giver may feel "punishing," or as if they wish to reject the person who is disturbing their own equilibrium. Finally, Turner

points out that some care givers feel “avoidant” or wish to ignore or deny the individual’s problems, and this, he suggests, may lead to denial of access to treatment.

Experts in the field of violence against women highlight the importance of providing support and counselling, including regular debriefing sessions, for individuals working with victims.⁸⁰ The extreme nature of women’s experiences and the correspondingly intense demands placed on care-givers indicate that providing support for staff is an essential element of any program assisting trafficked women.

Concluding remarks

The integration and reintegration stage can be a time of great trial and tribulation for trafficked women and for their support network. It can also be a period that includes triumphs over practical, emotional, and social hurdles. A great deal depends on the resources of the assisting organisation, the woman’s support network, and her own resilience.

Above we have offered an extremely broad outline of the process of integration and reintegration. This is in no way meant to represent a blueprint for service provision or a profile of all women’s needs. It is presented in order to indicate that patterns of need and care exist, and that it is possible to move away from a primarily reactive approach to a more proactive program that anticipates and is prepared to address key issues. More research is clearly needed, particularly a comparative analysis of international integration and reintegration practices.⁸¹

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6. Human rights analysis of health and trafficking

“Violations of human rights are both a cause and a consequence of trafficking in persons. Accordingly, it is essential to place the protection of all human rights at the centre of any measures taken to prevent and end all trafficking.”

International Principles and Guidelines on Human Rights and Human Trafficking, United Nations High Commissioner for Human Rights¹

The trafficking of women involves a plethora of egregious human rights violations. In the most extreme cases, this includes violation of the most basic right – the right to life. Article 6 of the International Covenant on Civil and Political Rights (ICCPR) states that, “Every human being has the inherent right to life. This right shall be protected by law.”² Trafficking can lead to direct violations of the right to life, as well as indirect violations, such as through the transmission of life-threatening infections, injuries, and illnesses. The physical and psychological toll on women leads to increased mortality and morbidity.³

From the perspective of victims, one of the most serious violations is the denial of the right to health. As described below, a variety of international instruments, such as the International Covenant on Economic, Social and Cultural Rights (ICESCR),⁴ make it clear that States are responsible for providing adequate health care and medical assistance to victims of trafficking.

In addition to being a basic right on its own, the right to health of trafficked women is fundamental to defending other rights, such as the rights to freedom of movement and freedom of expression. Healthy women are more conscious of and better able to defend their rights than women burdened with health problems.

As the victims of the most severe human rights violations, trafficked women have the right to a remedy. No remedy, including the arrest and conviction of a trafficker, is sufficient to redress these violations unless it also includes necessary health care.

This section focuses on the right to health and the many international instruments and policy statements that should act to promote and protect the rights of trafficking victims.

6.1 The UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children

The most important international legal and normative instrument related to trafficking is the 2000 United Nations *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children*.⁵ Thus far, the Protocol has been signed by more than eighty countries, including all 15 EU member states.

Article 3 of the Protocol defines trafficking as:

a) Trafficking in persons shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour, or services, slavery or practices similar to slavery, servitude or the removal of organs.⁶

Article 3(b) makes it clear that “the consent of a victim of trafficking in persons to the intended exploitation set forth in subparagraph (a) of this article shall be irrelevant where any of the means set forth in subparagraph (a) have been used.”⁷

“Exploitation” is the centrepiece of this definition. It is worth noting that neither force nor coercion is a necessary element of trafficking. Any one of a number of other acts, such as fraud, deception, the abuse of power, or position of vulnerability, is sufficient to qualify as a necessary element of the act of trafficking. In this way the Protocol does not distinguish between innocent and guilty, or deserving and undeserving, victims of trafficking, thereby obliging states to provide care for all those identified as victims of trafficking. By removing consent as an issue, the definition also removes a major burden on the victim, as proving lack of consent is a formidable hurdle in legal settings.

Article 6 of the Protocol, entitled, “Assistance to and protection of victims of trafficking in persons,” specifies in subsection (3) that:

Each State Party shall consider implementing measures to provide for the physical, psychological and social recovery of victims of trafficking in persons, including, in appropriate cases, in cooperation with non-governmental organisations, other relevant organisations and other elements of civil society, and, in particular, the provision of:

- a) Appropriate housing;
- b) Counselling and information, in particular as regards their legal rights, in a language that the victims of trafficking in persons can understand;
- c) **Medical, psychological** and material assistance [emphasis added]; and
- d) Employment, educational and training opportunities.⁸

In the United Nations Convention Against Transnational Organized Crime (to which the Protocol is a supplement), article 25, “Assistance to and protection of victims,” states that:

Each State party shall take appropriate measures within its means to provide assistance and protection to victims of offences covered by this Convention, in particular, cases of threat of retaliation or intimidation.⁹

In 1997, the EU’s Council of Ministers, the most senior law and policy making body in the EU, took up the issue of trafficking by issuing, *The Hague Ministerial Declaration on European Guidelines for Effective Measures to Prevent and Combat Trafficking in Women for the Purpose of Sexual Exploitation*.¹⁰ The Declaration calls on EU member states to work together to offer assistance and services to victims. It includes provisions on rights and medical assistance. For instance, Section III states that:

Under international law every state has the duty to respect and to ensure respect for human rights, which includes...to afford...appropriate assistance to those who have been injured by such violations.

Section III.2.1 of the Declaration calls on member states to:

Provide for adequate victim support, including safe shelter, medical and

social assistance, counselling in their mother language or in another language which they understand and speak sufficiently, and adequate financial support.

Section III.3 goes on to state that:

Appropriate assistance and support not only serve to remove or redress the consequences but also, by strengthening the position of women, contribute to the prevention and deterrence of trafficking.

It then instructs member states to:

Provide information about access to health care and to social services for the women involved...

This was followed up with the September 2002 *Brussels Declaration on Preventing and Combating Trafficking in Human Beings*, which has been presented by the EU Commission to the Council of Ministers for action. Representing a consensus of participating EU states, the Brussels Declaration calls for victim protection and assistance. Section 13, entitled “Immediate victim assistance,” states that:

Victims of trafficking must be granted access to a full range of support measures that should include access to shelter accommodation, physical, sexual and psychological health care and support and independent health, legal and social counselling. The provision of such treatment must be on a consensual and fully informed basis...

The obligation to provide medical and other assistance is quickly gaining international recognition beyond the EU, as well. Guideline 6 of the *International Principles and Guidelines on Human Rights and Human Trafficking*, published by the United Nations Office of the High Commissioner for Human Rights, states that:

The trafficking cycle cannot be broken without attention to the rights and needs of those who have been trafficked. Appropriate protection and support should be extended to all trafficked persons without discrimination. States and, where applicable, intergovernmental and non-governmental organisations, should consider:

2. Ensuring, in partnership with NGOs, that trafficked persons are

given access to primary health care and counselling.¹¹

Providing adequate care for and protecting victims' health must therefore be viewed as integral components of a trafficked woman's rights. States must dedicate sufficient resources, in coordination with appropriate non-governmental and intergovernmental organizations to meet the needs of women who have been trafficked.

6.2 The International Covenant on Economic, Social and Cultural Rights and the right to health

Just what is meant by the terms used in international declarations, such as sufficient "medical, psychological and material assistance" (article 6 of the UN Protocol); "assistance to and protection of victims" (article 25 of the UN Convention Against Transnational Organized Crime); "adequate victim support, including safe shelter, medical and social assistance" (section III.2.1 of the Hague Declaration); "physical, sexual and psychological health care and support and independent health, legal and social counselling" (section 13 of the Brussels Declaration); and "ensuring...that trafficked persons are given access to primary health care and counselling" (guideline 6.2 of the UNHCHR International Principles)?

For instance, the "medical, psychological and material assistance" specified in article 6(3)(c) of the Protocol is based on a qualified premise: each State shall "consider" implementing measures to provide this assistance. This apparently discretionary language appears to confer no claimable rights upon individuals.

But the right to health is a fundamental human right enshrined in international law. Article 25(1) of the Universal Declaration of Human Rights affirms that, "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services."

More importantly, the International Covenant on Economic, Social and Cultural Rights (ICESCR), ratified by 142 states, including all 15 EU member states, provides the most important statement of the right to health. Article 12 of the ICESCR states that:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the **highest attainable standard of physical and mental health** [emphasis added].
2. The steps to be taken by the States

Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(d) **The creation of conditions which would assure to all medical service and medical attention in the event of sickness** [emphasis added].

The "highest attainable standard of health" is also the term used in the preamble of the World Health Organization charter. WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."¹²

Additionally, the right to health is recognised in article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965 (CERD),¹³ in articles 11.1(f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979 (CEDAW),¹⁴ and in article 24 of the Convention on the Rights of the Child of 1989 (CRC).¹⁵ Several regional human rights instruments also recognise the right to health, including the European Social Charter of 1961 (article 11, see below).

Use of the terms "highest attainable standards of health" and "creation of conditions" in article 12 of the ICESCR may seem to make the right to health a qualified right. But "General Comment 14" on "the right to the highest attainable standard of health", published by the UN "Committee on Economic, Social and Cultural Rights," makes it clear that state obligations are many and specific.¹⁶ General Comments are the only official, and certainly the most authoritative, interpretation of the provisions of the ICESCR, including the right to health. Paragraph 1 of General Comment 14 states that:

Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity... Moreover, the right to health includes certain components that are **legally enforceable** [emphasis added].¹⁷

The right to health has many components (paragraph 12 of General Comment), including "availability", "accessibility", "acceptability", and "quality." Accessibility is defined to mean that:

...health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in

fact, without discrimination on any of the prohibited grounds...health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups.¹⁸

This definition clearly embraces trafficked women.

“Acceptability” requires that:

All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements.¹⁹

The above is particularly relevant to care for trafficked persons who come from a range of backgrounds.

Article 12.2(d) of the ICESCR, which calls for, “The creation of conditions which would assure to all medical service and medical attention in the event of sickness”, includes, according to the General Comment, “the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care.”²⁰

The ICESCR also prohibits “any discrimination in access to health care...as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion or other opinion, national or social origin...which has the intention or effect of nullifying or impairing the equal enjoyment of exercise of the right to health.”²¹ Given the multiple forms of discrimination experienced by most trafficked women, recognition of this fundamental right to equal access to equal treatment may be among the most important rights.

The General Comment also embraces two major principles of the ICESCR: “progressive realisation” of rights and the “core obligations” of states. The concept of progressive realisation recognises that rights that require the provision of resources cannot always be fully respected immediately (unlike most civil and political rights, which are immediately enforceable) by states that

do not have adequate resources. This concept should not apply to most, if not all, EU countries. As the General Comment puts it:

While the Covenant provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes on States parties various obligations which are of immediate effect. States parties have immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination of any kind (art. 2.2) and the obligation to take steps (art. 2.1) towards the full realization of article 12. Such steps must be deliberate, concrete and targeted towards the full realization of the right to health.”²²

A core obligation is the obligation of a State to fulfil that aspect of a right, without which the right loses its meaning. The General Comment recognises the concept of core obligations by establishing obligations to “respect, protect and fulfil” the right to health.²³ The obligation to “fulfil” is the most meaningful for victims of trafficking, as it incorporates “an obligation to facilitate, provide and promote” the right to health.

The obligation to provide requires states to provide the minimum core health needs, such as essential preventive and primary health care. One recognised source of the content of these obligations is the WHO, which includes basic health services such as maternal and child healthcare, family planning, immunization against major infectious diseases, appropriate treatment for common diseases and injuries, essential drugs, an adequate supply of safe water and basic sanitation, and freedom from serious environmental health threats as part of its basic health strategy.

The failure to provide individuals with basic health services constitutes a prima facie violation of the right to health. To show that it cannot meet its obligations under article 12 of the ICESCR, a State must demonstrate that every effort has been made to use all resources at its disposal as a matter of fiscal priority and that it was still unable to do so. This is a very stringent test, as the General Comment states that even in times of severe resource constraints, States parties have the duty to protect the vulnerable members of society. Further, “states parties are also obliged to *fulfil (provide)* a specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal.”²⁴

As the General Comment makes clear, the duty to

provide health care cannot blithely be dismissed simply by considering the possibility and then dismissing it. The obligation under article 25 of the UN Convention Against Transnational Organized Crime, for example, is clear: “Each State Party shall take appropriate measures within its means to provide assistance...” No EU state can make a serious claim that it is not within its means to provide health care to victims of trafficking within its borders; taken as a whole, any such claim by the EU would not pass the most basic test of rationality.

6.3 The European Social Charter

The European Social Charter (ESC), under the auspices of the Council of Europe, adds even more specific obligations to provide health care to trafficked women. Article 11 on “the right to protection of health,” states that:

With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed *inter alia*:

1. to remove as far as possible the causes of ill-health;
2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
3. to prevent as far as possible epidemic, endemic and other diseases.²⁵

Article 13, “the right to social and medical assistance,” states that:

“With a view to ensuring the effective exercise of the right to social and medical assistance, the Contracting Parties undertake:

1. to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition...”

The ESC sets out “hard-core” provisions, which includes article 13. All EU members have signed the ESC, though some signed with reservations on specific articles. None of the EU member states in this study made reservations on articles 11 or 13. Albania, also the subject of this study, is a signatory, though it has made a reservation on article 13.

With the adoption of a complaint procedure under the European Social Charter the right to protection of health in the ECS is susceptible to review by the Council of Europe. However, this procedure only allows specified organizations to submit complaints, not individuals.

6.4 The rights of migrants

It is often assumed that migrants, including undocumented aliens such as trafficked women, do not enjoy basic rights in a third country. However, international law makes it clear that, with few exceptions, rights are conferred on all “persons,” not all “citizens.” For example, under the International Covenant on Civil and Political Rights (ICCPR), to which all EU member States are a party, all rights conferred apply to all persons within the territory of a state.²⁶ According to the General Comment of the ICCPR (The Position of Aliens Under the ICCPR):

1. In general, the rights set forth in the Covenant apply to everyone, irrespective of reciprocity, and irrespective of his or her nationality or statelessness.
2. The general rule is that each one of the rights must be guaranteed without discrimination between citizens and aliens.²⁷

The General Comment to article 12 (right to health) of the ICESCR elaborates on this, stating:

In particular, States are under the obligation to *respect* the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women’s health status and needs.²⁸

Concluding remarks

Many countries are beginning to allocate significant resources to protect the right to freedom of movement (to fight kidnappings, abductions, and bondage), the right to bodily integrity (to fight rape and other violence), and the right to freedom of expression (to allow women to participate in criminal trials of traffickers and pimps). This is largely done through the efforts at prevention of trafficking through criminal investigations and prosecutions. These efforts must be matched by the allocation of sufficient resources to ensure that the right to health, through treatment, access, and information, is considered an equally high priority.

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- ² International Covenant on Civil and Political Rights (ICCPR) G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, *entered into force* Mar. 23, 1976. Article 6.
- ³ As discussed throughout this report, other basic rights are also violated by trafficking. For example, Article 7 of the ICCPR states that, “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.” Article 8 of the ICPR states that: (1) No one shall be held in slavery; (2) No one shall be held in servitude; and (3)(a) No one shall be required to perform forced or compulsory labour. Trafficking also infringes on other rights, such as freedom of expression, freedom of association and freedom of movement.
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- ⁹ United Nations Convention Against Transnational Organized Crime, G.A. res. 55/25, annex I, 55 U.N. GAOR Supp. (No. 49) at 44, U.N. Doc. A/45/49 (Vol. I) (2001).
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- ¹³ International Convention on the Elimination of All Forms of Racial Discrimination, 660 U.N.T.S. 195, *entered into force* Jan. 4, 1969.
- ¹⁴ Convention on the elimination of all forms of discrimination against women. G.A. res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46. Entered into force Sept. 3, 1981.
- ¹⁵ Convention on the Rights of the Child, G.A. res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989), *entered into force* Sept. 2 1990.
- ¹⁶ United Nations Committee on Economic, Social and Cultural Rights. (2000). General Comment 14, The right to the highest attainable standard of health, U.N. Doc. E/C.12/2000/4 (2000).
- ¹⁷ Paragraph 1, General Comment.
- ¹⁸ Paragraph 12, General Comment.
- ¹⁹ *Ibid.*
- ²⁰ Paragraph 17, General Comment.
- ²¹ Paragraph 18, General Comment.
- ²² Paragraph 30, General Comment.
- ²³ Paragraph 33, General Comment.
- ²⁴ Paragraph 37, General Comment.
- ²⁵ European Social Charter, 529. U.N.T.S. 89, *entered into force* February 26, 1965.
- ²⁶ ICCPR: Article 2(1) all individuals within its territory and subject to its jurisdiction.
- ²⁷ ICCPR. (1986). General Comment 15 on the Position of Aliens under the Covenant. A/41/40, Annex VI
- ²⁸ ICESCR. (2000). Paragraph 34, General Comment.

7. Principles for promoting the health rights of trafficked women

1. The right to health of trafficked women, including the right to necessary care and treatment, is a fundamental human right.
2. Trafficked women have the right to be asked specific questions to determine whether they require medical assistance (physical or psychological). State authorities must fully inform women of their rights to health care, and the health service options available to them. Medical assistance must be provided to trafficked women who request it or require it, before any other action may be taken.
3. No legal proceedings, or other actions that are likely to negatively impact the physical security, or physical or psychological health of trafficked women should be taken by State authorities unless women's health and well-being can be assured.
4. Trafficked women, given the level of harm and mistreatment they have experienced, should be offered access to quality health care on the same basis as citizens of the country which they are in.
5. Trafficked women have the right to non-discriminatory, gender-appropriate health care.
6. In all health interventions for trafficked women, the best interests of the woman must be the primary consideration. Governments, medical professionals, public health workers, and NGOs should collaborate to ensure that necessary and appropriate medical resources, including physical health care and psychological support, are made available. Care should be provided in women's own language, whenever possible.
7. Trafficked women should not be subjected to mandatory medical investigation, procedures or clinical testing, including for HIV/AIDS.
8. Trafficked women's right to privacy and confidentiality must be respected. This includes the right to a private setting for interviews, confidential testing, treatment, and medical files, and non-disclosure of personal information.
9. Trafficked women have the right to their medical and health records. In cases of deportation, removal or voluntary return, these records must be made available to women prior to their departure.
10. Trafficked women have the right to timely forensic examinations and medical reports to pursue cases of sexual or other violence against traffickers.

8. Conclusion: politics and the health of trafficked women

With the rise in international migration and the clandestine movement of individuals across borders, wealthier states are struggling to keep up with the influx of persons and the ever-changing modes of illegal entry. In many states, tightening borders and stemming the flow of migrants has become a populist political issue used in election rhetoric and deemed essential to government approval ratings. Viewing trafficked women as a law enforcement problem rather than as victims needing services, such as healthcare, can have significant effects on policy-making and allocation of funds to assist trafficked women.

Policy-makers and international donors routinely divide trafficking interventions into three categories: prevention, protection, and prosecution.¹ Prevention and prosecution commonly involve law enforcement, and focus on deterrence of illegal immigration. Prevention efforts may include improving border control and detection measures, and public awareness campaigns warning women about trafficking. These are primarily aimed at stopping irregular migration. Actions related to prosecution involve strengthening legislation related to trafficking, and increasing the arrest and prosecution of international traffickers. Protection is meant to include measures aimed at assisting the victims of trafficking. It is under this heading where the health and care of victims is generally addressed.

Not surprisingly, a great deal of international debate and resources have been targeted at prevention and prosecution efforts, while protection and assistance measures have received relatively less attention. Why?

First, as some have posited, decisions over allocation of resources centre around the immigration debate and come down to state security versus human security. Posed this way, concerns about state security have taken precedence.² The human rights, health, and security needs of trafficked women have thus been pushed down the agenda. While the non-governmental sector, in particular, has been promoting the human rights of victims, and working to foster the inclusion of trafficked women's rights in international instruments and national legislation, organisations providing assistance and services in countries of destination and origin remain relatively unrecognised and seriously under-resourced.

Second, prevention and prosecution activities, such as public awareness campaigns or development of new legislation, are seen to be more desirable because they are considered to be finite. From a funding and

implementation standpoint, they have a beginning and an end. "Inputs" and "outputs" can be more easily accounted for. Health care and treatment for victims of trafficking, like health care in general, can be a long-term prospect requiring significant input, with limited (numbers of persons assisted per invested resources) and sometimes uncertain (will the individual recover?) output.

Particularly in the case of trafficked women, as has been suggested throughout this study, the health consequences are commonly severe and long-lasting, indicating that intervention strategies will be resource intensive. Most destination countries do not want to accommodate and pay for new residents or citizens with significant health and social support needs.³ Most countries of origin have limited health resources even for the average needs of their citizens.

Third, the argument is often made that by stemming the problem at the source (prevention or deterrence through legislation and prosecution), women's well-being is being protected. However, at present, there is no sign that the trafficking of women is abating. Women and children continue to be a popular commodity, widely available, and readily moved. Traffickers are generally at least one-step ahead of law enforcement, regularly changing routes and operating strategies.⁴ Moreover, there are few signs that the countries from which women are fleeing are becoming safer, more prosperous places to live and raise a family, or that women have given up trying to escape poverty and unrest. Traffickers will continue to benefit from their desperation. All the indications are that the women will keep coming and will continue to suffer serious and life-impinging harm.

The damage to individual lives cannot be solved solely by tighter border controls, criminal trials, or awareness posters. Those who work towards improving support for trafficked women must aim for more than stronger laws, policies, and human rights provisions on paper. They must recognise that each individual woman has survived an experience of extreme violence and life-changing intimidation that requires the utmost individual attention and care. Service organizations carrying the human toll of this crime need recognition, funding, support, and gratitude.

Violence against women rarely results in finite consequences that can be addressed with a prescriptive or band-aid approach. Trafficking harms women in insidious ways that create 'messy' health problems. The physical and mental health consequences are not a side effect of trafficking, but a central theme. The aim of laws, funding, and resources should be to address the human consequences of trafficking and to assist women in recovering as much of their well-being as possible. This can, and must, be done as a complement to principled immigration policies of destination countries.

Conclusion

References

¹ United States Agency for International Development. (2003). *Trafficking in persons: the USAID strategy for response. February 2003*. [On-line report] URL. <http://www.usaid.gov/wid/pubs/pd-abx-358-final.pdf>

² Beare, M.E. (1999) Illegal migration: personal tragedies, social problems, or national security threats? In Williams, P. (Ed.), *Illegal immigration and commercial sex: The new slave trade*. London: Frank Cass.

³ For wealthier states, deportation is the preferable political and economic option. Although it has been argued that women who return to their own country will be safer in their own home, receive more culturally appropriate care, and better family support. This report however, has highlighted some of the deficiencies with this theory. Women who return home risk retribution and re-trafficking, face costly and poor health services, and often experience stigmatization and rejection by family and community members.

⁴ Graycar, A. (1999). Trafficking in human beings. *Paper presented at the International Conference on Migration, Culture & Crime*, Israel, 7 July 1999.

Recommendations

These recommendations are intended for States, non-governmental organizations, international organizations, and donors. To the greatest extent possible, these entities should work together to develop and implement the following recommendations.

1. Recognise trafficking as a health issue.
2. Recognise trafficked women's and adolescents' (hereafter referred to as "women") rights to health and health services as primary and fundamental elements of their legal and human rights.
3. Increase the priority and funding accorded trafficked women's health and protection to a level commensurate with the severe harm caused by trafficking.
4. States should adopt the UN Palermo Protocol.¹ States and donors should increase their commitment and financial support in order to implement provisions proposed in Article 6,² specifically to provide for the physical, psychological, and social recovery of female victims of trafficking, including medical, psychological, and material assistance, appropriate housing, counselling, legal information, and employment and training opportunities. Services should be gender and culturally appropriate.
5. Develop health and health-related prevention and intervention strategies for trafficking based on existing models of good practice established for other forms of violence against women (e.g., domestic violence, rape and sexual abuse) and models established for integration and reintegration of refugees and returnees (e.g., ECRE's *Good Practice Guide on the Integration of Refugees in the European Union*).³ Models should include gender- and culture-specific strategies developed for medical care, social service practices, medical and health education, public awareness, and protocols and training for law enforcement response (i.e., police response protocol and officer training for cases of rape, sexual assault, and domestic violence).
6. Increase awareness of the health risks and consequences of trafficking among governments, key policy-makers, public health officials, health care providers, law enforcement agencies, relevant non-governmental and international organisations, and donors.
7. Fund, develop, and implement training and education programs for health care providers in relevant sectors that include, but are not limited to: information on trafficking, physical, sexual, reproductive, and mental health consequences, and culturally competent treatment approaches.
8. Reduce the political, social, legal, and financial barriers that impede measures that promote the well-being of women at risk of being trafficked, and that hinder the provision of adequate health interventions for those who are trafficked.
9. Fund and promote health outreach services to vulnerable migrant women in sectors known to employ trafficked women in destination countries, and ensure that care is offered in appropriate languages.
10. Fund the development of victim-sensitive procedures to be used by law enforcement officials to identify, interview, and assist trafficked women.
11. Promote the development of a European Union and/or World Health Organization document to be distributed to migrant and travelling women from known countries of origin (produced in various languages) that includes, but is not limited to:
 - Summaries of primary health risks and consequences related to migration and trafficking;
 - Definitions and descriptions of symptoms of common and severe illnesses among migrant and trafficked women, and related treatment options;
 - Definitions of trafficking, various forms of gender-based violence, and forms of exploitation, including descriptions of the health implications; and
 - Translations of key health words and phrases in relevant languages of origin and destination.
12. Respect and apply the principles set forth in the European Council on Refugees & Exiles' (ECRE) *Good Practice Guide on the Integration of Refugees in the European Union*,⁴ integrating measures to meet the special needs of trafficked women (see *Integration and reintegration recommendations*). Specifically implement measures to meet the principles outlined for "health," including recognition that:
 - "...lack of adequate and healthy reception conditions during the initial phase of arrival can seriously undermine refugee long-term health and integration prospects."
 - "...specialised refugee services should form a permanent part of mainstream health provision and benefit from long-term public support. They should act as "bridges" to mainstream provision and focus on specific care and

treatment needs resulting from experiences in the country of origin and during a refugee's flight to safety."

- "...key priority should also be given to the establishment of interpreting and mediation services as well as the promotion of health education and prevention programmes."

13. Fund and carry out research on:

- Effective mechanisms for disseminating health-related information to migrant women, including a review of currently available information targeted at migrant women.
- Models of multi-disciplinary services working with migrant women at risk, including a review of outreach practices.
- Short and longer-term psychological outcomes of victims of trafficking.
- Statistical analysis of physical and mental health outcomes among trafficked women.
- Social well-being and the process of integration and reintegration among trafficked women.
- Models of service provision for integration and reintegration.
- Health-related services for victims of other forms of gender violence (i.e., intimate partner violence, sexual assault) to compare to current practices and advance existing support services for victims of trafficking in women.
- Good practice procedures and guidelines used by law enforcement officials, health care providers, and NGOs to assist victims of sexual assault and domestic violence that can be used as models to develop guidelines for trafficked women.

Pre-departure stage recommendations

States, non-governmental organizations, international organizations should work together to:

14. Incorporate health-related information into anti-trafficking programs and prevention campaigns. Prioritise at-risk and vulnerable females (i.e., single females with children, victims of sexual abuse or domestic violence, orphans, female refugees, and women in areas of extreme poverty known for recruitment for smuggling and trafficking).
15. Provide information to migrating women prior to their departure on basic health issues, rights to health services, and contact details of service providers in destination countries.
 - Information should be designed based on existing health knowledge and documentation

(e.g. World Health Organization, Tampep, Europap). Information should include, for example, prevention strategies, descriptions of symptoms of illness and infection, and on locations for treatment (including for sexual and reproductive health, infectious and transmissible diseases, nutrition, violence, addictions, and mental health problems).

- Information should be exchanged nationally and internationally through existing networks.
- States should establish mechanisms to distribute information to migrating women travelling from known countries of origin.

16. Strengthen public health promotion campaigns that provide information on trafficking in women, women's health, including sexual and reproductive health, and medical and health interventions through school-based curricula, and mainstream media. Specifically:

- Incorporate the subject of trafficking and the associated risks and health consequences into existing health-related programs, policies, education, and curricula (e.g., Ministry of Health, medical schools, international donor-funded health projects).
- Include information on trafficking, sexual and reproductive health, violence against women, and basic health in school curricula.

Travel and transit stage recommendations

States, law enforcement agencies, non-governmental organizations, and international organizations should work together to:

17. Develop and disseminate information on health, health services, and emergency contacts to migrant and travelling women from known countries of origin at points of departure, transit, and entry (e.g. consulates, embassies, train stations, airports, taxi cabs, harbours, immigration checkpoints, motels, hostels, and travel agencies). Specifically:
 - Provide information in both the woman's original language, and the language of the country to which she is travelling.
 - Strengthen coordination between NGOs and State officials in known countries of origin and those working at or near travel and transit locations in order to promote dissemination of information.
 - Develop sector-specific information for the travel and transportation industry that describes trafficking, and that lists local health and emergency resources available to migrant or immigrant women.

The health risks and consequences of trafficking in women and adolescents. findings from a european study.

- Strengthen coordination between anti-trafficking groups and individuals working in the travel and transportation industry to sensitise them to the problem of trafficking, enlist them to disseminate multi-lingual information, and refer migrant women in need of assistance to appropriate services.

Destination stage recommendations

States, non-governmental organizations, international organizations, and donors should work together to:

18. Require ministries of health and other key health policy-makers to formally recognise trafficking as a health problem, include trafficking as a health issue in strategic planning, and allocate funds for health interventions.

19. Establish a government-funded or internationally-funded independent coordinating body in each known country of origin and destination to:

- identify and develop a referral network of services nationally and internationally;
- disseminate service information, legal information, and news updates between groups; and
- coordinate the development and dissemination of health information for migrant women in multiple languages.

20. Improve health standards in high-risk work venues.

21. Provide funding and support for existing government and non-governmental organisations (e.g., health-related, legal services, NGOs) to augment their services to meet the range of health needs of women who may have been trafficked (i.e., migrant women working as sex workers, domestic workers, factory and agricultural labourers, street beggars). In particular, to enable providers to:

- provide support for increased outreach activities and mobile clinics to reach vulnerable female migrant populations.
- support organisations to establish in-house medical care or to facilitate referral to appropriate outside providers, as appropriate.
- make interpreting, translation, and cultural mediation available, as needed.
- ensure confidentiality and anonymity of women using services.
- recognise personal security risks related to trafficking and take appropriate measures to minimise dangers to women and service providers.
- recognise sensitive issues and the appropriate

time and circumstances for inquiries about, for example, a woman's legal status, background, or intimate partner relationships.

22. Require States to adequately fund interpreting and cultural mediation services for health-care providers to ensure correct diagnosis and treatment of migrant women.

23. Provide support for the development of literature on health and trafficking for service providers, including:

- a handbook describing trafficking in women, the ways that a range of possible treatment strategies be used by health practitioners.
- a resource book describing multi-cultural aspects of health, including country-specific and culture-specific descriptions of health-related beliefs, practices, disease rates, treatment, services, etc., for use by health practitioners.

Detention, deportation, and criminal procedures stage recommendations

States, law enforcement agencies, non-governmental organizations, and international organizations should work together to:

24. Develop and fund training and sensitisation programs for police and immigration officials that incorporate:

- definition and description of the dynamics of gender-based violence and trafficking in women;
- definitions and descriptions of the health related risks and consequences of trafficking;
- recommendations for appropriate responses, including treatment, protection, and referral;
- procedures for identifying and addressing women's physical and mental health needs; and
- victim-empowering means of establishing trust to obtain accurate and reliable criminal evidence.

25. Develop a set of evidence-based health assessment procedures to help women decide if they are physically and psychologically prepared to submit to an interview or participate in an investigation.

26. Develop and implement victim-sensitive guidelines for law enforcement personnel (i.e., immigration and police) based on existing models of good practice for other forms of gender-based violence (see above general recommendations no. 10) for use with women who are detained, or taken into custody and

suspected of having been trafficked. Guidelines should incorporate provisions that require officials to:

- Ensure migrant women from known countries of origin are asked appropriate questions in their own language by a neutral interpreter to ascertain if they have been trafficked.⁵
- Ensure women suspected of having been trafficked are treated as victims of crime, and accorded all of the rights available to victims involved in criminal investigations.
- Ensure that women are asked in appropriate ways, in a private setting, whether they have any immediate or urgent health concerns.
- Ensure that once a preliminary interview has been conducted, no full, in-depth interviews take place until women have the opportunity to meet with a specially trained health professional who can assess their physical, sexual, and mental health needs.
- Ensure that women who are psychologically unprepared to submit to questioning, or who are likely to be traumatised by an interview, receive professional assistance and sufficient respite that enables them to withstand the physical and psychological stress of interviews with officials.
- Ensure women are offered the option to be seen by a female or male health practitioner, and that female and male practitioners are readily available to respond when contacted.
- Ensure that before any meeting or interview takes place, women's basic needs are provided for (i.e., food, rest, urgent health needs).
- Ensure that meetings with medical practitioners, NGOs, or law enforcement officials take place in a private setting, in the women's own language, and in a culturally and gender appropriate manner.
- Ensure that if at anytime before or during an interview with officials women report or exhibit signs of trauma, or symptoms of a medical problem, the interview is postponed or terminated and women are immediately referred to an appropriate medical professional.
- Ensure that women are fully informed of their right to a forensic medical exam, and that, in all cases where a woman consents to the collection of forensic evidence, medical procedures are carried out promptly, in a gender and culturally sensitive manner, and according to professional standards consistent with model procedures for victims of sexual assault or domestic violence.
- Promote the participation of non-governmental organisations or specially trained government services to advise women while they are in detention or custody, and to provide

psychological support, and assistance with other service needs, as required (e.g., legal, social, health).

27. Recognise the personal safety and mental health risks associated with providing criminal evidence and testifying, and develop procedures to minimise the risks.
28. Provide a reflection delay of no less than three months that includes immediate access to all necessary health and health-related services in cases where there are indications that women have been trafficked.
29. Develop and promote legislation that permits women who have been trafficked the right to remain in countries of destination without the obligation to testify.
30. Increase the availability of state-sponsored victim protection measures available to women willing to provide criminal evidence in trafficking cases, and establish appropriate regulations to ensure that relevant agencies automatically provide information about victim protection measures available to vulnerable witnesses.
31. Require law enforcement officials to inform women of the risks of providing criminal evidence, and of testifying, prior to taking their statement. Descriptions of risks may include danger of reprisals to her or her family, potentially aggressive in-court interrogation by defence lawyers during trial, and potential for retraumatisation.
32. Promote the development and implementation of measures in court proceedings that minimise unnecessary trauma and psychological distress to women who testify against alleged traffickers, such as pre-trial and post-trial psychological support, separate entrances and waiting areas for witnesses, preliminary deposition of evidence, testimony in the absence of alleged traffickers and admissibility of testimony given to social workers or support persons.⁶
33. Recognise the functions and aims of NGOs and social services agencies providing humanitarian assistance to trafficked women as separate and distinct from those of police and immigration, and respect their independent role.
34. Ensure that proceeds confiscated from traffickers are used to fund victim-assistance programs, and that victims are informed of their legal rights to claim compensation from traffickers.
35. Offer women who present physical or mental health

complications the opportunity to remain in countries of destination or transit until adequate and successful treatment can be administered, or until sufficient financial and practical provisions can be made to ensure they receive appropriate care in their country of origin.

36. Offer women the opportunity to remain in countries of destination or transit when there is a reasonable suspicion they may suffer harm from reprisals or stigmatisation upon returning home.
37. Require states to collect and maintain up-to-date contact information for NGOs in countries of origin that can help facilitate women's safe return and access to medical care and support services.
38. Require immigration services to give women who are returning to their country of origin the option of being met at the port of entry by a family member or a local NGO representative, and to facilitate this encounter. However, no arrangements should be made without the explicit consent of the woman.
39. Develop confidential procedures to enable women returning to countries of origin to obtain and carry with them any personal medical records.
40. Protect women from discrimination and stigmatisation and ensure their right to privacy by prohibiting immigration and police officials in destination countries from revealing to officials in countries of origin that a woman had been trafficked, unless the woman requests otherwise.⁷

Integration, reintegration stage recommendations

States, non-governmental organizations, international organizations, and donors should work together to:

41. Incorporate training and sensitisation information on trafficking in education and training curricula for health care providers. Information should, at minimum, include:
 - definition and description of trafficking in women;
 - health, trafficking, and human rights;
 - descriptions of the range of health risks and consequences associated with trafficking;
 - opportunities and obstacles to the care and treatment of trafficked women;
 - the negative effects of stigma and discrimination on care and treatment; and
 - the benefits of and methods for providing culturally competent and socially sensitive care.

42. Increase state and international donor funding to improve medical care, housing, psychological support, and educational and occupational training options for women who have been trafficked.
43. Integrate programs for trafficked women within other existing programs and services (e.g., health, refugee, legal aid, social support services, domestic and sexual violence), where appropriate.
44. Recognise the long-term health consequences of trafficking (particularly mental health outcomes), and provide state and international donor funding to support long-term care strategies.
45. Recognise the importance of a woman's legal status to individual health and well-being, and implement measures that avoid delays in according trafficked women residency status.
46. Increase funding for NGOs assisting trafficked women to pay for external medical care and/or to provide in-house medical care to trafficked women.
47. Increase recognition of the wide range of different responses women may have to a trafficking experience, thereby avoiding the categorical "victim" stereotype or the "pathologising" of normal reactions to extraordinary circumstances. Affirm women's strengths and courage, while also being prepared to support women's physical, psychological, social, and occupational needs.
48. Recognise the importance of promoting women's active and consistent participation in all aspects of care, including diagnosis, treatment strategy, and integration or reintegration strategies.
49. Improve communication between service providers and women in their care to ensure that both are clear about the obligations and limitations of the service relationship. This may include, for example, clarifying the woman's expectations of the services by enumerating what the service organization is able to offer, its limitations, legal and organisational restrictions, and what the provider expects of women in their care.
50. Recognise the importance of culturally and socially sensitive care to integration and reintegration.
51. Increase the capacity of health service providers and those providing services for trafficked women to offer and/or refer women to culturally competent and non-judgemental care by funding measures, including the development of multi-cultural health awareness materials (see *Destination stage* recommendation, no. 23), and exchange of

information within the health sector, cross-sectorally, and internationally.

have been sexually abused or exploited, or immigrants.

52. Fund and promote mechanisms to share good practices, exchange information, and confidentially obtain advice on specific cases between care providers for trafficked women from different sectors (e.g. refugee services, cultural centres, anti-trafficking organisations) within the same country and internationally, as appropriate.
53. Recognise the value of holistic approaches to improving women's health and well-being, such as multi-dimensional projects that combine practical income generating or educational and training activities with psychological and social support mechanisms (e.g., community development projects, women's collectives, education and training programs).
54. Recognise and fund key service provision components that foster women's health and well-being, including:
- ensuring personal security;
 - providing for basic needs;
 - providing support to women who wish to make contact with, or return to family members to enable them to do this in confidential and physically and emotionally safe ways;
 - assisting with necessary documentation;
 - arranging and accompanying women to medical appointments;
 - offering screening for key health concerns, including, pregnancy, STIs (including HIV/AIDS), other infectious diseases;
 - offering voluntary counselling and testing (VCT) for HIV/AIDS, according to internationally established standards;
 - offering written information in the woman's own language on STIs (including HIV/AIDS), signs and symptoms of common injuries and illnesses, common and severe mental health responses to trafficking;
 - providing or referring women to a range of social support services, including occupational training and educational opportunities;
 - identifying culturally and socially appropriate strategies to establish trust;
 - providing interpreting and cultural mediation;
 - developing international, local, and regional links with other providers;
 - developing culturally competent care and referral to other culturally competent service providers; and
 - identifying and referring women to care providers who do not discriminate against trafficked women, sex workers, women who

55. Fund and strongly promote public awareness campaigns aimed at eliminating discrimination against immigrants and the stigma associated with trafficking in women.

References

¹ United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing The United Nations Convention Against Transnational Organized Crime.

² Section II, Article 6 *Assistance to and protection of victims of trafficking in persons*:

“3. Each State Party shall consider implementing measures to provide for the physical, psychological and social recovery of victims of trafficking in persons, including, in appropriate cases, in cooperation with non-governmental organizations and other relevant organizations and other elements of civil society, and, in particular, the provision of:

(a) Appropriate housing;

(b) Counselling and information, in particular as regards their legal rights, in a language that the victims of trafficking in persons can understand;

(c) Medical, psychological and material assistance; and;

(d) Employment, educational and training opportunities.

4. Each State Party shall take into account, in applying the provisions of this article, the age, gender and special needs of victims of trafficking in persons, in particular, the special needs of children, including appropriate housing, education and care.

5. Each State Party shall endeavor to provide for the physical safety of victims of trafficking in persons while they are within its territory. Each State Party shall ensure that its domestic legal system contains measures that offer victims of trafficking in persons the possibility of obtaining compensation for damages suffered.”

³ The European Council on Refugees & Exiles (ECRE) ECRE Task Force, Gaunt, S. et. al. (eds.) "Good Practice Guide on the Integration of Refugees in the European Union": http://www.ecre.org/erfproject/good_practice/intro.pdf

⁴ The European Council on Refugees & Exiles (ECRE) ECRE Task Force, Gaunt, S. et. al. (eds.) "Good Practice Guide on the Integration of Refugees in the European Union": http://www.ecre.org/erfproject/good_practice/intro.pdf.

⁵ Pearson, E. (2002) *Human traffic, human rights: redefining victim protection*. London: Anti-slavery International.

⁶ Ibid.

⁷ Ibid.

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