Trafficking in women
The health of women in post-trafficking services in Europe who were trafficked into prostitution or sexually abused as domestic labourers

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Abstract

Background

The trafficking of women and adolescents into exploitative and forced labour is a growing crime and a severe form of violence against women. Little theory or research-based evidence currently exists on the health risks and consequences associated with trafficking.

Objectives

This thesis presents conceptual models and describes systematically collected data on the health risks and consequences of trafficked women and adolescents, and considers methodological implications of research with this vulnerable group.

Methods

Two studies, one qualitative and one quantitative, were conducted with women trafficked predominantly for sexual exploitation. The formative research exploring trafficking-related health risks was carried out in five European states with a total of 28 women. The quantitative survey was conducted with a cohort of 207 attending post-trafficking services in seven European States. Semi-structured interviews were carried out over three time periods (0-14 days, 28-56 days and 90+ days) to document reported pre-trafficking and trafficking-related risk exposures and post-trafficking physical, sexual, reproductive and mental health symptoms.

Results

Risk exposures included high levels of pre-departure and in-trafficking violence (physical and/or sexual). Perceived physical health symptoms were prevalent, especially at the first interview, with neurological symptoms (e.g., headaches) being the most prevalent and persistent. Most physical symptoms reduced between the first and second interviews.

Symptoms suggestive of post-traumatic stress disorder were reported over the three interviews by 56%, 12% and 7% of women, respectively. Depression levels remained extremely high throughout the study. Anxiety and hostility levels were also high, but decreased more than depression.

Conclusions

These descriptive analyses offer theoretical models and new evidence on risk and health symptom patterns. Findings suggest the need for urgent and long-term comprehensive health care services, an adequate legal period of recovery and reflection, and research methods sensitive to the risks associated with studying this vulnerable population.

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Abbreviations

BSI	Brief Symptom Inventory
CAST	Coalition Against Slavery and Trafficking
CWASU	Child and Woman Abuse Studies Unit
EU	European Union
GAATW	Global Alliance Against Trafficking in Women
HIV	Human Immunodeficiency Virus
HTQ	Harvard Trauma Questionnaire
IOM	International Organization for Migration
LMU	London Metropolitan University
LSHTM	London School of Hygiene & Tropical Medicine
NGO	non governmental organisation
OSCE	Organization for Security and Cooperation in Europe
PTSD	Post-traumatic stress disorder
STI	sexually transmitted infection
ToP	termination of pregnancy
UK	United Kingdom
UN	United nations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNIPD	University of Padua's Department of Sociology
US	United States
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

Trafficking in women has been viewed by many as a problem of law enforcement, immigration or women's rights.[1-5] For a growing number of advocates and academics, trafficking is part and parcel of the dialogue on labour exploitation and globalisation.[6-8] For some, trafficking discussions occur only within a prostitution-sex work debate.[9-12] Yet, despite the obvious adverse health repercussions of this form of abuse, women's health is an aspect of trafficking that is regularly neglected. For the women who are trafficked, trafficking is about survival, health and future well-being. As noted by Salt and Hogarth at the time this research began:

> [A] little-explored aspect of trafficked migrants is the health factor...Almost no work has been done on the impact trafficking has on the health of migrants and those who deal with them".[13]

To respond to the absence of research on trafficking and health and to foster a more informed dialogue on victim protection, two studies—one qualitative, one quantitative—were carried out between 2001 and 2005 that specifically focussed on the health risks and consequences associated with trafficking in women. Both research projects were collaborative university-NGO, multi-country studies funded by the European Commission's Daphne Programme. These studies are the subject of this thesis. The aims of this thesis are to:

1) identify a range of health issues associated with trafficking in women;

2) describe operationalisable conceptual models for studying health and trafficking in women;

3) describe women's exposure to abuse and other health risks;

4) measure the physical, sexual, reproductive and mental health symptoms and symptom levels perceived by women in post-trafficking service settings;

5) review women's post-trafficking symptomatology over three time periods;

6) document how individual women perceive their health following a trafficking experience;

7) discuss the implications of the health risks and consequences for policies and services for trafficked women;

8) Propose policy recommendations to improve post-trafficking medical and other health care services; and

9) Propose methodological recommendations for future studies on health and trafficking in women.

These studies represent research on a limited population of women who were trafficked either to or from a European setting, were sexually exploited and were in contact with service providers.

The initial formative, qualitative study contributing to this thesis was conducted between 2001 and 2003 in five countries in collaboration with three

non-governmental organisations and two university partners. This research project was designed as an "exploratory study"[14] because it was among the first attempts to delve into the area of health and trafficking. It set out to map the health risks and consequences and key intervention issues associated with trafficking, as well as to establish conceptual models through which health in the context of trafficking might best be investigated. Qualitative data were gathered via interviews with women who had been trafficked and with diverse key informants, such as health care providers, law enforcement and immigration officials, non-governmental organizations and policy makers. By identifying and situating a broad set of trafficking-related health factors, this study was intended to serve as the basis for the quantitative research that followed. It also raised and discussed important methodological dilemmas inherent in conducting research on the health of women who have been trafficked, in particular, the ethical and safety dimensions of this type of research. The study resulted in the report: *The health risks and consequences of trafficking in women and adolescents.*[15]

The second study, which comprises the majority of the results chapters of this thesis, was a quantitative survey of a consecutive cohort of women entering seven post-trafficking service organisations. This study measured women's exposure to abuse and explored perceived physical and psychological health consequences. The research was conducted collaboratively with non-governmental and international organizations in seven countries, between 2003 and 2005. The study had a prospective component—interviewing women over three time intervals—in order to capture how women perceived changes in

symptoms. It resulted in the report: *Stolen smiles. The physical and psychological health consequences of women and adolescents trafficked in Europe*[16], which provided an important new evidence-base to inform policy and service strategies.

This thesis represents the combined knowledge generated from these two research projects. Findings are descriptive analyses. Future multivariate analyses are needed to explore possible associations, for example, between different exposures and reported health symptom levels. These analyses were beyond the scope of this thesis.

The next chapter, Chapter 2: *Background*, presents a review of the literature that informed both studies. In specific, the *Background* chapter provides general information on trafficking in women, including discussions on the difficulties associated with definitions, prevalence estimates, the diverse dynamics and patterns of trafficking, descriptions of "traffickers" and "women who are trafficked" and the limited existing literature on health and trafficking. It then describes relevant aspects of key bodies of literature (sex work, migrant women, labour exploitation, violence against women and torture) to identify conceptual, methodological and substantive issues related to health risks and outcomes.

Chapter 3, *Conceptual models and ethical and safety guidance* offers descriptions of the two conceptual models and discusses the foundation for the ethical and safety approaches used in these studies. Discussions of each conceptual model include an overview of the literature that informed the models and descriptions of the models, including their potential theoretical and

methodological application. The first model, the *Stages of the trafficking process,* depicts health from a migratory perspective, following the geographical movement and/or time cycle of an individual's experience. This multi-staged model formed the primary theoretical foundation for both studies. Each stage of the model is defined, and the main health factors are described. The second conceptual model, *Abuse, health risks and consequences*, functions in conjunction with the first model, complementing it by providing a detailed structure from which to examine specific health dimensions (e.g., physical health, sexual health, psychological health, occupational health). Together, these models provide operationalisable framework to integrate knowledge about the health of trafficked women. This chapter concludes with an explanation of the ethical and safety implications (e.g., physical, psychological and social risks) of studying women who have been trafficked and a description of the recommendations developed for interviewing trafficked women.

Chapter four, *Methods,* outlines the methodological steps used in both studies. For each study, it describes: the aims; research partners; study instruments; participants/study sample selection critieria; fieldwork; data transfer and entry; and analytical framework. Where relevant, explanations are offered for some of the methodological decisions made in response to the somewhat unique practical, ethical and safety constraints and support opportunities associated with carrying out a study on this highly vulnerable and generally distressed population.

Chapter five, *Formative study on health risks and consequences associated with trafficking* is the first of the results chapters, and presents findings from the formative study. Results from this exploratory research are presented in order of the stages of the trafficking process: 1) pre-departure stage; 2) travel and transit stage; 3) destination stage; 4) detention, deportation and criminal evidence stage; 5) integration or reintegration stage. The pre-departure section focuses on events that occurred before women left home, e.g., reasons for leaving home, exposure to violence. Transit and travel describes the risks women faced while moving from home to destination points. The destination section describes a range of health risks women reported, such as physical and sexual violence, psychological abuse, and drugs and alcohol use. The detention section describes authorities' views of health and trafficking, and women's experiences in the custody of authorities. Data presented in the reintegration/integration section primarily highlights the views of service providers and assistance provided to women during this stage.

Chapter six, *Study sample characteristics*, describes the demographic characteristics of the sample group of participants for the quantitative survey. This chapter offers a profile of the women in the study, including basic demographic data, such as women's age, countries of origin and destination, marital status, number of children, pre-departure residence and the time women spent in and out of the trafficking situation.

Chapter seven, *Risk exposures*, describes the different exposures to violence and other health risks. This chapter includes a data on sexual and

physical violence women experienced as an adult or child prior to being trafficked, as well as violence, threats and restrictions they experienced while in the trafficking situation. This chapter also discusses data on drug and alcohol use while in the trafficking situation.

Chapter eight, *Physical health symptoms* describes women's perceptions of their physical health, detailing specific symptom severity in nine domains (e.g., neurological, sexual and reproductive, gastrointestinal). Changes in women's symptoms are measured over three time periods (0-14 days, 28-56 days and 90+ days). Women's qualitative comments are included to add depth and expression to the statistics. This chapter also includes data on the medical attention received by the women remaining in the study at the second and third interviews.

Chapter nine, *Symptoms associated with post-traumatic stress disorder PTSD*, discusses the results of the psychometric scale used to measure symptoms suggestive of PTSD (subscale of the *Harvard Trauma Questionnaire*, *HTQ*) over the three interviews. This chapter includes a description of trauma and its relationship to PTSD. Qualitative comments are integrated to give a voice to women's distress.

Chapter ten, *Depression, anxiety and hostility*, describes the changes in these three symptom levels reported by women, measured by three subscales of the *Brief symptom Inventory*. Each symptom is defined and reporting levels are discussed. Again, quotes from the women highlight the individuality of each woman's distress and show the multi-faceted nature of what might otherwise be considered broad clinical diagnoses.

Chapter eleven, *Identity, coping and hopes for the future*, offers analyses of women's perceptions of themselves after the trafficking experience and how they imagined their future. This chapter gives weight to what are generally considered non-clinical mental health issues, showing, for example, the relevance of guilt and shame and the importance women place on what they foresee (or not) for themselves in the future.

Chapter twelve, *Discussion*, presents interpretations of the key findings and discusses their implications for victim assistance services and policies and for future research. The limitations of the study are first described. This is followed by discussions of various findings and their implications for health care, law enforcement and policy-making on trafficking.

CHAPTER 2: BACKGROUND

2.1 Chapter introduction

This chapter describes the background theory and data that informed the studies conducted for this thesis. It offers conceptual and evidence-based information from both trafficking- and non-trafficking-related literature. The latter included documentation on forms of violence against women, torture, sex work, and migration, and was examined to supplement the paucity of health-related knowledge on trafficking.

The first step in the literature review was a comprehensive search of the published and grey literature on trafficking in human beings (general), women, and children in Europe. Literature on trafficking to and from the countries participating in the study was of particular interest, as was documentation on common countries of origin and destination for the women most likely to be interviewed during the studies (e.g., Albania, Thailand, Nigeria, Kosovo, Russia, Turkey). Documents on trafficking in other regions (Africa, South Asia, Southeast Asia, Latin America) were also consulted for information on relevant service or policy issues.

The second step was an investigation of resources on related subjects, such as violence against women, torture, migration, labour exploitation, and sex work for relevant background information, data and methodological examples for research on risk and health. These different bodies of work offered theory, conceptual frameworks, potential study instruments, health-related data, case examples, and national, regional and international policies and legislation.

Although not highlighted in this thesis, regular media reports, newspaper articles and trafficking list-serve notes provided useful updates on current developments, and dialogue on trafficking-related issues.

Documents for this study—particularly those proposing theory or policy—were read with an especially critical eye because of the potential for the discourse (trafficking, sex work, immigration, etc.) to be 'politically loaded'. Writing in these subject areas can often reflect information through a politicised/biased lens of the author.

Table 2.1 summarises subject areas within which literature was sought and highlights some of the key sub-topics. This table is meant only as a summary of the topics explored, and is not intended to imply that a thorough review of each body of literature was carried out.

Table 2.1 General subject areas reviewed for studies on health and trafficking

Literature Reviewed	
Subject	**Specific areas**
Trafficking	General, health-related, international, regional, national specific case studies
Gender	Health, rights, globalisation
Violence, violence against women	Theory, research methods, intimate partner violence, sexual abuse, child sexual abuse physical, sexual and reproductive health, HIV/AIDS, mental health, services, risk, study instruments and design
Torture and trauma	Theory, torture methods, physical and mental health outcomes (post-traumatic stress disorder, depression, anxiety, etc.), treatment, services, study instruments and design
Sex work	Theory, sexual and reproductive health, HIV/AIDS, violence, migrant sex work, sociological and political analyses, services, study instruments and design
Migration	Theory, health and health services for refugee and migrant populations
Labour	Migrant domestic labour, other forms of labour exploitation
Ethics and rights	Biomedical ethics, media ethics, women's rights, human rights and gender-based violence- and trafficking-specific rights and standards.
Country-specific	Survey/epidemiological data, gender-specific indicators for health, economic and political status, domestic violence, equality, and political analyses
International instruments, European policy documents and national legislation	Trafficking, asylum, migration, health, women's rights, human rights.

These documentary resources provided background information and guidance for the methodology, and offered theory and data that helped to interpret the findings of both studies. As will be evident throughout this thesis, the studies providing data on health outcomes of other vulnerable groups (e.g., battered women, child sexual abuse survivors, torture victims[a]) were particularly useful as a point of reference and comparison for the findings of these studies.

2. 2 Defining trafficking

The trafficking in women and adolescents[b] into forced sex work and other forms of forced labour or exploitative conditions, has been increasingly recognised as a growing crime, a significant human rights violation, and an important form of violence against women.[17-20] Few corners of the world appear to be free of trafficking.[17, 21, 22]

While trafficking and sexual abuse are by no means new to the world,[23, 24] the rapidly globalising market has made it easier for traffickers to operate across borders and turned individual desperation into a ready resource feeding the demand for exploitable labour. Women and children are frequently highlighted as being particularly vulnerable to trafficking, particularly trafficking for sexual exploitation and forced prostitution.[24-27]

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[a] The term "victim" has been somewhat controversial in feminist discussions (see for example, Kelly, L, et. al. 1996). This thesis generally uses the term trafficked women or women who were trafficked. When the terms "victims" and "survivors" are used, they are meant to be interchangeable, as it is believed that those who have been trafficked and live through this crime are both victims and survivors.

Several of the more recognised forms of trafficking-related exploitation of women include: forced prostitution, domestic servitude, forced marriage, factory and agricultural labour, and street begging.[24, 28, 29] Individuals are trafficked and transported internationally, regionally and internally, within their national borders (although, unjustifiably, internal trafficking receives significantly less attention than international trafficking from poorer to wealthier countries).

The complexity, diversity and controversy associated with this phenomenon has made the search for a definition a "terminological minefield".[30] Although it remains a source of debate,[31] the most commonly accepted definition of trafficking is found in the *United Nations Protocol to Prevent, Suppress, and Punish Trafficking in persons, especially women and children, supplementing the United Nations Convention Against Transnational Organized Crime* (commonly referred to as the *Palermo Protocol*). The Palermo Protocol defines trafficking as:

> 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. [32]

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[b] For brevity's sake, "women and adolescents" will hereafter be referred to as "women". There is likely to be important differences and similarities between the responses of "adolescents" and "older" women that should be explored in the future.

This definition was adopted after a long and difficult process, particularly because of the divisive feminist debate about sex work.[9, 33] Definitional complexities did not disappear even after the ratification of the Palermo Protocol.[c] The difficulty and consequences of separating "trafficking" from other forms of exploitation, for example, still remain matters of current debate.[34, 35]

In reality, wading through the definitional morass between "trafficking", forced labour and other forms of exploitation (e.g., forced begging, bride sales, smuggling with exploitative debt regimes) is a problem that pervades both theoretical discussions on trafficking and practical measures to address it. Each may involve a certain level of coercion and abuse of power or circumstance, and each has larger human rights, legal, and political consequences, many of which are tied to prominent public debates on immigration, prostitution, and the north-south economic inequity.[1, 7] Anderson and O'Connell Davidson point out the practical difficulty with the term "trafficked":

> It would be naïve to imagine that migrant workers can be divided into two entirely separate and distinct groups—those who are trafficked involuntarily in to the misery of slavery-like conditions in an illegal or unregulated economic sector and those who voluntarily and legally migrate into the happy and protected world of the formal economy.[36]

Separating "trafficking" from closely-related, overlapping, or even duplicative abusive behaviours or exploitation is challenging conceptually and practically. In some sense, it requires a type of 'abuse demarcation point', which, if an

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[c] Absent from this definition is an operational definition of "coercion", which is often viewed as an integral element of trafficking. "Forced labour" has been defined in the ILO Forced Labour Convention as "all work or service which is exacted from any person under the menace of any penalty and for which the said person has not offered himself voluntarily"(Article 2(1), International Labour Organization, 1930)

individual who migrated for work suffers abuses beyond that point, can be labelled as trafficking. The potential consequences of this ambiguity can be significant. Policies and services may neglect the needs of highly vulnerable individuals or marginalise or ignore certain groups who do not fit neatly within what in reality turns out to be a very untidy definition.

While recognising these critical definitional and conceptual problems and their potential practical consequences for individuals who are exploited, it is simultaneously accepted that the term "trafficking" has become a widely accepted concept that seems to include and exclude certain individuals. It is a label around which laws and policies are being conceived, services are being developed and within which a small portion of the larger group of very vulnerable persons are being assisted. For this thesis, "trafficking in women" is addressed first and foremost as a form of violence against women in which exploitation for profit is a key feature, and harm is a primary consequence (see Chapter 4: Methods). In this sense, I am cautious not to conflate the terms "violence against women" and "gender-based violence. Trafficking in women for labour purposes does not universally have to be defined as gender-based violence, as in many circumstances, (e.g., trafficking for road construction) both men and women may be similarly recruited for their labour, and the gender-related embodiment of that labour is generally irrelevant.

2.3. Trafficking in women and health

Despite the widening recognition of trafficking in women, and in the face of the profound and enduring human physical and psychological harm it causes, the subject of "health"[d] in the context of trafficking in women is an area that has received extremely little attention and even less evidence-based inquiry.

A number of international instruments acknowledge the injury caused by trafficking and now include protection and assistance provisions. In Article 6(3) of the Palermo Protocol, for example, specifies 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 organizations, 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) <u>Medical, psychological and material assistance</u>; [emphasis added] and
> (d) Employment, educational and training opportunities.[32]

Despite the weak language ("shall consider"), this seminal document recognises that States should address the health consequences of trafficking.

More recently, on May 5, 2005, the Council of Europe adopted the *Council of Europe Convention on Action Against Trafficking in Human Beings*, which states in Article 12, "Assistance to victims":

> 1. Each Party shall adopt such legislative or other measures as may be necessary to assist victims in their physical, psychological and social recovery. Such assistance shall include at least:

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[d] For the purposes of this study, the research team adopted the definition of health proposed by the World Health Organization: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

(a) standards of living capable of ensuring their subsistence, through such measures as: appropriate and secure accommodation, psychological and material assistance;
(b) access to emergency medical treatment;

This Article also includes a subsection specifying that each State will "provide necessary medical or other assistance to victims lawfully resident within its territory who do not have adequate resources and need such help."[37] Although this phrasing places conditions on assistance (i.e., legal status, lacking in financial means), the Council of Europe has recognised that health care is a fundamental element of assistance.

One of the first (and only) conferences on health and trafficking took place in Budapest in early 2003. The resulting document, the *Budapest Declaration on Public Health And Trafficking in Human Beings*, highlights the health needs of women who have been trafficked, and strongly suggests that further research on health is urgent and necessary.[38] Other than this document, international statements on health and the health service implications of trafficking have, until recently, been relegated to narrow sections of international instruments (such as those cited above) and generally given somewhat cursory mention in reports on trafficking—when mentioned at all.[39-41] Aside from the research associated with this thesis, there appears to have been no data-driven documentation published on trafficking to date.

This is not to say that health has not been a subject of great concern to those organizations and individuals providing services to women. These groups, most often local NGOs, have been helping women with a wide variety of health

complications for many years. They have gained much experience, but continue to work without systematically collected evidence on which to base service protocols or carry out public advocacy.

At the time this study began, neither the health community nor the humanitarian and human rights groups involved in anti-trafficking activities had given much attention to the specific health needs of trafficking survivors. When "health" was mentioned in the context of trafficking, discussions were generally limited to sexually transmitted infections—specifically the potential public health implications of trafficking for the HIV/AIDS epidemic.[42-44]

This relative neglect of individual women's health is not unprecedented in the area of violence against women. Health was also a relatively belated area of activism and research for important issues such as domestic violence and sexual assault.[45, 46] Both used to be considered largely inaccessible private matters, eventually becoming legal and human rights matters, and only more recently (and following targeted advocacy) recognised as concerns for the medical and public health community. A similar pattern has emerged for the subject of health and trafficking.

2.4 Global scope of trafficking and the number problem

To date, accurate statistics on the scale of trafficking have proven elusive.[47] Since 1999, the most quoted figure on trafficking of women and children has been from a U.S. State Department report suggesting that "between 700,000 and two million" are trafficked across international borders each year.[3]

Later, in 2004, the State Department estimated that annually 800,000 to 900,0000 men, women, and children are trafficked internationally.[22]

More recently, in a report released in May 2005, the International Labour Organization (ILO) estimated that at least 2,450,000 persons globally are in situations of forced labour as a result of trafficking at a given time.[21] Disaggregating by gender, the ILO suggested that of the world's forced labour, women make up 56% of the victims of economic exploitation and 98% of those exploited in commercial sex, with the greatest number of trafficked persons in Asia and the Pacific (1,360,000), followed by those in industrialising countries (270,000).[21] These numbers, however, are prefaced by many caveats to explain that they these are only "minimum estimates" of which some may be "unreliable" or been "subject to error".[48]

Efforts to gather precise data have been fraught with complexities and confounders. During the early 1990s one main difficulty in collecting quantitative evidence on trafficking was the lack of an accepted definition of trafficking. Until the definition in the Palermo Protocol became widely recognised, "trafficking" estimates were regularly intermingled with data on smuggling or illegal migration.[49] Other complications still remain, among which the most significant is the level of under-reporting. Unless detected through police or assistance services, women are not likely to come forward to report having been trafficked. In addition, in many, if not most countries, trafficking had not been legislated as a crime,[50] and even in states where it has been criminalised, it is frequently given a low priority by authorities.[2] Further, the lack of systematic and proven methods

for data collection and the incompatibility of sources from country to country still frustrate those seeking statistics.[49]

Selected indicators are frequently simply proxy estimates, such as the number of "entertainment" visas awarded to women[51, 52], statistics on undocumented migrants[53], extrapolations from law enforcement figures or data on migrant sex workers.[2, 54]

Proposed prevalence has so often proven to be wild 'guesstimations' that the United Nations Educational, Scientific and Cultural Organization (UNESCO) office in Bangkok established the "Trafficking Statistics Project" that serves to expose the statistical inconsistencies that are put forth around the globe.[55] According to those who have attempted to follow-up on the proposed estimates, there is little evidence for most of the current data, or as stated by a UNESCO staff member, "Very often, we found no source or a source that provided no methodology."[56] The UNESCO representative also questioned the common assertion that women and children comprise the majority of trafficked persons and that most females are trafficked for sex. He stated, "It is said over and over again that the majority of trafficking is for sex, but there's absolutely no data to substantiate that...There's also no data to substantiate the ubiquitous characterization of victims as 'mostly women and children.'"[56]

Because a legitimate survey methodology has yet to be identified, experts in this field have generally agreed that accurate figures are nearly impossible to come by.[57]

Figures from assistance centres are more precise, but so small they are hardly able to hint at the global magnitude, or even the scale to or from any one country.[58, 59]

One aspect that is certain about most trafficking figures that circulate the globe, is that the numbers cited rarely include the far larger indeterminate number of people trafficked within national borders.[60]

The inability to quantify the problem has not, however, prevented regular media attention, international consternation and debate, or national rhetoric and legislation. Ultimately, what it does demonstrate however, is the difficulty in obtaining a broad and accurate picture of human trafficking.

2.5 Trafficking in Europe

The numbers

Accurate numbers on trafficking in Europe have been equally absent. Although there has been a great deal of discussion about the increase in trafficking in women to and within Europe, attempts to quantify the problem have not had any greater success.[25, 61] Estimates are wide ranging—even contradictory. Since 1994, the figure most commonly cited is that between 100,000 and 200,000 persons are trafficked to Europe. However, the calculations used to derive these figures do not appear to withstand serious scrutiny.[13] One estimate on the number of trafficked persons entering the United Kingdom, for example, suggests that between 142 and 1420 women are trafficked per year into the UK. This figure was derived from extrapolations of

figures from police, on migrant sex workers, immigration statistics, and media reports.[54] It is almost certainly very low.

In 2001, the European Commission "estimated 120,000 women and children are being trafficked into Western Europe each year."[62] However, in that same year a report by Europol, acknowledged:

> The overall number of victims trafficked in the EU is still unknown and only estimates are available. What is clear is the fact that the number of victims is much higher than the official statistics from investigated cases in Member States.[2]

More recently, the IOM, in the 2003 World Migration report, cited the estimate of the Swedish NGO, Kvinniforum's of 500,000 women trafficked into the EU, the report simultaneously cited *The Economist* referencing the International Centre for Migration estimate of 500,000 a total of illegal migrants entering the EU each year. The latter also included a Unicef estimate of 120,000 women and children trafficked into the EU annually[17]—a number which is also included in a 2004 article published by the Migration Policy Institute.

In an all out effort to quantify trafficking in Europe, the International Organization for Migration (IOM) commissioned a study in 1998 in which only 12 of 25 European countries could offer data on cases of trafficking in women and only seven on trafficking in children.[63]

The routes

Data on the "from" "to" and "via" of trafficking routes, while perhaps better understood, is nonetheless also problematic. Women who are trafficked may be

crossing borders legally or illegally. In the case of the former, it would be extremely difficult, if not impossible to estimate the percentage of legal migrants that might be trafficked. For those who cross borders illegally, this is, by definition, a covert activity that regularly changes in its modes and routes to avoid detection and to respond to changing opportunities and barriers. This mutability makes it extremely difficult to sketch a single static portrait. Nonetheless, some general trends have been observed. As suggested above, by most estimates, there has been a notable increase in the numbers of women trafficked from Central and Eastern Europe.[19] Scholars have repeatedly remarked that the decline of socialist and former Soviet states, and the corresponding collapse of their economies created rampant unemployment and social inequities that disproportionately affect women, frequently pushing them to look for viable opportunities elsewhere.[4, 64]

Another trend is the way in which Balkan countries have become common source and transit locations for Western European destinations (except where a military presence has created a large local market for sex work, making these destination locations, as well, as with Kosovo). Albania, for example (a partner location for the first study), has been identified as a transit country for Moldovans, Romanians, and Bulgarians headed for Western Europe.[64] This is said to be a similar route to that used for arms and drugs.[40] From Albania, many women are trafficked to or through Italy, because of its geographical proximity by boat. (Many of the women interviewed in Italy were from Albania or had passed

through there). Based on discussions with trafficked women[e] and police, we found that it is also not uncommon for women trafficked to Britain to have passed through Italy or Belgium. Romania has also been identified as a source and transit country, from where Ukrainian and Moldovan women, in particular, are trafficked to Western Europe.

Although Central and Eastern Europe figure prominently in the literature and the media as source countries for women trafficked into forced sex work, in fact, women are coming from numerous other countries around the world. Even before trafficking began gaining international attention, health outreach workers and several activist organizations in Western Europe were aware that women from Thailand and Nigeria were being subjected to conditions now widely recognised as trafficking.[65] IOM, in 2001, highlighted the trafficking of Nigerian women to Italy, Belgium and the Netherlands, and Thai and Brazilian to the UK, while noting that Ukrainian women were often ending up in Germany and the Balkans.[66]

2.6 The dynamics of trafficking

The literature on trafficking demonstrates how difficult it is to characterise the dynamics of trafficking.[67-69] The dynamics can radically differ from place to place, route to route, and trafficker to trafficker.[70, 71] Features of the crime, such as recruitment methods, financial arrangements, trafficking networks, travel and visa arrangements, manners of exploitation, and forms of abuse are generally

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[e] The use of the term "trafficked women" is not meant to imply that "trafficked" is a woman's single identifying feature, it is only meant to simplify the language used in this thesis (i.e., rather than

related to the context, including geographical location, cultural aspects, and individual personalities involved.

Different regions often have particular trafficking characteristics.[67] For example, one common type of exploitation is the trafficking of women, children and the disabled and elderly from Cambodia to Thailand for street begging.[72] Recruiters use a range of deceptive tactics that usually include promises of immediate cash and urgings that the individual must depart quickly before the opportunity is missed (e.g., a ceremony with cash donations to be made by the King).[29]

Trafficking from Nigeria to Italy, on the other hand, may involve a large up front payment by a girl or her family to traffickers for promised jobs and study opportunities. Women are subsequently made to sign contracts that obligate them for the remaining sum demanded by the traffickers. In a report by IOM, the authors explain the role of the recruiter or go-between in this transaction:

> A strong link is established between the trafficked woman and the Madam or Mama remaining in the country of origin, which according to testimonies from our interviews is based on "contracts" originating in the Voodoo practices. The Mama subjects the girls to initiation rites in order to reinforce the bonds based on psychological subordination. These bonds remain even after migration, since in Voodoo practice, transgressions can be punished even from a distance.[73]

While differences between trafficking experiences can be significant, one theme that seems to characterise the dynamics of trafficking is that of "power". The trafficker has it and uses it, while for the woman, her power over her

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continually using the phrase: "women who had been trafficked").

circumstances and body diminishes. From the perspective of a victim's mental health, loss of control may be among the most influential relational dynamics.[74]

The progression of this loss of control appears to be nearly universal across different regions and experiences. Women's sense of self-determination over their lives and well-being begins to spiral out of their control before they even consider migrating, starting with their inability to find a job, pay for basic goods, or identify options for supporting themselves or their family. Paradoxically, for the many women who sought to take control of their lives by looking for employment abroad, there is a terrible irony in being trafficked into a situation where nearly every aspect of their lives is out of their control.

Traffickers often mislead women as to the type of work, labour conditions, or debts to which they will be subjected, obligating them to usurious repayment plans, or what often amounts to debt-bondage.[24] Debt bondage has been closely associated with trafficking and is a concept tied to slavery. It is characterised by the perpetual servicing of a debt through one's personal services or labour.[f] In a typical trafficking situation, traffickers generally take control of travel arrangements and documents, often leaving women ignorant as to whether they have legitimate or illegitimate papers. Many women travel illegally without documents or with false documents, and at some point, many lose possession of their papers to the traffickers. Ultimately, women are installed in exploitative

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[f] The United Nations Supplementary Convention on the Abolition of Slavery, the slave trade and institutions and practices similar to slavery (1956) defines "debt-bondage" as: "The condition arising from a pledge by a debtor of his/her personal services or those of a person under his/her control as security for a debt. If the value of those services as reasonably assessed is not applied toward the liquidation of the debt or the length or nature of those services are not respectively limited or defined." (Article 1).

labour situations that expose them to harm, and leave them little place to turn to for help or safety. For women who believed that they had actually exerted a great deal of control by taking the initiative to leave home in search of a better future, to feel this power over their future, their bodies diminish so significantly is a terrible irony.

Loss of control is also a central theme in terms of health. In the exploitative setting, women are vulnerable to a range of forms of risk and violence that leave them with little say over what happens to their bodies, and that usually destroys their spirit. This spectrum of manipulation and punishment is undoubtedly among the most notable characteristics associated with trafficking.

Another key feature of trafficking—which helps explain why it is a proliferating industry—is the profit level. Trafficking can be highly lucrative. In 1998, profits from trafficking in human beings was estimated at US$7 to ten billion annually.[75] In 2005, it was estimated that illicit profits produced by trafficked labour have reached US$32 billion per year.[21] It is now considered among the largest sources of profits for organized crime.[22]

According to the UN Office on Drugs and Crime, "The relatively low risks of trafficking and substantial potential profits have, in some cases, induced criminals to become involved as an alternative to other, riskier criminal pursuits"[76]—by which they mean drugs or arms. Even from a policy perspective, most agree that this profit level, combined with the large number of individuals regularly seeking to migrate to places of greater economic and political

opportunity, means that trafficking is not about to abate anytime soon (Schloenhardt, A., 2001). [77]

2.7 The social, political and economic context for trafficking and health

Fundamental to understanding trafficking in women and women's health is to comprehend the social, political and economic context in which trafficking takes place.

In looking at trafficking and health, it is useful to take as a starting point that trafficking in women is first a form of gender-based violence. Like other forms of violence against women, trafficking does not occur in a vacuum, but in a social, cultural and political environment that tolerates or condones it. Situating trafficking within this framework helps to gain insights into etiology, origin, and consequences. As Koss, et. al. explain:

> When discussing violence against women, it is important to understand that, even though each act of violence is perpetrated by an individual, violent behaviour takes place in a socio-cultural context...At the societal level, male violence against women is seen as a manifestation of gender inequality and as a mechanism for the subordination of women.[78]

In addition to the academic literature, international instruments addressing violence against women also recognise the structural elements that are associated with violence, or cite broad social or cultural changes necessary to reform.[79, 80]

Like domestic violence, sexual abuse, or sexual harassment, trafficking of women relates, to a great degree, to gender disparities and cultural norms that

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permit or foster mistreatment of women. In Cambodia, for example, a common proverb is, "plates in a basket will rattle", suggesting that if people live in the same house, there will inevitably be some collisions, it's normal, it cannot be helped.[81] Violence against women in many societies is tolerated, and even in places where many would state that it is not acceptable. Its toleration is often demonstrated by the lack of social and legal responses. Noting the "normalisation" of gender violence, Kelly and Radford,[82] citing Johnson, explain:

> That sexual violence is so pervasive supports the view that the locus of violence rests squarely in the middle of what our culture defines as "normal" interaction between men and women.[83]

In many ways, trafficking in women has been similarly normalised. It has been normalised as a form of violence, and it has become part and parcel of a global economy that disadvantages its most vulnerable, and then inhales them into exploitative market sectors where their labour is used and abused. Trafficked women may well be viewed as a component of the labour market—albeit often of an underground or shadow economy.[84] Thus, at an economic level, trafficking, to varying degrees, is ignored, and therefore accepted. On the 'supply' side of the equation, this may be due in part to the dire economic state and massive corruption in many countries. The resulting crisis of poverty striking individuals and families has made women fodder for cheap labour markets. On the 'demand' side, ignorance or passive acceptance may be associated with a dominant consumer mentality that views labour and services—even illegal or exploitative

sectors—as part of a neutral global marketplace. This neutral view of international economics and global movement of goods and labour makes it possible to look away from the human rights abuses that occur in its midst.

From both sides, supply and demand, vulnerable women are pushed to the margins of society, which leaves enormous opportunities for traffickers to exploit their vulnerability, their labour and their sex. Writing on globalisation and women, Bandarage summarises the gender inequities that have accompanied the international labour market:

> ...[the] policies of current global restructuring...have not improved women's lives, but changed the form and manner of women's oppression.[85]

Women's economic and social disadvantages cannot be separated from the trafficking phenomenon. In defining social deprivation, Bassuk, Donelan, et. al. explain:

> Social deprivation extends far beyond economic factors...People who are socially deprived lack freedom of choice, opportunity, political voice and dignity. They experience barriers to full participation in community life. Frequently, through a process of oppression and domination, they are denied the most basic human rights to food and housing; education and work, health and safety and an equal share in the benefits of social progress.[86]

Not only is this type of disadvantage likely to affect women's decisions to leave home, but it is also likely to have a significant impact on physical and psychological health. Studies have repeatedly shown that inequity and low socio-economic conditions are associated with poor health indicators and risk-taking

behaviours.[87, 88] Struggling to survive against a panoply of environmental stressors, women feel anxiety, depression[86, 89]—and desperation.

In many cases, women who are trafficked may represent the sum of the effects of social deprivation, both in their health and well-being and in their decisions about and means of migration. At a time of increasing anti-immigrant sentiment, it is worth recalling that if women could find decent employment, social security and gender equality, most would probably prefer to remain in their own country near family and friends. 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.[90] The UNDP "Gender Development Index" – which ranks countries according to gender equity and women's comparative economic, social and political development—suggests, for example, that in the broadest sense, the gender disparity that is likely to influence women's decision to migrate to countries where they imagine greater possibilities for a better, healthier life. See Table 2.2.

Table 2.2: 2005 UNDP Gender Development Index (GDI) for countries studied.[90]

Country	UNDP GDI ranking
Albania	50
Belgium	9
Bulgaria	45
Czech Republic	30
Italy	18
Moldova	91
Netherlands	12
Thailand	57
United Kingdom	15
Ukraine	59

The modern world economic and social order appears to have fostered international labour exploitation, and for many, created new circumstances of poverty and inequalities that have increased the supply of poor, desperate individuals, who are left to fend for themselves in a market place in which they are invisible, at best.

Sassen, in her article "Women's Burden: Counter-Geographies of Globalization and the Feminization of Survival", highlights the global economic forces that increasingly impoverish women and push them into "counter-geographies of globalization" that she also refers to as "survival circuits".[84] She explains:

> These circuits could be considered as indicators of the (albeit partial) feminization of survival, because it is increasingly on the backs of women that these forms of making a living, earning a profit and securing government revenue are realized.[84]

Governments of poorer nations may have little reason to curb these circuits. Some have observed that government coffers of poorer states actually

benefit from the remittances returned from women in these unregulated markets.[84] However, governments of wealthier states have tried to respond to irregular migration with increasingly tighter immigration laws. Yet, time and again, experts have explained that restrictive migration policies limit the legal options of persons seeking to migrate for work or flee danger, which, many contend, has the counter-effect of creating greater opportunities for traffickers.[1, 30, 74, 91] In an early report on smuggling and trafficking of refugees, Morrison and Crosland explain:

> "[T]here are very few legal means by which an asylum-seeker can enter European territory, so illegal entry is a reality for many, if not most refugees."[1]

This desperation for jobs in the face of ever-higher barriers against immigration is taking place while studies on migrant workers repeatedly show that most rich nations have a proven need for immigrant labour[92]

Amidst these forces that appear to create and sustain trafficking in women, trafficking is a subject whose dialogue exists in a political and social morass. As noted by Anderson and O'Connell Davidson, trafficking is a subject that abounds with controversy:

> [D]ifferent groups identify trafficking as a problem for very different reasons and often have very different political agendas with regard to the issue.[34]

The authors accurately identify three broad groupings of particular significance: (1) governments, whose interest is often grounded in concern over irregular immigration or transnational organized crime; (2) feminist abolitionist NGOs who view trafficking as central to and emblematic of the increasing globalisation of

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female sexual exploitation; and (3) rights organisations, such as migrant worker and other labour organisations and human rights activists who approach trafficking with a more general concern for abuses. These are each debates for which the discussion extends beyond the scope of this thesis. However, as will be further discussed, these are not small concerns in the context of research and action in this subject area.

Further complicating and politicising discussions on trafficking is the fact that trafficking generally falls within the category of "irregular migration", where attempts have been made to distinguish it from "smuggling"[17, 93] Yet, in reality, the distinctions between smuggling and trafficking are often not clear. In a detailed discussion, Anderson and O'Connell Davidson describe the vast "grey area" between "trafficking" and "smuggling" and note that the ambiguities in "the trafficking/smuggling distinction represents a gaping hole in any safety net for those whose human rights are violated in the process of migration."[36]

This social, economic and political panorama around trafficking helps to situate many features of trafficking that affect women's health, such as violence, routes, and interventions, as well as the neglect of the severe health consequences and the lack of dedicated service responses. When violence and exploitation are part of a larger socio-economic culture that overlooks, even tolerates, these abuses, women's health is unlikely to be high on the agenda of those who can allocate resources.

The backdrop against which trafficking occurs is not static, nor are the dynamics of trafficking. One might imagine, for example, that in response to

stricter border controls, traffickers identify border entry routes that entail higher risks, thereby putting women in greater jeopardy. Or, as traffickers become more astute in their coercion tactics, perhaps using methods that are less visible, women's injuries may become less visible, as well.

2.8 Who are trafficked women

There is no single profile for a potential victim of trafficking. As noted above, there is a lack of empirical studies on human trafficking, which helps to explain the absence of information on characteristics of trafficked persons. John Salt explains that existing information provides:

> ...snapshots rather than a comprehensive picture and thus far no study has tried systematically to bring the various findings together. The emphasis tends to be on age and gender and there is very little on socio-economic status and other aspects of their lives in their home countries.[94]

For example, although it is often alleged that relative poverty is a distinguishing feature of most women who are trafficked, in numerous settings trafficking fees are high and the poorest of women or their families would not have enough money or collateral to pay for the trafficker's alleged services.[52, 95] In contrast however, in a great many cases, poor women make good recruitment targets both because they are desperate and because they can be obligated to service a debt.

Similarly, while sex-trafficking has the most commonly recognised form of trafficking in women, Jennifer Stanger at the Los Angeles-based Coalition Against Slavery and Trafficking (CAST) has suggested that "sex trafficking gets a

lot of attention simply because it's sexy."[56] As previously noted, women are trafficked into a range of different forms of exploitation.

Faced with the difficulty of profiling the diversity of "women who are trafficked", it is perhaps more useful to look instead at the *causes* of trafficking and, from there, to consider who might be most susceptible or vulnerable to one or more of these factors.

Most literature on trafficking has discussed the "push" and "pull" factors that contribute to trafficking.[96, 97] *Push factors* are the physical, social, psychological, financial or political events or conditions in places of origin that motivate women to emigrate. Some have suggested that there is a "migratory probability" that influences women's ability to move, which is determined in the "interaction of women's roles, status and age within a particular socio-cultural context".[98] Although there are a host of different motivations for migration, very often the decision ultimately relates to financial problems or aspirations.

For women who seek to migrate to alleviate present crises, push factors may expose a woman's vulnerability at the same time as they reveal her resourcefulness and motivation. Irregular migration (frequently leading to trafficking) may be viewed as a coping strategy; strong and courageous women taking action in response to difficult or threatening circumstances.

Pull factors are the perceived opportunities associated with points of destination. These may include job opportunities, improved standards of living, and greater security or freedoms. Pull factors are often the perceived solution to the "push factor" or problem that compelled a woman to seek to migrate.

In addition to the push and pull factors, there appears to be an additional influential factor that might best be referred to as a *deciding factor*. *Deciding factors* are those practical features that make the migration and the job or other opportunity appear possible. Based on accounts of trafficked persons, many women appear to base their decision to migrate on the quality of the connection they have with the individual making the offer, such as a relative, friend of the family, or reference from someone who has gone and profited.[9] Although the poor, even seemingly hopeless conditions in a woman's home situation combine with the promises of elsewhere to lay the groundwork for migration decisions, these alone may not be enough to convince a woman to leave. In many, if not most cases, it is the "deciding" or intermediary factors that help tip the balance as to whether a woman will actually choose to depart—accepting risks that they would otherwise refuse. In some cases, an enticing offer from a trusted source may initiate the process for a woman who otherwise had not thought of migrating.

These factors may be further divided into those that are *individual* and those that are *structural*.

Micro-level or individual factors are personal events, conditions, or history particular to a woman that cause her to seek to migrate or make her vulnerable to or a target for recruitment. As shown in Figure 2.2., micro level factors may include age, education, single parenthood, family violence or

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[8] This concept is based on numerous discussions with service providers assisting women who were trafficked and accounts of various cases.

difficult family situation, other history of sexual or physical abuse, and geographic dislocation (often related to conflict).[h]

Macro-level or structural factors are generally linked to the state, society or culture and are the institutional or systemic mechanisms that impinge on an individual's well-being or, similarly, ignore, justify or condone inequities or abuses.[78, 99, 100] Macro level factors comprise broader social, political and environmental factors such as inequity, poverty, structural adjustment policies, unemployment, environmental degradation, and the accompanying loss of social safety nets, political or civil unrest.

Micro-level factors are integrally linked to and often caused or exacerbated by macro-level factors. Many of the unemployment and individual income crises in mid- and low-income countries can be partly attributed to international and national policies and practices that have eliminated job opportunities and dismantled social protections.[85, 101]

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[h] There are regular reports of women and children being trafficked from (and through) refugee camps and migration centres. See: Commission on Security and Cooperation in Europe (CSCE). (1999). The sex trade: The trafficking of women and children in Europe and the United States. *Hearing Before the CSCE 106-1-9*, 28 June 1999. Washington D.C.: US Government Printing Office.

Table 2.3 Push, pull and facilitating factors on micro and macro levels.

FACTORS	MICRO LEVEL OR INDIVIDUAL	MACRO LEVEL OR STRUCTURAL
PUSH	Age, education level; family protections and support; job loss/ spouse's unemployment, unliveable wages, increasing expenses and/or sudden or mounting debt, family crisis leading to sudden increase in expenses; single parenthood; orphaned; loss of key family member(s); limited education or training opportunities, domestic violence, sexual abuse, child sexual abuse, family discord, debts; dislocation; refugee status;	Under-development; poverty, inequity; high unemployment levels, inflation, structural adjustment policies; international trade policies; loss of national social support programs, state restructuring; ethnic marginalisation/cleansing, discrimination; gender inequities; environmental destruction/degradation; civil unrest/political strife; refugee conditions and policies; State, social and/or cultural tolerance (or condoning) of gender-based violence; absence of protective mechanisms responding to gender-based violence;
DECIDING	Recruitment by trusted source, such as relative, friend, boyfriend, fiance, person who previously migrated for work (or was trafficked); tempting financial offer, immediate payment to parents or other relatives, access to counterfeit visa/passport/documents;	Permeable borders, lax border controls, corruption among immigration or other officials,
PULL	Relative or friend already working; relative or friend hiring; images of better life or living standards; desire to increase standard of living; promise of high income, remittances for family.	Feminisation of migration and increasing opportunities for women the labour market; globalisation and ease of movement/travel; media showing the 'good' life in other countries; demand for low-wage or, undocumented migrant labour in underground or illegal labour sectors;

2.9 Who are traffickers?

To date, little research has been conducted on those who perpetrate or participate in the crime of trafficking. Information from law enforcement professionals and immigration experts suggest that, like victims, there is no one profile or network structure description that accurately captures all global trafficking. Traffickers may include, for example, amateur traffickers (small, opportunistic operators, such as those who provide a single service, e.g., transport); small groups of organised criminals (those that specialise in escorting migrants from country to country, sometimes based on family connections, but less 'professional' than those operating in international networks); and international trafficking networks (those who address all aspects, including recruitment, documents, accommodation, transport, placement or sale of women; these groups are often involved in other criminal activities).[5, 102]

Determining the defining characteristics of a "trafficker" is complex for many of the same reasons it is difficult to find a prototype for a trafficked woman or for the perpetrator of domestic violence. One might, for example, try to look at the various roles that a trafficker might play in order to understand perpetrators in practical ways, such as *how* they carry out the crime. Recruiters and recruitment in many situations include, for example, individuals posing as employment or travel services. In other circumstances, such as in Albania, recruitment tactics include men introducing themselves to women and their family as well-situated young men living outside the country. They then make marriage proposals, promising to care for the girl and send money home to the family.[103] 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."[34]

Alternatively, one might attempt to tie many of the features of a trafficker to *motives*. One might thus look at one of the most important motives: profit. There is enormous financial gain to be made in trafficking. Viewing motives would be to look at traffickers from criminal law enforcement and/or global market perspectives. Taking a market perspective may also mean looking at the way in which traffickers are responding to demand.[104]

Still looking at traffickers according to motive, one might examine them as perpetrators of violence against women, which would then lead one to consider the motives often discussed in literature on gender violence: *power and control*.[78] From this perspective, traffickers' desire for power and control underlie the expression and direction of their violence towards and exploitation of the women.[i] Starting from a commonality of power and control, it is possible to characterise those who perpetrate trafficking according to their tactics. Describing the control tactics used by traffickers at the most abusive levels lends itself to comparisons with the tactics employed by perpetrators of torture, domestic violence or child abuse. The aim of these forms of violence, coercion and psychological manipulation is to render the victim dependent and subservient by destroying the individual's sense of self and connection to others. By restructuring the person's

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[i] However, this does not help to explain the regular involvement of female traffickers. There is scant literature on gender-based female on female abuse where there is no intimate partnership.

perception of the world into that constructed by the perpetrator, the perpetrator thereby attains the obedience essential to the trafficked person's continued exploitation. Common techniques used by traffickers can be assembled based on case studies across the literature on trafficking—similarities in forms and execution of coercion and abuse emerge in examples from around the world. Explanations of the purpose and effects of these type of techniques are readily found in the literature on torture and domestic abuse.[105, 106] A summary of the techniques used in this type of repetitive abuse might include:

• **Terrorising:** to instil persistent and relentless fear;

• **Lying and deceiving:** to undermine individuals' trust in their perception of themselves and their understanding of the world around them;

• **Maintaining unpredictable and uncontrollable conditions:** to destabilise individuals and to dismantle their ability to plan or anticipate events based on their former concepts of the world, forcing them to relinquish previous life strategies in exchange for responsive and self-defensive survival strategies;

• **Severe limitation of options and freedom to choose:** to create the sense that the individual has few options other than those preferred by the perpetrator. Additionally, to give the sense that the individual's well-being and safety depends on pleasing the perpetrator; and

• **Emotional manipulation:** to maintain control over and intimacy with the individual by manipulating feelings, such as love and dependence (in the case of those who are in intimate partner relationships with the perpetrator).

This latter tactic, manipulation, also commonly involves a traffickers' efforts to highlight some positive virtues of the trafficking activity in a way that might appeal to the trafficked person's needs or desires, such as how the journey or work will enable them to send more money home to dependent family members, promises of love and future commitment, or enable them to fulfil social or religious obligations, or help them fulfil their individual dreams and aspirations for a better life.

The process used to inculcate dependence and submission has also been likened to the stages of mental manipulation employed by totalitarian regimes.[107] According to Maria Tchomarova, a psychologist working with victims of trafficking, the first stage of this process is when a woman is put in "extreme survival conditions" in which she is forced to face the very real possibility of death. The perpetrator makes the person know that she no longer controls her safety—the perpetrator does. The second stage involves "physical exhaustion." Women are forced to work long hours with no free time and minimal rest, which gives perpetrators significant control and, in the case of trafficking and labour exploitation, increased profits. Without time to recuperate, the individual is exhausted, unable to plan or contemplate self-defence strategies, and must simply focus on responding appropriately to commands and perceived threats. The final elements to ensuring dependence are control and isolation.

An analysis of the control tactics and methods of manipulation used by traffickers, and their effects on women's captivity, behaviour and health (post-

trafficking mental health, in particular) will be an important subject for future investigations.

2.10 Defining "health", "risk", "harm" and "power and control"

To explore health in a trafficking context, this study employed the inclusive definition of health provided by the World Health Organization:

> A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[108]

The broad reach of this definition to encompass various forms of "well-being" rather than simply "medical" conditions is useful especially when considering the concepts of risk, consequence and intervention. This definition is particularly important to discussions of trafficked women because it suggests that "health" is more than sexual and reproductive health, which is often implied in existing literature on trafficking in women. By including "social well-being", for example, this definition acknowledges a wider meaning of health, such as the impact of individual, family, community, and structural factors on health, and the range of non-traditional concerns that comprise health. This expansive conceptualisation has important political implications, as it recognises the influence of "upstream" factors, such as the larger socio-economic and political context in both causes and interventions.[109]

In addition to an expansive definition of health, fundamental to researching the health of trafficked women is an understanding of "risk." While a thorough analysis of risk is well beyond the scope of this thesis, it is useful to identify an operational concept of risk as it relates to health and trafficking. "Risk" as it is

discussed in the academic literature is complex and is considered most often from a sociological or anthropological perspective or statistical probability, but not necessarily health.[110-113] However, it is possible to apply several concepts and some of the terminology developed within this body of literature to health, particularly health in abusive or exploitative conditions. Alaszewski, in describing a "risk iceberg" where "risk forms the tip of an iceberg of related words and terms", offers a number of definitions that are useful in researching health in areas of high-risk. He closely associates risk with "hazard" or "danger", which he defines as "a potential threat which can result in harm, loss or negative consequences for an individual or group".[110] He defines "harm" as "the loss experienced by individuals or groups as the result of specific events or actions".[110] Adopting this more negative definition of risk, that associated with "danger", "hazard", or chance of "harm" (versus its more neutral connotation: probability), risks related to health might be considered those that may inflict illness, injury or threaten an individual's well-being, that is, cause harm. Another term of importance cited in the "iceberg" is "vulnerability", which is an individual's susceptibility to experience harm, noting that "safety" is "the absence of harm." Finally, "blame" is the process of allocating responsibility and punishments, and this is associated with "accountability"—identifying who is likely to be blamed. Terms such as "blame" are particularly important in discussions of the mental health of trafficked women.

Relevant to risk is the *context* in which the risk or risk-taking occurs. Sandra Wallman, in her article, "Global threats, local options, personal risk: dimensions of migrant sex work in Europe", states:

> On all counts risk is never context free: assessments of cause, gravity and what-to-do-about-it are governed by context, and they will change with any variation of its shape or scope. And by inference: merely *knowing* about dangers to health does not empower people to avoid them.[114]

Writing on "contextual risk versus risk behaviour" among sex workers, Priscilla Alexander contends that "the context in which [sex work] will be done is defined by the society and the state apparatus that surround it[115], suggesting that perceptions and behaviours related to risk cannot be easily teased out of the larger social and political situation. Echoing the above discussion on the context of trafficking, risk-taking is integrally tied to the structure in which the dangers are embedded and vulnerability is created.

By talking about "high risk situations" (vs. high risk behaviour) it is more likely that a broader perspective of risk will be adopted, thereby avoiding phrases and thinking that tends to stigmatise individuals or particular groups.[116]

Closely related to the terms risk and harm are the concepts of "power" and "control", because an individual's capacity to avert risk and address harm are linked to the balance (or imbalance) of power within circumstances, during events and between individuals. These are meaningful terms upon which large bodies of literature are built. "Power" is conceptualised often within social and economic sciences and international development documents.[117]

Particularly within the feminist literature, power is frequently described in conjunction with the term "agency" and with concepts and theories around "freedom" (INSERT REF). For example, Kabeer explains that power is related to "resources", "agency" and "achievement", where she describes agency as:

> the ability to define one's goals and act upon them. Agency is about more than observable action; it also encompasses the meaning, motivation and purpose that individuals bring to their activity, their *sense* of agency, or what feminists have called "the power within". Agency often tends to be operationalized as decision making in the social science literature, but it can take a variety of other forms. It can take the form of bargaining and negotiation, deception and manipulation, subversion and resistance as well as more intangible, cognitive processes of reflection and analysis.

This definition as applied to trafficked women reflects the fact that even within option-constrained circumstances, women are still making choices and asserting power. It highlights that there is a spectrum of greater or fewer resources available to women in exploitative conditions, and recognises that, as human beings, women still maintain the capacity to choose, even among what might be considered very poor options.

Power and freedom has also been discussed in relation to prostitution and sex work. O'Connell-Davidson, for example, in her book, "Prostitution, Power and Freedom" describes the diversity in the social organisation of sex work, from the fully independent sex-worker to the "enslaved".[118] This conceptualisation is important to this research because it highlights that trafficking for forced prostitution is simply one end of a spectrum and represents the "enslaved" or bonded prostitution situation, whereas, in reality, there is a gamut of circumstances in which women have more ability to exert decisions-making power.

"Control", particularly for this research, is often associated with conceptualisations around violence against women and related to torture and mental health outcomes.[78, 119] Control in relationships that involve gender-based violence is commonly associated with the dominant role of males—both within a society and culture and within an intimate partner relationship—who are said to use "controlling" behaviours". This generally does not necessarily reflect the opposite relational perspective of women who may be exerting significant "agency"—even under circumstances of subordination. In literature on torture, "uncontrollability" of events has been described by Basoglu in his discussions of torture-related trauma as one of the key predictors of poor mental health outcomes.[119]

When considering the trafficked-trafficker relationship and the interactions that a trafficked women may have with others (e.g., health care providers, police, the immigration structures and procedures), it is useful to consider the relational nature of power and the ways women may exert control amidst the options available.

Social (and political, economic and philosophical) theories around far-reaching concepts such as "power", "agency" and "control" are, without a doubt, profoundly linked to the health of individuals and society. They are tied to the dialogue on human rights, particularly the rights of the disadvantaged and marginalised. However, while the relative levels of women's self-determination in

different trafficking situations and the various ways they express their decision-making in more or less constrained circumstances must be recognised, a more extensive analysis of the implications of these concepts related to trafficked women and their health would extend well-beyond the scope of this thesis.

2.11 State of knowledge on health and trafficking

At the time this study was conducted, trafficking was a relatively nascent area of study. Evidence-gathering on trafficking had primarily focused on: estimating the scale of the problem; mapping routes (countries of origin, transit and destination); recording recruitment methods; documenting case histories and human rights abuses, and, most heavily, on reviewing and critiquing legal frameworks.[54] This list suggests the relative priority accorded to aspects related to immigration and law enforcement over more service-oriented interventions aimed at meeting victims' needs. As noted by Kelly and Regan, many major initiatives have not even involved contact with trafficked women[54].

In 2000, at the start of the first study (the formative research), health and trafficking was a subject for which no systematically collected data could be found, and it was even difficult to identify general literature focussing on the health of trafficked persons. Most of the documentation produced on trafficking and health, even today, dedicates much of the discussion to descriptions of the phenomenon of trafficking, rather than focussing on health.

The little health-related documentation that existed at that time, one of the more important conceptual discussions on trafficking and health was produced in 2000 by Gushulak and MacPherson. They offered a framework outlining the ways different stages of the migration process (pre-departure, transit and destination) can affect an individual's health.[120] They point out that, "The health and medical consequences of migrant trafficking have not been systematically studied..." Efforts to conduct a literature review of the subject at that time support this conclusion.

In the context of health, the work of Tampep and Europap on migrant sex work[121, 122] is also worth mentioning when considering the early work on "trafficking" in women for forced sex work—even though these groups determinedly avoided the term "trafficking". They dedicate much of their work to describing the presence of migrant sex workers in different countries in Europe, the dangers and difficulties of being a migrant sex worker, health interventions for this population and the politics of terminology, such as "trafficking".[122, 123] This latter debate goes well beyond the scope of this thesis.

One of the early, more applicable pieces of work on trafficking and health (although health occupies only one chapter) was developed by the Bangkok-based *Global Alliance Against Traffic in Women (GAATW)*, "Practical guide to assisting trafficked women." [124] GAATW bases this guide on their practical experience working with trafficked women, and in it they describe the physical and psychological reactions and service needs of trafficked women and proposed basic counselling skills.

In 2001 the Animus Association Foundation published a report offering extremely important insights into the mental health consequences of women who had been trafficked, which was based on their experience at their assistance centre in Sofia, Bulgaria.[125]

Research focussing on health and trafficking at that time was scant. The AIDS community had already begun to understand the impact of mobility on the HIV epidemic, and those working on migration had recognised the relationship between people on the move and HIV.[126-128] A report by Huntington and Guest, for example, considered reproductive health and HIV interventions, highlighting the potential parallels with care services for migrants.[43]

Very few data-driven reports on health are available. Among the research-based reports specifically describing results on trafficking and health is one completed by Raymond, et. al., in 2002.[71] This report presents the findings from a study conducted in five countries on trafficked women and highlights the health consequences. The authors of this report approach the subject of trafficking from an anti-prostitution position. In 2004, Holly Burkhalter, U.S. Policy Director for Physicians for Human Rights, testified before the House International Relations Committee on the health consequences of sex trafficking, in which she highlighted the impact that this form of violence can have on the transmission of HIV.[129]

Among the first peer-reviewed journal articles on trafficking using the terms "health" and "trafficking" in the title was an article written by Beyrer, in 2003, and published in Brown Journal of World Affairs. This article focuses

specifically on sexually transmitted infections, including HIV/AIDS among women trafficked for forced sex work in Burma.[130]

To date, extremely few articles on trafficking have been published in peer-reviewed health journals. Two informative pieces on health and trafficked women were produced by Cwikel, et. al. In 2003, Cwikel, et. al. published an article on brothel workers in Israel (82% of whom were trafficked) in the Journal of Epidemiology and Public Health that described factors that influenced women's risk exposure, including age at starting work, suicide attempts and PTSD symptoms. The article also discussed access to gynaecological care. [131] In 2004, Cwikel, et. al. followed up with a study that examined women in a detention centre awaiting deportation in which they found high levels of somatic symptoms and depression and that women with early exposure to trauma were more likely to experience work-related trauma and had poorer health outcomes.[132] Sample sizes in both studies were quite small, however (n=55, and n=49). In 2004, Busza, et. al, published a policy article on child migrants in Mali returning from the Ivory Coast and Vietnamese sex workers in Cambodia, suggesting that anti-trafficking efforts may actually be increasing health risks and deterring individuals from accessing services. In 2004, the Lancet published a review of the report produced from the formative study by Zimmerman, et. al. In the review, Beyrer highlighted in particular the study's contribution to greater attention on women's health and the importance of the proposed conceptual model to the study of trafficking and health, while noting the study's limitations because of the small sample size.[133] In 2005, a discussion article on trafficking was produced in the

Canadian Medical Association Journal in which Stewart and Gajic-Veljanoski provide a general overview of trafficking and include some of the potential health implications. In 2005, a short article on the ethical and safety implications of interviewing trafficked women, written by Zimmerman and Watts, was published in the Lancet.

In 2006, although women's well-being had become a subject repeatedly mentioned in public dialogue, and provisions highlighting the need for medical assistance were included in key international, regional and national instruments,[134-136] there remained little to no systematically collected data on the health of women who have been trafficked, aside from the study described in this thesis. In the peer-reviewed health journals in 2006, the only article that could be found was in the Lancet. This was an editorial that referred to the quantitative study associated with this thesis, in which its findings were associated with the alleged trafficking of women for the World Cup in Germany.[137]

In 2007 (when this thesis was being finalised), an article by Miller et. al., entitled "From a community health center. Migration, sexual exploitation, and women's health: a case report" was published in the journal *Violence Against Women.*[138] This piece describes the phenomenon of trafficking, highlights the health symptom findings from the quantitative study conducted for this thesis and presents a case study of a Spanish-speaking trafficking survivor accessing obstetrics services in Boston, Massachusetts.

2.12 Literature on vulnerable populations and relevant subject areas

Faced with a limited amount of information on the health aspects of trafficking, it was useful to explore other related subject areas that were better researched and could serve as a knowledge base for this study. This raised the question: What populations are similarly vulnerable or marginalised, like trafficked women, and might encounter similar health risks and outcomes, and require similar intervention approaches? This led to looking at groups who were exposed to violence—sexual violence, in particular, and were socially, politically and economically marginalised, i.e., living outside the accepted social margins and/or working in irregular sectors.

Ultimately, from a health perspective, the groups with the most relevant characteristics included: (1) women (the underlying dimension), (2) migrant women, (3) victims of violence against women, or torture; and (4) exploited labourers; and (5) sex workers. Figure 2.1 portrays these groups as overlapping spheres to represent the way that trafficked women share characteristics of each of these groups.
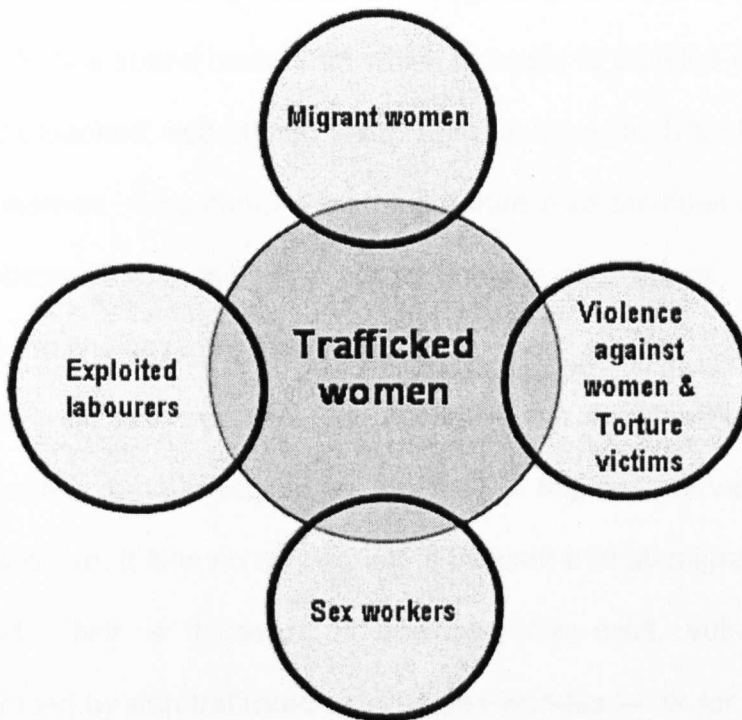
Figure 2.1 Marginalised and vulnerable groups

While individually none of these topics is able to capture the full range of issues associated with trafficking and health, considering features from each group helps to conceive the shared vulnerability and marginalisation between these groups and trafficked women, and to speculate about their corresponding health implications. To varying degrees, factors associated with each group also comprise elements that could be considered in the conceptual and practical design of a study of trafficked women.

Simultaneously, recognition of the differences in these populations suggests that there is a need to develop specific lines of inquiry for trafficked women. Drawing on both the parallels and differences between these groups and

trafficked women (individually and as an ensemble), the literature about these populations offers a sound basis from which to begin to develop conceptual and theoretical approaches, operational techniques, and research tools for the study of trafficked women. This compilation of literature also provides a diverse body of evidence-based information that can eventually supplement, support or put into question the findings from the study.

On an important side-note, in proposing this framework, it is with the greatest of caution that I 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.

The aim of the following short sections is to highlight the relevance of each subject area to the study of health and trafficking in women. In most cases, discussions focus on definitional, theoretical or conceptual information for each topic. These summaries are not meant to comprise an analysis or systematic review of the vast body of literature in each theme.

2.12.1 Sex, gender, and health

Underlying any discussion on trafficking of women and health are the biological and social factors related to being female. The physical, economic, cultural and political aspects tied to sex and gender define and influence whether and how trafficking affects women. Gender, in particular, can impact which

resources will be available to women, and how they access and use them. It is therefore important to define and briefly describe these fundamental terms.

According to the World Health Organization's policy on gender, *sex* is the "biological facts of being male and female", and *gender* is the "cultural norms that determine masculinity and femininity". Both are said to have an important impact on health."[139]

From a biological perspective, being female is a determinant for certain health characteristics that may increase or decrease vulnerability to harm, particularly in relation to reproductive and sexual health.[140] Equally or more influential is the role that gender plays on women's health. As summarised by Leslie Doyal, an expert on gender and health:

> Increasingly it is being recognised that gender issues must be central to [efforts to close the gender gap in health], since women comprise the majority of the world's poor. The health of these women is affected not just by their poverty and by failures to meet many of their sex-related (i.e., biological) and reproductive health needs, but also by the wider gender (i.e., social) inequalities that continue to shape their lives.[141]

Gender inequality is frequently at the centre of discussions of women's health, often employed in analyses of health differentials between men and women. Literature on health and gender inequality commonly describe socially discriminatory attitudes that lead to, for example, unequal distribution of basic resources (food, health, education), poor treatment of women's reproductive and sexual health is often a consequence.[142] Some authors have suggested that this gender-biased inequality has generational affects, passing disadvantages to daughters.[143] Social disparities are also said to contribute to women's unequal

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access to health services and health information, as well as poor health resulting from exposure to burdensome and high-risk labour environments, early marriage and male violence (see below).[144, 145]

As will be described, women—particularly women from poorer countries or regions—appear to be disproportionately negatively affected by recent global economic and political changes, which have put them at greater risk of poverty and simultaneously have placed on them the burden of alleviating this poverty, which in turn has put them at greater risk of being trafficked.

As noted previously, in order to better understand the interaction between gender, trafficking in women and forced prostitution and health, it is useful to consider issues integral to the trafficking phenomenon: migration, violence against women, labour and labour exploitation, and sex work.

2.12.2 Migration

Trafficking in human beings is generally considered a sub-category of migration, often set within the other sub-categories: irregular or undocumented arrivals and organized crime-facilitated migration.[2, 34, 146] Familiarity with some of the main concepts within the body of literature on migration, particularly that which discusses gender and health, is useful to studying the health of trafficked women.

Migration and gender

Migration has become a global theme in the 21st century. Recent estimates suggest that worldwide there are 175 million migrants[17]. Of these millions of people on the move today, 49% are women.[147] In fact, women have made up nearly half the world's international migrants since at least the 1960s.[148] The International Organization for Migration, among others, has referred to the growing proportion of females on the move as the "feminization of migration", and recognised the greater risks that many women face when they choose, or are forced to migrate:

> While as with men, women often choose to migrate because of poverty and lack of professional prospects, women migrants are more exposed to forced labour and sexual exploitation than men and are also more likely to accept precarious working conditions and poorly paid work.[17]

Like women's health, female migration is a distinctly gendered phenomenon that is strongly influenced and characterised by economic, social, political and cultural inequities.[149, 150] Writing on migration theory and gender, Boyd and Grieco explain that traditional thinking on migration had focussed on causes versus on *who* migrates, thus neglecting to recognise that labour migration is highly gender-specific.[98] By omitting gender from migration theory, they argue, it is difficult to examine, for example, the forces that influence women to migrate, the increasing presence of women in certain labour flows versus others, and different experiences between women and men.[98]

Viewing the problem of trafficking from an economic-migratory panorama, Sassen contends:

The growing inmiseration of governments and whole economies in the global south has promoted and enabled the proliferation of survival and profit-making activities that involve the migration and trafficking of women.[84]

The association between global economic changes, women's impoverishment (sometimes referred to as the "feminization of poverty")[151] and female migration has come to be somewhat commonplace.[152] In most societies, especially those undergoing market reform or in socio-economic transition, literature describes the ways in which women are disproportionately affected by poverty and unemployment.[85] In the case of trafficking, women appear to be targeted and transported by traffickers and exploited in ways that are directly related to a feminisation of certain market sectors (domestic labour, sex work, garment factories) and demands for low-skilled, low wage labour.[84]

Migration and health

There is a large library of resources on migration and health. For the design of the research described in this thesis, the literature discussing migration theory offered several useful frameworks within which to examine health and trafficking.

Migration models that look at broad aspects of health frequently adopt one of two perspectives: the epidemiological-demographic features (i.e., geographical patterns) or the chronological perspective that looks at migration and health according to the phases of an individual's journey.[153]

The epidemiological perspective represents a traditional focus on public health and specific disease patterns.[154] Particularly in discussions of immigration and refugee health, this literature often focuses on infectious diseases, such as, HIV/AIDS, malaria, and tuberculosis.[153, 155-157] Increasingly, however, experts argue that in discussing immigrant health, greater attention must be given to other areas of medical concern, such as chronic illness, reproductive health, occupational health, and psychological problems.[156, 158, 159]

In a model on the health of mobile and migrant populations proposed by Gushulak, the health of the individual is viewed within connected phases of migratory movement and include: (1) the pre-migration situation; (2) the migratory journey itself; (3) the reception phase; and (4) return migration.[153] This is an important framework that highlights the different stages of a migrant's journey and the impact each may have on the individual. By delineating stages chronologically this model emphasises both the independent and the cumulative nature of the potential factors affecting well-being. As will be discussed in the chapter *Conceptual models*, this framework could be readily adapted to consider the stages of the trafficking process.

A second body of literature that offers useful information for work on trafficking is the field of "refugee and/or immigrant health". Much of the most relevant work comes from research on individuals in post-conflict settings and refugee camps (usually in low-resource settings) and asylum-seeking immigrant groups. For the latter, the body of literature is growing rapidly, as the populations of developed countries have become more diverse and the health systems have

needed to address changing disease patterns and learn about and identify appropriate care approaches for an array of cultures and ethnicities.[160, 161] Some of the more important areas of health discussed in these documents are culture (including acculturation and medical cultural competency), trauma and mental health, reproductive health, access to and use of health services, and psycho-social support.[162-167] Each of these subjects is particularly relevant to health support for trafficked women, as many health problems stem from women's migrant status, their distance from home and culture, loss of their support network, and the feeling (and reality) that they are alien in the society in which they are residing. In addition to the common actualities of being a migrant, it is not uncommon for refugees to be grappling with reactions to past trauma.[168-170] This makes studies on torture and trauma among refugees a particularly important resource for comparison.

A number of practical documents specifically addressing the situation of women refugees and immigrants proposing guidance to meet their special health needs have emerged over the past decade.[167, 171, 172] These guides point out the complex matrix of factors involved in field interventions, particularly in cases of sexual violence, and emphasise the need for a greater understanding of refugee women's care needs, particularly from the perspective of the women themselves. The authors of one field guide highlight the relatively new state of knowledge on refugee women's health care needs, admitting:

> [It] became painfully clear that there was little hard information about even the most basic questions relating to refugee women—how many of the refugees in a given situation are women? How do they participate in

decision-making? What are their specific protection needs? Do they make equal use of existing assistance programmes and so on.[167]

Similar types of questions could, and should, be posed about trafficked women's health and assistance needs at this relatively nascent stage in intervention development. How many trafficked women are likely to be able to access health support services and how will they best access them? What types of support will women most want, how will they prioritise their needs, and what role will they wish to play in assembling their support and protection strategies?

In summary, the documentary resources on migration were helpful to conceptualise the research, from developing a framework within which to consider the health of a mobile population to formulating relevant questions and methodologies that incorporated migration-related dynamics and health risks.

2.12.3 Violence against women

As previously acknowledged, for this research, the subject of trafficking in women can be included in the broader category of violence against women. Within the large body of literature on violence against women, theory, as well as studies on health risks and outcomes, proved most useful to this research. The latter (studies on health and violence) are cited and discussed primarily in the context of the findings rather than in this section.

Theories or models for understanding or analysing violence helped to conceptualise the range of risk and health issues potentially associated with trafficking, as well as to formulate an appropriate and ethical methodology.

Looking at violence more generally, Galtung, in defining violence, proposed a model in which three aspects of violence are depicted in the form of a 'violence triangle'. The triangle consists of: structural violence (a social process), direct violence (an event), and cultural violence (an ongoing belief or attitude that provides the rationale for the other two).[86, 99, 173] Galtung thus summarises that "with the violent structure institutionalized, and the violent culture internalized, direct violence also tends to become institutionalized, repetitive, ritualistic..."[173] This description can readily be applied to the trafficking in women because so many facets of trafficking appear to result from the convergence of social disparities and culturally-based gender norms. Both manifest as, and contribute to, direct violence—particularly in the form of sexual abuse.

A second, more gender-focussed model is the "ecological model" described by Heise, which also portrays a broad multi-layered perspective that distributes the risk factors for violence to the individual, interpersonal, community, and societal levels.[174] This model provides structural parallels that are widely applicable or adaptable to trafficking in women by situating women within micro and macro risk factors.

Sexual violence is a field of special relevance to trafficking. In writing on sexual assault, for example, White and Humphry contend that models of victimisation can fall into four categories: (a) psychiatric and psychological models (personal characteristics of the individual); (b) cultural norms of violence and sexism (cultural attitudes); (c) social context (environmental and situational factors); and (d) developmental models (generational, violence learned in the

home will be repeated).[175] This again emphasises that to understand why women might be targets for abuse and exploitation, and how it affects them, one needs to take into consideration the multiple layers that may give rise to or contribute to and tolerate abusive behaviours.

Within the literature conceptualising gender-based violence, some discussion has been dedicated to the terms "victim" and "survivor".[176, 177] In addition to their social and legal implications, each label has also been viewed as having health implications. The term "victim", used nearly universally in law enforcement and human rights fields, has been criticised by feminists for the disempowering effects it has on women, whereas the term "survivor" is favoured because it is seen to recognise women's resourcefulness or agency in the face of violence. [82, 177] The term survivor may have particular importance in the field of mental health because it may help a woman identify her strengths in the face of extreme adversity.[177] Yet, from a practical administrative perspective, it can sometimes be beneficial to employ the term "victim" for asylum claims or social services in order to gain access to public funds, legal rights, etc. As one NGO in Mexico explains:

> The term "victim" in the context of violence against women has generated much discussion as it carries with it the connotation of powerlessness of women. However, in the area of human rights, the term "victim" has been used to refer to someone experiencing injustice for which the perpetrator is responsible. It is indicates that the person or persons experiencing human rights violations have the right to reparation. As such, we have been using the term "victim" with this clarification, to highlight that rape, sexual violence and gender-based violence/violence against women are grave violations of human rights and that governments (as well as others) have responsibility in prevention as well as reparation to "victim".[178]

From this researcher's perspective, both terms seem to work well, as women who have experienced violence are surely victims of a crime, an injustice. Using the term "victim" is one way of letting women know that they are not responsible for what happened to them—they are victims. At the same time, using the term "survivor" acknowledges that women have actively participated in managing and enduring extreme life-threatening situations—that they have survived. This does, of course, raise the question of the meaning of "survival", but that is a discussion that is well beyond the scope of this thesis. (Both terms will be used in this thesis).

Over the past several decades, a significant body of research has developed on gender-based violence and health outcomes. These studies have provided substantial information that has informed, supplemented and often supported the findings from the data collected in this study. Studies on the physical, sexual, reproductive and mental health sequelae, women's social responses, such as shame and stigma, the frequency of early abuse and sexual abuse among victims of adult violence, and health outcomes resulting from multiple episodes or chronic violence were of particular relevance.[179-186] A great deal of the literature on domestic abuse and sexual violence and health is discussed throughout the body of this thesis.

To review the literature on the psychological aspects of violence against women it was beneficial to expand the search to include writings on "torture". In the case of trafficking in women, this body of work is particularly informative because of the similarities in control tactics, violence severity, extreme captivity,

and subsequent health outcomes.[105, 187] In discussing survivors of mass violence and torture, S. Turner, et. al., explain:

> Torture is intentional and systematic. It takes place covertly, in a world where rules are arbitrary and where control over even the simplest personal decision may be lost.... Torture and related fear-provoking measures may be construed as a means of repression by challenging directly the relationships of trust people share with one another [188]

This could easily describe the dynamics involved in trafficking. The features outlined in the above description (i.e., intentionality, systematic nature, unpredictability, loss of control, repression, and loss of trust) appear to be basic elements of the psychological dynamics of torture. Not surprisingly, these may also be seen as primary dynamics of gender-based violence.[106, 189, 190]

Also not surprising are the many parallels between the health outcomes of these survivors of different types of violence, as will be discussed throughout this thesis.

2.12.4 Labour exploitation and health

The general body of literature on labour and occupational health forms a significant potential documentary resource. Unfortunately, this library rarely includes research on the health risks or outcomes of female labour exploitation—which, if readily available, would be the area most relevant to work on trafficking and health. Articles in peer-reviewed health or medical journals on morbidity associated with labour exploitation also appear to be extremely rare and could not be found for this thesis. General information on labour exploitation most

readily appears in the human rights literature, but medical evidence on risks and outcomes is limited in these documents.[21, 191]

Unable to identify reliable resources specifically focussing on health and labour exploitation, it was therefore useful to look for documentation on occupational hazards in high-risk labour settings (e.g., factory, agriculture, mining), workplace abuse, and health violations that might take place in unregulated sectors known to employ migrant labour. Based on the limited reports that could be found, health risks identified with these different forms of labour exploitation appeared to include long work hours, high-risk work practices, poor equipment and poor training leading to injury, exposure to hazardous chemicals, negative reproductive health outcomes, and psychosocial stressors.[192-195] Given that many of the same industries that have exploitative, abusive or significantly below-standard working conditions are also those into which women are trafficked, it is important to review existing information on these informal labour sectors.

Domestic work, for example, is a sector in which women may be exploited and for which the occupational risks are numerous.[28, 196] Domestic workers, house-cleaners, and nannies who are exploited may endure long hours work hours, psychological stress, regular exposure to harmful chemicals, and may be exposed to physical or sexual abuse.[195, 197, 198] In Fiji, for example, eight out of ten domestic workers reported that their employers sexually abused them.[199]

In the case of agriculture, the latest estimates on hired farm workers suggest that roughly 80% of seasonal workers in the US were Latin American,

over half were undocumented and nearly two-thirds were living in poverty (this does not mean that they were "trafficked", however it does suggest the lack of protections that can lead to abusive conditions).[200, 201] Agricultural labourers have been found to experience higher than average occupational risk exposure and poorer than average health status.[202, 203] Significant among the health-related problems are pesticide-related illnesses and elevated levels of anxiety and depression.[193, 204]

Factory settings also provide an example of the rise in female labour exploitation and negative health consequences. The rapid growth of "export processing zones" (EPZs), otherwise referred to by some as "zones of oppression and exploitation" or "danger zones", has meant that low-wage jobs for women have increased around the world.[205] It is estimated that women constitute 70-90% of workers in export processing zones (EPZs) worldwide.[206] Women working in these settings complain of headaches, eye burns dizziness, vomiting and a range of musculoskeletal disorders due to repetitive work, and also report verbal, physical and sexual harassment resulting in mental health problems, including anxiety and depression.[194, 207] As one study on women working in Sri Lanka concludes:

> The women clearly identified the impacts on their health after they started working in the EPZ factories. They experience the changes in their bodies from attractive and health to decayed lifeless skeletons within a few years of the factory work.[205]

These types of exploitative conditions operate within particular political and economic contexts, as pointed out by Anderson and O'Connell Davidson:

[N]ational governments are heavily implicated in the construction of both "poor work" and "vulnerable workers" through their policies on immigration, employment, economic development, welfare, education and so on...we can say that the state plays a role in the construction of such demand, either through policies that institutionalise discriminatory attitudes or through their failure to effectively challenge discriminatory social practices.[34]

Like gender-based violence, labour exploitation is tolerated, if not perpetuated by political and economic powers that marginalise women and the poor. It is within this policy environment that health hazards occur and in which women are obliged to seek assistance for the harm that they sustain.

2.12.5 Sex work or prostitution

To date, the most recognised form of trafficking-related exploitation (but not necessarily the most prevalent) is trafficking into forced prostitution.[69, 208] Although there are numerous critical distinctions between trafficking into forced prostitution and other sex work situations, there are also health implications that are similar, making it an important literature base.

How sex workers and their health characteristics are conceptualised was of great importance to this study. Historically, it was not uncommon for the link between sex work and health to be thought of solely in terms of its threat to public health and hygiene.[23] More recently, in certain realms, discussions of sex work (and trafficking) have somewhat echoed this connection, suggesting the close association with a more modern public health threat: the spread of HIV/AIDS.[209] As noted by one expert on health care and sex work:

> Many health experts with a limited hygienic focus are solely interested in what role sex workers play in the dissemination of HIV and what kind of effective interventions can be developed to slow down the spread of the virus.[210]

This type of dialogue that sees sex workers as 'vectors of disease' appears to overlook the vulnerability of sex workers—and trafficked women in particular—to client-introduced infection. Particularly in the case of women who are trafficked, rather than being viewed as a 'core' population in terms of infection transmission, where male clients are normally viewed as the 'bridging' population, these labels might more accurately be reversed. That is, women who are trafficked may be more representative of a 'bridging' population' who become infected by serial users of sex workers, and who then pass the infection to their clients. Clients would thereby represent the 'core' transmitters, being the source of infection of previously uninfected trafficked women. While this is a more complex discussion than can be undertaken in this thesis, the implication of this shift in conceptualisation is significant in part, because of the stigma associated with prostitution. If seen as 'vectors' of disease, this view attaches an element of blame that tends to dehumanise women in sex work, making them a 'public health threat' requiring control and containment, overlooking their identity as a vulnerable population.

More progressive thinking around sex work and health emphasises that the health implications of sex work cannot be separated from the social and legal context and structural factors.[115, 211, 212] Describing their work with migrant sex

workers, one influential group, Transnational AIDS/STD Prevention among Migrant Prostitutes in Europe (TAMPEP), explains:

> Our focal point is HIV/STD prevention, but with a view to behavioural change, we are also concerned with the overall health of migrant prostitutes, as well as their social position and working conditions. The context of prostitution and migration policies has a direct bearing on the welfare of the target group.[121]

Taking account of the socio-cultural foundations that impact health is not an unusual position in the field of public health, but not without debate. As noted by Meyer and Schwartz in the *American Journal of Public Health*,

> We are concerned that the study of social and economic factors in public health may have unintended consequences that paradoxically serve to preserve disparities rather than eliminate them. This can occur because public health research transports social issues into the health domain, where they are examined through the narrow prism of health relevance instead of within their political, social and economic contexts.[109]

Yet, in the field of health, migration and sex work, this health-politics dichotomy has been recognised as fundamental to the discourse on sex work. TAMPEP, for example, has responded by becoming active in both the health service and political arenas, providing health outreach services to sex workers, while campaigning against what they see as oppressive and discriminatory immigration and labour laws.[121]

Moreover, there is a great deal of discussion that squarely situates migrant sex work in the context of labour exploitation and immigration, and recognises the range of cultural, social, and political factors that affect women's health and well-being.[114, 213-215] Wallman, in her article "Global threats, local options, personal risk: dimensions of migrant sex work in Europe" describes how

risk and risk-taking behaviour must be seen on multiple levels: one which involves the larger global context, a middle level in which the risk emerges, and an individual level where personal, individual decision-making occurs. She explains:

> Common assumptions about 'risky behaviour' are challenged by these complexities, but they are not beyond understanding: in context, even unreasonable behaviour becomes intelligible.[114]

This suggests that the term "risk behaviours" should be used with caution, as it is only within these layered contexts that it is possible to interpret women's decisions about their health.

More traditionally, the larger body of research on sex work and health has tended to focus on the transmission of sexually transmitted infections, including HIV, and has increasingly included discussions on sex workers' exposure to high levels of violence.[131, 210, 216-220]

Literature on STIs and sex work frequently includes exploration of risk factors associated with disease prevalence. For example, behavioural studies suggest that condom use (and therefore infection rates) may be influenced by the circumstances of the sex work that dictate women's negotiating power.[221-223]

HIV/AIDS has received a great deal of attention in trafficking discussions. However, to date, no large-scale survey has established prevalence among trafficked women. Based on studies of women working in sex work, it is likely that prevalence among trafficked women follows regional patterns, as highlighted by Ward, Day and Weber:

Prostitutes are most at risk of HIV in situations of widespread heterosexual transmission, where control of other sexually transmitted infection is poor.[216]

As suggested above, in examining risk many researchers have focussed on structural and social factors.[115, 212] Factors that have been linked to increased risk include work hours and volume of clients, unhygienic conditions, violence by clients and/or pimps, lack of control over sex acts and finances, dangerous life-style and living conditions, and, most importantly, a marginalised, stigmatised social and political position.[131, 210, 214]

Migrant sex workers are deemed to be most susceptible to high-risk situations and to obstacles, such as legal and language barriers, limiting their access to information and essential services.[224] The high risk level for migrants has obvious implications for trafficked women, who are likely to encounter danger and service impediments that are equal to or greater than those experienced by migrant sex workers.

The library of literature on sex work also includes a large section on intervention strategies. For low resource settings or to treat mobile populations, it is not unusual for literature on sexual health services to highlight syndromic management and presumptive care.[225, 226] The use of presumptive care for trafficked women is described in the "Recommendations for Reproductive and Sexual Health Care of Trafficked Women in Ukraine" which states that "presumptive treatment is recommended when the STI/RTI prevalence is high among a population and the patient is considered unlikely to return for follow-up treatment.[227]

The range of literature on interventions for sex workers is too vast to summarise, however, the more progressive dialogue on appropriate care that includes the concept of user-friendly services and promotes the participation of sex workers in their care was particularly informative for work on trafficked women.[228, 229]

How sexual health and HIV/AIDS services might be adapted for trafficked women has been examined by Huntington and Guest, as noted above. In their document for the World Bank, they suggest looking at models of care for HIV prevention among sex workers, and propose a collaboration between anti-trafficking and reproductive health organizations because of the human rights framework used by many groups working on HIV.[43]

2.13 Responses to trauma

2.13.1 Post-traumatic stress disorder

Important to undertaking research on women who are trafficked and sexually exploited is understanding the nature of trauma and psychological responses to traumatic events.   In her work *Trauma and Recovery*, Judith Herman offers a useful description of the theory that explains psychological trauma and reactions to traumatic experiences:

> Psychological trauma is an affliction of the powerless. At the moment of trauma, the victim is rendered helpless by overwhelming force. When the force is that of nature, we speak of disasters. When the force is that of other human beings, we speak of atrocities. Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection and meaning.[186]

Traumatic stressors are said to include: "harm, injury, and encounters with death, either by having one's own life threatened or by experiencing the death of others".[230] These descriptions seem particularly applicable in the case of trafficking.

One of the more commonly mentioned psychological reactions in cases of trafficking is the diagnosis: Post-traumatic Stress Disorder (PTSD) (from the Diagnostic and Statistical Manual of Mental Disorders (DSM IV))[231] PTSD has been repeatedly applied in discussions of the mental health outcomes of trafficked women.[232, 233] The United States National Institutes of Health (NIH) offer a concise definition of PTSD:

> [A] psychiatric disorder that can occur following the experience or witnessing of life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape.[234]

PTSD is a mental health problem that is clinically diagnosed based on categorical criteria. To be diagnosed with PTSD, an individual must manifest symptoms within three primary symptom dimensions after one month following a traumatic event: (1) re-experiencing the trauma in nightmares, intrusive memories or "flashbacks"; (2) numbing of affect and avoidance or thoughts, acts and situations that symbolize the trauma; and (3) symptoms of excessive arousal.[235]

Less discussed than PTSD is "acute stress disorder", which may offer additional insights into the psychological state of some of the women who have just recently emerged from a trafficking situation, and for whom the intensity of

the initial response will subside.[236]j Acute stress disorder is used to describe responses to trauma occurring within the first 30 days of the event that have many of the same symptoms, but do not require the same criteria as PTSD (e.g., duration and number of symptoms).[236] While this psychological effect was not explored in this study, it is worth noting that for many women, their initial symptoms may be associated with acute stress disorder—which is of shorter duration than PTSD, but also has predictive value for PTSD.

PTSD is only one of a number of post-trauma reactions, and has been repeatedly questioned by experts in the field of trauma and refugee research.[237-239] Research on post-trauma psychiatric morbidity is increasingly demonstrating that in addition to PTSD, trauma exposure may precipitate symptoms such as depression, anxiety, and hostility.[235, 240, 241]

2.13.2 Depression

Depression is perhaps among the more recognised post-trauma psychological outcomes.[241, 242] Depression, according to the World Health Organization (WHO) is:

> ...a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration. These problems can become chronic or recurrent and lead to substantial impairments in an

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j Acute stress disorder refers to the "responses to trauma occurring within the first 30 days of the event" and this diagnosis requires that the individual experiences at least three dissociative symptoms, as well as re-experiencing, avoidance, and hyperarousal. (American Psychiatric Association, 1994 Diagnostic and statistical manual of mental disorders. DSM IV. Fourth Edition. Washington D.C.: American Psychiatric Association)

individual's ability to take care of his or her everyday responsibilities. At its worst, depression can lead to suicide...[243]

Depression is twice as common in women than in men, and thus far, no biological causes have been detected to explain this difference in prevalence.[89] To date, depression among women has been associated with social factors, within which violence figures prominently. Support workers contend, and research on violence and depression support the idea, that long-term and major depression is a common response to abuse, particularly chronic and/or repeated experiences of physical and sexual violence.[89, 183, 184, 244, 245]

Moreover, there is evidence of the body's chemical alteration associated with an abuse history. For example, research on sexual abuse survivors indicates that there are increased pituitary-adrenal and autonomic responses to stress and that women with a history of abuse had more than a six-fold greater hormonal response than age-matched controls who had not been abused.[246]

There is significant evidence that symptoms of major depression are also strongly connected to post trauma stress symptoms, and major depression is frequently detected among torture survivors and survivors of other traumatic events.[235, 244] Some experts have even warned that with the emergence of the PTSD as a diagnosis, symptoms indicating major depression may be lost within this diagnosis.[244, 247]

Moreover, research on co-morbidity of PTSD and major depressive episodes have found higher rates of suicide attempts in those with the co-occurrence of depression and PTSD than among individuals with only a history of major depressive episodes.[247]

In the literature on gender-based violence and depression, "hopelessness" and the inability to control events in the future hold a significant place. Some experts have posited a "hopelessness theory of depression". This theory describes how individuals who develop low or negative expectations about the outcomes of events, and feel helpless to change the course of events, are likely to develop depression that is characterised by a "more generalised expectation of hopelessness".[248, 249]

2.13.3 Anxiety

Anxiety is a symptom that is often associated with trauma and part of the constellation of traumatic responses.[250] Extreme forms of anxiety generally fall under the label "anxiety disorders", which includes "post-traumatic stress disorder" and are "chronic, relentless, and can grow progressively worse if not treated".[250] It is not uncommon for anxiety to co-exist with other disorders, such as depression, although research by Heller, et. al., suggests that "depression and anxiety are accompanied by distinct physiological, cognitive, and emotional characteristics that appear to reflect the activity and function of different regions of the brain".[242, 251-253]

Past physical and emotional abuse or childhood neglect have been shown to be strong predictors of anxiety.[254, 255] Symptoms of anxiety include nightmares and sleep problems, restlessness, nervousness, being easily startled, and having persistent frightening thoughts.[256] Some sufferers experience panic reactions, such as heart palpitations sweating, dizziness, or faintness. [255] In a study of rape

victims, for example, the most frequently reported anxiety-related reactions included "sense of unreality, fear of losing control of emotions or behaviour, shaking, and rapid heart rate". Nearly all victims reported four or more of these feelings during the rape.[256]

For those with a history of trauma, anxiety can be triggered by an event, sign or sensory observation that reminds the person of past trauma.[256] Research has suggested that anxiety related to a history of abuse may also make individuals more vulnerable to revictimisation. Nishith, et. al. have postulated that anxiety, among other post-trauma symptoms, may interfere with an individuals' "cognitive appraisal of risk in potentially vulnerable situations or lessened ability to resist and defend themselves once in a situation".[257]

2.13.4 Hostility

Symptoms of hostility have been linked to PTSD, and are aspect of the syndrome that have been studied primarily in Vietnam War veterans.[258, 259] Of the research that has looked at PTSD-related hostility and aggression among women, findings suggest that women may display symptoms of hostility, but are less likely to show signs of aggression.[260] Research has also connected a history of childhood violence with hostility.[247]

It has been hypothesised that hostility may be, in part, a result of an individual being cognitively attached to negative events and feeling unable to free herself of the debilitating consequences of these events (e.g., intrusive thoughts of powerlessness, victimisation, anger and sadness).[261]

Research on forgiveness related to hostility and PTSD suggests that forgiveness may have a "mediating effect" on hostility-related PTSD among survivors of childhood sexual abuse.[261] It has been postulated that through forgiveness of "self" and "circumstances", an individual may be less constrained by negative thinking and able to focus on more constructive thoughts. As explained by Synder and Heinze:

> A lack of forgiveness in PTSD in abuse survivors...may influence the development of PTSD symptoms in that the inability to "let go" of the traumatic experience creates a victim mentality wherein the person's hostile thoughts and feelings about the trauma are repeated over and over.[261]

The primary focus of the forgiveness was of significance for the self and the situation, and less so for the transgressor.

Importantly, in research on PTSD, depression and suicide, hostility is a particularly indicative symptom domain to consider when evaluating an individual's likelihood to carry out a suicidal act.[247]

2.14 Chapter discussion

A thematic thread that ties together the groups reviewed in this chapter is the marginalisation or vulnerability which they appear to share. Although each population may experience discrimination for different reasons, each seems to be disenfranchised in practical and psychological ways that can affect their health. A great deal of this thesis, from the conceptual models to the research instruments and the interpretation of the data, is grounded in the literature on these multi-faceted forms of risk and marginalisation. As will be seen,

discussions within each chapter refer often to the links with these various populations and their health characteristics. This not only adds depth and validity to the findings, it also suggests where the features of the populations might depart from those of trafficked women.

The next chapter, *Conceptual models*, highlights how this literature informed the development of the two conceptual models that form the basis of the studies. The frameworks presented are based on what is known or theorised about the health needs of other vulnerable groups, such as victims of domestic violence or torture, migrant labourers or sex workers. Piecing together relevant information on health risks, outcomes and service needs on the various populations was a primary step in developing operationalisable models for studying trafficked women and understanding the findings.

This review also contributed significantly to the ethical and safety recommendations that were developed as part of this research. The case examples from the literature on trafficking and the risks and ethical dilemmas documented in research with other vulnerable populations exposed many of the challenges that might be associated with investigating trafficked women. It suggested methodological questions such as how to safely contact, interview and produce information on individuals who are at risk and who live at the margins of society.

How this literature was developed into operationalisable frameworks for research is described in the following chapter.

CHAPTER 3: CONCEPTUAL MODELS AND ETHICAL AND SAFETY GUIDANCE

3.1 Chapter introduction

This chapter presents two conceptual models developed for the studies carried out for this thesis. These models are grounded in the literature described in the previous chapter and offer a specific framework for examining women's health in the context of trafficking. At the time this work was conducted, there was little to no conceptual thinking on health and trafficking and only a small number of documents attempting to place trafficking within a theoretical framework.[13] Therefore, developing theoretical and practical structures to guide the studies was an important first step in the research methodology.

The primary aim of the two models described in this chapter was to define and distinguish key concepts related to health in the trafficking context and to propose their coherence, i.e., how they link together. The secondary, but equally important goal, was to establish a structure that could be operationalised for research. That is, these models had to offer definitions, concepts and interconnections capable of being implemented in a study, e.g., applied for questionnaire development, analytical structure.

The first conceptual model, "Stages of the trafficking process", frames the health aspects of trafficking from a migration perspective, outlining the chronological/geographical movement of individuals. The second, "Abuses and health consequences chart" delineates health dimensions and detail about

different health characteristics in order to highlight potential areas of health and medical need.

The last section of this chapter describes the recommendations developed to address some of the potential ethical and safety challenges that may arise when researching women who have been trafficked. Rarely do the dangers to vulnerable groups diminish under the scrutiny of an investigator but, instead, very often research on trafficked women is replete with risks to the women being interviewed, to those conducting the interviews, and sometimes to individuals associated with one or the other.

The models described below form the foundation for the methods and frame and inform the findings of this thesis.

Health risks and opportunities
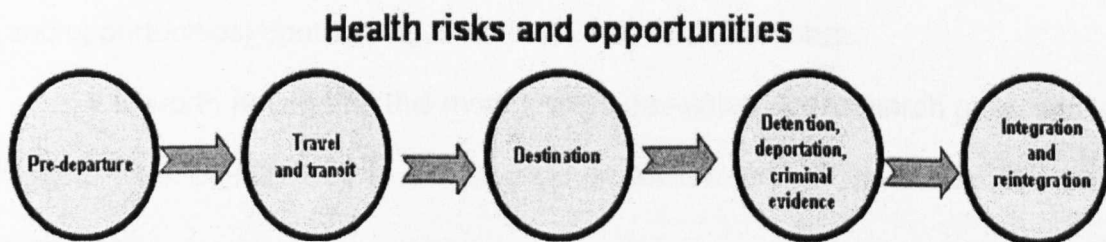
Figure 3.1 Stages of the trafficking process

3.2 Conceptual model one: *Stages of the trafficking process*

Drawing on existing literature and theoretical models, the first model, *Stages of the trafficking process* offers a conceptualisation of health and trafficking that informed the design of the studies and interpretation of findings. It

represents a migration perspective of women's exposure to health risks throughout five stages of the trafficking process.

This model builds heavily on two migration frameworks, one that adopts a health perspective[120] and the other that views trafficking as "an intermediary part of the global migration business".[67] The migration and health model, proposed by Gushulak and Macpherson, presents "three discrete but interdependent" stages of a migration process (pre-departure, transit and destination).[120] The second, described by Salt and Stein, defines three similar divisions: "mobilization and recruitment of migrants; their movement en route; and their insertion and integration into labour markets and host societies of destination countries".[67]

By adopting this migration view, the *Stages of the trafficking process* model separates potential health risks and effects of trafficking into chronological stages, while at the same time highlighting the cumulative nature of the risks (and opportunities) contributing to an individual's health status.

It is worth noting that this model, while developed for research purposes is likely to work equally well to contemplate targeted interventions associated with each stage.

3.2.1 Pre-Departure stage

The *pre-departure stage*[120] is the initial period in the trafficking process and encompasses the time before a woman enters the trafficking situation. This stage may influence a woman's vulnerability to being trafficked, reflect her mental and physical health characteristics at departure, influence her health-seeking

behaviour throughout the trafficking process, and affect her responses to care and her resilience.

It is reasonable to speculate that some of the factors that may negatively influence an individual's physical and psychological health during this early stage may also predispose them to being trafficked (e.g., poor living conditions political instability, interpersonal violence). Key dimensions of this stage considered fundamental to an individual's health were. 1) individual history; 2) experience with health care; and 3) epidemiological and socio-economic conditions. Each dimension will be discussed according to the ways it potentially affects a woman's health before and during the trafficking process and will be considered from a gendered perspective.

Individual history

There are many personal-individual factors which work together to construct a woman's health characteristics prior to leaving home. These may include *inter alia* a woman's biological and genetic make-up, socio-economic circumstances, and history of illness or injury. Particularly influential for most trafficked women however, is prior exposure to abuse. Because it is beyond the capacity of this thesis to research and analyse in-depth each of the possible individual health contributors, the discussion below focuses primarily on a woman's personal history of abuse.

History of abuse

Studies on partner violence from around the world indicate that gender-based physical, psychological and sexual abuse are prevalent.[262] Data from post-trafficking assistance centres suggest that a history of interpersonal violence and family dysfunction or instability is particularly common among women survivors of trafficking.[263, 264] For example, according to client data from IOM Kosovo, of the 76% of women living with their families prior to leaving home, over one-quarter reported having had difficult or very bad relationships with their parents or husband/partner. Of these, nearly 28% reported having been physically abused, and 13% reported having been sexually abused by a family member.[265] Similarly, client data collected by Animus Association Foundation of Bulgaria, a non-governmental organisation operating a Rehabilitation Center for victims of trafficking, also indicate that adolescents and women with past traumatic experiences made up a significant portion of their client base.[125] This included victims of domestic violence, sexual assault, children from orphanages, and children with a large number of siblings and only one parent.[125]

The implications of past abuse are multiple. First, there is reason to speculate that abusive or stress-filled living conditions may make women more vulnerable to being recruited for trafficking. Needing or desiring to flee abuse, women and girls may actively seek ways to escape or may display characteristics that make them appear vulnerable. For example, it has been suggested that traffickers may target young girls who they perceive to be poor,

distressed or who reveal family problems[40], and that young women and girls who come from dysfunctional families easily fall prey to traffickers.[266]

A second implication of previous exposure to abuse is the adverse health effects that may persist or be exacerbated during the trafficking process— particularly as other risk or high stress situations emerge. Behavioural and physiological changes that occur in response to high-risk, threatening events have been shown to have negative impacts on health even after violent episodes cease.[78, 267, 268] Both in the short and longer term, women's physical and mental health conditions may be affected by previous abusive or dysfunctional family or interpersonal relationships.[185, 254, 269] For example, research consistently finds that women who have experienced childhood sexual abuse and individuals 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.[270-272]

These experiences which, in themselves, have immediate negative health consequences, may also be predictive of future and perhaps greater morbidity.

Experience with health care

The nature of a health care system and a woman's access to and personal experience with health information and care can have direct effects on her present and future health-seeking behaviour.[273]

In the field of sexual health, for example, women's access to knowledge of and services for contraception and STI prevention are important protective

factors.[274] Yet, around the globe, women's awareness of reproductive and sexual health remains low, particularly among young women in less-developed countries.[275-277] When health promotion activities are conducted in the community where a woman lives, and they are of sufficient quality and duration, a woman is likely to be better prepared to protect herself from STIs than a woman who has not had ready access to this information.[86, 153, 278]

A woman's lack of health-based knowledge and poor experiences with the health sector in her own country can translate into limited capacity to know when she needs care and a hesitance to actually seek health services in another country. A woman's preconceptions about, for example, the expense and/or capacity of services or poor confidentiality may deter her search for care. These barriers are, of course, in addition to the more basic obstacles associated with an exploitative situation (e.g., captivity). Learning about women's notions of health and care in their home country and preconceptions about health services in a given destination setting is potentially important to developing accessible interventions.

3.2.2 Travel and transit stage

The *travel and transit stage* begins when a woman agrees to go, 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 can also include travel between work destinations and often involves one or numerous transit points.[24] A woman can have several periods of travel and

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transit, such as when she is sold from one work destination and "re-trafficked" to another.[91]

During this time women may be exposed to dangerous modes of transportation, high-risk border crossings, arrest, threats and intimidation, and violence, including rape and other forms of sexual abuse.[120] Events during this period can pose risk of injury and death, cause extreme stress, and establish a woman's vulnerability to later risk and ill-health. This period frequently represents the beginning of the cycle of harm to come.

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.[102]

Information about travel-related incidents do not often appear in the health literature, but are most likely to appear in news articles[279] or via service providers' accounts of women's stories.[280]

For this study, the features of interest for this stage were 1) the "initial trauma"; 2) high risk travel; and 3) buying and selling of women.

The initial trauma

While many women leave their homes with hope and courage, these feelings are frequently accompanied by uncertainty and anxiety. This is particularly common in cases of trafficking where the women perceive that a portion of what is taking place may be less than legal (e.g., forged documents,

illegal border crossing, unregulated employment). Many discover during the journey that their anxiety was merited as they learn that they are now in life-threatening danger with little or no way out. This psychological jolt may be considered the point of the "initial trauma"[281] Whether introduced by a violent act or experienced as shock from having learned their fate, this first trauma establishes the context of danger that now becomes the woman's reality.

High-risk travel

High risk travel is often an integral element of illegal migration. Some individuals who migrate illegally travel by standard means. However, it is not uncommon for many to face life-threatening dangers, such as rushing rapids, active war zones, malarial-infested jungles, suffocation in locked containers or drowning at sea.[146, 279] For those travelling by illicit means, journeys can be long and arduous, with periods of little sleep or nutrition, and may include armed escort.[282] Covert travel can pose many dangers, particularly because agents aim to make maximum profit from each trip and avoid detection, and are therefore prepared to take risks with women's lives. This can be a time of significant additional risk, as women who, suddenly recognising the danger they are in, go to dangerous lengths in their attempt to flee.[282]

Buying and selling of women

It is during this phase that the main financial transactions generally take place, 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". In a majority of trafficking cases, the arrangements for travel and the expenses incurred are tallied and multiplied, putting women in a situation of "debt-bondage".[135] The psychological effects of this type of "merchandising" of women has not yet been studied, but it is not difficult to speculate that being assigned a monetary value or being "traded" is a humiliating, dehumanising process that has serious social and psychological implications.

Physical and sexual violence frequently accompany these first transfers of women. While in transit 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. Regularly on the move, unfamiliar with their surroundings, often unable to speak the language, without legitimate papers or status and treated like "cargo", women are limited in their ability to seek help. Women may also believe—or have been told—that the risk of contacting authorities would be unhelpful at best (e.g., they won't help an undocumented migrant) and to their extreme detriment, at worst (e.g., they will be returned to the traffickers, their family will be harmed).

3.2.3 Destination stage

The *destination stage* is the period that a woman is put to work and her labour is exploited. The destination stage epitomises the range of abuses most often associated with trafficking[135] and the dangers and violence that pervade women's work and private existence.

The potential abuses and outcomes during this stage are so wide-ranging that they are best viewed within a categorical framework such as that outlined in conceptual model two (See Table 3.1).

The multiple forms of abuse (e.g., physical abuse, sexual abuse, psychological abuse, forced and coerced use of drugs) often occur simultaneously and can compound or exacerbate each another in ways that increase morbidity and risk of fatality.[283]

For women who have been trafficked internationally, this panoply of abuses takes place in a foreign country, which can increase their vulnerability to harm as they are in utterly unfamiliar surroundings, often do not speak the language, perceive they have no legal rights, and feel alienated physically and psychologically.[73, 284]

Exactly how these circumstances may affect women from different backgrounds is difficult to project. Cultural and social meaning of events and their consequences is likely to differ greatly for women who are within and between cultures.[82] A woman's social and cultural framework can influence how she contextualises abuse and the survival strategies she may develop both while she is enduring the abuse and once she has escaped it.

A trafficked woman's risk level and opportunities for assistance are further complicated by the perverse circumstance in which her relative well-being frequently depends on the very individuals who are harming her. Paradoxically, women's basic needs, health and safety e.g., not incurring harsher abuse or conditions, resale, reclamation of their documents, and often their passage out are dependent on pleasing (or not angering) those who are managing their exploitation.

Because trafficking situations can vary so widely, it is useful to think of trafficking-related risks and abuses as a continuum. Some women may suffer life-threatening to fatal assaults, while others may be less abused and emerge with their physical health relatively intact.

3.2.4 Detention, deportation, and criminal evidence stage

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 co-operating voluntarily, or under threat of prosecution or deportation in legal proceedings against a trafficker, pimp, exploitative employer or other abuser.

This stage applies primarily to the small minority of women who are detected or who come to the attention of authorities.

Women's vulnerability and rights during this stage have been noted in a number of human rights documents and government reports[19, 91, 285] and outlined

in key pieces of legislation.[134, 286] An increasing number of publications are also providing guidance on the treatment of victims by law enforcement.[287-289]

Women who leave or are freed from a trafficking situation and who come to the attention of authorities generally do so in one of several ways: they may be detained as an undocumented migrant, e.g., held in a detention centre; they may be picked up and immediately removed or deported, or they may be asked/given the opportunity to participate in a legal proceeding, e.g., give evidence to police and/or in a court of law. The legal provisions requiring women to cooperate in a prosecution in exchange for leave to remain/temporary residency are particularly stringent and influential, but beyond the scope of this thesis.

Nonetheless, for the most part, health has been an issue that is generally sidelined or disregarded when a woman is out of a trafficking situation and in the custody or auspices of authorities. Health-related issues key to this stage include: 1) Attention to women's health needs; and 2) Psychological impact of contact with authorities and/or participation in legal proceedings.

Attention to women's health needs

Although it may seem that once a woman is in the hands of authorities, she should begin to feel a sense of safety, desire for health care and hopes of recovery, this is often not the case. In reality, there are many stresses and dangers that may emerge at this stage. Women may be treated as victims of a crime and their immediate health needs left unattended. Women may be quickly removed or deported, with no inquiry into their physical or psychological health

needs, urgent or otherwise. And, even in cases in which a woman is identified as having been trafficked, officials may not be prepared or authorised to enquire about or respond to her health needs.

Moreover, the obligation to provide evidence or to testify in court placed on women who are recognised as victims[134] adds significant psychological burdens and, for some, physical risk. Women who are returned to their home country are generally left to fend for themselves, often confronting inadequate or inaccessible medical care in their home country and the possibility of reprisals of traffickers or perhaps the return to exploitative labour.

Psychological impact of contact with authorities and/or participation in legal proceedings

While not universal, for many women contact with authorities after a trafficking experience is stress-filled and, for some, may be traumatic. Women frequently mistrust and are nervous about the intentions of law enforcement or immigration officials (e.g., concerns about connections with the trafficker, being sent back, about imprisonment). Women may also doubt authorities' abilities to ensure their security (e.g., from the traffickers). When in the custody of authorities women are likely to be requested to recount highly distressing events to persons they hardly know. Interviews may take place in an environment that is not necessarily supportive or carried out by individuals who are unequipped to respond to strong emotional reactions. Law enforcement personnel are unlikely to have the necessary counselling skills to deal with, for example, suicidal

ideation, panic attacks, etc. Women may also have great difficulty grappling with and explaining the complexity of their circumstances while they were in the trafficking situation. It is not uncommon for a woman to have knowingly participated in illegal activities, while still also being a 'victim' of trafficking. She may have, for example, knowingly crossed a border illegally, used false documents, or assisted in collecting other potential victims. The seemingly contradictory role of being both victim and law-breaker can add further stress to conversations with law enforcement. For women required or requested to provide testimony for a prosecution, this psychological pressure of recounting past events is likely to fluctuate over months or even years. For many, their testimony may take place at time when they are trying to 'move on' psychologically; retelling events may be akin to reliving them, drawing them back into traumatic moments and emotions.

Unfortunately, no research has yet been conducted on the psychological effects of being in police custody, being in detention or participating in a prosecution.

3.2.5 Integration and reintegration stage

To define this post-trafficking stage it was useful to draw on the definition of integration in the European Council on Refugees and Exiles' (ECRE) Good Practice Guide on the Integration of Refugees in the European Union.[290] This stage is described as the "long-term and multi-dimensional process of either integrating into the destination country" or, in the case of an individual who is

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returning, reintegrating into one's own country. The definition emphasises that this is a "process" and that it 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".[290]

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

This stage very often overlaps significantly with the Detention, deportation and criminal evidence stage. However, events related to the Detention stage may, in practice, hinder a woman from fully immersing in the integration/reintegration process.

Literature on migrants, asylum-seekers, refugees, and survivors of sexual abuse highlights several key risks to health that may be associated with this period.[167, 291-294] Health-related features of interest may include: 1) personal security risks; 2) legal insecurity; 3) barriers to health care; 4) isolation, exclusion and stigma.

Personal security

Personal security risks perhaps most distinguish trafficking victims from victims of many other types of crime. Both women who remain in a destination setting and those who return home may face retaliation by a trafficker or his/her cohorts. This is particularly true when mafia-like organisations have been involved. A woman who has escaped or been freed may be viewed as a threat to their operation and liability leading to possible arrest. For trafficked women who have had an intimate relationship with their trafficker, the risk may be as great or greater.[295]

An important personal security risk linked to the post-trafficking period is the danger of being retrafficked. Retrafficking may occur either because the woman is forcibly re-recruited by the trafficker, or because the woman agrees to leave again (e.g., because she is stigmatised within her community, she has hopes of earning and keeping the money, etc.).

Legal insecurity

Legal insecurity primarily relates to those who are not returning home, who are trying to integrate into a new country and new culture. In many cases, women who stay in a destination country remain in a 'legal limbo', as acquiring official temporary or permanent residency status can be difficult.[91] This state of uncertainty can have practical as well as psychological implications. Women's access to care and support may be limited by her legal status. Unstable legal

status is a common source of immense distress for asylum-seekers and refugees.[296-298]

Potential barriers to health care

Although challenges in accessing health care in a destination setting may appear quite different from those confronted by an individual returning home, there are a number of clear similarities. Among the most obvious are the financial constraints faced by both immigrants and returnees. In destination settings, women may not have legal rights to public services or they may be in a state that does not have good access to publicly funded health services (e.g., United States). In low and many middle income countries of origin, while medical care may be officially free, in reality it is not uncommon for individuals be be required to pay for a variety of services.[299]

Fears over confidentiality are another common obstacle, especially those pertaining to sexual health —particularly for women who return home. For example, in Russia and other former Soviet states, former practice guidelines 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.[300] As recently as 2000, findings from Russia indicated that despite changes in law, confidentiality and anonymity continued to be poorly understood by medical practitioners, accorded little priority, and remained barriers to access.[300] Although confidentiality measures may be more reliable in destination settings, women coming from places where their privacy would not have been respected would have little reason to trust it elsewhere.

Mental health is another issue that will pose significant service challenges in either setting. Psychological outcomes from violence are frequently deeply felt and long-term[241, 301] and therefore identifying and paying for appropriate and ongoing care may be problematic.

For a woman who has returned home, finding time away from family or a job to attend medical appointments may not be feasible, and there may not be trained practitioners available in her local area to diagnose or treat her health problems.

Isolation, exclusion and stigma

Feelings of isolation, exclusion and stigma can significantly influence how well a woman integrates or reintegrates. Stigma, rejection and fear of rejection by family and/or community members are subjects that come up frequently in the literature on women trafficked for sex work.[12, 91, 302] Perception that one is an outsider or feelings of non-acceptance may lead to a host of negative consequences, such as inhibiting women from seeking support, adopting risk behaviours (e.g., substance misuse) or contributing to women's vulnerability to re-trafficking.

This model is meant to work as a definitional model, operationalising terms and concepts. In its entirety, it also functions to some degree as a very general causal framework. Like other migration models, this cycle model hypothesises that the risks associated with each stage are components that ultimately contribute to the health status of a trafficked person.

3.3 Conceptual model two: *Abuse, health risks and consequences*

Table 3.1 represents the second model, *Abuse, health risks and consequences*, which draws significantly on concepts and terminology from the body of work on violence against women and health.[46, 106, 190] This table was developed to complement the *Stages of trafficking process* model by delineating specific abuse-related health risks that can occur at each stage of the process, but most comprehensively at the destination stage. The two models work well together because the first captures health from a chronological and mobility perspective, while the second details potential risks and health outcomes.

The first three categories (physical abuse, sexual abuse, psychological abuse) are the most commonly recognised in research on gender-based violence. Many of the features of partner abuse and associated health consequences can readily be identified in the trafficking context.[179]

As detailed in Table 3.1, the "physical violence" category may include physical assaults, such as beating, kicking, and physical deprivation (e.g., food, sleep, light), or a combination. The abuses listed may be defined as acts of torture.[105] Health outcomes can include injury, exhaustion, starvation, and psychological harm.

The items in the category "sexual abuse" are drawn heavily from literature on sexual assault, sex work and sexual and reproductive health outcomes.[106, 123, 216, 303] Forced vaginal or oral sex, gang rape, anal rape and sexual humiliation are included among the risks. Sexually transmitted infections, including HIV/AIDS, damage to the reproductive tract, and unwanted pregnancies are

among the potential negative health outcomes. Poor mental health outcomes are closely linked with each of the forms of sexual abuse listed.[304-306]

The category of psychological risks and consequences plays an extremely important and cross-cutting role in this model. Although it is set as a separate category, in reality it is correlated with each of the categories. Because so many forms of risk are also psychologically abusive (e.g., assault, deprivation, economic abuses have psychological outcomes), the outcomes in this category cut across most of the other risk categories. Nearly all of the symptoms or pathologies listed under the heading "mental health" problems have been found among individuals exposed to repetitive trauma (e.g., depression, anxiety, suicidal ideation), including victims of other forms of gender-based abuse.[186, 245, 306, 307]

The fourth category, "forced and coerced use of drugs and alcohol", grew out of a combination of the literature on gender-based violence, sex work and case examples of trafficking.[121, 131, 308, 309] The idea that drugs are tools of power and control is important, for example, where pimps use a woman's addiction to drugs to keep her in sex work or maintain control over her income by controlling her access to the drugs. Coerced use of alcohol is a particular feature of trafficking of women to Japan and women to Kosovo.[265, 302] Women work in clubs where they are obliged to encourage the purchase of drinks by clients, which often results in the woman having to consume tremendous amounts of alcohol. Drug and alcohol use may be viewed simultaneously as negative coping behaviours.

"Social restrictions and manipulation" and "economic exploitation and debt bondage" are closely related to the social and economic forms of abuse that have been described in literature on intimate partner violence (e.g., restrictions on movement, emotional manipulation, controlling personal contacts, maintaining control of income).[310, 311] Additional forms of control for victims of trafficking might include: frequent relocation, favouritism among women, perquisites for compliant behaviour, and control over women's contact with home or outsiders. By maintaining control over a woman's social sphere, traffickers effectively ensure that the woman is singularly reliant on him/her.

"Economic exploitation and debt bondage" is closely associated with labour exploitation and is often seen as the defining feature of a trafficking situation. Women in the trafficking situation rarely have control over what they earn and are frequently subjected to deceptive accounting practices and usurious repayment obligations, such as housing, food, clothing, condoms, medical care and inflated debts related to travel costs. Women may also be financially penalised for perceived misdeeds, tardiness or non-compliance. The situation of unending debt or debt-bondage can place pressure on women to undertake high-risk practices (e.g., anal sex without condom) to increase their income. False promises of future payment keep women hoping that they will eventually earn the money that was offered—and that they have seen change hands. The consequence of this financial smoke and mirrors is that women are unable to control their access to basic necessities or health and medical care. For many

women, returning home without the promised income also leads to shame and stigma.

The next two categories, Legal insecurity" and High risk, abusive working and living conditions, emerged from the available information on trafficking and sex work.[5, 7, 115, 224] The confiscation of women's official documents (e.g., passport, visa, tickets) and women's subsequent concerns over their legal status are well-recognised aspects of control used by traffickers. Women's insecurity about their legal status in a destination state is nearly always a source of anxiety and can be a barrier to care. High risk, abusive working conditions are the primary labour exploitation aspects of trafficking—and highlight the difficulty in distinguishing it from "labour exploitation". The poor to intolerable circumstances of women's workplace and working conditions comprise the most widely recognised trafficking-related violation. Women's living conditions, when described, are generally mentioned as a side note—even though in some cases these situations may be even more violent, unhygienic or frightening than the work environment.

Finally, Risks associated with marginalisation is a category that relies heavily on health literature on immigrants and refugees, and the general literature on sex work.[74, 115, 210, 290, 312-314] Incorporating "marginalisation" in this model underlines the impact of the cultural, social and gender dimensions of trafficked women's compromised situation. Women who are trafficked internationally may experience any and all of these types of discrimination and/or isolation at any point in the trafficking process (or every point). By highlighting

the marginalisation women might experience as a result of their immigrant status, sex work, and as victims of gender-based violence, this model recalls the framework in the previous chapter (e.g., Figure 2.1 *Marginalised and vulnerable groups*). The immigration aspects of this category recognised that one cannot ignore that women who are trafficked are marginalised by nearly all of the same factors as other migrants (e.g., language, culture, logistics, discrimination), and it is this migrant status that constantly underlies all of the other trafficking-related factors.

A connecting and defining feature of the range of risks and abuses in this model is the element of "control". Power and control is frequently discussed in the literature on gender-based violence.[315-317] Most fundamentally, the traffickers have it, the women do not. Traffickers and their accomplices use their position of power to rule various aspects of a woman's existence, directing what a woman does and how she perceives the world. The degree to which an individual woman loses control over her body and her situation to a perpetrator of violence and/or exploitation can be seen as directly and indirectly related to her health and well-being.[317]

While this model is informative in providing a list of potential risks and outcomes, it is limited in its capacity to describe the relationship between them. For example, within each risk/consequence category, it is not possible to rank them in a continuum from least to most harmful or painful. They fall more realistically into a 'spectrum' in which risks and consequences can vary in characteristic and degree. Physical risks, for example, may range from lack of

control over what and when food is eaten to starvation. A blow to the head may be startling or deadly. Moreover, the degree to which one act of abuse might affect one woman versus another woman is unpredictable. Would a lie about a woman's child being ill be more or less distressing for one woman than a death threat to another?

Another question that this model does not attempt to answer is about the impact of multiple abuses. Risks and abuses are rarely singular in nature, but are instead often combined in a calculated manner to instil fear and ensure compliance. 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, one would have great difficulty in trying to link one specific type of abuse to a defined set of consequences. Most forms of violence listed in this framework, correspond to multiple negative health outcomes across categories. As noted above, mental health outcomes are perhaps the most ubiquitous. It is hard to imagine a category of "abuse" that would not result in some psychological complications. The cross-links between categories and outcomes are even more complicated than this, though. For example, evidence from studies show that sexual violence results in sexual and reproductive health complications and mental health problems (at minimum),[305, 318] which in turn can affect women's ability to function in social and occupational settings.[89]

In reality, the various forms of abuse and coercion intersect numerous times in different ways to create a labyrinth of risk and ill-health. While the categories in this chart may be delineated in somewhat artificial ways, practically, these distinctions are useful for exploring different health risks and consequences associated with trafficking. Examining each separately, while considering them collectively, provides a useful guide to understanding their comprehensive impact.

Table 3.1 Abuse, health risks, and consequences associated with trafficking in women

FORMS OF ABUSE AND RISK	POTENTIAL HEALTH CONSEQUENCES*
PHYSICAL ABUSE • Murder • Physical attacks (beating with or without an object, kicking, knifing, whipping, gunshots) • Torture (ice-baths, cigarette burns, suspension, salt in wounds) • Physical deprivation (sleep, food, light, basic necessities) • Physical restraint (ropes, cuffs, chains), confinement • Withholding medical or other essential care	**PHYSICAL HEALTH PROBLEMS** • Death • Acute or chronic physical injuries (contusions, lacerations, head and neck trauma, concussion, scarring, soft tissue injuries, musculo-skeletal damage, orthopedic trauma) • Acute or chronic physical disabilities, (nerve, muscle or bone damage, sensory damage, dental problems) • respiratory problems • Fatigue, exhaustion • Poor nutrition, malnutrition, starvation • Deterioration of pre-existing conditions leading to disability or death
SEXUAL ABUSE • Rape (vaginal, anal, of virgins) forced oral sex, coerced sex, gang rape, degrading sexual acts • Forced prostitution, inability to control number or acceptance of clients • Forced unprotected sex, forced sex without lubricants • Unwanted pregnancy, forced termination of pregnancy (TOP), unsafe TOP • Sexual humiliation, forced nakedness • Coerced misuse of oral contraceptives or other contraceptive methods	**SEXUAL AND REPRODUCTIVE HEALTH PROBLEMS** • Sexually transmitted infections (including HIV/AIDS), and related complications, including pelvic inflammatory disease (PID), cervical cancer, infertility • Urinary tract infections, (cystitis, kidney infection) • Amenorrhea, dysmenorrhea, irregular menstrual cycle • Acute or chronic pain during sex, tearing and other damage to vaginal tract, • Complications from unsafe termination of pregnancy (TOP), including incomplete TOP, tears in the cervix, perforation of the uterus, infection, septic shock, hemorrhaging • Irritable bowel syndrome, stress syndromes • Inability to negotiate sexual encounters

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* Many of the forms of abuse overlap, as do their consequences. In particular, negative mental health consequences frequently result from each of the different forms of abuse. To avoid repetition will be highlighted primarily under "Psychological abuse."

FORMS OF ABUSE AND RISK	POTENTIAL HEALTH CONSEQUENCES[*]
PSYCHOLOGICAL ABUSE - Intimidation of and threats to women and their loved ones - Lies, deception, blackmail to coerce women, to discourage women from seeking help from authorities or others, lies about authorities, local laws, legal status, family members - Emotional manipulation by boyfriend-pimp - Unsafe, unpredictable,uncontrollable events and environment - Isolation and forced dependency (see "social restrictions and manipulation" below)	**MENTAL HEALTH PROBLEMS** - Suicidal thoughts, self-harm, suicide - Chronic anxiety, sleep disturbances, frequent nightmares, chronic fatigue, diminished coping capacity - Memory loss, memory defects, dissociation - Somatic complaints (chronic headache, stomach pain, 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 with intimate relationships
FORCED AND COERCED USE OF DRUGS AND ALCOHOL - Non-consensual administering and coercive use of alcohol or drugs in order to: - Abduct, rape, prostitute women - Control activities, coerce compliance, impose long work hours, coerce women to engage in degrading or dangerous acts - Decrease self-protective defences, increase compliance - Prevent women from leaving or escaping	**SUBSTANCE ABUSE AND MISUSE** - Drug or alcohol overdose, self-harm, death, suicide - Participation in unwanted sexual acts, unprotected and high risk sexual acts, high risk activities, violence, crime - Addiction - Health effects of alcohol use: brain or liver damage, including pre-cancerous conditions - Health effects of drug use, including abscesses needle-introduced infection (HIV, hepatitis B, C) - Dependence on drugs, alcohol, cigarettes to cope with abuse, stress, anxiety (of work, long hours, pain, personal disgust; cold, physical deprivation, insomnia or fatigue)
SOCIAL RESTRICTIONS AND MANIPULATION - 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 or control over privacy	**SOCIAL PROBLEMS** - Feelings of isolation, loneliness and exclusion - 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.

[*] Many of the forms of abuse overlap, as do their consequences. In particular, negative mental health consequences frequently result from each of the different forms of abuse. To avoid repetition will be highlighted primarily under "Psychological abuse."

FORMS OF ABUSE AND RISK	POTENTIAL HEALTH CONSEQUENCES

ECONOMIC EXPLOITATION AND DEBT BONDAGE
 	
• 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
	ECONOMIC-RELATED PROBLEMS
	
	• Inability to afford
	  ◦ Basic hygiene, nutrition, safe housing
	  ◦ Protective equipment (e.g., condoms, gloves, gear for factory work or domestic service)
	  ◦ Pharmaceuticals
	  ◦ Health care (preventive & treatment)
	• Heightened vulnerability to STIs, infections, work-related injuries from high-risk work practices
	• Potentially dangerous self-medication or foregoing of medication
	• Punishment (physical abuse, financial penalties) for not earning enough or for withholding earnings
	• Physical or economic retribution for escape attempts
	• Rejection by family for not sending or returning with money

LEGAL INSECURITY • 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. • Fear that health providers will require identity documents or will report women to authorities	**LEGAL AND SECURITY PROBLEMS** • 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

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FORMS OF ABUSE AND RISK	POTENTIAL HEALTH CONSEQUENCES
HIGH RIKS, ABUSIVE WORKING AND LIVING CONDITIONS • 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 or isolation • Non-consensual marketing or sale, exploitation	**Occupational and environmental health** • Vulnerability to infection, parasites (lice, scabies) and communicable diseases • Exhaustion, dehydration, poor nutrition, starvation • Injuries and anxiety resulting from exploitation and labour conditions • Injuries and anxiety resulting from interpersonal violence
RISKS ASSOCIATED WITH MARGINALISATION • Cultural and social exclusion (social and cultural norms, language) • Limited access to public services and resources, including health care • Limited quality of care due to discrimination, language • Public discrimination and stigmatisation related to gender, ethnicity, social position, form of labour • Reduced income, weak negotiating power and financial hardship resulting from immigrant/migrant status • Clandestine movements and high mobility • Limited access to potential sources of assistance (law enforcement, public officials, national representatives) • Fear of authorities (e.g., law enforcement)	**HEALTH SERVICE UPTAKE AND DELIVERY** • 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-medicating • Inability to afford health promoting products and activities • Increased physical and psychological dependence on abusers or exploitative employers • Loneliness and other negative mental health outcomes • Adopting unhealthy coping strategies (cigarettes, over-the-counter medication, alcohol, illegal drugs), self-harming.

3.4 Ethical and safety guidelines

Because of the complex range of risks involved in research on the health

of women who are trafficked, standard biomedical ethics do not provide sufficient

guidance.[319] Issues that emerge in an investigation of trafficking and other forms

of violence against women demand integration of human rights principles. Like

other global problems, such as HIV/AIDS, conflict and humanitarian aid, the

subject of violence against women raises the inextricable relationship between

medicine and public health and ethics and human rights.[320] They highlight the

need to factor into research the human rights-related roles and responsibilities of

health professionals. Mann describes the relationship between ethics, human

rights and health:

> [H]uman rights is a language most useful for guiding societal level analysis
> and work, while ethics is a language most useful for guiding individual
> behavior...Thus, public health work requires both ethics applicable to the
> individual public health practitioner and human rights framework to guide
> public health in its societal analysis and response.[320]

Trafficking in women provides a good example of a subject that inherently links

health, ethics and human rights. In conducting research in this area one

immediately notes that the health risks to the individual are, or should be,

inseparable from her rights to safety, care, reparation, etc. Moreover, these risks

and rights have implications for the larger population of victims/survivors, obliging

researchers to regularly consider how an investigation might impact the wider

group of victims, politically, socially.[321] Standards for public health research and

policy must draw both from principles associated with the practical application of

medicine and medical research, and the norms laid out in the language of human rights.

Yet, both biomedical ethics and human rights standards appear to offer quite broad principles that leave one relatively rudderless in the face of specific ethical dilemmas such as those that emerge in the course of studying subjects such as trafficking in women, and other forms of violence against women. Describing medical ethics, Coughlin and Beauchamp point out:

> General precepts have insufficient resources to resolve deep or complex moral problems, and even specific norms are often indeterminate...There is no way we can anticipate the range of commitments that must be made in the process of accepting a moral precept, such as a rule of confidentiality, and we are unable in advance to specify a precept to the unique circumstances of concrete cases.[322]

In considering a study on the health of women who had been trafficked, this left a fairly large gap in the area of applicable ethical research guidelines.

To address the range of safety and health risks and the ethical concerns associated with conducting a study on trafficking in women, it was therefore important to develop a set of recommendations specifically for this population. Thus, prior to conducting the formative study on health and trafficking, a set of recommendations were developed to define ethical and safety criteria to guide the study protocol. While these guidelines were initially intended solely for the conduct of the study, they were later expanded and refined to become the *WHO Ethical and Safety Recommendations for Interviewing Trafficked Women* (hereafter *Recommendations*). Ultimately, the *Recommendations* were

distributed as a document applicable to a wider audience (e.g., NGOs, police, journalists). The main objectives of the *Recommendations* were to:

- identify and delineate the risks associated with conducting interviews with women who have been trafficked;

- minimise the physical and psychological dangers to women who are trafficked (and others close to her) that may be caused by coming into contact with an interviewer;

- encourage safe and supportive approaches to interviewing;

- identify and promote researcher behaviour that encourages women to disclose relevant and accurate information; and

- foster positive and progressive use of information provided by trafficked women.

The *Recommendations* took as a starting point the *World Health Organisation (WHO) Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women.*[323]

Documents outlining more traditional medical ethics, such as *World Medical Association's Code of Medical Ethics,*[324] the *Declaration of Helsinki, Ethical Principles for Medical Research Involving Human Subjects,*[325] and the Council for International Organizations of Medical Sciences' (CIOMS) *International Ethical Guidelines for Biomedical Research Involving Human Subjects*[319], also formed the basis of the study ethical protocol.

The recommendations also incorporated fundamental human rights standards. These offer value-based frameworks that not only take into account

physical or medical harm, but also recognise the social conditions and social determinants of health. Renowned human rights instruments, such as *The Universal Declaration of Human Rights* (UDHR) and the *UN Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW)[326], for example, promote concepts such as freedom, equality, non-discrimination, and personal security[327].

Rights-based documents more specific to trafficking that were consulted included *Human Rights Standards for the treatment of trafficked persons,*[328] *Human Rights and Trafficking in Persons: A Handbook,*[329] *International Principles and Guidelines on Human Rights and Human Trafficking,*[330] and *VIP Guide: Vision, Innovation and Professionalism in Policing Violence Against Women and Children.*[331] *Reporting guidelines for media and journalists*[332] was reviewed to understand the obligations of a sector that is very likely to interview trafficked persons.

Addressing the more specific issues associated with working on trafficking in women required input from individuals who had actually carried out research with women who had been trafficked, or provided direct assistance. I therefore drafted the ethical and safety protocol in consultation with a group of experts on trafficking and violence against women, most of whom had direct experience interviewing or assisting women who had been trafficked. For example, one member of the group worked for Human Rights Watch and had carried out field research interviewing trafficked women in Israeli prisons. A second group member had carried out numerous studies based on interviews with trafficked

persons in Cambodia, Vietnam, and Thailand. Another was renowned for her seminal work on trafficking of women from Burma to Thailand and of Thai women to Japan. The group also included the clinical psychologist for La Strada, Bulgaria (La Strada is a network of service organisations primarily in Central, Eastern (based in The Netherlands), providing assistance to women who have been trafficked). Members were consulted three times in writing, and once by phone for:

1) comments on the outline describing the proposed content of the *Recommendations*;

2) comments on a first draft of the Recommendations and responses to requests for suggestions of case examples of good and high-risk practices; and

3) final comments on, and endorsement of a final draft.

Key issues that emerged from the consultation included:

a) The need to broaden the guidelines to reach a wider audience that included journalists and other media professionals;

b) The need to expand the meaning of standard ethical obligations of "do no harm", "assuring confidentiality", and "gaining informed consent" in the context of a trafficking study;

c) The importance of emphasising the complexity of the subject of trafficking and encouraging researchers to know each situation and context;

d) The obligation of researchers to be prepared, offer help and support, while being careful not to promise more than is realistic; and

e) The obligation of researchers to make good use of information collected.

Nearly all of the experts consulted emphasised that the more safe and ethical the conduct of the study team, the more likely the information obtained will be truthful and accurate.

Based on these suggestions, the *WHO Recommendations* were organised around a set of ten guiding principles that summarise the obligations before, during and after an interview. See Figure 3.2.

Figure 3.2 Ten guiding principles of the WHO Recommendations for Interviewing Trafficked Women

DO NO HARM
1. Treat each woman and the situation as if the potential for harm is extreme until there is evidence to the contrary. Do not undertake any interview that will make a woman's situation worse in the short term or longer term.

2. KNOW YOUR SUBJECT AND ASSESS THE RISKS
    Learn the risks associated with trafficking and of each woman's case before undertaking an interview.

3. PREPARE REFERRAL INFORMATION. DO NOT MAKE PROMISES THAT YOU CANNOT FULFILL
    Be prepared to provide information in a woman's native language and the local language (if different) about appropriate legal, health, shelter, social support and security services, and to help with referral, if requested.

4. ADEQUATELY SELECT AND PREPARE INTERPRETERS AND CO-WORKERS
    Weigh the risks and benefits associated with employing interpreters, co-workers or others and develop adequate methods for screening and training them.

5. ENSURE ANONYMITY AND CONFIDENTIALITY
    Protect a respondent's identity and confidentiality throughout the entire interview process — from the moment she is contacted through the time that details of her case are made public.

6. GET INFORMED CONSENT
    Make certain that each respondent clearly understands the content and purpose of the interview, the intended use of the information, her right to not answer questions, and her right to terminate the interview at anytime and her right to put restrictions on how the information is used.

7. LISTEN TO AND RESPECT EACH WOMAN'ASSESSMENT OF HER SITUATION AND RISKS TO HER SAFETY
    Recognise that each woman will have different concerns and that the way she views her concerns may be different from how others might assess them.

8. 8. DO NOT RETRAUMATISE A WOMAN
    Do not ask questions intended to provoke an emotionally charged response. Be prepared to respond to a woman's distress and highlight her strengths.

9. BE PREPARED FOR EMERGENCY INTERVENTION
    Be prepared to respond if a woman says she is in imminent danger.

10. PUT INFORMATION COLLECTED TO GOOD USE
    Use information in a way that benefits an individual woman or that advances the development of good policies and interventions.

Each of these principles has potential to be operationalised in either a research context or by non-researchers working with trafficked women. For example: "2. Know your subject and assess the risks", requires researchers, journalists or police to read background information and learn about the local setting and the individual situation of women they suspect of having been trafficked. As will be discussed in the *Methods* chapter, the key to implementing many of these recommendations is to work with local groups who have experience and a good understanding of women's situations. These individual and organisations are generally best situated to conduct interviews in sensitive ways, respond to distress and provide various forms of assistance for participants.

These *Recommendations* were a fundamental starting point for the study both because they set the parameters for many of the methodological decisions and because they were deemed necessary to obtain good levels of disclosure to accurately represent the situation of this vulnerable group.

3.5 Chapter discussion

The conceptual models described in this chapter worked as a type of "map", laying out basic concepts and terminology, and connecting ideas and areas of interest to be researched. These theoretical frameworks served as the foundation of the research design for both studies. For example, for the exploratory or formative research on trafficking, the two conceptual models established the working definitions for the different stages of the trafficking

process, the health areas of potential interest, and offered a multi-faceted operational framework within which findings were examined and interpreted. For the second study, these models again signalled what areas of risk would be of interest (e.g., migratory stages of the trafficking process) and suggested potential harm associated with a range of risks (e.g., physical, psychological, sexual abuses) linked to different body systems (e.g., neurological, sexual and reproductive, psychological).

Operationally, the models steered the methodological strategies and research techniques. For example, the models proposed the content of and structure for the study instrument (e.g., pre-departure violence, risks during travel and transit) and optional frameworks within which the data could be analysed. They also suggested topical directions for enquiry, and provided guidance to tools used for related subjects—for example, psychometric tools used to study the mental health of sexually abused women were reviewed to find appropriate instruments for the survey.

An overarching theme within the models was the idea of looking at health from a human rights perspective. That is, these models were designed to examine trafficked women's health needs on an individual level instead of adopting a state security approach[333] which prioritises a state's desire to "protect" itself from outside threats, e.g., public health threats, such as infectious diseases or public order threats, such as illegal immigration.

The *Recommendations* further emphasise this rights-based approach to research. They demand measures that emphasise individual protection, prioritising a woman's safety and choice over data collection.

The neglect of trafficked women's rights, particularly to health, at the time of these studies was clearly recognised by experts in the field of migration. Salt and Hogarth in 2000, explained "thus far, the literature [on trafficking] offers only two discourses, the economic and the criminal..."[13] and correctly pointed out that the weaknesses of these approaches is that they "fail to take account of issues of human rights, and particularly the notion of the trafficked as victims."[13]

The victim-centred perspective and ethical standards described in this chapter are integrated throughout the methodology described in the following chapter. A human rights approach to women's health recognises both the numerous international standards that confirm women's rights to protection,[79, 80, 135, 334, 335] and the magnitude of the violations that are perpetrated against women in these circumstances, which entitles them to respect and reparations. Assuming that good public health is founded on programmes that recognise individual rights[320] to protection was the best way to ensure that findings might lead to the development of victim-focussed, rights-based interventions.

CHAPTER 4: METHODS

4.1 Chapter introduction

This chapter describes the methods used for the two studies contributing to this thesis. As will be discussed, methodological decisions were heavily influenced by the conceptual and ethical frameworks described in the previous chapter, which expressly incorporate the concept of individual need and rights to protection.

The chapter begins with a description of the qualitative methods employed for the formative study. This first study was an exploratory study[336] that aimed to map the health risks associated with trafficking and sexual exploitation by documenting the experiences of women who had been trafficked and the perceptions of key informants, such as service providers and law enforcement personnel. Formative research such as this serves as a preliminary step in the development of a larger scale survey.[336, 337] From this formative research emerged the conceptual bases and key measurement indicators to be used in the quantitative study that followed.

The second study, a survey of a consecutive cohort of women entering seven post-trafficking service organisations, measured women's exposure to abuse and a detailed range of their perceived physical and psychological health consequences. Recognising the importance of women's voices to understanding their health experiences, this study also incorporated a number of open-ended questions to help individualise women's experiences and symptoms.

The methodological strategies selected for these studies reflect, to a significant degree, approaches and tools used to learn about other vulnerable populations (e.g., victims of violence/trauma, refugees). This chapter details the research methods used and explains briefly the reasoning behind these approaches.

4.2 Operationalising a definition of trafficking for research

The term "trafficking", while having entered the popular lexicon and found a place in national legislation in many countries, in reality still defies clarity. This ambiguity is similarly problematic for research. In considering how to operationalise the term "trafficking" to define parameters for our samples in each study, we took as starting point the definition found in the UN Protocol (Chapter 2). But this definition is vast, much too broad to use to delineate inclusion and exclusion criteria. For this study, the term trafficking meant indivduals who had been exploited and/or bonded or held captive (by usurious debts, force or coercion) in labour situations (e.g., prostitution, domestic work). For the study, we elected to use the term: "trafficking in women" (to define the sex of the individual) and further narrowed the operational criteria include only: "women trafficked for prostitution or sexually abused as domestic workers."

We made this decision primarily on the basis of the focus of the study, health risks and outcomes, and the likely composition of our study population, mostly women trafficked into prostitution. Because the key study variables were to be

health-related, and sexual abuse has been clearly associated with a certain, and often more severe, set of health symptoms (e.g., compared to only physical abuse or no abuse) we were concerned that having a sample that included a minority of women who had not sexually abusive experiences might mis-represent their experiences and health outcomes.

We therefore excluded from the analysis women who had not been trafficked for prostitution and women who were trafficked for other purposes and had not been sexually abused (e.g., domestic workers who did not report sexual abused).

4.3 Formative study: Exploratory research of health risks and consequences associated with trafficking in women (study 1)

The first study was conducted between 2001 and 2003. Funded by a European Commission Daphne Programme grant, this study used qualitative methods to explore the health risks associated with trafficking in women. As this was among the first studies to look at health and trafficking, the research was designed as an exploratory study to identify and describe the spectrum of health-related issues associated with women who were trafficked primarily for forced sex work. Specifically, the research aimed to:

- develop conceptual frameworks within which to understand health in the context of trafficking;

- map the range of health risks associated with trafficking;

- document women's experience of risk and their perceptions of the health consequences associated with trafficking;

- document how others who work with or may potentially work with trafficked women (e.g., health service providers, law enforcement officials, post-trafficking services) perceive and would address the health consequences of trafficking;

- propose recommendations on meeting the health needs of women who have been trafficked; and

- propose future directions for research.

In a broader sense, like most exploratory studies, the goals were those outlined by W.L. Neuman, in *Social Research Methods*:

- to become familiar with basic facts, people and concerns involved.

- to develop well-grounded mental picture of what is occurring.

- to generate many ideas and develop tentative theories and conjectures.

- to formulate questions and refine issues for more systematic inquiry.

- to develop techniques and a sense of direction for future research.[336]

The research was approached as a mapping exercise to develop a broad picture of women's health in the context of trafficking. By creating conceptual frameworks and collecting the perceptions of trafficking-related health risks and consequences from trafficked women and key informants, it would be possible to

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develop a strong basis for future research. Ultimately, the study comprised the

following stages:

1) Review of literature

2) Development of conceptual models.

3) Expert consultation to develop ethical and safety guidelines for the study
(which were ultimately adapted to become the *WHO Ethical and Safety
Recommendations for Interviewing Trafficked Women*).

4) Development of study instruments, reviewed and tested by myself and
study partners.

5) Interviews with 28 trafficked women and adolescents in Italy, United
Kingdom, the Netherlands, Ukraine, Albania and Thailand.

6) Interviews with 78 key informants in eight countries from the health, law
enforcement, government and NGO sectors.

7) Design of thematic framework for data entry and analysis using qualitative

analysis programme: NVIVO

8) Data entry, analysis and interpretation.

9) Discussion of results with partner organisations

4.2.1 Research partners (study 1)

Research partnerships were three established service-providers and two other

research institutes. Service organisations included:

- La Strada, Ukraine

- The International Catholic Migration Committee, Albania (ICMC)

- STV, Foundation for Women, the Netherlands

These groups had experience and support resources that ensured that

participants' needs would be prioritised. Their expertise in care provision and

advocacy also informed the methodology towards results that would be relevant to service provision and policy.

Research groups included:

- London Metropolitan University's (LMU), Child and Woman Abuse Studies Unit (CWASU)

- Global Alliance Against Trafficking in Women, Thailand (GAATW),

- University of Padua's Department of Sociology (UNIPD),

Each of the above study partners had substantial expertise in conducting research and/or training in relevant areas (trafficking, sex work, violence against women) and added different perspectives (health, sociological and political) to the inquiry and analysis.

The Poppy Project of Eaves Housing (first services and accommodation for trafficked women in the UK) emerged during the course of the study and became an informal partner, offering access to participants and input on women's health.

4.2.2 Study instruments (study 1)

Data from the different participant groups was gathered using six semi-structured questionnaires, one corresponding to each of the following groups:

1. Trafficked women;

2. Health and medical care providers;

3. Non-health-specific service providers and NGOs (e.g., trafficking, women's groups, social services, refugee agencies);

4. Law enforcement officials (e.g., immigration and police);

5. Policy-makers (e.g. donors, health care, law enforcement); and

6. Madam, pimps and owners.

The six questionnaires generally followed parallel topic structures in order to gather comparable or intersecting information. That is, the same set of subjects was discussed with each participant group. Closely coordinating the questionnaires allowed us to triangulate the data, thereby comparing the responses of different participant groups.

Table 4.1 outlines the different questionnaires by respondent, and highlights key themes of the interviews.

Table 4.1 Overview of qualitative study instruments

Information category	PARTICIPANT GROUPS				
	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

The structure of the questionnaires relied heavily on the conceptual

model, *Stages of the Trafficking Process,* with questions generally clustered by

the stages: pre-departure; travel and transit; destination; detention, deportation

and criminal evidence; and integration and reintegration. Questions were framed

to gather respondents' perceptions of the health risks related to the trafficking

experience, including health consequences, and intervention opportunities and

obstacles.

Draft instruments were reviewed and revised collaboratively at the three-

day "Fieldwork Preparation Workshop" at which all partners were present.

4.2.3 Participants (study 1)

Selecting a sample participant population of "trafficked women" was

complicated by the difficulties inherent in defining trafficking. As pointed out in the

previous chapter, distinguishing trafficked persons from a more general

population of exploited labourers can create a somewhat false dichotomy.[6]

Despite the research group's acknowledgement of the many problems

associated with defining a 'trafficked woman', the partners decided that, for the

purposes of the study—and to move beyond the rather polarised political

opinions within the group—interviewers would, to the extent possible, assess

women's profile based on the definition in the Palermo Protocol. It was accepted

that we would not be able to tightly frame the level to which any one woman had

to be "deceived", "coerced" or "exploited" and that because of the myriad of

blurred areas related to trafficking, we would have to rely on the judgement of our

partners. Ultimately, most women were interviewed because they were in contact with services specifically designated to assist victims of trafficking. Yet, as with most purposive sampling used to access a difficult-to-reach, specialized population, we do not know to what extent the cases selected reflected the larger population.[336]

Participant age

For both of the studies contributing to this thesis, the research teams decided to include adolescent girls. The partners, who were all professional service providers, determined that the two main issues relating to interviewing adolescents concerned "informed consent", and the adequacy of support surrounding participating in the study. This was only an issue for those participants in non-destination settings. No persons under age 18 in the destinations settings were interviewed because, by law and statute, they would have been placed in child-dedicated services.

We discussed age inclusion criteria at the onset of the study. As experienced service professionals providing counselling to women and children who had been trafficked, the research partners in this study emphasised the need to include adolescents because of the relative importance in the group of females trafficked for sexual exploitation and the likely similarities in patterns of risk exposures and health outcomes (to those over age 18). The discussion of their inclusion also reflected the reality that, although the UN and national legislation must make an

empirical delineation regarding the age distinguishing a child from an adult (i.e.,

18 years-old), childhood may be more accurately described as socially

constructed. Both the adolescents and the adults attending partner services had

been sexually abused and had been working in the sex industry. An 18 or 19

year-old versus a 15 year-old is likely to have had similar or equally different

perceptions of their experiences in the sex industry. One of the trauma

specialists, M. Tchomarova from Animus Association Foundation, spoke of the

psychological state of "arrested adolescence" experienced by the adults of 24 or

25 who are trafficked and sexually abused, for example, which she compared to

the state of younger women who are trafficked. She highlighted the similarity in

the ways that mental health practitioners approach counselling for these younger

and older women who have had sexually exploitative circumstances.

Further, the situation of legal guardianship was discussed. In the service settings

where the study was conducted, the NGOs acted as legal guardians, responsible

for ensuring adolescents' welfare. Adolescents in their care generally have few

other individuals who can reliably be determined to be in the adolescent's best

interest to make decisions for them (lack of clarity whether parents were involved

in the trafficking). At the time of interviews, participants would nearly always be

the legal responsibility of each service organisation.

It was agreed that for potential participants perceived to be particularly vulnerable

(evident signs of distress, young age), decisions about participation would be a

two-stage process. In the first instance, professional support workers (in conjunction with other staff members, where appropriate) would judge the potential risks associated with an interview, and if an interview was deemed safe, support workers would take additional time and effort to describe the content of the study questionnaire and query the potential participant about any concerns she might have about participating.

4.2.4 Fieldwork (study 1)

Interviews were carried out in Albania, Italy, the Netherlands, Thailand, Ukraine and England. Women who were interviewed in Albania, Netherlands and Ukraine were clients of the research partner organisations and were interviewed by their staff members who had been trained to carry out the study. Women in Thailand were identified by the sister organisation of GAATW and interviewed by an experienced researcher from GAATW. Researchers at University of Padua identified women to be interviewed through their contacts at local NGOs and carried out the interviews themselves. In the U.K., women were identified via several sources, including local organizations providing health outreach services, a newly forming shelter for trafficked women (i.e., Poppy Project) and word of mouth. Key informants (e.g., police, health care staff, NGO staff) were selected in each country according to the study design and the judgement of the country partner researchers, who also carried out interviews. I conducted all but one of the interviews in England (an outreach worker conducted one interview).

Interviews with women generally took between 45 minutes to 1 ½ hours. Interviews with key informants ranged from 30 minutes to 2 hours, depending on amount of experience the individual had with trafficking and his/her time limitations.

Interviews were not tape-recorded to avoid intimidating participants or inhibiting disclosure. Interviews with trafficked women were conducted in the native language of the participant, and in some cases an interpreter was required. Responses were recorded in writing in the language used by the participant. When not in English, responses were then translated into English by staff members of the partner organisations who were bi-lingual. Where an interpreter was used, the responses were recorded on two questionnaires in both the language of the respondent (by the interpreter) and in the language of the staff member conducting the interview. Copies of all questionnaires were sent to LSHTM. Participant questionnaires were returned by post or by email. Upon arrival, they were logged as having been received and stored securely in a locked cabinet.

Regular contact was maintained with partner organisations to monitor their progress with interviews, enquire about problems arising and maintain a check on the quality and depth of the data collected. Where it was observed that partners were having difficulty or not probing adequately, suggestions and support was offered. Once the questionnaires were transferred to LSHTM, where there was missing data or transcriptions were unclear partner organisations were queried. As the data was returned, partners were also regularly consulted for

their interpretations and perceptions of participants' responses. Regular discussions took place with partners about participants' health, well-being, safety and the services that were provided to assess how well the teams were able to respond to women's needs and to adhere to the ethical and safety guidance agreed on for the study.

Due to funding limitations, only one site visit was made (to Ukraine), where the largest amount of the data was collected.

4.2.5 Data entry and analysis (study 1)

Interview data were entered and coded using NVIVO NUD*IST for qualitative research analysis. Data were analysed using a multi-layered thematic approach, defining data sets generally by their relationship to the stage in the trafficking process, and by their association with different aspects of health. In addition, for the interview data from the women, every attempt was made to also consider the entirety and individuality of each woman's experience in conjunction with patterns and themes identified throughout the group as a whole.

The larger analysis of the findings brought together women's responses alongside the perceptions and experiences of key informants.

Thematic analysis was undertaken using NVIVO "nodes" established to reflect both the questions in the instrument and themes identified across interviews, including outlying issues. The following thematic scheme provides an example of the node set-up for two subject areas from the women's interviews, "work destination" and "health":

📁 **WORK DESTINATION**
- 📁 Time abroad
- 📁 Destination countries
- 📁 Work destinations
- 📁 Time abroad working
- 📁 Languages / ability
  - 📁 Initial languages
  - 📁 Spoken
  - 📁 Reading

📁 **HEALTH**
- 📁 General health problems
- 📁 Contact with health providers
- 📁 Language barriers
- 📁 Medications
- 📁 Contraception
  - 📁 Access
  - 📁 Knowledge
- 📁 Current partner
  - 📁 Contraception with partner
- 📁 Clients
  - 📁 Contraception with clients
  - 📁 Pregnancy and clients
  - 📁 Preventing infection
  - 📁 Work through menstruation
  - 📁 Protection for other acts
- 📁 Prior STI knowledge
  - 📁 What known
  - 📁 Source of information
- 📁 Awareness of treatment options/services
  - 📁 Gynaecological exams
  - 📁 TOP services
  - 📁 Required documents
  - 📁 Free services

The remaining major subject categories included: work, personal life, home and journey, mental health, detention, and trafficking. In addition to being coded by question and subject category, the data was also coded by additional themes, under NVIVO's "free nodes". Themes included: countries (Albania, UK, Ukraine, etc.); personal background; buying persons; control; dependence; legal action; money; isolation; other workers; and violence. These categories were employed first to capture specific issues that emerged during study that may not have been associated with a particular question or subject area.

Key informant interviews were coded to represent the questions that were asked to individuals about the women and about services. Where informants were asked about the women, the "nodes" generally paralleled the nodes for the women's questionnaire. Major nodes included:

📁 Organisational information
📁 Services
📁 Trafficked women
📁 Women's health
📁 Women's work
📁 Women's journey
📁 Social assistance

Free nodes predominantly mimicked the free nodes developed to code the interviews with the women.

Comparisons were made between women's and key informants' perceptions of health needs, priorities, and experiences with treatment (uptake and delivery) and efforts were made to understand the contextual factors that may have influenced women's and providers' perceptions and behaviours.

Research and discourse from related subject areas (e.g., other forms of violence against women, vulnerable groups and health care provision to marginalised populations) assisted in the interpretation of findings, sometimes supplementing, filling gaps, and/or supporting or explaining, while at other times highlighting differences and contradictions with other groups.

'Triangulation' of (1) women's experiences; (2) key informant information; and (3) documentary resources was important to contextualising and explaining women's experiences. For example, women were asked about sexually transmitted infections, but most did not know what, if any, infections they had,

and were only able to describe symptoms and fears about reproductive health.

Service providers conducting outreach care provided information on women's

perceptions of symptoms and clinical data on infection patterns. Study partners

further contributed to the interpretation of data, and to bringing together issues

raised through the other information sources. For example, while most

individuals and a great deal of the literature describe women who are trafficked

within a persona of a victim, two of the study partners emphasised their

complexity, strengths and resourcefulness. Speaking of a woman she

interviewed more than once for different purposes, one of the researchers

explained:

> As you can see from the published story [in a book she co-edited][338] and
> from the interview, we cannot identify *Mirella* with the sterotype of the
> "victim" as generally understood: strong coercion; lack of self-
> determination; total refusal of her position of prostitute; lack of freedom;
> indiscriminate violence. But at the same time, we cannot say that she
> lived with all her experiences with serenity.[338]

Based on the analysis and interpretation of the data, I drafted a

preliminary report that was reviewed and discussed by the study partners at the

"Study Partner Review Meeting" in November 2002. During this three-day

working meeting, study findings were discussed and evaluated. Interpretation of

the findings and terminology were particularly important. For example, partners

spent a great deal of time discussing the difference between the terms "mental

health outcomes" and "reactions", as several felt that term "reactions" better

captured the normalcy of women's responses to what they had experienced.

At this meeting, the study partners also jointly drafted a set of general policy- and trafficking 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 also reviewed and finalised at this meeting.

4.3 Quantitative Study: Survey of women in post-trafficking service settings (study 2)

The second study was carried out between 2003 and 2005 and was also funded by the Daphne Programme, with additional support provided by the International Organization for Migration, Ukraine office, which was also one of the research partners. For this study, quantitative methods were used to measure perceived health symptoms and exposure to violence among a cohort of women attending post-trafficking services in seven European countries. The study used a longitudinal design in order to capture women's perceived changes in their health symptoms by conducting interviews at three different time periods.

The study aimed to collect quantitative data (supplemented by limited qualitative data) on women's physical, sexual, and emotional health symptoms while they were in the care of post-trafficking service providers. The study had the following specific objectives:

- Gather quantitative and supplementary qualitative data on the perceived physical, sexual and psychological health symptoms of women attending post-trafficking services;

- Document how women's health needs change over three stages: crisis intervention; adjustment; and long term symptom management;

- Identify symptom patterns and health priorities of women in post-trafficking service settings;

- Gather data on women's exposure to physical and sexual violence before and during the trafficking experience; and

- Develop recommendations for health services and policies for trafficked women.

In addition to these primary objectives, the study team also hoped to develop a survey tool that could be employed in other settings to assess the health status of women who have been trafficked and which could possibly be adapted for use with other similarly vulnerable groups.

4.3.1 Research partners (study 2)

This study was conducted with experienced non-governmental and international organizations working with trafficked women across Europe. The non-governmental and international organization partners in this study were:

- Poppy Project (United Kingdom);

- On the Road (Italy);

- Pag-Asa (Belgium);

- La Strada (Czech Republic);

- La Strada/Animus Association Foundation (Bulgaria); and

- International Organization for Migration (IOM) Rehabilitation Centre, Moldova

- International Organization for Migration (IOM) Rehabilitation Centre, Ukraine.

The UK, Italy, Czech Republic, and Belgium are generally considered destination and/or transit countries, where the majority of trafficked women are foreign nationals. Bulgaria, Moldova and Ukraine are predominantly countries of origin, where service providers largely support citizens who return home after having been trafficked abroad.

Experienced staff from each organization carried out the fieldwork, and collaborated on the study design and interpretation of the findings.

4.3.2 Study instrument (study 2)

Because of the absence of previously tested instruments for measuring the health of trafficked women, one of the key challenges of this study was to develop an appropriate tool for assessing women's perceptions of their physical and mental health. As such, in addition to the main aim of gathering health information about trafficked women, the study team also hoped to create a useful and targeted survey tool that could be employed in the future by groups in other settings to assess the health status of women who have been trafficked.

A key challenge in questionnaire design for this cohort was the linguistic and cultural diversity. Generally, health assessment tools (questionnaires or structured-interviews) have been validated for research in a single cultural and linguistic group. Tools that have been used extensively in international

populations are often designed for general population screening, rather than assessment of a cohort that has suffered repeated physical and psychological abuse.[339]

A second challenge was finding an instrument to look at a broad range of physical health concerns. One common technique for assessing physical health status uses the respondent's ability to function, i.e., carry out tasks associated with "normal" daily life, as a proxy measure for physical health. This technique presumes that the respondent is living in a "normal" environment, where physical health status can be assessed based on changes in "normal" daily functioning, such as going shopping, socializing with family, and working inside or outside the home.[340] These questions are almost meaningless for women who are living inside a shelter, are not in their regular social and linguistic setting, or for whom it is impractical or unsafe to return to "normal" life. Other tools that have been used with survivors of violence include questions about sexual functioning or desire, which the study team felt would be inappropriate to ask and difficult to interpret in a group that had recently suffered repeated sexual violence and forced prostitution[341]. Many excellent questionnaires, particularly mental health instruments, simply had too many items to be practicable if we were to capture more than a single aspect of mental or physical health.[342]

In order to address the issues of interest to the study team, a questionnaire consisting largely of closed questions was created based on both unique question sets, some developed specifically for this study and others based on existing study instruments that have been previously validated in other

related populations. Ultimately, the questionnaire comprised the following four sections:

I. Demographic information

II. Physical health

III. Experiences

IV. Mental health

For the first interview, all four sections were administered. For Interviews 2 and 3, the first section, "Demographics", and the third section, "Experiences", were not re-administered, because this was information that was not expected to change. Furthermore, the study team felt that it would be unnecessarily distressing for respondents to go through the section on violent experiences again. Questions in sections II and IV, "Physical" and "Mental Health", remained nearly identical throughout all three interviews in order to capture changes in women's perceived health symptoms. Below is a description of the contents and general aim of each section of the questionnaire. See Appendix for questionnaire.

I Demographic information. Questions included items such as, marital status, country of origin, children, destination country during trafficking, duration of trafficking, and type of work during trafficking. In addition, it was important to learn how much time had elapsed since women had escaped or been freed from traffickers, as this may have affected reported symptom patterns and health needs. Women were also asked with whom they were living before they were

trafficked in order to gain insight into whether their pre-departure situation might have contributed to their vulnerability to being trafficked and explore their post-trafficking housing options.

ll Physical health. The physical health section was developed by the study team based significantly on the Miller Abuse Physical Symptoms and Injury Survey[179], which is a physical symptom scale developed by North American researchers to study the physical health sequelae of intimate partner violence. The study team modified this scale for use with female survivors of trafficking, with the intention of exploring the proportion of women that were experiencing symptoms of interest, and to what extent women were affected by each symptom. Women were asked about 26 symptoms categorised by body systems into nine symptom domains. This "body systems check-list" included the following domains:

1) Fatigue and weight loss;

2) Neurological;

3) Gastrointestinal;

4) Sexual and reproductive health;

5) Cardiovascular;

6) Musculoskeletal;

7) Eye pain, vision problems;

8) Ears, colds, flu, sinus infections; and

9) Dermatological.

For individual symptoms within each domain, a woman was asked to report whether she had experienced the symptom in the "past two weeks, including today". If she had experienced the symptom, she was then asked to assess "how much has it bothered you or caused you pain", ranking its severity: "not at all"; "a little", "quite a bit", "extremely/very much". These corresponding severity levels were scored from 0-4. Symptoms reported as bothering women "quite a bit" or "extremely/very much" were considered to be in the "upper severity level".

By dividing these symptoms into domains was not meant to speculate about the cause of symptoms, only to indicate their manifestation.

To explore which domains were most problematic, an average severity score for each domain was calculated. Scores only represent trends, and each woman had unique problems that required individual diagnoses and care strategies.

In addition to gathering information about individual symptoms, such as headache and vaginal bleeding, the Likert scale was able to be scored numerically, making it possible to compare an average score for all women over the three time frames.

In addition to the more detailed questions about physical health, women were also asked to rate their overall health ("Thinking back over the last two weeks, how would you say your health has been?"). Questions that solicit self-perceived health assessments have proven to be reliable measures of health

status with sub-populations and have been demonstrated to be more stable over time than physician ratings.[343]

Twelve closed-ended questions focusing on sexual health, reproductive health, infectious disease, substance use, and injuries were also included.

Women were also asked several open-ended questions such as, "For which problem would you most like to see a doctor?".

III Experiences Women were asked about their experience of violence both before and during the trafficking experience. Previous work on trafficking strongly suggested that violence both before and during trafficking is common.[91, 344] In addition, studies have consistently shown that exposure to violence is associated with physical injury and psychological outcomes, and that prior experiences with abuse—particularly childhood sexual abuse—can impact resilience and recovery after trafficking.[257, 260, 345] Detecting prior violence—domestic abuse, child abuse—was also important because of the potential risks posed for women returning home.

To learn about pre-departure abuse, women were asked: "Before you left home did any of the following people ever physically hurt you when you were a child or an adult?" Women were then read a list of individuals that included: "mother"; "father"; "other family member"; "husband"; "boyfriend"; "acquaintance"; and "stranger". Perpetrators were then noted. To learn about abuse before age 15, women were asked: "Before you were 15 years old, did any of the following people ever make you, or persuade you to do something sexual when you didn't

want to?" As part of the investigation into pre-departure risk and its potential implications for women's return, women were also asked "Did your parents or any family member know the traffickers or introduce you to the traffickers?"

To learn about physical violence during the trafficking situation, or at the destination location, women were asked whether anyone had ever hit, kicked or otherwise physically hurt them while they were in the trafficking situation. Women were asked two consecutive questions to explore sexual abuse. Women were first asked: "While you were in the trafficking situation, did anyone physically force you to have sex or do something sexual when you didn't want to?" They were then asked "Did you ever have sex with someone or perform some sexual act because you were afraid something bad would happen?" (emphasis included in the questionnaire). Women were asked about threats of harm to themselves and family members. The findings from the previous study suggest that another defining feature of the trafficking experience is the loss of freedom, and thus women were asked: "Were you free to do what you wanted or go where you wanted? Would you say "never", "occasionally", "often" or "always"?"

IV Mental health Mental health symptoms were measured using: (a) the post-traumatic symptom scale from the Harvard Trauma Questionnaire (HTQ)[346] and (b) the depression, anxiety and hostility subscales of the Brief Symptom Inventory (BSI) short validated alternative to its parent instrument, the SCL-90-R).[347] Both scales have been used in diverse populations to identify individuals

with a psychopathology that is suggestive of a high probability that she or he will be diagnosed with a certain syndrome.[348-351]

The Harvard Trauma Questionnaire (HTQ) is a self-reported questionnaire that has been used extensively with refugees and other survivors of violence.[352] It is made up of multiple sections, including a post-traumatic symptom set comprising sixteen questions, which we included in our study. These sixteen questions are based on the clinical diagnostic criteria for post-traumatic stress disorder (PTSD). PTSD-related symptoms fall into three symptom domains: (1) Re-experiencing traumatic events; (2) Psychological arousal; (3) Avoidance and numbing. At each interview, women were read a list of 16 symptoms and asked to indicate the extent to which they were bothered by each in the previous week ("not at all" = 1; "a little" = 2, "quite a bit" = 3; or "extremely"= 4). Women who scored at or above the cut-off point (2.5), while not diagnostic, could be considered at risk of developing PTSD.[11] A score of greater than 2.5 is comparable to the scores of refugees who have been diagnosed with PTSD.[346] In addition to the overall scores, most questions are important in their own right. For example, an "inability to remember parts of the most hurtful or traumatic events" is a well-described post-traumatic symptom that also has obvious implications for prosecution of traffickers and petitions for asylum.

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[11] There may be some question as to the duration of women's symptoms at the first interview. A diagnosis of PTSD requires that symptoms fitting the PTSD criteria persist for more than one month. Because 88% of the women had been in the trafficking situation for more than a month, it seems likely that these criteria may be applicable for the majority of the women at the first interview.

The Brief Symptom Inventory (BSI) was developed as a short screening tool for the assessment of psychological distress.[353] The full BSI has nine symptom domains, but for this study, subscales for depression, anxiety and hostility were selected because they are frequently observed among survivors of traumatic events, including interpersonal violence,[235, 244] and were detected in a previous study of trafficked women.[15] The scores (calculated in the same manner as the HTQ 16-item subscale) are not diagnostic, however they indicate significant patterns of psychological distress. Again, many of the items are also important in their own right (e.g., "Thoughts of ending your life").

In the results chapter, data on individual symptoms within the HTQ and the BSI are presented and discussed. Although looking at single symptom prevalence and severity is not a traditional way of using these instruments, it is believed that this perspective, along with women's qualitative comments, provide important and deeper insights into women's psychology after a trafficking experience.

The mental health section also included a number of primarily qualitative questions exploring non-clinically classified issues, such as identity and stigma, trust, shame and self-disgust and coping.

The research tool was a self-reported questionnaire. The study team elected to use self-report rather than clinical review as our primary data collection methodology in order to better understand how women perceive and prioritise their own health needs. This method was also selected because of the difficulty in accessing medical records in countries where women are not cared for by in-

house or resident medical staff, but instead attend private or public clinics, and because financial constraints prohibited providing medical care within the study protocol.

While the format of the questions was aimed primarily at gathering quantitative data, a substantial qualitative element was included to help interpret quantitative data, to capture outlying experiences, and to portray, as best as possible, the complexity of women's experiences. Women were also asked various open-ended questions such as, "Do you think being trafficked has changed the way that you view yourself?" and "what are your hopes for the future?"

Because prior qualitative research suggested that women's health needs change significantly during their time with service providers,[354] the instrument was administered over three time periods.

Following discussions with partners, it was agreed that the first interview (Interview 1) would be carried out 0 to 7 days upon entry into the service setting. This timing aimed to capture what the service providers termed the point of "crisis intervention", i.e., the time when women first come into contact with a service provider. The second interview would be conducted between four and six weeks after the first interview to explore women's needs after their immediate and urgent needs had been met and they had had time to rest and begin to move away from the "crisis period" of need. The third interview would take place twelve or more weeks following the first interview date. The timing of the third interview reflects the balance between obtaining long-term follow up, the risk of increased

loss to follow-up when women may no longer access support services, and the limitation of the resources to extend the study. It was expected that the information gathered from the third interview would be largely qualitative.

A study protocol (*Study User Guide*) was drafted that described the procedures for carrying out the study, including:

1. Introduction: purpose of the *Guide*, intended users, study aims and partner roles;

2. Ethical obligations;

3. Study participation criteria;

4. Codes and coding;

5. Questionnaire description and use;

6. Arranging follow-up interviews;

7. Interpreting data;

8. Data storage and transferring data to LSHTM;

9. Financial compensation for women participating in the study; and

10. Other problems or questions.

The study questionnaire and protocol underwent three rounds of revision by key-informants in Bulgaria, the UK, and Italy, including practicing social workers, psychologists, and one woman who had survived trafficking. They were asked to comment on each item in the questionnaire, with a particular focus on instrument selection (for pre-existing instruments), wording, applicability, cultural considerations, and utility in the service setting. The protocol was reviewed for clarity and practicality in the service setting. The draft questionnaire was then

piloted at the three centres (Bulgaria, UK, Italy) and the Czech Republic. The final drafts of the questionnaire and study protocol were finalised after a formal meeting of all project partners and a fourth round of item-by-item review.

For translation, bilingual key-informants with training in social work or psychology and "cultural insider" status translated the Italian, Russian, Ukrainian, Bulgarian, and Czech versions of the questionnaire. Lithuanian and Polish versions were translated by professional translation services and then back-translated by professional interpreters who routinely work with women who have been trafficked from these communities. Questions underwent item-by-item review, with an emphasis on capturing the meaning of each question, in order to provide culturally and linguistically meaningful, rather than word-for-word, translation.

4.3.3 Participants (study 2)

It was agreed that the sampling would be consecutive, i.e., all women entering the service setting during the period of the study would be invited to participate. Inclusion criteria were: aged 15-49 (see above for discussion of inclusion of adolescent girls), trafficked for sex work or domestic labour, and experience of trafficking-related sexual abuse. Exceptions would be women who interviewers judged to be severely mentally ill with poor reality testing (i.e., symptoms of psychosis) or those judged to be too distressed or in pain to participate. We decided to exclude women trafficked for domestic labour who were not sexually abused because the study team determined that sexual

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exploitation and/or abuse was central to the health outcomes of interest. Each study partner was asked to target a minimum of 25 completed interviews. Ultimately, a consecutive sample of women entering post-trafficking services of partner organisations beginning in January 2004 was the cohort for this study. Detailed descriptions of both study cohorts are provided in Chapters 5 and 6.

4.3.4 Fieldwork (study 2)

Interviews with the women were conducted by support staff members of the post-trafficking service organisations involved in the study. Women were interviewed in private in the offices of the service organisations in each of the partner countries, following the guidance provided in the *Study User Guide.* Interviews took between approximately 45 and 90 minutes.

The majority of interviews were conducted without an interpreter. Where an interpreter was used, the interpreter was experienced in working with trafficked women and had been trained by research partner staff to use the questionnaire. In Italy, professional cultural mediators participated in the interviews.

The work of the study partners was regularly monitored, supported and guided by the LSHTM team. LSHTM contacted partners on a regular basis, for example, to learn the numbers of interviews that had been conducted, ask about problems with or benefits of the questionnaire, interview length and support of participants. Of particular importance was to learn about the reactions of the

participants to the survey, particularly, distress that may be caused by their participation.

When problems were reported, they generally centred on the need for interpreters or translated questionnaires (especially in London), and the length of the interviews when women reported significant distress or personal problems. In Belgium, the partner organisation reported difficulty identifying women who were willing to participate. This was the only site where participation was poor.

Partners were regularly contacted to acquire their insights into the data received, ask for their interpretation of qualitative comments and their comments on patterns being detected within their sample group. Of particular interest were conversations about interviewers' experience of administering the questionnaire and their interaction with participants, which many noted proved to be an effective format for partners to learn about the health needs of their clients.

Completed questionnaires were systematically coded so that no personal details were included. Questionnaires were copied and transferred to the core study team for data entry. Copies of completed questionnaires were kept in secured facilities where they were accessible only to relevant country team members and core research team staff.

4.3.5 Data entry and analysis (study 2)

Quantitative data were entered using Epi-data and analysed using STATA 8.0 (© Statacorp, Texas USA), a statistical analysis tool. An overview of women's physical health symptoms was obtained by generating a severity score for all

symptom domains combined (fatigue and weight loss, neurological, gastro7intestinal, cardiovascular, sexual and reproductive health, musculoskeletal, eyes, ears/colds/flu/sinus infection, and dermatological), which was based on women's ratings according to a Likert scale (0-4). Each symptom domain score was divided at the mean point to reflect high or low severity levels relative to the study sample at each interview time.

Symptom levels of depression, anxiety and hostility were calculated using methods described in the Brief Symptom Inventory (BSI) manual. [355] Standard scoring methods for the BSI subscales were adhered to by calculating an overall symptom score based on the possible responses to each symptom (0-4, e.g., 0=not at all, 4=extremely).

The PTSD scores were calculated according to methods defined in the Harvard Trauma Questionnaire (HTQ) manual.[356] For the HTQ, the standard cut-off item score of 2.5 or greater was used to indicate women with a probable PTSD diagnosis.

Both the Brief Symptom Inventory (BSI) and the Harvard Trauma Questionnaire (HTQ) have very good reliability.[346, 357] Among the trafficked women in the study sample, the Cronbach's coefficient alpha measure of internal-consistency reliability was estimated to be 0.89, 0.91 and 0.77 for the BSI depression, anxiety and hostility subscales respectively, and 0.94 for the PTSD subscale of the HTQ. Other studies have also found similarly high internal-consistency reliability[350, 358-361] and test-retest reliability, ranging from 0.79 to 0.84 for the BSI subscale measurements[355] and 0.89-0.92 for the HTQ[360,

[362] measuring traumatic events. Although neither instrument has been previously validated among trafficked women, both have been used in cross-cultural settings and among other traumatised populations.[242, 350, 363-368]

Qualitative responses were coded with NVivo (© QSR International, Melbourne Australia) and then cross-referenced to quantitative findings to provide depth and context for quantitative data interpretation. Data were coded first according to the question number in which the qualitative information appeared in order to compare across women's experiences and look for patterns and outlying experiences that helped to explain the quantitative findings.

Data was also coded thematically. Thematic codes included those that identified "attitudes or behaviours", such as:

- anger/revenge
- feelings of betrayal
- feelings of disgust
- hatred of men
- maturity/growth
- identity
- resilience

Women's comments were also coded to identify particular "experiences or events", for example:

- escape
- criminal justice proceeding
- asylum/immigration proceeding
- orphanage situation

Qualitative data was used to supplement the quantitative data and was also analysed independently to identify and examine new issues that emerged e.g., those that were not directly targeted by any particular question.

A formal meeting for data review and interpretation with all study partners and a panel of research personnel was held in November 2005. Study partners were provided details on the quantitative and qualitative findings. Over the course of three days, study partners contributed their insights about the findings based on their direct experience with survivors, their professional training (e.g., social workers, medical doctors, psychologists), and their experiences having conducted the interviews. Country partners were also instrumental in providing country- and culture-specific interpretations.

Research personnel included experts in the fields of gender-based violence research, human trafficking research, health policy analysis, medical anthropology, sexual and reproductive health epidemiology, internal medicine, and statistics. This input was also instrumental to the data interpretation.

4.4 Ethical and safety protocol

The *WHO Ethical and Safety Recommendations for Interviewing Trafficked Women* was the basis for the ethical protocol used in both studies. It provided guidance on key issues such as the expansion of the concept of "do no harm", confidentiality, consent, referral, support and assistance to participants, and selection of interviewers.

To meet these standards, partnerships were formed with local groups providing services to women who were trafficked. This made it possible to implement principles such as ensuring study participants could be contacted safely, have ready access to health care and other forms of assistance, and

would be treated with respect. Groups working with women who are trafficked also had in place appropriate security and confidentiality measures to protect women and the information they provided. In addition, by working with groups who often both provided services and conducted advocacy on behalf of trafficked women, the information gathered would have the greatest potential to be used to inform both interventions and policy advocacy.

Women entering services were offered clear information in their own language about the purpose and subject of the study. In an effort to avoid suggesting services were contingent on participation, interviewers emphasised the voluntary nature of participation and efforts were made to separate the study from the normal intake and other service procedures.

For women agreeing to participate, a formal consent procedure was carried out, during which each participant was informed that their responses would be kept anonymous and confidential, e.g., no names would be used on questionnaires, questionnaires would not be seen by anyone outside the study, such as police or immigration services. Each was advised that she did not have to answer any questions she did not wish to, she could take a break or terminate the interview at anytime, and that declining to participate would not in any way affect the services she received. Despite these explanations, nonetheless, there is the chance that women who would have otherwise declined to be interviewed might have agreed because the request came from the organisation that was providing assistance, housing, etc., and women may have participated out of gratitude or the feeling of obligation to the service provider.

All participants were interviewed in private by experienced support staff (psychologists or social support workers) of the service organizations whom were part of the study team. In some cases, an interpreter was present who was known to the organisation and had been sensitised to work with trafficked women.

Selecting experienced members of staff to conduct the interviews was a key decision in both studies. As trained staff of support organisations, they were well-positioned to ask sensitive questions, react appropriately to difficult emotions, recognise when to terminate or postpone an interview, and organise care for reported medical problems. It was felt that as care providers, support workers were most likely to gain women's trust and would therefore be best able to garner truthful, in-depth information about highly sensitive and traumatic experiences. Disclosure can be particularly difficult for women who were betrayed in their recent past, and are therefore reluctant to trust others. We judged that whatever might be lost to the standard "objectivity" of the interviewer would be small compared to that which would be gained in veracity and detail by using individuals who had already developed a rapport.

Throughout the study, all partners agreed that as service providers, they would make every effort to respond to reported medical, security or other stated problems either within their own services or through their referral networks.

A primary ethical aim of both studies was to make certain the information was put to good use. Copies of the findings of the first study were sent to all participating partners and distributed globally to key organisations working on

trafficking. Findings of the second study were presented at numerous venues, including a High Level Meeting of the Organization for Security and Cooperation in Europe (OSCE), attended by delegates of 54 member states, and law enforcement personnel and NGO staff from numerous states. Two parliamentary presentations of the findings took place in Westminster and the Scottish Parliament. Numerous training and information sessions have been carried out for police working on trafficking and international and local NGOs, e.g., the La Strada network of services. Findings were also contributed to support a number of individual asylum cases and prosecution efforts.

Both studies received ethical clearance from the LSHTM Ethics Committee.

4.5 Chapter discussion

This chapter described the methodology employed for both studies that informed this thesis. It highlighted the way the formative study laid the groundwork for the quantitative research by developing operationalisable elements, such as a conceptual framework and preliminary evidence on health indicators. Because so little research had been previously conducted on health and trafficking, this formative work was not only important in its own right, but also necessary to inform the methodology for the quantitative survey.

Additionally the methodology selected for these studies builds on strategies used for previous research carried out with similarly vulnerable populations. Several key methodological decisions (e.g., selection of study population) and survey instruments (e.g., HTQ) were based on work that had

been done with victims/survivors of gender-based violence and trauma victims.[323, 360]

These types of studies, like the studies carried out for this thesis, approach health from a human rights perspective, prioritising individual symptoms and experiences, rather than focussing on the public health implications and state's rights. These methods recognise the various instruments that define the rights of individuals to personal security, protection, and not least, health.[79, 369, 370]

As the methods were developed within an individual rights framework, the following results chapters also present the findings within this perspective. The health patterns found among trafficked women are discussed as an overview, which are regularly supplemented with the words of the women about their experiences, emotions and opinions.

CHAPTER 5: FORMATIVE STUDY ON HEALTH RISKS AND CONSEQUENCES ASSOCIATED WITH TRAFFICKING

5.1 Chapter introduction

This chapter presents the qualitative findings from the first study on health and trafficking conducted between 2001 and 2003. This study was undertaken when, in the United Kingdom (the location of the lead research team), there had been no public discussions on trafficking, no legal or social policies, and no assistance programmes for trafficked persons. Without direct evidence to build on, the study team adopted an exploratory approach, aiming to become familiar with the spectrum of individual health risks and symptoms, as well as develop a broad portrait of structural health influences. It was expected that these study findings would ultimately generate hypotheses and variables on health risks and consequences for a future, more systematic inquiry.[336]

The data presented represents primarily the findings from interviews conducted by NGO counsellors with women who had been trafficked. It also incorporates information collected from interviews with NGOs working on trafficking, health service providers, police and immigration personnel, and policy-makers.

The first section of this chapter describes the characteristics of the study participants. The remainder of the chapter discusses the findings, often drawing on existing literature to explain or put them into context. The discussion structure follows the phases of the trafficking cycle described in the chapter on conceptual models: pre-departure; transit and travel; destination; detention, deportation and

criminal evidence; and integration/reintegration. These phases were identified in order to explore the distinct and cumulative nature of the health risks faced by women.

At the conclusion of the chapter, the implications of the findings for the development of the subsequent quantitative study and for service provision and policy are discussed.

Table 5.1 Characteristics of study sample

Characteristic	Study participants (n=28)
Country of origin	
Ukraine	12
Albania	7
Romania	3
Kosovo	2
Laos	2
Lithuania	1
Togo	1
Country of destination*	
Italy	11
United Kingdom	4
Netherlands	3
Yugoslavia	3
Belgium	2
Kosovo	2
Thailand	2
UAE	1
Turkey	1
Greece	1
Albania	1
Age at time of interview	
13-17	5
18-21	5
22-25	8
26-28	10
Form of labour	
Sex work	25
Domestic labour**	3
Marital status	
Married or partnered	4
Single	13
Separated/divorced	11
Children	
Yes	9
No	19
*Several women were trafficked to and worked in more than one destination.	

5.2 Study sample: characteristics of the women

A total of 28 women were interviewed in different country partner locations: four in Albania, five in Italy, three in the Netherlands[l], two in Thailand[m], four in the United Kingdom and ten in Ukraine. The majority of women in this study came from Ukraine (12) and Albania (7). Only three were from outside Europe. The greatest number of women were trafficked within Europe. Most were trafficked to Italy (11). These proportions generally reflect the countries participating in the study. Most of the women in the study were over 21 (18) and only five were under 18 years-old. See Table 5.1. Results presented in the chapter do not always represent all of the 28 women, because not all women responded to each question.

Twenty-five of the women were trafficked for forced prostitution, and three were trafficked into domestic labour. All were sexually abused and/or exploited. The majority of women were not married (24), 11 were separated or divorced and 13 were single. Nine women had children, of whom seven were single parents. Other studies have found that many trafficked women come from single female-headed households.[107, 308, 371]

5.3 Pre-departure stage results

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[l] For two respondents, responses were very limited and are not often represented in the text.
[m] Two additional interviews were carried out with migrant women from Uzbekistan who worked in sex work in Bangkok and who were being held in the Immigration Detention Centre (IDC) in Thailand at the time of the interview. These women are not represented at any time as trafficked women and, are 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.

The *pre-departure stage*[120] encompasses the time before a woman enters the trafficking situation. See 4.2 *Conceptual Models.* Women were asked a series of questions about their lives before they left home to understand some of the factors that might have contributed to their vulnerability to being trafficked and influenced their health during and after their journey. They were also asked about their knowledge of sexual health and their awareness and use of health services to learn about possible protective factors.

The findings described below offer information on two particular health dimensions: 1) women's personal history of violence or sexual abuse; and 2) women's experiences with their home country's health services and individual health knowledge.

Table 5.2 Women's primary reason cited for leaving their country of origin

Reported reason for leaving country of origin	Number (n=28)
Earn money	17
Abducted	2
Marriage promise/love	2
Fleeing danger/abuse	2
"Don't know"	2
Seeking an interesting experience	1
Promise of tourist holiday	1
Study abroad	1

5.3.1 Personal history

Why she left home

Women were asked, "Why did you decide to travel from home?" The majority, 17 of 28 women, cited the need to earn money. Thirteen named unemployment, poverty, and the need to support children, siblings or parents.

One woman was only thirteen when she was lured from a refugee camp in Albania by a promise of marriage. She was soon thereafter sold/forced by her "fiancé" into sex work in Italy:

I left my home in Kosovo in 1998 with my family because we were forced out by the Kosovar crisis. We entered Albania through the Morina border and stayed at the refugee camp in Kukesi town. 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. I

decided to run away with R without letting my mother know what I was doing. Together we went to Shijak where we stayed for three weeks and then we went to Tirana to stay with R's brother for a few days, then we stayed with his cousins for four months during which time he told me that he was looking for jobs for both of us. I was 13 at the time.

She was one of the two women who said they were "hoping for a better life", one admitting:

Because I was naïve and was hoping for a better life.

Both women were recruited from Albania where a common *modus operandi* of traffickers is to lure young women with proposals of love or marriage.[103]

Two women reported that they were abducted by traffickers. One reported being sold by acquaintances and abducted from a local café, and 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 of a tumour. Two women professed to have no explanation 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.

Two young women stated that they accepted offers for travel that seemed enticing. Two other women said they fled violence. See below.

Understanding women's reasons for leaving home is difficult, first because these decisions are often not singular, but are usually involve a number of influences (e.g., financial, dysfunctional home life, etc.). Although poverty has

been regularly cited as an underlying cause of trafficking,[17, 372] it is not the case that all women who are trafficked were living in relative poverty, nor are all poor people trafficked.

Analysis of women's motivation is further complicated by the retrospective nature of the question, as women may have had difficulty recalling or did not wish to reconsider the cause of their violation. Women may also have been concerned about how their answers would be perceived by others.

History of violence, abuse, family problems

Of the 20 women responding to the question, "Did anyone ever hurt you while you were living in your home country," seven answered affirmatively. Two women reported being abused by their spouse, four by their father or "parents", and one by classmates. In describing how she came to be trafficked, one young woman explained:

> *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 very badly. This is one of the reasons why I left my country.*

Of the seven women reporting abuse, only two cited this as the primary reason for leaving home.

In addition to pushing women to seek a way out, abuse or dysfunction at home is likely to have negative impacts on health even after violent episodes cease,[78, 267, 268] including physical sequelae (e.g., chronic pain, gastrointestinal symptoms and negative health behaviours),[182] poor psychological reactions (e.g., anxiety, depression, aggression and self-harm)[271] and risk behaviours.[185, 373]

A psychotherapist from Animus Association Foundation, 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."

Two of the youngest respondents (ages 11 and 13 at time of trafficking) both lived in orphanages when they were recruited. One of these girls had been taken from her parents by child protective services, while the other was forced to reside in an orphanage when her mother remarried. The second explained:

> *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.*

Women without parents or parental support seem vulnerable to trafficking:

> *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.*

Illness in the family also appears to be a pressing concern causing women to migrate for income:

> *Sometimes we had no money to buy food. My husband was dismissed from his job several years ago. He couldn't find new one. I was the only*

bread-winner in the family. I have a small daughter O. Once, O burnt herself with boiling water. She was in the hospital for a long time. Burns were on 60% of the surface of her body. I had to earn big money for my daughter's treatment. I decided to go abroad and to earn money there. I didn't want to go. I wanted to stay with my ill child, but I had no other way out. I proposed to my husband that he go abroad and work as a builder, but he refused.

Another wished to help her mother: "I needed to buy medicines, and the debt for our flat payment increased." Two women were wooed with promises of love or marriage:

I was in love with my boyfriend and thought I could earn some money to buy a house and then get married.

While this study did not focus on situations of armed conflict or refugee settings, women who are in situations of civil unrest or residing in refugee centres appear to be particularly vulnerable to trafficking.[374-376]

Recruitment: trust and deception

As there are hundreds of thousands of women who are situations of poverty and personal or social crises, "push factors" alone (personal, social, financial crises) do not necessarily seem to explain who gets trafficked—From women's accounts of their recruitment, what might be the difference in outcomes between two women with similar risk situations is the credibility of the person who extends the job offer. The trust that this person instils appears to be the lynchpin that secures women's decision to depart.

Questions were posed to learn how each woman was ultimately convinced to leave. All but one respondent 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. One explained:

> *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 $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.*

One woman, who was beaten by her alcoholic father, was recruited by her

cousin:

> *A cousin said he would get me out of this situation and into a 'normal' life. He sold me like a slave.*

Another woman explained that her daughter needed urgent medical care and a

friend of her mother offered good money if she was willing to migrate for work:

> *One friend of my mother's had been working in Italy for several years. Sometimes she came home and left money for her family, but not often. She told me that I could make a lot of money and then come back home. I believed her and I went to Italy. The registering of the documents, visa and the road expenses my mother's friend took care of. I was supposed to give this money back after I found a job. I was promised a job as a nurse in a family.*

This woman's tale of her recruitment was similar:

> *I had a very bad financial situation and one of my old friends knew about this. He found me and said that his friend, Ivan, had a friend abroad who needed a baby sitter for her children. I accepted this proposal, because I knew Ivan. I had seen him somewhere before. He helped me to make my documents very quickly and agreed about my departure. He phoned to Istanbul and Maria promised to pay all necessary expenses for my arrival in Turkey.*

As noted above, two other women were deceived by promises of a 'fiancé' or boyfriend.

All of the women in this study were propositioned by private individuals (who may or may not have been part of a larger network). None had sought the services of an "employment agency" or responded to an advertisement in the paper. Other studies have found that some trafficked women had responded to ads for employment, modelling, etc.[52, 71] Despite women's condemnation of those who had deceived them, many nonetheless felt somewhat responsible for their fate. One woman:

I was so sorry that I had agreed—that I was this stupid.

As will be discussed, the culpability women feel for this ruinous decision may readily feed into a trafficker's control. However contorted the logic, both the trafficker and the woman often 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.

For the women who were trafficked by a lover or boyfriend, there are added emotional complications. The man who professes to love her is also the one that puts her up for sale and collects the profits. Women are caught in a dichotomy of love and abuse. Some women later come to understand the

incongruity of the professed 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.

These deceptive recruitment practices appear to have immediate and longer-term effects. Not only do they draw women into the trafficking situation, but they also cause women to lose faith in others and themselves.

The inability to trust others may reappear in counter-productive ways once women are out of the trafficking situation, such as in assistance settings. Longer term, this emotional contradiction may make it difficult for women to develop healthy relationships.[377]

Conversely, it is worth considering whether for some women, the hard-won scepticism gained from this experience may have a protective effect in the future and prevent some women from taking risks or relinquishing responsibility for their safety to others.

5.3.2 Experience with health information and care

Women were asked to discuss their sexual health knowledge and their experiences with their country's health care services in order to explore protective and health-seeking factors.

Individual health knowledge

Questions on health knowledge were designed to learn about women's decision-making in high risk situations. Time limitations for interviews meant that the inquiry into women's knowledge focussed primarily on sexual health as this was clearly an area of great risk, and one in which knowledge has significant potential protective value.[378] Questions were limited in scope to contraception and sexually transmitted infections.

When asked, "What did you know about sexually transmitted illnesses or HIV/AIDS before you left home?", only one woman stated that she felt well-informed:

Yes I did. By reading, doctors, commercials on T.V.

Of the remaining 22 women who responded, half explained that they had no knowledge or poor knowledge. The other eleven women felt they had a general sense or basic knowledge:

I knew some basic information on AIDS. I was told by some friends to always use condoms to protect myself against STDs and AIDS.

When asked about contraception, eight women said they were using the oral contraceptives. However, when probed, three explained that they had learned about them in the destination country. These awareness levels are consistent with the low levels of knowledge of STIs and use of modern forms of contraception in their countries of origin.[277, 379-381]

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 my pimp/madam/boyfriend*, or *from my friends/colleagues/other girls*, or:

> *To tell the truth, I didn't know how to use a condom before I came here.*

While a woman's ability to protect herself depended to a great extent on the presence of violence, prior knowledge may have enabled women who were allowed leeway for decision-making to mitigate the risks.

Individual experience with health care

Women were asked about their experiences with the medical sector in their home country. When asked about accessibility, more than half of those who responded 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*

Another concurred:

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

When asked about quality of care, four women said the service was "good" in their country, but two added that it depended on one's ability to pay. Another was wholly negative about the care:

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Everything is more difficult [in home country]. Treatment is worse and we had to pay.

One woman who was trafficked from Ukraine to Kosovo and Yugoslavia said that she disliked the *bad service* and the *bad attitude of doctors* in her country.

When asked what they liked about the services, few women were able to think of a response. Three women said that they liked the doctors. One woman simply said: *I was at home.*

5.4 Travel and transit stage results

The *travel and transit stage* begins when a woman agrees to go 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.

It is too simplistic to view this stage solely as how women got from one place to another. This stage is more correctly understood as the sum of the events and atmosphere that a woman experiences while she is being brought to the destination point.

The travel and transit stage is generally the time when illegal activities and movements begin. Crimes are multiple and include, *inter alia*, abduction, use of

forged documents, facilitation of illegal border crossings, harbouring and employing undocumented persons, battering, rape and other violent acts.[102]

To understand this stage, the following issues were explored: the time of the "initial trauma"; risks women encountered during their travel; and how/if they were "sold".

5.4.1 The initial trauma

For most of the women in this study, the travel and transit period was the point at which they realised that they had been horribly misled and their future would be bleak. In her narrative, one of the women explained:

> 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.

Similarly, another woman's fears and suspicions also emerged after it seemed it was too late:

> 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.*

The distress associated with discovering their fate might be thought of as
the "initial trauma."[382] 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.[383]

At the moment of this realisation, most women may be rendered
powerless by threats, violence, the rapid pace of travel, their illegal status,
fear of authorities, inability to speak the language, and other logistical
barriers.

5.4.2 Transport conditions

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

Women reported travelling by car, mini-bus, boat, train, plane, on foot, and
concealed in trucks. Albanian women travelling to Italy were brought to the Italian
shores 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. Of the
17 who talked about their travel, twelve reported being in transit from one to two
days and five said the journey took between one week and two months.

Illicit travel poses many dangers, as trafficking agents aim to make maximum profit from each trip, and avoid detection. 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." Women who travelled to the Balkans were most likely to report strenuous and danger-filled routes, for example:

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

One woman recounted how she was one of three women who crossed mountains by foot at night, and another described:

> *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.*

Another woman who travelled from Moldova to Romania was forced to stretch out across fibreglass insulation in the ceiling of a train in order to avoid detection.[384]

Women caught by authorities risk being turned back, or being sent to a third country (such as the case of an Uzbek woman who was deported from Turkey to Ukraine).[280]

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.*

Those who travelled by rubber dinghy reported being transported clandestinely at night:

> *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.*

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

One client of La Strada, Ukraine explained that her companion was unable to swim against the current and had drowned while trying to pass from Poland to Germany.[280] Neither is it 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.*

Women reported periods of poor nutrition, little sleep, and exhaustion as they were moved from one place to the next. Twelve of 17 women stated that they did not sleep or slept extremely little throughout the journey, some explaining that they had little to no sleep over a period of several days. Sleep deprivation and disruption can affect cognitive functioning and decrease the body's natural protection mechanisms related to pain and the immune system.[385, 386]

Women also reported not being fed regularly or being given food that was not nutritious:

> We were accompanied by two men and were fed only bread and water. We crossed through Poland, Germany, and Holland.

Twenty-three of 28 women interviewed were escorted throughout their travel by the trafficker or an agent in the smuggling chain. By accompanying women, perpetrators ensure that women arrive at the intended destination. One woman from Ukraine, for example, reported how police, complicit with the traffickers, drove 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 explained:

> 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...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.[387]

Five women reported being given their documents and travelling alone. They were, however, accompanied to the departure point and met at the designated destination by the trafficker or a relative of the trafficker.

5.4.3 Buying and selling women

In their narratives, eleven women reported having witnessed or been told of their 'purchase'. Five women stated they were sold multiple times. Women recounted sale prices ranging from €700 to €15,975 Euros. One respondent, a 15 year-old from Romania en route to the United Kingdom, gave a detailed account of her journey and sale:

I left my village to go to Timisoara, where I stayed about 3 days in a hotel. Then I 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 friends. Then, a Serbian bought me as well, and took me by car to Trieste, Italy, transiting through Bosnia-Herzegovina.

Three women reported having been purchased at auction-like settings. (e.g., at Arizona Market, outside Brcko in North-West Bosnia) where prospective pimps and agents came to select new 'merchandise.' These type of auctions have also been reported by journalists working in these regions.[388, 389] While it is beyond the scope of this document to review the range of trafficking-related trade

arrangements, in terms of health it may be important to understand the physical and psychological effects of being "bought and sold".

5.4.4 Violence and sexual abuse

Fourteen women reported having been confined, raped or beaten once or several times during this stage—before starting to work. Ellen described events after her abduction:

> *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 Schengan 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 there [in hospital] and I couldn't talk to anyone.*

A number of women said that they were abused after having refused to work as prostitutes. Only two women reported receiving any medical attention following sexual abuse or violence (both required an abortion) during this stage. One woman was so severely beaten that she was subsequently hospitalised:

> *J 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 this intention, but Sergey 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 J staying with me all the time to guard me.*

Life-threatening forms of violence are meant to show women the price of disobedience and that, to survive, they must submit. Imposed dependence is a key feature of captor-captive relationships. Writing on 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.[390]

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

5.5 Destination stage results

The destination stage is the period that a woman is put to work and her labour is exploited. The destination stage generally encompasses the forms of abuse that are classically associated with trafficking (e.g., those described in the Palermo Protocol).[135]

During the destination stage most women encounter multiple forms of risk and abuse that reinforce and exacerbate each another in ways that increase

morbidity and risk of fatality. The forms of risk and abuse and the range of health consequences can be roughly divided into nine broad categories that are discussed in this section (detailed in conceptual model: *Health risks, abuses and consequences*).

1)   *physical risks and abuse;*

2)   *sexual risks and abuse;*

3)   *psychological risks and abuse*

4)   *forced, coerced use of drugs and alcohol;*

5)   *social restrictions and manipulation;*

6)   *economic exploitation and debt bondage;*

7)   *legal insecurity;*

8)   *abusive working and living conditions; and*

9)   *risks associated with marginalisation.*

The last, risks associated with marginalisation, encompasses a vast subject area and was not explicitly explored for this study.

5.5.1 Physical abuse and other risks

Physical violence

When women were asked whether anyone had intentionally hurt them since they left home, 23 of 25 women replied "yes". Two women offered descriptions of violence:

T 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.

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.

One of the women who replied "no" recognised her good fortune:

No, I've been lucky about that.

Two women noted that beatings were carried out in such a way as to avoid making the injuries visible:

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.

One woman who worked as a domestic servant was beaten about the head and suffered chronic headaches and regularly lost consciousness.

Women explained that punishments were inflicted as a response to perceived disobedience, to force them to have sex or sell sex, when they did not earn enough money, and when customers complained about them. One woman who fled an abusive father in Ukraine and was trafficked to Belgrade, explained:

We were beaten if we refused to work, and even if we didn't understand the language. If [the owner] found any tips, we were beaten and the money was taken away

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.[103] While it is not confirmed how many of

these were cases of trafficking, these groups are commonly associated with trafficking in Italy.

Law enforcement officials interviewed for this study 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 described women who were beaten and forced to sit in an ice bath for hours in order to make the contusions less visible.

Abuse can be carried out by anyone in the trafficking chain, including trafficking agents, employers, boyfriend-pimps, clients, law enforcement officials[91, 212] and members of the armed services, including peacekeepers.[391]

Deprivation

Perpetrators also punished women by depriving them of food, human contact or valued activities or items. One woman who physically collapsed from hunger and required hospitalisation said:

> *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.*

Another said:

> *The girls were beaten and not fed for every fault.*

The majority of the women said that they were often hungry and lost significant amounts of weight. Women explained that they were treated like "animals", not

given enough to eat and that what they were given was "not fresh or nutritious". Three women reported losing between ten and twenty-three kilos.

These violations resulted in numerous health problems and women described what they perceived as associated symptoms:

Stomach-ache, losing consciousness because of no food

Several women recognised that their symptoms were associated with stress, but some discounted these as not being "real" health problems.

I did not have any serious health problem, mostly stress. I lost 10 kilos after I started working as a prostitute.

No physical illness. Fears and anxieties because of the life I was living. I have lost a lot of weight, but never dieted.

Research on other forms of violence against women highlights that chronic pains and illnesses and immune suppression may be associated with stress and anxiety caused by abuse.[271, 392-395 394, 395]

While none of the women in this study sustained serious injuries from an escape attempt, other women have.[396] For example, one Ukrainian woman fell two stories after towels that she tied together into a rope had broken, resulting in a serious spinal injury, requiring two months of hospitalisation and leaving her with a permanent disability.[280]

Women reported being prevented from accessing medical care or dissuaded from seeking care for financial reasons:

I decided not to go to the doctor because I thought I would have to pay.

When this woman finally collapsed, she was taken to an emergency service, where she learned that she was six months pregnant and had syphilis.

5.5.2 Sexual and reproductive health: abuse and other risks

Forced sex and sexual assault

In the context of trafficking, harm to reproductive and sexual health generally results from forced and coerced sexual violence and/or coercion. Each woman in this study, including two domestic workers, reported some form of sexual abuse or non-consensual sex act, such as including 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 acts.

Women who were forced to sell sex reported having been raped by traffickers, pimps, acquaintances of traffickers and pimps, and clients. Two women employed as nannies and housekeepers described being raped repeatedly by their employers and by other men. One was vaginally and anally raped and subjected to other acts that she found degrading (but preferred not to discuss) by her employer:

> *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. There was pain during intercourse because it wasn't normal sex, it was anal. Now I have pain in rectum, colon dysfunction and digestion problems. I have chest and heart pain. I*

had bruises on my arms and shoulders from where the husband would grab me for the sex.

The second woman said that when she was punished, she was brought down to the street or *strada*, where she was made to work as a prostitute.

One of the women interviewed escaped before traffickers could prostitute her, but not before she was raped by her trafficker. The rape resulted in a pregnancy and the birth of a daughter diagnosed with congenital syphilis. She described her rape:

I said, "no"...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.

Perpetrators appear to use rape as a tactic to wear down women's defences to the point where they "agree" to sex work. Rape is also used to extort money from women's families. A report from the Australian Institute of Criminology referred to reports of Chinese female migrants who were raped while family members were on the phone in order to persuade families to pay off debts.[102]

Over half the women reported symptoms commonly associated with sexually transmitted or reproductive tract infections or other signs of gynaecological ill-health, including unusual or heavy discharge, pelvic pain, pain or bleeding during intercourse, amenorrhea, and heavy and irregular bleeding. Several women stated that they had been diagnosed with specific STIs including, Hepatitis B, Syphilis, and Human Papillomavirus (HPV or genital warts). Women

also reported diagnoses of urinary tract infections, renal dysfunction, cervical dysplasia, ovarian inflammation, and complications from a botched abortion.

The importance of the link between sexual abuse and STIs is increasingly recognised.[303, 397-399] Women sold into sex work are likely to be at very high risk of various STIs, including HIV.[216] Literature on sexual abuse also suggests that rape, repetitive sexual abuse and coerced sexual risk-taking can result in tearing of the vaginal tract and genitals and unwanted pregnancy.[303, 304, 318, 392] Forced sex has also been linked to allergies, skin disorders, tension headaches, nausea, irritable bowel syndrome, chronic pelvic pain, dysmenorrhea, depression, and poor overall individual health.[400, 401]

Adolescent victims of sexual abuse are likely to suffer long-term health consequences, such as sexual dysfunction, an increased risk of contracting sexually transmitted disease later in life, adulthood substance misuse, difficulty with intimate partner relations, and psychological problems, such as depression and suicide. [402-405]

Clients

Trafficked women working in prostitution rarely have control over the number or type of clients they accept, or the sexual acts they perform. Eleven women estimated they served between ten and twenty-five clients per day and seven said fewer than ten. Two women reported serving as many as forty to fifty on any given night. One expressed her repulsion this way:

After two or three clients, I felt tired and disgusted with myself

And the other said:

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

To earn enough money to buy their freedom and respond to their employer's demands, women were frequently obliged to accept many clients per day.

Condom Use

Seventeen of twenty-three women who spoke of condom use reported regularly using condoms with clients. Twelve reported having ever used condoms with intimate partners (i.e., pimps, boyfriends or husbands). Fear led to a less safe practice for one woman:

> *Sometimes I used two condoms because I was so afraid.*

When asked about condom protection for other sexual acts, ten of nineteen women reported using condoms for oral sex, and three of sixteen reported using condoms for masturbation. Six of thirteen women reported having unprotected anal sex. One woman said:

> *My owner ordered me not to use condom for oral sex. It was very rare when I used condoms for anal sex*

Even when women are aware of the benefits of condoms, use is often at the discretion of the owner, pimp, or client. Nine of thirteen women said pimps or owners were their sole source of condoms. For example, this woman explained:

> *Some of them [customers] refused to use condoms. 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.

Other women said:

My owner ordered me not to use condoms for oral sex.

I worked without condoms unless clients requested them, then the owner gave me condoms. Normally, I had no condoms.

Research on HIV among Thai 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.[218]

Women also had difficulty accessing and affording condoms. In some cases, the cost of condoms was inflated by owners and then added to a woman's debt. Health outreach workers in London explained that even when they gave free condoms to brothel managers, workers were not confident condoms were passed on to women without charge.

Unprotected sex often commands higher fees, motivating women to undertake high-risk acts. One woman in the UK observed:

Girls without condoms make good money in one year, two years, but then they don't have good health and cannot enjoy the money.

Research and outreach staff working with sex workers suggest that women are frequently at risk of infection from their non-commercial sexual partners.[216] As a sign of trust and love, or because they are given little 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

Other forms of contraception

When asked about contraception, eight of seventeen women reported using an oral contraceptive. Several began taking the pill after an abortion. Aside from condoms, no other form of contraception was reported.

Misconceptions and concerns over side effects also affected women's decision to use oral contraceptives. A lead clinician for termination of pregnancy services in the UK suggested that culturally-based beliefs may dissuade some women from using contraception:

> In some cultures, women have problems taking contraception that alter their menstrual cycle and stops periods. They fear that their period builds up inside them.

Some women also explained that they felt they were unable to access or to afford contraception.

Douching and working through menstruation

Many women believed that douching was important to their health and hygiene:

I tried to clean myself as deeply as I could.

This comment was echoed by most women we interviewed. More than half the women used either a feminine cleansing product purchased at a pharmacy,

"syringed" with soda, or simply washed with soap and water. Two women in the UK 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.[406] 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.[217, 407]

Seven women reported working through menses, all of whom explained that they inserted a sponge for absorption. One 17-year-old, who intensely 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.[408]

Access to reproductive health information and services

Of the twenty women who were asked whether they knew where women could go for treatment of STIs, only four could cite a treatment location. Each mentioned outreach services or public clinics (consultorio in Italy). Two who did not know said they would go to the "owner" who would arrange a private physician. A woman trafficked to Kosovo noted the inadequacy of care:

When the doctor came to the brothels he only examined us externally.

Another who was in Kosovo explained that women "self-treat." 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.

Only six of twenty women reported having gynaecological exams while in the destination-work setting. Some exams were provided by NGOs and others were conducted at brothels or clubs. Inability to access health services not only deprived women of care, but also denied them a meaningful source of information. One woman who had been in London for some time explained:

I knew a little [before leaving home]. But I learned all I know here. I'm always terrified of STD or HIV, and I've always had tests every six months.

A client survey conducted by one non-governmental organisation in Italy revealed that of all the sexual health services provided, information on HIV and other sexually transmitted infections was most highly valued by migrant sex workers.[409] Interestingly, the only NGO activity more highly rated was "chatting"—perhaps suggestive of the isolation felt by many migrant sex workers.

Abortion, termination of pregnancy (ToP)

Six women reported having had at least one unintended pregnancy in the destination country. One carried the foetus to term, and the remaining five elected to have a termination of pregnancy (ToP). One reported 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 rape, coerced sex, contraception failure or problems, or unprotected sex with intimate partners or pimps. One doctor providing abortion services 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.

When women who had never been pregnant were asked: "What would you do if you got pregnant in Country X?" the majority expressed a preference for termination. Only two of twelve women who had never been pregnant were able to identify an accessible ToP provider.

Ignorance of abortion services and abortion legislation, and the absence of free or affordable ToP services increase the likelihood that women will turn to illegal practitioners. While the safety of illegal ToP services depends on the context, in most locations, the risk of having complications from an unsafe termination rises when services are illegal.[410] One woman who had an illegal abortion suffered life-threatening complications. One young woman who was fourteen years-old when she underwent an illegal abortion in the United Arab Emirates said:

> *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.

It is worth noting that in some locations, complications from unsafe abortions reportedly account for most maternal deaths.[411]

5.5.3 Psychological abuse

Psychological coercion and mental abuse are hallmarks of violence against women. The systematic process of creating terror often described by the women in this study might easily be associated with the abuses inflicted by perpetrators of torture, domestic violence or child abuse. As described in the *Background* chapter, the tactics include acts that serve to terrorise, deceive, destabilise and disempower the women. The intention of these tactics is to render the individual dependent and obedient by destroying her sense of self and her connection to others. This can restructure the victim's perception of the world into one constructed by the perpetrator. In this way, the perpetrator attains the obedience necessary to the victim's continued exploitation. As explained by Saporta and van der Kolk:

> 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.[272]

Control may be achieved when a woman can no longer distinguish her independent personal and social self from the identity constructed through her exploitation.[390] As 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.

Threats and fear

Most women interviewed were made to understand early on that traffickers would extract a high price for non-compliance. Women explained that warnings were in the form of overt and subtle threats of physical and sexual violence, financial punishments, and harm to family members:

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.

One woman, assuming some blame, recounted:

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.

Witnessing others being punished also served to warn women against disobedience.

Over one-third of the women interviewed reported that traffickers threatened to harm family members. Threats against family members are frequently cited as the primary reason women feel trapped.[91, 103] Threats against children are particularly intimidating. Even when not directly threatened, women generally perceived their family to be at risk. One woman explained:

No [we were never threatened], but I was very afraid of it.

Traffickers also blackmail women into compliance by threatening to reveal compromising details to a woman's family or show photos of the women at work. One Kosovan girl (age 13 when recruited) explained:

> *I am afraid to tell my family. I feel ashamed and worry that my father will not accept me.*

Upon return home, women anticipate stigmatisation and rejection. Young, unmarried women are likely to be thought of as "damaged goods", and married women may be considered unfaithful or an embarrassment.

Women were intimidated by threats of being resold or re-trafficked—with the attendant implications of a new (and larger) debt, a longer period of repayment, worse working conditions, and loss of any friends and support they may have had. Resale was particularly common among women in Kosovo and Yugoslavia.

Lies and deception

Traffickers frequently led women to believe that whatever the miseries of their current circumstances, appealing for help would make their situation far worse. Common ploys included telling women that if they were discovered without documents they would be imprisoned or unable to return home, or asserting that the local police are accomplices and would return or sell them (in numerous locations, this is true). For women who come from locations with corrupt law enforcement, these warnings are readily believed. Cultural, social and language barriers further dissuade help-seeking. One woman recalled:

> *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".*

Emotional manipulation

Seven women from Albania, Romania and Kosovo said they were trafficked and/or pimped by a boyfriend or fiancé. These women were subjected to cycles of seduction, rejection and abuse that are characteristic of intimate partner violence and noted for increasing women's entrapment and diminished coping capacity.[412] Reflecting on her relationship, this woman said:

> *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.*

Women in these situations seemed to struggle 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 a lover-abuser relationship, the negative aspects of dependence intermingle with positive ones related to care and support.[186] Describing perpetrators, Herman explains:

> But simple compliance rarely satisfies him; he appears to have a psychological need to justify his crimes, and for this he needs the victim's affirmation. Thus he relentlessly demands from his victim professions of respect, gratitude, or even love. His ultimate goal appears to be the creation of a willing victim. [186]

For a number of women, this type of dichotomous relationship involved moments of kindness, making it all the more difficult for them to accept that they were being exploited, or to turn against these men. Women reported 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, he persuaded her that until he could find employment, she could make good money to support 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.

Promises of money and remittances to family were also persuasive incentives for women to stay in the situations.

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

Traffickers benefit from keeping women perpetually "on edge", by creating an environment in which women are unable to predict or control what will happen to them at any given moment. Perpetrators of torture are known to employ similar tactics aimed at destabilising their victims and creating extreme uncertainty about the future.[413] Research on torture suggests that the two variables that most

dramatically affect whether certain stimuli will have deleterious health consequences are the degree of predictability and control that an individual has over an event.[119]

Reported mental health symptoms while working

As a formative study, it was useful to look briefly for psychological symptom patterns of distress. We used a short mental health screening tool was developed based on a World Health Organization (WHO) questionnaire (SRQ20) and the Composite International Diagnostic Interview 1.1 (CIDI),[414] also developed by WHO.[n] The brief amended tool used for this study was not scientifically tested and not intended to be predictive or diagnostic.

Twelve respondents were asked 22 yes-or-no questions about their feelings and behaviours over two different time periods: 1) retrospectively, 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 of the twelve women responded positively for half or more of the symptoms (11+), suggesting high levels of distress. Four women responded positively to 15 to 18 of the 22 symptoms.

Certain symptoms were reported by nearly all respondents for the period while they were working, including: *easily tired or tired all the time; crying more*

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[n] CIDI is a comprehensive interview for adults that can be used to assess current and lifetime prevalence of mental disorders through the measurement of symptoms and their impact on day-to-day activities.

than usual; frequent headaches frequently unhappy or sad; had no interest in things; felt tense; and anxious all the time.

Describing her fatigue ("easily tired, tired all the time"), one woman elaborated:

> *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.*

A woman 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.*

She 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.*

Also widely reported was: "felt as if they weren't as good as other people or permanently damaged". Eight of 12 women said they felt this way. 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?'*

Another respondent said:

> *I used to feel like I am not a person.*

Like other forms of violence against women, trafficking degrades women's self-esteem.

Two women stated they felt "dirty" or "bad". Mired in humiliating, degrading circumstances, women's self-perception may be altered, as they no longer feel like the person they were at home, and 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" on the floor above her when she lived on the top floor. Two women said that throughout their lives, they had always heard voices, and the fourth said that she heard her mother's voice.

Suicide

When asked, "Have you ever thought of ending your life", six of nine women said "yes." Two women who confirmed having suicidal ideation said that these thoughts occurred "often." One explained:

I always felt anxiety and fear. Nothing interested me, and I felt I wanted to die.

Research on domestic violence and suicide suggests that suicide attempts may be provoked by women's "entrapment" and by being treated as "property", emphasising the role of the perpetrator's "coercive control". [415]

Describing one study participant, 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.*

One participant 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.*

5.5.4. Forced and coerced use of drugs and alcohol

In trafficking situations, drugs and alcohol can be tools of power and control. Under their influence, women are thought to be more pliant. Anaesthetised by narcotics or alcohol, women may readily take on more clients, work longer hours and perform acts they might otherwise find objectionable or too risky. In cases where substance use becomes dependency, women are further tied to their trafficker and may work in order to support their addiction.

They can also be a means of coping. 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.[89, 189]

Drugs

None of the women reported a current drug addiction. Three women reported that they had taken sedatives regularly. One woman said that she took two Diazepam tablets (anti-anxiety agent) daily, while simultaneously 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".

Some women reported being drugged to facilitate their kidnapping or transit. One young woman said that she slept throughout the journey from Albania to Italy because her pimp put something in her drink. 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".

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 when they are sold into prostitution.[29] Drugs may be used to render young women defenceless for sex with their first clients.

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, which can be addictive if used regularly].

Alcohol

Four of nineteen women said they drank significant amounts of alcohol (from seven glasses of vodka and juice to two bottles of .05 whiskey per day) while working. Four others drank moderately. None of these eight respondents reported drinking prior to leaving home country. None of those who reported drinking while in the work setting reported current drinking habits.

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

The youngest respondent, who was trafficked to the UAE and experienced horrible abuse, stated that the worst part of her existence was when she was made to drink.

The manager of a non-governmental organisation assisting sex workers in Italy 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 they were women of ill-repute, and thus unworthy of kindness or sympathy.

5.5.5 Social restrictions and manipulation

Much of trafficked women's isolation is a direct result of confinement and restrictions imposed by a perpetrator. Other aspects of women's isolation are associated with their illegal status and social exclusion, not unlike that

experienced by immigrant women[166] and female refugee populations,[416] emerging from the absence of social support and logistical, linguistic and social barriers.

None of the women reported ever feeling free to do as they wished. For many of the respondents, "not free" meant exactly that:

> 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.

For those in an intimate relationship with their pimp, their confinement was often related to their risk calculation. Expressing a wish to go out might provoke suspicion of infidelity or escape. Many would simply be accompanied, "I wanted to go out, but he wouldn't let me. He would follow me".

Women are also escorted to health clinics and abortion services. As one health worker in Italy noted, "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". Even in the case where health workers go out to visit women at their work venue, visits are regularly interrupted by phone calls from pimps confirming women's whereabouts and earnings. One young 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 hidden microphones. Another said, I could go to the city to make a call but only with the barman.

The absence of meaningful interpersonal contact seemed to reinforce their belief that relief or escape was futile:

> *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.*

Traffickers seemed to manipulate women's contact with others in ways that increase their dependence. Few women were able to phone home and for those who did, candid discussions were rarely possible:

> *I called home once in two months, but the owners were listening.*

Women are also disoriented by the unfamiliar context. A social worker explained that one woman was intimidated from going out on her own because she was afraid she would get lost, she had no money and didn't speak the language. Traffickers further play on women's ignorance:

> *Andrey [the trafficker] warned me that if I was out, I could be stopped by the police and could be put in jail.*

Co-workers were a potential source of support, but in many cases, conversations were limited by time and context:

> *Sometimes in the van I could speak briefly with the other women in the van on the way to work, otherwise we were locked in separate rooms*

One woman highlighted the limits 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*

Traffickers also reportedly manipulated the nature of women's relationships with their co-workers. For example, bar or brothel owners may intentionally schedule women who speak the same language for different shifts. Owners may also 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"[417]. Certain women may receive perquisites (e.g., fewer clients, extra freedom) for loyalty and complicity (e.g., spying on colleagues). Mind games, such as subjective systems of rewards and punishments, discourage rebellion.

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.

Particularly for sexual health information, colleagues could be an important source of advice. Five women reported receiving guidance from "other girls".

Girls help each other, I would ask friends. [five women]

Unfortunately, five other women stated that there was no one they could ask; four were instructed by the pimp or madam.

Language

When women were asked about friends or acquaintances within the local community, few women reported having had contact with local residents. Only

three of 26 respondents said that they could speak the language of the destination country. Language barriers hindered women's ability to negotiate services, prices, and safe sex, and prevented them from understanding an employer's or client's demands, which sometimes resulted in physical punishment:

> *We were beaten if we refused to work, even if we didn't understand the language.*

> *[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".*

Language also prevented escape. One woman was confined all day and watched by her Serbian pimp while at work:

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

One woman trafficked to the United Kingdom tried to call the local emergency number but was unable to explain her situation.[418]

5.5.6 Economic exploitation and debt bondage

Even women who have successfully avoided physical violence are kept under the control of traffickers by economic exploitation or debt bondage. Women in this study reported owing, or having been purchased for €700 to €15,975 euros. Traffickers oblige women not only to repay real and 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:

> *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.*

Another woman said:

> *When I first came to the hospital, the owner cured me on credit, which was deducted from my salary.*

In addition, women frequently incur fines for numerous alleged infractions, such as tardiness, time off for illness and perceived misdemeanours.

Women who are trafficked are rarely 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 study participants said:

> *I don't know. I didn't get anything. Also I didn't understand their money system. I gave money to my owner.*

Traffickers appear to have devised various schemes to extract the most work for the highest return. 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.

Pressures to earn and repay debts can be fierce, which can push women to take risks, withstand long hours, and/or serve more clients to earn higher fees. One woman, who was able to make a choice, noted 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*

Women may also be re-sold before they can begin earning the money they were promised:

> *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).*

Few women had access to cash, which hindered their ability to care for themselves, such as purchasing necessities, hygiene products, medications, etc.:

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

The 17 women who knew how much money they earned, reported making between €45 to €1,200 per day. Five did not have any idea how much money they made. Fourteen women said they were not able to keep any money at all and eight said 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. According to health outreach workers from one London-based service, women working in apartments in the centre of London in 2002, for example, earned between GBP£20-45 (€28-63) per client for oral sex, hand

masturbation or vaginal sex.[o] However, outreach workers explained that before taking home any cash, women were required to pay GBP£250-300 (€352-422) 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 had to serve, on average, 10 clients per day simply to break even.

For many women their persistent financial reliance served to crystallise their powerlessness and the belief that they would remain penniless. Yet, some continued to work in hopes that someday their debt would be paid off and they would earn for themselves. As one woman who worked as a domestic worker remarked:

> *I was never paid by the second family, but continued to work in hopes that I would eventually get paid.*

5.5.7 Document confiscation, uncertain legal status

Thirteen women reported travelling with passports, nine of whom stated the passport was counterfeit. None of the women had arranged their travel documents or work permits. Six reported having no documents at all. As one woman explained:

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

A 12 year-old travelled as a dependent and never had her own papers

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[o] Interviews with CLASH and PRAED STREET project outreach staff.

For undocumented women, insecurity over their legal status can dominate their existence and affect decisions about their health and willingness to seek help. Fear of police and immigration services can often be greater than fear of traffickers because of the risk of deportation or imprisonment for illegal entry or prostitution. This works to the advantage of the trafficker, according to one expert on migration:

> 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.[94]

Women's anxiety over uncertain or illegal status influences their contact with potential sources of assistance:

> *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.*

A health worker providing outreach services to women in prostitution 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.

Ignorance and discrimination on the part of medical service providers can also inhibit treatment. 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 and unnecessary burdens of proof on migrant women.[195]

5.5.8 Abusive working and living conditions

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.

Reports from around the world indicate that women are trafficked into labour conditions that pose serious health and safety risks, conditions that are degrading, menacing, unhygienic, under-ventilated, unheated, overcrowded, high risk for injuries, and for these reasons and many others, nearly always stress-filled.[187, 266]

Work conditions

Seventeen of 20 women interviewed about their work conditions said they worked seven days per week. Many reported punishing schedules, up to 14 hours per day, often starting in the evening and finishing in the early morning. Most described their work conditions as "bad" or "terrible." One woman in a Yugoslav brothel stated:

> *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.*

Another said:

The conditions were awful. Too difficult to talk about, or to remember.

When asked whether they felt safe in their workplace, not one of the 20 participants reported ever feeling safe. Women feared violence, diseases, work without condoms, being without documentation, being re-sold, and the police.

Living Conditions

Ideally, one's living-personal space is where an individual finds comfort and refuge, and is the place that reflects one's sense of self. 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 woman described:

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

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 those who resided in a different location from where they worked, their home environment was reported as stress-filled, as they were under surveillance, lock and key, or lived with their pimp or boyfriend. One young woman trafficked to the UAE described how she was locked in the bathroom and forced to sleep on the floor.

Most of those trafficked to the UK and a number in Italy described their physical living conditions as residing in a "normal" apartment or house. Ten women felt the physical comfort was acceptable, but living with their pimps made

their home life stressful, confining and often violent. 'Home' was not a place to rest, recover, or feel safe.

Summarising the feelings of many with regards to work they were made to do, one woman explained:

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.

The term "meat" was used by at least two other women.

5.6 Detention, deportation and criminal evidence stage results

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 co-operating, voluntarily or under threat of prosecution or deportation, in legal proceedings against a trafficker.

This section focuses on authorities' awareness of women's health needs, their preparedness to assess and address these needs and the implications for cooperating in legal proceedings. Findings are based primarily on interviews with a limited number of officials whose mandate at the time of this study included work on trafficking or who had experience dealing with trafficked women. Further research in this subject area is urgently required.

5.6.1 How authorities come into contact with women

Officials came into contact with women most often either through non-governmental organisations or via police or immigration actions. Seldom did women present themselves to authorities as victims of a crime.

Officials and NGO staff interviewed in Italy agreed that women are generally identified through NGOs, who have often been alerted by women's clients or colleagues. For example, of approximately 400 calls to Caritas help-line workers, the vast majority of assistance requests came from clients or women's friends.[419] A similar pattern was reported by the Italian government's national "hot line" (numero verde).[420]

Women are also found during police and immigration raids, which appear to be increasing as a result of growing anti-immigrant and anti-prostitution sentiment in many locations. One Italian public official noted:

> Since September 2002, deportation procedures are being applied more rigorously than humanitarian provisions, such as Article 18.[421, 422p]

Two women interviewed for this study came into contact with authorities when family members initiated a search for them:

> 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.

And another stated:

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[p] 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.

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

Women are also reportedly turned over to authorities by traffickers who wish to avoid paying them, or when they are no longer of use. 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, The trafficker reportedly told the girl, "Go home and send your sister in your place".[423]

Self-identification appears to be relatively rare. Women face numerous deterrents to reporting to authorities, including fear of retribution and political and social forces against migrants and sex workers that deter reporting of abuse[1, 34] Many trafficked women assume that they are not "victims" of a crime, but have entered into a bad contract, made a "stupid" mistake, or were simply unfortunate.[308] Women also anticipate being prosecuted for illegal acts (e.g., immigration violations, prostitution) or deported. Because police corruption is commonplace in many home countries, women may also suspect (sometimes correctly) that police are in collusion with traffickers and will return them to traffickers or will re-traffic them if they make it home. Unwillingness to come forward can impact women's health by deterring them from seeking medical assistance, and thereby allowing medical conditions to deteriorate.

5.6.2 How officials viewed health of trafficked women

None of the officials interviewed were ignorant of the abuses and harsh conditions suffered by trafficking victims. Most were even able to offer examples of violence and injuries. Law enforcement officials from Italy and the United Kingdom recounted cases in which women had been burnt with cigarettes, hanged from the ceiling, or had salt poured into their wounds.

Nonetheless, few officials considered inquiries into women's health and safety a procedural priority. Immigration officials said they had no health-related procedures for trafficked persons. Individuals are simply asked: "Are you fit and well?" One UK immigration official said:

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

This appears to be emblematic of the policies and attitude of immigration services in general. One high-raking police inspector put it succinctly:

> Few care. To immigration they are just numbers.

According to both police and immigration officials few procedures are in place to determine whether a woman needs medical attention and what to do if she does. Women are likely to be taken into custody without any query about their health. One woman trafficked to Italy stated:

> *[Italian police] 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.*

When asked about procedures related to victim's health, Italian, Dutch, Ukrainian and Belgian officials reported that women are generally referred to a local NGO. In the UK, at the time of this study, no such NGO existed (it was not until 2003 that Eaves Housing established the POPPY Project). Because police actions were likely to be conducted jointly with immigration, women were likely to be treated as alleged illegal entrants and asked routine questions (e.g., current medications, chronic conditions). In cases of visible injuries, severe distress or rape, where forensic evidence in required, women are immediately referred for emergency medical assistance.

Women themselves reported that they were unwilling or afraid to ask for help and did not feel that the offers were genuine. When asked about offers of support, one woman replied:

Yes, but I never believed them or accepted.

One official in the UK police recognised women's reluctance and mistrust:

After what's happened to her earlier in the day [the arrest], a woman has no reason to believe that [officials] are people who actually care, so you know we try to build a bridge.

Health-related inquiries by officials were often a formality, offered in hostile and high-pressure contexts. As one high-ranking police official put it:

This is clearly not a conducive environment for a woman to express her concerns.

5.6.3 Removal, deportation, voluntary return

Only in the minority of cases was there coordination between authorities in a destination location and officials or groups in a woman's home country, according to officials interviewed.

The lack of a safe return procedure has significant personal security and health implications. Women returning home may be met by their traffickers, who may arrange for women to be re-trafficked, sometimes 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 again in the UK. Many women returning home find it difficult to afford health services or ensure confidentiality, often leaving health problems untreated. In addition, poverty, outstanding debts to traffickers, and the lack of protection from reprisals can make women susceptible to offers to traffickers or to engage in other high-risk activities. In some countries, such as Nigeria, upon return women may be subject to medical screening and involuntary HIV testing. Accounts have been detailed of women whose HIV status was disclosed to state officials.[91]

Increasingly, the network of offices of the International Organization for Migration (IOM) has been involved in arranging the voluntary return of trafficked women. Many IOM facilities in home and destination settings 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. The reality for the great majority of women, however, is that they must fend for themselves.

5.6.4 Co-operating in a prosecution

In most countries in Europe, temporary residence permits, as well as assistance and support, are contingent on a woman's agreement to co-operate in a criminal investigation.[q] Despite the opportunity for temporary residency, only a minute percentage of trafficked women have provided testimony to date.[91]

The health implications of cooperating with police can be conflicting. Women's access to necessary services may depend on their co-operation, yet their physical safety and psychological well-being may equally depend on *not* co-operating.

Law enforcement officials and other experts describe several reasons women decide not to participate in prosecutions. Many fear reprisals against them, especially against 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.

One woman 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.*

An NGO staff member working with trafficked women in Belgium recounted:

> 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 her 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. But under Belgian law she would have had to go back if she wouldn't testify.

Even for women who agree to testify, most states have no legal obligation to offer her residency after the conclusion of the trial.

In addition to fear, women have other reasons to avoid testifying against traffickers. Women who had or have intimate relationships with their trafficker may have conflicting emotions about testifying. Women may also be unable to testify because they actually know very little about the perpetrator's activities. 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

Officials often ask women to recall details around the time of the "initial trauma" or about the most disturbing events too soon. Psychological responses to trauma may inhibit them from providing accurate evidence. In these cases, women may be perceived as untruthful or uncooperative. The lack of victim-sen4sitive procedures may deter women from participating.

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[q] Italy is an exception: migrants in situations of abuse or severe exploitation have the formal right to stay without having to testify. (Pearson, 2002)

5.6.5 "Reflection period"

A "reflection delay" or "reflection period" is a grant of temporary residency (up to three months) that the state allows for a woman to recover and decide whether she wishes to participate in a prosecution.[134]

The reflection period comes at a key point for a trafficked woman's health. Temporary residency status entitles women to medical care, housing, and often social benefits. It permits women time to rest from an exhausting and traumatic experience before having to make many stress-filled decisions related to her future (such as, assisting police and prosecutors to pursue her trafficker or returning home). It provides the opportunity for a woman to develop relationships with individuals and organisations who can counsel her about the risks and benefits of participating in a prosecution, and practical, legal, medical and emotional tasks.

Police suggest that asking women to participate immediately after contact may inhibit participation:

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

Another detective concurred:

> I feel [the victim] 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.

Without a law for a reflection period, police in the UK at the time of this study were obliged to arrange support for victims. As one London-based detective explained:

> 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.

Politics related to immigration in the UK challenge the implementation of a legal reflection period. When asked whether special procedures might be instated for victims of trafficking, one UK 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 trafficked.

According to police officials interviewed in the UK, this is not an uncommon perception on the part of immigration officials.

5.6.6 Trial and testimony

Three cases in which women gave evidence in UK courts were reviewed for this study. Two cases were described by London Metropolitan police detectives directly involved in the investigation. I attended the trial of the third case.

Police described trials that were delayed or adjourned due to the woman's extreme distress and inability to proceed. Of the first case, the detective interviewed explained:

> Eva had to come to court over the course of five to six 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.

In the second case, the trial was nearly called off because the woman was unable to gain enough composure to enter the courtroom. The third woman, a minor at the time of the trial, was provided a screen in court and presented her evidence clearly and assuredly.

For victims of trafficking, taking the stand can mean confronting the individual that abused and humiliated her. It may require defending explaining equivocal circumstances, for example, where she had an ostensibly consensual partnership with the perpetrator.

Proceedings involving crimes of sexual abuse can often reflect on the witness.[424, 425] Defence lawyers' tactics can be aggressive, as they attempt to discredit or blame the woman. During the trial of an Albanian trafficker, the defence accused a 17-year-old adolescent from Romania 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 she imagined Britain as "the goose that laid the golden egg." In another case, the woman testifying was accused of being money-crazed, while the perpetrator was portrayed as an innocent man who simply could not live up to the financial ambitions of this money-hungry woman.[426]

One detective explained how he discouraged the witness from attending court for the verdict because he feared that if the trafficker were not convicted, she might feel the pain and humiliation of having been judged to be a liar.

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

5.7. Integration and reintegration stage assistance results

Integration has been described by the European Council on Refugees & Exiles as "long-term and multi-dimensional processes that are achieved when an 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".[290] Re-integration for victims of trafficking might be described similarly.

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

Based on interviews with service providers working with women in Italy, Ukraine, Albania, Belgium, Netherlands, and Bulgaria, it seems possible to divide the process of post-trauma care into three broad stages: (1) crisis intervention; (2) adjustment; and (3) longer-term symptom management. The discussion below follows this structure. Information provided by key informants is

supplemented by women's comments and, as needed, by relevant literature on service provision.

In cases where issues of integration and reintegration are very different, they will be discussed separately. Otherwise discussions will describe issues common to both.

5.7.1 Crisis intervention

Meeting practical needs

In the first meetings with a woman, service providers aim to take care of personal security matters 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 primary 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 social support worker 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.

Providers explained 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.

Providers highlighted that for some women, the trafficking experience has made them stronger and more self-reliant. Having independently navigated through a treacherous time, these women may not readily accept assistance and resent being treated as helpless or as victims. They noted however, that for some women, an outward show of strength may belie internal emotional vulnerability.

Ensuring personal security

Arranging to provide for a woman's security was reported to be among the first concerns of a service organisation. Staff at Payoke in Belgium 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.

One woman explained:

> 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.

Expression of fear of reprisals are not uncommon, and in many cases, not unfounded—particularly for those participating in a prosecution. In a twelve-country study on witness protection, witnesses in half of the countries experienced incidents of reprisals.[91] The study stated that reprisals were more likely to occur in a woman's home country, not least because local police are ill-equipped to protect women.

Four women were afraid of reprisals in the destination country. Seven feared for their safety in their home country. One woman who was severely abused in Turkey stated:

I was looking forward to coming back, but I am still afraid of meeting the trafficker.

Women may also be in danger from persons other than traffickers. One woman explained, *I am afraid to return home because my father is an alcoholic who beat me.*

Allaying fears and relieving distress can be particularly difficult if an individual perceives she is still being pursued. S. Turner, a psychiatrist working with victims of torture, notes:

[F]or some people only limited gains are possible. This is especially true for as long as the violence or the threat of further violence persists."[427]

Few women who are trafficked are likely to receive professional assistance, thus most are left to deal with personal security concerns on their own. One woman who was living alone with her child in a destination setting 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.

Assistance with documentation

Assistance preparing documentation (e.g., immigration, social services, entitlements, etc.) is reportedly a pressing concern for women in destination countries. Providers explain that administrative procedures are generally

cumbersome, confusing and rarely offered in translation. 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.

Another provider stressed 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.

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 co-operate and/or pay the health care in advance.

Nearly all providers reiterated that legal limbo is among women's greatest sources of anxiety. They contend that applying for regularisation appears to have mental health benefits, giving women a sense of legitimacy that alleviates feelings of guilt and criminality and anxiety over immediate deportation. Nonetheless, many women 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.*

Arranging shelter, housing and multi-sector service coordination

Emergency shelter and longer term housing for trafficked women have proven problematic in both integration and reintegration contexts because of legal and funding constraints. Organisations in destination settings may risk legal or funding penalties and be accused of harbouring undocumented immigrants.[r] Moreover, shelter organisations often depend on public funds or donor funding for shelter-associated costs.

Opinions on the best residential strategy for trafficked women differ significantly. Some organisations provide emergency shelter in a central multi-service facility intended for trafficked women. Residency in such emergency shelters can range from one to two days in some locations that do not have a fully funded residency program, such as La Strada, Bulgaria, to five to six months, such as Italy, after which women are referred to longer term housing elsewhere. The Italian NGO, *Associazione On the Road*, offers immediate accommodation in a "flight house" for very short periods, a second refuge with high security for longer periods, family placement, and independent housing.[91]

Some organisations believe that housing women, even for short periods, in one central facility can put women and staff at risk, because of the greater likelihood of the shelter location becoming known to traffickers. These organisations prefer a more diverse system of housing that, for example, places women directly in apartments or group housing in different parts of a city. They try to maintain regular contact with women to provide necessary services and information.

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[r] In Italy, however, a public debate on the need to protect providers from these risks resulted in Immigration Law n. 40/1998, which permits the provision of shelter and humanitarian care to

Some NGOs suggest that central 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, support workers 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 woman" or "prostitute". In addition, providers suggest that women can begin to feel confined and controlled in centres with high security and numerous restrictions. Having just left a controlling exploitative setting, a structured environment may impede women's efforts to learn to live independently. Providers have also observed that in some of the more closed shelter settings women can have too much free time to get lost in their thoughts or become overwhelmed by boredom. One woman explained how the stress, combined with the free time meant that she smoked more:

> *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.*

Care providers described the importance of giving women small tasks (navigating the local area transport, shopping, etc.) to women's reclamation of independence. Negotiating the universe around them serves as a sign of their growing self-reliance to women who previously depended on traffickers as their go-between with the outside world.

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irregular migrants.428.   1998. *Italian Immigration Law 40*, in *Article 18*.

5.7.2 Adjustment

Once women's basic and urgent needs are met, they begin to move beyond the crisis stage to address other less pressing needs, and they start to consider their future. Non-urgent medical problems are usually dealt with during this period. Clinical examinations and treatment most often takes place after crisis and subsistence requirements are met.

Physical, sexual and reproductive health

NGO staff reported that nearly all clients needed some level of medical care for physical and/or sexual and reproductive health complications. The most common problems were gynaecological. All women interviewed reported having been treated for STIs either before and/or after (or both) leaving the trafficking setting. One support worker stated:

> We have seen women with black eyes, bruises, injuries from rape and internal bleeding, complications from botched abortions. Two-thirds have STD's, and at one point ten of twelve women at the shelter had syphilis. Approximately 5-10% are HIV positive. Chlamydia is also common. 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.

The researcher from La Strada, Ukraine, reported common physical health issues such as headaches and sinus infections, skin problems, including lice and scabies and dental problems.

Physical injuries are particularly severe among women who have tried to escape or flee a trafficker. One assistance program manager recounted:

> 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.

Women commonly wish to address reproductive health problems immediately, because of pain and irritation, fears of damage to their reproductive health, and to prevent transmission to intimate partners. None of the women interviewed for this study reported having tested positive for HIV or AIDS.

Medical care and referral

Few groups interviewed were a "one-stop shop". Most did not provide in-house medical care. NGOs generally coordinated with external health services for diagnostic testing and treatment. Staff at La Strada, Ukraine 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.

Most organisations talked about the importance of accompanying women to medical facilities in order to offer practical assistance and emotional support through unfamiliar and sometimes intimidating bureaucratic processes. This is particularly important in destination countries where women encounter language and cultural barriers—including discrimination. An STV staff member described one client's situation:

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> 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.

A provider in Italy noted escorting women was also a trust-building exercise:

> Staff consider accompanying women to take such examinations as a crucial moment for developing a relation of trust between the community and the woman.

Psychological reactions

For many women, the psychological sequelae were often the most enduring and complex health outcomes. One woman described how even when the physical pain subsides, she often relives it in her mind:

> *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.*

During the integration or reintegration stage, providers compared the symptoms women suffer to those of survivors of other forms of chronic trauma (e.g, domestic violence, child sexual abuse, torture).[s]

Although many reports on trafficking have attributed symptoms observed among trafficked women to PTSD[283][t] many of the critics of PTSD have cautioned

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[s] Some psychologists have attempted to differentiate the symptomology associated with the aftermath of chronic trauma (vs. one traumatic event) as "complex post-traumatic stress disorder" (vs. post-traumatic stress disorder) as survivors of prolonged and repeated trauma appear to develop profound personality changes that are not included in the diagnosis of post-traumatic stress disorder (PTSD). See Herman, J.L. (1997).

[t] PTSD is a controversial diagnosis that has been criticised for its medicalisation of what are believed to be normal responses to extreme stress. However, many have noted that as a "diagnosis" PTSD can be useful to mobilising resources for refugees and victims of torture. See: Watters, C. (2001).

against pathologising or medicalising what may be normal, even constructive or existential reactions to extraordinary stress.[429] 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.[238]

These concepts are echoed in the comments of one provider:

> 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].

Resilience is an area that requires investigation in cases of trafficking, as it is not known what factors may influence a trafficked woman's recovery. One experienced support worker explained:

> 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.

Mental health support

Mental health support can come in many forms and is closely related to the resources available, and the customs and culture of a setting. In some locations "professional" support by a psychiatrist or psychologist, social worker, counsellor or therapist is more common, while in other settings, particularly those with limited resources, informal support is the norm (for example, participation in a community development project or joining a women's co-operative). In one community in Thailand, for example, 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.[430] Most providers and experts agree, however, that what best fosters a woman's recovery is care and understanding from those who are close to her, such as her family, friends and community.

The issues that providers cited as most elemental to women's mental health care are discussed below.

Assuaging women's guilt and shame

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 staff said that they encourage women to take pride in the strategies they adopted to avert further harm under such untenable

circumstances, and make it clear that they, the support workers, do not hold the women responsible. Support workers suggest that removing this barrier is a necessary first counselling step. They try to encourage women to start developing future goals, however small or short term. In setting realisable benchmarks, a woman is more likely to feel as if she has a future.

Building trust

Providers insist that it is only once a support worker gains a woman's trust that the process of working through other debilitating problems can progress.

Deception and betrayal during the trafficking cycle often leaves women with little reason to have faith in themselves or others. Staff of NGOs explained that they try to earn women's trust by 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.[u]

For women who are reorienting outside the exploitative 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

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[u] In some cases, however, trust can be undermined when NGOs are caught in a dichotomous role in which their support for the woman may conflict with their coordination with immigration services. In Belgium, for example, in order to maintain a good working relationship with immigration the NGO is expected to report on women's compliance with immigration conditions. Payoke believes that "this introduces a negative element of control into what should be a solely supportive role."

may influence how she fills her role as parent, spouse, daughter, employee, and citizen.[431]

While a woman's experience changes her in many and often invisible ways, she enters a new situation or returns to a family or community context that has not witnessed this change. For example, 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 stated that they chose not to reveal anything at all to close family members about the trafficking experience (particularly sexual abuse), anticipating that relatives would be unlikely to comprehend or accept them. The profound disapprobation and humiliation would compound the distress. They thus lived alone with their trauma and memories. Providers emphasise that women should have space to share experiences, but not be forced or pressured to reveal information about themselves or past events.

Understanding women's hostility

Many providers noted that hostile behaviour is not uncommon. This hostility may be directed at support persons, or others close to the woman, including family members. Resentment and hostility may have become normalised reactions 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.[432] One woman trafficked to the UK was keenly aware of these feelings, describing herself as having a *short fuse* and *having trouble keeping her temper.*

Hostility can affect a woman's ability to keep a job or maintain a relationship. For some—especially those who survived longer periods in a trafficking situation—persistent negative emotions can lead them to return to prostitution or to traffickers' services because it is for this type of setting and these interpersonal dynamics that their practical skills and survival mentality are best suited.

5.7.3 Longer-term symptom management

Each woman requires a different time period to deal with her memories and begin to prepare for the future. The period after a woman has begun to accept the new terms of her life is a time when care may not be required often or regularly. This is often a time when individuals need support in dealing with the post-trauma symptoms. These may be physical, psychological or in the category of life-skills. During this phase, providers offering psychological counselling often state that they begin to focus on preparing a client for a more independent and self-sufficient future. This stage can also vary greatly in time and scope depending on the woman and the circumstances.

Recognising longer term psychological reactions

Providers explain that many of the more enduring psychological effects appear after a woman's immediate needs have been met. Once somewhat beyond reflections of the past, a woman has more time to dwell on her past and fear for her future. A support worker with Payoke in Belgium suggests that it can take some time for a woman's deeper reactions to appear:

> 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.

While some symptoms of trauma may subside, it is not uncommon for the manifestation of other symptoms to become chronic or more severe. 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.

Studies on the physiological responses to trauma suggest that chemical changes in the body, specifically, 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.[272]

In the aftermath of violence, women 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. When she was under stress, s he would do unusual things, like bite someone or walk through the streets bare-foot, and afterwards she would not remember doing these things.

Assisting women to return home

A woman's return home can be an immensely emotional and tension-filled event. When asked how she felt about her return home, one woman from Romania replied:

> *I'm worried about my family's reaction when I get back home, and sad about what happened to me.*

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 a victim of a common and serious crime, and to prepare the family for a woman's mental distress. One provider explained:

> [The relatives] are more 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.

According to providers working with women who have returned to their home country, many trafficked women do not tell their husbands about forced prostitution or sexual abuse for fear that he will blame or leave her. One woman

in Ukraine, 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.*

A psychologist with significant experience working with victims of sexual abuse suggests 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 present. In revealing stigmatising events women risk destroying the other person's image of them. A woman's need to conceal her emotions, her fear of exposure, and her inability to seek support from intimate partners may add greatly to a woman's psychological burden.

One support worker with Payoke reported that in the past two years only a few of her clients developed good, healthy relationships with men. 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 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.

Fostering occupational skills and employment

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, and language and cultural training in destination settings.

Practical self-development activities can advance income prospects and foster self-confidence. In destination settings, acquiring a local language represents the beginning of the process of moving from practical and emotional isolation to inclusion. A support worker from Payoke, in Belgium, explained that in addition to language training, cultural orientation is also important:

> 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.

According to most NGO staff, employment is the critical element leading to a future of self-sufficiency. 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.

In addition to the challenges of finding employment, women may also be hindered by persistent destablising reactions to past and present events prevents. A psychologist at 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.

Assistance organisations agreed that this last stage is the most indefinite in time.

An STV staff member stated:

> [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.

5.8 Chapter discussion

The descriptive qualitative data emerging from this formative study offer some of the first evidence and potential indicators on the health of trafficked women. This was essential exploratory work required before larger, quantitative work could be carried out. This chapter described a range of risk factors and health consequences reported by a small and very diverse cohort of women in post-trafficking service settings.

This study also tested the potential to operationalise the conceptual models developed for this research on health and trafficking. The results suggest that a migration-based model combined with a framework delineating various aspects of health (such as, physical, social, occupational) is beneficial in its potential to capture the time, geographical and individual health dimensions.

Findings on showed the variety health risks women experienced while in the hands of the traffickers—findings that were anticipated—but results also

demonstrated that women faced a host of health threats before and after they were out of the trafficking situation. These dangers included those that were interpersonal (e.g., family violence, social crises and civil unrest), environmental (e.g., dangerous travel routes, unhygienic conditions) and structural (e.g., unsympathetic, corrupt officials, denied legal status).

Evident from the findings was the range of harm women reported to their physical and mental health. While women were clearly vulnerable to the most commonly recognised health outcome for trafficked women—sexually transmitted infections or reproductive health complications, women reported numerous other symptoms of poor health.

The different dimensions of risk and the ways they potentially affect various aspects of women's health point to key areas for systematic inquiry. For example, risks to women's self-perception and identity and stigma were identified as important variables for further investigation.

Findings from this study suggest that it is important to consider risks from a chronological perspective because women's health status will be a composite of the risks she faces before, during and after the trafficking experience. Moreover, risks must be viewed on an individual level, as well as a structural or contextual level; one must recognise the difference between "risk-taking behaviours" and "contextual risk" or high risk situations.[114] In discussions of trafficking and sexual health, it is particularly important to use terminology such as "contextual risk" in order not to lay blame on the victims but the circumstances and the social and political structures in which risk occurs.[116]

The results presented in this chapter also emphasise the chasm between women's view of their health needs and knowledge of the officials who are most likely to encounter women soon after a trafficking ordeal. While a number of officials could recite the litany of abuses commonly associated with trafficking, few had measures in place to deal with their health needs. Similarly, there was recognition that while trial proceedings could be extremely stressful, if not traumatic for women, there were few if any support mechanisms for pre- and post-trial periods.

This formative work also contributed to an understanding of women's post-trafficking symptomatology and its progression. Interviews with providers offered an outline of three general phases of post-trafficking intervention: crisis intervention, adjustment and longer term needs. Women's needs appear to change and progress over time, progressing from urgent and basic needs to more individual needs, such as individual diagnostic and medical treatment, to longer-term support needs, such as psychological support. This pattern suggests that future research should include a longitudinal or multi-staged interview approach to learn how women's symptoms might change over time. Future work should try to add information about how service providers might better prepare to meet women's different post-trafficking periods of need.

Serving as the basis for the research that followed, this study identified key variables and suggested a structure and methods that could be used in a quantitative study. The follow chapters present the results from the survey on trafficked women's health, which reflects a more systematic inquiry of many of

the questions and variables that emerged from this formative study. The quantitative findings highlight the importance of this formative work.

CHAPTER 6: SURVEY SAMPLE CHARACTERISTICS

6.1 Chapter introduction

Following on from the qualitative results, this chapter describes the results from the quantitative survey of a cohort of women who were identified by and in the care of study partner organisations providing services for trafficked persons.

Between January 2004 and June 2005, 213 consecutive women who met the inclusion criteria, entering a study partner programme, were invited to participate in an interview. 212 agreed. Of these, five of the women were excluded because they were not trafficked for sex work or domestic service and were not sexually abused. Ultimately, the findings represent data collected from 207 women who were interviewed in private by professional support workers or psychologists trained to assist women who have been trafficked.

Of these, 170 (82% of Interview 1) participated in the follow-up second interview, and 63 (29% of Interview 1) in a third interview. The follow-up rates based on the 100% (n=207) at first interview were: 82% women participating at the second interview and 30% at the third interview. The mean number of days between a woman's entry into care and Interview 1 was 4 days (SD 3.14). The mean number of days between entry into care and Interviews 2 and 3 were 35 days (SD 14.03) and 125 days (SD 60.54), respectively.

The characteristics described in Table 6.1 include the demographic features of the participants (e.g., age, nationality, marital status, parity), countries of destination, time spent in and out of the trafficking situation, pre-trafficking

residence and residence of their children, and their exposure to physical and sexual violence before leaving home and during the trafficking situation.

Table 6.1: Study participant's by home country and research site.

Participant's home Countries						
	Interview 1 n=207		Interview 2 n=170		Interview 3 n=63	
EU Member State	%	n	%	N		n
Czech Republic	1.4	3	1.8	3	1.6	1
Poland	0.5	1	.6	1	1.6	1
Lithuania	6.8	14	4.1	7	9.5	6
Slovak Republic	0.5	1	0.0	0	0.0	0
	9.2	19	6.5	11	12.7	8
Other European States						
Ukraine	25.1	52	30.6	52	17.5	11
Russian Federation	1.0	2	1.2	2	3.2	2
Romania	8.2	17	5.9	10	11.1	7
Moldova	35.7	74	42.9	73	38.1	24
Macedonia	0.5	1	.6	1	0.0	0
Bulgaria	8.2	17	1.8	3	0.0	0
Kyrgyzstan	1.4	3	1.8	3	3.2	2
	80.2	166	84.7	144	73	46
Non-European States						
Cameroon	0.5	1	.6	1	1.6	1
Jamaica	0.5	1	.6	1	1.6	1
Nigeria	5.3	11	4.7	8	9.5	6
	6.3	13	5.9	10	12.7	8
Not Reported						
No data	4.3	9	2.9	5	1.6	1

Participant By Study Site						
	Interview 1		Interview 2		Interview 3	
Study site	%	n	%	n	%	n
Belgium	1	3	0	0	0	0
Bulgaria	10	20	2	4	0	0
Italy	13	26	12	20	22	14
Czech Republic	2	5	1	2	0	0
Moldova	37	77	45	77	40	25
Ukraine	24	50	29	50	14	9
United Kingdom	13	26	10	17	24	15

6.2 Home and destination locations

6.2.1 Home countries and interview site

Women interviewed came from fourteen countries. (Table 6.1) Countries of origin included four European Union member states (9%) six other European states (80%), and four non European states (6%), which included two African states, one Caribbean state, and one central Asian state, and 4% were unreported. These proportions generally reflect the study site locations at Interview 1, with the largest percentage of women having been interviewed in Moldova and Ukraine.

As noted, the participants were similarly distributed throughout the study sites, with the majority of participants for interviews 1 and 2 being interviewed in Moldova (37%, 45%) and Ukraine (24%, 29%). By the third interview, the majority of women were interviewed at study sites in Moldova (40%), UK (24%) and Italy (22%).

6.2.2 Destination countries

When asked about destination locations, women were trafficked to a total of 24 countries.[22] More than half (53%) were trafficked to European Union member states, 38% to other European States, and 8% to non-European States. Other than the women trafficked to the main study sites, Italy (18%) and the United Kingdom (16%), the greatest number of women interviewed were

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[22] (n=165): Not all women reported a destination location. Several women reported more than one destination location.

trafficked to Turkey (15%), the Russian Federation (14%), and Germany (8%). These patterns are likely to reflect common routes from the study countries.[433]

Table 6.2. Personal characteristics of study participants.

Study population characteristics						
	Interview 1 n=207		Interview 2 n=207		Interview 3 n=207	
Age Distribution (years)	%	n	%	n	%	n
15-17	12	24	12	21	10	6
18-20	21	44	19	33	22	14
21-25	42	86	41	69	41	26
26-30	17	36	19	33	17	11
31-45	7	15	8	13	8	5
n/d	1	2	1	1	2	1
Marital status before trafficked						
Single	71	147	71	120	75	47
Married / Living as married	11	23	11	19	11	7
Separated / Divorced	17	35	17	29	13	8
Widowed	0.5	1	1	1	2	1
n/d	0.5	1	1	1	0	0
Children						
Yes	38.6	80	39	66	46	29
No	60.9	126	61	104	54	34
n/d	0.5	1	0	0	0	0
Type of Work						
Sex Work	92.3	191				
Domestic Work	4.3	9				
Sex & Domestic Work	3.4	7				
Time in Trafficking Situation						
1 day-1 month	11	23	11	18	13	8
1-3 months	21	44	22	38	22	14
3-6 months	20	41	21	35	13	8
6 months-1 year	20	41	21	35	17	11
1-2 years	10	20	9	15	11	7
2+ years	10	21	10	17	16	10
n/d	8	17	7	12	8	5
Time out of Trafficking Situation						
1-2 days	1	2	1	2	3	2
3-7 days	7	14	6	10	11	7
1 week - 1 month	32	66	29	50	27	17
1-3 months	21	44	22	38	16	10
3-6 months	16	33	18	31	14	9
6+ months	22	45	21	36	25	16
n/d	1	3	2	3	3	2

6.3 Personal characteristics of women in the survey

Table 6.2 represents the characteristics (age, marital status and number of children, time in trafficking, time out of trafficking) of the women in the study at each of the three interviews.

6.3.1 Age

The youngest individual interviewed for this study was 15 and the oldest was 45. The largest age group throughout the three interviews was made up of women between ages 21 and 25 (42%, 41%, 41%), followed by those between 18-20 (21%, 19%, 22%), and then 26 to 30 year-olds (17%, 19%, 17%). Adolescents[434] between the ages 15 and 17[23] made up 12%, 12% and 10% of the sample at the three different interviews, and the smallest proportion were women over the age of 30 (7%, 8%, 8%).

6.3.2 Marital status before trafficked

When asked about their marital status prior to leaving home, nearly nine in ten women (89%) participating in the first interview were not living with a husband or an intimate partner at the time they left home. Nearly three-quarters, or 71%, of women reported having been single, i.e., never married, 17% were separated or divorced, and nearly 1% was widowed. Only 11% were married or

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[23]An adolescent is between the ages of 10 and 19, according to the WHO Department of Child and Adolescent Health. Under the age of eighteen is the generally accepted age to be defined as a child, particularly for legal definitions for statutory rape. See World Health Organization, 2000-2004. *Overview of child and adolescent health*. 2000-2004, WHO.

living as married at the time they were trafficked. These proportions remained nearly the same throughout the following interviews.

6.3.3 Women with children

Of the women who participated in first interview, 39% reported that they had children. Women had between one and four children, with approximately half reporting that they had one child. This proportion did not increase until the third interview when 46% of the sample reported having children.

Of the women with children at the first interview, by far the largest proportion, 82%, reported that they were single (*not married or not living as married*) before leaving home. Specifically, 44% stated they had never been married, 37% said they were separated or divorced, and 1% was widowed, while only 18% were married or living as married before they home.

Table 6.3. Residence of trafficked women's children at first interview. (n=80)

Residence of women's children		
	(%)	(n)
Woman	16%	13
Woman's parents	41%	33
Husband / Partner / Ex-husband	15%	12
Grandmother	3%	2
Other relatives	13%	10
Institutional setting	8%	6
No data	9%	7

* Total equals 104% as several women with more than one child had placed them with different caregivers.

The eighty women with children at the first interview (39%) were asked who was currently caring for their children. Of those who responded, only a minority of women, 15%, reported that their children were with the children's

father. The most common arrangement was for children to be living with the woman's parents or mother (41%). Sixteen percent of the women had the children with them in the shelter setting or living with them while they were accessing services. Thirteen percent reported that their children were living with other relatives, including grandparents, parents of the ex-husband, or siblings. In six cases, women reported having placed their children in an institutional setting, such as an orphanage or having put the child into foster care, and one stated that her child had been adopted.

At the time of the first interview, 8% of women believed they were pregnant, and 1% said that they did not know. (See the Sexual and Reproductive Health chapter for a further discussion on pregnancy.)

Women's marital status and whether or not they had children did not appear to be a significant factor influencing whether or not women stayed in contact with a service provider.

Table 6.4. Women's residence prior to trafficking. (n=198)

Women's residence prior to trafficking		
	(%)	(n)
Boyfriend	7%	14
Children	3%	6
Grandparents	5%	11
Husband	7%	13
Parents / Mother / Father	59%	117
Self	6%	11
Siblings	4%	9
Others	9%	17

6.3.4 Pre-departure residence

Table 6.4 gives a general, rather than a complete picture of who women were living with before they left. It is only a partial picture because in many cases women's living arrangements were complex and often included a variety of family members.

Based on women's primary response, it appears that the majority (59%) were living with one or both parents. Of these women, over half reported residing with "parents". However, more than one-third specified that they were living only with their mother.

Of those women who said "other", several explained that they had been living in a childcare institution prior to being trafficked. One woman explained: "I am an orphan and I lived in a hostel. There everyone had beaten me. I was harmed throughout my childhood." Another said:

> I was raised in an orphanage, so you can imagine that anybody can do [anything] to you.

6.3.5 Women who reported a family member knew the trafficker

Nearly one in five women (17%) reported that their relative knew the trafficker. For some women, this was a case of perfidy and betrayal, as exemplified by their comments:

> My mother sold me to a stranger.

It is because of my father that I am in this situation.

In some cases, women were uncertain as to the involvement of their family, as this woman suggested: "I am not totally sure. It is possible but I don't want to believe it. The trafficker's friend knew my mother and had slept with her."

For numerous women, their relative did not appear to be directly involved in the trafficking, but instead the trafficker was acquainted with a family member—often a parent. For the following woman, it appears that her mother was ignorant of and shocked by her partner's role in her daughter's recruitment:

I am worried about the heart attack that my mother had after she had understood that her boyfriend had sold me. I worry about her and about how this man could do such a thing to me. I am also thinking a lot about my poor child. I am afraid because I don't know where he is and who is taking care of him while my mother is in a hospital.

Many women explained that they were recruited by a friend or an acquaintance: "All these problems are happening now because of my friend, she tricked me". Offers made by friends seemed particularly trustworthy and reliable. One woman explained that a rape led to her trafficking: "One friend and his two friends raped me and that's what led to being trafficked".

6.3.6 Labour exploitation

Women interviewed for this study were forced into: sex work (92%), domestic work (4%), and both sex and domestic work (4%). Seven women were

interviewed who were trafficked for other forms of exploitation, such as forced

panhandling, and exploitation in the food and textile industry. These women

were not trafficked into sex work or domestic work, and none reported having

been sexually abused or exploited, thus they were excluded from this data set

because their profile did not fit within the protocol. The exclusion of these women

from this data set does not represent any devaluation of the dangers or trauma

that they may have experienced. Further research is urgently needed that

includes a broader spectrum of types of exploitation.

6.3.7 Time spent in trafficking situation

Nearly nine in ten women (89%) at Interview 1 had been in the trafficking

situation for more than one month (Table 6.2). This proportion remained the

same throughout the following interviews. At Interviews 1 and 2, ten percent of

the women had been trafficked for more than two years, and by Interview 3, 16%

of the women remaining in the study were trafficked for more than two years.

The proportion that was trafficked for less than one month was 11% at Interview

1 and 2 and 13% at Interview 3. Nearly half of those reporting being trafficked for

less than one month at Interview 1 were there for less than two weeks.

6.3.8 Time out of the trafficking situation

Well over half the women at each interview had been out of the trafficking

situation for less than three months from the time they first contacted the support

service. Forty percent were released less than one month prior to the first interview. Most women were referred (e.g., police, clients, other women) or found their own way (e.g., hotlines, advertisements) to an assistance centre very shortly after their release from the trafficking situation. Twenty-two percent of the women in this study estimated that they were released six or more months before the interview.

6.3.9 Referral to assistance programs

From the data collected on sources of referral, it seems that the majority of women were referred to study partners either by the police or by other NGOs, some had been referred by clients, and some had self-referred. Due to some initial problems with the questionnaire, this information was not systematically collected by all partners, so a full set of quantitative data is not available.

6.4 Chapter discussion

The characteristics of the women in this study, while fairly diverse, nonetheless are likely to represent a relatively limited segment of women who are trafficked. At best, they are probably a portrait of a certain segment of individuals who have been trafficked for sex work and who reached a service provider in the participating study countries. It is not clear how well their demographic features compare to a general population of women who are trafficked in Europe or elsewhere. As it is probable that populations of trafficked

women vary significantly—particularly from region to region—it is not certain how generalisable the findings from this study are.

In reality, the larger population of women who are trafficked are not likely to come in contact with law enforcement, service providers or to self-report (e.g., confined domestic workers, women working in more covert sex work contexts or who are not found). These women are not represented in the sample and may have even greater health needs. Additionally, in some countries (including the UK, Belgium, and the Czech Republic), women who are foreign nationals are required to cooperate with police anti-trafficking investigations if they wish to avoid deportation, it is likely that some might be afraid to or not wish to cooperate with police. These women would be unlikely be well-represented in this study sample. It is difficult to speculate where this group's health status lies in relation to the women in this study. Given the large sector of exploited female labourers around the world[150, 206, 435, 436], it is also imaginable that there are many women in conditions that could be considered trafficking.[135] who may not be seen as, and might not view themselves as trafficked. Seen simply as "exploited labourers", they would not be represented in most samples of trafficked persons.

When looking at the characteristics of the women over the course of the three interviews, the profile of the group does not seem to alter very much. The characteristics of the group of women participating in Interview 1, seem similar to those who participated in interviews 2 and 3. This is an important fact for the descriptive analysis offered in the following chapters.

One particularly notable feature of the population interviewed is that four-fifths of the women with children were single parents. This is important and not surprising, because while single women frequently make up a majority of those who are trafficked for forced sex work, the number of single mothers deserves greater recognition. Data on Armenian women who were trafficked, for example, show that 72% of the women were divorced and 2% were separated.[437] Economic hardship is particularly evident among women from states where former government support systems have been dismantled or have broken down; unemployment has had a disproportionate effect on women, such as has taken place in former Soviet states.[438] The financial implications of single parenting (or caring for other dependents, e.g., elderly parents, younger siblings) are significant, and being a sole carer should be considered a possible contributing factor for being trafficked.

One question that is rarely asked in the study of trafficked women is: "What happens to women's children while they are trafficked?". While it was not the intention of this study to investigate the children of trafficked women, the limited data gathered suggests that there is a need for further research into this area. While nearly three-quarters of the women reported that their children were residing with a relative (grandparents, other relatives, husband) at the time of women's first interview, nearly 10% of women said that their children were living in an institutional setting and 16% said they were with the woman herself. Greater attention must be paid to physical and psychological well-being of these children, and to the necessity of post-trafficking services to accommodate the

practical (e.g., housing, subsistence, education) and psychological support needs of children.

Women's residence prior to being trafficked also appeared to be a factor for further consideration. Individuals residing in child care facilities or orphanages, for example, may be of particular note both because of individuals' apparent vulnerability to being recruited and because of the difficulty of identifying options for safe accommodation upon return.

Related to this is the number of women who reported that a family member knew the trafficker/recruiter. That nearly one in five women said their relative knew the trafficker provides some insight into women's justification for accepting the offer of the recruiter, and suggests how difficult it might be to dissuade a certain portion of women from accepting job offers abroad. Many women appeared to have good reasons for believing that the job offer was legitimate and trustworthy. This again has implications for women's safe return, as well. If recruiters are known to the woman's family, she may be easy to coerce, and if returned, will be easy to find.

One of the more problematic issues with the data from this cohort was the differences in time that each woman had spent *in* the trafficking situation and the difference in time that each had been *out* of it. Because of the relatively limited sample size, it is somewhat difficult to interpret how these differences (particularly the latter) may have affected women's reported health. The point of departure for the findings was therefore from the time that women had entered a service provider's care.

CHAPTER 7: RISK EXPOSURES

7.1 Chapter introduction

This chapter describes some of the main risks to which women were exposed prior to attending post-trafficking services. For the purposes of this study, risk is best understood as exposure to hazards or dangers that can result in harm, particularly adverse health consequences and that risk and risk behaviours are never context-free.[110, 114, 142]

Risks explored in this study included sexual and physical violence that women experienced as an adult or child prior to being trafficked, trafficking-related sexual and physical violence and threats, injuries sustained during trafficking, and restriction of movement. Findings on women's use of alcohol and non-prescription drugs, condom use, and access to sexual health services are also presented.

Most of the health risks measured for this study were identified as common concerns during the exploratory study and have also been found to be prevalent in previous studies on women's health.[182, 315, 393, 439]

Quantitative data are complemented by women's comments in order to add depth and give voice to women's perceptions of their specific experiences.

7.2 Pre-departure violence

7.2.1 Overview of pre-departure patterns of physical and sexual violence

Figure 7.1 shows that 60% of the women in this study reported having experienced at least one form of violence (physical or sexual) prior to being trafficked—before leaving their home country. Half of the women (50%) said that they had been physically assaulted. Nearly one-third (32%) reported a forced or coerced sexual experience. Twenty-two percent of the women reported both physical and sexual violence. Fourteen percent reported sexual abuse before age 15.

Figure 7.1 Percentage of women reporting different forms of pre-departure violence (n=207)
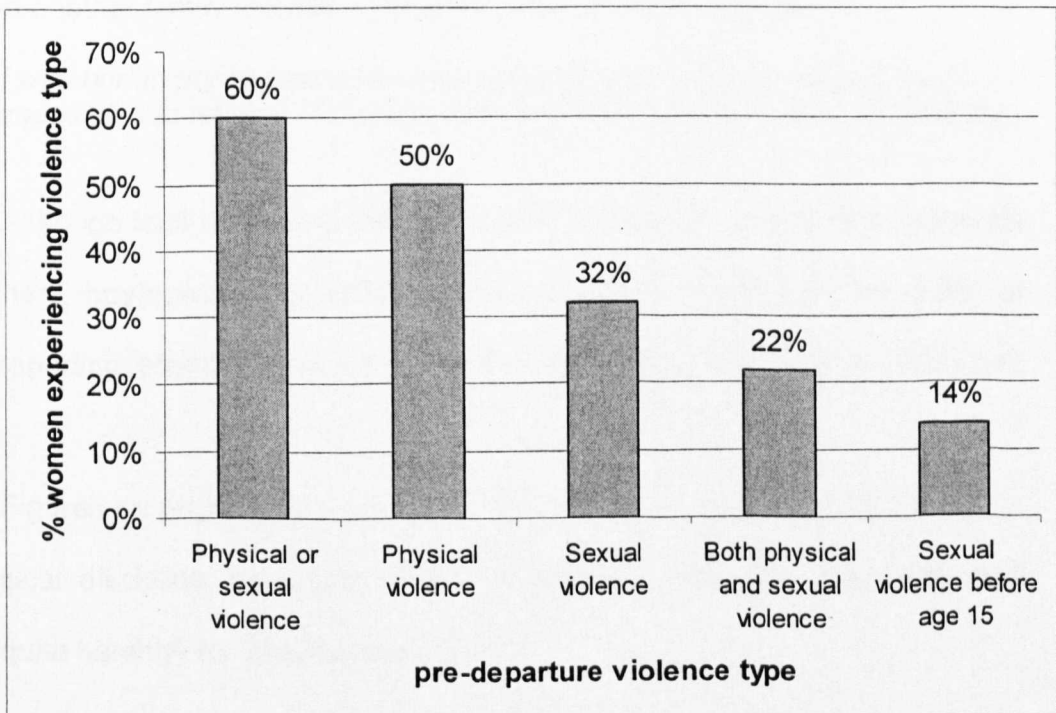
Table 7.1 Perpetrators of physical violence prior to departure. (n=104)

Physical violence by different perpetrators		
Reported perpetrator	Yes (%)	Yes (n)
Father or stepfather	44%	46
Mother	31%	32
Other family member	25%	26
Husband/Partner	13%	13
Boyfriend	12%	12
Acquaintance	9%	9
Stranger	12%	12
Other	4%	4

*Percentages add up to 148% as 29% of respondents reported more than one perpetrator

7.2.2 Physical violence prior to being trafficked

Of the 50% of women who reported being physically hurt, 44% said the harm was inflicted by their father or stepfather, 31% their mother, and 25% reported another family member (Table 7.1). One woman explained:

I was hurt in my childhood and my teenage years. I can't explain. It's impossible to tell you. They hurt me, they beat me. They wanted to kill me.

Although less commonly cited, a number of women mentioned husbands or partners, boyfriends, acquaintances and strangers. Almost a third (29%) of those reporting physical violence said they had been hurt by more than one person.

Figures on physical abuse prior to departure may include some situations of physical discipline, as some women commented that they were punished (albeit quite harshly) for "misbehaving".

The study team attempted to solicit responses primarily about physical violence that was likely to have hurt or injured the respondent, and based on their

qualitative responses, women who responded affirmatively to this question were generally reporting violence that was abusive in nature. One woman noted:

> *Since we were babies our father beat us. He beat my mother when she was pregnant.*

"Others family members" (25%) included older brothers and NGO staff of partner organisations suggested that in some settings male children may be given the authority to punish their sisters.

Table 7.2 Percentage of women reporting sexual violence overall, before and after age 15. (n=66)

Sexual violence by age		
Sexual violence	Yes (%)	Yes (n)
Any sexual violence	32%	66
Sexual violence before age 15, only	15%	29
Sexual violence after age 15, only	25%	51
Sexual violence both before and after age 15	7%	14

7.2.3 Overall levels of sexual violence prior to being trafficked

The breakdown of women's history of sexual abuse by age is depicted in Figure 7.2. Combining women's responses on forced or coerced sexual experiences before and after age 15, overall nearly one-third (32%) of women reported a sexually abusive experience prior to being trafficked. Before they were 15 years old, 14% of the study sample had experienced sexual violence. After age 15, 25% of the women experienced sexual violence, and 7% of the women experienced sexual abuse both before and after age 15.

No prior experience of sexual
violence 68%
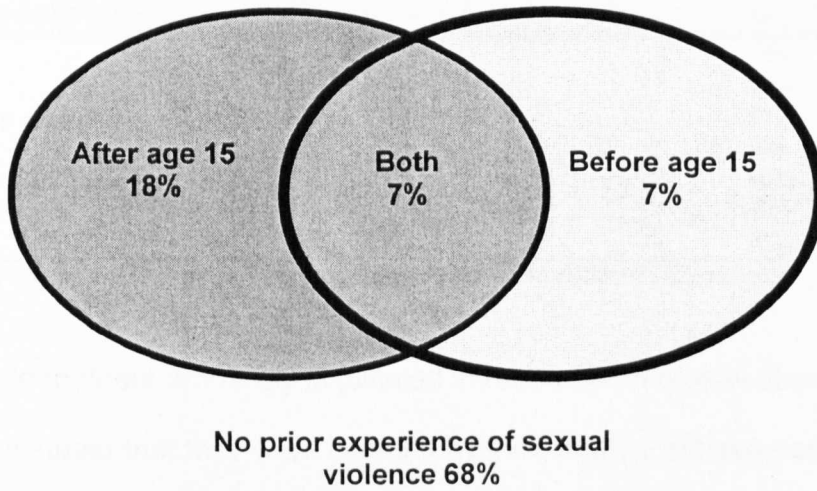
Figure 7.2 Overlap of sexual violence before and after age 15, before being
trafficked. (n=66)

7.2.4 Sexual violence before age 15, prior to being trafficked

One in seven women (14%) reported having a forced or coerced sexual
experience before age 15, prior to being trafficked. Almost one quarter (24%)
cited more than one perpetrator.

Although the numbers in this sub-sample are small, of the 14% reporting
early sexual abuse. over half reported being sexually abused or coerced by a
family member, with more than one-quarter stating that the abuse was
perpetrated by a father (14%) or step-father (14%) (Table 7.3). When asked at
what age her father abused her, one woman explained she had been sexually
abused by her father when she was three and ten years old.

Table 7.3 Perpetrators of sexual violence before age 15. (n=29)

Sexual violence by different perpetrators before age 15		
Reported perpetrator	Yes (%)	Yes (n)
Father	14%	4
Stepfather	14%	4
Other family member	17%	5
Mother	7%	2
Boyfriend	10%	3
Acquaintance	38%	11
Stranger	31%	9

*Percentages add up to 131% as 24% of respondents reported more than one perpetrator

While mothers are rarely implicated in research on sexual abuse of girls, two women stated that they were coerced by their mother to have sex with older men. One woman (who had also been assaulted by her uncle when she was 14 years old) explained that when she was 12 years old her mother wanted her "to have sex with a man over 30." She added, "Maybe the man offered her some money". Another said:

> My mother forced me to have sex with strangers when I was eleven and twelve years old. Strangers would force and beat me.

Seventeen percent of the women reported child sexual abuse by other family members. Uncles and stepfathers were frequently implicated. One woman stated:

> My mother's half brother raped me when I was 11.

More than one-third of women (38%) indicated that abuse was perpetrated by an acquaintance or a stranger. Several women who had been housed in an orphanage or child care facility reported abuse by a male care-taker. One woman

who had been sexually abused by a priest at the orphanage at age 10 had also been previously sexually abused by her father.

Table 7.4 Perpetrators of forced sex after age 15 (n=51)

Sexual violence by different perpetrators after age 15		
Reported perpetrator	Yes (%)	Yes (n)
Mother	4%	2
Father	4%	2
Other family member	6%	3
Husband/Partner	0%	0
Boyfriend	10%	5
Acquaintance	45%	23
Stranger	45%	23
Other	4%	2

*Total percentage adds up to more than 118% as 10% respondents reported multiple perpetrators.

7.2.5 Sexual violence after age 15, prior to being trafficked

Just over one-quarter of the women (26%) reported a forced or coerced sexual experience after age 15, prior to being trafficked. The majority of these women stated that the abuse was perpetrated by either an acquaintance or stranger, with only a few women reporting sexual abuse by family members, or boyfriends. (Table 4.4) Several women reported having been made drunk and then raped.

To gain further insights into the nature of the coerced sex, women were also asked what they thought would happen to them if they refused to comply. Many of those who were not physically forced reported believing that they "would be killed" if they had refused sex.

Table 7.5 Percentage of women reporting different forms of violence while in the trafficking situation (n=207)

Violence during trafficking		
Form of violence	Yes (%)	Yes (n)
Physical violence	76%	158
Sexual abuse	90%	186
Either physical or sexual abuse	95%	196
Both physical and sexual abuse	71%	148

7.3 Violence during trafficking

7.3.1 Physical violence

More than three-quarters (76%) said that they had been physically assaulted while in the trafficking situation. (Table 7.4) Women reported physical violence by traffickers, pimps, brothel and club owners, clients, and their boyfriends.

While women were not asked for specific descriptions of the abuse, several offered details of chronic and/or extreme levels of violence. One woman described:

I was brutally beaten, covered with cigarette burns, and had my face held underwater.

Another said:

At one point I was beaten so brutally I could not protect myself anymore. My hands just fell to my sides—the person had to be dragged away, otherwise he would have killed me

Ironically, one woman explained that she was safest when she was "working":

He was beating me often; every time when he was upset or didn't like something. The only place where he couldn't do this was on the street.

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Women were not asked how often they were assaulted, but numerous women stated that they were beaten "nearly everyday". Women were abused to make them obey, as punishment for perceived transgressions, and many reported being beaten for no apparent reason. Women reported being castigated numerous times in various ways:

When I was punished, I was locked in a dark underground cellar.

Many women described how they were assaulted when they pleaded not to be forced into sex work or showed signs of reluctance:

I was badly beaten for refusing the group sex, and asking for condoms.

Some women aimed to avoid being assaulted by being completely obedient, "I complied with everything". Yet, for many, avoiding the abuse seemed unimaginable:

Even the clients asked me why is this happening to you. Why am I allowing this to happen? But, if I explained to them the real reason, my pimp will learn of this and will hurt me again.

Some women talked about violence by clients:

Some clients were very violent and abusive. I complained to [the brothel manager] but she told me I had to go with them. With one very violent client she just closed the door and left me with him.

For some, violence was an aspect of the experience they preferred not to discuss or reflect on:

These are not nice things to talk about.

There was so much [violence], but I do not remember how.

Assault with gun, knife or other object

Women were asked whether they had ever been hurt with a "knife, gun, or other object". Thirty-percent of the women answered "Yes".

Of the 27 women who acknowledged this type of abuse, six said that the perpetrator used a gun, eight said a knife, and 19 described another object that was used to harm them. Women who mentioned a gun were primarily speaking of having been threatened with a gun (i.e., rather than actually having been shot). One woman described a client who held a gun to her head demanding prolonged sexual intercourse.

When speaking of knife violence, women frequently referred to cuts or slashes that they received. One woman stated that the trafficker *cut my wrist with a knife*, while others spoke of slashes across their face or legs.

The list of objects with which women were struck, battered, and beaten unconscious includes, but is not limited to: sticks, phone receivers, full bottles of water, umbrellas, bats, broken plates, sticks, billiard sticks, rubber sticks, wet towels, shoes and kitchen utensils. One woman said that she was nearly strangled with a metal wire.

7.3.2 Injuries

Over half of the women interviewed (58%) reported having been injured at some point while they were trafficked. Of these women, 68% said that an injury sustained during that time still caused problems or pain.

Physical sites of women's reported injuries included: head, face, mouth, nose, eyes, back, neck, spine, legs, hands, feet, kidneys, pelvis, ovaries, abdomen, and the genital area. Many women spoke of head trauma resulting from having been hit in the head with a bat or other objects, from having their head slammed against the wall or the floor, or having been kicked in the head. One woman explained:

> *It was terrible. I have scars all over. He used all kinds of things [for beating].*

Women described being bruised "all over my body" from beatings, which for some women, occurred daily. They had black eyes and bloodied noses. Some women said they still had scars from the assaults, including from cigarette burns.

One woman recalled having been beaten so badly that she "was hospitalized in neurosurgical department [for head trauma]". Another told how after being repeatedly kicked in the head and the face, she regularly has headaches and loses consciousness. One woman said that she had been hit in the teeth and had to have the upper dental arc rebuilt.

Women usually recounted not one, but several injuries. For many women, questions about injuries elicited comments about their deep psychological distress. As one woman put it, "My wounds are inside, you can't see them".

Table 7.6 Percentage of women reporting sexual abuse or coercion during the trafficking situation. (n=207)

Sexual abuse and coercion during the trafficking situation		
Form of force or coercion	Yes (%)	Yes (n)
Any sexual abuse (forced or coerced)	90%	186
Physically forced sex	84%	174
Coerced sex	83%	172

7.3.3 Sexual abuse

Nine out of ten women in this study (90%) reported having been physically forced or intimidated into having sex or doing something sexual against their will during the time they were trafficked. (Table 7.6)

Of the 203 women who responded to this question, 84% stated that they were physically forced to have sex. Women added the following comments:

The two traffickers and their friends raped me. They forced me to give oral sex.

I was forced to have anal sex, I was raped by trafficker and was made a slave provided to customers.

They made me have all types of sex and group sex—up to 10 persons.

Coerced sex was reported by 83% of the women. Over 9 in 10 (93%) of these women reporting intimidation said they had also been physically forced. The following question-answer sequence was common:

Interviewer: "Did you ever have sex with someone or perform some sexual act because you were afraid something bad would happen?"

Woman: *All the time.*

Both women trafficked for forced sex work and those trafficked for domestic labour reported sexual abuse and coercion. Of the nine women who reported

having done domestic work, six said that they were forced to do something sexual.

Of the 21 women (10%) who did not report sexual abuse, 15 said that they had been threatened, 10 women were physically abused, and 7 stated that they had been injured.

Eighteen of the women in the study reported that they had never had sexual intercourse, or were virgins, prior to being trafficked. They ranged in age from 16 to 30 years old.

Women made a point of stating that they were forced to work through menstruation, and many indicated that they were bothered by this because they thought it would cause long-term damage to their reproductive health.
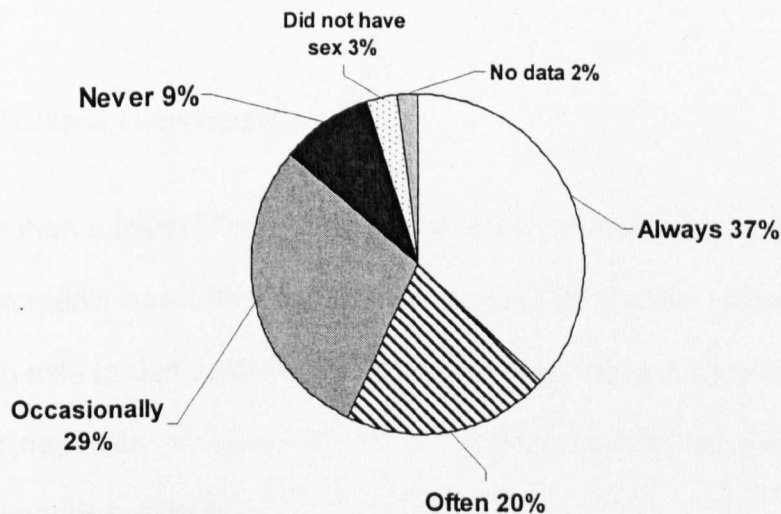
Figure 7.3 Percentage of women reporting how often they used condoms while in the trafficking situation. (n=204)

Condoms

When women were asked how often they were able to use condoms during trafficking ("always", "often", "occasionally", "never", and "did not have sex"), one in ten women reported that they were "never" able to use condoms. (Figure 7.3). As one woman explained:

> *All clients refused to use [condoms], even if I requested it. At the beginning, I had different clients. Then, a man bought me and kept me just for himself for two months. He also never used them.*

Thirty percent of women said that they wore condoms "occasionally", and several added "When a client wanted it". One woman who responded "occasionally", clarified that:

> *Most of time I was raped.*

More than a third (37%) said that they were "always" able to use condoms. However, women's qualitative responses revealed that while women may have always been able to use a condom with clients, they may not have had the power or desire to negotiate condom use in their non-commercial sexual relationships (*e.g.*, traffickers or boyfriends):

> *I don't use condoms with my boyfriend, he doesn't want to.*

Those who said "always" also frequently excluded forced sex by those exploiting them:

[I] always [used condoms] with clients but my exploiter always forced me to have sex without condoms.

With clients I always used condoms but with the person who trafficked and kept us, we were never allowed to use protection.

Miscarriages and induced abortions

Seventeen percent of the women in this study reported having at least one abortion during the time they were trafficked, of whom 84% said that they had only one, while 13% reported two abortions and 3% reported three abortions.

The formative research suggested that women want to access abortion services if they become pregnant in the trafficking setting. For women in this study, induced abortion was a common first request among those who recently left the trafficking situation:

I want to see the gynaecologist because first of all, I have to have an abortion.

Miscarriages were also reported by women who had been trafficked. Nearly one in ten women stated they had one or more miscarriages (spontaneous abortion) during the time they were trafficked. This may however, be an underestimate as some women were not always certain whether they had a miscarriage:

I don't know, but I could have [had a miscarriage] because I had three weeks of heavy bleeding.

I don't know. I think I was given emergency contraception.

Sexual and reproductive health care during trafficking

Nearly seven in ten women (67%) said they did not have a sexual health check while exploited. For the 32% who reported having some care, most were unclear about what procedures were conducted and diagnoses given. This woman explained:

> *Yes [I had a sexual health check], after which I had a monthly injection, but was never told for what.*

Another recalled:

> *When I asked about my diagnosis, I was told 'everything would be ok with you. No has died from this work yet'*

For one woman, even the authorities did not provide her with medical charts or information:

> *[I had a sexual health check] only once, in the prison, before deportation, but I have no idea which tests...I was never provided with test results or any explanation.*

Several women explained that medical care was provided when they became pregnant or required a termination. Pregnancy did not necessarily provide a respite from the work, as one woman described:

> *I was pregnant. Up to the sixth month I was forced to provide sexual services. I was sent home to give birth. At seven months I gave birth. I was told that the child was dead.*

7.3.4 Threats

Threats against the woman

Of the 204 women responding, nine out of ten (91%) said they were threatened and 37% said that family members were threatened. (Table 7.7) Women were intimidated with a variety of threats, including death, beatings, increased debt, harm to their families, and re-trafficking.

Table 7.7 Percentage of women reporting threats to themselves or their family members. (n=204)

Threats		
	Yes (%)	Yes (n)
Woman was threatened	91%	185
Woman's family was threatened	37%	75

When discussing the credibility of these threats, most women assured the interviewer that warnings were very often carried out, or as one woman put it: *Threats were followed, as promised, by beatings and severe traumas.*

Of the women who reported being threatened, 82% said they were also assaulted, confirming that threats were often to be believed. (Figure 7.4)

Reluctance towards sex work (e.g., *if I didn't want to go on the street*), would instigate threats and often beatings. In trying to refuse sex work, one woman was told by the brothel Madam that she would have "acid thrown on her".

Admonitions against escape were among the most frequent. Murder threats were not uncommon. One woman was warned, "If you try to run away, I will cut your face and will take you to Albania". Women were repeatedly told that

they could be killed without any consequence to the trafficker, "They kept telling me that they will cut me into pieces and send me back like that".
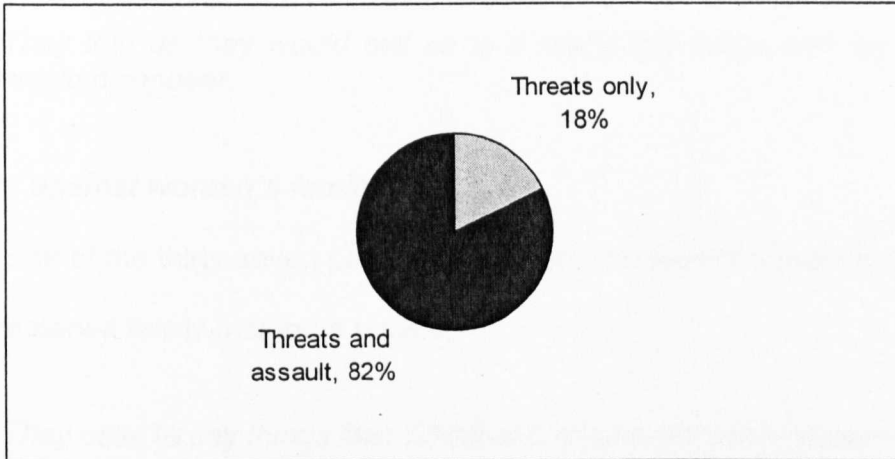
Figure 7.4 Percentage of women who were threats only or threats and assaults during trafficking. (n=204)

Traffickers frequently held women's documents and were often able to convince them that, if found by authorities without their documents, they would be jailed. Traffickers also threatened to turn women over to police, who they warned would "kill them" or would re-sell them. As many of the women came from countries where police corruption is rampant and police officers are often violent, women had every reason to believe that they were safer keeping their distance from police. One woman trafficked to Moscow explained:

> *Sometimes the clients after 'using me', would send me back alone. I was afraid to escape because one girl did. She ran to the police, but after giving information she was severely beaten and sent back or resold to the "owner".*

Women were made to know that their fate was in the hands of the traffickers. In addition to threats of violence, many women were warned that they could be sold

to venues where the conditions would be much worse, and violence could increase. This woman, like many others, explained that her children were included in these threats:

> They told us they would sell us to a really bad place and my daughter would disappear.

Threats against women's family

One of the thirty-seven percent of women who reported that the traffickers had threatened family members recalled:

> They used to say things like: 'Children's organs are really expensive, and children can be kidnapped'.

Threats against children were especially effective. Even if a woman felt prepared to risk harm to herself, few would have been willing to put their children at risk. As one woman said, *If they threatened my family, I couldn't do anything.*

Women also were aware that these were not idle threats, as traffickers usually knew where they and their family lived, and often had agents or colleagues in the woman's home town or nearby. These individuals were frequently the same ones who had recruited the woman in the first place. In some cases, women explained that their family had actually been contacted, "My "boss" threatened and hit my mother".

Fears for their family weighed heavily on women's decisions to escape. For those who had escaped and were cooperating with authorities in actions against their traffickers, it was not unusual for the threats to continue. The risks to

the women and their families of those women who agree to participate in a prosecution have been well-documented.[91]

7.3.5 Loss of freedom and control

Nearly eight in ten women (78%) were adamant that they were "never" free to do as they wished. Comments offered included:

I was locked up like an animal and I was beaten almost every day.

I was locked up in a room, only let out to go to toilet.

A further 10% said that they were "seldom" free, and explained that if they were permitted out, they were under guard. (Figure 7.5)
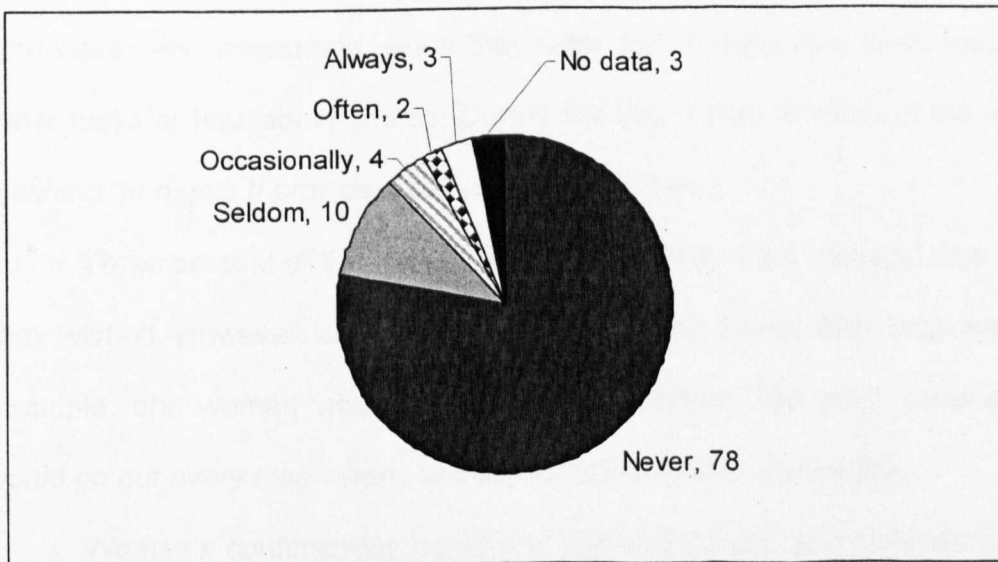
Figure 7.5 Percentage of women who reported how often they felt free to do as they wished or go where they wanted. (n=207)

Qualitative responses made it clear that many were not free to choose what happened to their bodies, how or when it happened, or by whom. Many reported that they were not allowed to decide when or what they ate, when they slept, went to the toilet, or rested. Not only were many women unable to voice an opinion or preference, for some, simply to make a request or state a preference would be to receive a violent reaction.

For women forced into sex work, a classic arrangement is for them to be locked up or watched during non-working hours, and then when it is time for work, they are either escorted to the work venue, to the client, or to the streets:

> *I was driven to work, picked up after work, and taken back to the flat and was locked up.*

Some women were made to work in the same place where they slept. For those who were very unfortunate, when they were not working they were made to do other tasks or household chores: *During the day, I was working at the bar, dish washing, at nights [I provided] sex- related services.*

Three percent of the women reported that they were "always" free to do as they wished. However, comments they added often belied their responses. For example, one woman who replied "Always", added: *The pimp believed me. I could go out every time when I wanted to, but only with somebody.*

Women's confinement, combined with the threats and violence served to underline the limited opportunities they had to escape or run away. For most, their sense of entrapment was absolute. As one woman explained:

> *I was afraid to even talk to anybody,*

Another stated:

I tried to run away several times. But there was no way to leave.

For some, the sense of imprisonment did not end after being released from the trafficking situation. There were a number of women who reported feeling as if they had experienced a sequence of imprisonments, because even after they were freed from traffickers, they were then detained by authorities for violating either immigration or prostitution laws.

Table 7.8: Percentage of women according to how often they reported consuming alcohol. (n=207)

Alcohol and drug use					
Alcohol use	Not at all (%)	Occasionally/ Sometimes (%)	Most days (%)	Everyday (%)	No data
Women reported drinking	40	32	10	17	1
Drug use	Yes (%)	No (%)			
Women reported using drugs	14	86			

7.4 Alcohol and drugs exposure

Alcohol

Nearly one in five (17%) women reported drinking alcohol everyday while in the trafficking situation. Ten percent of the women reported that they drank most days. (Table 7.8)

Many women said they drank to numb themselves to their circumstances and to endure the abuse. Women often said that they drank to make themselves "be able to do" what they were being made to do.

One woman speculated that her trafficker had reasons for wanting her to drink: *When the Albanian man beat me, he would go and buy me vodka. Probably to make me talk.* Some women mentioned other motives for drinking:

> *I drank often to keep my exploiter company; in this way she got drunk and I could stay calm.*

> *If I was on the street and I got angry, I drank.*

> *I had abdominal pain so I drank vodka to soothe the pain.*

Once they were in a shelter situation, many stopped drinking or reduced their alcohol consumption relatively quickly. Yet, for some women, their dependence had become too strong. One support worker described a woman who was in an alcoholic daze when they found her on the streets. After having testified in court (successfully) against her traffickers, but not having been referred to support services, she resorted to living and drinking on the streets. Once placed in the care of an assistance organisation and housed in an independent living situation, she nonetheless continued to self-medicate with alcohol while the NGO struggled to place her in a detoxification program. In a classic "Catch 22", the detoxification program officials insisted that the woman required mental health support before they would be willing to assist, and the mental health support agency asserted that detoxification must come before

mental health care. Support opportunities were further encumbered by the fact that the woman was not yet eligible for social assistance funding.

For nearly three-quarters of the women in this study, alcohol consumption occurred only occasionally or never.

Illegal drugs

When asked about illegal drug use, 14% of women said that they had used or were given an illegal drug during the time they were trafficked. (Table 7.8) The drugs women cited included: marijuana, cocaine, ecstasy, heroin, and unnamed stimulants. In some cases the women were given narcotics by the traffickers, while in others, clients provided them.

It is not unheard of for traffickers to drug a woman while crossing a border, perhaps to keep her from seeking help, or simply to prevent her from making any mistakes in front of immigration officials. One woman said: [I was drugged] *when we were crossing the state border but I don't know what kind of drug it was. I was asleep.* Another recalled: *I don't know which drug I was administered by the traffickers—once orally, once intravenously.*

One woman in Bosnia reported that she became addicted to drugs while in prison, "In prison [I was] forced to smoke hashish and injected heroin".

Drug use appeared more commonly among women who reported drinking everyday than among those who reported lower levels of drinking.

7.5 Chapter discussion

Women who are trafficked are exposed to a variety of health risks. This chapter described some of the key risk patterns reported by this study cohort. Among the most important health hazards faced by a majority of this sample population was violence—both before and during the trafficking episode.

Data presented in this chapter indicate that tales from around the world of the violence and cruelty associated with trafficking are not simply isolated cases or limited examples about women who are the most brutally treated, but are likely to be typical of the trafficking experience. Nearly all the participants said that they had been physically or sexually abused and more than half had been injured, indicating severity of the violence.

However, while patterns of abuse were detected, it is important to recognise that trafficking episodes are diverse. Some women may have suffered extreme violence and endured months or years in a trafficking situation, while others may have been less abused and spent little time in the grips of traffickers. In fact, one of the limitations of this study was the relatively small sample size, which made it somewhat difficult to undertake multivariate analyses to make clear associations between risk exposure and specific health outcomes.

Importantly, the above findings indicate that women in a post-trafficking service setting are likely to have a repetitive history of abuse. As described, nearly two-thirds of the women (60%) reported that before being trafficked they had been sexually or physically abused. While findings on sexual abuse and

coercion after age 15 may be somewhat difficult to interpret,[24] they highlight the importance of the presence of pre-departure risk.

To put this pre-departure violence in perspective it is useful to look at the data from WHO's Multi-Country Study on Domestic Violence and Women's Health. Although it is not possible to compare the same variables as used in our study, and the WHO study explored other nationalities using different measurement instruments, the comparison nonetheless offers a hint at the relative picture of the violence levels reported in this study. The WHO data show national prevalence levels that generally fall between 23% and 49%.[262] The level of pre-departure physical and sexual violence was 60% for this study cohort, which is well above the general levels for the WHO study countries. Women who are trafficked appear to be more exposed to violence than women in a general population, further implying that pre-departure violence contributes in certain ways to women's vulnerability to being trafficked. While there are no studies on trafficking that have demonstrated an association between pre-departure violence and trafficking, studies on other forms of violence have discussed an increased likelihood of revictimisation for women and girls exposed to early violence.[403]

In addition, revictimisation can have significant health implications. Research on other forms of violence have shown that multiple traumatic events have greater adverse health effects than single traumas.[183, 184, 306] This early

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[24] Figures on coerced sexual experiences prior to being trafficked are complicated by the wide age in respondents, and the age at which they were trafficked.

history of violence has implications for post-trafficking assessments of women's health and treatment regimes.

One of the less central, but nonetheless interesting, questions emerging from the data on trafficking-related sexual abuse is why 10% of the women in the study did not report being sexually abused—despite having said they were trafficked for sex work or sexually abused as domestic workers. Some women were not in the trafficking situation long enough to have been sexually abused. But others may not have perceived their experience of sexual exploitation as "abuse". This may be due, in part, to women's perception that, at some point, they had "agreed" to engage in the sex work. The coercion that was involved in getting them to come to this agreement is not always recognised. Without the physical violence, some women may not have registered their experience as forced or abusive in a way that is typified in "rape". For some women, that they had "consented" to sex work under the burden of a debt (costs owed for travel, documents etc.) may have caused them to believe that the sex work was a voluntary exchange. Women who were in intimate partnerships with their pimp-trafficker are particularly likely to describe their engagement in sex work as a response to their partner's urgings—they were in such a weak position that they felt they had consented, rather than been coerced. There is not enough in-depth information from this study to further analyse women's perceptions of sex and sexual abuse.

The reality of trafficking-related violence and coercion is that it occurs on a continuum. Some women may be physically confined or beaten, while others

may have relative freedom or experience lesser and more complex degrees of coercion. This is an important area for further inquiry because there is little doubt that how women perceive their experience will impact their interaction with the criminal justice system (e.g., willingness/ability to testify to rape) and influence their resilience.[440]

One primary feature of sexual violence is a woman's diminished ability to negotiate safe sex. Based on their qualitative comments, condom use appeared most dependent on women's circumstances rather than their choice.

Not surprisingly, for some women, the inability to use condoms led to unwanted pregnancies. Other work has suggested that induced abortions are not uncommon for women who are trafficked and sexually abused.[441, 442]

The findings that only a small percentage of women had a sexual health check while they were in the trafficking situation highlights that women with sexually transmitted infections are likely to go untreated, increasing their vulnerability to infertility and HIV infection.[443-445]

Like physical and sexual violence, threats are a hallmark of the trafficking experience. Women themselves were threatened, and many received threats against family and children—the latter being an incredibly effective incentive for obedience.

Asking women to choose between their own safety and that of their children or other loved ones has been referred to as the "impossible choice" in literature on psychological torture.[446] As described by Ebert, et al,:

> The impossible choice method places the victim in a situation where, regardless of the victim's actions, something aversive will happen to the victim and/or another person.[446]

The imposition of the "impossible choice" is said to effectively undermine an individual's capacity for self-determination, leaving them in a state of "mental defeat", which is defined by Ehlers, et al.:

> Mental defeat is defined as the perceived loss of all autonomy, a state of giving up in one's own mind all efforts to retain one's identity as a human being with a will of one's own.[447]

Mental defeat is described in contrast to "mental planning", where one feels she has the ability to influence the actions of a perpetrator, or minimise the harm.[447, 448] By suggesting they could and would hurt a woman and her family—including her children—traffickers wielded tremendous power.

The level of drugs and alcohol use among the women interviewed seems to vary significantly and appear, from the formative study, to depend greatly on the setting into which women are trafficked (e.g., some trafficked into venues where alcohol is sold). Unfortunately, data from this study are unable to hint at which situations might be higher risk for drug or alcohol use. Nor were the data able to suggest the influence that a trafficking experience might have on women's addiction to alcohol or drugs, particularly because It is not known to what degree any of the women drank prior to being trafficked. Alcoholism has been found to be a significant problem, for example, in former Soviet states.[449] A national survey conducted in Ukraine for example, found that nearly 9% of women were heavy consumers of alcohol, and that being between 18 and 25

years old was a risk factor for women.[450] It is possible that women were drinking and/or using drugs prior to being trafficked. Moreover—although not reported—it is possible that these habits may have contributed in some way to their vulnerability to being trafficked. In any case, substance use should be considered a risk factor when designing post-trafficking care.

Although the exposures described in this chapter may represent some of the more influential risks to women's health, there is undoubtedly a broader range of physical, psychological and social hazards experienced by women in a trafficking situation that were not possible to explore in a single study. Nonetheless, these major health influences help to situate the symptom levels presented in the following chapters.

CHAPTER 8: PHYSICAL HEALTH SYMPTOMS

8.1 Chapter introduction

Prevalence levels of women's reported physical health symptoms are presented in this chapter. These findings attempt to fill an important knowledge gap in the trafficking literature and in the health literature. To date, there has been only speculation on the levels of physical harm caused by trafficking, but no survey-based evidence.[38, 451] When the topic of women's health appeared in the literature, discussions have primarily centred on sexual and reproductive health, and more specifically on migrant sex workers or speculation in relation to HIV.[44, 130] This has served to minimise inadvertently the constellation of other physical health problems that women may experience.

This chapter begins with a brief discussion of women's perceptions of their general health. Data is then presented on reported symptom prevalence and severity over the three interview periods. To capture a more holistic view of women's health, women in this study were asked at each of the three interviews (Interview 1: 0-14 days; Interview 2: 28-56 days; and Interview 3: 90+ days) about a variety of physical health symptoms they had experienced in the *past two weeks* and were given an opportunity to rate the severity of each symptom at three different time intervals. A broad overview for all symptoms is provided, followed by more detailed descriptions of key symptoms. Data on women's reported visits to a doctor following the first interview are also presented.

8.2 General health status rating

When asked at each of the three interviews: "Thinking back over the last

two weeks, how would you say your health has been?", the majority of women

perceived improvements in their health while in the care of a service

organisation. At the first interview, most women (56.1%) rated their health as

"poor", but at each of the following interviews (after at least 28-56 days and then

90+ days in care), only 3.7% and 4.8% said it was "poor".[25] The greatest change

in women's perception of their health occurred between the first two interviews.
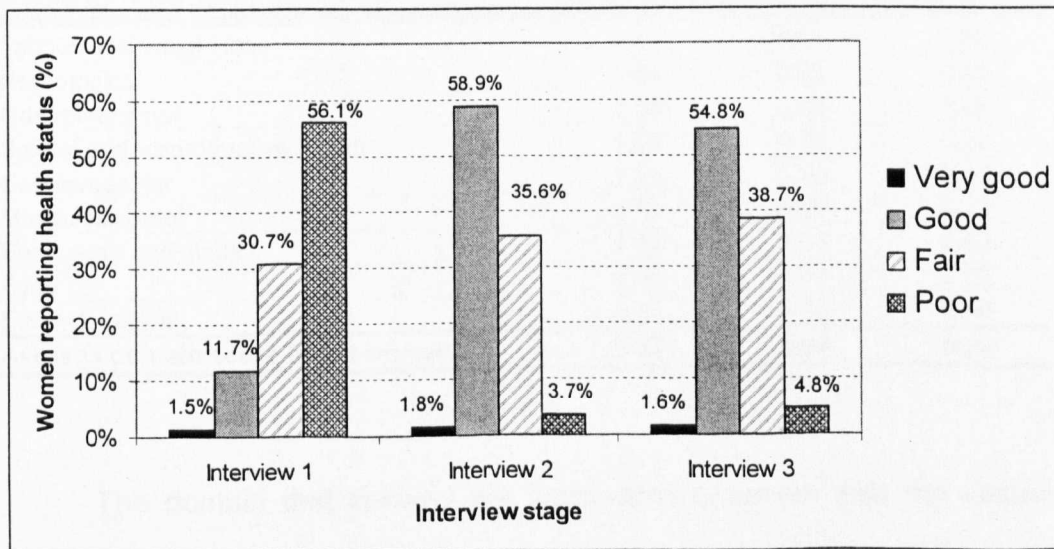
Figure 8.1 Women's perception of their health status over three interviews (n-207).

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[25] While it is possible that some of this positive change may be attributed to a "social bias" or the desire to please the interviewer, the internal consistency of women's responses to other questions, qualitative and quantitative, suggests that social bias probably accounted for very little, if any, of this change.

8.3 Physical health symptom domains

Table 8.1 shows that although the physical health domain scores decrease over time (higher scores represent more prevalent and severe symptoms), the priority that women gave to the different health symptom domains does not alter very much. For example, the physical symptom domains that were consistently rated as most burdensome were: neurological; fatigue and weight loss; and gastrointestinal.

Table 8.1: Average symptom domain scores for all women over three interviews.

Physical health symptom domains			
Symptom domain	Interview 1	Interview 2	Interview 3
Fatigue and weight loss	1.97	0.91	0.63
Neurological	1.84	0.92	0.85
Gastrointestinal	1.58	0.58	0.65
Sexual and Reproductive health	1.24	0.28	0.22
Cardiovascular	1.21	0.55	0.49
Musculoskeletal	1.11	0.56	0.43
Ears, nose and sinus	0.94	0.54	0.68
Eyes	0.98	0.47	0.25
Dermatololgical	0.81	0.33	0.44
Average domain score for all women	**1.39**	**0.58**	**0.50**

The domain that showed the most rapid reduction was the sexual and reproductive health domain. At Interview 1, sexual and reproductive health problems rank fourth in importance (average score=1.24), and by Interview 2, they have descended to last (average score=0.22). Most women in this study received rapid treatment for sexual health complications, such as sexually transmitted infections, perhaps accounting for some of this reduction in reported severity.

The average score for the "neurological" symptom domain reduces the least of the higher scoring domains. This is likely attributable in great part to the chronic and painful headaches reported by the large majority of women in the study.

The last row of Table 8.1 shows an average physical health score for all 26 symptom domains combined. The scores summarise the decrease in physical health symptom prevalence and severity between Interview 1 (average score=1.39) to Interview 2 (average score=0.58) to Interview 3 (average score = 0.5)

8.4 Symptom prevalence level and severity rating

When women were asked about the symptoms within the nine physical health domains, nearly each and every one of the 26 symptoms was acknowledged by some portion of the women at all three interviews. The prevalence levels for individual physical symptoms ranged between 2% and 82%. (Table 8.2) The lowest prevalence levels generally appeared at the second and third interviews.

Over the course of the study, the four symptoms that were consistently prevalent and ranked in the upper severity levels were headaches, fatigue, dizzy spells, difficulty remembering, and abdominal pain.

Results in the following section are presented according to the different symptom domains. General findings on the symptom domain are briefly described first and followed by more detailed information on selected symptoms within each domain.

Table 8.2. Prevalence and severity rating of physical health symptoms. (n=207)

Physical health domains and individual symptoms						
	Interview 1		Interview 2		Interview 3	
	Any (%)	upper severity (%)	Any (%)	upper severity (%)	Any (%)	upper severity (%)
Fatigue and weight loss						
Easily tired	82	75	55	25	41	28
Weight loss	47	70	27	12	19	25
Loss of appetite	64	59	37	24	25	32
Neurological						
Headaches	81	78	72	28	67	41
Dizzy spells	71	68	36	15	38	12
Difficulty remembering	63	70	42	22	30	33
Fainting	22	41	1	0	5	33
Gastrointestinal						
Stomach or abdominal pain	63	72	30	16	33	43
Upset stomach, vomiting, diarrhoea, constipation	45	66	18	23	19	54
Sexual and reproductive health						
Urination pain	17	78	8	8	3	50
Pelvic pain	59	79	24	37	17	36
Vaginal discharge	71	73	11	17	17	27
Vaginal pain	24	60	7	30	2	0
Vaginal bleeding (not menstruation)	10	85	2	50	2	100
Gynaecological infection	61	82	20	27	10	50
Cardiovascular						
Chest/Heart Pain	50	58	30	22	24	28
Breathing Difficulty	40	54	17	36	17	36
Musculoskeletal						
Back Pain	69	70	18	17	37	31
Fractures / sprains	12	52	8	53	13	43
Joint or muscle pain	36	68	18	17	14	22
Tooth pain	58	65	43	20	24	50
Facial Injuries	9	76	1	0	5	0
Eyes						
Vision problems / eye pain	35	58	20	31	10	67
Ears, colds, flu and sinus infections						
Ear pain	15	39	8	25	6	25
Cold, flu, sinus infection	31	47	14	52	27	40
Dermatological						
Rashes, itching, sores	29	59	15	21	19	33

*High severity indicates that women rated the symptom as bothering them "quite a bit" or "extremely/very much", versus "not at all", or "a little".

8.4.1 Fatigue and weight loss

This domain included the individual symptoms, "easily tired", "weight loss", and "loss of appetite" and had the highest score of any domain at the first interview (average score=1.97). It also had the second highest score at Interview 2 (average score=0.91) and Interview 3 (average score=0.63) (Table 8.2).

While fatigue, weight loss, and loss of appetite are frequently associated with depression and stress, for women who are trafficked, these symptoms may also result from or be compounded by the deprived conditions, arduous activities, and long work hours they endured. The formative research identified that women forced into prostitution may work as many as 12 to 14 hours per day with few hours of sleep or rest—despite serving as many as 20 to 30 clients per day. One woman explained:

> *I wasn't even permitted to sleep. I could eat, but very fast, just a few minutes. I had no right to sleep. If I decided to go to bed, he would beat me, and throw me on the street.*

"Being easily tired" was reported by 82% of the women at the first interview, and 75% rated it high on the severity scale. For some, the fatigue seemed to pervade their existence, as one woman stated: *Even the weather can make me tired.*

Feeling "easily tired" seemed to be a very persistent and strongly felt symptom, as 41% of the women participating in a third interview still reported it as a significant problem. Fatigue ranked as the second most frequently reported symptom of all 26 symptoms at this time.

"Weight loss" and "loss of appetite" were also common and were given high severity ratings. Forty-seven percent of the women reported weight loss, and 64% reported "loss of appetite". At the first interview, weight loss was considered by many (70%) to be a serious problem. Two women explained:

I was in Dubai for two years. I was so thin—only 42 kg—that the clients did not want to have sex with me.

My weight before trafficking 72 kilos, but the trafficking experience brought me down to 40 kg.

Another woman who had escaped her traffickers one week prior to the interview said:

I was kidnapped for 3 days without eating.

After this, she was hospitalised for repeatedly fainting.

Several women attributed their loss of appetite to stress (e.g., *Only when nervous*). One quarter of the women continued to feel a loss of appetite by the third interview and one-third ranked this problem in the high severity levels.

8.4.2 Neurological symptoms

Symptoms associated with the central nervous system were among the most prevalent and most persistent. When asked about the "worst symptom", many women cited headaches. At the first interview, 81% of the women reported having headaches, and 78% ranked these in the upper half of the severity scale. Women described severe pain:

The headaches were very bad. I could not take my head off the pillow.

Sixty-seven percent of women participating in a third interview reported headaches, and 41% ranked them as "quite a bit" or "extremely painful", suggesting that headaches are an enduring symptom.

Many women rated their headaches as the "worst" symptom and frequently associated them with their psychological state, speculating that headaches were caused by "worrying too much", "thinking too much", or dwelling on emotionally charged subjects:

> *When I am thinking about my family or if there's confusion, I have a headache.*

When compared to findings from studies on intimate partner violence, these levels are still extremely high—even at the third interview. For example, in two studies of abused women in the U.S., 48% of women reported headaches, while the second indicated prevalence levels of 37% for migraines, and 29% for other frequent headaches—compared to 67% of the women in this study.[452, 453]

Although headaches may have been perceived as stress-related, some said the pain was the result of an assault. Women described being struck in the head or thrown against walls or the floor:

> *The worst pain is from the headaches, especially the constant pain in the left-side temple, caused by an extremely brutal hit to the head, in trafficking. I can not even make moves with this hand.*

Some who reported headaches also noted severe eye pain, which is a defining symptom of migraine headaches.

A number of women reported epileptic seizures.

Dizzy spells were reported by nearly three-quarters of women (71%) at the first interview. By the second and third interviews, 36% and 38% respectively continued to report dizzy spells.

Memory difficulty is a common and extremely meaningful problem for trafficked women. When asked about memory difficulty well over half (63%) stated that they were having memory problems at the first interview and 70% of these women ranked them in the upper severity levels. One woman attributed her memory problems to a blow to the head:

> *I was hit in the head by my trafficker, and I sometimes have problems remembering things from yesterday.*

Memory difficulties continued to remain a problem even after two weeks in care. By the second interview the number of women reporting memory problems had declined, but 42% were still reporting difficulty remembering. Notably, at the third interview, memory problems were among the most prevalent symptoms for the women remaining in the study (30%).

A serious, but less common symptom was fainting. At the first interview, nearly one quarter of the women (22%) said that they had fainted within the past two weeks. This symptom may indicate a physical condition or a psychological reaction to the events experienced in a trafficking situation.

8.4.3 Gastrointestinal symptoms

At the first interview, 63% of the women said they experienced stomach or abdominal pain. By the third interview this pain remained prevalent and severe compared to other reported symptoms.

Of the 45% of women reporting other gastrointestinal problems (upset stomach, vomiting, diarrhoea, constipation), 66% ranked them at the upper end of the severity scale. Women reported episodes of vomiting, diarrhoea, and constipation. By the third interview, the number of women experiencing these problems had decreased to 19%--however, over half of those reporting these symptoms (54%) rated them as bothering them "quite a bit" or "very much".

8.4.4 Sexual and reproductive health

Reported prevalence of individual sexual and reproductive health symptoms showed a sharp decline in number and severity between Interviews 1 and 2. For example, vaginal discharge was the most commonly reported sexual and reproductive health symptom at the first interview (and among the most frequently reported sexual health symptom overall), as 71% acknowledged having "unusual or bad smelling discharge", with 73% rating this in the upper severity levels. Qualitative responses from the women indicated they were extremely concerned about this symptom:

> *The most life disturbing problems are related to gynaecology—I am tired of vaginal secretions.*

By the third interview, only 17% of those remaining in the study still reported discharge.

At the first interview, pelvic pain was reported by more than half of the women (59%), with 79% of the women rating these problems in the upper severity levels. By interview 2, reported pelvic pain decreased to 29%, with a corresponding decrease in severity (37%). By the third interview, the number of women reporting pelvic pain was 17%, of whom 36% still ranked this problem as very painful.

At the first interview, 61% self-reported a gynaecological infection. By the second interview, 20% reported infections, while 10% still reported these by the third interview. These are likely to be underestimates of infections, as a number of common conditions are asymptomatic (*i.e.* gonorrhoea and chlamydial infection).[454] At the first interview, women were asked about previous diagnoses; 44% had received an STI diagnosis. The three most common infections were candidiasis (33%), trichomoniasis (12%) and bacterial vaginosis (11%). While clinical samples were not collected for this study, self-reported STI has been known to be a viable data collection method method.[455]

HIV

HIV/AIDS was of great concern to numerous women in this study. For some women, fears of HIV were foremost in their mind:

> *I have worrying thoughts about my health. Problem number one: HIV testing.*

Women were asked whether they knew their HIV status at the first interview, but not their status. Some women who knew their status chose to disclose it. A positive HIV diagnosis was reported by 2% of the women at the first interview. Questions regarding STIs/RTIs and HIV were only asked at the first interview, therefore the numbers reported are likely under-estimate the true levels of HIV infection, particularly as HIV testing often occurred following the first interview.

In the following case, the woman did not find out her positive HIV status until the third interview:

> *I had blood tests and the results show that I am HIV positive...I cannot think about anything else, only about my disease. I think I will become crazy. And, my parents do not know the truth. I am ashamed and scared to tell them...I have nightmares and I cannot rest because of this. I have headaches and I am very depressed and scared.*

Pre- and post-test counselling and information appeared to be an issue for women in this study:

> *One week ago, when I was examined for my pregnancy in my home town, I was simply told that I am HIV positive and have syphilis—without any explanations or counselling...Only now has it been explained what is HIV positive, and that this is for rest of my life! This makes me understand that I can die, and that my child can be born infected.*

One HIV infected woman reported a co-infection with TB. Globally, TB is the opportunistic infection occurring most frequently among HIV infected individuals.[456] Another woman who was trafficked as a minor and escaped by jumping out of a window, sustaining serious injuries, reported HIV and syphilis co-infection at the first interview.

When asked about her future at the first interview, one of the women replied that she wanted only *not to die and to deliver a healthy child.* Fears about her health and that of her child were compounded by concerns about what others would think if they knew her HIV infection status. She said:

> *I have been referred for my HIV to a residence HIV/AIDS clinic. I am afraid they will not be understanding, and will judge me...I worry that my life will become more difficult, and that people will distance themselves from me as soon as they find out. I worry that my fiancé will leave me and his parents will judge me.*

Women in this study expressed regret over "what they had done" and many voiced a strong desire to "know what was going on inside"—to be reassured about a central health issue that they could neither see, nor check for themselves. In addition to easing the pain and irritation of gynaecological symptoms, women also wanted reassurances of their fertility. They suspected irreparable damage:

> *I have pain in my womb which came from working and having intercourse too much. I am worried that this may have caused permanent damage.*

Many had envisioned a future with children, home and husband:

> *My dream is to get married, have children, and a normal job, to have a happy family life.*

Most were eager to quickly receive gynaecological care to ensure that their recent past would not destroy their future.

8.4.5 Cardiovascular symptoms

Cardiovascular symptoms were reported by approximately half the women at the first interview, over half of whom ranked these problems in the upper severity levels. By the third interview, less than a quarter of women in the study still reported these problems, approximately one-third of whom referred to them as severe.

Chest/heart pain was reported at relatively similar levels as breathing difficulty at both first (50% vs. 40%) and third interviews (24% vs. 17%). Describing her symptoms, one woman explained:

> *I have intense coughing up until vomiting and difficulty breathing during sleep.*

Cardiovascular problems may be symptomatic of a range of different medical conditions, including infection (e.g., tuberculosis), injury, colds and flu. At Interview 1, three women in the study reported having been diagnosed with tuberculosis. It is possible that other women had tuberculosis, but later diagnoses were not gathered.

Cardiovascular symptoms such as heart palpitations and shortness of breath have been associated with acute anxiety and panic attacks.[250] One woman remarked that she felt chest or heart pain when she was "nervous or frightened". Anxiety symptoms are discussed in greater detail in Chapter 10.

8.4.6 Musculoskeletal symptoms

Women were asked about back pain, fractures, sprains, joint or muscle pain, dental pain, and facial injuries. Two of the most persistently painful health problems fell within this symptom category: back pain and dental problems.

At the first interview, 69% of women reported back pain and 58% reported dental problems. By the third interview, back pain was the second most prevalent physical health problem, reported by 37% of women still in the study.

Victims of sexual and physical abuse by an intimate partner report back pain at similar levels.[457] Prevalence levels among survivors of intimate partner violence are also near 40%,[458] and similarly, among the highest of all reported symptoms. Back pain has also been associated with stress and depression.[452, 453] Importantly, a number of women linked back pain to injuries they had sustained:

> *Especially in my spinal column, it causes me pain. It is because I was pushed down the stairs.*

> *I feel pains in my vertebrae, in the spinal column and my heels because I jumped from the third floor to run away.*

Reports of joint or muscle pain at the first interview were also prevalent, as more than one-third of the women (36%) stated they had joint or muscle pain, most of whom also reported having back pain (86%).

Pain related to sprains or fractures was reported by 12% of the women. Among these women, 80% reported having been hit, kicked or otherwise physically hurt by someone during the trafficking experience.

Of the 18 women (9%) reporting facial injuries, 14 said they had been physically abused. Describing her facial injuries, one woman explained: *bruises, and scars after cigarette burnings.*

The findings show that of those women who remained in the study by the third interview, few felt relief from the pain of sprains, fractures and facial injuries. At the first interview, 12% and 8% reported pain from fractures or sprains and facial injuries, respectively, and by the last interview, 13% and 5% still reported them.

The formative study suggested that women who have been trafficked are likely to report dental problems. Dental complaints may be common because of poor access to care or poor quality care in women's home countries, and their inability to seek care while in the trafficking situation. One woman told how her teeth had deteriorated:

My teeth are crumbling after being in Turkey.

Another described the symptoms from a toothache:

My whole cheek and my eye swelled up.

Dental complaints may also relate to blows to the face or head.

8.4.7 Eye pain, vision problems

Eye pain

Women were asked about vision problems or eye pain specifically *unrelated to needing glasses.* Thirty-five percent of women in the first interview

reported eye problems. Over half of these women ranked the pain in the upper severity levels.

Eye problems, such as pain, blurred vision and double vision have also been identified in survivors of other forms of gender-based violence, such as one study showing that abuse survivors had nearly 2.5 times greater odds of reporting blurred or double vision than women who had not experienced abuse.[179, 457]

When asked to speculate about the cause of their eye problems, women had diverse answers. Some identified it with their headache pain. One woman said: *It is because I have been crying too much.* Another said it was from a pre-existing problem: *I experienced eye pain in Lithuania. The doctor thought it was glaucoma.*

By the third interview, 10% of women remaining in the study acknowledged vision problems or eye pain, well over half of whom (67%) reported it in the upper severity levels.

8.4.8 Ears, colds, flu and sinus infections

Ear pain

Sixteen percent of women reported ear pain at the first interview, and 6% said they had ear pain at the third interview. Ear pain appeared to be independent of colds or flu symptoms for most women reporting ear pain. Again, it is worth recalling that many women received strong blows to the head during the trafficking experience.

Colds, flu, sinus infection

When asked about colds, flu and sinus infections, 31% of women at the first interview reported these symptoms. Between 40% and 52% rated them in the upper half of the severity scale.

Again, these symptoms appear to fit within the health profile of an abuse survivor, as studies show higher rates of infection among abuse survivors, which some have suggested may be a result of lower immune function than those not been abused.[453, 459] Interestingly, a study by Campbell, et. al., suggests that those who have been sexually abused have higher rates than those who reported only physical abuse.[453]

It has been suggested that the frequency of these problems may be related to chronic stress[460], as stressful events have been linked to reduced functioning of the immune system by reducing the number of circulating white blood cells (i.e., cells involved in fighting off infection).[461, 462] It is also worth recalling the high number of women reporting severe fatigue and the impact of sleep disruption on the immune system.

8.4.9 Dermatological problems

Skin problems affected 29% of the women in the first interview. The prevalence of these problems dropped by nearly half to 15% at the second interview and then remained a similar proportion (19%) at the third interview. Women reported boils, dry skin, itching, pimples, sweating and rashes. For some

women, skin problems such as itching were intolerable. One woman explained:

When I'm nervous, every centimetre of my body itches.

Again, higher rates of skin problems such as rashes, itching, sensitive skin and excessive sweating have been found among women who have been abused.[439] For the women in this study, reasons for skin problems may include sexually transmitted infections, allergies, skin infections which may be consequences of unhygienic conditions (e.g., scabies, lice), and stress. Mental distress has been shown to be strongly associated with skin problems, as persons suffering mental distress have an odds ratio of two and half times higher for dermatological outbreaks, such as itching, face rash, and acne. [463]

8.4.10 Concurrent symptoms

Within the first 14 days after entry into a service setting, 57% of the women reported experiencing 12 or more concurrent adverse symptoms of physical health. The reported number of concurrent physical health symptoms dropped significantly with 7% reporting 12 or more symptoms after 28-56 days in care, and 6% after 90 or more days in care. (Figure 7.2)

0-14 days   **28-56 days**   **90+ days**

57%   7%   6%

43%   93%   94%

□ 0 to 11 symptoms
■ 12 to 23 symptoms
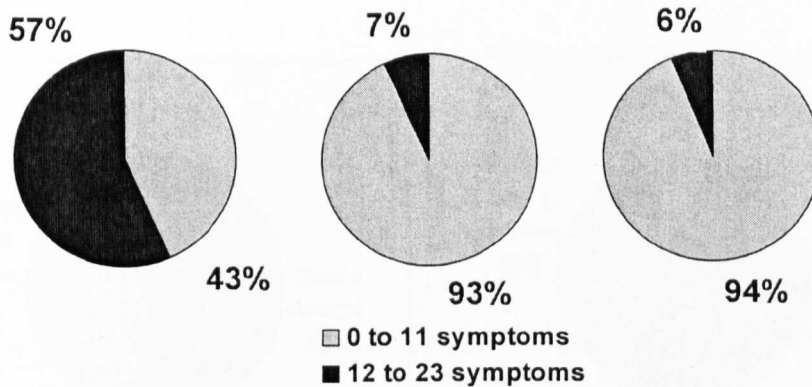
Figure 8.2 Percentage of women reporting concurrent physical health symptoms over three time periods following entry into a post-trafficking service setting. (n=207; n=170; n=63)

While Figure 8.2 is not a traditional way of looking at symptom patterns, this format provides a more striking view of how women's collective symptoms decrease over the three interviews. This figure shows clearly that for the majority of the women in the study, physical pain and discomfort was prominent at the first interview. By the second and third interviews, only a minority were reporting a high number of different painful symptoms.

8.5 Doctor visits

Women who participated in a second interview were asked whether they had seen a doctor for the health symptom that most concerned them. More than half (54%) the women had seen a medical practitioner by the second interview. (Figure 8.3) Women in single dwelling shelters where in-house medical assistance was available were generally more likely to report having been treated. In some destination locations, delayed assistance was due to women's legal status and their inability to access public funds.
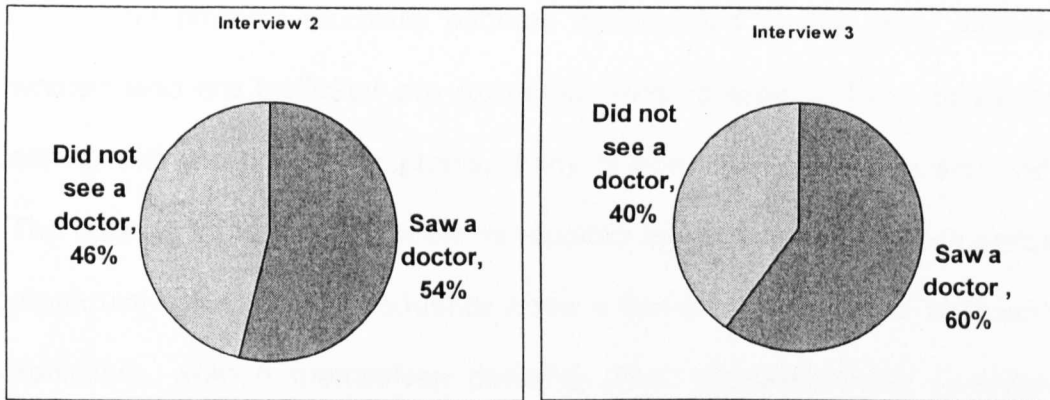
Figure 8.3: **Women who reported seeing a doctor for health symptom that most concerned them at interviews 2 (n=167) and 3 (n=63).**

Most women reported "good" or "very good" service. This positive rating may have been due to the good quality of the care, but responses may also have been influenced by women's wish not to offend care providers, i.e., the interviewer.

At the third interview, women were asked again about problems that most bothered them and asked whether they had seen a medical practitioner for this problem. Among the women remaining in the study, 60% reported having seen a doctor for their worst symptoms. Again, access to practitioners was more common for women in single dwelling shelter settings.

Some women stated firmly (and sometimes emotionally) that they did not want to see any more doctors. This feeling was not isolated to any single location or assistance project.

8.6 Chapter discussion

The physical morbidity patterns documented in this study indicate that women who are trafficked are extremely likely to emerge from an exploitative setting with a range of symptoms, many of which will be severe and enduring. The diversity of the health problems reported highlights that although sexual and reproductive health has frequently been a focus of discussions on health and trafficking, women themselves perceive other physical health symptoms as equally or more problematic. This is not to imply that sexual and reproductive health is not of great importance—both for individual and public health reasons. It simply serves to highlight the need for an expanded discussion on health to include a wider spectrum of complications that appear to be of great concern to trafficked women themselves.

The first data presented in this chapter suggest that most women perceived their general health to be poor at the first interview. Research on intimate part violence suggests women who experience partner abuse are nearly 1.5 - 3.5 times more likely to perceive their health as poor than women who have not been abused.[457, 458] Yet what this data is not able to show is to what degree women's assessments of their initial health reflect any change from when they were still in the trafficking situation. That is, if women were evaluating their health compared to how they felt before escaping the trafficking situation, perhaps these assessments likely under-represent how poorly women were feeling on a normative scale, or compared to an average health level.

The results also show how women's symptoms declined over the series of interviews. While it was extremely promising to see the rapid decrease in symptoms over the study period, this relative view is somewhat deceptive. The symptom prevalence at the second and third interviews, while much lower than at the first interview, is nonetheless high. A significant portion of women—even months after the exploitation had ended—remained highly symptomatic, and troubled by their symptoms.

The reported symptom patterns, such as headaches, backaches, and gastrointestinal problems, are consistent with the health outcomes identified in survivors of sexual abuse, rape and intimate partner violence.[439, 452, 453]

The most prevalent symptom, "feeling easily tired", seems to be a predictable post-trafficking outcome, given the type and hours of work required of many trafficked women. Sleep loss and disrupted sleep were reported by many women in the formative study. In addition to the direct effects on a woman's well-being, sleep disruption and sleep deprivation can affect an individual's cognitive functioning and decrease the body's natural protection mechanisms for pain and the immune system.[385, 386]

Headaches were the symptom most consistently reported throughout the study, but without specific diagnostic testing, it is difficult to know how many of these women's headaches were solely stress-related and how many were associated with blows to the head or neck. Research on intimate partner violence has shown that the most frequently injured body region is the head, neck and face, which account for 48% of reported injuries.[464]

Dizzy spells were also reported at high levels, particularly at the first interview. Studies on dizziness have shown that dizzy spells may be associated with psychological distress, autonomic arousal, social anxiety, stigma, and panic disorder.[255]

The finding with important implications for policing and prosecution purposes is that nearly two-thirds of women felt they had memory problems within the first 14 days after a trafficking experience.

Memory and recall are of particular significance when women come into contact with government officials, law enforcement personnel, and the judiciary. Often a woman's credibility is based on the quality and consistency of her memory of events. In turn, if a woman is not believed, she may receive fewer resources from the authorities. Her ability to offer details about her past may affect her present and future security, as well as rights and opportunities to prosecute and testify against traffickers.

Difficulty recalling events and exposures may also pose difficulty for diagnosis and treatment. Women's inability to remember the past may, for example, limit medical history taking or hinder psychological counselling and support.

The problems that individuals have in recalling and reconstructing traumatic experiences soon after the event has been confirmed by numerous studies.[465, 466] Peri-traumatic dissociation, or when individuals block out events at the time of trauma, has been closely related to post traumatic stress disorder (PTSD).[466-468] Dissociation, or "the experience in which a person's normal awareness, memory,

identity or perception of the environment is temporarily disrupted", may subsequently result in the "inability to recall important personal information that is not explained by ordinary forgetfulness".[466]

The natural process of blocking out peripheral details about the most violent or danger-filled events is particularly problematic for survivors of trafficking who are required to cooperate with authorities, as this is often the exact time period that is of interest to officials (e.g., travel arrangements, names of trafficking agents, ports of entry, etc.). It is similarly common for an individual's memories to fluctuate or alter over time.

Memory difficulty has been demonstrated in refugee populations. A study on asylum seekers in Britain with post traumatic stress symptoms showed, for example, that the numbers of discrepancies in an individual's memory of highly emotional events increased over time, with more discrepancies appearing in those details that were peripheral to the event than in those that were central to it.[469] Research with rape survivors has also shown that women's memory of the rape experience lacked clarity, detail, chronological or meaningful order, and had limited sensory components.[307]

It is not surprising that many participants reported gastrointestinal pain. Gastrointestinal problems have been shown repeatedly to be an important part of post-trauma symptomatology, commonly associated with anxiety and stress.[439] It is not uncommon for women who have experienced abuse to report, for example digestive problems (e.g., frequent indigestion, diarrhoea and gastric reflux).[452] It has also been shown that a significant portion of women seeking medical care for

gastrointestinal problems,[439, 442, 470] treatment for abdominal pain, and surgery for chronic pelvic pain have been abused.[182, 470]

Findings showing high reporting levels for sexual and reproductive health symptoms are also supported by the literature on sexual violence.[305, 345, 401, 439] Data showing that nearly two-thirds of women reported sexually transmitted infections confirms that STIs are common among women who are trafficked and sexually exploited. Presence of STIs are of particular concern because of the potential for long-term damage if certain conditions are left untreated and because they may put women at an increased risk for HIV infection. Epidemiological studies have shown, for example, an association between the presence of STIs and RTIs (e.g., bacterial vaginosis (BV), PID, cervicitis) and an increased risk of acquiring or transmitting HIV infection.[443, 444, 471-473]

Findings on sexual and reproductive health were also of interest because, in the past, it has been assumed that sexual health problems were the most significant health outcomes for women trafficked for sexual exploitation—often to the exclusion of other symptoms. While clearly of great importance, the data suggest that women themselves perceive other health problems to be of equal or greater gravity. The ranking of sexual and reproductive health symptoms highlight that they comprise part of a more global set of adverse health outcomes.

HIV was not widely reported by the women in this study. This may have been due, in part, to the fact that questions about HIV were not repeated at the second and third interviews. Or, low reported rates may also reflect the low

prevalence in the countries where the women were exploited. While few women reported being HIV positive, for those who were, there can be little doubt that this new and permanent health fact will intensify difficult emotions and magnify women's memories—making it difficult for them to regain normality in their lives.

Women in this study reported inconsistent access to medical practitioners. This is of great concern, given the high symptom levels reported, which makes this an important area for further inquiry.

In the following chapters, discussions on women's reported psychological symptoms will help to shed light on the probable links between women's mental and physical health.

CHAPTER 9: SYMPTOMS ASSOCIATED WITH POST-TRAUMATIC STRESS DISORDER

9.1 Chapter introduction

This chapter presents findings on symptoms suggestive of post-traumatic stress disorder, as assessed by the use of the Harvard Trauma Questionnaire (HTQ).[360]

In the discussion below, the data is presented according to the three symptom groups that define the PTSD syndrome. It is worth noting that the international application of the diagnosis of "PTSD" has been questioned by numerous experts in the field of mental health for cultural, clinical, and contextual reasons.[237, 238]

The summary trend of women's PTSD-related symptoms is discussed first in this chapter. This standard presentation of the data is followed by more detailed descriptions of the symptom levels reported within each symptom domain comprising the Harvard Trauma Questionnaire (re-experiencing traumatic events, psychological arousal, and avoidance and numbing). Although reviewing individual symptoms and the severity levels reported may not be a classic way of reviewing HTQ results, it is believed that this view adds valuable, more in-depth insights about women's reactions. For symptoms deemed particularly important, more detail is offered.

9.2 Summary trend of PTSD symptoms over three interviews

At the first interview, 56% of women entering post-trafficking services scored symptom levels equal to or above the 2.5 cut-off level on the Harvard

Trauma Questionnaire (HTQ)—levels suggestive of PTSD-related symptomology (Figure 9.1).[34626] The percentage of women showing these symptom levels decreased at each interview interval. A large reduction took place between the first (56%) and second (12%) interviews[27], declining by the third (6%).

At the first interview, symptom severity was extreme for many women. Fourteen of the sixteen symptoms show prevalence levels of over 50% reporting in the upper severity (Table 9.1). Five women ranked each and every symptom at its highest severity level ("extremely").
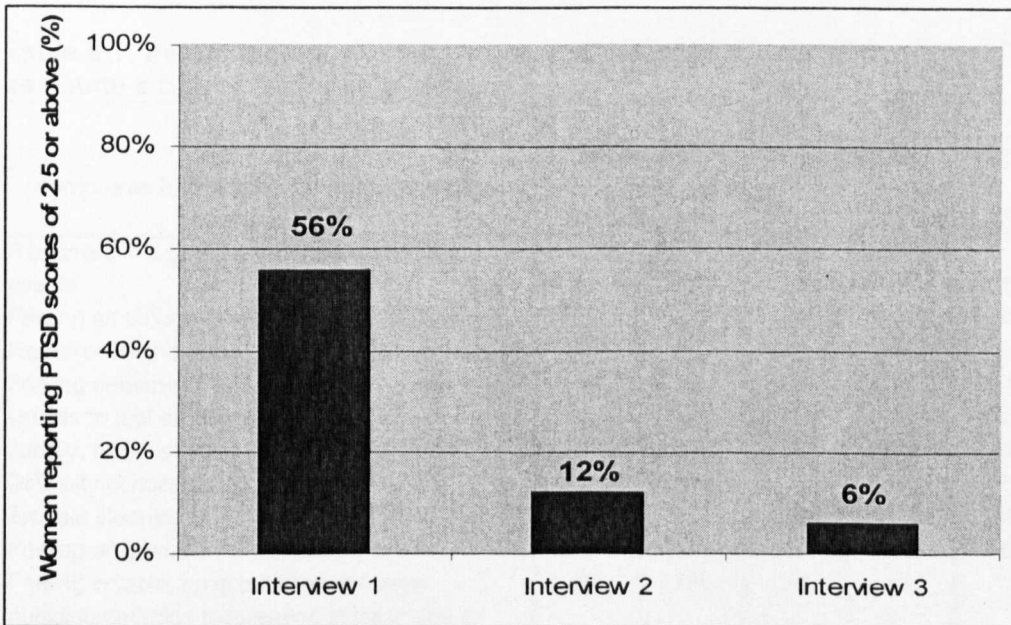
Figure 9.1: Percentage of women reporting symptom levels suggestive of PTSD at each interview (n=204; n=165; n=63).

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[26] A diagnosis of PTSD requires that symptoms fitting the PTSD criteria persist for more than one month. There may be some question as to the duration of women's symptoms at the first interview, however, because 88% of the women had been in the trafficking situation for more than a month, it seems likely that these criteria may be applicable for the majority of the women at the first interview.

[27] Most second interviews took place one month or more after the first interview.

9.3 PTSD symptom domains

Table 9.1 presents the percentage of women who reported that a post-trauma-related symptom bothered them "quite a bit" or "extremely/very much"—in the *upper severity levels*. Each of the symptoms in this table represents an element of one of three symptom domains: re-experiencing traumatic events (also known as "intrusion"); psychological arousal; and avoidance or numbing. Each dimension and selected symptoms within that dimension are presented and supported by women's qualitative comments.

Table 9.1: Percentage of women who ranked individual symptoms of the HTQ as "quite a bit" or "extremely" severe.

Symptoms in the post-traumatic symptom scale of HTQ	Interview 1*		Interview 2*		Interview 3*	
	(%)	n	(%)	n	(%)	n
Recurrent thoughts / memories of terrifying events	75	153	35	58	16	10
Feeling as though event is happening again	52	106	18	30	8	5
Recurrent nightmares	54	110	16	26	13	8
Feeling detached / withdrawn	60	122	26	43	14	9
Unable to feel emotions	44	90	10	17	2	1
Jumpy, easily startled	67	137	20	33	16	10
Difficulty concentrating	52	106	15	25	8	5
Trouble sleeping	67	137	35	58	24	15
Feeling on guard	64	131	20	33	6	4
Feeling irritable, have outbursts of anger	53	108	19	31	16	10
Avoiding activities that remind of traumatic or hurtful event	61	124	11	18	13	8
Inability to remember part of most traumatic or hurtful events	36	73	6	10	3	2
Less interest in daily activities	46	94	10	17	6	4
Feeling as if you don't have a future	65	133	36	59	10	6
Avoiding thoughts or feelings associated with the traumatic events	58	118	17	28	23	14
Sudden emotional or physical reaction when reminded of the most hurtful or traumatic events	65	133	16	26	14	9

*Interview 1: n=204; Interview 2: n=165; Interview 3; n=63

9.3.1 Re-experiencing traumatic events

At the first interview, the symptom rated as most severe by the greatest number of women (75%) was: "recurrent thoughts or memories of the most hurtful or terrifying events". Numerous women reported experiencing disturbing or upsetting memories each day. Women expressed vivid sensory recollections of their recent past:

Sometimes I get the sense he's coming after me. Sometimes I can smell his deodorant in the room.

The second highest severity levels were reported for another symptom in the "re-experiencing" domain: "sudden emotional or physical reaction when reminded of the most hurtful or traumatic event", with 65% ranking it as "quite a bit" or "extremely" severe. Again, numerous women said that they had strong reactions brought on by sensory reminders:

Things that smell, like bath stuff, that remind me of them. Using room spray. I avoid using the same brand of toothpaste my pimp had.

...when I see a car with foreign plates, it might be their car and they may kill me. It doesn't matter that there are people around me. .

For some women their reaction felt overwhelming:

You feel as if you could die.

For a number of women, this feeling was associated with dangers they felt were still present. Some women tried to identify strategies to fight off these memories:

I try not to remember them. If those thoughts come, I hug my child and get them away or try to be among people and not alone.

By the second interview, just over one-third of women remaining in the study reported difficulty with recurrent memories (35%), and by the third interview, "recurrent memories" was no longer the highest reported symptom. A few women seemed to begin to put the memories behind them at this later point:

The worst memories are gone. I am emotionally healthy.

Over half the women (54%) at the first interview reported having recurrent nightmares that bothered them significantly. For most women the nightmares were about trafficking-related events:

It comes every time when I close my eyes...Always in dreams I see that I am still taken to clients.

For others, they were less defined:

I have nightmares nearly every night. I dream about my father or like I'm being pulled down in a whirlpool.

Sleep disturbance is associated with the after-effects of trauma, such as rape,[474] and has also been linked to depression and potential suicidality in rape victims with PTSD.[245, 475]

By Interviews 2 and 3, 16% and 13%, of women, respectively, continued to have recurrent nightmares they reported as severe. For many, the images remained very frightening:

I dreamt about being in a scary place and wanting to leave. I also dreamt about the boss and place I worked, and being locked in.

9.3.2 Psychological arousal

The second most severe symptoms reported at the first interview were within "psychological arousal" dimension: "feeling jumpy or easily startled" (67%) and "trouble sleeping" (67%). Many described the sense of being followed or under threat:

Sometimes when I am washing up, I feel like someone is standing behind me

For one woman, the description, "feeling jumpy or easily startled" was not strong enough to explain how she felt:

I'm feeling hysterical, not nervous.

Other women described feeling on edge:

If I go out I feel scared even of an ordinary cat. People stop and ask me if I'm okay.

It is notable that "feeling jumpy" was among the three most reported symptoms even at the third interview.

Many women who reported "feeling jumpy" also reported having "trouble sleeping". When asked about sleep, women added comments such as:

I feel awake permanently.

I will awake during the night feeling scared.

I cannot fall asleep.

One explained that she frequently *wakes up crying.*

A high proportion of women in this study were prescribed sedatives and anti-depressants and the positive effects of medication on their sleep was recognised and appreciated by the women during the interviews.

Serious "trouble concentrating" was reported by just over half of the women (52%) at the first interview. Women explained how they were unable to read a book or watch television and complained of frequently forgetting what they were doing or where they were going:

I miss my stop on the bus or when I'm walking, I suddenly won't know where I am and need a few seconds to reorient myself.

When responding to questions within the "arousal" symptom dimension, several women perceived links between their anxiety and anger:

The aggression comes from fear. Because you cover yourself with a mask so no one would see inside you.

Sometimes I'm in the street, and I feel like everyone's looking at me and I want to shout at them. I'm tired of being afraid.

9.3.3 Avoidance and numbing

Avoidance and numbing are elemental and highly predictive symptoms of PTSD, and studies suggest that individuals who manifest symptoms in the other two domains, but do not report symptoms in this category, are less likely to develop full PTSD.[476]

The symptom, "feeling as if you don't have a future", is an important symptom within the "avoidance and numbing" dimension. This was among the most highly ranked symptoms throughout the interview periods (65%, 36%, 10%). It was the most highly rated symptom at the second interview.

For numerous women, positive hopes for the future seemed inconceivable:

I have only negative thoughts. All future life scenarios are so bad.

I can't even imagine how [the future] should be.

Even by the second and third interviews, the "future" was a subject about which numerous women seemed to feel trepidation or emptiness. After having their most basic and pressing needs resolved, women had more mental space to begin worrying about the longer term future. Confronted with their future, several women articulated their paralysis. Some described dismay over vital practical realities, such as how they would survive the poor economic situation in their home country. Some talked about the untenable situations they had fled, such as violent homes and orphanages, many beginning to comprehend that they were probably going to return worse off than when they left—and many had few safe places to go.

Women not only felt distanced from their future, they also reported high levels of detachment that did not easily dissipate over time. "Feeling detached or withdrawn from people" remained among the most highly ranked symptoms throughout the three interviews (60%, 26%, 14%). Women commonly associated their social distancing with their feelings about "trust":

> *When we escaped from the trafficking situation I could not even look at people. We were never allowed to look up when going to work. We always walked with our head down.*

Women found scepticism necessary:

> *To avoid giving trust I have learned to be hard and to distance myself.*

Some women felt reclusive for fear that others would respond badly to their secrets should they be disclosed:

> *I always think how other people's attitude can change if they find out— that's why I keep myself isolated.*

Women also reported feeling numb or emotionally empty. At the first interview, 44% said they were "unable to feel emotions". Some described feeling "vacant". Some felt confused:

> *I have chaos in my thinking*
> .

By the second interview, 10% of women still reported being unable to feel emotions. Emotional numbing may have been a psychological defence strategy to protect against the highly emotive events that occurred on a daily, sometimes hourly basis while they were exploited.

Memory problems, another component of the "avoidance and numbing" dimension, are a disability of some significance, as previously discussed. Initially, 36% of the women rated their "inability to remember parts of the most traumatic or hurtful events" in the upper end of the severity scale (i.e., "quite a bit", 21% or "extremely", 15%. In contrast however, numerous women said that they "remember always and everything". By the last interview, 2% of women said they had problems recalling the events that were most distressing. One explained:

> *Even if I try hard, I may never remember it, probably, because the memory is lost*

9.4 Chapter discussion

While there has been much debate about the relevancy of the PTSD diagnosis across cultures,[162, 237, 238] the findings suggest that many of the symptoms associated with this label were clearly recognised by the women in this study. The data presented add further detail to what has been observed by many post-trafficking support workers: women who are trafficked appear to display numerous symptoms associated with post-traumatic stress disorder.[232] In fact, the symptom levels found in this study appear to compare with levels documented for survivors of war-time trauma,[477] and near levels identified in torture victims.[478]

From women's descriptions of trafficking-related abuse, these levels are not surprising, as the circumstances described closely fit the criteria of trauma-inducing events.[105] Traffickers appeared able to impose a sense of imminent danger. Their actions and ominous threats cause women to exist in a heightened state of alert and feel the limits of their ability to protect themselves. Experts in the field of torture and trauma explain that in response to this type of lethal danger, the normal human reaction triggers integrated physical and psychological responses that prepare an individual to either flee the situation or to defend herself from the imposing danger.[272] When the threat is chronic—as it appeared to be for so many of the women in the study—the literature suggests that individuals are often unable to "turn off" their "basic biological and safety alarm mechanisms".[272] They remain constantly prepared to defend themselves against life-threatening events.[479] Some trauma psychologists have speculated

that repetitive helplessness of this kind may "disorganise cognitive processes" or disable an individual's instinctive ability to respond appropriately, i.e., in proportion to the threat.[272]

While it was beyond the scope of this thesis to consider possible contributing factors to women's distress levels, it is reasonable to speculate that those who experienced pre-trafficking abuses (60%) were particularly vulnerable to strong post-trauma reactions. Research suggests that previous exposure to trauma, including, childhood trauma, may influence the emergence and the severity of the symptoms of PTSD.[183, 234, 235, 257, 345] Herman, in her book "Trauma and Recovery" proposes that those who have a "history of subjection to totalitarian control over a prolonged period (months to years)" should be differently diagnosed, and terms the new diagnosis: "Complex Post-Traumatic Stress Disorder".[186] This proposed diagnosis has been a subject of considerable debate.[306] Writing on the development of PTSD, Yehuda, et. al., explain:

> One of the most salient predictors of chronic PTSD is the nature of the traumatic event that has been experienced. Events associated with torture or prolonged victimization are associated with the highest estimates for chronic PTSD.[480]

Certainly for many of the women in this study, their victimisation could be described as "prolonged".

Importantly, population prevalence of PTSD has been correlated with gender differences. Epidemiological studies show that although women are less likely to be exposed to traumatic events than men, lifetime prevalence of PTSD is higher in women (5%-6% versus 10%-14%).[235]

Worth noting as well, in relation to the emergence of PTSD, is research that has correlated PTSD with biological factors or changes in the way the body reacts to stressors.[240, 480]

Of significance in this study is the promising decline in women's post-trauma symptom levels. Yet this reduction does not necessarily indicate that women whose symptoms declined, or who were never within this categorical definition for PTSD, are not at risk of recurrence or of developing PTSD at some future time—particularly if they encounter stressful or traumatic events.[481-483]

Unfortunately for women who are in the process of re-establishing their lives, stressful events may be a defining feature of their near-term future. Women are likely to face one or more tension-inducing situations, such as family reunions, return to husbands or partners who may or may not know about their recent past, dire economic circumstances, or being re-trafficked. Women in destination settings may be pursuing asylum claims, or awaiting immigration responses that will determine their future, and possibly their safety.

A number of women will also be living in fear of their trafficker.[91] As will be discussed in the following chapter, for many women their anxiety is based on a well-founded fear of genuine danger.

Perhaps most highly vulnerable to stress are those women who are participating in a legal proceeding against a trafficker, and who are required to testify in court—in his presence, and possibly his cohorts, and those who have tested positive for HIV/AIDS.

One of the key symptoms included in the HTQ was memory. Using this tool, women were asked to rate their inability to recall the most traumatic events, (whereas in the physical health instrument women were asked to rate their general memory capacity). Although levels differed, (fewer women reported an inability to remember the most hurtful events versus more reported general memory problems), both questions confirm that women who are trafficked are likely to have memory problems, especially during the first few weeks following a trafficking experience. As previously noted, memory problems can raise scepticism about a woman's credibility, which in turn may have practical implications for asylum claims, access to social benefits, etc. The authors of a study on asylum-seekers in the United Kingdom, trauma and autobiographical memory conclude:

> The assumption that inconsistency of recall means that accounts have poor credibility is questionable. Recall of details rated by the interviewee as peripheral to the account is more likely to be inconsistent than recall of details that are central to the account. Thus, such inconsistencies should not be relied on as indicating a lack of credibility.[469]

Further suggesting the impact of traumatic events on memory are findings from a study of sexual assault survivors. The researchers concluded that memories associated with rape were more "emotionally intense, but less clear and coherent, and were less often thought of or talked about" than memories of non-traumatic events.[307]

While PTSD is a term often mentioned in conjunction with victims of trafficking,[484] it is important to recognise that PTSD is not an inevitable

consequence of trafficking, nor is it necessarily likely to be the most prevalent or most severe psychological manifestation experienced by trafficked women. As the National Center for Post-traumatic Stress Disorder explains:

> PTSD is complicated by the fact that it frequently occurs in conjunction with related disorders such as depression, substance abuse, problems of memory and cognition, and other problems of physical and mental health. The disorder is also associated with impairment of the person's ability to function in social or family life, including occupational instability, marital problems and divorces, family discord, and difficulties in parenting.[485]

The high PTSD-associated symptom levels reported by a portion of this study cohort at the first interview represent women's initial distress, and may also be indicative or predictive of other social and emotional consequences, such as depression, anxiety and hostility. [235, 240, 241]

The following chapter explores three important symptoms (depression, anxiety, hostility) that are frequently detected among survivors of violence and observed by support workers assisting trafficking victims.[241, 242, 245, 261]

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CHAPTER 10: DEPRESSION, ANXIETY, HOSTILITY

10.1 Chapter introduction

This chapter describes the reported symptom levels suggestive of these three psychological dimensions: depression, anxiety and hostility. These are reactions commonly identified in individuals who have experienced one or more traumatic events.[235, 241, 244, 486]

Women's symptom levels are presented below following the structure of the three associated subscales of the Brief Symptom Inventory (BSI)—the instrument used to measure these psychological dimensions.[347] These symptom domains have been described by the authors of this tool, Derogatis, et. al.:[355]

Depression: The symptoms of the depression dimension reflect a representative range of the indications of clinical depression. Symptoms of dysphoric mood and affect are represented, as are lack of motivation and loss of interest in life.

Anxiety: General signs such as nervousness and tension are included in the anxiety dimension, as are panic attacks and feelings of terror. Cognitive components involving feelings of apprehension and some somatic correlates of anxiety are also included as dimensional components.

Hostility: The hostility dimension includes thoughts feelings or actions that are characteristic of the negative affect state of anger.

In the first section of this chapter, the overall symptom domain scores for depression, anxiety and hostility are presented. The next section describes how trafficked women's symptom scores might compare with those of an average US female population. This comparison is intended to put trafficked women's

symptoms in perspective and hint at the implications of women's psychological state and their ability to re-enter mainstream social interactions. The largest portion of this chapter is dedicated to discussions of the individual symptoms that comprise each of the three symptom domains. Although looking at individual symptoms is not a standard way of reviewing symptoms scored using the BSI, it is believed that this view offers important insights into women's post-trafficking emotions.

10.2 Summary trend of BSI subscale scores over three interviews

Figure 10.1 shows an overall picture of women's symptom patterns based on the average symptom dimension subscale scores for all women at each interview (calculated according to the BSI scoring templates and worksheet[355], see Methods chapter). Women's symptom levels for each dimension (depression, anxiety and hostility) decrease steadily over the three interview periods, with the greatest reduction occurring between Interviews 1 and 2.

From this perspective, it can be observed that depression symptoms were consistently the most severe over the three interviews. Depression scores declined most between Interviews 1 (2.09) and 2 (1.26), and reduced again by Interview 3 (0.78). Depression was an emotion that was mentioned frequently, and perhaps described most succinctly by one woman who said:

I feel like they have taken my smile and I can never have it back.
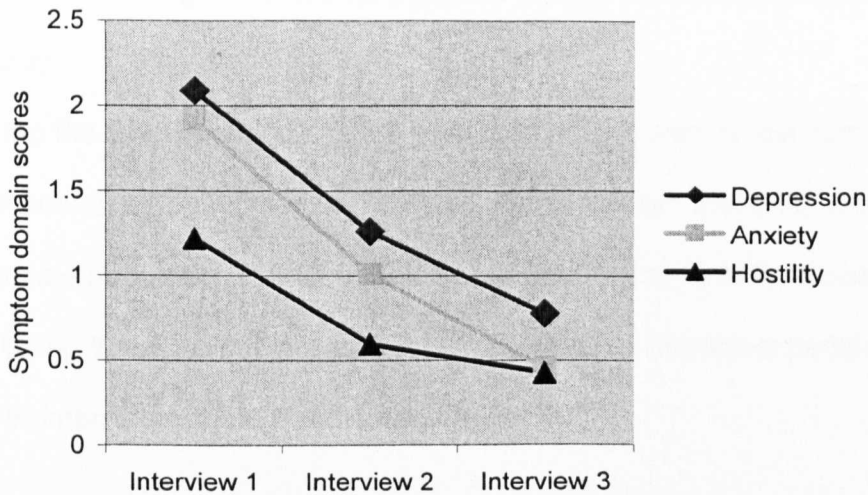
Figure 10.1 Average depression, anxiety and hostility scores for all women over three interviews (Interview 1: n=204; Interview 2: n=165; Interview 3: n=63).

Anxiety was the second most prevalent symptom, and followed a similar pattern to depression, taking a relatively steep decline between Interviews 1 and 2 (1.92, 1.01), and a more tapered reduction between Interviews 2 and 3 (0.46).

Hostility symptoms were reported at relatively lower levels than depression and anxiety (1.22, 0.06, 0.43). This lower symptom level may be due, in part, to a reporting bias. That is, women in service settings may have been reluctant to admit feeling angry or aggressive for fear that service providers might view them as a difficult client or unworthy of sympathy. However, the consistency of women's response patterns throughout the interviews and their comments suggest that this data on hostility reflects women's actual feelings.

10.3 Comparing trafficked women's symptoms to a general adult female population

While Figure 10.1 provides a promising view of women's recovery, a less hopeful picture emerges when women's symptom levels are compared to

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published norms for a general US female population (non-psychiatric patients).

(Figure 10.2)

Using the BSI weighting system permitted us to compare the symptom

dimension scores of the women in our study with the mean subscale scores for a

general female population ("adult female non-patient norms") in the United

States.[28] Using these norms, it is possible to achieve an important perspective on

trafficked women's psychological health. (Figure 10.2)
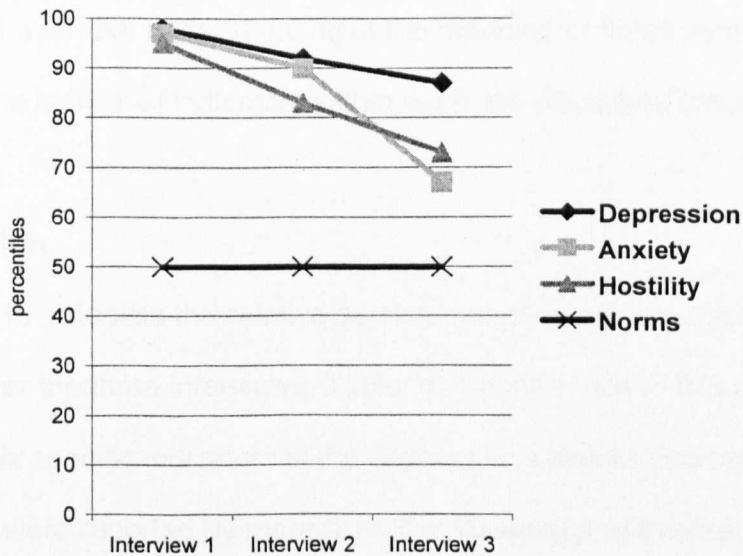
Figure 10.2: Depression, anxiety, and hostility levels for women over three interviews compared with these symptom level norms for an average female population (Interview 1: n=204; Interview 2: n=165; Interview 3: n=63).

When trafficked women's symptom dimension scores are compared to the

published norms for an adult female population, they are consistently above the

mean symptom levels of an average adult woman. Strikingly, at the first

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[28] The scores available for a general female population (i.e., non-patient) are taken from validated studies conducted in the United States. We did not have access to comparable sores for other female populations from Eastern or Central Europe.

interview, women's depression, anxiety and hostility levels were all within the top tenth percentile of a general population (98th, 97th, 95th percentile).

Significantly, by the second interview, symptom levels still remained comparatively high, with depression (92nd) and anxiety (90th) levels still falling within the 90th percentile, and hostility (83rd) just above the 80th percentile. It is only at the third interview when women's anxiety and hostility symptom levels (67th, 73rd) make a noticeable reduction. However, women's depression levels (87th) continue to remain very high compared to a general female population.

To gain a deeper understanding of the meaning of these symptom dimensions, the individual indicators within each are discussed below.

10.4 Depression

Figure 10.1 depicts the relative persistence of symptoms associated with depression over the three interviews. Table 10.1 contributes to this picture, detailing the six specific indicators in the depression symptom domain. All but one symptom were reported by more than 7 in 10 women at the first interview. Nearly all symptoms were so severely felt at this point that over half of the women ranked most symptoms in the upper severity levels ("very much" or "extremely). In fact, 5% of the women reported feeling each symptom of depression at the highest severity level (only three women reported feeling none of these symptoms).

Table 10.1 Reported prevalence and high severity levels of depression symptoms for three interviews (Interview 1: n=204; Interview 2: n=165; Interview 3: n=63)

Depression Symptoms	Interview 1		Interview 2		Interview 3	
	Any symptom reported (%)	High severity level* (%)	Any symptom reported (%)	High severity level (%)	Any symptom reported (%)	High severity level (%)
No interest in things	74	39	56	7	41	8
Hopelessness about the future	76	50	72	27	59	5
Worthlessness feelings	78	47	68	24	52	6
Loneliness	88	61	79	31	72	13
Depression/Very sad	95	64	90	31	75	11
Suicidal thoughts	38	16	9	4	6	2

*High severity level includes women who reported experiencing the symptom "quite a bit" or "very much/extremely".

The emotions within this domain that were most commonly experienced at the first interview were: "feeling very sad" (95%), and "feeling lonely" (88%). These were also those most intensely felt. Throughout the three interviews, both remained among the most strongly reported symptoms. As one woman explained:

> I wish to forget, but this is impossible. These memories will stay for the rest of my life.

Many women lamented that disturbing and frightening memories continually invaded their thoughts and worried that they would never be free of them.

Women also frequently associated their depression with their isolation and the time it left them to contemplate the past and future:

> I feel deep depression. I have a fear of being alone because I think so much.

Loneliness was a highly prevalent emotion that many women linked to being away from their family. The following were sentiments uttered by numerous women:

> *I miss my family. I feel so alone.*

> *I'm quite sad when I'm remembering how it was at home and I want to go home.*

Absence of loved ones was particularly difficult for women who were physically ill or psychologically distressed:

> *The worst feeling is feeling far away from my mother. Above all, now that I'm not well, I wish that she were here.*

Some women were contending with complicated personal histories of loss and loneliness, such as one woman who had been obliged to place her child in institutional care in her home country:

> *The worst emotion is loneliness, I think of my child who was fostered; I'm scared I won't see her again. I start to cry just thinking about it.*

The presence of others, even boyfriends, was not necessarily a source of comfort for women's loneliness. One woman explained that although she lived with her boyfriend and his family, she was unable to feel a part of their world, which reinforced her sense of being alone:

> *Nobody's with me. My partner has a lot of family and he eats with them, I eat on my own in the house. I feel like I am dead.*

For a number of the women, their boyfriends—both present and past—were a source of anguish. When asked to speculate about causes for sadness or depression, numerous women mentioned arguments with boyfriends, pangs of hope for long-term partnerships and longing for boyfriend-clients who had facilitated their escape, but had left behind.

While many women spoke of the day-to-day loneliness, a number of women also expressed a more universal sense of being alone, such as this woman who lamented, "I have nobody who loves me".

Several women recognised that enlarging their social circle was one way of avoiding loneliness, and perhaps their memories and associated depression. One woman speculated, "If I had more friends, if I was among a bigger group of friends, I could forget everything".

Among the more important individual psychological symptoms associated with depression is "hopelessness". At the first interview 76% of the women said that they felt: "hopeless about the future".

For some women, their expression of hopelessness suggested their fear of its permanence: *I have lost my last hope—I feel I have no way out.*

Comments often reflected women's feelings of paralysis. For one woman, the inability to mobilize her psychological and intellectual strength was cause to blame herself. At the second interview, she remarked:

> *I have one problem, which disturbs me even now. I don't think I know what I want. I want a lot of things but I'm not doing anything to get them.*

Nearly half the women also reported "feelings of worthlessness" at the first interview. What it means to have been "bought and sold" and its impact on women's sense of self is a question that was raised in the previous study on health and trafficking. While this was not a central question of this study, women's comments suggest that having been forced to sell their bodies for sex had altered their sense of themselves, their identity. It put into question who they had been, and who they would be now and in the future.

Many women recognised that they had become little more than merchandise. For one woman, this impression was sealed as she was dehumanised and felt mocked:

> *I felt hate and anger about how I was treated like a thing and not a person—that I was used and sold and they could laugh at me and make me do things I didn't want to do.*

Women participating in this study described how they felt dirty and disgusting to themselves. They expressed their lost faith in humanity and lost sense of themselves. For many, the impression of being contaminated and labelled gave them the feeling of being hyper-visible, particularly in relation to men. Identity, stigma and hypervisibility are discussed in greater detail in the following chapter.

Of particular note within this symptom domain is the rapid decrease in the number of women reporting the most severe levels of "feeling no interest in things". Reported levels declined from 39% to 7% between Interviews 1 and 2.

This decrease is likely to be directly related to the fact that the women in this study were under the care of a professional service provider. Particularly in destination countries, many of the services assisted women with access to training and educational opportunities, which is likely to have positively affected their active participation and their focus on goals. When asked about her hopes for the future, one woman in a destination setting said:

> *I would like to finish my education and work as a psychologist and have my own place to live.*

What causes women to regain an interest in life, activities and social interaction is an area that would benefit from further investigation to learn what type of support most effectively contributes to positive change.

Suicide

Suicide is the most extreme expression of depression. Suicide was an option contemplated by numerous women in this study. Women were asked how much they had "thoughts of ending their life". At the first interview, 48% of women stated that within the past week they had these thoughts. (Figure 10.3) Sixteen percent ranked these feelings in the upper end of the severity scale ("quite a bit" or "extremely").
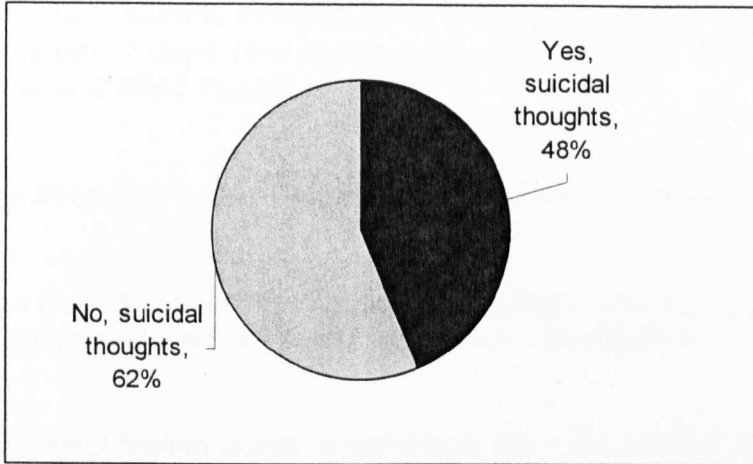
Figure 10.3: Percentage of women reporting suicidal thoughts at Interview 1. (N=207)

By the second and third interviews, suicidal ideation remained a consideration for 9% and 6%, respectively.

Reporting on suicidal ideation for some women appears to have been affected somewhat by the stigma associated with suicide, and the contradiction it held with women's religious beliefs. As it challenged their religious tenets, these women said they could not consider suicide:

I never have, and never will—it is so sinful.

Never. Only because I believe in God and I know that killing yourself is not acceptable.

A number of women who denied current thoughts of suicide admitted to having seriously considered it during the time that they were held captive. The following are several representative responses:

Not now, but I had those thoughts before in trafficking: to jump into a river.

I used to have suicidal thoughts while I was in the trafficking situation, but not in the past 7 days. Had nobody helped me, I'd have filled the tub with hot water and killed myself.

During the first interview, several women described their longing for an end:

I have a feeling of wanting to escape everything. I feel too scared to really do it and haven't tried or thought about how I would do it.

The strongest feeling is that of wanting to die. I feel tired of fighting and I feel alone.

The NGO partners reported that suicide is a very real feature of a post-trafficking psychological profile. One research partner stated that over the past year and a half, they had six suicide attempts, and a second NGO said that one of their clients had killed herself.

10.5 Anxiety

Table 10.2 details the six anxiety-related symptoms women ranked for this section of the study. "Nervousness" and "fearful" are the most commonly reported symptoms at Interviews 1 and 2. For those remaining in the study at Interview 3, "nervousness" remained most prevalent and most severe of the anxiety symptoms. Ranked third was "tense or keyed up".

Table 10.2 Reported prevalence and high severity levels of anxiety symptoms for three interviews (Interview 1: n=204; Interview 2: n=165; Interview 3: n=63).

Anxiety Symptoms	Interview 1		Interview 2		Interview 3	
	Any symptom reported (%)	High severity level* (%)	Any symptom reported (%)	High severity level* (%)	Any symptom reported (%)	High severity level* (%)
Fearful	85	48	71	15	43	10
Tense or keyed up	84	43	68	15	37	8
Terror / panic spells	61	18	33	4	8	2
Restlessness	67	37	51	9	19	0
Scared suddenly without reason	75	34	61	5	24	6
Nervousness or shakiness inside	91	48	81	19	51	13

*High severity level includes women who reported experiencing the symptom "quite a bit" or "very much/extremely".

Particularly difficult were occurrences that reminded women of their traffickers. One woman explained that when she saw someone who reminded her of her trafficker, she felt as if her "heart stopped". Women described feeling tense and keyed up by explaining that they were unable to sit still:

> I can't stay in one place for more than five minutes. I cannot relax like other normal people. I can't stop my thoughts from going back to my past experiences.

Importantly, a number of the women in this study who reported strong symptoms of anxiety were also participating in a criminal prosecution and specifically cited trials or testimonies as having caused distress or anxiety. Highlighting anxiety as the worst symptom they had experienced in the past week, several women spoke of the stress associated with legal proceedings:

I feel tension and anxiety during the meetings with the policemen.

After the interview with police I was really nervous. I wasn't quite panicking, but I felt very insecure.

For a number of women, this insecurity was related to the safety of their family:

I am in a court procedure, and I worry that my mother will be threatened.

For some women, their fears pervaded their waking moments and fuelled persistent anxiety. Comments such as the following arose frequently:

I am very scared and I am afraid of everyone.

One woman acknowledged that her anxiety tended to manifest in aggressive behaviours:

When I get nervous, I would burst, especially, on my youngest child, at whom I start yelling and paddling... And, it is always him first to bring me water, so that I can calm down. I hurt him! I feel so sorry.

Anxiety is a somewhat complex symptom to consider in the case of trafficking survivors, as many women still face real dangers related to their trafficking experience even once out of the situation. As one woman stated:

I am afraid that the traffickers will come after me. Because I prosecuted them, I am afraid of revenge.

This is particularly true of women who have had contact with authorities, who are participating in a criminal prosecution, who are returning to the place from which they were trafficked, and who still "owe" sums of money to their traffickers. It is useful to recall that 91% of the women were threatened while in the trafficking situation, many of whom were told that they would be harmed if they escaped, and that 37% reported that traffickers threatened their family.

Moreover, a significant number of women reported being trafficked by family members or by someone in their community.

While in care, women continued to express fear for their safety from the traffickers:

I am afraid of everything, even to go outside. The trafficker told me that if he finds me, he will kill me.

It is not uncommon for trafficked women to continue to receive threats by phone and in-person, both against themselves and their families. To date, protections by authorities have been extremely limited.[91] Women's manifestations of fear and anxiety very often are practical reactions to actual danger. This woman is one of many to report her fears of traffickers because of her association with law enforcement:

The thing I've most worried about is that they [traffickers] have my address and if I go home to do this trial [her mother reported this case to the police]

they can put this man in prison but his friends will know where I am and will not leave me alone.

Others related concerns about danger posed by other individuals unrelated to the traffickers, such as family members:

I am afraid of everyone; I do not trust anybody and I do not know what to do. My husband is an alcoholic and hurts me all the time.

Some women spoke of anxiety that seemed to torment or overwhelm them:

I am scared for no reason. I think that someone is behind my door, window. Someone will find me. Pick me up, beat me and kill me. My mood changes all the time. I cannot control my mind.

Much has changed inside, I'm scared, something has snapped inside

10.6 Hostility

Women were asked about five symptoms within the hostility dimension. At the first interview, the most commonly reported symptom was "feeling annoyed or easily irritated" (83%), and 41% rated these feelings at the highest severity levels ("quite a bit" or "extremely") (Table 10.3). However, as previously suggested, women's responses may have been affected to some degree by the wish to not attribute socially undesirable characteristics to themselves that might, in turn, negatively affect support workers' view of them.

Table 10.3 Reported prevalence and high severity levels of hostility symptoms for three interviews (Interview 1: n=204; Interview 2: n=165; Interview 3: n=63).

Hostility Symptoms	Interview 1		Interview 2		Interview 3	
	Any symptom reported (%)	High severity level* (%)	Any symptom reported (%)	High severity level* (%)	Any symptom reported (%)	High severity level* (%)
Urges to beat, injure or hurt someone	36	11	8	4	8	6
Urges to break or smash things	29	9	8	7	8	6
Frequent arguments	57	18	12	3	8	5
Annoyed / irritated easily	83	41	27	15	19	11
Temper outbursts that cannot be controlled	67	27	12	5	10	5

*High severity level includes women who reported experiencing the symptom "quite a bit" or "very much/extremely".

Women remarked that they were "easily upset", or "irritated by everything". Similarly, women described outbursts of temper that they were unable to control or comprehend:

> *When I was in the shelter in [Country], there were moments when I was throwing the food from the table and breaking different things.*

> *I explode at everything and at everybody. I hit my daughter*

Support workers at shelters also noted the problems associated with tension and hostility that frequently erupted into arguments between residents and, at times, hostility towards shelter staff.

Not surprisingly, a great deal of women's anger was aimed at their traffickers, and manifested in their desire for justice and vengeance:

I want to send the traffickers to the prison. If the law will not help me I will manage by myself.

Reflecting back on her emotions during the trafficking situation, one woman expressed her surprise at her own feelings of aggression:

...before, one customer asked me for "domination". He asked for a beating. First I said "sorry" to him. Later, I got very angry and I beat him very hard. Afterwards I felt very good. It is something that remains in my mind.

Women described punching walls, throwing items, and hitting others.

A number of the women who reported symptoms at a lesser severity in the hostility domain said that they had these feelings, but they were able to "control them".

10.7 Chapter discussion

The findings on depression, anxiety and hostility add further dimension to women's post-trauma symptomatology. Of particular importance is the comparative perspective of participants' symptoms in relation to the norms for a general population of adult females. This comparison highlights that even after several months of support trafficked women's mental health is comparable to some of the most distressed women in a general population. With this view, it becomes clear just how poorly prepared psychologically many women will be to function in "normal" daily life. That is, women who have been recently trafficked are likely to find it difficult to re-enter family, social or employment settings. As will be discussed, most women, when asked about their hopes for the future,

explained that they wished to re-establish a "normal life". Looking at the reported

symptom levels, this may be an elusive goal for many, particularly those who are

not accessing support of an appropriate duration.

This overview specifically emphasises the severity and duration of

depression symptoms. In contrast to the changes over time seen for anxiety and

hostility symptoms, depression levels do not seem to adhere to this same

downward slope. Even after several months with professional assistance, the

mean depression level for the women in this study remained within the upper 80th

percentile of women in an average population. This finding on depression will not

be surprising to those providing longer-term support to women who have been

trafficked or to other victims of chronic abuse.

While this study did not have the resources to continue long enough to

understand women's psychological status after six months or one year, support

workers strongly contend that depression is a symptom that not only persists, but

may fluctuate, or become worse over time.[487] This impression is supported by the

literature on depression and gender-based violence, which indicates that there is

a strong association between depression and childhood abuse, sexual violence,

and later abuse.[89]

The results in this section also highlight that suicide is a very serious part

of the post-trafficking symptomatology, as nearly half of the women said they had

considered it within the past two weeks of the first interview. This is an area of

concern that should be taken very seriously by service providers and

policymakers. Of particular interest to researchers and practitioners should be

the particular characteristics of those women who were still reporting suicidal thoughts after 12 weeks in care.

The slowly decreasing trend for depression-related symptoms suggests that for trafficked women to reach a population norm for this symptom domain it may be a long, if not interminable process.

The sustained presence of these symptoms strongly suggests that ongoing support, both from formal (i.e., professionally trained) and informal resources (e.g., family, friends) is likely to be of value, as studies suggest that coping in the aftermath of violence may depend significantly, *inter alia,* on the quality of women's support network.[260, 488, 489] Yet, the reality is that the vast majority of women around the globe who have been trafficked are unlikely to ever receive post-trafficking care.

Additionally, the data offered in this chapter show that anxiety is a symptom that may dissipate significantly in a service setting. While it is not clear whether this is a causal relationship (i.e., care = reduced anxiety), it can easily be speculated that women's sense of security under the care of professional service organisations contributed significantly to a decrease in anxiety. It is under these conditions that women may begin to allow the events of the past to become the past, and to move beyond their immediate fears—as further suggested by the reduction in arousal symptom changes measured by the Harvard Trauma Questionnaire.

The hostility levels reviewed reveal an important, yet often under-recognised aspect of post-trauma symptomatology. This data shows that in

addition to feeling sad and anxious, women are also likely to feel irritable, even

aggressive. To those untrained in dealing with victims of trauma, a woman's

hostility may mistakenly be perceived as ingratitude or anger towards those

trying to assist. Although symptoms of hostility may decrease along with anxiety,

even after several months in care survivors of trafficking may display levels of

anger that are in the top 30th percentile of an average population. For service

provision, this implies that anger management techniques might prove helpful to

women trying to move beyond a trafficking situation.

From this data, it is easy to speculate that in the aftermath of a trafficking

experience, for many women their mental health symptoms may be among the

most intransigent and painful health problems. The abuses perpetrated against

women appear to leave a deep, yet invisible psychological imprint. As one

woman in the study said succinctly:

My wounds are inside. They are not visible.

The constellation of symptoms identified in this and the previous chapter

may also have a negative impact on women's cognitive functioning.[177] Cognitive

impairment has serious implications for women's health, as well as for practical

matters, such as participation in a police inquiry, immigration procedures,

employment and making sound decisions regarding their safety, such as whether

to return home or seek asylum. In particular, as discussed in the *Physical health*

chapter, the prevalence of memory problems at this time may affect women's

credibility with authorities. While women may be haunted by their past in their

waking moments and their nightmares, they may still have difficulty providing

clear details of events, as has been demonstrated among other populations

exposed to trauma.[469] If women are not given sufficient time for the worst

symptoms to wane, cognitive distortions or memory lapses are likely to hinder

criminal investigations.

The two previous chapters on mental health outcomes have attempted to

outline psychological symptom trends, not to categorise all trafficked women.

Each individual will have varying reactions to their personal experience of

trauma. This means that it is important to assess each woman's needs

independently. What this data is able to offer is the information from which

service providers may plan their scarce resources and develop care plans to

respond to some of the most common reactions.

While the psychological symptoms presented in these chapters have been

discussed using clinical terminology, study partners who provide care to

trafficking survivors tended to describe women's symptoms as "normal reactions

to extremely abnormal circumstances".

However women's post-trauma reactions are labelled, for many the

emotional suffering appears to be a lingering and painful aftermath of the

trafficking experience.

CHAPTER 11: IDENTITY, COPING AND HOPES FOR THE FUTURE

11.1 Chapter introduction

There are a number of important psychological reactions that emerge among trafficking survivors that do not fall into "diagnostic" categories. This chapter discusses the changes that women perceived in themselves and their altered views of the world. Key issues discussed include: (1) loss of trust; (2) self-condemnation and guilt; (3) self-disgust and shame; (4) stigma; and (5) maturity, self-reliance and empowerment. This chapter also describes women's hopes for and worries about the future.

Identity and self perception are subjects that are frequently discussed in relation to persons who have been exposed to trauma. Herman suggests that those most affected are individuals who have experienced repeated abuse:

> People subjected to prolonged, repeated trauma develop an insidious, progressive form of post-traumatic stress disorder that invades and erodes the personality. While the 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.[186]

Sexual violence is considered to have particularly strong influences over an individual's sense of self.[177] This chapter attempts to highlight women's feelings about themselves and their impressions of how they are viewed by others.

Many of the feelings highlighted are both potential impediments and facilitators to women's resilience. Coping and resilience are subjects of

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considerable discussion in the literature on trauma.[490, 491] Coping has been

defined as:

> A person's constantly changing cognitive and behavioural efforts to
> manage specific external and/or internal demands that are appraised as
> taxing or exceeding the person's resources.[492]

There is a wide range of strategies that might fall under the heading of "coping".

Studies on post-trauma coping, for example, suggest that psychological

strategies that include cognitive distancing (e.g., didn't let it bother them, tried to

forget, etc.), positive thinking and acceptance lead to improved coping instead of

self-blame

This chapter provides an overview of the range of emotions that women

were grappling with during the post trafficking period and some of the strategies

they felt were useful as they tried to move beyond the trafficking experience.

Women's beliefs about their future are an important indicator about how

they are coping. The data below, which is primarily qualitative, describes the

wide range of hopes and expectations were for the women in this study.

Figure 11.1. Percentage of women reporting that being trafficked changed how they felt about themselves. (n=196, n=155, n=55).
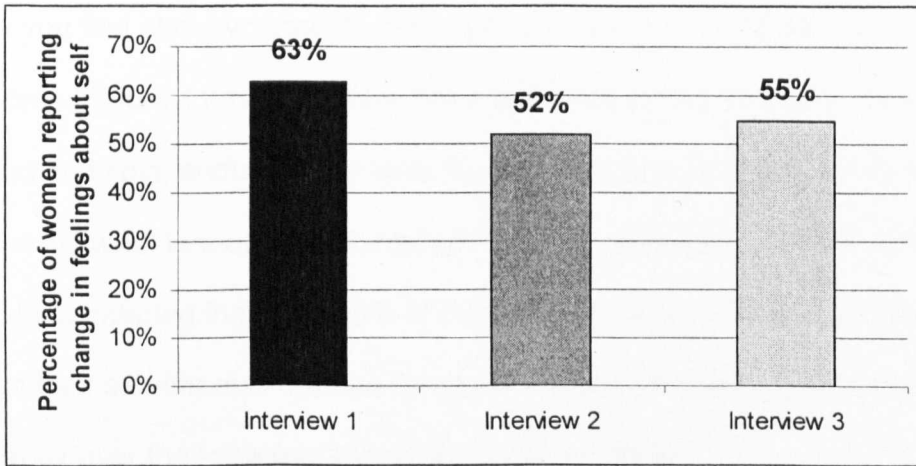
11.2 Identity and self-perception

When women were asked: "Do you think that being trafficked has changed the way you feel about yourself?", the majority said they felt differently about themselves (Figure 11.1). For many, the experience of having been deceived, marketed and sold, endured work they found degrading, and having lost control over who did what to their bodies, had altered their perception of themselves.

Upon entering the care, 63% of the women said that trafficking had changed their self-impression, and the prevalence of this feeling did not alter significantly over the following interviews (52% and 55%).

As will be discussed in greater detail below, women's altered self-perception included feeling dirty, guilty and ashamed. Many expressed an inability to slip back into their former roles, and a sense that others would also see them differently, as well.

11.3 Loss of trust

Profound mistrust was a reaction reiterated by the women in this study. Some women were deceived and led into the trafficking situation by strangers or acquaintances, others were tricked by family members, boyfriends, or other persons who they believed cared for them. For most women, this first deception was the most cutting and was generally followed by a series of events and circumstances that caused them to continue to lose all faith in their fellow human beings. A significant portion of the women in each country repeated similar refrains:

> *I do not believe in anyone and I am afraid of everyone.*
> (A woman who was trafficked twice)

> *I have become less communicative, less trustful, more isolated.*

For the many women who had been trafficked by someone who should have been trustworthy, they associated their newly-founded mistrust with this type of encounter:

> *I was tricked once and will never trust anyone again.*

> *At the beginning I thought that my fiancé didn't know anything. Then I found out that I had been sold by "my husband".*

> *I went to Turkey because somebody promised me a good job, but I was tricked and sold. I was too trusting.*

For some women, the trafficking-related deception had been preceded by other experiences of betrayal:

> *One friend and his two friends raped me and that's what led to being trafficked. Before that, at 18, somebody I trusted raped me.*

A number of women understood their mistrust as a loss of naïveté and gaining of a protective scepticism.

> *That which has changed is both positive and negative—before I was too trusting, now I'm not.*

> *Now I do not trust anyone, and thus, no one trusts me. I am strange to them now.*

11.4 Self-condemnation and guilt

Women's repeated phrases of self-condemnation echo service providers'

contentions that women frequently blame themselves for what happened.

Women perceive they were guilty of falling prey to a dubious offer, having

'agreed' to do work that was odious to them, and guilty for not having found a

way to free themselves. The following comments suggest women's views of their

culpability:

> *I suffer from feelings of guilt; that I could have envisaged what can happen—and, now, what attitude people will have towards me? I have strong feelings of being guilty!*

> *I feel very stupid that I didn't recognize the traffickers and left my children without me.*

Self-condemnation is a response often associated with more intractable mental

health morbidity.[180] With less than clear hindsight, women inconveniently forget

the many difficult circumstances and hopes for a better future that motivated

them to seek income and a better life for themselves and their families:

> *I feel guilty. I blame myself that I was not able to foresee this tragedy.*

Particularly in the early stages of recuperation, women felt harsh pangs of

remorse for what they believe they "allowed" to happen to themselves and for

what they were forced to do. As one woman stated, *I hate myself for what I did.*

For some, self-condemnation extended beyond the circumstances, and

was a verdict on their character:

I am too weak. I consider myself a person unable to achieve anything.

How could I end up like this? I knew so much! When I returned back, I thought that I do not deserve to live together with my husband.

11.5 Shame and self-disgust

Women repeatedly stated that they were repulsed by what they had done and felt irreparably tainted. They believed that this contamination was visible to others. The term "dirty" was uttered numerous times by women from various countries. The following comments are emblematic of numerous women's feelings of disgust[29]:

You always remember what has happened to you, you are not clean like you were before.

I am bad and dirty.

I always feel a "sediment" or "dirt" inside of me.

I think I am a dirty person and I cannot look in anyone's eyes.

Women regularly referred to their "low self-esteem". When asked what she most wanted in the future, one woman replied:

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[29] On a practical service level for care providers and health workers, it is important to understand that women's sense of being "dirty" may also contribute to women's urgent desire to be treated for sexually transmitted infections. As previously mentioned, while working, women reported the need to douche, or to "clean" themselves deeply. In addition to being a necessary part of physical health care, gynaecological treatment may also be an important first step in psychological care.

I picture myself as beautiful. I want to be happy with myself. I want to forget all that I have done, all that has happened to me. I want to be a different person...like the others.

For some, the way in which they had violated their religious tenets also contributed to their self-condemnation. While women were not asked specifically about their religious beliefs, a number of them volunteered comments about the difficulty they were having reconciling their recent past with their faith. For example, in contemplating how to communicate what had happened to her mother, this woman explained:

My mother asked me where I have been all this time and I said that I do not want to talk about this. I think she deserves to know the truth but I am ashamed in front of her and I am afraid of God.

The loss of self-respect and self-confidence in key character realms, intelligence, morality and respectability appeared to socially incapacitate numerous women.

11.6 Stigma

Sexual abuse and prostitution are highly stigmatised.[12] In response to the question, "Do you think that being trafficked will change the way others feel about you?", 37% believed that what had happened to them had changed or would change the way others viewed them, 46% said "no" it would not change other's opinions, and 17% replied that they did "not know". (Table 11.1)

Table 11.1 Percentage of women reporting that being trafficked changed how others felt about them.

	Interview 1
Do you think being trafficking will change the way others feel about you?	**%** **(n=195)**
Yes	37
No	46
Don't Know	17

Many of the women said that no one was aware of what happened to them, and it is likely that the number of "no" responses include those who thought others did not know, i.e., others would have no reason to view them any differently:

> It has not changed the way others feel because no one knows and I hope no one will ever find out.

Among the women who believed others' views of them would change, many had the impression that people somehow knew or would know what they had done, and that their opinions would be primarily negative:

> I feel that no one could be proud of me. When someone says that I'm pretty, I want to punch them. I will never be how I was before it happened. I cannot be happy, can't make myself happy.

> I feel that everybody knows about my experience, I feel ashamed and I hate myself.

Women repeatedly said that people would think of them as prostitutes or whores:

> Even my relatives think I am a prostitute.

> My neighbours think I am a prostitute.

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My friends think I am a prostitute.

People consider me a prostitute and keep asking me disgusting questions.

In forecasting the opinion of others, many women surmised they would encounter little understanding or sympathy—only disdain and derision. These thoughts clearly plagued them as they considered returning to a 'normal' life:

> *If anybody on the streets was to know I had been a prostitute they would just think I am cheap, worthless.*

> *There are people who think that you like being trafficked. They look at you in a strange way—even policemen.*

Women were certain they would be labelled, blamed and stigmatised. They feared enormous difficulty reintegrating into their families and communities.

> *I think that everybody knows what happened to me, and they think it is all my fault.*

> *The people around me do not respect me anymore. I am afraid to leave the assistance centre because I fear they will call me a 'prostitute'. They all consider me different from other normal people.*

Women worried immensely about the reaction of family members, and of parents, in particular. Some women had already been informed that they would not be welcome at home:

> *I'm from a Muslim home. They stone prostitutes to death.*

> *My father and other relatives hate me and don't want to see me ever again.*

I hear voices judging me, calling me 'bitch' and 'prostitute', even though they made me one. My parents won't look at me how they did before, especially my father.

One woman remarked that because she felt as if she was a different person from the woman who left home, this would affect the way others related to her and how she related to them:

I feel other people's opinions of me will have changed because I have changed so much. I am not the same person; people see me differently. I won't be able to look my brother in the eyes any more.

For the women who had already tried to re-enter their previous existence, fears of isolation or rejection seemed to be realised in their perceptions, if not also in reality. The implications of having been sexually exploited were particularly daunting for those who were married, and threatened the future of their relationship.

My husband probably thinks that I was not forced to prostitution. He thinks I did it voluntarily.

My husband told me that I am a prostitute.

It appears to be fairly common for women to avoid revealing the truth of their ordeal to spouses or boyfriends for fear of losing them.

My hope is that my boyfriends never find out. He is the type of man who will never touch me if he finds out I've been with someone else.

The challenges associated with non-disclosure were difficult for some:

My husband has no idea about the trafficking experience. Since that time, we sleep in separate beds. However, he expects some initiative from my side, which I am unable to show.

Once back home, I returned with Trichomoniasis (STI). My husband found out. I told him that was raped.

For many of the women in this study, the stigma had so deeply infiltrated their thoughts and identity that a number had the impression others could somehow intuit or detect that they had worked as prostitutes. They felt as if they wore their shame—as if their past was visible:

People look at me differently, and I do not know why. Nobody knows of "my story" in [city], I am 100% sure, but they still look at me differently.

I have a permanent feeling that the entire world knows—actually nobody knows about this. A small boy passed by me, and, I felt he knew everything about me.

A number of women expressed a sense of heightened visibility—they had the impression that others were staring at them. This hyper-sensitivity to other's gaze was felt particularly strongly when women were in the presence of men, especially for women still residing in a destination country.

I feel like eyes are focused on me. Men approach me in public places.

When I'm walking in the streets or in the shops, I think people are looking at me. Men look at me like they are hungry and want to eat me.

When asked about other's perceptions of them, a few women had very positive descriptions of the carers in the assistance centre. One 16 year-old girl, who reported having been regularly abused by her mother and her mother's boyfriend, stated:

> *Because of my experience of trafficking, many people started to care about me whereas nobody needed me before.*

11.7 Maturity, self-reliance and empowerment

Although many women described very negative changes in their self-perception, there were numerous exceptions. Particularly during the second and third interviews, some women recognised the strengths they had gained as a result of what they had endured. Some felt they had become wiser, more mature and more self-reliant:

> *In truth, I have grown up. Earlier, I was a child, now I am a woman.*

> *I learned a lot about myself and about my mistakes. I feel matured, anyway. I think more rationally. I have life experience.*

> *I became smarter. I am confident of not getting into such a situation again.*

> *It's made me stronger. I don't know how I'll be feeling in the future, but for now I feel stronger.*

Yet, this maturing process was not viewed positively by all:

> *I have gotten older. Three months were like three years.*

Quite a number of women were able to recognise—even at the first interview—that surviving such an ordeal had made them stronger. Rather than destroying their ability to take control of their lives, they were more determined than ever to be independent and make decisions for themselves. This sense of empowerment and self-determination was evident in many of their observations:

> *I have arrived at the conclusion that having survived such an experience, I have become stronger now.*

> *I have become more calm and self-confident. I try to solve all my current problems by myself. I have learned to be independent.*

While the self-confidence of many had been lost amidst the degradation, for some women, reclaiming their sense of self and their self-esteem was possible. In the most positive sense, they took pride in their strength:

> *I am not afraid of anything, after all that happened to me, nothing scares me anymore.*

> *I understand that I have a "myself"—that I have survived and haven't lost myself. I survived!*

Having endured and emerged from the experience had inspired some to assist others:

> *Perhaps it changed me for the better because I feel so strong and capable of overcoming many things. I even feel ready to help other people.*

> *I am a doctor, I want to speak with women in my country about my experiences, I want to speak with journalists about this problem.*

11.8 Disclosing their experience to others

Like the women interviewed during the formative study, women in this

study also chose not to talk to others about their ordeal. When women were

asked whether they would tell anyone outside the assistance centre about what

had happened to them, most said that their anticipation of ostracism and

negative reactions made them to feel unsafe to disclose their stories. As one

said:

I will pretend like nothing happened.
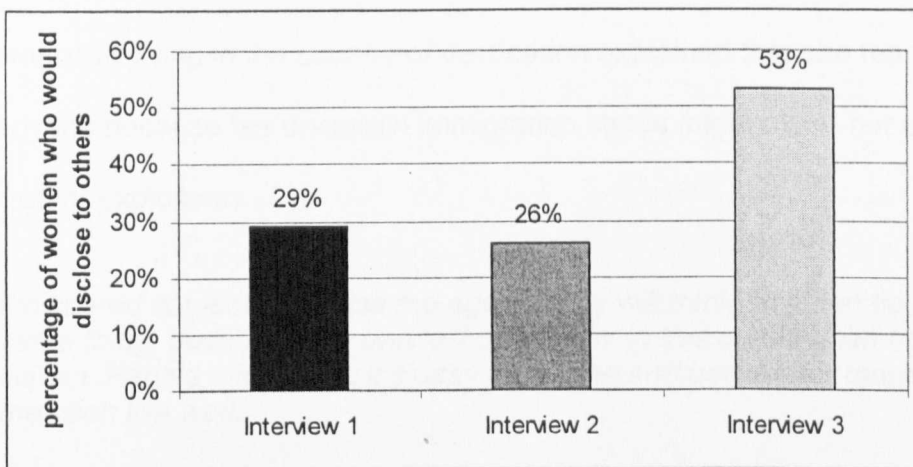
Figure 11.2. Percentage of women reporting whether they would disclose their experience to someone outside the assistance centre (n=193, n=158, n=62).

Less than a third of women during the first two interviews felt they would

be able to disclose their experience to others. (Figure 11.2) Of those remaining in

care at the third interview, only 53% planned to, or had revealed their recent past

to someone outside the assistance centre.

Women's primary reason for not telling others was their expectation of

shame. One woman explained:

The main problem of sharing my experience is the feeling of shame—that I let myself be tricked so stupidly—me, who I considered to be smart enough. If I ever tell somebody, I think they will judge me, they will think that I knew where I was going. It will be difficult to convince them that I did not know anything before departure, since I always looked attractive. By the way, now my hair is totally grey.

Other reasons women rejected the idea of telling others included their preference to put the experience behind them—to "try to forget". In disclosing to others, women felt they would relive events:

I do not want to remember this nightmare.

One woman still living in the country of destination explained that she feared telling anyone because her uncertain immigration status might make her easy prey for other exploiters:

I'm scared someone will use me again. They will think they can do the same thing, because I am only a 'half person' in this country. I'm not a full citizen. People might think it's easy to sell me and use me for money so they can live well.

Several women indicated that they would not tell because they did not want to burden loved ones with their problems:

It's my problem. I don't want my mum to worry.

It really wouldn't help my family or boyfriend to know. They wouldn't understand it and because they have problems of their own.

Women seemed to be fairly adept at keeping their secret. One woman who had been trafficked twice explained:

How could I trust anybody? No one knew after the first time [being trafficked] I even lied to my mother.

Yet, numerous women reiterated that they felt able to speak freely with support workers at the NGO:

Yes, with assisting organizations, as the confidentiality approach is guaranteed, and never with relatives and close people.

By the second interview, a number of women had forgiven themselves and thereby felt they were more ready to disclose what had happened to others:

Now, I think it is not my fault, and I can talk about it to others.

Of those who wished to share their experience with others, or who had already done so, they most frequently cited family members as trustworthy. Women mentioned parents and siblings, in particular:

[I will tell] my mother and my brother because my brother is the only one that can help me, and my mother had unintentionally involved me in this.

Some women recognised the value in sharing their experience with others in order to warn them against dangers such as trafficking.

I will talk about it only with girls who are thinking of travelling abroad. I will not necessarily say that I myself was in such a situation, but I can still tell them what can happen there.

First I will talk about it with my husband, then to my kids when they're grown up. Because I don't want them to do what I have done.

One woman understood both the risks and benefits of disclosing her story:

I'm not sure. Maybe some people could call me "dirty whore", but for others I might be a girl who can give them good advice.

Several women reported that they could tell others because they had also been trafficked:

I will tell my cousin because she lived through the same experience as me.

A number of women stated their reluctance to tell boyfriend for fear of being rejected:

I am afraid that when my boyfriend finds out the truth, he will leave me.

In contrast, some women believed that they could trust and rely on their intimate partners for support.

With my current fiancé, he understands me; he knows that I'm suffering.

It is worth noting that a number of women had developed a relationship with an intimate partner while they were in the trafficking situation. This poses a unique set of questions that deserve further study.

Women did not always have the best outcomes after disclosing their past to someone who they felt could be trusted. One woman who had shared her past with her priest explained at her second interview how she felt betrayed:

I feel angry with the priest who started by helping me, but now judges me and tells me what to do. It reminds me of people telling me what to do before. I shouldn't trust people. I have to push them away again. I must recognise who are the people I can trust.

As will be discussed below, disclosure to intimate partners did not always result in acceptance.

11.9 The future, women's hopes and worries

Women were asked to speculate the "best future they could imagine" and to ponder their hopes and dreams. For the overwhelming majority of women, their best future was a "normal life". Few asked for much more. A "normal life" generally included "job", "family" "children" and a "home".

I want to live like normal people. I want to have children.

I want to marry, to have children, to have a normal life.

Most women also recognised that having a job was a priority:

When you can work, you can make everything else possible.

I want to find a job, to support myself and my child.

In many ways, thinking about employment was a sad reminder of why they were exploited in the first place, and that they were effectively back where they started: unemployed and poor. One woman reminisced:

I would wish to have old times back [i.e. Soviet times]. I used to have a very good, leading and well-paid profession to be able to support my children.

For many, especially the younger women, the picture of their immediate future included education:

The best future I can imagine is if I manage to go to college and I train to become a nurse. I don't want my life to be useless. I want to feel useful, I want to work. I want to be now, how I wanted always to be. I want to use my brain. I want to be a good girl. I want to be proud of myself.

For some, to obtain these simple requests seemed idyllic:

A job, and then a good husband with whom to have a family—'a fairy tale'

Others feared that these wishes would be spoiled by their recent past:

In the past I wanted to finish my education and get a good job. But now with the talk in [home town], I'm not sure.

When considering their most fervent desires, a number of women could not avoid reflecting back on the horror of their experience and worry that their loved ones might someday fall prey to exploiters.

I hope my children will not have the same experiences as I have...that they will not meet bad people and nobody will beat them.

Numerous women stated that their future was all about their children.

To raise my daughter so that she can become a good person. I do not care about myself.

Not surprisingly, some simply wished to "be happy".

As most women had just been freed from the hands of their exploiters, many were focussed on the concept of justice. They wanted their tormentors to be punished:

> *My greatest hope for the future is to punish the one who sold me.*

> *I would like justice to be done, for traffickers to be punished and put in prison. He treated us like dolls. I would tell him that we are women—that would satisfy me. I want to show the men who raped me that they haven't broken me I want then to know that.*

One woman wanted to demonstrate her survival to those who had abused her:

> *I want to show the men who raped me that they haven't broken me...I want then to know that*

For some women, their thoughts of the future were somewhat existential. These women were not only bereft of notions of what they would or could do in the near or longer term, they felt incapable and fearful of having dreams of the future:

> *I don't know how to live in this life. What I am supposed to do or how to survive. Too much is uncertain in my life. I don't know sometimes where I am or where I'm going to go.*

> *I don't have dreams for the future. I'm afraid that [the traffickers] will find me and disturb me. I want to get back on my feel but I can't imagine how.*

Psychologists on the research team pointed out that when women's assumptions about the world have been so violently altered, when they are

confronted with such a myriad of self-doubts and doubts about others, they are afraid to make decisions or plans. They fear being wrong again. In this way, their view of the future, of what is possible is seriously askew. Women's paralysis in the face of time was evident in comments such as: "What do you mean by 'future' ?" Their comments revealed how immobilised women felt:

I'm feeling hopeless and I feel tense, I do not know how to live.

I worry most about having no future. I don't know where to go from here.

When the research partners gathered for the data analysis stage of the study, the psychologists and support workers attempted to describe this paralysis. Psychologists Tchomarova from Bulgaria and Kefurtova from the Czech Republic described this paralysis:

> For some period, women can't think past where they are at that moment...it is difficult it is for them to look to tomorrow. It's like a hole. This reflects depression and a condition of lacking internal resources.[493, 494]

The psychologist from Italy noted that women's feeling that they "did not have a future" may also reflect a realistic comprehension of their state as a social outcast."[495]

One woman in the study pointed out how her self-determination had been effectively disabled by having been directed by someone else for such a long time. She recognised that it had pushed her into an unwelcome state of indecision and apathy about her future: [186]

> *Sometimes I don't see the point in doing anything. It seems useless.*
> *When someone has controlled you and made decisions for you for so*
> *long, you can't make them for yourself anymore.*

It is not uncommon for individuals who have been trapped in slavery-like

circumstances to lack the confidence reclaim full decision-making power[496] Some

women recognised the effort it took to look towards a future:

> *Istri ve for the future and force myself into planning it.*

Planning for the future was particularly difficult for women who tested positive for

HIV. They were inundated with feelings of fear and hopelessness. When asked

about the future, one eighteen year-old woman who was HIV positive and four

months pregnant stated through her tears, *I believe I will die soon.*

Conversely, for some of the women, this question about their future was

their opportunity to express that they did have plans and hopes. Particularly by

the second interview, many women were more positive in their responses:

> *Now I know what to do in order to change my life so that I can achieve*
> *some results. When I am back, I will get training to become a*
> *cook/waitress. For the first time in my life somebody [NGO support*
> *workers] is helping me unconditionally. I appreciate this. I will try to*
> *change my life.*

> *Now I started college and I am happy.*

Women's feelings about men

Women were asked about their future, many women voiced their disdain for and distrust of men. The following are a sample of the many comments expressing women's rejection of men:

I am afraid of people, especially of men.

My perfect future: no man...sweet family, my family, big house, garden, and a little business.

I want to live in [Country] with my son and I will try to find the job there—but I don't want to have any man. I hate them.

For numerous women, a history of male violence—even before the trafficking experience—dictated their impression of men. One woman lamented that past abuse had caused her to question her ability to evaluate a potential mate or enter into a supportive relationship. For this woman, these doubts seemed dire:

[I want] a good husband, family, job, children. I am worried about the man who I will meet. I want him to be a good person, but I don't know how I will be able to judge him. When your childhood was awful, and from then you got married in the same way as your parents, and then this [trafficking] happens to you...in such case, it's better for you to die than to live.

Many women were apprehensive that they would now be unlovable; that what they had done meant they would never wed.

Sometimes I do see myself married with children and a normal life, like everyone else. But that doesn't last, as I am always reminded of the things I have done and think "who would want a cheap, worthless person?" I am worried that no one would ever want to marry me.

Women's views of men frequently seemed contradictory. On the one hand, they based their hopes for the future on having a husband and family. Yet, they repeatedly declared their disdain for and hatred of men. Some recognised the incongruity of these feelings:

> *In my ideal world I'd like to have my own home. A family. A normal life. But I will never have it because I hate all men.*

> *My dream is to have a nice job, to have a baby and not be alone-- because I don't want a man, as I don't trust them. I don't see happiness with a man.*

Although the sentiment was not common, a few women described their newly acquired self-reliance and independence from their partner, as this woman explained:

> *Now, I feel more confident in myself. I do not argue with my husband anymore. I only told him that I always could replace him.*

Unlike this woman, for many, their future relationships with men and their capacity for trust and intimacy is likely to be negatively affected by having been so profoundly deceived and repeatedly sexually exploited. This is of particular concern for adolescents, who are still undergoing stages of relationship and sexual maturing.[497]

Women's worries

When, at the first interview, women were asked: "What are your worries and fears?", a majority included in their list "the fear that the trafficker would find them and harm them or their family members".

I am also worried that if the man who forced me to live with him (trafficker) is not put in prison he'd find me and kill me or hurt my family.

I fear for my sister because she is still a virgin and young. My exploiter could hurt her.

I am afraid to return to my country and be trafficked.

For many, these thoughts did not dissipate, even by the third interview. They continued to feel that they may be spotted on the street by their exploiters, or that the traffickers would pay a visit to their family.

A number of women found it difficult to imagine that this experience might not happen again. Particularly for women whose past involved abuse, their expectations of safety were limited. One woman who, prior to being trafficked, had been repeatedly abused by male family members said:

I am afraid of men doing something to me again.

Health was also an expressed concern. Particularly at the first interview, as previously discussed, many women understood that it was highly likely that they had contracted a sexually transmitted infection (STI). Some were recovering from an illness. Very often concerns about STIs were directly linked to women's apprehension about being infertile.

I am afraid that I will not be able to have children.

I am really worried I could have caught infectious diseases which could affect me

For women who had been diagnosed with HIV, this was the overwhelming focus of their fears:

I'm so scared of my illness [HIV].

I am afraid of death.

Disclosure of STIs posed particular dilemmas for women with intimate partners:

After I come home, I will have to tell him he needs treatment (for STIs).

Several women with serious mental disorders, a number of whom had been or were hospitalised, understood that their psychological problems could prevent them from regaining their lives. One woman stated:

My greatest worry is to not succeed in being ok.

Particularly by the second and third interviews, the most common apprehension was related to the future:

I am afraid of the future.

I feel uncertainty and fear of not succeeding.

I don't know if I will succeed in doing everything, and I worry about my ghosts from the past.

A number of women talked about justice:

My worry is not managing to punish the one who sold me.

A very few had acquired a strength and independence that dominated any fears:

I am not afraid of anything.

11.10 Chapter discussion

After a trafficking experience, most women seem to contend with a wide range of emotions, as they revise their perceptions of themselves, reflect on memories of the past, and deal with their apprehension and hopes for the future.

Women in this study appeared to have significant difficulty reconciling who they were and who they had become. To some degree, many seemed to have lost their identity. The experience of abuse, particularly sexual violation and exploitation, had left them feeling dirty—for some, irrevocably soiled—no longer the person that they once had been. Issues concerning identity have been recognised as part of the post-trauma aftermath in other studies, such as those on PTSD in political prisoners.[447] Research suggests that this loss of identity can go as far as losing one's sense of being human, which may occur when one reaches "mental defeat", or a "state of giving up in one's own mind all efforts to

retain one's identity as a human being with a will of one's own".[448] Researchers surmise that women whose memories reflected "mental defeat" and those who developed an "overall feeling of alienation or permanent change", or were unable to "return to their normal selves" were more likely to have negative mental health consequences [448] They were also less likely to respond well to common forms of treatment for PTSD (e.g., exposure treatment).

The trafficking experience had left many women feeling lost and defeated. For some, this was not their first sense of "defeat". As previously discussed, many came from difficult backgrounds of abuse, neglect or family dysfunction that had previously damaged their self-esteem. Researchers on abuse and coping have associated defeatism with feelings of worthlessness:

> [R]epeated and systematic physical and emotional attacks, characteristic of abusive relationships, also undermine an abused woman's self-esteem and may contribute to her view of herself as worthless, inadequate, unlovable and deficient, and ultimately lead to depression.[244]

This helps to explain why research partners in this project state that an initial focus of their work with women who have been trafficked is to assure the women that what happened to them was not their fault that they are victims of, rather than responsible for, the deceptive and cruel behaviour of others'.

How women intellectually process the abuses inflicted upon them appears to be correlated to women's psychological state, according to research on shame and stigma. Researchers propose that the way an individual perceives the reasons that the abuse occurred, or the causal inferences she makes, can

directly affect her subsequent feelings of shame. Lewis outlines three influential

dimensions:

> (1) internality (self is the cause) versus externality (someone or
>
> something outside is the cause);
>
> (2) stability (the reason will stay the same) versus instability (the
>
> reason may change); and
>
> (3) globality (the reason affects my entire self or everything that
>
> happens to me) versus specificity (the reason applies to a particular
>
> event or aspect of the self).[498]

Feelings of shame are said to be most indelible when the attributions a woman

applies to the event are internal, stable, and global—e.g., "this happened

because I am a [bad, stupid, worthless] person".[498] Moreover, models on

stigmatization suggest that "shame" (versus guilt) is a core element leading to

stigmatization.[440]

In turn, shame and stigmatization are psychological and social outcomes

of sexual abuse that are strongly associated with poor mental health, and

depression in particular.[440, 488]

It is possible that for many trafficked women, they will experience an

amplifying interplay between their own sense of worthlessness and

powerlessness and their anticipation (or actual experience) of stigmatisation by

family members and others (e.g., boyfriends, husbands, parents, community

members). This multiple sense of isolation and rejection may persuade some that

they are in fact, undeserving social outcasts—which they may in turn, make their reality.

The most obvious manifestation of stigmatisation is women's decisions not to disclose their ordeal to others. Women who do not confide in persons close to them are thus obliged to live silently with their past and, often with its many invisible health consequences—and risk losing the support that is considered important to recovery.[304] Women who maintain their secrets may live alongside family members who observe seemingly inexplicable physical and sexual health complications, mood swings and other manifestations of what they have been through. However, when they weighed the perceived likelihood of rejection versus appearing to be difficult or distant, anxious or angry, many appeared to choose to maintain their secrets.

For women who were married or in intimate partnerships, their mental health repercussions place potentially great stress on their relationships. Findings from one study of Bosnian immigrants in the U.S., for example, indicated that Post-traumatic Stress Disorder (PTSD) had a significant effect on marital satisfaction.[313] The difficulty of returning to a marriage after this type of traumatic and stigmatising experience is a complex subject in need of further investigation—particularly given the number of women who will try to return to or will eventually enter into an intimate partnership.

The "future" was an important area of investigation in this study. Women clearly had strong feelings about the future. They had both fears and hopes. Those women who expressed an inability to imagine or plan for the future are of

particular concern. Research on survivors of sexual violence found actively deciding to put traumatic memories in the past and to be more forward-looking was a positive form of cognitive processing that was associated with better coping and greater resilience to trauma.[260] This would suggest that women who perceived that they had "learned" or "become stronger" from their experience might be advantaged.

Similarly, independent decision-making, confidence and control have been identified as potentially influential factors related to better mental health.[249] For example, Clements, et. al., found that, for battered women, self-blame and lower capacity for problem-focussed coping were associated with dysphoria, or depressed and anxious feelings, while women who had higher expectations for control over future events in their lives had lower levels of dysphoria.[249]

Considering the findings in this chapter together with the other symptoms discussed in previous chapters highlights how women in this study were frequently dealing with a variety of physical pains and seemingly intractable distress. Whether women are attempting to adjust to a destination setting or they are trying to reintegrate in a home country, their tumultuous physical and inner psychological world is set amidst a social and/or political environment that is often stress-filled and alienating.

In this study, many women were able to find an inner strength, were able to voice hopes, and sometimes plans for their future, which demonstrates a resiliency that not all women found.

CHAPTER 12. DISCUSSION

12.1 Chapter introduction

The two studies conducted for this thesis were among the first to investigate the topic of health and trafficking. Forging an inquiry into this new area of research was challenging both conceptually and methodologically because of the absence of formative work, the vulnerability of the study population and the sensitive and political nature of the subject.

Conceptually, initiating research on trafficking broached questions such as how to conceive of health in a trafficking context; the possibility of detecting a common range of health risks and outcomes, and identifying realistic intervention possibilities.

Methodologically, these studies also posed numerous dilemmas, including how to conduct rigorous research using ethics-based techniques, how to take into account the particular vulnerabilities (e.g., personal safety, trauma) and support needs of participants, and determining what tools are appropriate to use with a cohort of trafficked women.

This final chapter will summarise how these studies have contributed to both the methodological and substantive body of current and potential future work on health and trafficking. I will first outline the challenges and limitations of the studies presented in this thesis. I will then discuss the implications of the findings from both the formative work and the multi-site survey. These discussions will begin with descriptions and implications of the conceptual models developed for these studies, followed by discussions of selected study

findings, and concluding with a discussion of the lessons learned about research methods for studying the health of trafficked women. Each of these discussions will offer a summary analysis of the findings and recommendations for future directions for policy, intervention or research.

12.2 Challenges and limitations

As one of the first studies on this highly sensitive subject, the challenges and limitations were numerous. This work was complicated by certain key issues:

- absence of existing information, previous studies

- social and political sensitivities of the topic

- ethical and safety considerations

- difficulty accessing safely the study population

- diversity of trafficking situations (e.g., multiple regions, cultures, trafficking methods, interpersonal dynamics between trafficker and trafficked person)

- diversity of the study population, including languages and cultures

- mutable nature of the subject (e.g., changes in routes, methods, form to avoid detection, changing laws).

These issues affected the selection of strategies used in these studies. The main challenges and limitations resulting from these complications are discussed below.

12.2.1 Absence of knowledge-base and validated instruments

One of the first challenges in undertaking a study on the health of trafficked women was the absence of a developed knowledge-base. At the time of the first study, there was limited writing on the subject of trafficking and almost no literature on health in this context. There was a lack of conceptual, theory-based information and no data-driven evidence to guide the formative work. The research strategy therefore drew heavily on themes within the literature on migration and health, violence against women and other marginalised groups (e.g., sex workers, refugees) in order to develop conceptual models suitable to guide the study design. These models had not been previously tested in other studies.

A second similar challenge was the absence of physical health measurement and psychometric instruments validated for this or a similar population. Instead, this study relied on existing research tools that had been validated in culturally diverse populations exposed to high levels of violence and trauma.[348, 499, 500] These instruments may have failed to fully capture the unique and extreme features of the physical and psychological trauma and the culturally different ways these are experienced or expressed by these women.

12.2.2 Generalisability of findings

How generalisable to the wider population of trafficked women are the findings from this quantitative study? Because reliable prevalence figures on trafficked women are difficult to obtain, the situations of different trafficked

women can vary so significantly and the size of our sample was relatively small, it is not possible to know how representative the findings are.

For example, a serious limitation of the studies was the inability to interview women who were still in the trafficking situation or those who never reached a service provider. The covert and illegal nature of trafficking meant that it was too risky to interview women in the trafficking situation and it would have been unethical to interview women who had been trafficked without providing services and support. Therefore, only women accessing services were interviewed, resulting in this selection bias.

This approach did ensure that women were interviewed by supportive interviewers who were already known to them in a setting where they were safe and able to receive a range of health and care services. As many of the providers had ongoing relationships with their clients, this setting also facilitated relatively good follow-up rates (particularly between the first and second interviews) for the second study. However, it is not possible to assess the extent to which the samples for either study may be representative of the broader group of women and adolescents who are trafficked and sexually exploited. This sample of women accessing services represents a small minority of women who are trafficked, as most trafficked women are unlikely to ever reach care facilities. It is unclear whether this group has different characteristics than women who do not receive assistance. It is therefore unclear how well these findings might apply to other trafficked women. This is an important weakness in trafficking research because of the wide diversity of cultures and context-specific situations. Yet,

because of the diversity of the study samples (women, locations, experiences) these data may be able to suggest some patterns of risk and consequences among women trafficked in Europe, especially those who were trafficked to the study partner countries.

12.2.3 Objectivity and consistency versus disclosure and reliability

Because of the sensitive nature of the subject and the vulnerability of the study group, methods were selected that prioritised women's safety, confidentiality and attempts to increase disclosure over traditional methods that rely on an objective, neutral researcher.[501] Priortising women's safety and well-being meant that, even with the rigour and guidance provided by the study protocol and procedures and the lead researchers, we are likely to have lost some consistency and richness in data collection between interviewers and interview sites. Because we agreed to use study partners as interviewers, who came from different backgrounds and worked in different settings, interviews may ultimately have been carried out in somewhat different ways. Depth of the qualitative data is likely to have differed in different sites because of the varying approaches interviewers had to probing and follow-up questions.

However, by collaborating with service agencies and having support workers of these organisations conduct the interviews, we cannot be certain the extent to which social bias may have affected women's responses, because the interviewers were also those who the women relied on for services. However, in this way, we were able to safely access our study population, ensure that

trafficked women's well-being was prioritized throughout the study, and likely achieved fuller disclosure. It was felt that whatever might be sacrificed in objectivity was small in comparison to what would be gained in data quality. These severely betrayed and now suspicious women would more readily respond truthfully and in greater detail to individuals who had demonstrated that they could be trusted. Most importantly, as trained support staff, these interviewers knew when interviews could be safely conducted and they were well-positioned to respond to women's needs. Our partners' knowledge-base was also important to the interpretation of the data and to later dissemination of the findings and advocacy.

These studies offer examples of methodological approaches that may, in the future, be used to conduct rigorous and ethics-based research on other highly vulnerable populations because they: a) recognise the vulnerability of individuals and groups; b) prioritise safety, confidentiality and disclosure over data collection; and c) consciously endeavour to gather and disseminate data that promotes the rights and well-being of those who are vulnerable.

12.2.4 Descriptive versus explanatory research

The findings from this study are primarily descriptive rather than explanatory, which means they are better able to answer the "what", not necessarily the "why"—providing a portrait of risk and outcome patterns, versus

proving associations. Future studies will be required, for example, to develop evidence on effective interventions.

These findings provide an initial panorama of health-related variables to help service providers and policy-makers gain a picture of what is happening. These data also make available evidence upon which to base future explanatory research. Questions such as: "what are the protective factors associated with better health outcomes" or "how different post-trauma therapies affect depression levels" remain areas for future investigation.

12.2.5 Translation and interpretation

Translation may have been a weakness of these studies. Because the studies were carried out in multiple sites and numerous and urgent translations were sometimes required, the ways that information was translated was not consistent throughout the study sites. In addition, because the interviews were not tape-recorded, in order to avoid intimidating participants, some responses may not have been recorded verbatim, but interviewers or interpreters may have paraphrased qualitative responses.

12.2.6 Navigating the politics

From this study emerged a concrete example of what it means to conduct research on a "sensitive topic".[502]

The subject of health and trafficking is laden with volatile politics in areas such as sex work, immigration, labour and exploitation. The topic has profound social implications related to stigma, class, discrimination and diverse cultures, and deeply personal and potentially shame-filled experiences.

For this study, the subject of sex work versus prostitution was the primary area of potential conflict. Study partners for both research projects came to the table with divergent political ideologies on this subject.

Ultimately however, as the study was focused on the "health" of women who are trafficked, it was surprisingly simple to move beyond the politics in order to investigate women's health. The one potential point of major contention was quickly agreed upon: the definition of trafficking. It was agreed that this would be taken from the Palermo Protocol.[135]

It is likely, however, that had we intended to examine interventions during the destination stage, differences might have flared. Those in the "abolitionist" camp would have favoured "exit strategies" over sexual health outreach services, concluding that the latter merely enables the trafficker and the exploitation. Those in the 'sex worker rights' camp would have protested that an abolitionist stance comes at great cost to the women in sex work, that for well-founded reasons some women have opted to do sex work, and that granting them rights and legitimacy will ultimately make them safer.

From a health point of view, the politics of trafficking for forced prostitution might be best viewed from a "both/and" versus an "either/or" perspective. That is,

prostitution/sex work should be treated as both a form of violence against women and as a high risk occupational sector.

Women who are coerced by physical force, threat, or by circumstance to sell sex can in most circumstances be viewed as victims of gender-based violence—what can also be referred to as interpersonal and/or structural violence. Few women in sex work, if given other financially viable alternatives, would *choose* to sell sex. From this point of view, prevention and so-called "exit strategies" can be considered fundamental intervention components, supporting women to evade and escape a discriminatory and often abusive situation.

From a health perspective, it is important to treat prostitution/sex work as a high-risk occupation requiring sector-specific intervention strategies. Interventions for women in sex work should be designed with individual and public health approaches that recognise and contextualise the range of health risks from both social and medical perspectives.

Despite these limitations, both studies provided ground-breaking evidence to inform service provision and policy-making, and advance research techniques in this area. In addition, these studies appeared to increase recognition of trafficking as a health problem—and the health concerns of those who are trafficked.

12.3 Conceptualising health and trafficking: new models to frame future theory and research

12.3.1 Two complementary models for chronicling risk

One of the most significant contributions of knowledge resulting from this research project was the creation of conceptual models for understanding health in the context of trafficking. These models proved fundamental for this study and are likely to serve as theoretical frameworks for future research.

For this study, the models *Stages of the trafficking process* and the *health risks and consequences* were well-suited to an exploratory study because they offered a structure for investigating a diverse range of health-related issues and how they might relate to one another.

The first model (Figure 3.1 *Stages of the trafficking process*) illustrates a conceptual approach based on a migration and health framework that is chronological in structure.

By depicting health in a migratory cycle, this model suggests that health influences can emerge at each stage, while showing that ultimately health status is a composite of all stages combined. This model also implies that health is not static, but changes over time; some problems are exacerbated, some persist, and some may ameliorate.

This model also has the potential to contribute to a future dialogue on post-trafficking interventions by highlighting the full "cycle" of the trafficking process. It is not unusual for international discussions on and funding for protection to lose sight of what happens to women much beyond the rescue. For example, states

returning women to their home countries generally do not seem concerned that women suffering the ill-effects of events in the destination country must fend for themselves without access to services once they are returned.

The second model (Table 3.1 *Health risks and* consequences) complements the first, offering a more bio-medical perspective, specifying different categories of health risk and consequence. It relies on concepts gleaned from the different bodies of literature on the health of vulnerable groups (i.e., migration, sex work, violence, forced labour, and gender) to delineate relevant health categories.

The feature of this second model which somewhat pushes the boundaries of traditional health theory is the expansion of the category of risk. By including risk categories such as "social restriction and manipulation", "forced and coerced use of drugs and alcohol", "economic exploitation and debt bondage", "legal insecurity" and "risks associated with marginalisation", this model moves the concept of health closer to those social and structural factors that influence it. Conceptually, the links between health and the social, economic and political conditions are not new,[109] but for research on a subject whose causality and consequences are so integrally tied to these factors, an overt acknowledgement of them is an important reflection of reality.

By providing broad frameworks representing chronological and categorical risk, these models are likely to provide useful theoretical bases for future research on health and trafficking. In fact, after the publication of the two studies, a new IOM report on health and trafficking in Africa was published (*Breaking the*

cycle of vulnerability. Responding the health needs of women in east and southern Africa) in which both models were used to frame the study.[503]

The first model (Figure 3.1), in particular, lends itself to many possible research directions, as each of the phases may contain different factors of interest. For example, this model could be used to identify and analyse structural factors that might impact women's health and safety, including social, political and (3) economic influences.

Alternatively, these models may be used to consider intervention opportunities and strategies (e.g., information, outreach, services) at the various stages and/or for various aspects of health.

In considering future possible models to examine health and trafficking, it may also be useful to explore existing theory on occupational health, particularly given the wide variety of forms of exploitation and the 'grey area' between trafficking and other forms of labour exploitation.

The remainder of this chapter will discuss key policy and service implications and research gaps associated with the different stages of the trafficking process.

12.4 The pre-departure stage: Implications for prevention of trafficking and pre-trafficking risk reduction.

Although this study did not focus heavily on prevention, the findings have a number of potential programming implications for efforts to prevent trafficking,

possible pre-departure harm reduction and promoting women's ability to protect themselves.

12.4.1 Pre-trafficking violence: a contributory factor to women's decision to leave home

Findings from both studies suggest that many trafficked women have prior histories of violence, neglect and/or other family problems. For example, 60% had experienced either physical or sexual violence prior to leaving home, and 15% had been sexually abused before the age of 15.

Exactly how these levels of violence may have affected a woman's decision to take up the offer of a trafficker or made her a target for recruitment is difficult to assess from these findings alone. Yet, this high percentage of women reporting pre-departure violence hints that abusive situations may be a contributing factor in women's vulnerability to being recruited.

These levels of pre-departure abuse point to the need to intervene on other forms of abuse, such as domestic violence, child abuse, and sexual assault. The prior abuse reported by trafficked women highlights the potential benefit of viewing trafficking in women as part of the larger problem of violence against women. Programmes to address violence should be based on the concept that different forms of violence are linked in a way that may lead to re-victimisation. Preventing early violence through, for example, gender attitude and awareness campaigns, anti-violence legislation, and victim support and shelter, may decrease the vulnerability of some women to being trafficked. Donors and those interested in investing in trafficking prevention should give

greater attention and funding to interventions targeted at domestic violence and child abuse and child sexual abuse in women's home countries.

Similarly, the high number of single mothers in this study implies that single parenting or being a sole carer in financial difficulty or crisis may also be a contributing situational factor to being trafficked. Children in institutional care may also be particularly vulnerable to being recruited. Again, trafficking intervention may depend significantly on how well programmes are able to address other forms of gender inequality and the quality of social support for children.

Importantly, women's history of physical and sexual violence also suggests that women who are abused prior to departure may adopt risk-taking behaviour in the future, as past sexual abuse is a demonstrated risk factor for increased risk-taking.[403] This is a rather disturbing finding, as it suggests that the women who are highly vulnerable to being trafficked may also tend towards greater morbidity once caught up in the trafficking process.

12.4.2 Improving pre-departure health knowledge to help women protect themselves and reduce health risks

Findings from the formative study suggest that prior to leaving home, many women have extremely limited knowledge about sexual health, contraception, and protection against sexually transmitted infections. When interviewed for the formative study, many women appeared to have been uninformed or had learned what they knew through the work that they were forced to do.

Distributing information on sexual health and other aspects of health to the same groups that are being targeted for anti-trafficking prevention campaigns will

comprise an important health promotion strategy. As there are no signs that trafficking is abating anytime soon, it is best if women who are considered most at risk of being trafficked are as well-informed as possible about protecting their health—in case they are given the opportunity to make choices.

12.4.3 The "Recruitment equation": a new model to explain trafficking-related decision-making

The findings from these studies suggest that the traditional view of push and pull factors may be too simplistic to explain how women are recruited into a trafficking situation.[24, 96] The "recruitment equation" (Figure 12.1) was developed based on the accounts of women participating in the formative study and from cases described by study partner countries.

Push factors, such as unemployment and poverty, civil and political unrest and gender inequity have been associated with women's desire to migrate, while images of good jobs, political freedoms, wealth and the ease of travel are said to pull women towards what they hope will be a better life.[54, 64, 504]

PUSH & PULL FACTORS
DECIDING FACTORS

Vulnerabilities

Hopes

Strengths

+

Credibility of the offer

Quality of the offer

Timing of the offer

=

ACCEPTS OFFER
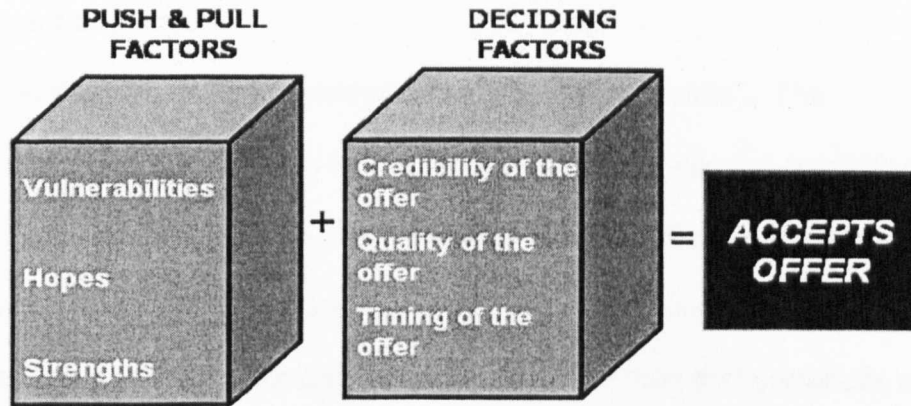
Figure 12.1: Recruitment equation

Figure 12.1 is a model that modifies slightly the traditional view of the

factors contributing to trafficking. It rephrases the "push and pull" factors and

adds the "deciding factor". In this model, the "push" and "pull" factors have been

reframed as "vulnerabilities", "hopes" and "strengths" in order to reflect the

individual nature of so-called push and pull factors. The first, "vulnerabilities",

encompasses the push factors, or the macro- (e.g., political, social crises) and

micro-situations (e.g., domestic violence, individual financial crisis) that might

make a woman vulnerable to be recruited, i.e., cause a woman seek to leave her

current situation. The second, "hopes", includes what a woman anticipates

gaining (e.g., money, job, freedom, safety) from moving elsewhere. The third,

"strengths", recognises the positive individual characteristics, such as courage and resourcefulness that enable women to take a positive and active step towards changing their life for the better. This model obviously excludes those individuals who are abducted.

A unique component of this framework is the: "Deciding factors". The *deciding factors* reflect a reality told in women's stories—that it was the credibility of the offer that convinced them to go. This represents the factor or factors that "clinch" the deal. This is most easily understood at the persuasiveness of the offer to migrate. The deciding factor can be seen as the lynchpin that convinces a woman who may have any or all of the push and pull factors to accept an offer of a job or travel. Deciding factors in this model comprise the "credibility", "quality" and "timing" of the offer. The most important of these is the "credibility", or how believable is the person making the offer, and how credible is the offer. As was discovered in both studies, it is common for a woman to be recruited (or sold) by someone she knows or someone known to her family or friends, i.e., someone who she had good reasons to trust.[95, 432] The "quality" of the offer refers to the job, money, location or other features of the offer that might make it enticing. The "timing" refers to whether or not the offer is perceived as propitious, i.e., made at a period when the women is particularly desirous or in need of a job, money, or leaving home.

In addition to defining terms and redefining concepts related to recruitment, this equation underlines the individuality of the influences that may contribute to

someone falling prey to a trafficker. It may begin to help answer the question: "Who are trafficked women?"

While it is tempting to believe that women who are trafficked and sexually exploited are savvy entrepreneurs who are culpable for knowingly selling themselves into prostitution, or to imagine the opposite, which is that women who are trafficked are all naïve, poverty-stricken, young and uneducated virgin girls from the countryside, the reality is that there is no single portrait of a trafficked woman. A more useful perspective from which to consider who is trafficked is to look at some of the causes of trafficking, and from there, to contemplate what makes individuals vulnerable to being trafficked.

From a programming perspective, this *deciding factor* complicates efforts to identify interventions based on patterns of vulnerability. While it is possible to identify certain circumstances that might make a woman vulnerable to being recruited (e.g., orphaned, family violence, single parent, ill relative) and make them a good target of an awareness campaign, this model suggests that an awareness campaign may not convince some women. For them, the trust they place in a one-to-one relationship carries more weight. In these circumstances, it is hard to know what intervention might be able to influence this decision-making process. If a woman has heard from what she considers to be a reliable source or sources (e.g., friend, parent, trafficked woman-turned-recruiter) that the offer is reliable (e.g., he has provided good jobs for many women), it may be difficult to dissuade her that she will be one of the most unlucky migrants.

12.5 The travel and transit stage: The need for policies that support safe travel options

12.5.1 Reducing potential travel dangers

Rarely mentioned are the risks women face while being transported (and sold) from one place to another. While many women travel by safe means (plane, train), other women encounter numerous health risks (suffocation, drowning, daring escape attempts) while en route.

These findings add further evidence to arguments in favour of immigration policies that recognise the need for low-skilled labour and to provide legitimate transnational employment opportunities—and against stricter measures that appear to push traffickers to take greater risks with women's lives.[1, 74] If industrialised nations enact legislation to provide visas for low-skilled labourers, they will be able to supply and regulate this key component of the economy, while simultaneously reducing the need for women to undertake high-risk travel options.

12.5.2 What does it mean to be bought and sold?

What are the health consequences of being marketed, bought and sold? This study raises this important question that is generally not posed for many other forms of violence against women, suggesting an avenue for future investigation. Indeed, in a global economic climate that appears to foster and

financially reward labour exploitation, this subject will comprise an important area for future study.

Some of the most evocative comments made by women were those that expressed their horror and shock at having been treated like a "piece of meat with two eyes". Two women in separate interviews made this same observation, *verbatim*. Another woman described how she was awe-struck at seeing herself and other women sold at a market-place where women were made to stand on blocks and have their legs and teeth checked like animals being valued for slaughter.

There is currently little evidence on the sequelae of being "bought and sold", although it appears to be a fundamental component of trafficking in persons. As the international labour market becomes increasingly open and exploitative, reeling people in, churning out their labour, and jettisoning them like human detritus when they are no longer of use, understanding the effects of these abuses will be important.

Health care is likely to be among the first needs of persons who are bought and sold. Yet, while the larger population of persons trafficked for various forms of exploitation is now gaining greater recognition,[21] it is necessary that the gendered aspects of these abuses remain visible.[152] When, at some future time, trafficked women may be included in studies of the larger group of exploited and bonded labourers, researchers must be careful to recognise the implications of being female and the significance of sexual coercion and abuse. Disaggregation

by sex will generally provide a more detailed and accurate picture of the risks and health outcomes of labour exploitation.

12.6 The Destination stage: Factoring abuse and coercion into policing procedures and health programmes.

12.6.1 Answering the question "Why don't women leave?"

Findings on violence and risk during the destination stage show that it was extremely unlikely for a woman in this study to emerge from a trafficking situation without having been physically assaulted, raped, psychologically abused, or deprived of some or many of her basic freedoms. Violence, threats and psychological manipulation were reported by an overwhelming majority of the group surveyed. In most cases, qualitative responses described abuse that was perpetrated in such a way as to cause enough harm to instil obedience, but generally not so much that the victim was no longer able to function. However, in some cases, abuse was less physical or visible, and women described being trapped by the anticipation of harm (to them or their family) as a result of disobedience or non-payment.

Victims of this type of abuse may easily come to believe that their best chances for survival lie in pleasing or even aligning themselves with the perpetrator of the violence [505] Sexually abused children have been found to be particularly susceptible to this latter type of insidious relationship.[506]

Findings about the violence and threats during the period of exploitation address the question: Why don't women flee? This is a question that is frequently

asked by authorities and others who cannot conceive of this sort of entrapment and thus doubt a woman's veracity. Findings on violence indicate that whether or not they are physically restrained, women may be held captive through intimidation and fear of what might be done to them, their children or other family members.

Experts on torture suggest that the two variables that most dramatically effect whether certain stimuli will have deleterious health consequences are the degree of "predictability" and "control that an individual has over an event".[119] The women we interviewed had neither.

It is important to mention that while presenting the findings in various country settings, country partners (service providers) began to describe ways in which traffickers' coercion tactics had changed. Traffickers were said to be using less violence and to be giving women more money as a way of keeping women working. Effectively, they were making women complicit in their own exploitation. Psychologists from Ukraine, Belarus and Bulgaria speculated that while this tactic may be causing less physical harm, the psychological damage from this type of coercion seemed much more complex. By becoming complicit in their own exploitation, by taking some of the profits, passively agreeing to stay in an exploitative situation, a woman had, to a certain degree, accepted that she was a "prostitute". This sense of participation appears to increase women's guilt, further distance themselves psychologically from their former selves. Psychologists and psychiatrists speculated that this is a psychological profile that is very difficult to

treat. Future work on trafficking and exploitation will have to consider this relatively different form of coercion and exploitation.

Moreover, from a legal perspective, this relative complicity/acceptance may also further challenge the line that is perceived to divide trafficking from smuggling. Prosecutors may have a more difficult task convincing a jury that a woman was trafficked if there is not evidence of physical assault, she was given a portion of her earnings and she can only testify to "implicit" threats—that is, she knew what her captors could and would do, so they never actually had to say it.

These findings indicate that authorities (including police, immigration, prosecutors and judges) should be trained to understand the violence, as well as the subtleties of the coercive relationship that frequently define a trafficking situation. They need to understand why they cannot discount a woman's reports of trafficking based on doubts about her perceived ability to escape.

12.6.2 The need for health outreach services for migrant sex workers

Findings also highlight the serious challenges posed for service providers trying to offer support to women who are still in a trafficking situation. The risks of contacting women and the sensitivity required to make them feel (and be) safe, and gain their trust and confidence may be significant. Yet, these findings also make it abundantly clear that their need for assistance is great. Women's limited mobility and choice emphasise the need for health outreach services, services that provide care at the venues where women work. Health services cannot rely on women's ability to attend clinic-based services. Although philosophically some

point out that providing on-site services, such as condom distribution and hepatitis shots, may be viewed as supporting the financial enterprises of the traffickers, women interviewed clearly voiced their gratitude for these programmes and, in some cases, attributed their escape to such assistance. While remaining aware of this concern, women's health must remain the priority in making decisions about the provision of services.

12.7 The Detention, deportation and criminal evidence stage: Authorities require greater awareness and health-specific procedures

12.7.1 Institutional preparedness for women's reactions and health needs

Policy-level findings from the formative study indicate that, in general, law enforcement professionals (police and immigration) have been unprepared to detect or respond to health problems of trafficked women.

For those interviewed, this negligence does not appear to be a result of ignorance of the abuses involved in trafficking, as most were able to describe gruesome examples of trafficking-related harm. In some settings, such as the UK, officers were not familiar with available services, or did not have referral options. In addition, police generally prioritised the urgency to gather evidence over the assistance needs of their witness—in those cases when they actually recognised the woman as a victim. On a higher policy-level, this denial of the problem of trafficking is most probably related to fears over the politics of immigration.

From the quantitative data, the poor state of women's health within the first 14 days of entry into a service setting implies not only their need for medical care, but also suggests women's limited ability to communicate clearly with and/or cooperate with authorities. For example, the formative study presented several examples of women who suffered as a consequence of participating as a witness in a criminal proceeding. One collapsed on the stand, while another was unable to testify to certain aspects of the crime due to overwhelming anxiety. This is likely to be a common response among women who are asked to give evidence.

This research demonstrates the need for authorities to understand the implications of women's health symptoms and to have in place procedures that recognise health-related complications and respond to women's health needs through direct assistance or referral.

Procedures should take into account the ways that women's physical and psychological limitations may affect their participation in an immigration procedure or criminal investigation. A proportion of women are likely to have difficulty enduring lengthy questioning or responding accurately immediately upon identification.

Women sitting through immigration or police interviews are likely to experience a host of symptoms causing them pain and distress. Demanding information from a woman suffering this high level of symptomatology is likely to exacerbate her discomfort and trauma, and is not likely to generate meaningful and reliable information. Cognitive difficulties, such as memory problems, can

make it difficult for trafficking survivors to substantiate their status as a victim (many do not even know the term "trafficking"), offer detailed evidence related to the crime, make decisions about cooperating in a prosecution against a perpetrator, and to determine whether to return home or to petition for resident status. Symptoms such as severe headaches, extreme fatigue, dizziness, depression, anxiety, and memory disruption or dissociation can impede women's ability to respond clearly and accurately about events in the past, and can hinder them from making sound decisions about their future—including about their safety and well-being.

The high levels of memory problems reported, i.e., 63%, are particularly noteworthy because of the potentially serious repercussions that biographical inconsistency can have for women whose residency status (e.g., asylum petition) and social benefits might depend on their credibility with authorities. Memory discrepancies may also hamper prosecutions.

Development of victim-centred legal policies and procedures are subjects that should be considered priority areas for progress. While it is unlikely that policies will significantly alter the behaviour of traffickers or radically reduce the number of trafficked women in the near-term, it is possible to rapidly change the way women are treated by state authorities. Law enforcement procedures are squarely under government control, and with political will, states can relatively quickly institute procedures aimed at meeting women's health needs.

To influence policy in this area, what is required is a systematic policy review and comparative study on the special procedures used for victims of

sexual assault or domestic violence, and qualitative inquiry into police and immigration officials' perceptions of trafficked women.

12.8 The Integration and reintegration stage: Responding to women's health needs

Findings on health outcomes after a trafficking experience provide evidence to support what service providers have known for sometime: women in post-trafficking service settings present numerous, concurrent, and often severe physical and mental health symptoms that require both urgent and longer-term care.

12.8.1 Post-trafficking intervention service stages: A model for responding to changes in women's care needs

The medical and health care needs of trafficked persons have been clearly recognised in the "United Nations Protocol to Prevent, Suppress And Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Convention Against Transnational Organized Crime". In Article 6, section 3, it states:

> Each State Party shall consider implementing measures to provide for the physical, psychological and social recovery of victims of trafficking in persons...[135]

The "Council of Europe Convention on Action against Trafficking in Human Beings" also acknowledges the care needs of victims of trafficking. This

document specifies individuals' rights to "emergency medical treatment", as stated in Article 12, section 3:

> ...each Party shall provide necessary medical or other assistance to victims lawfully resident within its territory who do not have adequate resources and need such help.[507]

Although neither of these documents provides a legally binding guarantee of appropriate medical care for all trafficked women, each clearly recognises that individuals who have been trafficked are likely to require medical care, and each recognises, however tentatively, that the state should meet these needs.

Based on the results of the studies and the input of the partner organisations, it appears that service provision for trafficking survivors may be divided into three general stages (Figure 12.2):

1. Crisis intervention stage

2. Adjustment stage

3. Longer-term symptom management stage

These stages represent a system of trauma-informed care that recognises the changes in women's needs over time. Upon first contacting support services, service providers agree that women typically go through a period of "crisis"—to which providers offer crisis intervention care that is organised around providing emergency and basic support assistance (e.g., housing, food, security, rest, and emergency medical care, if necessary).[432, 508]
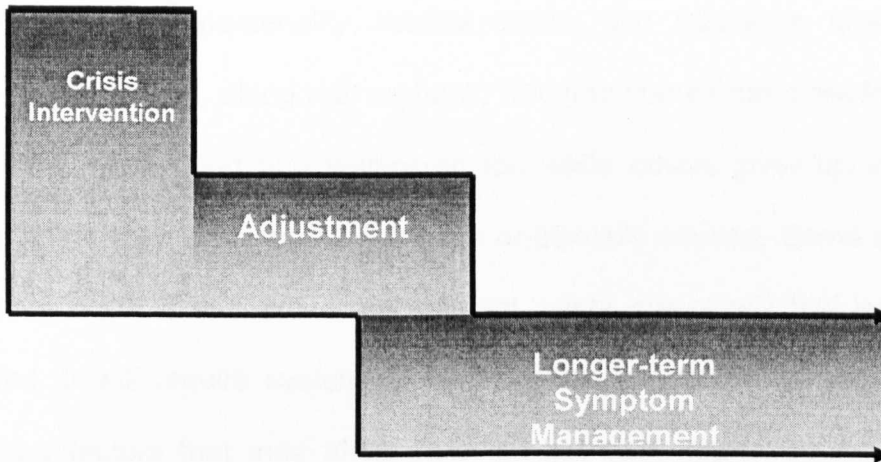
Figure 12.2 Stages of post-trafficking intervention.

Once women's basic needs are attended to, the next phase may be termed an "adjustment" phase. This is the time during which many women begin to experience relative stability, as they adapt to their new surroundings and relative safety, and, where available, they receive medical treatment for a variety of urgent and non-urgent symptoms.[432, 509, 510]

Following the adjustment phase, women's longer-term needs begin to appear. Some women continue to reorient themselves and look to the future, while others become increasingly distressed as they reflect upon their experiences and face stress-filled decisions and events.[107, 508]

These proposed stages reflect women's changing patterns of illness, distress and recovery, as documented in these studies and noted by professionals working with women who have been trafficked. However, this model does not attempt to propose a timeframe within which these stages might

occur. Trafficking survivors are an extremely diverse group. They differ in age, culture, nationality, personality, marital status, and education level. Medical doctors are trafficked, along with orphans. Women come from close-knit families where they were loved and well-cared for, while others grew up in alcoholic homes where they were regularly beaten or sexually abused. Some women will be recovering in a supportive environment, while others will feel isolated and alienated. It will require systematic investigation to identify the individual and contextual factors that may affect how this process might occur for different women in different circumstances.

12.8.2 Medical history-taking and needs assessment: Recording and incorporating pre-departure abuse

The pre-departure abuse levels reported in these studies underline that a woman's post-trafficking symptomatology is likely to represent not only the harm she sustained during the trafficking experience, but the cumulative toll of the abuse before and after she left home.

This has implications for understanding women's health needs and for designing a treatment programme. Effective strategies are likely to be those that take into account women's entire history of abuse and other risks. This historical information will be particularly informative for psychological support. Service providers should be trained to collect this information in a sensitive and supportive way.

The presence of violence at home also has serious implications for women's safety if they choose, or are forced, to return home. It is reasonable to suspect that a portion of women may encounter dangers to their safety and well-being if they return to the situations they left. This underlines the need for thorough pre-return assessment procedures to determine the risks to women's safe return i.e., beyond those related to a trafficker. And, if a woman chooses to return, appropriate protection mechanisms should be implemented on a case by case basis.

12.8.3 Physical health symptoms: The need for a holistic diagnostic programme

Overall physical morbidity patterns observed in this study indicate that women who are trafficked are extremely likely to emerge from an exploitative setting with a range of symptoms, some of which will be severe and enduring.

The diversity and the ranking of the health problems reported highlights that although sexual and reproductive health is frequently at the centre of discussions on health and trafficking, women themselves are likely to report a host of other physical health symptoms that concern them or cause them pain. This is not to imply that sexual and reproductive health is not of great importance—both for individual and public health reasons—but to suggest that programmes for health should attempt to address a much wider spectrum of complications. Women emerging from a trafficking situation will report a variety of symptoms that will require comprehensive diagnostic and treatment services. Some symptoms will

benefit from rapid diagnosis and care (e.g., unwanted pregnancy, injury, panic attacks), while other symptoms will require longer-term treatment (e.g., HIV/AIDS, depression). Women will also report symptoms (e.g., fatigue, weight loss, anxiety) that should be addressed by responding to basic needs (e.g., rest, nutrition, safety).

Post-trafficking health interventions must have strong diagnostic capacity, because post-trafficking symptomatology appears to be complex. Women's symptoms might be the result of a physical injury or infection and/or somatic (non-psychiatric symptoms associated with psychological reactions). Practitioners will be required to take particular care in diagnosing symptoms for trafficked women. Although many women will be experiencing deep distress and anxiety following a trafficking experience, physical violence is a hallmark of trafficking in women and symptoms may very well have a physical origin.

Similarly, health practitioners should be well-informed on the aetiology of gender-based violence in order to recognise that even where an identifiable physiological or biological cause cannot be found, this does not reduce the pain or the disability caused by a given symptom. Somatic symptoms associated with psychological morbidity are often severe, and have been recognised as having an enormous impact on quality of life.[269] Practitioners should also be prepared to refer women to other appropriate forms of support.

While it was extremely promising to see the rapid decrease in symptoms over the study period, this relative view is somewhat deceptive. The symptom prevalence at the second and third interviews, while much reduced, is

nonetheless notable. A significant portion of women remained highly symptomatic and troubled by their symptoms.

Perhaps most important of all, it is necessary to recall that this study cohort had access to ongoing support services. While it is not possible to understand how the health of these women would compare to the vast majority of trafficked women who do not receive care, the first interviews hint at the very poor health of this invisible cohort.

Although many physical symptoms appear to subside greatly within the first four to six weeks if women are provided professional support services, many women will continue to suffer numerous forms of pain and discomfort (e.g., headaches, fatigue, dizzy spells, back pain). It will be important to plan and budget for interventions capable of treating complications that require longer-term medical attention.

12.8.4 Sexual and reproductive health symptoms: The need for rapid response to sexual and reproductive health as part of a comprehensive package

Not surprisingly, this study found that immediately after being trafficked and sexually exploited, women presented in services settings with numerous sexual and reproductive health symptoms that caused them significant pain and worry. Findings also highlighted women's concerns that their experience might have left them with an unwanted pregnancy, infections that might be transmitted to partners and/or jeopardised their future ability to have children. This made it

important for women to receive urgent care for sexual and reproductive health problems(e.g., testing and treatment for STIs/RTIs and terminations).

Encouragingly, the data shows that it is possible to achieve a striking reduction in perceived symptoms within the first six weeks women are in care. Qualitative data in particular, indicate that a portion of women's psychological well-being is linked to their sexual and reproductive health and that women's distress can be positively affected by providing rapid information and treatment (e.g., STIs, fertility, unwanted pregnancy).

This provides substantial evidence favouring rapid access to a programme of services offering clinical examinations, diagnostic testing, syndromic management and presumptive treatment of common STIs/RTIs.[227] Rapidly provided clinical care can alleviate women's pain and allay fears about infertility, unintended pregnancies, and prevent further transmission of infections to intimate partners. A comprehensive care package is not only necessary to treat clinical conditions, but is also medically practical, as gynaecological symptoms may be linked to other presenting medical complications. For example, the association between depression and anxiety disorders and gynaecological symptoms has been documented by other studies. [511-515]

Case examples from these studies also demonstrate in the starkest terms the implications of poor HIV counselling and testing. From women's accounts of poor practice, it appear that post-trafficking service organisations must take the time to identify medical care services capable of providing professional counselling and testing for HIV. Organisations should also be prepared to offer

the necessary psychological support women may require before, during and after diagnoses.

Once again, it is a sad reality that the women in this study who received gynaecological care are probably among the smallest portion of trafficked women. Most women are unlikely to access care, and many risk living with untreated, asymptomatic infections that may lead to outcomes such as infertility or cancer—unalterable legacies of their trafficking nightmare.

12.8.5 Mental health symptoms and service implications: The need for policies and funding that support longer-term psychological assistance

However women's mental health is labelled—as normal post-trauma reactions or as diagnosed psychological conditions—their emotional suffering appears to be a lingering and profoundly painful aftermath of the trafficking experience. While there has been little doubt that the abuses and exploitation perpetrated on women who are trafficked have deleterious mental health consequences, the findings presented in this chapter attempt to measure patterns and add further detail to what has been observed by support workers in post-trafficking centres.

Data show an extraordinarily high prevalence of psychological morbidity among women first entering a support organization. Figures also show that symptoms appear to show a relative reduction over time.

Yet, using a broader lens, comparing trafficked women's symptom levels after four months in care to those of a general female population, women who

are trafficked appear to be burdened by symptom levels that are comparable to some of the most distressed individuals. Specifically, this psychological portrait shows post-trafficking depression levels, in particular, will persist, perhaps hindering women's ability to fully participate in either an integration or reintegration situation.

As such, these symptoms may clearly reduce a woman's quality of life and hinder her daily functioning—preventing her from regaining what most women stated they wanted: to have a "normal life".

The general improvements in women's health documented over the study period suggest the benefits to women's well-being of having access to support services that provide both crisis intervention and longer-term support. Although only a case-control study would be able to indicate the effects of treatment, this would be an unethical study because it would leave control group without important support services. Therefore, these findings are perhaps the most relevant indication of the potential effects of professional service provision.

The multiplicity and severity of women's physical and psychological health symptoms gives an indication of the extent of the diagnostic assessment and treatment needed to address the health of trafficking survivors. Dissecting the constellation of women's symptoms is not likely to be an easy or short-term task. For example, chronic headache may be neurological, traumatic, or psychiatric in origin, and in this population all three factors may contribute to any given woman's symptomatology. Similarly, gastrointestinal problems are well-described somatic manifestations of anxiety and stress,[439] but for trafficked

women they may also be associated with poor nutrition or sexual and reproductive health complications. Post-trafficking health services should therefore be based on best practices for domestic violence, sexual assault, and torture victims.

12.8.6 Mental health symptoms and legal implications: The need for immigration and policing procedures that take account of post-trauma psychological changes

The psychological symptom patterns observed in this study indicate that women's cognitive functioning may be negatively affected by their post-trauma reactions.[177] Cognitive impairment has serious implications for women's health and for practical matters, such as their participation in a police inquiry, immigration procedures, and for women's capacity to make sound decisions regarding their safety, such as whether to return home or seek asylum. In particular, the prevalence of memory problems at this time may affect women's credibility with authorities. While women may be haunted by their past in their waking moments and their nightmares, this does not mean that they are immediately able to provide the clear details of events. Difficulties with autobiographical memories have been documented among other populations exposed to trauma.[469] If women are not given sufficient time for the worst symptoms to wane, cognitive distortions or memory lapses are likely to hinder criminal investigations.

Based on the findings of this study, it appears that it is not until after approximately 90+ days that women are likely to experience a decrease in the

presence and severity of those symptoms most likely to affect their cognitive functioning (e.g., depression). In other words, women will be most capable of offering recollections of past events and making well-considered decisions about their future after they are provided support services for a minimum of four months.

The thesis has attempted to outline mental health trends. But, each individual will have specific reactions to her personal experience of trauma and different social, psychological or psychiatric support needs. This means that it is important to assess each woman's needs independently. What this data is able to offer is the information upon which service providers may plan their scarce resources and develop care plans to respond to some of the most common reactions.

The extent to which women are able to carry on a 'normal life' will likely depend on their access to appropriate support that enables them to cope with the psychological aftermath.

12.8.6 Mental health symptoms and training: Improving the capacity of service professionals to understand and respond to post-trauma reactions

The high level of post-trauma symptoms recorded in this study indicates the importance of psychological support both in the short and longer term. In addition, these prevalence levels, particularly the initially high levels of hostility, suggest that individuals who are not trained to deal with trauma victims may have difficulty working with or assisting trafficked women. It would be useful for individuals working with trafficked women to be made aware of these symptoms and to have some training on how to deal with them.

The table below proposes a summary of some of the most common psychological reactions to trafficking and how they might manifest in a services setting. This chart is based on the women's comments, interviews with service providers, and relevant literature on chronic trauma and psychological support.[89, 183, 186, 232, 249, 313, 516]

Table 12.1 Reactions manifested by trafficking survivors and supportive responses

COMMON REACTIONS	HOW REACTIONS MAY APPEAR	SUPPORTIVE RESPONSES
Fear, insecurity, anxiety	• Reluctance to meet people, go outside, or be alone • Trembling, shaking, heart racing • Difficulty sleeping and nightmares • Difficulty sitting still, concentrating	• Implement and describe security measures • Assure confidentiality • Escort to outside appointments, when possible
Mistrust of others	• Wariness of law enforcement, of offers of assistance • Reluctance to disclose information; Giving false information • Difficulty with social interactions	• Be patient and persistent in developing rapport • Offer to provide practical assistance and moral support • Regularly inquire about her needs and well-being
Isolation, loneliness	• Sadness, depression • Disengagement from others and activities, lethargy • Seemingly self-absorbed or self-centred • Belief no one can understand	• Offer phone contact with family, friends, etc. • Reassure she won't be abandoned after meeting, if true. • Provide emergency contact for officer(s) she knows
Dependence, subservience, defensiveness powerlessness	• Reluctance to make decisions • Desire to please, easily influenced • Inability to assert self or personal preferences • Complaining • Refusal or reluctance to accept assistance, advice.	• Reassure her of her abilities • Not fostering dependence by assuming all responsibility, giving small tasks • Encourage her suggestions when, how to be assisted • Give information, explain slowly
Mistrust of self, low self-esteem	• Passivity • Difficulty making decisions or trusting one's decisions • Difficulty imagining future • Hyper-sensitive to people, events	• Reaffirm that she did nothing wrong, that she was a victim of a common crime. • Praise for survival, for courage, • Praise for memory and information given
Self-blame, guilt, shame	• Difficulty making eye contact • Difficulty expressing self • Difficulty disclosing details of events and feelings	• Reassure she is not at fault • Remind that trafficking is a crime that victimizes many • Remind of her courage under extreme conditions
Hostility, irritability	• Hostility or aggression towards others, even support persons • Self-inflicted physical harm • Sabotaging her own situation • Seemingly uncooperative or ungrateful responses	• Be patient and calm • Do not reacting with anger, or showing frustration; • Commiserate with her anger (e.g., "I can imagine that you must feel angry about what they did")

In understanding women's post-trafficking reactions, it is important to recognise the strength and resilience of many women. As described in the findings, although women described emotions associated with distress and hopelessness,

many women, particularly by the second and third interviews, spoke of their maturity, determination, and self-reliance. While women's vulnerabilities should be understood, women should have their independence and decision-making rights recognised and respected throughout all forms of assistance.

12.9 Legal policy for signatures to the *Council of Europe's Convention against Trafficking*:

12.9.1 Legislating an appropriate period of "recovery and reflection"

The symptom patterns observed among the trafficking survivors provide important evidence about the time that it is likely to take for most women to begin to feel improvements in their health. From this study, it is clear that the majority of women emerging from a trafficking situation are not in a good state to make rapid decisions about cooperating with authorities against the traffickers and about their safety. This evidence supports the implementation of a period of "recovery and reflection", as described in the Council of Europe's Convention against trafficking.[134] That is, a trafficked woman should be permitted temporary legal residency during which she would have access to services and time to recover before making such decisions. Based on the range of health problems identified among the women in this study and the duration of their symptoms, it appears that trafficked women will require comprehensive medical care and at least 90 days in care before their most severe symptoms would likely subside.

12.9.2 Funding and implementing specific and targeted health-related measures

This is a propitious moment for a study of health and trafficked persons, as most states are now recognizing that trafficking is a problem that they must address. It is a phenomenon that has rapidly come centre stage both in the law enforcement and the political realm. Yet, often what seems to get lost amidst the debates on legislation, immigration, migrant labour, smuggling versus trafficking, sex work versus prostitution, and even in the larger human rights and women's rights debates is the health and well-being of the individual women. When the health outcomes seem so obvious, one has to ask the question: Why do protection and assistance measures seem to receive less attention than prevention and prosecution?

The damage to individual lives cannot be solved solely by tighter border controls, criminal trials or awareness posters. 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. Those who assist trafficked women must be supported. Service organizations are carrying the human toll of this crime and they need human and financial resources commensurate with their workload.

Measures that specify the diagnostic and treatment services to which women are entitled, including physical, sexual and mental health care, must be legislated and implemented. Clear referral mechanisms must be put into place to ensure that women reach and are cared for by providers that have the capacity

to provide this level of post-trauma care. These service procedures must be regularly monitored and evaluated by a competent body.

12.11 Research methodology to adapt for other vulnerable populations

The research designs for each of the studies contributing to this thesis were based on strategies that recognised the vulnerabilities of the research participants, the potential dangers posed for both researchers and participants and the social and political sensitivity of the subject. As noted above, under limitations, research techniques were selected that prioritised disclosure, safety and mental and physical health. The methods employed in these studies were developed to be adapted to be used for studying other vulnerable populations.

The methods drew heavily on evidence, concepts and tools used with other populations facing similar forms of vulnerability and marginalisation. Above all, however, conducting research with trafficked women demanded the close collaboration with experienced service providers and familiarity with the possible safety risks and physical and psychological vulnerabilities of their clientele. The importance of this type of research collaboration is difficult to overstate. These studies demonstrated that it is possible to undertake research with a population of seriously harmed individuals without further endangering their well-being. In fact, in a number of cases, study partners reported that the process of the study was informative to both the participants and them as service providers. For example, several study partners opted to integrate many of the questions in the

study instrument into their regular intake form because they found it gathered highly relevant data for service provision.

The collaboration between university, NGO, and international organisations also made it possible to ensure that the data collected would be considered a trusted evidence base and would also be put to use for both advocacy and interventions.

Many features of the methodology used to study trafficked women are likely to be transferable or adaptable to study other vulnerable persons. Like strategies to study trafficked women, research techniques for other similarly vulnerable populations calls for an approach that: a) fully recognises the different ways that individuals and a group as a whole may be vulnerable; b) prioritises the short and longer-term well being of individuals and support and responsiveness over data collection; and c) consciously endeavours to gather and disseminate data to promote the rights and well-being of those who are vulnerable.

12.12 Concluding remarks

Over the time of these studies, health has remained a topic that is hardly mentioned in policy dialogues or documents. Why is this? Given that the harm caused by the abuses associated with trafficking is the primary reason why governments and NGOs object to the trafficking and exploitation of women, it is difficult to fathom why health has been such a neglected area of interest by policy-makers, lawyers and human rights advocates alike. Pain, illness and distress are subjects that regularly receive lip service and even genuine

sympathy by those working on trafficking, but these are rarely a focus of serious attention, inquiry or funding.

With the continually emerging transnational strategies, international conferences, reports, handbooks, guides, and high-level and low-level meetings offering lamentation for those who are trafficked, it seems that it would be possible amidst this new corner of the aid business to commit the necessary resources to adequately address the health needs of victims of trafficking. To date, this does not seem to have happened.

It is hoped that these studies provide the convincing evidence required to fund and implement assistance services that meet women's needs and are available for the time they require them.

REFERENCES

1. Morrison, J. and B. Crosland, 2000. *The trafficking and smuggling of refugees: The end game in European Policy?* United Nations High Commission for Refugees (UNHCR): Geneva.

2. Europol, 2001. *Crime assessment. Trafficking of human beings into the European Union (open version).* Europol: The Hague.

3. O'Neill Richard, A., 1999. *International trafficking in women to the United States: A contemporary manifestation of slavery and organized crime. DCI exceptional intelligence analyst program. An intelligence monograph.* U.S. State Department's Bureau of Intelligence and Research.: Washington, D.C.

4. Salt, J., 2003. *Current trends in international migration in Europe.* Council of Europe: London.

5. Schloenhardt, A., 1999. *The business of migration: organized crime and illegal migration in Australia and the Asia Pacific Region.* Adelaide Law Review, **21**(1): p. 96-97.

6. Anderson, B. and O.C. Davidson, 2003. *Is Trafficking in Human Beings Demand Driven? A Multi-Country Pilot Study.* J International Organisation for Migration (IOM), **IOM Migration Research Series**(15).

7. Anderson, B. and B. Rogaly, 2005. *Forced Labour and Migration to the UK.* Centre on Migration Policy and Society (COMPAS) in collaboration with the Trades Union Congress: Oxford.

8. International Labour Organisation, 2003. *Forced labour outcomes of irregular migration and human trafficking in Europe.* ILO: Geneva.

9. Doezema, J., 2002. *Who Gets To Choose? Coercion, Consent and the UN Trafficking Protocol.* Gender and Development, **10**(1): p. 20-27.

10. Ditmore, M., 2003. *Morality in new policies addressing trafficking and sex work.* Institute for Women's Policy Research (IWPR): Presented at "Women working to make a difference" Institute for Women's Policy Research (IWPR).

11. Bindman, J. and J. Doezema, 1997. *Redefining Prostitution as Sex Work on the International Agenda.* Anti-Slavery International and the Network of Sex Work Projects (NSWP). London.

12. Kanics, J., 1997. *Removing the Whore Stigma: Report on the Asia and Pacific Regional Consultation on Prostitution.* Global Alliance Against Traffic in Women (GAATW),: Bangkok.

13. Salt, J. and J. Hogarth, *Migrant trafficking and human smuggling in Europe: A review of the evidence,* in *Migrant trafficking and human smuggling in Europe: A review of the evidence with case studies from Hungary, Poland and Ukraine,* D. Thompson, Editor. 2000, IOM: Geneva.

14. Kelly, L., 2001. *Conducting research on Trafficking. Guidelines and suggestions for further research. A report prepared for the International Organization for Migration, Gender Working Group and Research and Publications Division.* IOM: Geneva.

15. Zimmerman, C., K. Yun, C. Watts, I. Shvab, L. Trappolin, M. Treppete, F. Bimbi, S. Jiraporn, L. Beci, M. Albrecht, J. Bindel, and L. Regan, 2003. *The health risks*

and consequences of trafficking in women and adolescents. Findings from a European study. London School of Hygiene & Tropical Medicine and the Daphne Programme of the European Commission: London.

16. Zimmerman, C., M. Hossain, K. Yun, B. Roche, L. Morison, and C. Watts, 2006. *Stolen smiles. The physical and psychological health consequences of trafficking in women.* London School of Hygiene & Tropical Medicine: London.

17. International Organization for Migration, 2003. *World migration 2003. Managing migration. Challenges and responses for people on the move.* International Organization for Migration: Geneva.

18. United Nations High Commissioner for Human Rights, 2001. *Traffic in women and girls Commission on Human Rights,* in *Resolution 2001/48.*

19. Commission of the European Communities, 2001. *Trafficking in Women: The Misery behind the Fantasy: From Poverty to Sex Slavery -A Comprehensive European Strategy.* Commission of the European Communities: Brussels.

20. U.S. Citizenship and Immigration Services, 2004. *Trafficking in Persons Report.* http://www.state.gov/g/tip/rls/tiprpt/2004/34021.htm, accessed.

21. International Labour Organization (ILO), 2005. *A Global Alliance Against Forced Labour.* ILO: Geneva.

22. U.S. Department of State, 2003. *Trafficking in Persons Report.* U.S. Department of State: Washington, D.C.

23. Derks, A., 2000. *From white slaves to trafficking survivors: Notes on the trafficking debate,* in *Working paper for the Center for Migration and Development. Working Paper Series.Princeton University*: Princeton.

24. Wijers, M. and L. Lap-Chew, 1999.*Trafficking in women, forced labour and slavery-like practices in marriage, domestic labour and prostitution.* Utrecht: Foundation Against Trafficking in Women, Global Alliance Against Traffic in Women.

25. Lehti, M., 2003. *Trafficking in women and children in Europe.* HEUNI papers, **18**.

26. United Nations Office on Drugs and Crime, U., 2006. *Trafficking in Persons: Global Patterns.* UNODC: Geneva.

27. Coontz, P. and C. Griebel, 2004. *International Approaches to Human Trafficking: The Call for a Gender-Sensitive Perspective in International Law.* Women's Health Journal, **4/2004**(Latin American and Caribbean Women's Health Network).

28. Anderson, B., 1993.*Britian's secret slaves.* London: Anti-slavery International & Kalyann.

29. Derks, A., 1997. *Trafficking of Cambodian women and children to Thailand.* International Organization for Migration / Center for Advanced Study: Phnom Penh.

30. Skeldon, R., 2000. *Trafficking: a perspective from Asia.* Perspectives on Trafficking of Migrants, **38**(3-Special Issue 1/2000): p. 7-28.

31. Singh, M., 2003. *Debate on Trafficking and Sex-Slavery. The feminists sexual ethics project.* http://www.brandeis.edu/projects/fse/Pages/traffickingdebate.html, accessed on Access 2003.

32. 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*, in *G.A. res. 55/25, annex II, 55 U.N. GAOR Supp. (No. 49) at 60, U.N. Doc. A/45/49 (Vol. I)*.

33. Ditmore, M. and M. Wijers, 2003. *The negotiations on the UN Protocol on Trafficking in Persons*. Nemisis, **nr 4**.

34. Anderson, B. and J. O'Connell-Davidson, 2002. *Trafficking - a demand led problem? Part I: Review of evidence and debates*. Save the Children, Sweden: Stockholm.

35. Pearson, E., 2005. *The Mekong Challenge. Human Trafficking: Redefining Demand*. International Labour Organization (ILO): Bangkok.

36. Anderson, B. and J. O'Connell Davidson, (draft). *Review of evidence and debates on "the demand side of trafficking.* (draft): http://www.childtrafficking.com/Content/Library/Search/?KEYWORD=demand &btn_search=++Search++&IN=ALL.

37. *Council of Europe Convention on Action Against Trafficking in Human Beings*, in *CM(2005)32 Addendum 1 final*.

38. International Organization for Migration (IOM) and United States Agency for International Development (USAID), 2003. *Summary & report of the regional conference on public health and trafficking in human beings in Central, Eastern & Southeast Europe*. International Organization for Migration (IOM), United States Agency for International Development (USAID): Budapest Hungary.

39. Gülçür, L. and P. Ilkkaracan, 2002. *The "Natasha" experience: migrant sex workers from the former Soviet Union and Eastern Europe in Turkey*. Women's Studies International Forum, , **25** (4): p. 411 - 421.

40. Limanowska, B., 2002. *Trafficking in Human Beings in Southeastern Europe: Current Situation and Responses to Trafficking in Albania, Bosnia and Herzegovina, Bulgaria, Croatia, The Federal Republic of Yugoslavia, the Former Yugoslav Republic of Macedonia, Moldova, Romania*. United Nations Children's Fund (UNICEF), Organization for Security and Cooperation in Europe/Office for Democratic Institutions and Human Rights (OSCE-OHIDR), United Nations Office of the High Commissioner for Human Rights (UNOHCHR): Belgrade.

41. Orhant, M., *Trafficking in Persons*, in *Reproductive Health and Rights—Reaching the Hardly Reached*, E. Murphy and A. Hendrix-Jenkins, Editors. 2002, Program for Appropriate Technologies in Health: Washington, D.C.

42. Breyer, C. and J. Stachowiak, 2003. *Health consequences of trafficking in women and girls in Southeast Asia*. Brown Journal of World Affairs, **X**(1): p. 105-117.

43. Huntington, D. and P. Guest, 2002. *Trafficking in persons: concepts, intervention models and implications for reproductive health and HIV/AIDS Programs*. World Bank.

44. Peroff, N., 2002. *HIV and reproductive health risks to trafficked women in the sex industry*. unpublished paper: Geneva.

45. Heise, L., 1994. *Violence against women. The hidden health burden. World Bank Discussion Papers 255*. The World Bank: Washington, D.C.

46.   Heise, L., A. Raikes, C.H. Watts, and A. Zwi, 1994. *Violence against women: a neglected health issue in less developed countries.* Social Science & Medicine, **39**: p. 1165-1179.

47.   Loff, B. and J. Sanghera, 2003. *Distortions and difficulties in data for trafficking.* The Lancet, **363**(9408).

48.   International Labour Organization (ILO), 1930. *Convention concerning Forced or Compulsory Labour.*

49.   Laczko, F. and M. Gramegna, 2003. *Developing better indicators of human trafficking.* Brown Journal of World Affairs, **X**(1): p. 199-194.

50.   U.S. Department of State, 2006. *Victims of Trafficking and Violence Protection Act of 2000: Trafficking in Persons Report* http://www.state.gov/g/tip/rls/tiprpt/2006/, accessed on Access 2006.

51.   International Organization for Migration, 1995. *Trafficking and Prostitution: the growing exploitation of migrant women from Central and Eastern Europe.* IOM: Geneva.

52.   Caldwell, G., S. Galster, and N. Steinzor, 1997. *Crime & Servitude: an Exposé of the traffick in women for prostitution from the Newly Independent States.* Global Survival Network: Washington.

53.   Meese, J., K. Van Impe, and S. Vanheste, 2000. *Multidisciplinary Research on the phenomenon of trafficking in human beings from an international and national perspective: A pilot study with Poland and Hungary. University of Ghent Research Group Drug Policy, Criminal Policy, International Crime.*, in *Migrant trafficking and human smuggling in Europe: A review of the evidence.* In D. Thompson (Ed.), Cited in Salt, J. (2000), Editor. 1998, IOM: Geneva.

54.   Kelly, L. and L. Regan, 2000.*Stopping traffic: Exploring the extent of, responses to, trafficking in women for sexual exploitation in the UK.* Police Research Series Paper 125. London: Home Office Crown Copyright,.

55.   United Nations Educational Scientific and Cultural Organization (UNESCO), 2006. *The Trafficking Statistics Project.* http://www.unescobkk.org, accessed on Access 2006.

56.   Block, J., 2004. *Sex trafficking. Why the faith trade is interested in the sex trade.* Conscience, (summer/autumn.).

57.   Laczko, F., 2002. *Human Trafficking: The Need for Better Data.* http://www.migrationinformation.org/Feature/display.cfm?ID=66, accessed on Access 2005.

58.   International Organization for Migration (IOM), 2001. *Trafficking of victims in the Balkans.* IOM: Geneva.

59.   Pag-Asa, 2003. *Rapport Annuel 2002.* PagAsa: Brussels.

60.   U.S. Department of State, 2004. *Trafficking in Persons Report.* http://www.state.gov/g/tip/rls/tiprpt/2004/34021.htm, accessed.

61.   Laczko, F., A. Klekowski von Koppenfels, and J. Barthel, 2002. *European conference on preventing and combating trafficking in human beings: Global challenge for the 21st Century.* International Organization for Migration/International Centre for Migration Policy Development: Brussels.

62.   European Commission, 2001. *Preventing and combating trafficking in women. A comprehensive European Strategy.* European Commission: Brussels.

63.   International Organization for Migration, 1998. *Analysis of Data and Statistical Resources Available in the EU Member States on Trafficking in Humans, Particularly in Women and Children, for Purposes of Sexual Exploitation, unpublished.* IOM: Geneva.

64.   Kligman, G. and S. Limoncelli, 2005. *Trafficking Women After Socialism: From, To, and Through Eastern Europe.* Social Politics: International Studies in Gender, State and Society, 12(1): p. 118-140.

65.   Kinnell, H. and C.l. Praats, 2000. *EUROPAP regional report.* EUROPAP: London.

66.   International Organization for Migration, 2001. *New IOM figures on the global scale of trafficking.* Trafficking in Migrants Quarterly Bulletin, (23).

67.   Salt, J. and J. Stein, 1997. *Migration as a business: The case of trafficking.* International Migration, 35(4): p. 467-491.

68.   Interview, 2002. *Ukraine*: Kyiv.

69.   U.S. Department of State, 2005. *Trafficking in Persons Report.* U.S. Citizenship and Immigration Services (USCIS): Washington, D.C.

70.   Nelson, S., J. Guthrie, and P.S. Coffey, 2004. *Literature Review and Analysis Related to Human Trafficking in Post-Conflict Situations.* Office of Women in Development, Bureau for Economic Growth, Agriculture and Trade, (EGAT/WID) USAID,: Washington, D.C.

71.   Raymond, J.G., J. D'Cunha, S.R. Dzuhayati, H.P. Hynes, Z.R. Rodriguez, and A. Santos, 2002. *A Comparative Study of Women Trafficked in the Migration Process: Patterns, Profiles and Health Consequences of Sexual Exploitation in Five Countries (Indonesia, the Philippines, Thailand, Venezuela and the United States.* Coalition Against Trafficking in Women: Rhode Island.

72.   International Organization for Migration (IOM), 1999. *Paths of Exploitation. Studies on the trafficking of women and children between Cambodia, Thailand and Vietnam.* IOM: Geneva.

73.   International Organization for Migration, 1995. *Trafficking in women to Italy for Sexual exploitation.* IOM: Geneva.

74.   Khoser, K., *Asylum policies, trafficking and vulnerability,* in *Perspectives on trafficking of migrants,* J. Salt, Editor. 2000, IOM: Geneva.

75.   United Nations, 1998. *Global Programme against trafficking in human beings.* New York: Office for Drug Control and Crime Prevention: New York.

76.   United Nations Office on Drugs and Crime, 2003. *Fact sheet on human trafficking.* http://www.unodc.org/unodc/en/trafficking_victim_consents.html, accessed on Access 2003.

77.   Schloenhardt, A., 2001. *Migrant trafficking and regional security.* Forum for Applied Research and Public Policy, **Summer.**

78.   Koss, M., L.A. Goodman, A. Browne, L.F. Fitzgerald, G. Keita, N. Puryear, and F. Russol, 2002.*Male violence against women at home, at work and in the community.* Washington, D.C.: American Psychological Association.

79.   United Nations, 1981. *Convention on the Elimination of All Forms of Discrimination Against Women.*

80.   United Nations, 1993. *Declaration on the Elimination of Violence against Women,* in *G.A. res. 48/104, 48 U.N. GAOR Supp. (no.49) at 217.*

81. Zimmerman, C., 1994. *Plates in a basket will rattle: domestic violence in Cambodia*. The Asia Foundation: Phnom Penh.

82. Kelly, L. and J. Radford, *Sexual violence against women and girls: An approach to an international overview*, in *Rethinking violence against women*, R. Emerson Dobash and R.P. Dobash, Editors. 1998, Sage Publications: London.

83. Johnson, A., 1988. *On the prevalence of rape in the United States revisited.* Signs: A journal of women in culture and society, 6(11): p. 136-146.

84. Sassen, S., 2002. *Women"s Burden: Counter-Geographies of Globalization and the Feminization of Survival.* Nordic Journal of International Law, 71(2): p. 255-274.

85. Bandarage, A., 1998.*Women, population and global crisis*. London: Zed Books.

86. Bassuk, E.L. and B. Donelan, *Social deprivation*, in *Trauma interventions in war and peace. Prevention, practice and policy*, B.L. Green, et al., Editors. 2003, Kluwer Academic/Plenum Publishers: New York.

87. Acheson, D., D. Barker, J. Chambers, H. Graham, M. Marmot, and M. Whitehead, 2000. *Independent inquiry into inequalities in health report.* The Stationary Store: London.

88. Leon, D. and G. Walt, 2001.*Poverty, inequality and health: An international perspective*. Oxford: Oxford University Press.

89. World Health Organization, 2000. *Women's mental health: An evidence based review*. World Health Organization: Geneva.

90. United Nations Development Program (UNDP), 2005. *Human development indicators*. http://hdr.undp.org/statistics/data/pdf/hdr05_table_25.pdf, accessed on Access 2006.

91. Pearson, E., 2002.*Human traffic, human rights: Redefining victim protection*. London: Anti-slavery International.

92. Sum, A., N. Fogg, and P. Harrington, 2000. *Immigrant workers and the great American job machine. The contributions of new foreign immigration to nationals and regional labor force growth in the 1990's*, in *National Business Roundtable*. Center for Labour Market Studies, Northeastern University: Washington, D.C.

93. Kaye, M., 2003. *The migration-trafficking nexus: combating trafficking through the protection of migrants' human rights.* http://www.antislavery.org/homepage/resources/the%20migration%20trafficking%20nexus%202003.pdf, accessed on Access 2004.

94. Salt, J., *Trafficking and human smuggling: A European perspective*, in *Perspectives on Trafficking of Migrants*, J. Salt, Editor. 2000, International Organization for Migration: Geneva.

95. Derks, A., *Focus on Cambodia: Trafficking flows and the return home*, in *Paths of exploitation. Studies on the trafficking of women and children between Cambodia, Thailand and Vietnam*, F. Laczko, Editor. 1999, International Organization for Migration: Geneva.

96. Sanghera, J., *In the belly of the beast: sex trade, prostitution and globalization*, in *Moving beyond the whore stigma: report on the Asia and Pacific regional consultation on prostitution*, Global Alliance Against Trafficking in Women and Friends of Women Foundation, Editor. 1997: 17-18 February.

97.   International Organization for Migration (IOM), 1999. *Traffickers make money through humanitarian crises.* Trafficking in migrants. Quarterly bulletin, **19**(July).

98.   Boyd, M. and E. Grieco, 2003. *Women and migration : incorporating gender into international migration theory.* www.migrationinformation.org, accessed on Access 2005.

99.   Galtung, J., 1990. *Cultural violence.* Journal of Peace Research, **27**: p. 291-305.

100.   Dobash, R.E. and P. Dobash, 1998.*Rethinking violence against women.* Thousand Oaks, California: Sage Publications, Inc.

101.   Nelson, J. and S. Eglinton, 1993. *Global goals, contentious means: issues of multiple aid conditionality.* Overseas Development Council: Washington, D.C.

102.   Graycar, A. *Trafficking in human beings.* in *International Conference on Migration, Culture & Crime.* 1999. Israel.

103.   Renton, D., 2001. *Child trafficking in Albania.* Save the Children: Tirana.

104.   Anderson, B. and J. O'Connell Davidson, 2001. *The Demand Side of Trafficking. A Multi-Country Pilot Study. Part 2.*: (draft) http://www.childtrafficking.com/.

105.   Basoglu, M., 1992.*Torture and its consequences: Current treatment approaches.* Cambridge: Cambridge University Press.

106.   Renzetti, C., J.L. Edleson, and R. Kennedy Bergen, 2001.*Sourcebook on violence against women.* London: Sage Publications.

107.   Tchomarova, M., *Trafficking in women - personal, psychological and social problems in (non)-united Europe,* in *Trafficking in Women,* Animus Association Foundation/La Strada, Editor. 2001: Sofia, Bulgaria.

108.   World Health Organization, 1946 and entered into force on 7 April 1948. *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,* in *p. 100.*

109.   Meyer, I.H. and S. Schwartz, 2000. *Social issues as public health: promise and peril.* American Journal of Public Health, **90**(8): p. 1189-90.

110.   Alaszewski, A., *Risk in modern society,* in *Risk, health and welfare.,* A. Alaszewski, L. Harrison, and J. Manthorpe, Editors. 1998, Open University Press.: Brickingham.

111.   Douglas, M. and A. Wildavsky, 1982.*Risk and culture.* London: University of California Press.

112.   Giddens, A., 1991.*Modernity and self identity.* Cambridge: Polity Press.

113.   Lupton, D., 1999.*Risk.* London: Routledge.

114.   Wallman, S., 2001. *Global threats, local options, personal risk: dimensions of migrant sex work in Europe.* Health, Risk & Society, **3**(1): p. 75-87.

115.   Alexander, P., 2001. *Contextual risk versus risk behaviour: The impact of legal, social and economic contexts of sex work on individual risk taking.* Research for sex work, **4**.

116.   Parker, R., 1996. *Empowerment, community mobilization and social change in the face of HIV/AIDS.* AIDS, **10: Suppl 3: S27-S31.**

117.   Scott, J., 1994.*Power: Critical Concepts.* New York and London: Routledge.

118.   Davidson, O.C., 1998.*Prostitution, Power and Freedom.* Cambridge: Polity Press.

119. Basoglu, M. and S. Mineka, *The role of uncontrollable and unpredictable stress in post-traumatic stress responses in torture survivors*, in *Torture and its consequences: Current treatment approaches*, M. Basoglu, Editor. 1992, Cambridge University Press: Cambridge.

120. Gushulak, B.D. and D. MacPherson, 2000. *Health issues associated with the smuggling and trafficking of migrants.* Journal of Immigrant Health, 2(67-78).

121. Brussa, L., 1999.*Health, migration & sex work. The experience of TAMPEP*. Amsterdam: Tampep International Foundation,.

122. European Network for HIV-STD Prevention in Prostitution EUROPAP/TAMPEP, 1994-2005. *EUROPAP REPORTS*. http://www.europap.net/, accessed on Access 2000-2005.

123. EUROPAP/TAMPEP, 1998. *Hustling for health: Developing services for sex workers in Europe*. EUROPAP/TAMPEP: London/Netherlands.

124. Global Alliance Against Traffic in Women, 1997.*Practical guide to assisting trafficked women.* Bangkok: Global Alliance Against Traffic in Women (GAATW).

125. Animus Association Foundation/La Strada, 2001. *Trafficking in women*. Animus Association Foundation/La Strada,: Sofia Bulgaria.

126. UNAIDS, 2001. *Population mobility and AIDS*. UNAIDS: Geneva.

127. Skeldon, R. and L.-N. Hsu, 2000. *Population Mobility and HIV Vulnerability in South East Asia: An Assessment and Analysis*. United Nations Development Programme (UNDP): Bangkok.

128. Guinness, L. and L. Kumaranayake, 2002. *The Potential Costs and Benefits of Responding to the Mobility Aspect of the HIV Epidemic in South East Asia: A conceptual framework*. UNDP: Bankok.

129. Burkhalter, H., 2004. *Testimony of Holly Burkhalter, U.S. Policy Director, Physicians for Human Rights before the House International Relations Committee, Subcommittee on Terrorism, Nonproliferation and Human Rights*. Physicians for Human Rights: Washington, D.C.

130. Beyrer, C., 2003. *Health consequences of trafficking of women and girls into Southeast Asia*. Brown Journal of World Affairs, X(Summer/Fall): p. 105-117.

131. Cwikel, J., K. Ilan, and B. Chudakov, 2003. *Women brothel workers and occupational health risks*. Journal of Epidemiology and Community Health, 57: p. 809-815.

132. Cwikel, J., B. Chudakov, M. Paikin, K. Agmon, and R.H. Belmaker, 2004. *Trafficked female sex workers awaiting deportation: comparison with brothel workers*. Arch Women's Ment Health, 7(4): p. 243-9.

133. Beyrer, C., 2004. *Is trafficking a health issue?* Lancet 363(9408): p. 564.

134. Council of Europe, 2005. *Council of Europe Convention on Action Against Trafficking in Human Beings*, in *CM(2005)32 Addendum 1 final*. Council of Europe.

135. United Nations, 2000. *Protocol to prevent, suppress and punish trafficking in persons, especially women and children, supplementing the United Nations convention against transnational organized crime*, in *G.A. res. 55/25, annex II, 55 U.N. GAOR Supp. (No. 49) at 60, U.N. Doc. A/45/49 (Vol. I)*.

136. United States of America, 2000. *Victims of Trafficking and Violence Protection Act of 2000*, in *106th Congress*.

137. Editor, 2006. *Trafficking of women is a health issue*. Lancet, **367**(9527): p. 1954.

138. Miller, E., M.R. Decker, J.G. Silverman, and A. Raj, 2007. *Migration, Sexual Exploitation, and Women's Health: A Case Report From a Community Health Center*. Violence Against Women, (13): p. 486-497.

139. World Health Organization (WHO), 2002. *WHO gender policy. Integrating gender perspectives in the work of WHO*. http://www.who.int/gender/mainstreaming/ENGwhole.pdf accessed.

140. Doyal, L., 2001. *Sex, gender, and health: the need for a new approach*. British Medical Journal, **323**: p. 1061-3.

141. Doyal, L., 2004. *Gender and the 10/90 gap in health research*. Bulletin of the World Health Organization, **82**(3).

142. Walters, V., 2004. *The social context of women's health*. Biomedical Central Women's Health, **4 (Suppl 1)**(S2): p. 1472-6874.

143. Osmani, S. and A. Sen, 2003. *The hidden penalties of gender inequality: fetal origins of ill-health*. Economics and Human Biology, **1**: p. 105-121.

144. Matthews, S., O. Manor, and C. Power, 1998. *Social inequalities in health: are there gender differences?* Social Science & Medicine, **48**(1): p. 49-60.

145. Ostlin, P., G. Sen, and A. George, 2004. *Paying attention to gender and poverty in health research: content and process issues*. Bull World Health Organ, **82**(10): p. 740-5.

146. Caouette, T., K. Archavanitkul, and H.H. Pyne, 2000. *Sexuality, reproductive health and violence: Experiences of migrants from Burma in Thailand*. Institute for Population and Social Research, Mahidol University.: Bangkok.

147. United Nations, 2004. *World survey on the role of women in development: women and international migration*. United Nations, Department of Economic and Social Affairs: New York.

148. Zlotnik, H., 2003. *The global dimensions of female migration*. Migration Information Source.

149. Boyd, M. and E. Grieco, 2003. *Women and migration : incorporating gender into internatioal migration theory*. www.migrationinformation.org, accessed on Access 2005.

150. Pedraza, S., 1991. *Women and migration: The social consequences of gender*. Annual Review of Sociology, **17**: p. 303-325.

151. Buvinic, M., 1997. *Women in poverty: a new global underclass*. Foreign Policy, (108): p. 38-53.

152. International Labor Organization, 2002. *Gender & migration*. http://www.ilo.org/public/english/protection/migrant/projects/gender/, accessed on Access 2006.

153. Gushulak, B., 2000.*Health Determinants in migrants: the impact of population mobility on health*. Health, migration and return, ed. P.J. van Krieken. The Hague: Asser Press.

154. United Nations Development Program, 2005. *Human development report. International cooperation at a crossroads: Aid, trade and security in an unequal world*. UNDP: Geneva.

155. Macpherson, D.M., 2001. *Human health, demography, and population mobility.* Migration and health, **International Organization for Migration**(1/2000.).

156. Gushulak, B.D. and D.W. MacPherson, 2000. *Population mobility and infectious diseases: the diminishing impact of classical infectious diseases and new approaches for the 21st century.* Clinical infectious Diseases, **31**: p. 776-80.

157. Gushulak, B. and D.W. MacPherson, *The impact of population movement on HIV/AIDS in Europe,* in *HIV/AIDS in Europe. MOving from death sentene to chronic disease management,* S. Matic and J.V. Lazarus, Editors. 2006, WHO: Geneva.

158. Carballo, M., *Emerging health challenges in the context of migration,* in *Health, migration and return,* P.J. van Krieken, Editor. 2001, Asser Press: The Hague.

159. Bollini, P., 2001. *The reproductive health of immigrant women.* Migration and Health Newsletter, (2/2001): p. 1-2.

160. Flores, G., 2000. *Culture and the patient-physician relationship: Achieving cultural competency in health care* J Pediatr, **136**(1): p. 14-23.

161. Lipson, J.G., S. Dibble, and M. P., 1995. *Promoting cultural competence in and through nursing education: A critical review and comprehensive plan for action* American Academy of Nursing: Washington, D.C.

162. Watters, C., 2001. *Emerging paradigms in the mental health care of refugees.* Social Science & Medicine, **52**: p. 1709-18.

163. Arcia, E., M. Skinner, D. Bailey, and V. Correa, 2001. *Models of acculturation and health behaviors among Latino immigrants to the US.* Social Science & Medicine, **53**: p. 43-53.

164. Salant, T. and D.S. Lauderdale, 2003. *Measuring culture: a critical review of acculturation and health in Asian immigrant populations.* Social Science & Medicine, **57**: p. 71-90.

165. Paasche-Orlow, M., 2004. *The ethics of cultural competence.* Acad Med, **79**(4): p. 347-50.

166. Meadows, L.M., W.E. Thurston, and C. Melton, 2001. *Immigrant women's health.* Social Science & Medicine, **52**: p. 1451-1458.

167. Kelley, N., 1989. *Working with Refugee women. A practical guide.* United Nations International NGO Working Group on Refugee Women: Geneva.

168. Basoglu, M., M. Paker, O. Paker, E. Ozmen, I. Marks, C. Incesu, D. Sahin, and N. Sarimurat, 1994. *Psychological effects of torture: a comparison of tortured with nontortured political activists in Turkey.* Am J Psychiatry, **151**(1): p. 76-81.

169. Steel, Z., D. Silove, R. Brooks, S. Momartin, B. Alzuhairi, and I. Susljik, 2006. *Impact of immigration detention and temporary protection on the mental health of refugees.* Br J Psychiatry, **188**: p. 58-64.

170. Burnett, A. and M. Peel, 2001. *Asylum seekers and refugees in Britain. The health of survivors of torture and organised violence.* BMJ, **322**(7286): p. 606-609.

171. United Nations High Commissioner for Refugees (UNHCR), 1999. *Reproductive health in refugee situations: an inter-agency filed manual.* UNHCR.: Geneva.

172. United Nations High Commissioner for Refugees (UNHCR), 1995. *Sexual violence against refugees: guidelines on prevention and response.* UNHCR: Geneva.

173. Galtung, J., 1969. *Violence, peace and peace research.* Journal of Peace Research, **6**(3): p. 167-191.

174. Heise, L., 1998. *Violence against women: an integrated ecological framework.* Violence Against Women, **4**: p. 262–290.

175. White, J.W. and J.A. Humphrey, *A longitudinal approach to the study of sexual assault. Theoretical and methodological considerations,* in *Researching sexual violence against women. Methodological and personal perspectives,* M.D. Schwartz, Editor. 1997, Sage Publications: Thousand Oaks, CA.

176. Becker, J.V., L.J. Skinner, G.G. Abel, and J. Cichon, 1986. *Level of postassault sexual functioning in rape and incest victims.* Archives of sexual behavior, **15**(1): p. 37-49.

177. Kelly, L., S. Burton, and L. Regan, *Beyond victim and survivor: Sexual violence, identity feminist theory and practice,* in *Sexualizing the social: The social organization of power,* L. Adkins and V. Merchant, Editors. 1996, Macmillan: London.

178. Billings, D., 2004. *World Health Organization Sexual Violence Research Initiative: List-serve discussion contribution from Ipas,Mexico.* accessed on Access 2004.

179. Campbell, J., J. Jones, J. Dienemann, J. Kub, J. Schollenberger, P. O'Campo, A. Gielen, and C. Wynne, 2002. *Intimate partner violence and physical health consequences.* Archives of Internal Medicine, **162**(10): p. 1157-63.

180. Arata, C.M., 1999. *Cope With Rape: The Roles of Prior Sexual Abuse and Attributions of Blame.* Journal of Interpersonal Violence, **14**(1): p. 62-78.

181. Felitti, V.J., R.F. Anda, D. Nordenberg, D.F. Williamson, A.M. Spitz, V. Edwards, M.P. Koss, and J.S. Marks, 1998. *Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults The Adverse Childhood Experiences (ACE) Study.* Am J Prev Med, **14**(4).

182. Koss, P. and L. Heslet, 1992. *Somatic consequences of violence against women.* Archives of Family Medicine, **1**: p. 53-59.

183. Green, B.L., L.A. Goodman, J.L. Krupnick, C.B. Corcoran, R.M. Petty, P. Stockton, and N.M. Stern, 2000. *Outcomes of single versus multiple trauma exposure in a screening sample.* J Trauma Stress, **13**(2): p. 271-86.

184. Casey, E.A. and P.S. Nurius, 2005. *Trauma exposure and sexual revictimization risk. Comparisons Across single, multiple incident, and multiple perpetrator victimizations.* Violence Against Women, **11**(4): p. 505-530.

185. McNutt, L.A., B.E. Carlson, M. Persaud, and J. Postmus, 2002. *Cumulative abuse experiences, physical health and health behaviors.* Ann Epidemiol, **12**(2): p. 123-30.

186. Herman, J.L., 1997.*Trauma and recovery.* New York: Basic Books.

187. Amnesty International, 2001. *Broken bodies, shattered minds: Torture and ill-treatment of women.* Amnesty International Publications: London.

188. Turner, S., S. Yuksel, and D. Silove, *Survivors of mass violence and torture,* in *Trama interventions in war and peace. Prevention, practice, and policy,* B.L. Green, et al., Editors. 2003, Kluwers Academic/Plenum Publishers: New York.

189. Koss, M.P., L.A. Goodman, and A. Browne, 1994.*No Safe Haven*, ed. M.P. Koss, L.A. Goodman, and A. Browne. Washington, D.C.: American Psychological Association.

190. Schwartz, M., 1997.*Researching sexual violence against women. Methodological and personal perspectives*. Thousand Oaks, CA: Sage.

191. Human Rights Watch, 2006. *Women workers*. http://hrw.org/women/labor.html, accessed on Access 2006.

192. Eskenazi, B., S. Guendelman, E.P. Elkin, and M. Jasis, 1993. *A preliminary study of reproductive health outcomes of female maquiladora workers in Tijuana, Mexico*. American Journal of Industrial Medicine, 25(2): p. 309.

193. Magana, C. and J.D. Hovey, 2003. *Psychosocial stressors associated with Mexican migrant farmworkers in the Midwest United States*. Journal of Immigrant health, 5(2).

194. Nishigaya, K., 2002. *Female garment factory workers in Cambodia: migration, sex work and HIV/AIDS*. Women Health, 35(4).

195. Flanagan, K., 1997. *Commission for Filipino migrant workers health research report: An assessment of the health experiences and needs of overseas domestic workers in London and the South East of England*. Commission for the Filipino Migrant Workers: London.

196. Human Rights Watch, 2004. *Bad Dreams. Exploitation and Abuse of Migrant Workers in Saudi Arabia*. Human Rights Watch: New York.

197. Ramirez-machado, J.M., 2003. *Domestic work, conditions of work and employment: a legal perspective*. International Labor Organization / International Labour Office.: Geneva.

198. Unicef, 1999. *Child domestic work. Innocenti Digest 5*. Unicef: Florence.

199. Save the Children, 1996. *Kids for hire: a child's right to protection from commercial sexual exploitation*. Save the Children.: London.

200. Villarejo, D., 2003. *The health of U.S. hired farm workers*. Annual Review, 24: p. 175-193.

201. Labor, U.S.D.o., 2005. *Findings from the National Agricultural Workers Survey (NAWS) 2001 - 2002. A Demographic and Employment Profile of United States Farm Workers.* , U.S. Department of Labor Office of the Assistant Secretary for Policy Office of Programmatic Policy, Editor. U.S.D.A. Census of Agriculture,.

202. Villarejo, D., 2003. *The health of US hired farm workers*. Annual review of public health, 24: p. 175-193.

203. Human Rights Watch, 2000. *Fingers to the bone: United States Failure to protect child farmworkers*. Human Rights Watch: New York.

204. Calvert, G.M., D.K. Plate, R. Das, R. Rosales, O. Shafey, C. Thomsen, D. Male, J. Beckman, E. Arvizu, and M. Lackovic, 2004. *Acute occupational pesticide-related illness in the US 1998-1999: surveillance findings from the SENSOR-pesticides program*. American Journal of Industrial Medicine, 45(1): p. 14-23.

205. Attanapola, C., 2004. *Changing gender roles and health impacts among female workers in export processing industries in Sri Lanka*. Social Science & Medicine, 58(2301-2312).

206. Athreya, B., 2003. *Trade is a women's issue*. Global Policy Forum: Geneva.

207.	Romero, A.T., 1995. *Export processing zones: Addressing the social and labour issues*. International Labor Organization: Geneva:.

208.	International Organization for Migration, 2005. *World Migration 2005*. IOM: Geneva.

209.	The Henry Kaiser Family Foundation, 2005. *Bush Administration To Require U.S. AIDS Groups Take Pledge Opposing Commercial Sex Work To Gain Funding*. http://www.kaisernetwork.org/daily_reports/rep_hiv_recent_rep.cfm?dr_cat=1&show=yes&dr_DateTime=02-28-05#28358, accessed on Access 2005.

210.	Wolffers, I., 2001. *Violence, repression and other health threats: sex workers at risk*. Research for sex work, 4(Amsterdam: Department of Health Care and Culture, Vrije Universiteit medical centre.): p. 2-3.

211.	Wawer, M., C. Podhisita, U. Kanungsukkasem, A. Pramualratana, and R. McNamara, 1996. *Origins and working conditions of female sex workers in urban Thailand: consequences of social context for HIV transmission*. Social Science & Medicine, 42(3): p. 453 462.

212.	Trappolin, L. and M. Treppete, 2002. *Violence against people working as prostitutes. Unpublished paper*: Padua.

213.	Virgilio, M., *Laws and rights*, in *A manual for interventions in the world of migrant prostitution*, S.M. Treppete, Editor. 2001, Asterios: Trieste.

214.	Shara Ho, P., 2001. *Some conditions influencing HIV/AIDS prevention and health promotion in Hong Kong*. Research for sex work, 4: p. 6-7.

215.	Beyrer, C., 2001. *Shan women and girls in the sex industry in Southeast Asia: political causes and human rights implications*. Social Science and Medicine, 53(543-550).

216.	Ward, H., S. Day, and J. Weber, 1999. *Risky business: health and safety in the sex industry over a 9-year period*. Sexually Transmitted Infections, 75: p. 340-3.

217.	Morara, N.S., G. Ramjeea, E. Gouwsa, and D. Wilkinson, 2003. *Vaginal douching and vaginal substance use among sex workers in KwaZulu-Natal, South Africa*. South African Journal of Science, 99(7/8).

218.	Kilmarx, P., K. Limpakarnjanarat, T. Mastro, S. Saisorn, J. Kaewkungwal, S. Korattana, W. Uthaivoravit, N. Young, B. Weniger, and M. St. Louis, 1998. *HIV-1 seroconversion in a prospective study of female sex workers in northern Thailand: Continued high incidence among brothel-based women*. AIDS, 12: p. 1889-98.

219.	World Health Organization, 2002. *Guidelines for the Management of STIs in Female Sex Workers*. WHO: Geneva.

220.	Kinnell, H., 2001. *Murderous clients and indifferent justice. Violence against sex workers in the UK*. Research for sex work, 4.

221.	Wong, M., C. Archibald, K. Roy, A. Goh, T. Tan, and C. Goh, 1994. *Condom use negotiation among sex workers in Singapore: findings from qualitative research*. Health Education Research, 9(1): p. 57-67.

222.	Vanwesenbeeck, I., R. de Graaf, G. van Zessen, C.J. Straver, and J.H. Visser, 1995. *Professional HIV risk taking, levels of victimization, and well-being in female prostitutes in the Netherlands*. Archives of sexual behavior, 24(5): p. 503-515.

223. Vanwesenbeeck, I., R. de Graaf, G. van Zessen, C.J. Straver, and J.H. Visser, 1993. *Condom use by prostitutes: behavior, factors and considerations.* Journal of Psychology and human sexuality, **6**(1): p. 69-91.

224. Tep, M., 2001. *Different mindsets, different risks: Looking at risk factors identified by Vietnamese sex workers in Cambodia.* Research for Sex Work, **4**(Amsterdam: Vrije Universiteit Medical Centre).

225. Bloem, M., 1998. *Syndromic management and need based services in Bangladesh.* Research for sex work, **1**(June).

226. Centers for Disease Control & Prevention, 2002. *Sexual Assault and STDs.* http://www.cdc.gov/std/treatment/8-2002TG.htm#AssaultSTDs, accessed on Access 2005.

227. Hossain, M., C. Zimmerman, S. Hawkes, and C. Watts., 2005. *Recommendations for reproductive and sexual health care of trafficked women in Ukraine.* London School of Hygiene & Tropical Medicine: London.

228. Wolffers, I., 1999. *Appropriate health services for sex workers.* Research for sex work, **2**(August).

229. Wilson, J., 1999. *Outreach programmes for female commercial sex workers.* International journal of STD & AIDS, **10**(697-698).

230. van der Kolk, B.A., 1987.*Psychological Trauma.* Washington, D.C.: American Psychiatric Press.

231. American Psychiatric Association, 1994.*Diagnostic and statistical manual of mental disorders. Fourth Edition.* Vol. DSM IV. Washington D.C.: American Psychiatric Association.

232. International Organization for Migration, 2004. *Psychosocial support to groups of victims of human trafficking in transit situations.* Psychosocial Notebook, **4**(February).

233. Baráth, Á. and e. al, 2004.*The Mental Health Aspects of Trafficking in Human Beings, Training Manual.* Budapest.

234. National Institutes of Health and U.S. Library of Medicine, 2003. *Medical Encyclopedia.* http://www.nlm.nih.gov/medlineplus/ency/article/000925.htm#Definition, accessed on Access 2005.

235. Breslau, N., 2002. *Epidemiologic studies of trauma posttraumatic stress disorder and other psychiatric disorders.* Canadian Journal of Psychiatry, **47**(10): p. 923-929.

236. Marshall, R.D., R. Spitzer, and M.R. Liebowitz, 1999. *Review and critique of the new DSM-IV diagnosis of acute stress disorder.* American Journal of Psychiatry, **156**(11): p. 1677-1685.

237. Summerfield, D., 1999. *A critique of seven assumptions behind psychological trauma programmes in war-affected areas.* Social Science & Medicine, **48**: p. 1449-1462.

238. Summerfield, D., 2001. *The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category.* British Medical Journal, **322**: p. 95-98.

239. Watters, C., 2001. *Emerging paradigms in the mental health care of refugees.* Social Science & Medicine, **52**(1709-18).

240. Nemeroff, C.B., D.J. Bremner, E.B. Foa, H.S. Mayberg, C.S. North, and M.B. Stein, 2006. *Posttraumatic stress disorder: A state-of-the-science review.* Journal of Psychiatric Research, **40**: p. 1-21.

241. Wenzel, T., H. Briengl, T. Stompe, S. Mirzai, and W. Kieffer, 2000. *Psychological disorders in survivors of torture: exhaustion, impairment and depression.* Psychopathology, **33**(6): p. 292-296.

242. Silove, D., I. Sinnerbrink, A. Field, V. Manicavasagar, and Z. Steel, 1997. *Anxiety, depression and PTSD in asylum-seekers: Associations with pre-migration trauma and post-migration stressors.* . Br J Psychiatry, **170**: p. 351-357.

243. World Health Organization, 2005. *Mental health. Depression.* http://www.who.int/mental_health/management/depression/definition/en/, accessed on Access 2005.

244. Cascardi, M., K. Danel O'Leary, and K. Schlee, 1999. *Co-occurrence and correlates of posttraumatic stress disorder and major depression in physically abused women.* Journal of Family Violence, **14**(3).

245. Krakow, B., A. Artar, T. Warner, D. Melendrez, L. Johnston, M. Hollifield, A. Germain, and M. Koss, 2000. *Sleep disorder, depression, and suicidality in female sexual assault survivors.* Crisis, **21**(4): p. 163-170.

246. Heim, C., D.J. Newport, S. Heit, Y.P. Graham, M. Wilcox, R. Bonsall, A.H. Miller, and C. Nemeroff, 2000. *Pituitary-adrenal and autonomic responses to stress in women after sexual and physical abuse in childhood.* JAMA, **284**: p. 592-597.

247. Oquendo, M., D.A. Brent, B. Birmaher., L. Greenhill, D. Kolko, B. Stanley, J. Zelazny, A.K. Burke, S. Firinciogullari, S.P. Ellis, and J.J. Mann, 2005. *Posttraumatic Stress Disorder Comorbid With Major Depression: Factors Mediating the Association With Suicidal Behavior.* American Journal of Psychiatry, **162**(3): p. 560-566.

248. Abramson, L.Y., G.I. Metalsky, and L.B. Alloy, 1989. *Hopelessness depression. A theory-based subtype of depression.* Psychological Review, **96**(2): p. 358-372.

249. Clements, C.M., C.M. Sabourin, and L. Spiby, 2004. *Dysphoria and hopelessness following battering: the role of perceived control, coping and self-esteem.* Journal of Family Violence, **19**(1): p. 25-36.

250. National Institute of Mental Health (NIMH), 2000. *Anxiety Disorders.* http://www.nimh.nih.gov/publicat/anxiety.cfm, accessed on Access 2005.

251. Taylor, S., W.J. Koch, S. Woody, and P. McLean, 1996. *Anxiety sensitivity and depression: how are they related?* Journal of Abnormal Psychology, **105**(3): p. 474-479.

252. Keller, J., J.B. Nitschke, T. Bhargava, P.J. Deldin, J.A. Gergen, G.A. Miller, and W. Heller, 2000. *Neuropsychological Differentiation of Depression and Anxiety.* Journal of Abnormal Psychology, **109**(1): p. 3-10.

253. Heller, W., J.B. Nitschke, M.A. Etienne, and G.A. Miller, 1997. *Patterns of regional brain activity differentiate anxiety subtypes.* Journal of Abnormal Psychology, **106**: p. 375-385.

254. Spertus, I.L., R. Yehuda, C.M. Wong, S. Halligan, and S.V. Seremetis, 2003. *Childhood emotional abuse and neglect as predictors of psychological and*

physical symptoms in women presenting to a primary care practice. Child Abuse Negl, **27**(11): p. 1247-58.

255. Simon, N.M., M.H. Pollack, K.S. Tuby, and T.A. Stern, 1998. *Dizziness and panic disorder: a review of the association between vestibular dysfunction and anxiety.* Annals of Clinical Psychiatry, **10**(2): p. 75-80.

256. Falsetti, S.A. and H.S. Resnick, 1997. *Frequency and Severity of Panic Attack Symptoms in a Treatment Seeking Sample of Trauma Victims.* Journal of Traumatic Stress, **10**(4): p. 683-689.

257. Nishith, P., M.B. Mechanic, and P.A. Resick, 2000. *Prior interpersonal trauma: the contribution to current PTSD symptoms in female rape victims.* Journal of Abnormal Psychology, **109**(1): p. 20-25.

258. Lasko, N.B., T.V. Gurvits, A.A. Kuhne, S.P. Orr, and R.K. Pitman, 1994. *Aggression and its correlates in Vietnam veterans with and without chronic posttraumatic stress disorder.* Compr Psychiatry, **35**(5): p. 373-81.

259. Byrne, C.A. and D.S. Riggs, 1996. *The cycle of trauma; relationship aggression in male Vietnam veterans with symptoms of posttraumatic stress disorder.* Violence Vict, **11**(3): p. 213-25.

260. Valentiner, D.P., E. Foa, D.S. Riggs, and B.S. Gershuny, 1996. *Coping strategies and posttraumatic stress disorder in female victims of sexual and nonsexual assault.* J Abnorm Psychol, **105**(3): p. 455-8.

261. Snyder, C.R. and L. Heinze, 2005. *Forgiveness as a mediator of the relationship between PTSD and hostility in survivors of childhood sexual abuse.* Cognition and Emotion, **19**(3): p. 413-431.

262. World Health Organization, 2005. *WHO multi-country study on women's health and domestic violence against women, summary report of initial results on prevalence outcomes and women's responses.* World Health Organization: Geneva.

263. Dickson, S., 2004. *When women are trafficked: Quantifying the gendered experience of trafficking in the UK.* Poppy Project, Eaves Housing,: London.

264. IOM Ukraine, 2005. *unpublished data from IOM Rehabilitation Centre.* International Organization for Migration.

265. International Organization for Migration (IOM), 2002. *Return and reintegration project. Situation Report. February 2000 to September 2002.* http://www.iom.int/DOCUMENTS/PUBLICATION/EN/Kosovo_sit_report.pdf, accessed on Access 2004.

266. United Nations Economic and Social Commission for Asia and the Pacific (ESCAP), 2000. *Sexual abuse and sexual exploitation of children and youth in Asia: Information kit.* United Nations: Bangkok.

267. Kiecolt-Glaser, J.K. and R. Glaser, 1987. *Psychosocial moderators of immune function.* Annals of Behavioral Medicine, **9**: p. 16-20.

268. Maman, S., J. Campbell, M.D. Sweat, and A.C. Gielen, 2000. *The intersections of HIV and violence: directions for future research and interventions.* Social Science & Medicine, **50**(4): p. 459-478.

269. Dickinson, L.M., F.V. deGruy, 3rd, W.P. Dickinson, and L.M. Candib, 1999. *Health-related quality of life and symptom profiles of female survivors of sexual abuse.* Arch Fam Med, **8**(1): p. 35-43.

270. Bensley L, Van Eenwyk J, and W.S. K., 2003. *Childhood family violence history and women's risk for intimate partner violence and poor health.* American Journal of Preventive Medicine, 25(1).

271. Sutherland, C., D. Bybee, and C. Sullivan, 1998. *The long-tem effects of battering on women's health. Women's Health.* Research on Gender Behavior and Policy, 4(1): p. 41-70.

272. Saporta, J. and B.A. van der Kolk, *Psychobiological consequences of trauma,* in *Torture and its consequences: Current treatment approaches,* M. Basoglu, Editor. 1992, Cambridge University Press: Cambridge.

273. Bauer, H., M. Rodriguez, S. Quiroga, and Y. Flores-Ortiz, 2000. *Barriers to health care for abused Latina and Asian immigrant women.* J Health Care Poor Underserved, 11(1): p. 33-44.

274. Stoneburner, L. and D. Low-Beer, 2004. *Population-level HIV declines and behavioral risk avoidance in Uganda.* Science, 304(5671): p. 714-8.

275. WHO/UNFPA, 1997. *Family planning and reproductive health in Central and Eastern Europe and the Newly Independent States.* WHO: Geneva.

276. Solim, L., C. O'Brien, and M. Davis, 1997. *Young people, HIV/AIDS, STDs and sexual health project: Survey of Knowledge, attitudes and practices.* Save the Children Fund (UK) Cambodia,: Phnom Penh.

277. UNAIDS, 1999. *Sex and youth: contextual factors affecting risk for HIV/AIDS. A comparative analysis of multi-site studies in developing countries* UNAIDS: Geneva.

278. Lou, C.-H., B. Wang, Y. Shen, and E.-S. Gao, 2004. *Effects of a community-based sex education and reproductive health service program on contraceptive use of unmarried youths in Shanghai.* Journal of Adolescent Health, 34(5): p. 433-440.

279. Hopkins, N.L., 2000. *Grim find of 58 bodies in lorry exposes smugglers' evil trade,* in *Guardian Unlimited:* London.

280. La Strada Ukraine. *Final workshop: Responding to the health needs of trafficked women. 28-30 November* 2002. London.

281. Barry, S., 2002. Personal communication on 25 May.

282. Various post-trafficking service providers, 2001. *Informal interviews:* Ukraine, Albania, Belgium, Italy.

283. Kozhouharova, N., *How we help women, survivors of trafficking,* in *Trafficking in women. Questions and answers,* A.A. Foundation, Editor. 2001, Animus Association Foundation: Sofia.

284. International Organization for Migration, 2003. *Trafficking in Germany.* Trafficking in migrants quarterly bulletin, (27): p. 1-2.

285. On the Road, 2002. *Article 18: Protection of victims of trafficking and fight against crime (Italy and the European Scenarios. Research Report.* On The Road Martinsicurro.

286. US Department of State, 2000. *Victims of Trafficking and Violence Protection Act,* in *Public Law 106-386.*

287. Home Office, *Crime reduction toolkits: Sexual offences,* in *Citation from: Jordan, J. (1998). Reporting rape: Women's experiences with the police, doctors, and*

support agencies. Wellington: Institute of Criminology, Victoria University. 2003: London.

288. Anti-Slavery International (ASI), Police Academy in the Netherlands, On The Road (Italy), Eaves Housing for Women (UK), and STV (NL), 2005. *Protocol for identification and assistance to trafficked persons and training kit.* Anti-Slavery International (ASI): London.

289. International Organization for Migration (IOM), 2006. *Resource book for law enforcement officers on good practices on combating child trafficking.* IOM: Geneva.

290. European Council on Refugees & Exiles (ECRE), 1999. *Good Practice Guide on the Integration of Refugees in the European Union.* ECRE: Geneva.

291. UNAIDS, 2000. *Regional Summit on pre-departure post arrival and reintegration programs for migrant workers.* Caram Asia: Kuala Lumpur.

292. World Health Organization, 2003. *Clinical management of survivors of rape. A guide to the development of protocols for use in refugee and internally displaced persons situations* http://www.who.int/reproductive-health/publications/rhr_02_8/clinical_management.pdf, accessed on Access 2004.

293. Stark, E., *Health intervention with battered women: from crisis intervention to complex social prevention*, in *Sourcebook on Violence Against Women*, C.M. Renzetti, J.L. Edleson, and R.K. Bergen, Editors. 2001.

294. United Nations High Commissioner for Refugees (UNHCR), 2001. *Prevention and response to sexual and gender-based violence in refugee situations.* UNHCR: Geneva.

295. Mahoney, P., L.M. Williams, and C.M. West, 200.1 *Violence against women by intimate relationship partners*, in *Sourcebook on Violence Against Women*, C.M. Renzetti, J.L. Edleson, and R.K. Bergen, Editors. 2001, Sage: Thousand Oaks.

296. Koser, K., 2000. *Asylum policies, trafficking and vulnerability.* International Migration, **38**(3): p. 91-112.

297. Richman, N., *Looking before and after: refugees and asylum seekers in the West*, in *Rethinking the trauma of war*, P. Bracken, Editor. 1998, Free Association Books: London

298. Frommer, N., 2003. *Failing to understand: Refugee determination and the traumatised applicant. Presentation at Symposium: The asylum crisis: refugee, trauma and the response of the West.* http://www.nswiop.nsw.edu.au/Conference/resources/Abstracts/Steel-The%20Asylum%20Crisis.pdf, accessed.

299. Balabanova, D., M. McKee, J. Pomerleau, R. Rose, and C. Haerpfer, 2004. *Cross-Country Comparisons. Health Service Utilization in the Former Soviet Union: Evidence from Eight Countries.* Health Services Research, **39** (6p2): p. 1927

300. Platt, P. and M. McKee, 2000. *Observations of the management of sexually transmitted diseases in the Russian Federation: A challenge of confidentiality.* International Journal of STD & AIDS, **11**(563-567).

301. Campbell, R., C.M. Sullivan, and W.S. Davidson, 1995. *Women who use domestic violence shelters: changes in depression over time.* Psychology of Women Quarterly, **19**(2): p. 237.

302. Skrobanek, S., N. Boonpakdi, and C. Janthakeero, 1997.*The Traffic in Women: Human realities of the international sex trade.* Bangkok: Foundation for Women.

303. Golding, J., M. Cooper, and L. George, 1997. *Sexual assault history and health perceptions: Seven general population studies.* Health Psychology, **16**(5): p. 417-25.

304. Kimerling, R. and K. Calhoun, 1994. *Somatic symptoms, social support, and treatment seeking among sexual assault victims.* Journal of Consulting and Clinical Psychology, **62**(2): p. 333-40.

305. Mullen, P., S. Romans-Clarkson, V. Walton, and G. Herbison, 1988. *Impact of sexual and physical abuse on women's mental health.* Lancet, **1**(8590): p. 841-5.

306. Roth, S., E. Newman, D. Pelcovitz, B. van der Kolk, and F.S. Mandel, 1997. *Complex PTSD in victims exposed to sexual and physical abuse: results from the DSM-IV Field Trial for Posttraumatic Stress Disorder.* J Trauma Stress, **10**(4): p. 539-55.

307. Koss, M.P., A.J. Figueredo, I. Bell, and M. Tharan, 1996. *Traumatic memory characteristics: A cross-validated mediational model of response to rape among employed women.* Journal of Abnormal Psychology, **105**(3): p. 421-432.

308. McDonald, L., B. Moore, and N. Timoshkina, 2000. *Migrant sex workers from Eastern Europe and the former Soviet Union: The Canadian case.* Status of Women, Canada's Policy Research Fund: Toronto.

309. Surratt, H.L., J.A. Inciardi, S.P. Kurtz, and M.C. Kiley, 2004. *Sex Work and Drug Use in a Subculture of Violence.* Crime & Delinquency, **50**: p. 43-59.

310. Johnson, M.P., 1995. *Patriarchal terrorism and common couple violence: Two forms of violence against women*
Journal of marriage and the family, **75**(2): p. 283-294.

311. Walker, L.E., 1979.*The battered woman.* New York: Harper & Row.

312. Doná, G. and J.W. Berry, *Refugee acculturation and re-acculturation.*, in *Refugees, Perspectives on the Experience of Forced Migration*, A. Ager, Editor. 1999, Pinter: London.

313. Spasojevic, J., R.W. Heffer, and D.K. Snyder, 2000. *Effects of posttraumatic stress and acculturation on marital functioning in Bosnian refugee couples.* Journal of Traumatic Stress, **13**(2): p. 205-217.

314. Amin, A., 2004. *Risk, Morality, and Blame: A Critical Analysis of Government and U.S. Donor Responses to HIV Infections Among Sex Workers in India.* Center for Health and Gender Equity (CHANGE): Takoma Park, Maryland.

315. Coker, A.L., P. Smith, L. Bethea, M. King, and R. McKeown, 2000. *Physical health consequences of physical and psychological intimate partner violence.* Archives of Family Medicine, **9**(5): p. 451-457.

316. Johnson, M.P. and K.J. Ferraro, 2000. *Research on Domestic Violence in the 1990s: Making Distinctions* Journal of Marriage and Family, **62**(4): p. 948.

317. Kyriacou, D.N., D. Anglin, E. Taliaferro, S. Stone, T. Tubb, J.A. Linden, R. Muelleman, E. Barton, and J.F. Kraus, 1999 *Risk Factors for Injury to Women from Domestic Violence.* New England Journal of Medicine, **341**(25): p. 1892-1898.

318. Campbell, J. and P. Alford, 1989. *The dark consequences of marital rape.* American Journal of Nursing, **89**: p. 946-49.

319. Council for International Organizations of Medical Sciences in collaboration with the World Health Organization, 1993. *International ethcial guidelines for biomedical research involving human subjects.* CIOMS: Geneva.

320. Mann, J.M., 1997. *Medicine and public health, ethics and human rights.* Hastings Center Report, **27**(3): p. 6-13.

321. Beyrer, C. and N. Kass, 2002. *Human rights, politics, and reviews of research ethics* The Lancet **360**(9328): p. 246-251.

322. Coughlin, S. and T.L. Beauchamp, 1996.*Ethics and epidemiology.* Oxford/New York:: Oxford University Press.

323. World Health Organization (WHO), 1999. *Putting women's safety first: ethical and safety recommendations for research on domestic violence against women.* WHO: Geneva.

324. World Medical Association, 1949. *Code of medical ethics of the World Medical Association.* URL: http://www.wma.net/e/policy/c8.htm, accessed on Access 2004.

325. World Medical Association, 1964. *World Medical Association declaration of Helsinki Ethical principles for medical research involving human subjects.* URL: http://www.wma.net/e/policy/b3.htm,, accessed on Access 2004.

326. United Nations, Adopted in 1979/entered into force 1981. *Convention on the Elimination of All Forms of Discrimination Against Women.*

327. United Nations, 1948. *Universal Declaration of Human Rights*, in *G.A. res. 217A (III).*

328. Global Alliance Against Traffic in Women and Foundation Against Trafficking in Women and Global Rights, 1999. *Human rights standards for the treatment of trafficked persons.* GAATW/STV: Bangkok.

329. Global Alliance Against Traffic in Women (GAATW), 2001. *Human Rights and trafficking in Persons: A Handbook.* GAATW: Bangkok.

330. Office of the United Nations High Commissioner for Human Rights (UNHCHR), 2002. *International principles and guidelines on human rights and human trafficking.* UNHCR: Geneva.

331. Kelly, L., 2000. *VIP guide: Vision, innovation and professionalism in policing violence against women and children.* Council of Europe: Strasbourg.

332. Presswise, 2002. *Ethical Topics.* www.presswise.org.uk, accessed on Access 2002.

333. Beare, M.E., *Illegal migration: personal tragedies, social problems, or national security threats?*, in *Illegal immigration and commercial sex: The new slave trade*, P. Williams, Editor. 1999, Frank Cass: London.

334. United Nations General Assembly, 1998. *Declaration on the Elimination of Violence against Women*, in *U.N. Doc. E/CN.4/1998/52.*

335. United Nations High Commissioner For Human Rights (UNHCHR), 2002. *Principles and Guidelines on Human Rights and Trafficking.* United Nations High Commissioner For Human Rights: Geneva.

336. Neuman, W.L., 1991.*Social research methods: qualitative and quantitative approaches.* Massachusetts: Simon & Schuster, Inc.

337. Heise, L., K. Moore, and N. Toubia, 1999. *Sexual Coercion and Reproductive Health: A focus on Research.* Population Council: Washington, D.C.

338. Signorelli, S. and M. Treppete, 2001.*Services in the window: A manual for interventions in the world of migrant prostitution*. Trieste: Asterios.

339. Goldberg, D., 1978. *Manual of the General Health Questionnaire*. NFER Publishing: Windsor.

340. Ware, J.J. and C.D. Sherbourne, 1992. *The MOS 36-item short-form health survey (SF-36) conceptual framework and item selection*. Medical Care, **30**: p. 473-83.

341. Derogatis, L., R. Lipman, K. Rickels, E. Uhlenhuth, and L. Covi, 1974. *Hopkins Symptom Checklist (HSCL): a self-report symptom inventory*. Behavioral Science.

342. Beck, A.T., C.H. Ward, M. Mendelson, J. Mock, and J. Erbaugh, 1961. *An inventory for measuring depression*. Archives of General Psychiatry, **4**: p. 561-571.

343. Shields, M. and S. Shooshtari, 2001. *Determinants of self-perceived health*. Health Reports, Statistics Canada, Catalogue 82-003, **13**(1): p. 35-52.

344. Zimmerman, C. and C. Watts, 2003. *WHO ethical and safety recommendations for interviewing trafficked women*. London School of Hygiene & Tropical Medicine and World Health Organisation.: London.

345. McGuigan, W.M. and W. Middlemiss, 2005. *Sexual abuse in childhood an interpersonal violence in adulthood: a cumulative impact on depressive symptoms in women*. Journal of Interpersonal Violence, **20**(10): p. 1271-1287.

346. Mollica, R., Y. Caspi-Yavin, J. Lavelle, S. Tor, T. Yang, S. Chan, T. Pham, A. Ryan, and D.H. de Marneffe, 1991.*Harvard Trauma Questionnaire (HTQ) Manual: Cambodian, Lao, and Vietnamese Versions*. Boston:: Harvard Program in Refugee Trauma.

347. Derogatis, L.R. and N. Melisaratos, 1983. *The Brief Symptom Inventory: an introductory report*. Psychol Med, **13**(3): p. 595-605.

348. El-Bassel, N., R.F. Schilling, K.L. Irwin, S. Faruque, L. Gilbert, J. Von Bargen, Y. Serrano, and B.R. Edlin, 1997. *Sex trading and psychological distress among women recruited from the streets of Harlem*. American Journal of Public Health, **87**(1): p. 66-70.

349. Keller, A., B. Rosenfeld, C. Trinh-Shevrin, C. Meserve, E. Sachs, J. Leviss, E. Singer, H. Smith, J. Wilkinson, G. Kim, K. Allden, and D. Ford, 2003. *Mental health of detained asylum seekers*. Lancet, **362**(9397): p. 1721-3.

350. Aroian, K., C. Patsdaughter, A. Levin, and M. Gianan, 1995. *Use of the Brief Symptom Inventory to assess psychological distress in three immigrant groups*. Int J Soc Psychiatry, **41**(1): p. 31-46.

351. Ponizovsky, A., M. Ritsner, and I. Modai, 2000. *Changes in psychological symptoms during the adjustment of recent immigrants*. Compr Psychiatry, **41**(4): p. 289-94.

352. Hollifield, M., T. Watner, N. Lian, B. Krakow, J. Jenkins, J. Kesler, J. Stevenson, and J. Westermeyer, 2002. *Measuring trauma and health status in refugees: a critical review*. JAMA, **288**(5): p. 611-21.

353. Derogastis, L.R. and N. Melisaratos, 1983. *The Brief Symptom Inventory: an introductory report*. Psychological Medicine, **13**(3): p. 595-605.

354. Zimmerman, C., K. Yun, I. Shvab, L. Trappolin, M. Treppete, F. Bimbi, S. Jiraporn, L. Beci, M. Albrecht, J. Bindel, and L. Regan, 2003. *The Health Risks and Consequences of Trafficking in Women and Adolescents. Findings from a*

European study. LSHTM, Daphne Programme of the European Commission,: London.

355. Derogatis, L.R., 1993.*Brief Symptom Inventory (BSI). Administration, Scoring, and Procedures Manual*. Minneapolis: NCS Pearson.

356. Harvard Program in Refugee Trauma, Accessed May 5 2006. *Harvard Trauma Questionnaire.* Available at: http://www.hprt-cambridge.org/Layer3.asp?page_id=19. , accessed.

357. Derogatis, L.R., 1993.*BSI Brief Symptom Inventory. Administration, scoring and procedures manual*. Minneapolis: NCS Pearson Inc.

358. Aroian, K. and C. Patsdaughter, 1989. *Multiple-method, cross-cultural assessment of psychological distress*. Image J Nurs Sch, 21(2): p. 90-3.

359. Morlan, K. and S. Tan, 1998. *Comparison of the Brief Psychiatric Rating Scale and the Brief Symptom Inventory*. J Clin Psychol, 54(7): p. 885-94.

360. . Mollica, R.F., Y. Caspi-Yavin, P. Bollini, T. Truong, S. Tor, and J. Lavelle, 1992. *The Harvard Trauma Questionnaire: validating a cross-cultural instrument for measuring torture, trauma and post traumatic stress disorder in Indochinese refugees*. J. Nerv. Ment. Dis, 180: p. 111-116.

361. Mollica, R.F. and Y. Caspi-Yavin, 1991. *Measuring torture and torture-related symptoms*. Psychol. Assess, 3: p. 1-7.

362. Ekblad, S. and G. Roth, 1997. *Diagnosing posttraumatic stress disorder in multicultural patients in a Stockholm psychiatric clinic.* . Journal of Nervous & Mental Disease, 185(2): p. 102-107.

363. Shapiro, J., K. Douglas, O. de la Rocha, S. Radecki, C. Vu, and T. Dinh, 1999. *Generational differences in psychosocial adaptation and predictors of psychological distress in a population of recent Vietnamese immigrants*. J Comm Health, 24(2): p. 95-113.

364. Peltzer, K., 1999. *Trauma and mental health problems of Sudanese refugees in Uganda*. Canada African Journal of Medicine, 45(5): p. 110-114.

365. Mollica, R.F., K. Donelan, S. Tor, J. Lavelle, C. Elias, M. Frankel, and R.J. Blendon, 1993. *The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thailand-Cambodia border camps*. JAMA, 270(5): p. 581-586.

366. Strober, S., 1994. *Social work interventions to alleviate Cambodian refugee psychological distress*. International Social Work, 37(1): p. 23-35.

367. Mghir, R. and A. Raskin, 1999. *The psychological effects of the war in Afghanistan on young Afghan refugees from different ethnic backgrounds*. International Journal of Social Psychiatry, 45(1): p. 29-36. .

368. Bilanakis, N., A. Pappas, V. Baldic, and M. Jokic, 1996. *The mental health of refugees of war in one collective center in Serbia*. Psihijatrija Danas, 28(1-2): p. 57-65.

369. United Nations, 1954. *Convention relating to the Status of Refugees*, in *189 U.N.T.S. 150*.

370. United Nations, 1987. *Convention against torture and other cruel, inhuman or degrading treatment or punishment,*, in *G.A. res. 39/46, [annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984)]*.

371. International Organization for Migration (IOM), 2001. *Trafficking in women and children from the Republic of Armenia: A study*. IOM: Geneva.

372. Miko, F.T. and G.J.-H. Park, 2002. *Trafficking in women and children: The U.S. and international response*. Congressional Research Service/The Library of Congress-CRS Report for Congress: Washington, D.C.

373. Zierler, S., L. Feingold, D. Laufer, P. Velentgas, I. Kantrowitz-Gordon, and K. Mayer, 1991. *Adult survivors of childhood sexual abuse and subsequent risk of HIV infection*. American Journal of Public Health, **81**: p. 572-75.

374. Hobson, M., B. Verhey, Emily Delap, R. Taouti-Cherif, and A. Sewonet, 2005. *Forgotten Casualties of War: Girls in Armed Conflict*. Save the Children, : Harare.

375. Commission on Security and Cooperation in Europe (CSCE), 1999. *The sex trade: The trafficking of women and children in Europe and the United States.* , in *Commission on Security and Cooperation in Europe (CSCE)*. US Government Printing Office: Washington, D.C. p. 1-9.

376. Juhász, J., *Migrant trafficking and human smuggling in Hungary*, in *Migrant Trafficking and Human Smuggling in Europe: A review of the evidence with case studies from Hungary, Poland and Ukraine*, F. Laczko and D. Thompson, Editors. 2000, IOM: Geneva.

377. Pan American Health Organization, 1993. *Violence against women and girls: Analysis and proposals from the perspective of public health. Annex paper*, in *Annex paper*. PAHO: Washington.

378. Langille, D., P. Andreou, R. Beazley, and M. Delaney, 1998. *Sexual health knowledge of students at a high school in Nova Scotia*. Can J Public Health, **89**(2): p. 85-89.

379. World Health Organization, 2000. *Highlight on women's health: Ukraine*. WHO Regional Office for Europe, Women's and Reproductive Health Programme: Copenhagen.

380. World Health Organization, 2000. *Highlight on women's health. Albania*. WHO Regional Office for Europe, Women's and Reproductive Health Programme,: Copenhagen.

381. United Nations Population Fund (UNFPA), W.H.O.W., : , 2000. *Family planning and reproductive health in Central and Eastern Europe and the Newly Independent States*. WHO Regional Office for Europe: Copenhagen.

382. Barry, S., 2002. Personal communication on 25 May.

383. Klein, E., C. Y, and G. S., 2003. *The relation between memory of the traumatic event and PTSD: evidence from studies of traumatic brain injury*. Canadian Journal of Psychiatry, **48**(1): p. 28-33.

384. London school of Hygiene & Tropical Medicine, 2005. *Health and trafficking data review and analysis meeting: 12-15 October 2005*. LSHTM: London.

385. Moldofsky, H., 2001. *Sleep and pain*. Sleep Med Rev, **5**(5): p. 385-396.

386. Ozturk, L., Z. Pelin, and D. Karadeniz, 1999. *Effects of 48 hour sleep deprivation on human immune profile*. Sleep Research Online, Websciences, ([On-line journal]: URL http/www.sro.org/ozturk/1999).

387. Research Group, 2002. Personal communication on November 22th, 2002.

388. Carrol, R., . 2000. *Auctions for sex: Europe's thriving slavery industry*, in *The Guardian*: London.

389. McGhie, J., 2000. *Woman for Sale*, in *Red Pepper*. p. [On-line magazine].

390. Miller, T.W., *Long term effects of torture in former prisoner's of war*, in *Torture and its consequences: Current treatment approaches*, M. Basoglu, Editor. 1992, Cambridge University Press: Cambridge.

391. Ryan, S., 2001. *The cost of peace: Trafficking in women for prostitution.* . University of Geneva: Geneva.

392. Jamieson, D. and J. Steege, 1997. *The association of sexual abuse with pelvic pain complaints in a primary care population.* American Journal of Obstetrics and Gynecology, **177**(6): p. 1408-12.

393. Campbell, J., 2002. *Health consequences of intimate partner violence.* Lancet, **359**(9314): p. 1331-6.

394. Sternberg, E.M., 2001. *Neuroendocrine regulation of autoimmune/inflammatory disease.* Journal of Endocrinology, **169**(3): p. 429-35.

395. Niess, J.H., H. Monnikes, A.U. Dignass, B.F. Klapp, and P.C. Arcka, 2002. *Review on the influence of stress on immune mediators, neuropeptides and hormones with relevance for inflammatory bowel disease.* . Digestion, **65**(3): p. 131-40.

396. Pallen, D., 2003. *Sexual slavery in Bosnia: The negative externality of the market for peace.* Swords & Ploughshares, **XXII**(1): p. 27-44.

397. Garcia-Moreno, C.W., C., 2000. *Violence against women: Its importance for HIV/AIDS* AIDS, **14(Suppl 3)**: p. S253-S265.

398. Lamba, H. and S.M. Murphy, 2000. *Sexual assault and sexually transmitted infections: An updated review.* International Journal of STD & AIDS, **11**: p. 487-91.

399. World Health Organization, 2001. *Violence against women and HIV/AIDS: Setting the research agenda. Meeeting report. Geneva, 23-25 October 2000.* WHO: Geneva.

400. Leserman, J., Z. Li, D.A. Drossman, T.C. Toomey, G. Nachman, and L. Glogau, 1997. *Impact of sexual and physical abuse dimensions on health status: Development of an abuse severity measure.* Pscyhosomatic Medicine, **59**: p. 152-160.

401. Leserman, J., D.A. Drossman, Z. Li, T.C. Toomey, N. G., and L. Glogau, 1996. *Sexual and physical abuse history in gastroenterology practice: How types of abuse impact health status.* Pscyhosomatic Medicine, **58**: p. 4-15.

402. McCaulley, J., D. Kern, K. Kolodner, L. Dill, A. Schroeder, H. DeChant, J. Ryden, L. Derogatis, and E. Bass, 1997. *Clinical characteristics of women with a history of childhood abuse: Unhealed wounds.* . JAMA, **277**(17): p. 1400-1.

403. Maker, A., M. Kemmelmeier, and C. Peterson, 2001. *Child sexual abuse, peer sexual abuse, and sexual assault in adulthood: A multi-risk model of revictimization.* . Journal of Traumatic Stress, **14**(2): p. 351-68.

404. DiLillo, D., 2001. *Interpersonal functioning among women reporting a history of childhood sexual abuse: Empirical findings and methodological issues.* Clinical Psychology Review, **21**(4): p. 553-76.

405. Wingood , G. and R. DiClemente, 1997. *Child sexual abuse, HIV sexual risk, and gender relations of African-American Women.* American Journal of Preventative Medicine, **13**(5): p. 380-4.

406. Stone, A., 2002. *Microbicides: A new approach to preventing HIV and other sexually transmitted infections.* Nature Reviews, **1**: p. 977-85.

407. Sean, K.S. and A. Barr, 1997. *Illegal labor movements: The case of trafficking in women for sexual exploitation.* Mekong Region Law Center: Phnom Penh.

408. Tanfer, K. and S.O. Aral, 1996. *Sexual intercourse during menstruation and self-reported sexually transmitted disease history among women.* Sexually Transmitted Disease, **23**(5): p. 395-401.

409. LILA-Milan, 2001. *Data from project "Pricilla" from 29 September 2000 to 30 June 2001.* Lila: Milan.

410. Henshaw, S.K., S. Singh, and T. Haas, 1999. *The incidence of abortion worldwide.* International Family Planning Perspectives, **25 (Supplement)**: p. S30-S38 [On-line journal].

411. Salter, C., H.B. Johnson, and N. Hengen, 1993. *Care for post-abortion complications: Saving women's lives.* Population Reports, Johns Hopkins School of Public Health, Population Information Program, **Series L**(10.).

412. Ellsberg, M.C., 2000. *Candies in hell: Research and action on domestic violence against women in Nicaragua.* Umea University Medical Dissertations, **New Series No. 670**.

413. Kordon, D., L. Edelman, D. Lagos, E. Nicoletti, D. Kersner, and M. Groshaus, *Torture in Argentina*, in *Torture and its consequences: Current treatment approaches*, M. Basoglu, Editor. 1992, Cambridge University Press: Cambridge.

414. World Health Organization, 1990. *Composite International Diagnostic Interview 1.1.* World Health Organization: Geneva.

415. Stark, E. and A. Flitcraft, 1995. *Killing the beast within: Woman battering and female suicidality.* International Journal of Health Services, **25**(1): p. 43-64.

416. Callamard, A., *Refugee women: A gendered and political analysis of the refugee experience*, in *Refugees: Perspectives on the experience of forced migration*, A. Ager, Editor. 1999, Continuum International Publishing Group: New York.

417. Zimmerman, C., 2002. *Personal communication with Vandenberg, Martina, Human Rights Watch.*: New York.

418. Zimmerman, C., 2002. *Interview with Metropolitan Police, Central Clubs and Vice Unit, Charing Cross.*: London.

419. Caritas Ambrosiana of Milan, T.a.P., Interview with Caritas,, 2001. Personal communication.

420. University of Padua research team, 28-30 November 2002. Personal communication.

421. Franca Bimbi, M.o.P.a.I.R.T.L., 28-30 November 2002. Personal communication.

422. 1998. *Immigration Law*, in *Article 18*.

423. British Immigration Officer, 2002. Personal communication.

424. Kelly, L., J. Lovett, and L. Regan, 2005. *A gap or a chasm? Attrition in reported rape cases.* Home Office: London.

425. Harris, J. and S. Grace, 1999. *A question of evidence. Investigating and prosecuting rape in the 1990's.* Home Office: London.

426. Metropolitan Police Central Clubs and Vice Unit Charing Cross, 2001. Personal communication.

427. Turner, S., 2000. *Psychiatric help for survivors of torture.* Advances in Psychiatric Treatment, **6**(295-303).

428. 1998. *Italian Immigration Law 40,* in *Article 18.*

429. Eisenbruch, M., 1991. *From post-traumatic stress disorder to cultural bereavement: Diagnosis of Southeast Asian refugees.* Social Science & Medicine, **33**: p. 673-68.

430. Global Alliance Against Trafficking in Women, November 2002. *Comments at LSHTM Final Workshop.*

431. Baker, R., *Psychosocial consequences for tortured refugees seeking asylum and refugee status in Europe,* in *Torture and its consequences: Current treatment approaches,* M. Basoglu, Editor. 1994, Cambridge University Press: Cambridge.

432. Tchomarova, M., 2003. *Personal communication.* Animus Association Foundation, Bulgaria,.

433. U.S. Department of State, 2005. *Victims of Trafficking and Violence Protection Act of 2000: Trafficking in Persons Report.* http://www.state.gov/g/tip/rls/tiprpt/2001/3927.htm, accessed on Access 2006.

434. World Health Organization, 2000-2004. *Overview of child and adolescent health.* http://www.who.int/child-adolescent-health/, accessed on Access 2006.

435. Dodson, B., 1998. *Women on the Move: Gender and cross-border migration to South Africa. Migration Policy Series No. 9.* South African Migration Project: Cape Town.

436. Clawan, A., 2002. *Female labour migration to Bangkok: Transforming rural-urban interactions and social networks through globalization.* Asia Pacific Population Journal, **17**(3).

437. International Organization for Migration (IOM), 2001. *Trafficking in women and children from the Republic of Armenia: A study.* http://www.iom.int/DOCUMENTS/PUBLICATION/EN/Armenia_traff_report.pdf, accessed on Access 2006.

438. Pascall, G. and N. Manning, 2000. *Gender and social policy: comparing welfare states in Central and Eastern Europe and the Former Soviet Union.* Journal of European Social Policy, **10**(3): p. 240-266.

439. Leserman, J., Z. Li, D.A. Drossman, and Y.J.B. Hu, 1998. *Selected symptoms associated with sexual and physical abuse history among female patients with gastrointestinal disorders: the impact on subsequent health care visits.* Psychological Medicine, **28**(2): p. 417-425.

440. Camp, D.L., W.M. Finlay, and E. Lyons, 2002. *Is low self-esteem an inevitable consequence of stigma? An example from women with chronic mental health problems.* Soc Sci Med, **55**(5): p. 823-34.

441. Zimmerman, C., 2006. *Trafficking in women: a qualitative study to conceptualise and map health risks. Doctoral Thesis,* in *Public Health Policy Unit.* London School of Hygiene & Tropical Medicine (LSHTM): London.

442. Letourneau, E.J., M. Holmes, and J. Chasedunn-Roark, 1999. *Gynecologic health consequences to victims of interpersonal violence.* Women's Health Issues, **9**(2): p. 115-120.

443. Sexton, J., G. Garnett, and J.A. Rottingen, 2005. *Metaanalysis and metaregression in interpreting study variability in the impact of sexually transmitted diseases on susceptibility to HIV infection.* Sex Transm Dis, **32**(6): p. 351-7.

444. Cohen, M., 1998. *Sexually transmitted diseases enhance HIV transmission: no longer a hypothesis.* Lancet, **351**(Suppl 3): p. 5-7.

445. Centers for Disease Control & Prevention, 2005. *Chlamydia - CDC Fact Sheet.* http://www.cdc.gov/std/Chlamydia/STDFact-Chlamydia.htm, accessed on Access 2005.

446. Ebert, A. and M.J. Dyck, 2004. *The experience of mental death: The core feature of complex posttraumatic stress disorder.* Clinical Psychology Review, **24**: p. 617-635.

447. Ehlers, A., A. Maercker, and A. Boos, 2000. *Posttraumatic stress disorder following political imprisonment: the role of mental defeat, alienation, and perceived permanent change.* J Abnorm Psychol, **109**(1): p. 45-55.

448. Ehlers, A., D.M. Clark, E. Dunmore, L. Jaycox, E. Meadows, and E.B. Foa, 1998. *Predicting response to exposure treatment in PTSD: the role of mental defeat and alienation.* J Trauma Stress, **11**(3): p. 457-71.

449. Pomerleau, J. and M. McKee, 2003. *Types of alcoholic drinks consumed and beliefs related to alcohol intake in eight countries of the Former Soviet Union.* Living Conditions, Lifestyle and Health, (http://www.llh.at/publications/02_uk_1_04.pdf).

450. Webb, C.P.M., E.J. Bromet, S. Gluzman, N.l. Tintle, J.E. Schwartz, S. Kostyuchenko, and J.M. Havenaar, 2005. *Epidemiology of heavy alcohol use in Ukraine: Findings from the world mental health survey.* Alcohol and Alcoholism, **40**(4): p. 327-335.

451. International Organization for Migration (IOM) and the United States Agency for International Development (USAID), 2003. *Budapest Declaration on Public Health and Trafficking in Human Beings. Regional Conference on Public Health and Trafficking in Human Beings in Central, Eastern and Southern Europe, held on 19-21 March 2003*: Budapest.

452. Coker, A.L., P.H. Smith, L. Bethea, M.R. King, and R.E. McKeown, 2000. *Physical health consequences of physical and psychological intimate partner violence.* Arch Fam Med, **9**(5): p. 451-7.

453. Campbell, J., A.S. Jones, J. Dienemann, J. Kub, J. Schollenberger, P. O'Campo, A.C. Gielen, and C. Wynne, 2002. *Intimate partner violence and physical health consequences.* Arch Intern Med, **162**(10): p. 1157-63.

454. Rogers, S.M., H.G. Miller, W.C. Miller, J.M. Zenilman, and C.F. Turner, 2002. *NAAT-identified and self-reported gonorrhea and chlamydial infections: different at-risk population subgroups?* Sex Transm Dis, **29**(10): p. 588-96.

455. Niccolai, L.M., T.S. Kershaw, J.B. Lewis, D.V. Cicchetti, K.A. Ethier, and J.R. Ickovics, 2005. *Data collection for sexually transmitted disease diagnoses: a comparison of self-report, medical record reviews, and state health department reports.* Ann Epidemiol, **15**(3): p. 236-42.

456. Venn, J. and J. Godinho, *HIV and TB: a critical coninfection,* in *HIV/AIDS in Europe: Moving from death sentence to chronic disease management*, S. Matic,

J.V. Lazarus, and M.C. Donoghoe, Editors. 2005, WHO Regional Office for Europe: Copenhagen. p. 155-170.

457. Lown, E.A. and W.A. Vega, 2001. *Intimate partner violence and health: self-assessed health, chronic health, and somatic symptoms among Mexican American women.* Psychosomatic Medicine, **63**: p. 352–360.

458. Coker, A., P. Smith, R. McKeown, and M. King, 2000. *Frequency and correlates of intimate partner violence by type: physical, sexual, and psychological battering.* American Journal of Public Health, **90**(4): p. 553-559.

459. Garcia-Linares, M.I., S. Sanchez-Lorente, C.L. Coe, and M. Martinez, 2004. *Intimate male partner violence impairs immune control over herpes simplex virus type 1 in physically and psychologically abused women.* Psychosomatic Medicine, **66**: p. 965-972.

460. Cohen, S. and G.M. Williamson, 1991. *Stress and infectious disease in humans.* Psychological Bulletin, **109**(5-24).

461. Segerstrom, S.C. and G. Miller, 2004. *Psychological stress and the human immune System: A meta-analytic study of 30 years of inquiry.* Psychological Bulletin, **130**(4): p. 601-630.

462. Herbert, T.B. and S. Cohen, 1993. *Stress and immunity in humans: a meta-analytic review.* Psychosomatic Medicine, **55**(4): p. 364-379.

463. Dalgard, F., Å. Svensson, J. Sundby, and O.S. Dalgard, 2005. *Self-reported skin morbidity and mental health. A population survey among adults in a Norwegian city.* British Journal of Dermatology, **153**(1): p. 145.

464. U.S. Department of Health and Human Services, 2002. *Intimate Partner Violence Injuries.* http://ncadi.samhsa.gov/govpubs/mmwr/vol54/mm5442a2.aspx#tab2, accessed on Access 2006.

465. Giezen, A.E.v., E. Arensman, P. Spinhoven, and G. Wolters, 2005. *Consistency of memory for emotionally arousing events: A review of prospective and experimental studies.* Clinical Psychology Review, **25**(2005): p. 935–953.

466. Griffin, M.G., P.A. Resick, and M.B. Mechanic, 1997. *Objective assessment of peritraumatic dissociation: psychophysiological indicators.* Am J Psychiatry, **154**(8): p. 1081-8.

467. Panasetis, P. and R.A. Bryant, 2003. *Peritraumatic Versus Persistent Dissociation in Acute Stress Disorder.* Journal of Traumatic Stress, **16**(6): p. 563-566.

468. Punamäki, R.-L., I.H. Komproe, S. Qouta, M. Elmasri, and J.T.V.M.d. Jong, 2005. *The Role of Peritraumatic Dissociation and Gender in the Association Between Trauma and Mental in a Palestinian Community Sample.* Am J Psychiatry, **162**(3).

469. Herlihy, J., P. Scragg, and S. Turner, 2002. *Discrepancies in autobiographical memories--implications for the assessment of asylum seekers: repeated interviews study.* British Medical Journal, **324**(9 February 2002).

470. Drossman, D., J. Leserman, G. Nachman, Z. Li, H. Gluck, T. Toomey, and M. CM, 1990. *Sexual and physical abuse in women with functional or organic gastrointestinal disorders.* Ann Intern Med, **113**(11): p. 828-833.

471. Pinto, A.P., H.C. Baggio, and G.B. Guedes, 2005. *Sexually-transmitted viral diseases in women: clinical and epidemiological aspects and advances in laboratory diagnosis.* Braz J Infect Dis, **9**(3): p. 241-50.

472. Schmid, G., L. Markowitz, R. Joesoef, and E. Koumans, 2000. *Bacterial vaginosis and HIV infection [editorial].* Sex Trans Inf, **76**: p. 3-4.

473. Centers for Disease Control & Prevention (CDC), 2002. *Sexually Transmitted Diseases Treatment Guidelines 2002.* MMWR: Recommendations and Reports, **51(RR-6).**

474. Burgess, A.W. and L.L. Holmstrom, 1974. *Rape trauma syndrome.* Am J Psychiatry, **131**(9): p. 981-6.

475. Clum, G.A., P. Nishith, and P.A. Resick, 2001. *Trauma-related sleep disturbance and self-reported physical health symptoms in treatment-seeking female rape victims.* Journal of Nervous & Mental Disease., **189**(9): p. 618-622.

476. Breslau, N., V.C. Lucia, and G.C. Davis, 2004. *Partial PTSD versus full PTSD: an empirical examination of associated impairment.* Psychological Medicine, **34**: p. 1205-1214.

477. Basoglu, M., M. Livanou, C. Crnobaric, T. Franciskovic, E. Suljic, D. Duric, and M. Vranesic, 2005. *Psychiatric and cognitive effects of war in former yugoslavia: association of lack of redress for trauma and posttraumatic stress reactions.* Jama, **294**(5): p. 580-90.

478. Moisander, P.A. and E. Edston, 2003. *Torture and its sequel--a comparison between victims from six countries.* Forensic Sci Int, **137**(2-3): p. 133-40.

479. Green, B.L., *Traumatic stress and its consequences,* in *Trauma interventions in war and peace. Prevention, practice and policy,* B.L. Green, et al., Editors. 2003, Kluwer Academic/Plenum Publishers: New York.

480. Yehuda, R., A.C. McFarlane, and A.Y. Shalev, 1998. *Predicting the development of posttraumatic stress disorder from the acute response to a traumatic event.* Biological Psychiatry, **44**: p. 1305-1313.

481. Osuch, E.A., M.A. Brotman, D. Podell, M. Geraci, P.L. Touzeau, G.S. Leverich, U.D. McCann, and R.M. Post, 2001. *Prospective and retrospective life-charting in Posttraumatic Stress Disorder (The PTSD-LCM): A pilot study.* 14, 1: p. 229-239.

482. Campbell, J., 2005. Personal communication on 18 January.

483. Breslau, N., 2005. Personal communication on 20 January.

484. International Organization for Migration. *Psychosocial and mental well-being of migrants.Conference Room Paper, 99th Session of the Executive Committee.* IOM: Geneva. p. 4 July 2002.

485. Disorder, N.C.f.P.T.S., 2005. *What is Posttraumatic Stress Disorder? A National Center for PTSD Fact Sheet.* accessed on Access 2005.

486. Momartin, S., D. Silove, V. Manicavasagar, and Z. Steel, 2003. *Dimensions of trauma associated with posttraumatic stress disorder caseness, severity and functional impairment: a study of Bosnian refugees resettled in Australia.* Social Science & Medicine, **57**: p. 775-781.

487. Study partners, 2005. *Health and trafficking data review and analysis meeting: 12-15 October 2005.* London School of Hygiene & Tropical Medicine: London.

488. Feiring, C., L. Taska, and M. Lewis, 1996. *A process model for understanding the adaptation to sexual abuse: the role of shame in defining stigmatization.* Child Abuse & Neglect, **20**(8): p. 767-782.

489. Folkman, S., R.S. Lazarus, C. Dunkel-Schetter, A. DeLongis, and R.J. Gruen, 1986. *Dynamics of a stressful encounter: cognitive appraisal, coping, and encounter outcomes.* J Pers Soc Psychol, **50**(5): p. 992-1003.

490. Waller, M.A., 2001. *Resilience in ecosystemic context: Evolution of the concept.* American Journal of Orthopsychiatry, **71**(3): p. 290-297.

491. Aldwin, C.M. and L.A. Yancura, *Coping and health: A comparison of the stress and trauma literatures,* in *Trauma and Health. Physical health conseqences of exposure to extreme stress,* P. Schnurr and B.L. Green, Editors. 2003, American Psychological Association: Washington, D.C.

492. Folkman, S., R.S. Lazarus, C. Dunkel-Schetter, A. DeLongis, and R.J. Gruen, 1986. *Dynamics of a Stressful Encounter: Cognitive Appraisal, Coping, and Encounter Outcomes.* Journal of Personality and Social Psychology, **50**(5): p. 992-1002.

493. Kefurtova A (La Strada-Czech Republic), 2005. *Health and trafficking data review and analysis meeting: 12-15 Oct.* London School of Hygiene & Tropical Medicine: London.

494. Tchomarova M (Animus Association Foundation-Bulgaria), 2005. *Health and trafficking data review and analysis meeting: 12-15 Oct.* London School of Hygiene & Tropical Medicine: London.

495. Scodanibbio S (On the Road - Italy), 2005. *Health and trafficking data review and analysis meeting: 12-15 Oct.* London School of Hygiene & Tropical Medicine: London.

496. Bales, K., 2002. *The social psychology of modern slavery.* http://jmm.aaa.net.au/articles/1219.htm, accessed on Access 2005.

497. Mullen, P.E., J.L. Martin, J.C. Anderson, S.E. Romans, and G.P. Herbison, 1994. *The effect of child sexual abuse on social, interpersonal and sexual function in adult life.* Br J Psychiatry, **165**(2): p. 35-47.

498. Lewis, M., 1992. *Shame: The exposed self.* New York: The Free Press.

499. Silove, D., Z. Steel, and R.F. Mollica, 2001. *Refugees - Detention of asylum seekers: assault on health, human rights, and social development.* The Lancet, **357**(9266): p. Viewed on website Medecins Sans Frontieres.

500. Campbell, J.C. and P. Miller, 1993. *Miller abuse physical symptoms and injury survey (MAPSAIS).*

501. Sieber, J.E. and L.J. Stanley, 1998. *Ethical and professional dimensions of socially sensitive research.* American Psychologist, **43**: p. 49-55.

502. Lee, R.M. and C.M. Renzetti, *The problems of researching sensitive topics: An overview and introduction,* in *Researching sensitive topics,* C.M. Renzetti and R.M. Lee, Editors. 1993, Sage Publications Ltd: London.

503. Barwise, K., B. Rijks, and J.S. Houlding, 2006. *Breaking the cycle of vulnerability. Responding the health needs of women in east and southern Africa.* International Organization for Migration (IOM): Geneva.

504. Asia Watch-Women's Rights Project, 1993. *A modern form of slavery,* in *Trafficking of Burmese women and girls into brothels in Thailand.* Human Rights Watch: New York.

505. Graham, D.L., E.I. Rawlings, K. Ihms, D. Latimer, J. Foliano, A. Thompson, K. Suttman, M. Farrington, and R. Hacker, 1995. *A scale for identifying "Stockholm*

syndrome" reactions in young dating women: factor structure, reliability, and validity. Violence Vict, **10**(1): p. 3-22.

506. Julich, S., 2005. *Stockholm syndrome and child sexual abuse.* J Child Sex Abus, **14**(3): p. 107-29.

507. Council of Europe, 2005. *Council of Europe Convention on Action against Trafficking in Human Beings.* Council of Europe: Brussels.

508. Jiraporn, S., 2003. Personal communication on 28 May.

509. Dickson, S., 2004. Personal communication on 27 November 2004.

510. Johansson, A., 2005. Personal communication on 23 February.

511. Patel, V., S. Pednekar, H. Weiss, M. Rodrigues, P. Barros, B. Nayak, V. Tanksale, B. West, P. Nevrekar, B.R. Kirkwood, and D. Mabey, 2005. *Why do women complain of vaginal discharge? A population survey of infectious and psychosocial risk factors in a South Asian community.* Int J Epidemiol, **34**(4): p. 853-62.

512. Ballinger, C.B., A.H. Smith, and P.R. Hobbs, 1985. *Factors associated with psychiatric morbidity in women--a general practice survey.* Acta Psychiatr Scand, **71**(3): p. 272-80.

513. Hodgkiss, A.D., R. Sufraz, and J.P. Watson, 1994. *Psychiatric morbidity and illness behaviour in women with chronic pelvic pain.* J Psychosom Res, **38**(1): p. 3-9.

514. Byrne, P., 1984. *Psychiatric morbidity in a gynaecology clinic an epidemiological survey.* Br J Psychiatry, **144**: p. 28-34.

515. Gath, D., M. Osborn, G. Bungay, S. Iles, A. Day, A. Bond, and C. Passingham, 1987. *Psychiatric disorder and gynaecological symptoms in middle aged women: a community survey.* Br Med J (Clin Res Ed), **294**(6566): p. 213-8.

516. Foa, E.B., T.M. Keane, and M.J. Friedman, 2000. *Guidelines for treatment of PTSD.* Journal of Traumatic Stress, **13**(4): p. 539-588.

APPENDICES

APPENDIX A: FORMATIVE STUDY QUESTIONNAIRE FOR WOMEN

Women

We are conducting research on migrant women's health in order to identify better ways to provide health services to women who may be in situations that make it difficult for them to learn about or access the health care.

To understand how to provide better, more convenient health services we would like to ask you about your current health, how your travels and your work has affected your health and about the services that you might have used or wished were available. If at anytime you don't wish to answer a question or would like to ask me a question, please feel free to stop me.

I won't ask you your name, but if you want to tell me your name or make up a name to use for the interview, please just let me know. Everything you tell me will be kept strictly secret. You can stop the interview at any time, or skip any questions that you don't want to answer. There are no right or wrong answers. Some of the topics may be difficult to discuss, but many women have found it useful to have the opportunity to talk.

Your participation is completely voluntary, so you should feel free to decline this interview or to stop when you want, but your experiences could be very helpful to other women in COUNTRY.

Do you have any questions?

(The interview takes approximately * minutes to complete). Do you agree to be interviewed?

NOTE WHETHER RESPONDENT AGREES TO INTERVIEW OR NOT

[ ] DOES NOT AGREE TO BE INTERVIEWED
THANK PARTICIPANT FOR HER TIME AND END

[ ] AGREES TO BE INTERVIEWED

Is now a good time to talk?

	EU COUNTRY	NON-EU COUNTRY
1. WORK DESTINATIONS	First, I am going to ask you some general questions about your journey, okay?	
a.	Can you tell me how long you have been away from *your country*?	Can you tell me how long you have been away from *your country*?
	How long have you been here?	
b.	Can you tell me which other countries you have been in? In which of these places did you work in?	Can you tell me which countries you have been in? In which of these places did you work?
c.	How long have you been working here?	How long did you work in each of these places?
d.	Did you speak *English/Italian/Dutch/Other* when you first arrived here?	What languages do you speak? How well did you speak *British/Italian/Dutch/Other* when you first arrived there? How well do you speak it now?
	Do you speak better now?	
e.	Which languages can you read?	Which languages can you read?
2. HEALTH	Now I am going to ask you some questions about your health and the health services in this/these place(s), okay?	
a.	Can you tell me about any health problems you have had since you arrived in *Country X*? Explain physical illnesses pains injuries *How did this injury happen?*	Can you tell me about any health problems you had while you were in *Country X*? Can you explain. physical illnesses pains injuries *How did that injury happen?*

	EU COUNTRY	NON-EU COUNTRY
	skin problems weight problems (i.e., diets, pills, etc.) other	skin problems weight problems other
b.	What did you do about this problem(s), if anything? Nothing Why? What happened? Self-treatment, explain Waiting to go home to treat Why? NGO/outreach project Formal/public clinic Private provider Traditional medicine Other? *Probing questions if she went to a service provider:* Can you tell me about what they did for you? What did you think of the service/advice/treatment they provided? Were they polite to you? Did the person explain things clearly? Do you have any suggestions how they could have provided better service/treatment/help? Did you have to pay? Who told you about this place?	What did you do about this problem(s), if anything? Nothing, why? What happened? Self-treatment, explain Waited to come home Why? NGO/outreach project Formal/public clinic Private provider Traditional medicine Other? Was language a problem? If yes, how did you communicate? *Probing questions if she went to a service provider:* Can you tell me about what they did about your health problem? What did you think of the service/advice/treatment they provided? Were they polite to you? Did the person explain things clearly? Do you have any suggestions how they could have provided better service/treatment/help? Did you have to pay? Who told you about this place
e.	Can you tell me about any <u>other</u> contact you have had with any health professionals or NGOs here? Outreach workers?	Can you tell me about any <u>other</u> contact you had with any health professionals or NGOs there? Outreach workers?

	EU COUNTRY	NON-EU COUNTRY
	Other people who provided information to you? Who?	People who provided information to you? Who?
d.	Was language ever a problem in getting information or services? Can you explain? If yes, how did you and the person(s) who helped/treated you communicate? Friend helped interpret/translate Service had an interpreter Made gestures (pantomimed) and used what language skills we had We gave up, "I never understood/couldn't communicate"	Was language ever a problem in getting information or services? Can you explain? If yes, how did you and the person(s) who helped/treated you communicate? Friend helped interpret/translate Service had an interpreter Made gestures (pantomimed) and used what language skills we had We gave up, "I never understood/couldn't communicate"
e.	Since arriving here, have you taken any kind of medication/pills/drugs? Aspirin, other pain killers Sleeping pills, sedatives Antibiotics Diet pills Other?	While you were there in *Country X* did, you take any kind of medication/pills/drugs? Aspirin, other pain killers Sleeping pills, sedatives Antibiotics Diet pills Other?
f.	What forms of contraception have you ever used (with a partner/husband/boyfriend or a client)? Condom. Pill Depo-provera Diaphragm Intra-uterine device (IUD) Cervical cap	What forms of contraception have you ever used (with a partner/husband/boyfriend or a client)? Condom. Pill Depo-provera Diaphram Intra-uterine device (IUD) Cervical cap

	EU COUNTRY	NON-EU COUNTRY
	Sponge Withdrawal Another method? For each method mentioned: *When did you use this method?* *Where did you get/buy it from?* *How much did it cost?*	Sponge Withdrawal Another method? For each method mentioned: *When did you use this method? Where did you get/buy it from? How much did it cost?*
g.	How did you learn about each of these methods that you used?	How did you learn about each of these methods that you used?
h.	Do you have a partner/husband/boyfriend now? (if no, before?) What type of contraception do/did you use with him?	Did you have a partner/husband/boyfriend now? What type of contraception do/did you use with him?
i.	What type of contraception do you use in your work with your clients to prevent pregnancy to prevent disease to stop bleeding while you work?	What type of contraception did you use in your work with your clients to prevent pregnancy to prevent disease to stop bleeding while you work?
j.	In your work, what protection do you use for oral sex on clients? clients performing oral sex on you? Anal sex? Masturbation or hand-jobs? Other acts? How did you learn about any of these methods? Do you use Lubricants Why or why not? For what acts? dental dams	In your work, what protection did you use for oral sex on clients? clients performing oral sex on you? Anal sex? Masturbation or hand-jobs? Other acts? How did you learn about any of these methods? Did you use Lubricants Why or why not? For what acts? dental dams

	EU COUNTRY	NON-EU COUNTRY
	gloves? Anything else to protect yourself from sexually transmitted diseases?	gloves? Anything else to protect yourself from sexually transmitted diseases?
k.	Have you ever had vaginal or anal sex without a condom?	Have you ever had vaginal or anal sex without a condom?
l.	Have you ever washed internally or douched with anything ? Soap? Creams? Antiseptic wash, cleaning product? Feminine product? Explain. How did you learn about this/these practice(s)?	Have you ever washed internally or douched with anything ? Soap? Creams? Antiseptic wash, cleaning product? Feminine product? Explain. Who told you about this/these practice(s)?
m.	What did you know about sexually transmitted diseases or HIV/AIDS before you left home? Do you think you know more now? How did you learn about these illnesses? Do you know where women go for treatment of these illnesses if they need it?	What did you know about sexually transmitted diseases or HIV/AIDS before you left home? Do you think you know more after you experience in X country? How did you learn about these illnesses? Do you know where women went for treatment of these illnesses if they needed it?
n.	What would you do if you got pregnant? Where would you go for any services you needed for your pregnancy?	What would you do if you got pregnant in Country X? Where would you have gone for any services that you needed for your pregnancy?
o.	Do you know where women go if they want to terminate a pregnancy/have an abortion? Please explain?	Do you know where women went in Country X if they want to terminate a pregnancy/have an abortion? Please explain?

EU COUNTRY	NON-EU COUNTRY
p. Have you ever had a gynaecological or sexual health check up? For example, a cervical smear? Tested for any illnesses, STDs, HIV/AIDS When? Where?	Did you ever had a gynaecological or sexual health check up in *Country X?* For example, a cervical smear? Tested for any illnesses, STDs, HIV/AIDS When? Where?
q. Are there any medical services that are free in this country?	Were there any medical services that were free in *Country X?*
r. Do you know what papers or documents do you need to get free medical care here?	Do you know what papers you needed to get free medical care there?

3. WORK
Now I am going to ask you a little about your work, okay?

EU COUNTRY	NON-EU COUNTRY
a. Would you tell me a bit about a regular working day? Number of days, hours, free time? What do you think about the conditions you work in? Do you feel safe? Number of clients? Do you have any regular clients? Do they ever take you out anywhere?	Would you tell me a bit about a regular working day? Number of days, hours, free time? What do you think about the conditions you worked in? Did you feel safe? Number of clients? Did have any regular clients? Did they ever take you out anywhere?
b. Who would you ask if you wanted advice about work? *Possible prompt questions* About services to provide and how to do them What to charge	Who would you have asked if you wanted advice about work? *Possible prompt questions* About services to provide and how to do them What to charge
c. How much money do you earn in a day? How much money do you keep in cash each day?	How much money did you earn in a day? How much money did you keep in cash each day?

	EU COUNTRY	NON-EU COUNTRY
	What do you usually do with your cash? *Possible prompt questions:* Pay debts owed Pay rent (home? Work?), other living expenses (to whom?) Paid manager, maid, madam, pimp, owner Send to family Give to boyfriend Save a lot Spend on self Other?	What did you usually do with your cash? *Possible prompt questions:* Pay debts owed Pay rent (home? Work?0, other living expenses (to whom?) Paid manager, maid, madam, pimp, owner Send to family Give to boyfriend Save a lot Spend on self Other?
d.	Do you ever feel like you cannot buy any basic necessities? For example: food, tampons, sanitary pads, shampoo, soap, Aspirin (non-prescription) pain killers), underwear	Did you ever feel like you could not buy any basic necessities? For example: food, tampons, sanitary pads, shampoo, soap, Aspirin (non-prescription) pain killers), underwear
e.	How has your diet been since you arrived?	How was your diet while you were there?
f.	What do you think is the most difficult aspect of your life here? Difficult aspect of your work?	What do you think was the most difficult aspect of your life there? Difficult aspect of your work?
g.	Do you ever feel in danger or afraid? Can you explain?	Did you ever feel in danger or afraid or stress? Why?
h.	Has anyone ever intentionally hurt you since you left home? Can you explain?	Has anyone ever intentionally hurt you since you left home? Can you explain
i.	What do you like best about living here? Best part of your work?	What did you like best about living there? Best part of your work?

	EU COUNTRY	NON-EU COUNTRY
	4. PERSONAL LIFE Now I am going to ask you a little about your work, okay?	
a.	How is the place where you live, sleep?	How was the place where you lived, slept?
b.	Do you live with anyone? Who?	Do you live with anyone?
c.	. Do you ever have free time? What do you do in your free time? Boyfriend Friends Stay alone Work another job	. Did you ever have free time? What did you do in your free time? Boyfriend Friends Stay alone Work at another job
d.	Who do you talk to most while you are here? How do you know most of the people you talk to?	Who did you talk to most while you were there? How do you know most of the people you talked to?
e.	Do you feel free to do what you want and go around where you want?	Do you feel free to do what you want and go around where you want?
f.	Do you drink beer or other alcohol regularly? About how many cups a day	Did you drink beer or other alcohol regularly while you were there? About how many cups a day?
	Did you drink before you started working here?	Did you drink before you started working there?
	Do you think you drink more or less than before coming here?	Do you think you drink more or less than before going there?

	EU COUNTRY	NON-EU COUNTRY
		What about now?
g.	Do you smoke regularly? About how many cigarettes per day?	Did you smoke regularly while you were there? About how many cigarettes per day?
	Did you smoke before you started working here?	Did you drink before you started working there?
	Do you think you smoke more or less than before coming here?	Do you think you drink more or less than before going there?
		What about now?
h.	Do you ever do any kind of drugs? What kind? How often?	Did you ever do any kind of drugs while you were there? What kind? How often?
	Is this more than before you started working here?	Is this more than before you started working there? And now?
i.	Do you ever have contact with your family?	Did you have any contact with your family while you were in *Country X*?
j.	Do you ever have contact with other from *her ethnic community*, besides work colleagues in this country? For example, go to church or temple? Festivals, community centre?	Did you ever have contact with other from *her ethnic community*, besides work colleagues in this country? For example, go to church or temple? Festivals, community centre?
k.	Do you ever have contact or conversations with any *British/Italian, etc.* people other than clients? Any friends?	Did you ever have contact or conversations with any *British/Italian, other etc.* people other than clients? Any friends?
l.	Can you use a phone whenever you want?	Could you use a phone whenever you wanted?

	EU COUNTRY	NON-EU COUNTRY

m.	What do you find most stressful about living here?
	    ♦ work situation, hours, clients, type of work
	    ♦ Money
	    ♦ Pimp, madam, maid, manager, agent
	    ♦ Other sex workers
	    ♦ Language
	    ♦ Worried of getting stopped by police or other authorities
	    ♦ Worried about crime
	    ♦ Not knowing way around or afraid of getting lost?
	    ♦ Uncomfortable with local people
		What did you find most stressful about living there?
		    ♦ work situation, hours, clients, type of work
		    ♦ Money
		    ♦ Pimp, madam, maid, manager, agent
		    ♦ Other sex workers
		    ♦ Language
		    ♦ Worried of getting stopped by police or other authorities
		    ♦ Worried about crime
		    ♦ Not knowing way around or afraid of getting lost?
		    ♦ Uncomfortable with local people

n.	Has anyone ever threatened you or your family since you left your country?	Did anyone ever threaten you or your family while you were away?

5. HOME AND JOURNEY
Now I am going to ask you a little about you home and your travels.

	EU COUNTRY	NON-EU COUNTRY
a.	Where are your parents? How many sisters and brothers do you have?	Where are your parents? How many sisters and brothers do you have?
b.	How old are you?	How old are you?
c.	Are you or were you ever married?	Are you or were you ever married?
d.	Children?	Children?
e.	Why did you decide to travel from home?	Why did you decide to travel from home?
f.	How was your health before you left home? Did you have any health problems?	How was your health before you left home? Did you have any health problems?
g.	Did anyone ever hurt you while you were living in *home*	Did anyone ever hurt you while you were living in *home*

	EU COUNTRY	NON-EU COUNTRY
	country?	*country?*
h.	Did you feel like it was easy to get medical care in *her country?* What did you think of the quality of the care? Did you have to pay?	Before you left *her country*, did you feel like it is easy to get medical care? What did you think of the quality of the care? Did you have to pay?
i.	What did you dislike most about the medical care in *her country?*	What did you dislike most about the medical care in *her country?*
	What did you like the most?	What did you like the most?
j.	Can you tell me a little about your trip to get here? For example ◆ Type of transport? Over crowded? ◆ Who did you travel with? ◆ How many days on the move? Any dangerous passages? ◆ Did you sleep enough? Where? How were these places?	Can you tell me a little about your trip to get here? For example ◆ Type of transport? Over crowded? ◆ Who did you travel with? ◆ How many days on the move? Any dangerous passages? ◆ Did you sleep enough? Where? How were these places?
	What would you say was the most difficult part of the journey?	What would you say was the most difficult part of the journey?
k.	Did you have any health problems while you were travelling here?	Did you have any health problems while you were travelling there?
	What did you do about this/these?	What did you do about this/these?
l.	What documents did you have for your travel and your stay here: • Passport? ◆ Visa do you know what kind? Is it still valid?	What documents did you have for your travel and your stay there: • Passport? ◆ Visa do you know what kind? Was it valid the

	EU COUNTRY	NON-EU COUNTRY
	◆ Residence permit ◆ Permission to stay ◆ Identity card? ◆ Other? Do you still have all of these documents now?	entire time? ◆ Residence permit ◆ Permission to stay ◆ Identity card? ◆ Other? Do you still have all of these documents now?
m.	Have you ever been stopped or detained by any authorities, such as police or immigration? What happened?	Same
n.	Did they ever offer you any help or support? ◆ Phone call? ◆ Medical care? ◆ Contact with any other groups? Or Anyone else?	Same
o.	How was your health when they detained you? Did you have need for medical care at anytime while you were there? Did you ever ask for medical care?	Same
p.	How were the detention conditions? ◆ Clean? ◆ Food? ◆ Crowded? ◆ Sleep? ◆ Showers? Clean clothing ◆ Supplies (tampons, pads, shampoo, soap, etc.)	Same
q.	How do you feel about returning home?	How did you feel about returning home?
r.	Would you have a safe place to stay if you return home?	Do you have a safe place to stay in *home country*?
s.	How would you earn money if you go home?	How will you earn money *here/in home country*?
t.	*If she has mentioned any medical problems: If you were at home, who would you go see for medical treatment for X*	*If she has mentioned any medical problems: Who would you think to go see for medical treatment for X problem*

	EU COUNTRY	NON-EU COUNTRY
	problem mentioned?	*mentioned?*

6. TRAFFICKING

a.	What do you think of when you hear the term "trafficking in women?" How would you describe this situation?	What do you think of when you hear the term "trafficking in women?" How would you describe this situation?

APPENDIX B. FORMATIVE STUDY QUESTIONNAIRE: NGO-NON-HEALTH CARE PROVIDER

NGO, SERVIC PROVIDER (non-health, direct contact with women) We are conducting research on migrant women's health, especially those who may have been involved in a trafficking situation, in order to identify better ways to provide health services to women who may be in situations that make it difficult for them to learn about or access health care.

As an organisation that has contact with women who may have been trafficked, we are hoping that you can help us learn about the services offered to migrant women, their health needs, and discuss some of the difficulties reaching and working with these hidden populations.

Subheading and Number	Question: EU/Destination	Question: Non-EU/Return setting *Questions the same, except when specified*
1. Organisational Information		
1a	Name of organisation	
1b	Contact details: Address Phone: Fax Email	
1c	Governmental Non-governmental Other:	
1d	Respondent name:	
1e	Position	

2. Services		
2a	Main areas of service provision/activities	
	When did you begin providing services?	
	Can you describe the population you serve or for whom the activities are intended? Men? Number/day? Age range? Women? Number/day? Age range? Geographic coverage?	
	Do any of these activities specifically address health issues?	
	Who are the main agencies you work with/co-ordinate with? Please describe.	
3. Experience working with trafficked women		
	Can you tell me about your experience working with migrant or trafficked women?	N/A
	Where do the women you work with come from? Can you 'guestimate' the percentages from different countries?	

Can you discuss some of the most common health concerns and needs?	
Have you ever seen signs of ill-health among the women you assist? (e.g., injuries, illnesses, psychological disorders)	
What are some of the greatest difficulties or barriers to getting health care for migrant women in this country?	What are the greatest difficulties accessing healthcare for women who have been trafficked
What is the age range of the women you assist?	
What percentage would you say have children?	
What subjects make migrant women uncomfortable, embarrassed, feel stress or anxiety?	
What are some of the greatest difficulties in working with migrant women? How have you tried to overcome these?	What are some of the greatest difficulties in working with trafficked women
4. Experience with health service	
What are you experiences trying to get health care for migrant women?	Can you talk about your experiences getting health care for trafficked women
How do service providers feel about treating women who are migrants? Sex workers? Trafficked?	How do you feel about assisting women who have been trafficked, sex workers?
How do women feel about seeking treatment here? For reproductive health? STDs?	
Have you noted any traditional or "street" beliefs women have regarding their health, symptoms of ill-health, including, reproductive health?	
4. Perception of trafficking and	

migrant women	
	What comes to mind when you hear the term "trafficking in women"?
	What sort of dangers do women face when they are trafficked?
	How would you describe the 'recovery process' for a woman who has been trafficked?
	In the UN Protocol addressing the trafficking of women and children, Section II, Article 6 calls for states to "consider implementing measures to provide for the physical, psychological and social recover of victims…." "in particular, medical, psychological and material assistance"
	What do you think is meant by this?
	What do you think might be the barriers to the implementation of these measures?
5. Physical Violence and Illness	
	Have you ever heard about or seen any signs of physical abuse among the women you meet? Explain.
6. Sexual and reproductive health	
	Where would a woman go for health

	care if she was pregnant? If she thought she had an STD? How much would she have to pay for these services?
	Where would she go for an abortion? How much would she have to pay for these services?
For sex workers	
	How would you describe condom use among the women you meet?
	What sort of sexual risk-taking is common among the women
	How would you describe women's use of condoms with their intimate partners? Other contraception?
7. Psychological health	
	What symptoms of stress have you noted among the migrant women you treat?
	What would you say are your client's greatest sources of stress or anxiety?
	What percentage of women do you think are able to 'recover' from this experience and return to a 'normal' way of life?
8. Substance use	
	Do any of the women you treat have

	alcohol or drub problems? Explain	
	Do you think any of the women were coerced to drink or use drugs? Explain	
9. Economic exploitation, financial control		
	How would you describe the pay arrangement between the women and their employer? Can you be specific (probes: how is she paid, what money does the employer get, etc)	
	How would you describe their financial situation? Do they have access to cash? Do they owe money?	
	Do you think money is a factor for women when deciding to seek medical care?	
10. Confinement, isolation, social exclusion		
	How do women hear about your services?	
	Do most women come to your office alone or with others? Who?	
	What sort of free time do you think the women have while they were working?	
11. Documents		
	Does your office ask for any documentation from the women you	

	assist? What sorts?	
	In your opinion, what sort of documentation do most women have?	
12. Working travelling and living conditions		
	What do you know about women's working conditions, hours, time off, etc.?	
	What do you know about women's living situation?	
	How long do you think women stay in the area of your office?	
	Do you have any knowledge of their journey or travel arrangements?	
13. Health workers perception of the law		
	What are the rights of migrant women with documentation to healthcare? Without?	N/A
14. Referrals		
	If a woman wanted to escape a difficult situation, what is your office able to do to assist?	
	If a woman needed legal advice, who would you refer her to?	
	If a woman needed shelter to escape a difficult situation, who could you	

	contact?	
	If a woman wanted to go home, who could you contact to help her?	N/A
15. Suggestions	What would you think needs to be done to improve services to migrant women who are abused or exploited?	
16. Prosecution	Do you think women wish to prosecute the person(s) who abused them?	

APPENDIX C. STUDY USER GUIDE

Multi-Country Study on the Health Outcomes of Trafficked Women and Adolescents in Service Settings

STUDY USER GUIDE

CONTENTS

1. INTRODUCTION

Purpose of the Study User Guide and intended users

The *Study User Guide* provides specific instructions on methodological procedures associated with using the 3 questionnaires. The guide has been developed to help ensure methodological consistency of methods between all country partners and comparability of data and findings.

This guide is intended for use by Country Partner team members, including Research Managers/Coordinators, interviewers, and other individuals responsible for key aspects of the study. The entire *Study User Guide*, or sections of it can also be made available to interpreters, on a case by case basis, as necessary. Ultimately, it is the responsibility of the individual coordinating the Country Partner's participation to be familiar with this guide and ensure that the research team is carrying out the study correctly.

For this study, it is anticipated that most interviewers will be trained social workers or psychologists. Many, if not all interviewers, will have had experience working directly with trafficked women. For this reason the *Study User Guide* is limited in its discussions of psychological and social support necessary to interview women who have been victimised, with the understanding that the interviewers are well aware of the emotional vulnerability of the women, and the risks involved in asking sensitive questions. If, for any reason, a Research Manager, or the interviewer herself, feels that she is unequipped or unable to pose questions in an empathetic manner, or respond effectively if women become distressed during an interview, appropriate training must be arranged from a qualified member of the country partner staff. Until this time, the interviewer should not conduct any interviews.

Study aims

The *Multi-Country Study on Health Outcomes of Trafficked Women and Adolescents* is a follow-up study to the qualitative research, *Identifying the health risks and consequences of trafficking in women and adolescents. Findings from an EU study.* The three primary aims of the current study are:

1) To collect statistical and qualitative data on the physical and psychological health needs of trafficked women and adolescents (hereafter referred to as "women") attending services.
2) To explore women's perceived immediate and longer-term psychological health needs.
3) To document and compare different models of care provision and service delivery (this will be conducted as a separate component from the statistical study).

In this current study, we will systematically collect data on trafficked women's health in order to identify the range and severity of health complications among women in service settings. Data will be gathered and analysed using both quantitative and qualitative methods. In addition, a particularly important and unique feature of this study is the longitudinal investigation into trafficked women's health. Where possible women will be interviewed at three points in time to help identify how their perceived mental and physical health needs change over time. By examining health *quantitatively, qualitatively,* and *longitudinally,* we hope that the findings will assist

service organisations to better identify health service priorities, develop more precise and effective plans and protocols for assessing and treating trafficked women, and allocate their precious funds in the most efficient ways—particularly providers that are in low-resource settings.

Study Partners

The partners for the statistical portion of the study include:

- Poppy Project (project of Eaves Housing), London
- Animus Association Foundation/La Strada, Bulgaria
- La Strada, Moldova
- La Strada, Ukraine, Kiev
- Associazione On the Road
- Pag-Asa
- International Organization for Migration, Ukraine
- STV, Foundation for women, Netherlands
- London School of Hygiene & Tropical Medicine, London (study co-ordinator)

Contact information for study partners is provided in the Appendix A.

2. ETHICAL OBLIGATIONS

The general ethical and safety obligations to be adhered to throughout this study are outlined in detail in the *WHO Ethical and Safety Recommendations for Interviewing Trafficked Women.*[30] These recommendations were written by the co-ordinators of this study and copies should have been given to all country partners. If partners need to obtain copies please see the web page: http://www.lshtm.ac.uk/hpu/staff/czimmerman.html, under "selected publications" at the bottom of the page. Alternatively, contact Cathy Zimmerman (cathy.zimmerman@lshtm.ac.uk).

The additional methodological ethical and safety concerns discussed in this *Study User Guide* relate primarily to the use of the questionnaire and the handling of data, and are described in the relevant sections below.

The following is a brief overview of basic rules to be respected and followed by interviewers and other research team member.

➲ Privacy The interviewer must ensure that the location(s) where an interview is taking place is where others cannot overhear or where the interview will be easily interrupted. Persons present during an interview should be limited to the trafficked person, the interviewer(s), an interpreter (where necessary). Turn off mobile phones during interviews. Put a "do not disturb" or other similar notice on the door and close the door.

➲ **Respondent comfort** The interviewer must introduce herself, explain her role in the organization (if the woman does not already know who she is). Before the

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[30] Zimmerman, C. & Watts, C. (2003). *World Health Organization Recommendations for Interviewing Trafficked Women.* London/Geneva: London School of Hygiene and Tropical Medicine/World Health Organization.

⮩ **Interviewer begins the interview, the interviewer should find out whether the woman:**

• Feels physically comfortable (seating, wants water or tea, needs to use the toilet, feels any pain, especially inquiring about head-aches and offering non-prescription pain medication, where appropriate).
• Feels safe and able to answer questions in this location

The interviewer should then read the "consent form." (In addition to reading the *consent form*, the interviewer may also choose to explain in her own words about the study or what will happen during the interview).

⮩ **Anonymity** No names should be written on the questionnaire. The interview coding sheet should be kept in a secure location. No discussions of any respondent or her case should take place outside the individual's support team without her permission.

3. STUDY PARTICIPATION CRITERIA

To qualify to participate in the study:

☑ **For the first interview:** Women must be interviewed within **1 to 7 days** of their entry into an assistance programme using the FIRST PERIOD Questionnaire. In exceptional cases, interviews may take place as late as 10 days. In practice, women should be interviewed as early as ethically and practically possible.

☑ Women must be entering an assistance programme (i.e., not still working without having entered an assistance programme).

☑ Women must be between the ages of 12 and 45 years old.

☑ Women must be interviewed before they receive a general medical exam organized by the assistance programme. This does NOT include any urgent care or emergency medical treatment, or women who have seen a medical practitioner for one or two medical problems. Exceptions may be made for this, however. Please contact Cathy if questions arise.

☑ Women must have been working in either <u>sex work</u> or <u>domestic labour</u> (<u>or both</u>). Women who have been exploited ONLY in sectors such as, factory labour, agricultural labour, handicrafts, etc., are NOT eligible to participate in this study.

☑ Women may have been trafficked internally (i.e., domestically) or internationally.

For the Second and Third Period Questionnaire:

☑ **Second Period Questionnaire:** Only women who were interviewed using the first period questionnaire are eligible to be interviewed using the second and third period questionnaire. Women must be interviewed within FOUR TO SIX WEEKS after the first interview using the *Second Period Questionnaire*. In cases where the woman will leave the programme or facility after two to three weeks (i.e., IOM Programme), the interview can be conducted as long as it is *at least* 2 weeks after her entry into the assistance programme. In such cases the interview should take place as close to the date of woman's departure from the programme as possible.

☑ **Third Period Questionnaire:** Women who are available to be interviewed for a third time must be interviewed TWELVE OR MORE WEEKS from the first interview, using the *Third Period Questionnaire*. If a woman has completed the first interview, but has not completed the second interview, she may still be interviewed using the third period questionnaire.

4. CODES AND CODING

No names should be written on questionnaire forms. The *Respondent Coding Sheet* should be used (provided in Appendix B) that is stored separately and securely away from the questionnaires.

The Respondent Coding Sheet:
Records the woman's full name
Designates an identification number to her that will be used on all questionnaires (rather than using her name). The code will be assigned as follows (please use upper case letters):

- The first three digits of the NGO: |_|_|_|

Animus Association Foundation	|A|A|F|
IOM, Ukraine	|I|M|U|
La Strada, Ukraine	|L|S|U|
La Strada, Moldova	|L|S|M|
On the Road Association	|O|T|R|
Pag-Asa	|P|A|G|
Poppy Project:	|P|O|P|
STV	S|T|V|

- The fourth and fifth digits are the number designated to the woman based on the order in which she entered the study. For example, the first woman in the study will be |0|1|, the second woman will be |0|2|, etc. These numbers have already been entered into the Respondent Code Sheet.

- The sixth digit is the first letter of the woman's first name. For example, if the woman's first name is "Maria", you would write |**M**|.

Therefore, if *Maria* is the *first* woman interviewed by the *Animus Association Foundation* then her code would be written as: |A|A|F|0|1|M|

Code numbers should <u>always</u> <u>be written at the top of each page of each questionnaire (in the space provided) before the start of each interview</u>, to avoid problems if the pages should ever become separated.

5. DESCRIPTION AND USE OF QUESTIONNAIRES

Description
The study is comprised of a series of three questionnaires that cover three time periods.

First Period Questionnaire: ONE TO SEVEN DAYS of their entry into an assistance programme.

Second Period Questionnaire: FOUR TO SIX WEEKS of the *First Period Interview.* (In cases where the woman will leave the programme or facility after two to three weeks (i.e., IOM Shelter), the interview may take place earlier as early as two weeks after the first interview, but preferably as near to the date of her departure as possible.

Third Period Questionnaire: TWELVE OR MORE WEEKS from the *First Period Interview,*

The questionnaire is divided into four parts.

Part I: Background and demographic information.
Part II: Physical health.
Part III: Experiences with violence.
Part IV: Emotional well-being.

All four parts appear in the First Period Questionnaire. Only parts III and IV appear in the Second and Third Period Questionnaire.

Using the questionnaire

1)Preparing the questionnaires

When a woman has met the criteria to be interviewed:

- A file should be created for the woman and a blank copy of <u>all three questionnaires</u> should be photocopied onto the appropriate colour papers[31] and placed in the file:

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[31] We recommend that many copies be made of each version of the questionnaire (on the appropriate colour papers) to have on hand and ready for interviews.

   📁 First Period Questionnaire = white paper
   📁 Second Period Questionnaire = blue paper
   📁 Third Period Questionnaire = green or pink paper

- A code number should be assigned to the woman and written on the top of each page in each questionnaire (see above).

- General information about the woman (age, nationality, duration of trafficking experience, type of labour exploitation, etc.) that can be answered based on file information should be completed in advance of the interview. In addition, where other information is available, for example, abortion and pregnancy history; and HIV, TB, and STI status, please transfer this information from the file rather than making the woman repeatedly answer difficult questions. **However, please ask every question in the physical health and emotional health checklists.**

2) Conducting the interview

Beginning the interview: the Consent Request Statement
Before the interview begins, the interviewer should make certain that the woman is comfortable and feels safe (see above: "Ethical obligations").

For all interviews the interviewer must read the full *Consent Request Statement.* Reading the statement in an explanatory and welcoming manner (vs. rote or commanding way) can help put the woman at ease (vs. intimidating her) and open the way for a more trusting relationship and relaxing interview. Therefore the interviewer (and interpreter) should familiarise herself with it before the interview begins.

The woman should not be asked to sign the statement herself, but instead read the questions and simply asked to answer "yes" or "no", acknowledging whether she agrees or not to the interview and whether she feels it is a good time for the interview. The interviewer will then check the appropriate boxes on the *Consent Request Statement.* The *Consent Request Statement* is included on all three questionnaires before the question sections begin. Please note that the *Consent Request Statement* in the first period questionnaire differs from the one in the second and third period questionnaires. A woman who gives consent to be interviewed at the first interview is free to decline to consent to later interviews.

Question and response structure
Ideally, all four parts of the questionnaire should be completed during one interview. However, if necessary, they may be administered in several segments (over as long as a 3-day period).

Open-ended questions Some questions are open-ended, and require the interviewer to write down the respondents response. For these questions please record, as best as possible, the entirety of a woman's answers in words as close as possible to her own. If what the woman has said is unclear, the interviewer should probe to clarify the response. Interviewers should NOT try to reinterpret or rephrase what the woman has said. However, interviewers are encouraged to add their own

comments or explanation to supplement the woman's response. In this case, the interviewer must make it clear that the comments are hers (i.e., by putting the comment in brackets, for example, "[*she said this because her step-father used to beat her....*]" and putting the interviewer's initials next it.

YES/NO questions Please CIRCLE the correct answer, either circling only the number or putting a circle around both the phrase and the number.
For example:

YES..............1

NO................2

or:

Single/never married..1

Married and living with husband or living as married....................2

Multiple choice, scaled questions ["not at all", "a little", etc.], please put a check or "X" in the box following each question under the response indicated by the woman. If women make additional comments, please record them at the bottom of the page, in the margins or on back of the form; and include the appropriate question number.

NO.	QUESTION	YES = 1 NO = 2 Circle the response	NOT AT ALL =3	A LITTLE = 4	QUITE A BIT = 5	Extremely/ VERY MUCH = 6
				Mark/tick response		
16a. 16b.	Skin problems, such as rashes, red areas, unusual bumps, sores or itching	YES............1 NO................2 *If yes,* *how much has it bothered* *you or caused you pain:*		X		

Adding comments by the woman or interviewer *If you have sufficient time,* please feel free to ask follow-up questions to any response. If possible, note both the additional questions and answers on the interview form. However, please be careful that these additional questions do not become too burdensome, as this could potentially jepordise the successful completion of the main questionnaire.

Skipping questions If a woman does not wish to answer a question, she should not be coerced or pressured to answer it. The interviewer should simply note that the woman <u>"Did not wish to answer the question"</u> or <u>"DW"</u> and move onto the next question. The response space should not be left blank/empty. If the woman gives a reason for not wishing to answer, the interviewer should note this. If for some reason the interviewer feels she must to skip a question and not ask it (although this is discouraged), the reason for this must be given.

Woman doesn't know the answer to the question If the woman does not know an answer to a question, the interviewer should write <u>"Doesn't Know"</u> or <u>"DK"</u>. The response should NOT be left blank/empty.

Terminating an interview before all the questions have been asked If you or the woman decide to stop the interview at any time before the questionnaire is completed, please note at what question and for what reason on the interview form and where appropriate time to complete the interview should be scheduled. Second period interviews should only be scheduled for women who complete a reasonable majority of the questions in the first period interview (there can be some skips or non-responses in this).

A woman changes her response to a question after the interview is completed, in a later interview, or the interviewer knows information different from what the woman has stated. It is not unusual for a woman to give inaccurate information during a first interview. This may be because she does not feel comfortable telling the truth, or because she does not recall. A woman may feel more able to reveal sensitive information outside the interview setting, or during a second or third interview. If a woman changes her answer later, or the interviewer is aware that the information that the woman has provided is inaccurate, the interviewer should NOT challenge her about this information. After the interview, the interviewer should return to the question to which the woman responded inaccurately, and **in brackets [...] and initialed** (using the back of the page if necessary), the interviewer should note:

- the information as the interviewer knows it;
- how the interviewer knows differently;
- when the interviewer found out differently or when the woman told the information differently, and if possible;
- any speculation as to why the woman may have chosen not to disclose it.

3) Distress during the interview

The woman's well-being is always the priority. Women's requests to stop or take a break from the interview should always be respected. In cases where it is reasonable to ask, the interviewer should try to offer to restart the interview when the woman feels better, or may offer to reschedule it.

Women's distress
If women become very distressed or overwrought during an interview, her distress and counselling needs should immediately be treated as a priority. If the interviewer is not a trained therapist, counsellor or social worker, she should identify someone who is and can assist the woman and refer the woman to the trained professional as quickly as possible. However, women should never be coerced or pressured to follow-up with counselling.

If a subject comes up that suggests a woman may need counselling (e.g., suicidal thoughts) or medical attention (e.g., symptoms indicating an infection), the interviewer should note this during the interview. Unless the need is urgent (requires *immediate* attention), the interviewer should not try to address the problem during the interview. The interviewer should suggest to the woman that they discuss it more in-depth after the interview is completed (or offer to provide a referral after the interview). However, if the woman is unable to continue the interview, or feels it is essential to discuss her concerns immediately, her wishes should be respected.

4) Ending the interview

Closing statement and opportunity for the woman to ask questions or make requests
The interviewer should plan to leave adequate time at the end of an interview to answer questions and listen to any further information the woman wishes to discuss. The closing statement has been designed to let the woman know that the interviewer understands how tiring or demanding the questions may have been and it should be read in a tone that acknowledges the interviewer's gratitude to the woman for her bravery and generous cooperation.

Request for follow-up interview
The closing statement also includes a request to the woman to participate in a second or third interview. The follow-up period will not be the same for all the study partners. For example, for most partners, the second interview may take place in four to six weeks after the first interview, while for others (e.g., IOM) the interview may take place as early as two to three weeks. Before the interview begins, the interview should have clearly in-mind a proposed follow-up date and location. The interviewer should also be prepared to gather the woman's contact information at this time, (e.g., cell phone, address), and make arrangements for how the interviewer will make contact to remind the woman of the interview one or two days before it will take place.

Requests for copies of the questionnaire
If the woman requests a copy of the questionnaire, she should be provided a photocopy of the completed questionnaire, or the blank questionnaire (depending on what she wants).

Reviewing the completed questionnaire
As soon as possible after the interview, the interviewer (and translator) should review all of the responses she has written on the questionnaire to be sure that they are legible and that the information is complete and comprehensible. If details or explanations are needed, they should be added. If the added information is not in the woman's words, it should be put in brackets and initialled.

6. ARRANGING FOLLOW-UP INTERVIEWS

To encourage better attendance at second and third interviews, it is important for the interviewer to call or make contact with the woman a day or two (or several times) before the interview. The interviewer should ask the woman if the meeting place and time are still acceptable, and if the woman needs any practical help (babysitting, transport, etc.) or logistical assistance (more detailed directions, to be met somewhere to help her find her way). The woman's contact information should be put onto the Respondent Code Sheet in the secured file.

7. INTERPRETING

Interpreters should be carefully screened for security purposes and to be sure they are able to treat sensitive information appropriately and respond to women patiently and sympathetically. Interpreters should be given a briefing on the subject and aims of the study and the interview. They should also be carefully informed of the ethical obligations of interviewing, in particular, of confidentiality and women's right to refuse to answer any question.

Before the interview, interpreters should be provided with a copy of the translated questionnaire (in the language they will be using, i.e., not English) and enough time to review it. Interpreters should ask the questions exactly as they are written (in translation) on the questionnaire (i.e., not interpret from an untranslated/English language questionnaire). If a woman requires a further explanation of a question or clarification, the interpreter may try to explain, with the approval of the interviewer.

After the interview, the questionnaire must be returned to the partner organization. The interpreter may NOT keep the questionnaire after the interview is completed.

Even when interpreting is necessary, interviewers must ask the questions to the woman directly (i.e., not speaking to the interpreter, but making eye contact with the

woman), after which the interpreter will pose the question from the translated questionnaire.

Once the woman has replied to a question, or when the interpreter feels she/he can not take in any more information, interpreters should interpret for the interviewer. If the woman had not completed her thought, the interpreter should politely ask the woman to wait a moment and continue after the interpretation.

Follow-up questions posed by the interviewer that are not on the original form, or questions posed for clarification that are not on the translated form can be interpreted directly by the interpreter for the woman. The follow-up questions and the responses should also be written by both the interpreter and the interviewer.

After the interview is completed, the interviewer should ask the interpreter to step out of the room while the interviewer shows a card written in the woman's native language that asks the question:

"While you were talking with this interpreter, did you feel (please circle one):
a) very comfortable/relaxed
b) average comfortable/relaxed
c) less than comfortable/relaxed
d) not at all comfortable/relaxed

Your answer will remain completely confidential and will never be told to the interpreter."

If the woman selects "c" or "d", the interviewer will have to follow-up with this woman with another interpreter to identify the source of her discomfort (and how this may have affected the way she answered any of the questions).

7. DATA STORAGE AND TRANSFERRING DATA TO LSHTM

Storing questionnaires

Respondent code sheets
Respondent code sheets should always be stored in a secured location, away from the completed questionnaires.

The respondent code sheet serves several purposes:

- to identify the respondent code number with the respondent name;
- to record contact information necessary for follow-up interviews;
- to schedule dates for and keep track of follow-up interviews
- to record the dates and the means by which information is sent to LSHTM so that information is not overlooked/forgotten and does not get sent, or goes unnoticed if it is lost in the mail. If sent by courier, please note the "reference" or "tracking" number.
- to ensure the copy of the questionnaire sent to LSHTM was received by recording the "date received" (which will be provided by LSHTM by phone or email).

Name of respondent and contact information	Code for respondent [First three letters of NGO Number Woman's first name initial]	Date *First Period Interview* completed	Date *First Period Interview* sent to LSHTM	Date *Second Period Interview* scheduled: completed :	Date *Second Period Interview* sent to LSHTM	Date *Third Period Interview* scheduled: completed:	Date *Third Period Interview* sent to LSHTM	Co m me nts
	|_|_|_||0|1|_|		Date sent: Sent by: Email Fax Courier Mail Date received:	Date scheduled: Date completed:4	Date sent: Sent by: Email Fax Courier Mail Date received:	Date scheduled: Date completed:	Date sent: Sent by: Email Fax Courier Mail Date received:	

Questionnaires

Questionnaires completed by interviewers should be reviewed as quickly as possible after an interview is completed for missing information, illegible responses, and unclear answers. All questionnaires from different time periods should be kept in the same file. The file should be labelled with the woman's code number and kept apart from the *Respondent code sheet.*

If the questionnaire has not been completed in English (most partners), responses should be translated into English on a separate questionnaire as soon as possible. In cases where there are problems identifying a translator or undertaking a timely translation (within two weeks), please contact Cathy.

Questionnaires completed by interpreters should be stored with the questionnaires completed by the interviewers. They should have the woman's code number on the top of each page and should be clipped together with the questionnaire completed by the interviewer.

Transferring questionnaires to LSHTM

There are four ways completed questionnaires can be transferred to LSHTM research team (IMPORTANT: Please DO NOT send them to the LSTHM address in London, but to the addresses given below):

Regular mail: Questionnaires should be photocopied and sent by regular mail (from locations where the mail is considered reliable) to:
    Cathy Zimmerman
    233 Grove Road
    South Orange, New Jersey 07079
    USA

Fax: Questionnaires can be faxed to:
    Cathy Zimmerman
    Fax: 44-870-139-0587 (if in UK)
    Fax: 1-253-390-7641

Email: For questionnaires that are to be emailed, responses must be typed onto an electronic format (i.e., the form that is on the computer in a "Word" document) in English (preferably). The form should be sent as a Word document attachment to an email with "Confidential interview" written in the subject line of the email. The attachment should be emailed to:

cathy.zimmerman@lshtm.ac.uk

It is very important that, no matter how you have sent the information, you notify Cathy (either by email or phone) that questionnaires have been sent and by what means, so that we can quickly follow-up on any lost or misplaced information.

Courier/Express mail: If partner organizations would prefer to send completed questionnaires by private courier (e.g., Federal Express, DHL, etc.), they should speak with Cathy, as the study has budgeted funds to pay for this service in locations where it is either the most reliable or the least complicated method. In thse cases the questionnaires should be sent in batches once every month to six weeks to by the courier's economy service to:

> Cathy Zimmerman
> 233 Grove Road
> South Orange, New Jersey 07079
> USA

Steps for transferring information

Completed questionnaires should be photocopied before being packaged and sent (except for faxes). Email attachments should be printed and put into the respondent's file.
IMPORTANT: The day a completed questionnaire is mailed/sent/faxed, an email should be sent to cathy.zimmerman@lshtm.ac.uk to inform her of the date that it was sent, by what means, and by whom. This will ensure that if the questionnaire does not arrive, Cathy can follow-up.

The date the questionnaire was sent and by what method should be immediately recorded in the appropriate boxes/lines on the *Respondent code sheet.*

When the questionnaires have arrived, Cathy will send an email confirming that the questionnaire has been received. This may be recording the date next to the "Date received" line (optional) in the appropriate box.

9. FINANCIAL COMPENSATION FOR WOMEN PARTICIPATING IN THE STUDY

Where it is necessary and useful, the study has set aside a limited amount of funds to support the costs of women attending the second and third interview. These funds are designed to pay for expenses such as, transportation costs (of interviewer or respondent), childcare, and a reasonable amount for lost work time. These expenses will be determined on a partner by partner basis, and they should be discussed with LSHTM before commitments are made to the women.

10. OTHER PROBLEMS OR QUESTIONS

If there are other questions or problems that come up during the study, please contact Cathy Zimmerman by email: cathy.zimmerman@lshtm.ac.uk.

APPENDIX D. SURVEY QUESTIONNAIRE: First period interview

Closing statement to be read aloud by interviewer

Thank you very much. I know that some of these questions were not easy, but your responses were very clear and helpful. No one should have to go through what you have experienced. It is evident that you are a very courageous person for having managed to survive such a difficult experience.

If you agree, we would like to interview again three to four weeks from today to see how you are doing.. These interviews will include some of the same questions about your health, but you will not be asked the questions about your past experiences again. These questions will allow you to see how your health feelings have changed, they will help us identify how your health needs have changed. For this interview, you will be given money to cover your travel costs.

Will you meet again to answer questions like this in four to six (or two to three) weeks? (circle one)

Yes   No

[If No, please note reason for refusal: No reason, Too many questions or doesn't like questions, Too tiring or upsetting, Doesn't want to be contacted,
Other:_____]

LSHTM

Multi-Country Study on the Health Outcomes of Trafficked Women and Adolescents

in Service Settings

FIRST PERIOD QUESTIONNAIRE
1-7 DAYS
*(this form is to be photocopied on **white paper**)*

Part I: Background and demographic information.
Part II: Physical health.
Part III: Experiences with violence.
Part IV: Emotional well-being.

October 2003

Study participation criteria and brief guidelines for *FIRST PERIOD Questionnaire*

To qualify to participate in the study:

☑ Women must be interviewed within 0 to 7 days of their entry into an assistance programme using the *FIRST PERIOD Questionnaire* (to be copied on white paper). In exceptional cases, it may be as late as 10 days. In practice, women should be interviewed as early as ethically and practically possible.

☑ Women must be entering an assistance programme (i.e., not still working without having entered an assistance programme).

☑ Women must be between the ages of 12 to 45 years old.

☑ Women must be interviewed before they receive a general medical exam. This does NOT include any urgent care or emergency medical treatment.

☑ Women must have been working in either sex work or domestic labour (or both). Women who have been exploited in sectors such as factory labour, agricultural labour, handicrafts, etc., are NOT eligible to participate in this study.

☑ Women may have been trafficked internally (i.e., domestically) or internationally.

Using this questionnaire

The questionnaire is divided into four parts.

Part I: Background and demographic information.
Part II: Physical health.
Part III: Experiences with violence.
Part IV: Emotional well-being.

Ideally, all four parts should be administered in one interview. However, if necessary they may be administered in two interviews over a 3-day period.

The respondent's case file may already have answers to questions about duration of trafficking experience; work done when trafficked; abortion and pregnancy history; and HIV, TB, and STI status. In these cases, please collect this information from the file rather than the respondent herself, so that she will not be asked difficult questions repeatedly.

However, please ask every question in the physical health and emotional health checklists.

For open-ended questions, please record, as best as possible, the entirety of a woman's answers in words as close as possible to her own.

For close-ended questions, please check off the box following each question (see below). If women make additional comments, please record them at the bottom of the page, in the margins or on back of the form; include the appropriate question number.

Please feel free to ask follow-up questions to any response. As possible, note both additional questions and answers on the interview form.

If you or the woman decides to stop the interview at any time before the questionnaire is completed, please note at what question and for what reason on the interview form.

Writing responses on the questionnaire

Answers where there is a   YES.............1
                                NO.............2

Circle the correct response, either the entire "YES............1" or simply circle the word "YES" or "NO."

- If the respondent is unsure about a response (e.g., date trafficked), encourage her to try to estimate the time, and record the answer. Probing may help in such cases – e.g., in what year, what time of year etc.

- Multiple answers with boxes (i.e., a little, quite a bit, extremely)
Put a check mark or an X in the box under the response that corresponds to the woman's answer.

- In places where the question requires two responses (i.e., a YES or NO, and a severity level: a little, quite a lot, extremely), if first response is "YES", please then ask how much this upset her or caused her pain, and put a check mark or an X in the corresponding box.

Working with interpreters

- Interpreters should be provided with a copy (white) of the translated questionnaire and should ask the questions exactly as they are written (in translation) on the questionnaire (i.e., not interpret from an untranslated/English language questionnaire).
- Even when interpreting is necessary, interviewers should ask the questions to the woman directly, after which the interpreter will pose the question from the translated questionnaire.
- Once the woman has replied interpreters should interpret for the interviewer and write the woman's response on their translated form in the woman's native language.
- The interviewer should write the interpreted response on her form.

Follow-up questions posed by the interviewer that are not on the original form, or questions posed for clarification that are not on the translated form can be interpreted directly by the interpreter for the woman..

<u>**Information sheet and consent form**</u>

TO BE READ ALOUD

Hello, my name is _____. We're conducting research on the health of women who have been trafficked in order to identify better ways that we and other service providers can understand your health needs and provide better health services. The study is called the *Multi-Country Study on the Health Outcomes of Trafficked Women and Adolescents in Service Settings.* We would like to ask you some questions about your recent experiences, and about your health and well-being.

Although we will be recording your answers, no identifying personal details will be written down. We will not write down your name on this questionnaire, and we will not ask you about the name of your hometown, your trafficker's name, or record specific details about your family for any part of this study. There are no right or wrong answers. We only ask that you consider the questions carefully and answer as best you can. The information you provide will not be given to any government offices or others outside the support team that is directly assisting you.

Some of the questions may bring up difficult memories or feelings. You can take your time answering, and can decline to answer any question. Some of the questions that I will ask during this interview might bring up issues or problems that you wish to continue to discuss in more in-depth with your support team at a later time.

Each question is asked for a specific reason related to your health. If you don't understand why we are asking any particular question, please ask me.

You don't have to participate in this interview if you don't wish to. If you don't want to proceed it will not affect any of the other services that you receive. If you agree to proceed, you can stop the interview at any time. If you don't wish to answer a question or would like to ask me a question, please feel free to do so. This interview usually takes approximately XX minutes.

Do you have any questions?   Yes   No

Do you understand everything that I have read to you and what we are asking you to do?   Yes   No

Do you agree to be interviewed? (circle one)   Yes   No
Date_____
       [If 'No', please note the reason for refusal:
           Doesn't want to, No time, Feeling unwell, Other:_____]

Is this a good time and place to talk? (circle one)   Yes   No
       If No, what would be a good time and place for us to talk? (note)

Is there anything you need or would like to do before we begin?   Yes   No

ADMINISTRATIVE DATA										
	NGO name	AAF [ ]	OTR [ ]	POP [ ]	PAG [ ]	LSU [ ]	LSM [ ]	STV [ ]	IMU [ ]	IMM [ ]
1.	Interviewer name									
2. a.	Date of interview				____| |____| |____| d/d m/m yr					
2. b	Referred by:									
3.	Respondent ID number				__| |__|__|__|__|__|					
4.	Consented to be interviewed	YES..1 NO ....2 *If no, was a reason given?*									
5.	Interview completed (To be filled in at the end of interview)	YES..1 NO 2									

	PART I	
	BACKGROUND AND DEMOGRAPHIC INFORMATION	
6.	**From your organisation's records**, please note the date the woman entered into your care.	|_____| |_____| |_____| d/d m/m yr
7.	Age	|____|____|
8.	Home country	
9.	Who were you living with before you were trafficked	Probe: Anyone else?]
10.	Before you were trafficked what was your marital status?	Single / never married...1 Married and living with husband or living as married...2 Separated or divorced..3 Widowed..4 Other, explain:
11.	Do you have any children? How many?	YES...1 NO. ....2 *If yes:* Number of children........................|_____|

12.	*If she has children:* With whom are your children living now? In what country are they living?	Parent(s) Other relatives Friends Other (specify)
13.	What month and year were you trafficked from your home?	| | | | m/m yr Other answer:
14.	When you were in the trafficking situation, what type of work did they make you do?	Sex work..1 Domestic work..2 Other (explain why being interviewed)
15.	How long ago did you stop doing this work?	1 to 2 days...1 3 to 7 days...2 1 week to 1 month...3 1 month to 3 months..4 3 months to 6 months...5 6+ months..6 Other...7 Explain Doesn't remember..8 No Answer..9

PART II
PHYSICAL HEALTH

TO BE READ ALOUD:

I am now going to ask you some questions about your physical health.

PART II PHYSICAL HEALTH		
15.	Thinking back over the last two weeks, how would you say your health has been?	VERY GOOD..1 GOOD...2 FAIR..3 POOR...4

TO BE READ ALOUD:

I am now going to ask about if you have had different common symptoms or problems in the last two weeks. You may find some of these to be sensitive but they will help us get a better understanding of any health problems that you might have. For each question I will ask you if you have experienced any of these problems in the last two weeks, including today. If you have had any of these problems, I would then like to know whether this didn't bother you at all, whether it bothered you a little, whether it bothered you quite a lot, or whether it bothered you very much (show card that illustrates this)).

In the past two weeks have you had:

NO.	QUESTION	YES = 1 NO = 2 Circle the response	NOT AT ALL =3	A LITTLE = 4	QUITE A BIT = 5	Extremely/ VERY MUCH = 6
				Mark/tick response		
16a. 16b.	Skin problems, such as rashes, red areas, unusual bumps, sores or itching	YES...............1 NO.................2 *If yes,* how much has it bothered you or caused you pain:				
17a. 17b.	Headaches	YES..................... ...1 NO...................... ..2 *If yes,* how much has it bothered you or caused you pain:				

18a. 18b.	Fainting or losing consciousness	YES..................... ...1 NO........................ ..2 *If yes,* *how much has it* *bothered you or caused* *you pain:*				

NO.	QUESTION	YES – 1 NO – 2 Circle the response	NOT AT ALL =3	A LITTLE =4	QUITE A BIT = 5	Extremely/VERY MUCH = 6
			Mark/tick the box			
19a 19b	Dizzy spells	YES.....................1 NO..........................2 *If yes,* *how much has it bothered* *you or caused you pain*				
20a 20b	Significant weight loss	YES.....................1 NO..........................2 *If yes,* *how much has it bothered* *you or caused you pain*				
21a. 21b.	Being easily tired	YES.....................1 NO..........................2 *If yes,* *how much has it bothered* *you or caused you pain*				
22a. 22b.	Difficulty remembering things	YES.....................1 NO..........................2 *If yes,* *how much has it bothered* *you or caused you pain*				
23a. 22b.	Eye pain, injury or difficulty seeing (NOT related to needing spectacles/glasses)	YES.....................1 NO..........................2 *If yes,* *how much has it bothered* *you or caused you pain*				
24a. 24b.	Ear pain, injury or difficulty hearing	YES.....................1 NO..........................2 *If yes,* *how much has it bothered* *you or caused you pain*				
25a. 25b.	Tooth pain or other problems with your mouth or gums	YES.....................1 NO..........................2 *If yes,* *how much has it bothered* *you or caused you pain*				
26a. 26b.	Facial injuries (black eyes, bruises, bloody nose, jaw injury)	YES.....................1 NO..........................2 *If yes,* *how much has it bothered* *you or caused you pain*				

NO.	QUESTION	YES = 1 NO = 2 Circle the response	NOT AT ALL =3	A LITTLE =4	QUITE A BIT =5	Extremel y/ VERY MUCH = 6
			Mark/tick the box			
27a. 27b.	Difficulty getting your breath, painful breathing or other breathing problems	YES..........................1 NO..........................2 *If yes,* *how much has it bothered* *you or caused you pain:*				
28a. 28b.	Chest pain, heart pain, or heart palpitations	YES..........................1 NO..........................2 *If yes,* *how much has it bothered* *you or caused you pain*				
29a. 29b.	Loss of appetite	YES..........................1 NO..........................2 *If yes,* *how much has it bothered* *you or caused you pain*				
30a. 30b.	Pain in your stomach/abdomen	YES..........................1 NO..........................2 *If yes,* *how much has it bothered* *you or caused you pain:*				
31a. 31b.	Upset stomach, vomiting, or other digestive problems (diarrhoea, constipation, other)	YES..........................1 NO..........................2 *If yes,* *how much has it bothered* *you or caused you pain*				
32a. 32b.	Painful urination	YES..........................1 NO..........................2 *If yes,* *how much has it bothered* *you or caused you pain:*				
33a. 33b.	Pelvic pain	YES..........................1 NO..........................2 *If yes,* *how much has it bothered* *you or caused you pain:*				

NO.	QUESTION	YES = 1 NO = 2	NOT AT ALL =3	A LITTLE =4	QUITE A BIT =5	Extremely VERY MUCH =6
		Circle the response	Mark/tick the box			
34a. 34b.	Unusual or bad smelling discharge/secretion/fluid from your vagina (not blood)	YES.....................1 NO.....................2 *If yes,* *how much has it bothered* *you or caused you pain:*				
35a. 35b.	Pain in or around your vagina	YES.....................1 NO.....................2 *If yes,* *how much has it bothered* *you or caused you pain:*				
36a. 36b.	Vaginal bleeding (other than your menstruation/period	YES.....................1 NO.....................2 *If yes, has it bothered you:*				
37a. 37b.	Gynaecological infections or symptoms of infection	YES.....................1 NO.....................2 *If yes, has it bothered you:*				
38a. 38b.	Back pain	YES.....................1 NO.....................2 *If yes, has it bothered you:*				
39a. 39b.	Fractures or sprains (including old injuries)	YES.....................1 NO.....................2 *If yes, has it bothered you:*				
40a. 40b.	Joint or muscle pain	YES.....................1 NO.....................2 *If yes, has it bothered you:*				
41a. 41b.	Colds, sinus infections or flu	YES.....................1 NO.....................2 *If yes, has it bothered you:*				

TO BE READ ALOUD:

Thank you. Now I would like to ask you some more questions about how you have been feeling in the past two weeks. However, this time please answer these questions in your own words.

No.	QUESTION	RESPONSE
42	Please think of your body from head to foot and tell me about any other health concerns or things that have been hurting you in the past two weeks	
43.	Of all the problems you've had in the past two weeks, can you tell me more about the things that have been hurting or bothering you the most?	
44.	What do you think caused this problem?	
45.	Of all the problems you've had in the past two weeks, for which ones did you or do you most want to see a doctor or health practitioner?	

TO BE READ ALOUD:

Now I'd like to ask you some questions about your health while you were trafficked.

No.	Question	Response
46.	Do you think you might be pregnant at the moment?	YES..........................1 NO..........................2
47.	Did you ever have a miscarriage during the time you were trafficked?	YES..........................1 NO..........................2 *If yes, how many?*
48a.	Did you ever have an abortion during the time you were trafficked?	YES..........................1 NO..........................2 *If yes, how many?*
49.	During or after the time you were in the trafficking situation, were you ever diagnosed with TB?	YES..........................1 NO..........................2 *If yes, when?*

51.	During the time you were in the trafficking situation, did you ever have a sexual health check?	YES...........................1 NO............................2 *If yes, how often?*
52.	During or after the time you were in the trafficking situation, were you ever diagnosed with a sexually transmitted infection?	YES...........................1 NO............................2 *If yes, which ones [Prompt:* chlamydia, gonorrhea, syphillis, HPV(human papiloma virus), herpes, others]. *Please record whatever terms the woman uses to describe any illness or infection.*
53.	During or after the time you were in the trafficking situation, were you ever been diagnosed with hepatitis A, B, or C?	YES...........................1 NO............................2 *If yes, which one and when?*
54.	Have you ever been diagnosed with HIV?	YES...........................1 NO............................2 *If yes, when?* *Were you given counselling about the test* *- before the test?* YES...........................1 NO............................2 *- after the test?* YES...........................1 NO............................2
55.	Are you currently taking any medication?	YES...........................1 NO............................2 *If yes, which one(s)?)record names*

PART III
EXPERIENCES

TO READ ALOUD:

Thank you. Now I would like to ask you some questions about your experiences of being trafficked. These questions are important for us to understand all of your health need, but may bring up difficult memories. Feel free to take your time answering and can choose not to answer any question.

	PART III				
	EXPERIENCES				
56.	How heavily/often were you drinking during the time you were in the trafficking situation? Would you say not at all, occasionally, most days or every day. *Check the response*	Not at all = 1	Occasionally/ sometimes = 2	Most days = 3	Everyday = 4
57.	Were you using any type of drug [legal or illegal]?	YES………………………………………1 NO……………………………………….2 Didn't answer…………..………………9 *If yes, which drugs?*			
58.	When you had sex, would you say you were you able to use a condom never, occasionally, often, or always? *Check the response*	Did not have sex = 0	Never = 1	Occasiona lly = 3	Often = 4	Always = 5
		Comments (may be different for clients vs. boyfriend, if she had one):				

59.	Were you free to do what you wanted or go where you wanted? Would you say never, occasionally, often or always?	Never = 1	Seldom = 2	Occasionally = 3	Often = 4	Always = 5
	Check the response	Comments:				
60.	Did anyone ever threaten to hurt you?	YES...1 NO...2				
61.	During this time did anyone ever threaten to hurt your family or someone you care about?	YES...1 NO...2				

61.	Did anyone ever hit, kick, or otherwise physically hurt you?	YES...1 NO...2
62.	Did anyone ever hurt you with a gun, knife or other object?	YES...1 NO...2
63.	*For women without children:* Had you ever had sex before being trafficked?	YES...1 NO...2
64.	While you were in the trafficking situation, did anyone physically force you to have sex or do something sexual when you didn't want to?	YES...1 NO...2
65.	Did you ever have sex with someone or perform some sexual act because you were <u>afraid something bad would happen</u>?	YES...1 NO...2
66.	During this time, were you ever injured?	YES...1 GOTO 67 NO...2 GOTO 67 *If yes, please explain any injuries:*
67.	Do any of these injuries still cause you pain or problems?	YES...1 NO...2 *If yes, in what way do they still cause you pain or problems:*

TO BE READ ALOUD

Now, I would like to ask you a few questions about your experiences before you were trafficked.

68.	Before you left home, did any of the following people ever physically hurt you when you were a child or an adult? (ASK ABOUT EACH PERSON SEPARATELY)	Mother = 1	Father = 2	Other family Member = 3	Husband = 4	Boy-friend = 5	Acquaint-ance = 6	Stranger = 7
		Other (may include police, army, etc.) = 0 *Explain:*						
		If yes to any of the above, how old were you when this/these persons harmed you? (Please ask about each one mentioned) *Probe: What did you think would happen to you if you refused?*						
69.	Before you were 15 years old did any of the following people ever make you or persuade you to do something sexual when you didn't want to?	Mother = 1	Father = 2	Other family Member = 3	Step-father =4	Boy-friend = 5	Acquaintance = 6	Stranger = 7
		Other (may include teacher, police, army, etc.) = 0 *Explain:*						

| | | *If yes to any of the above, how old were you when this/these persons harmed you? (Please ask about each one mentioned)* |
| | | *Probe: What did you think would happen to you if you refused?* |

70.	After you were 15 years old did any of the following people ever force you or persuade you do something sexual when you didn't want to?	Mothe r = 1	Father = 2	Other family Memb er = 3	Husba nd or partner = 4	Boy-friend = 5	Acquai ntance = 6	Strang er = 7
		Other (may include police, army, etc.) = 0 *Explain:*						
		If yes to any of the above, how old were you when this/these persons harmed you? (Please ask about each one mentioned) *Probe: What did you think would happen to you if you refused?*						
71.	Did your parents or any family member know the traffickers or introduce you to the traffickers?	YES...1 NO..2 *If yes, please explain?* *Were you tricked sold by family member?*						

PART IV
EMOTIONAL WELL-BEING

TO BE READ ALOUD

Thank you. I would now like to ask you several questions about how you are currently feeling. Please listen to each one carefully and tell me how much, in the past week, each of the symptoms has bothered you, using one of these four responses: Not at all, A little, Quite a bit or Extremely/A lot.

During the past 7 days, how much were you distressed or disturbed by:

PART IV EMOTIONAL WELL-BEING					
No.	Question	Not at all = 0	A little = 1	Quite a bit = 2	Extremely = 3
72.	Recurrent thoughts or memories of the most hurtful or terrifying events.				
73.	Feeling as though the event is happening again.				
74.	Recurrent nightmares.				
75.	Feeling detached or withdrawn from people.				
76.	Unable to feel emotions.				
77.	Feeling jumpy, easily startled.				

Added comments (please cite question number comments refer to):

No.	Question	Not at all = 0	A little = 1	Quite a bit = 2	Extremely = 3
78.	Difficulty concentrating.				
79.	Trouble sleeping.				
80.	Feeling on guard.				
81.	Feeling irritable or having outbursts of anger.				
82.	Avoiding activities that remind you of the traumatic or hurtful event.				
83.	Inability to remember parts of the most traumatic or hurtful events.				
84.	Less interest in daily activities.				
85.	Feeling as if you don't have a future.				
86.	Avoiding thoughts or feelings associated with the traumatic or hurtful events.				
87.	Sudden emotional or physical reaction when reminded of the most hurtful or traumatic events.				

Added comments (please cite question number comments refer to):

TO BE READ ALOUD:
*Now when I ask you about the following symptoms, I am going to ask you to use
one of the following five responses: Not at all, A little bit, Moderately, Quite a bit, or
Extremely.*

During the past 7 days, how much were you distressed or disturbed by:

**Interviewer: Show visual severity indicator cards." Check/tick box corresponding to
response given.**

No.	Question	Not at all = 0	A little = 1	Moderately = 2	Quite a bit = 3	Extremely = 4
88.	Nervousness or shakiness inside					
89.	Feeling easily annoyed or irritated					
90.	Thoughts of ending your life					
91.	Suddenly scared for no reason					
92.	Temper outbursts that you could not control					
93.	Feeling lonely					
94.	Feeling blue (VERY SAD)					
95.	Feeling no interest in things					
96.	Feeling fearful					

Added comments (please cite question number comments refer to):

No.	Question	Not at all = 0	A little = 1	Moderately = 2	Quite a bit = 3	Extremely = 4
97.	Feeling hopeless about the future (D)					
98.	Feeling tense or keyed up (A)					
99.	Having urges to beat, injure, or harm someone (H)					
100	Having urges to break or smash things (H)					
101	Spells of terror or panic (A)					
102	Getting into frequent arguments (H)					
103	Feeling so restless you couldn't sit still (A)					
104	Feelings of worthlessness (D)					

Added comments (please cite question number comments refer to):

107	Do you think being trafficked has changed the way <u>you</u> feel about <u>yourself</u>?	YES..1 NO...2 *If Yes*, what has changed?
108	Do you think being trafficked has changed the way <u>others</u> feel about you?	YES..1 NO...2 *If Yes*, what has changed?
109	Please describe the best future that you can imagine for yourself?	 Probe: What are your worries and fears? What are your dreams?

110	Who would you like to live with after you finish NGO programme?	Probe: Why do you prefer to live with these people this person?
		Is this who you were living with before you were trafficked?
111	Do you think you will talk to anyone outside this service about what you have experienced?	YES..1 NO...2 *If yes, who will you talk to and why will you choose/have you chosen this person(s)?* *If no*, what makes you feel this way/think this?

112	Is there anything that's happened in the past week that's made you feel bad or worse?	
113	Of the types of assistance that you've received in the past week, what do you think is helping you the most?	Probe: how/why do you think this is helping?
114	Do you have any questions for me?	

Closing statement to be read aloud by interviewer

Thank you very much. I know that some of these questions were not easy, but your responses were very clear and helpful. No one should have to go through what you have experienced. It is evident that you are a very courageous person for having managed to survive such a difficult experience.

If you agree, we would like to interview again three to four weeks from today to see how you are doing.. These interviews will include some of the same questions about your health, but you will not be asked the questions about your past experiences again. These questions will allow you to see how your health feelings have changed, they will help us identify how your health needs have changed. For this interview, you will be given money to cover your travel costs.

Will you meet again to answer questions like this in four to six (or two to three) weeks? (circle one)

Yes   No

[If No, please note reason for refusal: No reason, Too many questions or doesn't like questions, Too tiring or upsetting, Doesn't want to be contacted, Other:_____]

APPENDIX E

My role as Principle Investigator in the formative study (study 1) and multi-site survey (study 2)

Formative study (study 1)

For this study, I served as the Principal Investigator, for which my role included:

- development of the research proposal, and securing of the funding.
- establishing and coordinating collaborative research partnerships.
- leading the overall design and management of the study.
- conducting the literature review.
- developing suitable conceptual models.
- developing ethical and safety protocol for the study (*WHO Ethical and Safety Recommendations for Interviewing Trafficked Women*)
- .drafting and revising the study instrument
- designing and overseeing the implementation of the study methodology.
- data management, entry and coding.
- supervising partner research, interviews, to ensure that the study maintained coherency and consistency across countries, disciplines and cultures.
- Data analysis and interpretation of the findings, including coordination of partner meeting to discuss and interpret findings.
- Drafting and revising the report (*The Health Risks and Consequences of Trafficking in Women. Findings from a European Study*).
- navigating, at times, the divergent politics of the subject of trafficking— even within our own research team.[32]

Fieldwork

I carried out the majority of key informant interviews (n=53), and two interviews with women in England and two with women in Kyiv, Ukraine. Throughout the study I consulted with and benefited from the expertise of Professor Charlotte Watts (Supervisor for both studies and this thesis).

Survey (study 2)

For this study, I was the Principle Investigator. I developed the research proposal and secured the funding. I established the research partnerships and negotiated the roles and responsibilities.

As the principle investigator, I had responsibility for overseeing all aspects of the study, including:
- development of the questionnaire- I designed the questionnaire based on the findings from the formative study, new reviews of the literature, partner input and the findings of a review

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[32] One partner viewed all sex work as a form of violence against women and held elimination of prostitution as an ultimate goal, whereas most of our partners favoured a sex worker rights' perspective.

of international measurement instruments for different aspects of physical and mental health. For this, I managed a review of measurement instruments conducted by a medical student who had worked with me in a volunteer capacity for the first study, and was contracted for this review in preparation for the second study.

- I designed the study protocol, based on the ethical and safety recommendations and on the needs, circumstances and resources available to the partners. See Appendix C: Study User Guide.
- I coordinated and monitored the work and progress of the study partners.
- I managed the return and storage of the data.
- I monitored the entry of the data, which was carried out by a graduate of the MSc course in sexual and reproductive health who was contracted for this purpose.
- I designed and produced the data entry screens.
- I designed the data analysis strategy, which was carried out primarily by the above-mentioned MSc graduate.
- I carried out the interpretation of the data, which was subsequently presented and discussed at a meeting of all of the partners and LSHTM experts, which I led.
- I incorporated partners' and experts' comments and suggestions of the partners and drafted the findings in the final report (*Stolen Smiles: The Physical and Psychological Health Consequences of Women and Adolescents Trafficked in Europe*).

APPENDIX F

PUBLISHING STRATEGY

No.	Title (provisional)	Brief description	Authors	Journals considered
1.	Conceptualising health and trafficking: A framework for research and intervention.	Description of conceptual frameworks, adapted from migration & health framework, health domains framework, substantiated with data from both trafficking studies.	Zimmerman, Watts	Social Sci & Medicine, AJPH
2.	Depression symptoms among trafficked and sexually exploited women.	Data from 63 women participating in all three interviews on BSI symptom levels for depression and association with, for example, other mental health symptoms, history of violence, injury, and physical health symptoms.	All study authors + M. Abas.	Lancet, JAMA, Journal of Traumatic stress.
3.	Methodological considerations for research on sensitive topics and disadvantaged populations: human rights and public health.	Discussion about methods for researching sensitive subjects, such as sexual health, interpersonal abuse, illegal activities. Paper will focus on problems associated with researching highly disadvantaged or marginalised populations and discuss the intersection between rights-based approaches and scientific methods.	Zimmerman, Watts, Wellings, Rhodes	Social Sci & Medicine, AJPH, other?
4.	Post-trafficking identity: trauma and expressions of guilt, shame, hopelessness and empowerment.	Description of qualitative data from three interview intervals to analyse the changes in women's "non-clinical" symptoms. Possible links to depression, anxiety, hostility or PTSD symptom levels.	Scott-Ram, Zimmerman, Hossain, Watts	Journal of traumatic stress, other?
5.	Trafficked women and violence: pre-departure violence and re-victimisation of women interviewed in Europe.	Description of data on violence women experienced before and during the trafficking experience. Comparison with literature on re-victimisation and other forms of VAW. Perhaps including associations with post-trafficking symptom levels.	Zimmerman, Hossain, Morison, Watts	AJPH, Soc Sci & Med.
6.	Trafficking of women: implications for health, policy and policing	Discussion piece using findings and work with UK police, UNODC expert meetings for judges, law enforcement to describe victim's health, primarily psychological and implications for policing	Zimmerman, ?	Migration journals?
7.	Handbook for Health Care Professionals (in progress)	To be published from Daphne Programme grant in conjunction with IOM Global initiative fund on trafficking (GIFT)		

PREVIOUSLY PUBLISHED WORK

No.	Journal, book, other	TITLE	Author(s)
1.	American Journal of Public Health	(in press) *The health of trafficked women: a survey of women entering posttrafficking services in Europe.*	Zimmerman, C, Hossain, M. Yun, C, et. al.
2.	Chapters in IOM Field Manual	(2007) Chapters: Health and trafficking, and Appendix 1 Ethical principles in caring for and interviewing Trafficked Persons, in The IOM Handbook on Direct Assistance for Victims of Trafficking.	Zimmerman, C
3.	Chapter in book, Hopkins Press, eds., Beyrer & Pizer	(2007) Documenting the effects of trafficking in women, in *Public health & human Rights. Evidence-based approaches*, eds. Chris Beyrer and Pizer, H.F.	Zimmerman, C, Watts, CW
4.	Slide training & presentation on GVH website	(2007) *Stolen Smiles: a slide presentation for training and sensitisation.* GVH website: www.lshtm.ac.uk	Zimmerman, C.
5.	LSHTM/Daphne Programme publications	(2006) *Stolen smiles: The physical and psychological health consequences of women and adolescents trafficked in Europe.*	Zimmerman, C, Hossain, M, Yun, K, et. al.
6.	WHO publication	(2005) *WHO ethical and safety recommendations for interviewing trafficked women*	Zimmerman, C, Watts, CW
7.	Lancet	(2004): *Risks and responsibilities: guidelines for interviewing trafficked women* 363(9408):565-565	Zimmerman, CW Watts, C
8.	LSHTM/Daphne Programme publications	(2003) *The Health Risks and Consequences of Trafficking in Women. Findings from a European Study,*	Zimmerman, C, Yun, K, Watts, CW