

STOLEN SMILES

The physical and psychological health consequences
of women and adolescents trafficked in Europe



London School
of Hygiene &
Tropical Medicine



Poppy Project



International
Organization
for Migration



On The Road



Animus
Association
Foundation



La Strada



Pagasa



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The views expressed in this report are those of the authors and do not necessarily represent the official policy of any organisations involved in this study.

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**“I feel like they’ve
taken my smile and I
can never have it
back.”**

Lithuanian woman trafficked to London

Acknowledgments

It is with the greatest respect and appreciation that we extend our gratitude to the women who participated in this study and shared their stories of hardship, pain and their dreams for a brighter future. We sincerely hope that their expression of need is received with the understanding and resources warranted, and that the necessary care and assistance is quickly accorded to the many women who have suffered in similar situations of exploitation.

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Executive summary

Main findings

Violence and risks before and during trafficking

Violence before trafficking: 60% of women reported being physically and/or sexually abused before they were trafficked.

Violence while trafficked: 95% of women reported physical and/or sexual violence while in the trafficking situation.

Injuries while trafficked: 58% of women reported injuries.

Restrictions while trafficked: 77% of women reported that they were "never" free to do as they wished or go where they wanted. A further 10% reported that they were "seldom" free.

Time in the trafficking situation: 89% of women were in the trafficking situation for more than one month and 20% for over one year.

Recruitment: Nearly one in five women reported that a relative knew their trafficker.

Physical health symptoms

Concurrent physical health symptoms: 57% of women reported suffering between 12 and 23 concurrent physical health symptoms when they entered care.

Prevalent and severe physical health symptoms: The most prevalent and severe physical health symptoms included: headaches, fatigue, dizzy spells, back pain, stomach/abdominal pain and memory problems.

Headaches: More than 8 in 10 women reported headaches upon entry into care, and nearly 7 in 10 women still reported having headaches after 90+ days in care.

Memory: 63% of women reported memory problems when they entered care.

Physical health symptom reduction: Women's physical health symptoms appeared to show a substantial reduction after 28-56 days in care.

Sexual and reproductive health symptoms

Sexual health symptoms: Over 60% of women reported pelvic pain, vaginal discharge and gynaecological infections upon entry into care.

Sexual and reproductive health symptom reduction: Symptoms associated with sexual and reproductive health showed the most rapid reduction, likely due to early gynaecological care.

Mental health symptoms

Post-traumatic stress symptoms: 56% of women reported symptom levels suggestive of post-traumatic stress disorder (PTSD) upon entry into care.

Depression, anxiety, and hostility: Trafficked women's depression, anxiety and hostility levels were extremely high—within the top 10th percentile of population norms for adult females.

Suicide and depression: 38% of women reported suicidal thoughts upon entry into care, and 95% reported feeling depressed.

Mental health symptom reduction: Women's depression, anxiety and hostility levels do not appear to decrease until after approximately 90+ days in care.

Persistent depression: Depression appeared to be the most persistent symptom dimension, showing very little reduction even after 90+ days in care.

Introduction

Trafficking is a severe form of violence against women and a serious violation of human rights. Women and adolescents who are trafficked suffer some of the most unspeakable acts of abuse, exploitation and degradation. The damage to their health and well-being is often profound and enduring. Yet, to date, little data has been available on the range and extent of the physical and psychological health damage experienced by women who are trafficked. This report presents some of the first-ever statistical data on the health consequences of women who have been trafficked. It also provides information on the violence and health risks that may have influenced these outcomes. It is hoped that this evidence base will contribute to improved policies and well-planned resources and services available for the many women who require assistance in rebuilding their health and well-being.

The study

For this study, 207 women who had been recently released from a trafficking situation were interviewed while in the care of assistance organisations in destination countries, as well as transit and home country settings. Using an epidemiological approach to identify patterns of pain and illness, women were asked about their experiences of violence and about their health. A portion of the women agreed to be interviewed on three separate occasions, which offered a portrait of the changing patterns in women's health symptoms over time. These findings largely represent the health characteristics of women who were emerging from a uniquely violent and terrifying period of their life.

Women in the study

Women in this study were from 14 different countries. The majority were from non-European Union member states. Women were between the ages of 15 and 45, most between 21 and 25, and 12% were under 18. Most women were single (71%) and 39% of women had children. The vast majority of women with children were single mothers (82%). Being a single parent may have implications for women's vulnerability to recruitment, and being trafficked may have implications for the well-being of their children. 89% of study participants were in the trafficking situation for more than one month, and 20% for more than one year. Nearly half of the women interviewed had been out of the trafficking

situation for less than a month at the time they were interviewed.

Violence prior to and during trafficking

A history of abuse prior to being trafficked was prevalent among trafficked women. 60% reported experiencing some form of violence before being trafficked, with 32% reporting sexual abuse and 50% physical violence. Nearly one in five women said they had been recruited by someone known to a family member. Physical or sexual violence while in the trafficking situation was reported by nearly all women (95%), and 71% reported experiencing both. Respondents described violence such as being kicked while pregnant, burned with cigarettes, punched in the face, choked with wire, and having a gun held to their head. Over half the women (58%) reported having been injured. Power over women was asserted through violence and maintained by imposing unpredictable, unsafe and extremely restrictive environments. 77% of women reported 'never' having freedom to do as they wished or go where they wanted.

Physical health symptoms

Within the first fourteen days upon entry into care women were burdened with numerous concurrent symptoms of physical ill-health. Over half (57%) reported experiencing between 12 and 23 symptoms. The most prevalent and severe individual symptoms included: headaches, fatigue, dizzy spells, back pain, stomach or abdominal pain and difficulty remembering. Many of these symptoms were also among the most persistent, such as headaches, fatigue and dizzy spells. These symptoms can have significant implications for women's capacity to participate in administrative and legal proceedings soon after a trafficking experience. Physical health symptoms appeared to show a substantial reduction after women had been in care between 28 and 56 days, after which time 7% reported 12 or more symptoms. Physical health symptom patterns detected in the first 14 days demonstrate trafficked women's need for immediate medical assistance that attends to urgent health problems (e.g., infections, injuries, acute pain), and care that responds rapidly to basic needs, such as security, rest and nutrition. Later symptom patterns indicate the importance of professional diagnostic services capable of assessing complex symptomatology and comprehensive treatment able to address a range of persistent health problems.

Sexual and reproductive health symptoms

More than 60% of the women reported pelvic pain, vaginal discharge, and gynaecological infections, and HIV was reported by 2% of the women upon entry into care. 9% of women reported "never" using condoms with clients while in the trafficking situation, 29% said "occasionally" and 37% said "always". 17% of the women reported having at least one induced abortion during trafficking. Testing for infections and pregnancy, and the desire for induced abortion were common first requests upon entry into care. Women frequently voiced concerns about fertility and their future ability to have children. Trafficked women appear to prioritise their sexual and reproductive health needs upon entry into care, which highlights the importance of early provision of sexual and reproductive health services.

Mental health symptoms

Upon entering care, over half the women (56%) reported symptom levels suggestive of post-traumatic stress disorder (PTSD). The number of women demonstrating these symptom levels decreased after approximately 28 to 56 days in care (12%), and again after 90+ days (6%). This decline in acute PTSD symptomatology suggests that women improve considerably when receiving care. However, women may be at continuing risk for recurrence of PTSD following traumatic events later in life, such as family reunions, asylum proceedings, criminal investigations or trials. Extremely high symptom levels for depression, anxiety and hostility were reported throughout the study. Within the first 14 days of entry into care, women's symptom levels were within the top 10% of a general population—or comparable to the most distressed individuals in a general female population. Not until approximately 90+ days in care was a relative decrease in anxiety and hostility levels observed, but depression levels remained near the top 10% of population norms. The continual presence of high symptom levels is likely to make it difficult for women to re-engage in normal daily activities, such as caring for family, employment or education. This suggests the need for ongoing, longer-term psychological support.

Implications

The findings from this study provide new evidence on the health consequences of trafficking and highlight the importance of professional medical care and psychological support for women

who have been trafficked

High levels of pre-departure violence may contribute to a woman's or adolescent's vulnerability to being trafficked and to later morbidity. Abuse may also have serious implications for women's safety if they choose to, or are forced to return home. During trafficking, the physical, sexual and psychological abuse, extreme limitations on women's movement and activities, and the unpredictable, uncontrollable, and life-threatening environment prohibit women from protecting their health and seeking help, and result in debilitating health complications.

Upon emerging from a trafficking situation, the severity and range of women's symptoms indicate the importance of crisis intervention care that includes emergency medical assistance, resources that meet women's basic needs (security, rest, nutrition), and specialised psychological support. The symptom patterns observed in this study also suggest that women who have recently been identified as being trafficked may not be in a good enough physical or psychological state to make well-considered decisions about cooperating with authorities against the traffickers and about their safety or to offer detailed evidence about past events. The findings indicate that it is not until approximately 90+ days in care that a woman's most severe symptoms are likely to show a substantial reduction, and women may experience an increase in cognitive functioning and emotional strength. Although an important reduction in many symptom domains was observed in this study, it was also clear that women's health problems were rarely eliminated, and that most are likely to live with physical and psychological burdens of what was done to them for a long time.

Perhaps most important of all, it is necessary to recall that this study cohort had access to ongoing support services. It is impossible to currently understand how the health of these women would compare to the vast majority of trafficked women who do not receive care.

That this violence suffered by trafficked women occurred on the territory of destination states and was often perpetrated by, or involved the participation of, residents of these states suggests that governments have a special obligation to provide a rights-based and health-based care package to repair the harm caused by a crime that occurred on their territory.

Key recommendations

- Recognise the serious health consequences of trafficking.
- Approve legislation that requires provision of healthcare for all women who have been trafficked, regardless of legal status or ability to pay.
- Require police and immigration personnel to ensure that women who are suspected of having been trafficked are asked about their health concerns and pain at the first point of contact, and that their urgent needs are immediately addressed.
- Implement a recovery and reflection period of a minimum of 90 days to ensure that women can make informed and thoughtful decisions about their safety and well-being and are able to provide more reliable information about trafficking-related events.
- Implement physical, sexual, reproductive and mental health support strategies that are adapted from models of good practice used for survivors of other forms of violence and for minority communities and refugees.
- Donate or designate funds and appropriate resources to support emergency and longer-term health care for women who have been trafficked.

CHAPTER 1 Introduction

Trafficking in women is a severe form of gender-based violence and a serious violation of human rights.

Particularly in the past decade, trafficking has grown to become a widespread, very profitable, international crime. Although reliable statistics on trafficking are difficult to obtain because of its underground nature, it is estimated that at least 2,450,000 persons globally are in situations of forced labour as a result of trafficking, and that women make up 56% of the victims of economic exploitation and 98% of those exploited in commercial sex.¹ Thousands of women from Central and Eastern Europe, Asia, Africa and the Americas are thought to be trafficked each year into and within the European Union.²⁻⁵

While trafficking in women is most commonly associated with forced sex work, and this is the aspect that was primarily examined for this study, in reality women and adolescents are trafficked into a large number of different labour sectors, including domestic labour, industrial work, agricultural labour, and street begging. Women in any of these environments are likely to be subject to psychological coercion, physical violence and sexual abuse.

Trafficked women suffer some of the most unspeakable acts of abuse, exploitation and degradation. Few victims emerge unscathed, either physically or psychologically, from a trafficking experience. Yet, despite the profound and enduring damage to women's health and well-being, relatively little action has been taken to identify and meet the health needs of victims.

Health in the trafficking context is best viewed as a cycle in which women's exposure to harm and their opportunities for assistance occur throughout a multi-stage process. (Figure 1.1.) Risks and opportunities may occur before a woman leaves home during the pre-departure stage, and during the travel and transit stage. Health threats are generally most concentrated during the destination stage. Even after a woman is no longer being exploited, many are still confronted with risks associated with detention, deportation, or criminal evidence-giving, before they move onto the challenges of the integration or reintegration process. Each of these stages poses dangers to women's health and offers chances to mitigate or repair harm. Further description of this conceptual model is provided in a previous study on health and trafficking in women.⁶

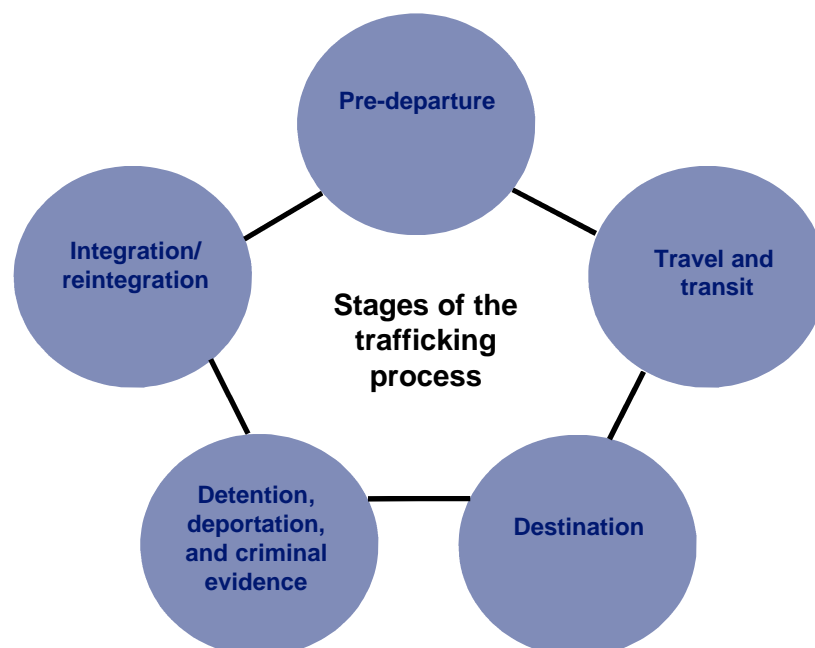


Figure 1.1. Stages of the trafficking process.

Once trafficked and exploited, only the smallest fraction of survivors are able to obtain adequate medical, psychological, and social assistance. While there is a great need for coordinated post-trafficking services, there are relatively few organisations that are able to provide the necessary range of shelter, counselling, economic support, and medical care or medical referral. Women may receive support in the country to which they were trafficked, a transit country, or their country of origin, depending on where they escape or are freed from traffickers, and whether or not they feel safe returning to their country of origin.

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...⁷

The Council of Europe Convention on Action against Trafficking in Human Beings also acknowledges the care needs of victims of trafficking. They have specified individuals' rights to "emergency medical treatment", and 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.⁸

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 has an obligation to meet these needs.

Service provision for trafficking survivors may be divided into three general stages (Figure 1.2.):

1. Crisis intervention stage
2. Adjustment stage
3. Longer-term symptom management stage

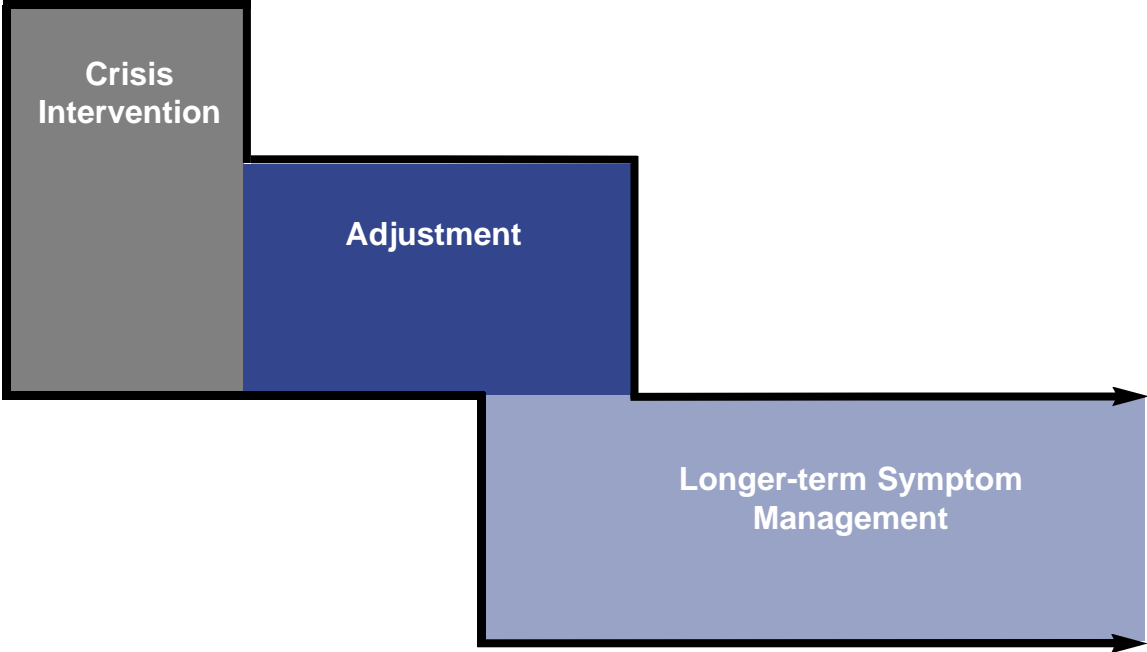


Figure 1.2. Stages of the post-trafficking intervention process.

Upon first contacting support services, 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).

Once women's basic needs are attended to, the next phase may be termed the "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.

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.

When considering the multi-staged needs of survivors, it is possible to identify broad patterns of illness, distress and recovery. However, developing more specific and individualised assistance strategies is a more difficult task. 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, some sexually abused.

Moreover, trafficked women face very different experiences of risk while in the trafficking setting. Some are held captive, unremittingly assaulted and horribly violated. Others are less abused physically, but are psychologically tormented, and live in fear of harm to themselves or their family members. Some women will spend years in a trafficking situation and others may be caught up for less than a month.

Trafficking in women is a subject that is fraught with political, definitional and legal complexities. The findings presented in this study are in no way meant to marginalise the health needs of other exploited or abused populations or individuals. They are intended to offer much needed information on a group around whom laws and policies are being drafted and for whom services are increasingly available.

To date, there has been little coherent evidence from which to begin to gain an understanding of the physical and psychological health needs of women who have been trafficked in Europe.

This study set out to provide some of the first-ever statistical data on the health of women and adolescents who have been trafficked and to examine violence and other health risks that may have influenced these outcomes. The findings will probably not be surprising to many, but they are nonetheless startling in the breadth and depth of the harm women sustained. The level of damage caused to many aspects of the women's physical, sexual, and psychological health was often severe. Addressing this litany of harm has posed a massive challenge to care providers and has taxed their economic and human resources as they work tirelessly to meet women's wide-ranging and very often urgent needs.

For too long now, attention to the issue of health and trafficking (when attention was given) has focussed on women's sexual health (i.e. sexually transmitted infections, including HIV). In this report, we intend to highlight that a trafficked woman's health is more than the sum of her reproductive and sexual health—that her health comprises the entirety of her physical, psychological, and social well-being.

To this end, our research team and the women who were trafficked have offered their expertise and insights, which culminated in a set of data on many discrete aspects of women's health, from neurological and respiratory problems, to post-trauma stress reactions, including depression and suicidal ideation, and women's hopes and dreams for their future.

With this study, we hope not only to call attention to the health implications of trafficking in women, but also to provide fact-based information that can lead to better, more holistic and well-resourced care for the many women who will be requiring assistance in rebuilding their health and well-being.

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Aims and objectives

This study was conducted to gain a comprehensive view of women's health needs after a trafficking experience in order to foster care policies and service strategies that will improve women's chances of regaining their health and well-being.

By carrying out a detailed assessment of women's physical, sexual, and emotional health symptoms while they were in the care of post-trafficking service providers, the study aimed to achieve the following specific objectives:

- Gather quantitative and qualitative data on the perceived physical, sexual and psychological health symptoms of women attending post-trafficking services;
- Examine how women's health needs change over three stages: crisis intervention; adjustment; and long-term symptom management; and
- Identify symptom patterns and health priorities of women in post-trafficking service settings.

In addition to these primary objectives, the study team also hoped to develop a useful and targeted survey tool that could be employed in the future by other groups in other settings to assess the health status of women who have been trafficked.

Study partners

This study was conducted jointly by researchers with expertise in the area of women's health and violence, and highly experienced staff from non-governmental and international organizations working with trafficked women across Europe.

Researchers from the Centre for Research on Gender Violence and Health at the London School of Hygiene & Tropical Medicine were responsible for overseeing the study design, supporting the data collection, data entry and analysis, and for drafting the report on the findings.

The non-governmental and international organization partners in this study included: the Poppy Project (United Kingdom); On the Road (Italy); Pag-Asa (Belgium); La Strada (Czech Republic); La Strada/Animus Association Foundation (Bulgaria); and the International Organization for Migration (IOM) Rehabilitation Centers in Moldova and Ukraine. Experienced staff from each organization carried out the fieldwork, and collaborated on the study design and interpretation of the findings.

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.

Ethics and safety

Human trafficking is fundamentally an act of violence and exploitation, and for this reason the study team placed special emphasis on the ethical and safety aspects of the methodology. In studying women who have been trafficked, it is necessary to think beyond traditional research methods and standard ethical guidance to ensure that a study does not put individuals or groups of individuals at risk of imminent or future harm, and yet, is still able to gather high quality data.

The ethical and safety measures applied in this study were based on a key document drafted for the World Health Organization by the lead researchers of this study: *WHO Ethical and Safety Recommendations for Interviewing Trafficked Women*.¹ The WHO recommendations propose ten guiding principles that outline minimum standards for work with women who have been trafficked (Figure 2.1.).

TEN GUIDING PRINCIPLES TO ETHICAL AND SAFE CONDUCT OF RESEARCH WITH WOMEN WHO HAVE BEEN TRAFFICKED

1. Do no harm.
2. Know your subject and assess the risks.
3. Prepare referral information—do not make promises that you cannot fulfill.
4. Adequately select and prepare interpreters and co-workers.
5. Ensure anonymity and confidentiality.
6. Get informed consent.
7. Listen to and respect each woman's assessment of her situation and risks to her safety.
8. Do not re-traumatize women.
9. Be prepared for emergency intervention.
10. Put information collected to good use.

The ability to respond to women's needs was among the foremost considerations in this study. Therefore, women were interviewed once they were in the care of a service organization. No women were interviewed while they were still in the trafficking situation, where the ability to respond to their stated health and safety needs would have been severely limited—and even approaching women in these situations for interviews might have put them in danger. As a result of the skills and the resources of each of the study partners, mechanisms were put in place to address health needs disclosed by study participants.

Further adhering to ethical standards, this study was also designed to collect information that would inform both intervention activities and policies addressing women's health needs. Towards this end, the questionnaire included items that the team believed would be most informative to assistance programs, and relevant to upcoming legislation and government policy agendas.

This study was approved by the ethical review board of the London School of Hygiene & Tropical Medicine.

Figure 2.1. WHO Ethical and Safety Recommendations.

Table 2.1. Sample distribution by study site and interview

Sample: Breakdown by study site and interview			
Study site	Interview 1 (n=207)	Interview 2 (n=170)	Interview 3 (n=63)
Animus Association Foundation, Bulgaria	10%	3%	0%
International Organization for Migration, Moldova	37%	45%	40%
International Organization for Migration, Ukraine	24%	29%	14%
La Strada, Czech Republic	2%	1%	0%
On the Road, Italy	13%	12%	22%
Pag-Asa, Belgium	1%	0%	0%
POPPY Project, United Kingdom	13%	10%	24%

Study sample

Within the wider population of trafficked women, the individuals included in this study are women and adolescent girls between the ages of 12 and 45 who had recently been trafficked to and within Europe for either forced sex work or domestic labour.

Although women are trafficked into many different labour sectors in addition to prostitution and domestic labour, the study focused on women who were most likely to have experienced sexual violence. There remains an urgent need to conduct research on the health of women and girls trafficked into other labour sectors, particularly as this population grows increasingly accessible.

As described above, because of the ethical and safety issues inherent in working with women who are still within the trafficking situation, our study sample was drawn only from women who had escaped their traffickers, entered the integration or reintegration phase, and were under the care of an assistance program.

Women were invited to participate in three interviews, each carried out at different time periods (time frames are discussed below).

Of the 213 women who were interviewed, 6 interviews were ultimately excluded because the women were not trafficked for sex work or domestic service (they were exploited for forced panhandling, and manufacturing). Ultimately 207 women participated in Interview 1. At the end of the interview, all participants were asked to return for a second and third interview. Follow-up Interviews 2 and 3 were completed by 170 and 63 women, respectively.

The majority of the study sample for each of the three interviews is comprised of participants who were interviewed in Moldova and Ukraine, and were primarily from these countries. (Table 2.1) The second largest number of participants were interviewed in Italy and the United Kingdom, which are generally considered countries of destination.

Respondents comprise a convenience sample rather than a random sample because of access problems and other restrictions outlined above. As such, the generalisability of the findings may be limited.

Study design

The primary research tool was a semi-structured questionnaire, which was administered by trained interviewers. The questionnaire included a number of open-ended questions to enable women to elaborate on the different issues explored in the questionnaire and to portray, as best as possible, the complexity of women's experiences.

The study team elected to use self-report rather than clinical review in order to better understand how women perceive and prioritise their own health needs. Moreover, in many of the study sites it is difficult to access medical records where women are not cared for by 'in-house' medical staff, but instead attend private or public clinics. Financial constraints also limited the option of study-supported clinical exams.

To gain insights into the changes in women's health status at key stages, as noted above, all women were invited to be interviewed at three different time periods. The study protocol suggested that Interview 1 be carried out zero to seven days upon entry into the service setting; Interview 2 be conducted between two and six weeks after the first interview, and Interview 3 would take place twelve or more weeks following the first interview date. However, the team discussed at length the reality of working with a complex group of women who are highly distressed, and the differences in the strategies and resources of the service providers, and it was determined that there would be significant flexibility in meeting these targets. The timing of the third interview reflects the balance between obtaining long-term follow up, the risk of increased loss-to-follow-up once women are no longer receiving support services, and the limitation of the resources to extend the study. A future study is needed that interviews women after a longer period following a trafficking experience.

Questionnaire development

One of the greatest challenges in assembling an appropriate questionnaire for women who were trafficked was trying to capture the range of health complications suffered by such an abused and exploited population. Tools that have been used extensively in international populations are often designed for general population screening, rather than for the assessment of a cohort that has suffered repeated physical and psychological

abuse.² Many of the questions in these existing tools are inappropriate for women who have been trafficked and sexually exploited. For example, one commonly used 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 upon changes in "normal" daily functioning, such as going shopping, socializing with family, and working inside or outside the home.³ These questions are generally meaningless for women who are living inside a shelter and for whom it is impossible 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.⁴ 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.⁵

Apart from trying to assess the enormous diversity of women's health complications, a further challenge in questionnaire design was this cohort's linguistic and cultural diversity. In addition to coming from different countries, women might come from minority lingual or ethnic groups within their home countries.⁶ The study relied on several tools that had previously been used in various international settings.

In order to address the issues of interest to the study team in the most effective way, a 115-item questionnaire was created based on both unique question sets developed for this study and existing validated research instruments. Questions that elicited both quantitative and qualitative data were included. The questionnaire was comprised of the following four sections:

- I. Demographic/background information
- II. Physical health
- III. Experiences of violence (pre-trafficking and during trafficking)
- IV. Mental health

For Interview 1, all four sections of the questionnaire were administered. For Interviews 2 and 3, the first section, "Demographics," and the third section, "Experiences," were not re-administered, because this historical information was not expected to change. Questions in sections II Physical health and IV Mental health remained nearly identical in the second and third interviews. The aim was to capture changes in women's perceived health status.

The following provides a description of each of the four parts of the survey instrument.

I Demographic/background information. This section included items on: marital status, country of origin, children, destination country during trafficking, duration of trafficking period, length of time since release from trafficking, and type of work during trafficking.

II Physical health. For this section, the study team modified a scale developed by North American researchers studying the physical health sequelae of intimate partner violence.⁷ Questions were structured to learn how many women were experiencing the symptoms of interest, and to what extent they were affected by each symptom. Using a Likert scale (e.g., not at all=0, a little=1, quite a bit=2, extremely/very much=3) it was possible to calculate a numerical score based on women's symptom levels, which permitted comparisons of average 'severity scores' for all women over the three time frames.

Additional questions were developed specifically for sexual health, reproductive health, infectious disease, substance use, and injuries.

Open-ended questions about physical health were included to give women the opportunity to describe, in their own words, the health problems that most bothered them, to speculate about the possible causes, and to name the problems for which they would most like to see a medical practitioner. For Interviews 2 and 3, women were also asked if they had received medical care and how they felt about the care they received.

III Experiences. Women were asked a series of questions about their experiences with violence both before leaving home and during the trafficking situation. These questions were included not only for their relationship to physical and psychological morbidity, but also because prior

experiences with violence—including family disruption, childhood abuse, and intimate partner violence—have been shown to impact resilience and recovery after trafficking, in part because it compromises the support network a woman may access if she returns home.⁸⁻¹⁰ Moreover, pre-existing violence may pose a safety risk for women who return home.

IV Mental health. Question sets in this section were intended to identify patterns of psychological symptomatology, and those constellations of symptoms that might be predictive of longer-term problems. This study did not attempt to establish clinical psychiatric diagnoses.

The mental health section focussed on four types of emotional or psychological reactions to trafficking: depression, anxiety, anger or hostility, and post-traumatic stress symptoms, as these were identified as key post-trauma symptoms.¹¹ Accordingly, for this study the study team selected two tools designed to capture these symptoms: a subscale of the Harvard Trauma Questionnaire (for Post-Traumatic Stress Disorder), and three subscales of the Brief Symptom Inventory (i.e., hostility, anxiety, and depression). Additionally, in consultation with the psychologists on the study team, a series of unique questions about guilt, shame, stigma, self-esteem, and hope for the future were developed.

The Harvard Trauma Questionnaire (HTQ) has been used extensively with refugees and other survivors of violence.¹² It is administered by trained professionals and relies on participant self-reporting. The full questionnaire is comprised of multiple sections, including a post-traumatic symptom set comprising sixteen questions, which was included in this study. These sixteen questions are based on the clinical diagnostic criteria for post-traumatic stress disorder (PTSD). A score of greater than 2.5 is comparable to the scores of other refugees who have been diagnosed with PTSD.¹³ The results presented in this report should not, however, be considered diagnostic, although, as will be discussed, scores above 2.5 may strongly suggest that the respondent is experiencing significant post-traumatic symptoms. In addition, 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-trauma symptom that also has obvious implications for women's participation in

the prosecution of traffickers and for asylum petitions.

The Brief Symptom Inventory (BSI) was developed as a short screening tool for the assessment of psychological distress.¹⁴ The full BSI has nine symptom domains, of which three were used for this study: anxiety, depression, and hostility. The last (hostility) is assessed by five questions, while the anxiety and depression subscales have six items each. The scores (calculated in the same manner as the HTQ 16-item subscale) are not diagnostic, however they are capable of detecting significant patterns of psychological distress. Again, many of the items are also important in their own right (e.g., "thoughts of ending your life"). This tool has the advantage of being able to compare the scores of the study group to scores of other study populations (e.g., general female population, female psychiatric outpatients).

Because the same tools were used for all three interviews, it was possible to view how these mental health symptoms changed over time. In addition to helping service providers understand symptom patterns, this information may be useful to the women themselves. Learning about general symptom patterns of women who are trafficked may serve to reassure individual women that their reactions are, in a sense, common responses to what they have survived, like those of other women in similar circumstances. Moreover, during the study period, as women reviewed their own symptoms at each interview stage, many were able to observe a relative improvement in their symptom levels over time.

Instrument revision and piloting

The study questionnaire and Study User Guide 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 Study User Guide, which provided a description of the study aims, and a detailed guide to each stage of the study, including security procedures, and step-by-step instructions on how

to implement the instrument, was reviewed for clarity, practicality in the service setting, and the timing of longitudinal follow-up. The draft questionnaire was then piloted in Bulgaria, the UK, Italy and the Czech Republic, and the questionnaire and study protocol were finalised after a formal meeting of all project partners, and a fourth round of item-by-item review.

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.

Interviewers

For reasons of ethics and research quality, all interviews were conducted by staff members of the study partner organisations. They were chosen over other potential sources of interviewers, as it was recognised that they would be highly knowledgeable about the population being studied, and were able to provide primary support and referral to other assistance, as needed. Furthermore, from a research perspective, as regular staff of the service provider organisation, these individuals were trusted by the women—who were asked to reveal highly personal, often shameful, and sometimes dangerous details. Importantly, as trained psychologists or social support workers, these individuals are able to respond sympathetically and supportively to difficult emotions, they know how to pose sensitive questions, and know when and how to terminate or postpone an interview. It was felt that this is not only a sound ethical approach, but is also the one most likely to garner truthful and detailed responses.

Representatives from each organization attended a three day meeting to finalise the Study User Guide. Representatives then provided on-site local training for social workers or psychologists within the individual service settings who would carry out the interviews. Professional interpreters known to the organisations were used for interviews, where necessary.

Study implementation

Between January 2004 and June 2005, women who met inclusion criteria and entered any of the partner service settings were invited to take part in the study. Exceptions were women who interviewers judged to be severely mentally ill with poor reality testing (i.e., symptoms of psychosis).

Ultimately, 84% of the first interviews were carried out within the first seven days following a woman's entry into the assistance programs, and 92% were conducted within the first 14 days.

For the second interviews, 49% were carried out four to six weeks after the first interview, and 70% were carried out between two and six weeks of the first interview.*

For the third interviews, 81% were conducted between two months and six months from the date of the first interview.

Data analysis

Quantitative data were entered using Epi-data, and analysed using STATA 8.0 (© Statacorp, Texas USA), a statistical analysis tool. In order to determine changes in health status over time, scores were generated within the physical and mental health domains based on women's severity ratings to related questions at each interview. Scores within the mental health domains (BSI subset measures, and symptoms suggestive of PTSD) were calculated for each interview according to methods described in the BSI Scoring Manual¹⁴ and the Harvard Trauma Questionnaire.¹⁵ A severity score was created for all physical health symptom domains (fatigue and weight loss, neurological, gastrointestinal, cardiovascular, sexual and reproductive health, musculoskeletal,

* It is worth noting that the majority of third interviews (66%) took place between five and twelve weeks after the second interview.

eyes, ears/colds/flu/sinus infection, and dermatological) based on 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.

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.

A formal meeting for data review and interpretation was held with all study partners and a panel of research personnel. Study partners—including professionals with social work, medical and psychological training and significant experience and expertise working directly with trafficked persons provided country and culture-specific insight to enrich interpretation of the data. 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.

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“ My parents were always telling me that I am useless. I tried to get money and look at the result. ”

“ In truth, I have grown up. Earlier, I was a child, now I am a woman. ”

Home and destination locations

Home countries

Women interviewed came from 14 countries. (Table 3.1) Countries of origin included four European Union member states (9%), seven other European states (80%), and three non-European states (6%), which included two African states and one Caribbean state. 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. (See Chapter 2: *Methods*)

Destination countries

When asked about destination locations, women were trafficked to a total of 24 countries.* 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 trafficked to Turkey (15%), the Russian Federation (14%), and Germany (8%). These patterns are likely to reflect common routes from the study countries.¹

Table 3.1. Percentage of women by home country.

Home countries		
EU Member States	%	Total responses
Czech Republic	1.4%	3
Poland	0.5%	1
Lithuania	6.8%	14
Slovak Republic	0.5%	1
	9.2%	19
Other European states		
Ukraine	25.1%	52
Russian Federation	1.0%	2
Romania	8.2%	17
Moldova	37.8%	74
Macedonia	0.5%	1
Bulgaria	8.2%	17
Kyrgyzstan	1.4%	3
	80.2%	166
Non-European states		
Cameroon	0.5%	1
Jamaica	0.5%	1
Nigeria	5.3%	11
	6.3%	13
Not reported		
No data	4.3%	9
(n=207) Responses reported by women at Interview 1.		

* (n=165): Not all women reported a destination location. Several women reported more than one destination location.

Table 3.2. Characteristics of the women in the study.

Study population characteristics		
Age distribution (years)	%	Total responses
15-17	12%	24
18-20	21%	44
21-25	42%	86
26-30	17%	36
31-45	7%	15
n/d	1%	2
Marital status before trafficked		
Single	71%	147
Married/Living as married	11%	23
Separated/Divorced	17%	35
Widowed	0.5%	1
n/d	0.5%	1
Children		
Yes	38.6%	80
No	60.9%	126
n/d	0.5%	1
Type of work		
Sex work	92.3%	191
Domestic work	4.3%	9
Sex & Domestic work	3.4%	7
Time period in trafficking situation		
1 day-1 month	11%	23
1-3 months	21%	44
3-6 months	20%	41
6 months -1 year	20%	41
1-2 years	10%	20
2+ years	10%	21
n/d	8%	17
Time out of trafficking situation		
1-2 days	1%	2
3-7 days	7%	14
1 week-1 month	32%	66
1-3 months	21%	44
3-6 months	16%	33
6+ months	22%	45
n/d	1%	3
(n=207) Responses reported by women at Interview 1 n/d= no data available		

Table 3.2. represents the characteristics (age, marital status and number of children, time in trafficking, time out of trafficking) of the women in the study.

Age

The youngest individual interviewed for this study was 15 and the oldest was 45. The largest age group was made up of women between ages 21 and 25 (42%), followed by those between 18-20 (21%), and then 26 to 30 year-olds (17%). Adolescents^{2*} between the ages 15 and 17 made up 12% of the sample, and the smallest proportion were women over the age of 30 (7%).

Marital status before trafficked

When asked about their marital status prior to leaving home, nearly nine in ten women (89%) 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% were widowed. Only 11% were married or living as married at the time they were trafficked.

Women with children

Of the women who participated in Interview 1, 39% reported that they had children. Women had between one and four children, with approximately half reporting that they had one child.

Of the women with children, by far the largest proportion, 82%, reported that they were *not married or 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 left home.

* 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.

Table 3.3. 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.

This is an important, but not surprising finding. 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.³ 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.

Economic hardship is particularly evident among women from states where former government support systems, have been dismantled or have broken down and unemployment has had a disproportionate effect on women, such as that which has taken place in Former Soviet Union states.⁴

The eighty women with children (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. (Table 3.3.) 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, and 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.

The effects of trafficking on the well-being of women's children is a subject that has received very little attention in discussions on trafficking, and is an area that deserves greater examination.

At the time of the first interview, 8% of women believed they were pregnant, and 1% said that they did not know. (See Chapter 7: *Sexual and reproductive health* 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.

Pre-departure residence

Women were 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. Moreover, by understanding women's past living arrangements, it was hoped that this might shed light on the viability of these housing options if women were to return.

Table 3.4. gives a general, rather than a complete picture of with whom women were living 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, more than one-third specified that they were living with their mother, only.

Table 3.4. 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

I think of my child who was fostered; I'm scared I won't see her again.

Of those women who said "other", several explained that they had been living in a childcare institution prior to being trafficked. As one woman explained: "I am an orphan and I lived in a hostel. There everyone had beaten me. I was harmed throughout my childhood."

Children in institutions may be another group who may be highly vulnerable to being trafficked.

Labour exploitation

Women interviewed for this study were forced into: sex work (92%), domestic work (4%), and both sex and domestic work (4%).*

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 3.2) Ten percent of the women were there for more than two years, and 11% for less than one month—nearly half of whom were there for less than two weeks.

Time out of the trafficking situation

Women were asked: "how long ago did you stop doing this work?" Well over half had been out of the trafficking situation for less than three months (61%). Forty percent were released less than one month prior to the first interview. Most women were referred to (e.g., by 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.

Referral to assistance programmes

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. Women who are less likely to come in contact with law enforcement or service providers—for example, confined domestic workers, women working in more covert sex work contexts—are not as well represented in the sample, and they may have even greater health needs.

I was raised in an orphanage, so you can imagine that anybody can do [anything] to you.

* 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. For a further discussion of this issue, see *Methodology*.

Additionally, in some countries (including the UK, Belgium, and the Czech Republic), foreign nationals are required to cooperate with police anti-trafficking investigations if they wish to avoid deportation. In some cases, women who were afraid to cooperate with police, or simply did not wish to, may not have been captured in the study sample. Again, it is difficult to speculate where this group's health status lies in relation to the women in this study. Finally, service centres primarily assist women who self-identify as trafficked or exploited persons. Some women working in conditions that may be considered trafficking, as defined by the Palermo Protocol⁵, might not view themselves in this way, and they are unlikely to be represented in our sample.

I used to have suicidal thoughts while I was in the trafficking situation... had nobody helped me, I'd have filled the tub with hot water and killed myself.

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“ My mother forced me to have sex with strangers when I was eleven and twelve years old. Strangers would force and beat me. ”

“ All these things are happening now because of my friend, she tricked me. ”

This chapter describes physical and sexual abuse women may have experienced prior to being trafficked and discusses the other risks that may have made women more vulnerable to being trafficked and have negatively influenced their later health.

Literature on interpersonal violence has increasingly recognised an association between a history of abuse (particularly child sexual abuse), and later experiences of violence, risk behaviours, poor physical and mental health, and greater use of medical services.¹⁻³

Overview of patterns of physical and sexual violence experienced by women prior to being trafficked

Women responded to a series of questions about violence before they left their home country. Ultimately, this helped to piece together the larger picture of the range of abuses perpetrated against them. The findings below describe the types of abuse that occurred, who perpetrated the abuse, and at what age or ages it took place.

The overview of pre-departure violence in Figure 4.1 shows that 60% of the women reported having experienced at least one form of violence (physical or sexual) prior to having been trafficked. 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.

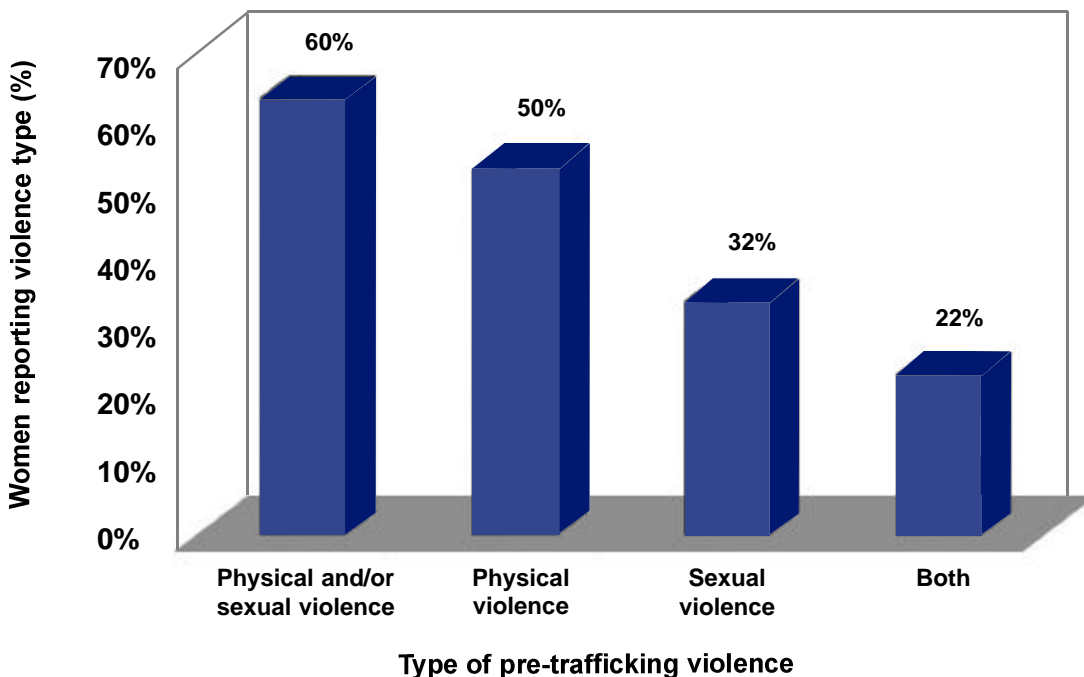


Figure 4.1. Percentage of women reporting physical and/or sexual violence prior to being trafficked. (n=207)

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.

Since we were babies our father beat us. He beat my mother when she was pregnant.

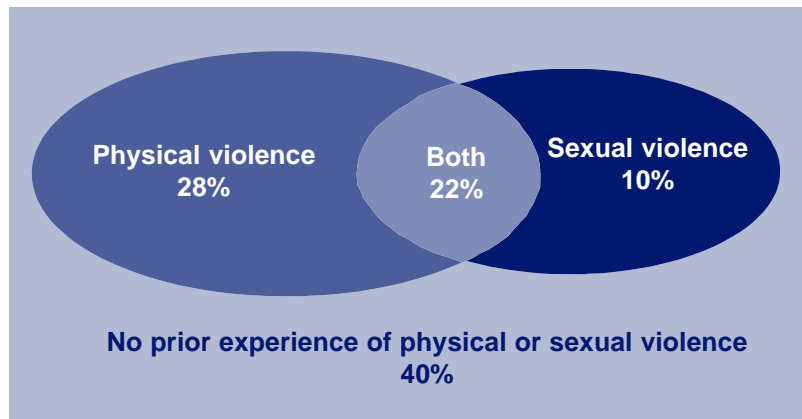


Figure 4.2. Overlap of physical and sexual violence prior to being trafficked.

An alternative view of the violence experienced by this study sample is offered in Figure 4.2. Among the respondents who reported a prior history of either physical or sexual assault, just under a half had experienced only physical violence prior to being trafficked (28% of total respondents). One-sixth had experienced sexual assault only (10% of total respondents), and over one-third had a prior history of both physical and sexual assault (22% of total respondents).

The discussion below offers details on the different types of violence experienced by women in this study.

Physical violence prior to being trafficked

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".

Of the 50% of women who reported being physically hurt, 44% said the harm was inflicted by their father, 31% their mother, and 25% reported another family member (Table 4.1).

Although less common, a number of women mentioned husbands or partners, boyfriends, acquaintances and strangers. Almost a third (29%) of those reporting physical violence reported that they had been hurt by more than one person.

Table 4.1. Perpetrators of physical violence prior to departure. (n=51)

Physical violence by different perpetrators		
Reported perpetrator	Yes %	Yes (n)
Father	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

Table 4.2. Percentage of women reporting sexual violence overall, before and after age 15. (n=207)

Sexual violence by age		
Sexual violence	Yes %	Yes (n)
Any sexual violence	32%	66
Sexual violence before age 15	14%	29
Sexual violence after age 15	25%	51
Sexual violence both before and after age 15	7%	14

These figures on the prevalence of physical abuse prior to being trafficked should be interpreted with caution, as some of the physical violence reported may reflect what were considered childrearing practices. Indeed, some women did note situations of physical discipline where they explained that they were punished for having been 'naughty' or 'misbehaved' (albeit sometimes quite harshly).

However, the study team attempted to elicit responses 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 primarily reporting violence that was abusive in nature. Women were generally explicit in separating the occurrences of discipline from situations of childhood physical violence.

As noted above, physical abuse may have been perpetrated by a range of family members, including male siblings. NGO staff highlighted that male children may be given the responsibility to punish their sisters on behalf of the family as a whole.

Overall levels of sexual violence prior to being trafficked

The breakdown of women's history of sexual abuse by age is depicted in two different ways in Table 4.2. and Figure 4.3. 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 overall 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.

From the time I was 13, my step-father asked me time and time again if I wanted to screw him.

I was sexually abused by the priest at the orphanage where I was staying. I was 10 years old.

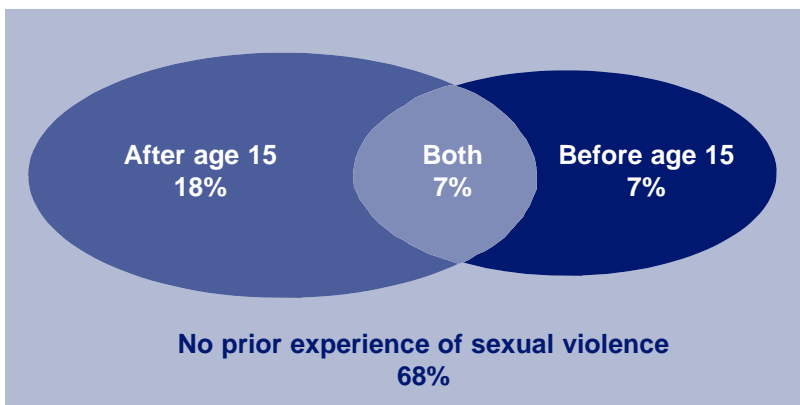


Figure 4.3. Overlap of sexual violence before and after age 15, before being trafficked.

Table 4.3. Perpetrators of sexual violence before age 15. (n=104)

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

Sexual abuse before age 15, prior to being trafficked

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?" (see list of individuals, Table 4.3.). 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 the women (52%) reported being sexually abused or coerced by a family member, with 28% stating that the abuse was perpetrated by a father (14%) or step-father (14%) (Table 4.3.). 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.

While mothers are rarely implicated in research on sexual abuse of girls, two women stated that they were sexually coerced by their mother. 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."

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.*

A majority of the 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 carer. One woman who had been sexually abused by a priest at the orphanage had also been previously sexually abused by her father.

Table 4.4. 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.

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.

These findings on sexual abuse and coercion after age 15, while difficult to interpret*, are an important indication of the repetitive history of violence experienced by many trafficked women. These abuses preceding the violations women endured during the trafficking period are likely to have taken a cumulative toll on their physical and psychological health, as suggested by numerous studies demonstrating that the negative effects of multiple traumas are greater than those of single traumas.⁴⁻⁶

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 reported believing that they "would be killed" if they had refused sex.

Women's family's relationship to the trafficker

The recruitment of women for trafficking appears to rely heavily on the "facilitating factor", or the quality and timing of the job offer, and most importantly, the credibility, i.e., the trust the woman has in the person making the offer.

Women in this study were asked "Did your parents or any family member know the traffickers or introduce you to the traffickers?"

Nearly one in five women reported that their relative knew the trafficker. (Table 4.5.) For some women, this was a case of perfidy and betrayal.

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 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. Offers made by friends seemed particularly trustworthy and reliable.

Women later reproach themselves for their credulity and naïveté. (See Chapter 8: *Mental health*)

Table 4.5. Percentage of women who reported relatives knew the trafficker.

Woman's relative knew trafficker		
	(%)	(n)
Yes - Relatives knew	17%	35
No - Relatives did not know	83%	168

* 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.

My mother sold me to a stranger.

The sexual abuse started when I was 13 and was due to get circumcised.

Implications

This chapter highlights the degree to which trafficked women often have prior histories of violence, neglect and/or other family problems. Indeed, some women had moved from very violent and unsettled circumstances into the trafficking situation.

These rates of violence compare with some of the highest national rates of gender-based violence in the world. Although the study design and demographics of the samples are quite different, to put these violence levels in perspective, in a recent WHO multi-country study on violence and women's health conducted in 11 countries, levels of reported partner and non-partner sexual and physical violence since age 15 ranged from 18.5% to 75.8%, with most study sites reporting prevalence levels below 60%.⁷ The WHO Multi-Country Study on Women's Health and Domestic Violence found prevalence rates of sexual abuse before age 15 between 1% and 21%, with only three study sites (of the total 15 sites) reporting rates higher than 15%.

Exactly how these levels of violence may have affected women's decision to take up the offer of a trafficker, or whether this may have made her a target for recruitment are difficult to assess. Nonetheless, this high percentage of women reporting pre-departure violence hints that abusive situations may be a factor in women's decision-making equation. Moreover, how pre-departure violence might have influenced women's risk-exposure during the trafficking experience, and how it impacted their subsequent health is a matter for in-depth analysis.

Importantly, women's history of physical and sexual violence also suggests that women surviving a trafficking ordeal are likely to have a complex health profile. A woman's

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.

In addition to the effects that violence may have on women's vulnerability to trafficking and on their subsequent health outcomes, the range of pre-departure violence reported by the women in this study has significant implications for questions surrounding women's return and reintegration and their safety. The prevalence and the nature of violence that women experienced in their home countries indicate that a significant portion may encounter dangers to their safety and well-being if they return to the situations from which they departed.

These findings have implications for both prevention and for post-trafficking policies and services. For prevention, they highlight some of the pre-departure circumstances that might increase an individual's vulnerability to being trafficked, such as child sexual abuse, domestic violence, single parenting or being a sole carer in financial difficulty or crisis, or living in institutional childcare.

For post-trafficking policies and services, these findings highlight that the most effective healthcare strategies will take into account women's history of violence and other risks. This historical information will be particularly informative for psychological support. Furthermore, previous exposure to violence, deprivation or other serious health threats indicate the need for a careful assessment of the risks that these circumstances may pose to women's safe return and appropriate protection mechanisms.

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“I was brutally beaten, covered with cigarette burns, and had my face held underwater.”

“They told us they would sell us to a really bad place and my daughter would disappear.”

Reports from around the world have offered heart-wrenching tales of the violence and cruelty that trafficked women have endured at the hands of their traffickers. Statistical evidence from this study demonstrates that these are not simply isolated cases, or limited examples about those women who are the most brutally treated, but are typical experiences of women who are trafficked.

In order to understand the dynamics of a trafficking situation, it is useful to consider the abusive tactics used by traffickers. The strategies used by traffickers to instil fear are an important part of maintaining control over a woman, and demonstrating the price of disobedience. Maria Tchomarova, a psychologist from Animus Association/La Strada Bulgaria, likens the stages of mental manipulation of women to those employed by totalitarian regimes.¹ She explains that women are immediately forced into "extreme survival conditions" during which the possibility of death is made real, and the woman recognises that she no longer controls her safety—the trafficker does. At the second stage women are driven to "physical exhaustion" through long hours, and extreme tension-filled environments. Unable to rest, a woman is debilitated and unable to consider her options or contemplate self-defence strategies. Control and isolation are the final elements in inculcating a woman's dependence. Ultimately, a woman is trapped physically and psychologically, and as explained in the previous report on health and trafficking in Europe:

In a captor-captive-like situation, where her only substantial contact is with the trafficker, a woman's perceptions of the world and herself are reflected through his skewed construction of her universe. His rules are her rules. His needs are her needs. His fears are her fears.¹ (p. 42)

Systematic and continual acts of intimidation have the effect of psychologically disabling a person. Repeatedly unable to exert power over what happens to her or her loved ones, a woman's sense of helplessness becomes internalized.

To better understand how events during the trafficking situation put a woman's health in jeopardy, women were asked about a range of experiences during the time that they were trafficked. Questions were posed about abuse and other risk factors that had the potential to negatively impact women's health.

The following section provides data on the different forms of violence, threats, and personal restrictions women experienced while in the hands of the traffickers. Data on women's levels of alcohol and drug use, and their access to medical care while they were under the control of traffickers are also presented.

I was locked up like an animal and I was beaten almost every day.

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.

Table 5.1. Percentage of women reporting different forms of violence while in the trafficking situation.

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

When I was 'punished', I was locked in a dark underground cellar.

I was badly beaten for refusing the group sex, and asking for condoms.

Violence

Physical violence

Women were asked whether anyone had ever hit, kicked or otherwise physically hurt them while they were in the trafficking situation. More than three-quarters (76%) answered "yes", they had been physically assaulted. (Table 5.1.) Women reported physical violence by traffickers, pimps, Madams, 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 extreme levels of violence, including being burned with cigarettes, choked, kicked in the head and the back, and having their hair pulled and head slammed against floors or walls.

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.

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.

Many women described how they were assaulted when they pleaded not to be forced into sex work or showed signs of reluctance.

Some women aimed to avoid being assaulted through complete obedience, *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 would learn of this and would hurt me again.

Violence was an aspect of the experience that many preferred not to discuss, *these are not nice things to talk about*, or even reflect upon it, *there was so much [violence], but I do not remember how*.

Assault with gun, knife or other object

Women were also asked whether they had ever been hurt with a "knife, gun, or other object". Thirty-percent of the women answered "Yes". Women were very sparse with details about these episodes, frequently pronouncing that they did not wish to speak further about this subject.

Of the 27 women who acknowledged this type of abuse, 6 said that the perpetrator used a gun, 8 said a knife, and 19 described another object that was used to harm them. For most of the women who noted that a gun had been used, they 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.

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 5.2.)

Women were asked two 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?" Of the 203 women who responded to this question, 84% stated that they were physically forced to have sex.

After women were asked about physical force, 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). 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.

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.

Table 5.2. 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

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.

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. The reasons these women may not have perceived their experience of trafficking for sexual exploitation as sexual abuse are complex. Women's comments both from this study and the previous study on trafficking and health offer some possible insights. First, trafficking-related violence and coercion occurs on a continuum and some women may have been more free, less coerced, and therefore did not perceive their experience as violent in a way that is typified in "rape" (as sex work does not have to be perceived as inherently a form of sexual violence). For some women, that they had 'agreed' 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 rather than 'forced'. For women who were in intimate partnerships with their pimp-trafficker, it is not uncommon to hear that the engagement in sex work was in response to a partner's urgings, thus they felt that they had 'consented', rather than been coerced.

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. This can have particularly negative implications for women's sexual and reproductive health. (See Chapter 7: *Sexual and Reproductive Health*)

Some women made a point of stating that they were forced to work through menstruation and indicated that they were bothered by this because they thought it would cause long-term damage to their reproductive health.

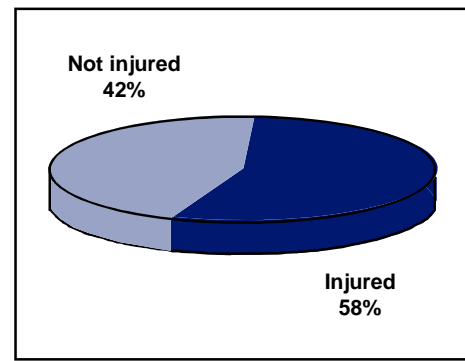


Figure 5.1. Percentage of women who reported being injured while trafficked. (n=204)

Injuries

Indicative of the severity of the violence inflicted on women is the level of injury they sustained. Well 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. (Figure 5.1.)

Reported physical sites of women's 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 and other objects, from having their head slammed against the wall or the floor, or having been kicked in the head.

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.*

Table 5.3. 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

Threats against the woman and her family

Like violence, threats are a hallmark of the trafficking experience. Women were asked if anyone had ever threatened to hurt them during the time that they were trafficked. Of the 204 women responding, more than nine out of ten (91%) said "yes". (Table 5.3.) Women were intimidated with a variety of threats, including death, beatings, increased debt, harm to their families, and re-trafficking.

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 5.2.)

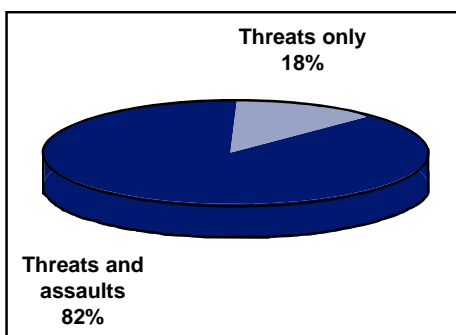


Figure 5.2. Percentage of women who reported threats only or threats and assaults during trafficking.

As previously noted, at any sign of reluctance towards sex work (e.g., *if I didn't want to go on the street*), women would be threatened and beaten. In trying to refuse sex work, one woman was told by the brothel Madam that she would have *acid thrown on her*.

Warnings against escape were among the most frequent. Murder threats were not uncommon. 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.*

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." As many of the women came from countries where corruption is rampant and law enforcement is lax, 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".

Intimidation occurred regularly for most, which served to maintain a relentlessly menacing environment.

It was terrible. I have scars all over. He used all kinds of things [for beating].

I was hit in the teeth and had to have my upper dental arc rebuilt.

He told me 'If you try to run away, I will cut your face and will take you to Albania.'

Every single day I heard the threat 'I'll kill you bitch'.

By creating an unpredictable and unsafe atmosphere, traffickers keep women continually "on edge", and thereby maintain a considerable amount of control. Perpetrators of torture are known to employ similar tactics aimed at destabilising their victims and creating extreme uncertainty about the future.²

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.

Threats against women's family

Thirty-seven percent of the women reported that the traffickers had threatened family members if the women did not submit to their demands. (Table 5.3.)

Asking women to choose between their own safety, that of their children or other loved ones has been referred to as the "impossible choice" in literature on psychological torture.³ 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.³

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.⁴

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.^{4, 5}

By suggesting they could, and would hurt a woman's family, traffickers wielded a great deal of power. 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. Women recognised that there was little they could do to protect their family.

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 families of those women who agree to participate in a prosecution have been well-documented.⁶

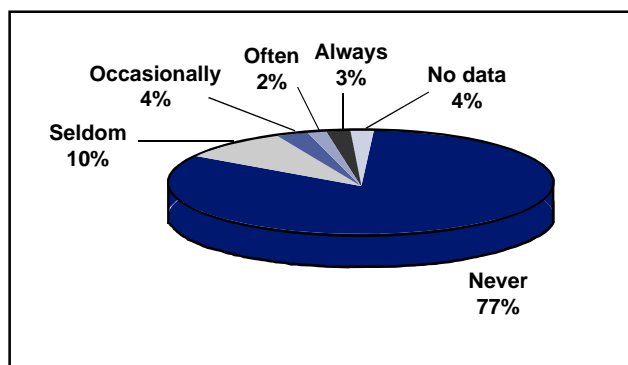


Figure 5.4. Percentage of women who reported how often they felt free to do as they wished or go where they wanted. (n=207)

Loss of freedom and control

The findings from this study suggest that another defining feature of the trafficking experience is the loss of freedom.

Women were asked: "Were you free to do what you wanted or go where you wanted? Would you say "never", "occasionally", "often" or "always"?"

Nearly eight in ten women (77%) were adamant that they were "never" free to do as they wished. Based on their descriptions, for most, their imprisonment was strict. A further 10% said that they were "seldom" free, and explained that if they were permitted out, they were under guard. (Figure 5.4.)

Few women were free to choose what happened to their bodies, how or when it happened, or by whom. Few were allowed to decide when or what they ate, when they slept, went to the toilet, or rested. Not only were women rarely given any chance to voice an opinion or preference, for many, simply to make a request or state a preference would be to solicit a violent reaction.

One woman summed up the situation of most: *I was locked up like a prisoner.*

For a majority of women forced into sex work, the classic arrangement is for women to be locked up or watched during all non-working hours, and then when it is time for work, either they are escorted to the work venue, to the client, or to the streets.

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,* and another stated: *I tried to run away several times. But there was no way to leave.*

They used to say things like: 'children's organs are really expensive, and children can be kidnapped'.

If they threatened my family, I couldn't do anything.

He didn't just threaten me, he beat me unconscious.

Even now, I have received threats, during the [legal] proceedings.

I had abdominal pain so I drank vodka to soothe the pain.

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', they were then detained by authorities for violating either immigration or prostitution laws.

Use of alcohol and drugs

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 5.4.)

Many 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. Some women who were working the streets on cold winter nights drank to keep themselves warm.

In certain locations women were forced to drink as part of their job in the bar where they were obliged to entice men to buy them beer and cocktails. This is particularly common in Kosovo and Japan.^{1,7}

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 enumerated 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.

Table 5.4. Percentage of women according to how often they reported consuming alcohol. (n=207)

Alcohol consumption					
	Not at all (%)	Occasionally/sometimes (%)	Most days (%)	Everyday (%)	No data
Women reported drinking	40	32	10	17	1

Table 5.5. Percentage of women who reported using illegal drugs during the trafficking situation. (n=207)

Illegal drug use		
	Yes (%)	Yes (n)
Woman reported using illegal drugs	14%	29

For many of the women who drank, once they were in a shelter situation they stopped drinking or reduced their level of 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 still 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.

It is not known how many, and to what degree any of the women drank prior to being trafficked. Alcoholism has been found to be a significant problem in Former Soviet Union States.⁸ 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.⁹

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 5.5.) 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.*

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.*

In other regions drug use is reportedly more common, particularly for drugging young women (i.e., virgins) to prepare them to be compliant with their first client.¹⁰

Drug use appeared more commonly among women who reported drinking everyday than among those who reported lower levels of drinking.

Implications

Findings presented in this chapter show that it is extremely unlikely for a woman to emerge from a trafficking situation without having been physically assaulted, raped, psychologically abused, and deprived of her basic freedoms. For the majority of the women in this study, the cruelty and disregard were unrelenting.

Abuse was perpetrated in such a way as to cause enough harm to instil

I don't know which drug I was administered by the traffickers –once orally, once intravenously.

I was closed in the basement with my friend and we were free to go only to work, and when the boss was drunk he would rape me.

I was driven to work, picked up after work, and taken back to the flat and was locked up.

First I was kept locked in a house, then in a hospital, then in a prison.

obedience and demonstrate who held constant and ultimate power—but generally not so much that the victim was no longer able to function. Repetitive abuse of this kind gives a captor regular control and makes a victim feel helpless to protect herself—which is particularly advantageous to exploiters, where profits depend on the woman's compliance. In addition to experiencing "mental defeat" as their options for escape and self protection are worn out, it is not uncommon for a woman to begin to believe that her best chances for survival lie in aligning herself and identifying with the perpetrator of the violence. This "traumatic bonding" has been termed the "Stockholm Syndrome"¹¹, and is most commonly represented by the situation where a captive identifies with her captor to protect herself against the reality of her actual powerlessness. Not only are these bonds sometimes difficult to break, these distorted dependent relationships deeply affect an individual's future ability to trust others. Sexually abused children have been found to be particularly susceptible to this insidious relationship.¹² As many of the participants were adolescents, the implications of these corrupted perceptions are significant for later treatment.

As described by the women, the abuse and control tactics employed by those perpetrating or participating in their captivity were all-encompassing and affected nearly every aspect of their sleeping and waking moments.

In the starkest terms, this chapter highlighted the limited freedom that women have when in a trafficking situation, as the overwhelming majority said that they were never free. There can be little question after learning these statistics of the limited opportunities that women have to escape a trafficking situation—whether or not they are physically restrained or

held captive through intimidation and fear of what might be done to them or their family members. Neither can there be much doubt that most trafficked women have little choice other than to obey—to do as they are instructed.

These severe restrictions are fundamental elements of women's situation that cannot be overlooked when outsiders, particularly government and law enforcement officials, question why women do not take every opportunity to leave or escape their traffickers.

The impact of this loss of self-determination and of movement on women's health cannot be overemphasised. 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".¹³ Given this criteria, for nearly 90% of this group of women, the impact of their living and working arrangements is likely to have had dramatic effects on their physical and psychological health status.

Finally, these findings also suggest the extreme challenges that exist in trying to provide support services to women who are still in a trafficking situation. The risks of contacting women and the sensitivity required to gain their trust and confidence are significant. Yet, conversely, these findings also make it abundantly clear that their need for assistance is great.

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“I was hit in the head by my trafficker, and I sometimes have problems remembering things from yesterday.”

“I feel pains in my vertebrae, in the spinal column and my heels because I jumped from the third floor to run away.”

Table 6.1. Physical health risks, abuse and consequences of trafficking.¹

Physical health	
Forms of risk and abuse	Potential health consequences
Physical abuse	Physical health
<ul style="list-style-type: none"> ■ Murder ■ Physical attacks (beating, kicking, slapping) ■ Assault with an object (baton, pole, chain) ■ Assault with a weapon (knife, gun) ■ Assault during pregnancy ■ Torture (burning with cigarette, mock drowning) ■ Physical restraint (ropes, cuffs, chains) ■ Physical deprivation (food, sleep, light, basic necessities) ■ Confinement 	<ul style="list-style-type: none"> ■ Death ■ Acute and chronic physical injuries ■ Neurological complications ■ Gastrointestinal complications ■ Sexual and reproductive health complications ■ Dermatological problems ■ Cardiovascular complications ■ Musculoskeletal complications ■ Cognitive problems, sensory and nerve damage ■ Exhaustion, poor nutrition, malnutrition, weakened immune system ■ Deterioration of pre-existing conditions leading to disability or death ■ Mental health problems

The greatest concentration of risks to a woman's physical health generally occurs during the time that she is at the destination location in the situation of exploitation. Risks to physical health are summarised in the table above. (Table 6.1.)

This chapter presents data on a broad range of physical health dimensions—from symptoms directly related to violence to those associated with physical deprivation. Past discussions on trafficked women's health have centred primarily on sexual and reproductive health, often minimising the constellation of other physical health problems women experience. In this study, women were asked about a wide variety of physical health symptoms and were given an opportunity to rate the severity of each at three different time intervals.

Women's rating of their overall health status

Prior to inquiring about specific symptoms, women were 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.²

The majority of women felt that their health had improved significantly while they were in the care of a service organisation. Most women (56.1%) rated their health as "poor" at the first interview, but by the latter two interviews (after at least two weeks in care), the majority subsequently perceived it as "good" (58.9%, 54.8%). (Figure 6.1.) Most changes occurred between the first two interviews, while less difference can be observed after the second interview.

What this data is not able to show however, is to what degree these assessments reflect how women perceived their current health status relative to their health while they were still in the trafficking situation. That is, if women were evaluating their health compared to how poorly they felt before escaping the trafficking situation, then these assessments likely under-represent how poorly women were feeling on a normative scale, or compared to an average health level.

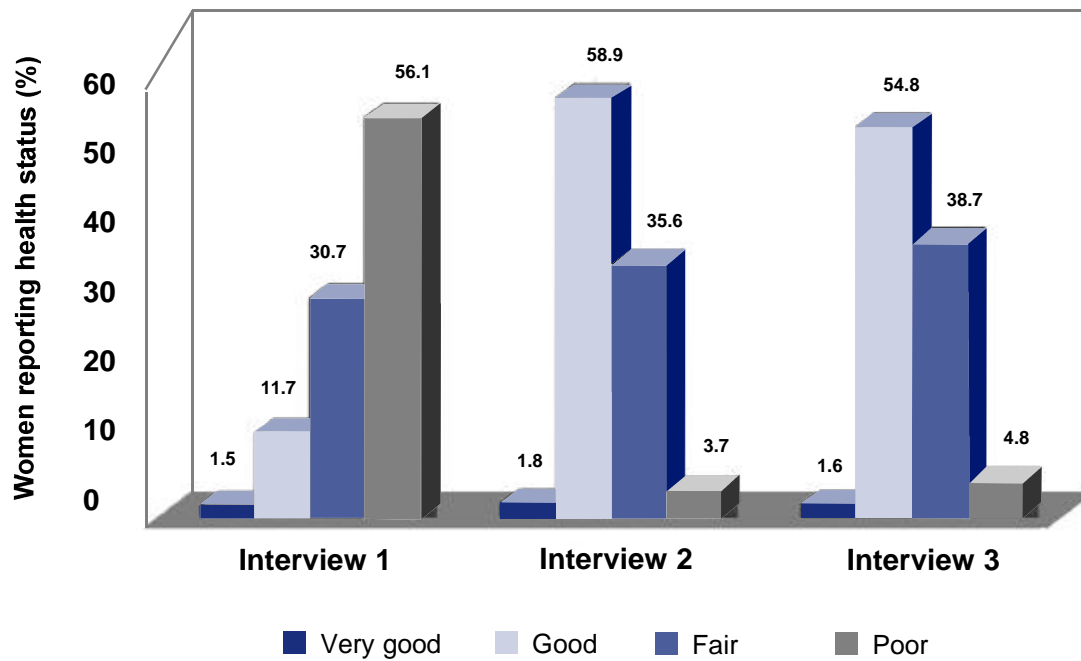


Figure 6.1. Women's perception of their health status over three interviews.

Further supporting the need to view women's assessments from a relative perspective, in comparison with a general female population, research on violence and physical health outcomes suggests women who experience abuse are nearly 1.5-3.5 times more likely to perceive their health as poor than women who have not been abused.^{3, 4}

Within the first 14 days after entry into a service setting, 57% of the women reported experiencing 12 or more concurrent physical health symptoms. For many, these symptoms caused significant pain and discomfort. 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 6.2.)

Concurrent symptoms

It is not surprising that women rated their health poorly upon emerging from a trafficking situation, as the majority of them were burdened with numerous and concurrent physical health problems.

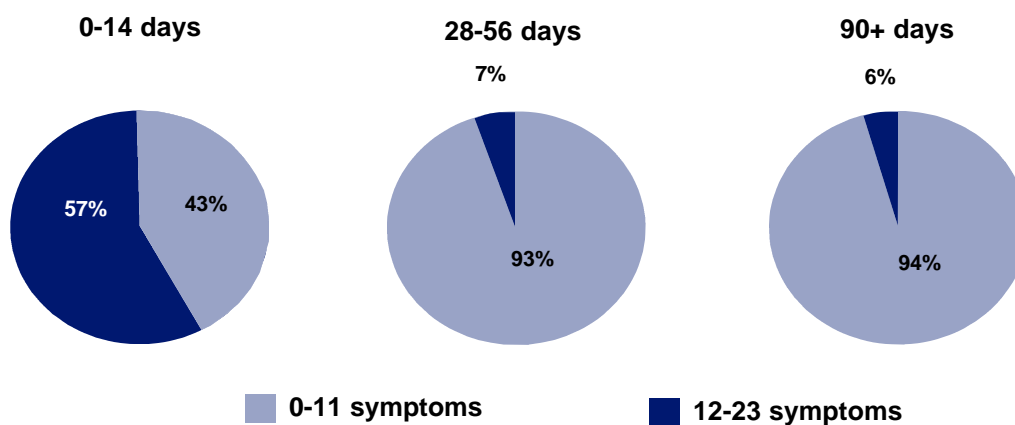


Figure 6.2. Percentage of women with concurrent physical health symptoms over three time periods following entry into a post-trafficking service setting.

Physical health symptom domains

To explore post-trafficking symptom patterns, women were asked a series of questions about different aspects of their physical health. These symptoms were organised similar to a medical history-taking and were categorised by body systems into nine symptom domains. This "body systems check-list" included the following symptom domains:

- 1) Fatigue and weight loss;
- 2) Neurological;
- 3) Gastrointestinal;
- 4) Sexual and reproductive health (See Chapter 7: *Sexual and reproductive health*);
- 5) Cardiovascular;
- 6) Musculoskeletal;
- 7) Eye pain, vision problems;
- 8) Ears, colds, flu, sinus infections;
- 9) Dermatological.

No clinical examinations or medical chart reviews were conducted and no specific diagnoses are presented. Symptoms levels are based on self-reporting only. Symptoms may be a consequence of injury, infection, may be somatic or stress-related, or, most likely represent some combination.

For each symptom, 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 according to a Likert scale: "not at all"; "a little", "quite a bit", "extremely/very much". These corresponding severity levels were scored from 0-4.

To gain a broad picture of which physical health domains were most problematic for all women, an average severity score for each symptom domain was calculated. It is important to note that this scoring system was used to detect symptom patterns only. Scores should be interpreted with caution, as they represent common symptom trends, but each woman had unique problems that required individual diagnoses and care strategies.

The average domain scores over the three interviews, and an overall average score for all domains combined is presented in Table 6.2.

Although the physical health domain scores decrease over time, the priority that women gave to the dimensions does not alter very much. For example, the physical symptom domains that were generally rated as most problematic were fatigue and weight loss; neurological; and gastrointestinal.

One notable trend occurred within the neurological symptom domain. The average score for the neurological symptom domain reduces the least over the three interviews. This is likely attributable in great part to the chronic and painful headaches reported by the large majority of women in the study.

Also notable is the trend within the sexual and reproductive health domain. At Interview 1, sexual and reproductive health problems rank fourth in importance (average score=1.24), but by Interview 2, they have descended to last (average score=0.22). Most women in this study received urgent treatment for sexual health complications, such as sexually transmitted infections, perhaps accounting for this reduction in reported severity. This highlights that with treatment, women quickly perceive an improvement in their sexual and reproductive health. (See Chapter 7: *Sexual and reproductive health*). It also suggests the possibility for similar improvement in other domains with targeted and adequate treatment.

To examine the trends in women's overall physical health, an average physical health score for all 26 symptom domains combined was calculated (bottom line of Table 6.2). These "average scores" highlight the significant decrease in physical health symptoms, or overall improvement, that women felt between Interview 1 (average score=1.39) to Interview 2 (average score=0.58), after several weeks of professional support.

Table 6.2. Average symptom domain scores for all women over three interviews.

Physical health symptom domain scores			
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
Skin	0.81	0.33	0.44
Average score for all women for all domains	1.39	0.58	0.50

Specific physical health domains and corresponding symptoms

Nearly each and every symptom of the 26 symptoms was acknowledged by some portion of the women at all three interviews. The prevalence level for individual physical symptoms ranged between 2% and 82%. (Table 6.3.) The lowest prevalence levels generally appeared at the second and third interviews.

Of the 26 symptoms, the ten most commonly reported physical health symptoms at the first interview, in order of prevalence, were:

- 1) Easily tired (82%)
- 2) Headaches (81%)
- 3) Dizzy spells (71%)
- 4) Vaginal discharge (71%)
- 5) Back pain (69%)
- 6) Loss of appetite (64%)
- 7) Difficulty remembering things (63%)
- 8) Stomach or abdominal pain (63%)
- 9) Gynaecological infection (61%)
- 10) Pelvic pain (59%)

Over the course of the study, the four symptoms that were consistently prevalent and severe were: headaches, fatigue (easily tired), dizzy spells, difficulty remembering and stomach or abdominal pain.

The symptom patterns detected among the women in this study are consistent with the health outcomes identified in survivors of sexual abuse, rape and intimate partner violence.^{3, 5, 6}

As this study also looked at severity, it is useful to note that prevalence levels often differed from how severely women felt these symptoms.

The following section describes the findings for each physical health domain, and its associated individual symptoms.

Most prevalent and severe symptoms over time
Headaches
Fatigue
Dizzy spells
Difficulty remembering
Stomach/abdominal pain

Table 6.3. Prevalence and severity rating of physical health symptoms.

Physical health domains and individual symptoms						
Fatigue and weight loss	Interview 1		Interview 2		Interview 3	
	Any (%)	Upper severity* (%)	Any (%)	Upper severity (%)	Any (%)	Upper severity (%)
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

* Upper severity indicates that women rated the symptom as bothering them "quite a bit" or "extremely/very much", versus "not at all", or "a little". The values represent the proportion of women who reported the presence of any symptom.
 ** Please see Chapter 7 for a discussion on sexual and reproductive health findings.

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.

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.

Fatigue and weight loss

This domain included the individual symptoms, "easily tired", "weight loss", and "loss of appetite" and as noted, had the highest score of any domain at the first interview (average score=1.97). It also had the second highest scores at Interview 2 (average score=0.91) and Interview 3 (average score=0.63). (Table 6.2)

While fatigue, weight loss, and loss of appetite are frequently associated with depression and stress, for women who are trafficked, these symptoms may also be caused or compounded by the deprived conditions, arduous activities, and long work hours most have endured. It is not uncommon for women forced into prostitution to work as many as 12 to 14 hours per day and to be permitted a few hours of sleep or rest—despite serving as many as 20 to 30 clients per day.¹

"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 still reported it as a significant problem at the third interview. Fatigue ranked as the second most frequently reported symptom of all 26 symptoms at this time.

In addition to the direct effects on a woman's well-being, sleep loss can have indirect effects on health. For example, sleep disruption and sleep deprivation not only affects an individual's cognitive functioning, it also decreases the body's natural protection mechanisms related to pain and the immune system.^{7, 8}

"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.

One woman who had escaped her traffickers one week prior to the interview explained, *I was kidnapped for 3 days, without eating*, after which she was hospitalised for repeatedly fainting.

For many women in the study the weight they lost was significant, as one noted:

My weight before trafficking was 72 kilos, but the trafficking experience brought me down to 40 kg. Now my weight is 68 kg.

Several women remarked that their loss of appetite was related to stress, as one explained that she lost her appetite 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.

Neurological symptoms

Symptoms associated with the central nervous system were among the most prevalent and most persistent, and headaches appeared to be the most problematic throughout the course of the study. At the first interview, 81% of the women reported having headaches, and more than three-quarters (78%) ranked these in the upper half of the severity scale. By the third interview, there was little decrease in the numbers of women reporting headaches, as 67% still reported headaches, and 41% ranked them as "quite a bit" or "extremely painful".

When asked about their worst symptoms, many women cited "headaches". Some said the pain was the result of an assault. 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.⁹

Additionally, many women associated headaches with their emotions or their psychological state, speculating that their headaches were caused by "worrying too much", "thinking too much", or thinking about emotionally charged subjects.

When compared to findings from studies on women who have experienced 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.^{3, 5}

Although headaches are often stress-related, a fact that cannot be overlooked is that many women were struck in the head or thrown against walls or the floor, which may have led to head or neck trauma. Complaints of headaches, dizziness, fainting and other signs of serious injury should receive appropriate attention.

Many women who reported headaches also noted severe eye pain, which is one 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. Studies on dizziness have shown that dizzy spells may be associated with psychological distress, autonomic arousal, social anxiety, stigma, and panic disorder.¹⁰

Memory difficulty is a common and extremely meaningful problem for trafficked women. When asked about memory difficulty, at the first interview, well over half (63%) stated that they were having memory problems, and 70% of these women ranked them in the upper severity levels.

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 (30%).

Memory problems are of immense concern for women's health and well-being because recollections of events and exposures may affect diagnosis and treatment. Women's inability to recall the past may, for example, limit medical history taking and can hinder psychological counselling and support.

Memory and recall are also 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 be limited in the resources she receives. 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.

It is not uncommon for individuals who have experienced trafficking-related trauma to have difficulty recalling details of events, including names, dates and locations. This is particularly true around the time of the "initial trauma". As detailed in a previous study, the initial trauma can best be described as the time when a

The headaches were very bad. I could not take my head off the pillow.

I was hit in the head by my trafficker.

When I am thinking about my family or if there's confusion, I have a headache.

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 cannot even make moves with this hand.

woman first learns that she is in life-threatening danger:

Whether introduced by a violent act or experienced as shock from having learned their fate, this first trauma establishes the context of danger that is now the woman's reality. According to experts on mental health and violence against women, this initial trauma is usually acute, generally engenders symptoms of extreme anxiety, and can inhibit memory and recall.¹¹

This initial trauma frequently occurs before or as a woman enters the exploitative setting. While in transit to the destination location is when women often realise that they are in danger. The body has a physiological response that takes over when confronted with danger, which is commonly known as the "fight or flight response". Research has shown that in response to this type of stress, chemicals are released by the brain that inhibit "selective attention," or one's ability to filter perceptions.¹² During this traumatic episode, the woman no longer observes details, but instead becomes hypervigilant to the central focus of the imminent threat in order to respond it.

The difficulty that individuals have in recalling and reconstructing traumatic experiences soon after the event, and in later discussions has been confirmed by numerous studies.^{13, 14} Peritraumatic dissociation, or when individuals block out events at the time of trauma, has been closely related to post traumatic stress disorder (PTSD).¹⁴⁻¹⁶ 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".¹⁴

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 participate with authorities, as it is often this 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.¹⁷ 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.¹⁸

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.

Gastrointestinal symptoms

At the first interview, 63% of the women said they experienced stomach or abdominal pain, and by the third interview this pain remained prevalent and severe compared to other reported symptoms.

Of the 45% of women reporting other gastrointestinal problems (i.e., upset stomach, vomiting, diarrhoea,

constipation) at the first interview, 66% ranked them in the upper half of the severity scale. Women reported regular 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".

Gastrointestinal problems have been shown repeatedly to be an important part of post-trauma symptomatology, commonly associated with anxiety and stress.⁶ It is not uncommon for women who have experienced abuse to report digestive problems, in particular, frequent indigestion, diarrhoea and gastric reflux³ and to seek medical care for gastrointestinal problems^{6, 19, 20} as well as treatment for abdominal pain, including surgery, for chronic pelvic pain.^{20, 21}

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 reported these problems, and approximately one-third referred to them as severe.

Chest/heart pain was more commonly noted than breathing difficulty at both the first (50% vs. 40%) and third interviews (24% vs. 17%). Of those reporting chest pain, approximately half simultaneously reported breathing difficulty. Chest pain was persistent throughout the interviews.

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 a number of other

women had tuberculosis, but later diagnoses were not gathered. Alternatively, one woman identified her breathing problems with "acute bronchitis", and suggested that, *the pain is due to the cold climate.*

Cardiovascular symptoms such as heart palpitations and shortness of breath are often associated with acute anxiety and panic attacks.²² 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 8: *Mental Health.*

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.

Back pain is a frequently reported problem among women who have been sexually abused, or physically assaulted by an intimate partner. Comparing back pain among survivors of intimate partner violence, prevalence rates are also near 40%, and similarly, among the highest of all reported symptoms. Back pain has also been associated with stress and depression.^{3, 5}

Importantly, a number of women linked back pain to injuries they had sustained. For example, several women reported having jumped from windows to escape.

I was hit in the head by my trafficker, and I sometimes have problems remembering things from yesterday.

I have intense coughing up until vomiting and difficulty breathing during sleep.

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 concurrent 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. It is important to recall that women were only reporting problems or pain that they felt in the past two weeks, i.e., not all of the injuries they sustained throughout the trafficking process.

Similarly, of the 18 women (9%) reporting facial injuries, 14 said they had been physically abused. Describing her facial injuries, one woman specified: *bruises, and scars after cigarette burnings.*

Women with pain and irritation from sprains, fractures and facial injuries experienced very little relief from these symptoms. At the first interview 12% and 8% reported pain from fractures or sprains and facial injuries, respectively, and at the last interview, 13% and 5% still reported them.

More information on injuries sustained during the trafficking experience is provided in Chapter 5: *Violence during exploitation.*

The previous study on health and trafficking suggested that many women who have been trafficked are likely to report dental problems.¹ 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. As a result of a toothache, one woman explained, *My whole cheek and my eye swelled up.*

Dental complaints may also relate to blows to the face or head.

Ears, colds, flu and sinus infections

Ear pain

Sixteen percent of the women reported ear pain at the first interview, and of those participating in the third interview, 6% said they had ear pain. Ear pain appeared to be independent of colds or flu symptoms for most of the 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 the women at the first interview reported these symptoms. The percentage of women reporting symptoms of colds, flu or sinus infections fluctuated throughout the three interviews, (31%; 14%; 27%). It is possible that women's vulnerability to infection or illness may not decrease even after the direct threats to their health are removed.

Women were clearly bothered by these problems, as between 40% and 52% rated them in the upper half of the severity scale at all three interviews.

Again, these symptoms appear to fit within the health profile of an abuse survivor, as studies show higher rates of infection among abuse survivors, suggesting lower immune function than for those who have not been abused.^{5, 23} Interestingly, a study by Campbell, et al. suggests that those who have been sexually abused have higher rates of illness than those who reported only physical abuse.⁵ (Further analysis of this data is necessary to determine whether this was true among trafficked women.)

It has been suggested that the frequency of these problems may be related to chronic stress²⁴, 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.^{25, 26} Women in this study may have been particularly vulnerable to infection because of their experience of acute and chronic stress both in the past and present, and because of the duration of the stressful events.

It is also worth recalling the high number of women reporting severe fatigue and the impact of sleep disruption on the immune system.

Skin 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.

Again, higher rates of skin problems such as rashes, itching, sensitive skin and excessive sweating have been found among women who have been abused.⁶ 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.²⁷

Women's expression of the problems they perceived as most painful

In order to give women the opportunity to express in their own words a description of their physical health problems (i.e., versus responding to listed symptoms),

women were asked two open-ended questions: (1) "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", and (2) "Of all the problems that you have had in the past two weeks, can you tell me more about the things that have been hurting or bothering you the most." These questions yielded important insights into women's concerns, both physical, and more often, psychological. While the proportion of the symptoms described generally reflected the quantitative data, when put in their own terms, the different expressions of pain and suffering are difficult to summarise. The following attempts to summarise women's responses.

While some women were able to identify a single physical health problem, most reported several:

My head, headache, eye pain. My back and abdomen, due to pregnancy. I am feeling very weak. Chest burning, sometimes I have tremors. Nerves.

Headache pain was repeatedly mentioned throughout the study.

For a number of women, "the thought of having HIV" was their foremost concern.

Many women cited back problems as disabling and keeping them from being able to sleep.

One woman said that being "cold" bothered her most, noting that:

It's cold outside and I don't have enough clothes.

Women also frequently mentioned concerns over liver and kidney problems. Without clinical assessments, it was difficult to interpret these comments.

When I'm nervous, every centimetre of my body itches.

Headaches and my dry skin. And now my back ache. Cigarette burns that are 4 months old. I don't seem to hear properly.

Doctors treat me like an animal I don't want to see a doctor!

At the first interview women were asked about physical health symptoms before they had been asked about their psychological symptoms, therefore many women responded by expressing emotions, such as anger, fear, anxiety and sadness.

Comments reflecting women's emotions and thoughts are discussed in greater detail in the mental health sections, however, it is important to recognise that while responding to questions within the interview section enquiring about their physical health status, a large portion of women wanted to discuss their emotions and personal distress.

By the second and third interviews, headaches remained a pressing medical concern, and a greater percentage of the women who remained in the study reported having stomach pain, and abdominal or pelvic pain. Women also continued to highlight painful dental problems. On the other hand, some women recognised improvements in their health, or indicated that they had reconciled themselves to certain health problems.

Women who were involved in legal or judicial proceedings related to the trafficking experience were more likely to report anxiety-related symptoms, particularly around the times that they were obliged to offer testimony. One woman reported: fainting, loss of appetite, heart problems, breathing. She then explained that she thought these symptoms resulted from nervousness due to the recent trial, at which she gave evidence against the trafficker.

Doctor visits

Women who participated in the second and third interviews were asked whether they had seen a doctor for the health symptom that most concerned them.

More than two-thirds (69%) of the women had seen a medical practitioner by the second interview. (Figure 6.3) Whether a woman had been seen by a doctor generally differed by location. Women in single dwelling shelter-settings where in-house medical assistance was available were generally more likely to have reported having been treated.

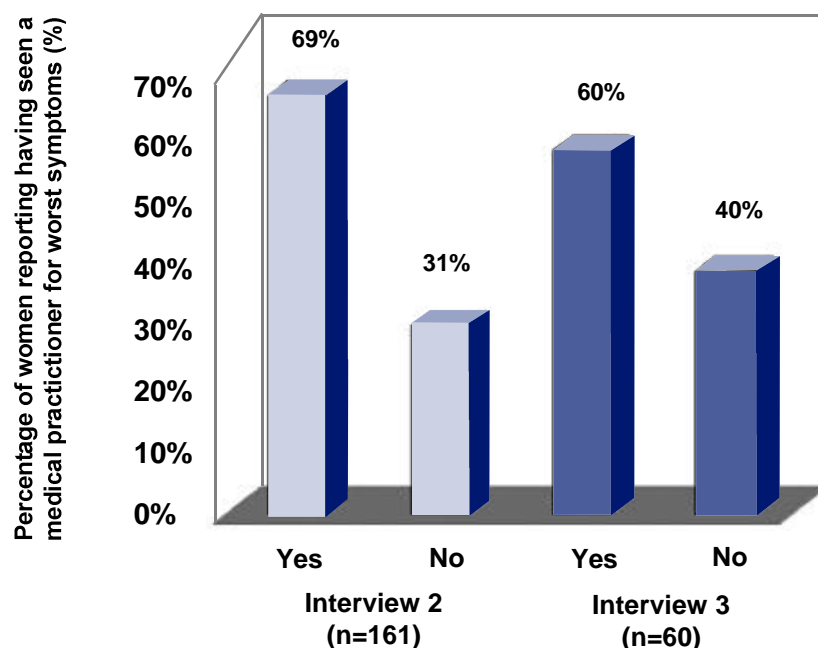


Figure 6.3. Percentage of women reporting having seen a medical practitioner for their worst symptoms at Interviews 2 and 3.

Women who did not live in a communal care setting were less likely to state that they had received the medical care they desired. In some destination locations, delayed assistance may have been due to women's legal status and their inability to access public funds. This is an issue that requires further investigation.

Most women reported that the service they received was "good" or "very good". This positive rating of care may have been due to the good quality of the care, but may also have been influenced by women's wish not to offend care providers, i.e., the interviewer.

At the third interview, women were again asked about the problem that most bothered them at that time 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. (Figure 6.3.) Again, it was more likely for women in single dwelling shelter settings to have received the desired services. At this point, a number of women stated firmly (and sometimes emotionally) that they no longer wanted to see doctors. This feeling was not isolated to any single location or assistance project. It is unclear why some women had not yet visited a practitioner for their health problems.

Implications

The 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, 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 foster an expanded discussion on health to include a wider spectrum of complications that appear to be of great concern to trafficked women themselves.

The intervention implications of these findings strongly suggest that women emerging from a trafficking situation require services that not only treat their acute and urgent medical needs (e.g.,

infections, injury, acute pain, unwanted pregnancy), but that also respond rapidly to their basic needs (e.g., safety, rest, and nutrition) in order to foster recuperation from symptoms such as, serious fatigue, loss of appetite, and weight loss. These needs were reiterated in women's qualitative comments that expressed women's impressions that it was a combination of various factors including rest, proper nutrition, medications for pain and/or infection, and/or anxiety or sleep, and an increased sense of security, that were responsible for alleviating much of their pain and discomfort.

Further, interventions must have the capacity to diagnose and treat a wide variety of physical health problems. Diagnoses may be complicated because women's symptoms might be the result of a physical injury or infection, and/or they may be somatic (non-psychiatric symptoms associated with psychological reactions). This is an important medical duality because it requires practitioners to take particular care in diagnosing symptoms for trafficked women. Although many women will be experiencing deep distress and anxiety following a trafficking experience, it is vital that symptoms commonly associated with depression, anxiety, etc., not be misread, and assumed to be solely psychological in origin. Physical violence and physical harm are hallmarks of trafficking in women and therefore symptoms suggestive of psychological distress 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.²⁸ Thus, practitioners must be prepared to refer women to other appropriate forms of support.

The symptom prevalence patterns found in this study have particular relevance to authorities and are likely to require special measures from officials, such as police, immigration and judiciary. Symptoms such as headaches, dizziness, and fatigue, in combination with pain, discomfort and distress, may have a disabling effect on women's cognitive functioning. For the women with more severe or more numerous symptoms, cognitive

impairment may be significant. It is worth recalling that a large majority of the women in this study reported memory problems. Decreased cognitive capacity can have important implications for women who are forced to draw on their memory and decision-making powers to, for example, participate in police interviews, make decisions about their safety, or engage in other administrative proceedings (e.g., asylum applications) immediately following a trafficking experience.

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. For a significant portion of women, even months after the exploitation had ended, they 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. It is impossible to currently understand how the health of these women would compare to the vast majority of trafficked women who do not receive care.

Although, women's symptoms appear to subside greatly within the first month to six weeks, many women exhibited symptoms that persisted even after several months in care. This suggests that for policy and planning, and particularly budgeting purposes, women should receive ongoing and longer-term care.

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“ 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. ”

This chapter summarises the sexual and reproductive health (SRH) symptoms reported by women in this study. Data on self-reported histories of abortions, miscarriages, condom use and sexually transmitted infections or HIV diagnoses and treatments were collected. Where useful, these findings are put in the context of the sexual and other abuse women experienced before and during trafficking.

When discussing trafficked women's sexual and reproductive health, it is important to recognise it as one of many aspects of the ill-health effects of the trafficking experience.

The adverse sexual and reproductive health outcomes among trafficked women are typically a consequence of sexual violence and coercion.¹ It is worth recalling that nearly the entire study sample (95%) reported being physically forced or coerced into a sexual act while trafficked. The short and long-term consequences of sexual violence are numerous and well documented.²⁻⁴

Table 7.1. presents an overview of the links between sexual abuse and a range of sexual and reproductive health consequences.

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.

Table 7.1. Sexual and reproductive health risks, abuse and consequences of trafficking.¹

Sexual and reproductive health	
Forms of risk and abuse	Potential health consequences
Sexual abuse	Sexual and reproductive health
<ul style="list-style-type: none"> ■ Forced vaginal, oral or anal sex ■ Gang rape ■ Forced degrading sexual acts ■ Forced prostitution, inability to control number or acceptance of clients ■ Forced unprotected sex and sex without lubricants ■ Sexual humiliation, forced nakedness ■ Coerced misuse of oral contraceptives or other contraceptive methods ■ Forced sex during pregnancy ■ Inability to negotiate sexual encounters ■ Refusal of or inability to access clinical services 	<ul style="list-style-type: none"> ■ Sexually transmitted infections (STIs), reproductive tract infections (RTIs) and related complications, including pelvic inflammatory disease (PID), urinary tract infections (UTI), cystitis, cervical cancer, and infertility ■ Unwanted pregnancy, forced abortion, unsafe abortion ■ HIV/AIDS ■ Amenorrhea and dysmenorrhoea ■ Acute or chronic pain during sex; tearing and other damage to vaginal tract ■ Negative outcomes of unsafe abortion, including haemorrhaging, genital and abdominal trauma, perforated uterus, sepsis, secondary infertility ■ Difficulties forming intimate relationships ■ Mental health problems

Sexual violence and sexual and reproductive health

Forced and coerced sex and physical violence are fundamental elements of the trafficking of women for sexual exploitation, and are key factors contributing to sexual and reproductive ill-health among trafficked women.

Research on sexual violence has increasingly recognised the association between sexual violence and STIs.^{1, 5-8} Sexual violence is not only associated with STIs, but other signs of gynaecological complications, including pelvic inflammatory disease, chronic pelvic pain, urinary tract infections, vaginal and anal tearing, bladder infections, excessive or irregular menstrual bleeding, painful intercourse, unwanted pregnancy and dysmenorrhea.^{2, 9-17}

Sexual violence includes vaginal rape, forced anal or oral sex, forced unprotected sex, gang rape, forced sex without lubricants, sex during menstruation, and sex accompanied by violent or degrading rituals.¹⁷ (Table 7.1.)

Women directly related coerced and forced sex to violence and fear of violence:

The two traffickers and their friends raped me. They forced me to give oral sex to traffickers.

Some clients were very violent and abusive. With one, they said he was not so violent, but I didn't believe them. I was so scared and shaking.

For some, the violence continued even after they left the initial trafficking situation.

The next boyfriend, whom I met after trafficking, happened to be a drug user. He always hurt me and forced me to provide sexual services in order to earn money for living.

Forced sex has also been linked to allergies, skin disorders, tension headaches, nausea, irritable bowel syndrome, bladder infections, urinary tract infections, chronic pelvic pain, dysmenorrhoea, sexual dysfunction, depression, pain during intercourse and poor overall individual health.^{10, 17-21}

For those women who have never had sex before, the consequences of forced sex may be significant, both physically and mentally. In this study sample, nearly 8% of the women reported no sexual intercourse experience prior to trafficking.

Other research has suggested that women without prior intercourse experience who have been sexually assaulted are more likely to experience some type of physical genital trauma, although the severity will vary depending on the specific circumstances of the assault.²²

Anal rape was reported by several women in the study. Anal sex is considered a highly risky sexual behaviour due to its association with an increased risk of acquiring STIs, and a high self-reported rate of genital herpes, hepatitis and gonorrhoea.²³

Several women said that they had been forced to have sex "even during menses." Vaginal penetration during menses is associated with a higher self-reported rate of STIs, including chlamydial infection, gonorrhoea, trichomoniasis and HIV.^{8, 17, 23, 24}

Condom use

Among the primary features of sexual violence is a woman's inability or diminished capacity to negotiate safe sex.

Women in this study were asked how often they were able to use condoms during trafficking ("always", "often", "occasionally", "never", and "did not have sex").

I was raped in a brothel by three men in a gang of five.

I could not refuse sex. I was so scared.

One in ten women reported that they were "never" able to use condoms. More than a third (37%) said that they were "always" able to use them. (Figure 7.1.) 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 to negotiate condom use in their non-commercial sexual relationships (e.g., traffickers or boyfriends).

Thirty percent of women said that they only wore condoms "occasionally", several of whom added that this was *when a client wanted it*. One woman who responded "occasionally", clarified that *most of time I was raped*.

While 38% of women said that they "always" wore condoms, based on their comments, it appeared that many had not actually been protected all of the time. Further evidence of this is that 29% of those who reported "always" using a condom, also reported a previous STI diagnosis.

For women who had an intimate partner relationship and responded "always", this answer generally referred to sex with clients and as part of the sex work, but not to the sex they had with their boyfriends.

Women may have made a distinction between work and love by not using condoms with their intimate partners, as a sign of trust and intimacy.

In addition, many women who responded "always" generally excluded the sex that was forced upon them by pimps, owners and traffickers. For example, these women responded "always":

[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.

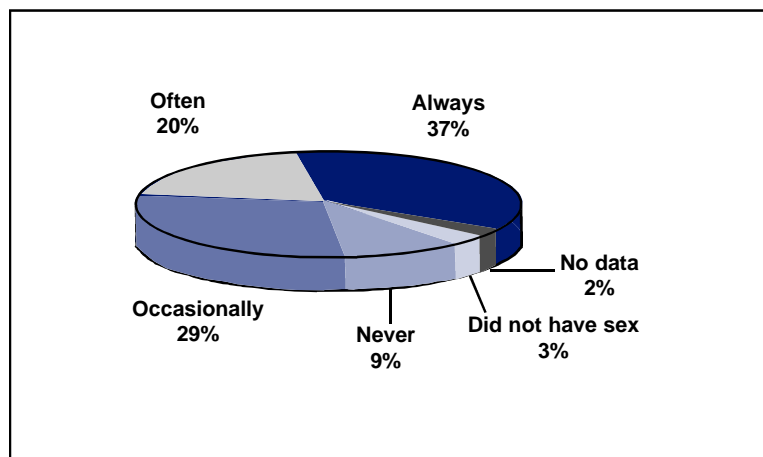


Figure 7.1. Reported condom use frequency during trafficking. (n=207)

Forced or unprotected encounters may be most likely to occur at the early stages of the trafficking process, as previous studies have suggested that women are most vulnerable to infection during the first six months of work when they have the least bargaining power.^{14, 17}

In situations where women were permitted and intended to use condoms for the sex work, women reported that condoms broke regularly, and sometimes they were raped by clients.

Location differences may have been a factor in women's reported use. As one service provider noted, "victims who were assisted in Macedonia were required to buy condoms for themselves". In addition, the previous trafficking study found cases where women were sold condoms at inflated prices by their exploiters and these expenses were added to their debt. One women reported being charged \$10 for each condom.¹⁷

In many places women earn more money for unprotected sex. Among women who were required to earn a certain amount everyday, this increased income may have been an incentive to not insist on condom use, even if they had the negotiation power.

I don't use condoms with my boyfriend, he doesn't want to.

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.

I was almost always able to control using condoms. Two times the customer was drunk and rough and did it without.

With my boyfriend I always [had sex] without [a condom], with clients only if they paid more and insisted.

Sexual and reproductive health care during trafficking

Women's ability to access health care was severely limited while in the trafficking situation. Nearly seven in ten women (67%) said that they did not have a sexual health check during the time they were trafficked. (Figure 7.2.)

Where sexual health care was available to the women, the quality was wide-ranging, from professional visits by state-funded sexual health outreach workers in some locations, to visits by dubious private 'practitioners' commissioned by pimps or club owners in others.¹ In nearly all cases, women were unclear about the specific procedures or tests carried out and diagnoses given during these visits. Like others, this woman explained: *Yes [I had a sexual health check], after which I had a monthly injection, but was never told for what.*

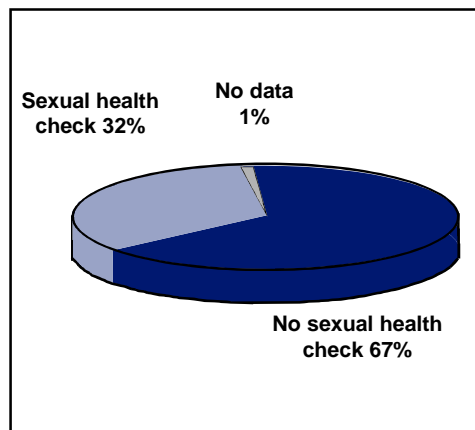


Figure 7.2. Percentage of women who received at least one sexual health check during trafficking. (n=207)

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.

Of the 32% of women who said they received medical attention during the time they were trafficked, most stated that the care was provided no more than once or twice during the trafficking period. Fewer than five women reported receiving a level of care that would be consistent with the type of high-risk work that they were doing (i.e., at least a monthly check). A number of women stated that they had been given a single sexual health check visit prior to starting work.

Several women explained that medical care was provided when they required a termination. In one case, the woman was taken to the doctor for the three times she became pregnant in order to receive an abortion.

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.

Overview of sexual and reproductive health symptom patterns

To explore common symptoms related to sexual and reproductive health functioning (urination pain, pelvic pain, vaginal discharge, vaginal pain, vaginal bleeding [not menstruation], self-reported gynaecological infection), women were asked whether they had experienced six specific symptoms within the last

two weeks, and were then asked to rank the corresponding severity level (Not at all, A little, Quite a bit, Very much). An overall score was then calculated for each woman and the average domain score for each interview is presented in Figure 7.3.*

The average sexual and reproductive health (SRH) domain scores decrease dramatically between Interviews 1 and 2 (mean SRH domain scores: 1.24 vs. 0.28), and the scores between Interviews 2 and 3 (0.28 vs. 0.22) show only a small change.

Interviews with women upon their entry at an assistance centre repeatedly highlighted their initial fears over their sexual and reproductive health. At this point, when women were asked what they would like to see a doctor for, many expressed a deep 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 desired reassurances of their fertility. Women understood that their sexual and reproductive health had been put at great risk, and most had hopes of future relationships, marriage, and children, therefore finding out whether these dreams were still a possibility was of the utmost importance.

By the second interview, for most women, many symptoms had subsided. As noted in the *Physical health* chapter, the average domain score for SRH is initially ranked fourth at the first interview, and fell to ninth by the second and third interviews. (See Table 6.2, Chapter 6: *Physical health*).

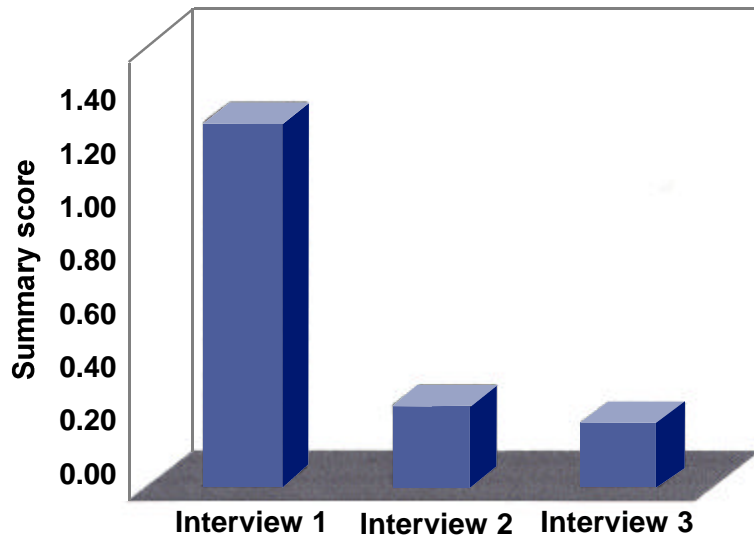


Figure 7.3. Sexual and reproductive health (SRH) average domain scores over three interviews.

This significant reduction in reported symptoms is likely due in part to the rapid attention often given to this aspect of women's health. The efficient diagnosis and treatment of STIs/RTIs may both quickly reduce discomfort and pain associated with infection, and allay women's concerns about their sexual and reproductive health (e.g., HIV, unwanted pregnancy, loss of fertility).

Despite this seemingly rapid improvement, it is important to recognise that this is a relative improvement within this sample population. When comparing trafficked women in this study to a non-trafficked female population, the prevalence of sexual and reproductive ill-health symptoms remains high.^{2, 9} For example, a US-based study of women surveyed in family practice clinics compared the physical health outcomes of women who had ever or never experienced intimate partner violence. Of the women reporting chronic pelvic pain, 17.3% of women reported experiencing intimate

When I asked about my diagnosis, I was told 'everything would be ok with you. No one has died from this work yet'.

I would like to speak with a doctor to see what has happened inside.

* Over the course of three interviews, an overall SRH domain score was calculated for each woman based on the number of questions answered and severity rating provided. An average SRH domain score was then calculated for each period in order to compare changes between periods. (See *Methods* chapter for additional details on scoring)

I would like to see a doctor for all of my problems...but mostly the gynaecological problems. I need to be doubly sure that I'm not pregnant.

I have headaches, tiredness, trouble sleeping, and gynaecological infections.

My dream is to get married, have children, and a normal job, to have a happy family life.

partner violence, while 9.4% of women had not.⁹ This prevalence level is significantly lower than that of our study population, for whom pelvic pain was reported by 59% of the women at the first interview, and by 17% at the third interview—similar to the level detected among survivors of intimate partner violence. Despite the apparent early decrease in reported symptoms, pain levels remain high when compared to a non-trafficked population.

A similar pattern is seen in self-reported sexually transmitted infections. In another study, 30% of women who ever experienced intimate partner violence self-reported a STI, while 10% of women who never experienced intimate partner violence self-reported a STI.² Among trafficked women, gynaecological infection was self-reported by 61% of the women at the first interview. Given the nature of the abuse and exploitation that women experienced, it is not surprising that this prevalence level is double that found in the study on intimate partner violence. By the third interview, most women had received medical treatment, and only 10% of the sample continued to report infection.

In addition to being a sign of infection or injury, gynaecological symptoms may also correspond to distress. In their qualitative responses, women made it clear that they felt that their health needs were not isolated to sexual and reproductive health care. When enumerating their problems, sexual and reproductive health issues were part of a list of other symptoms, for example: *I need medical care for my gynaecological problems and for my emotional state.* This suggests that women are best served by service providers who are able to either provide appropriate gynaecological and other support, such as mental health care or make the necessary referrals.

Fertility concerns

Women's strong focus on their sexual and reproductive health at the first interview not only reflects their concern over current infections and pain, but also represents their thoughts about their future and their ability to have a family. Fertility was a significant concern for the women in this study. Most women, when asked how they envisioned their future, described wanting children, and had a picture of a "normal life" that included children or being pregnant, a home, and in some cases, a male partner. (See Chapter 9: *Mental health: Special issues*). It is useful to recall that a significant percentage of women were still at an age where they might want children.

While the possibility of infertility is real, it is by no means an inevitable outcome for women who have been trafficked. Women stated their fears that having had too many sexual encounters might have reduced their fertility, or were concerned that having used lubricating gels for intercourse may have "blocked their tubes". These fears were compounded by the constellation of gynaecological symptoms that they were experiencing. However, none of these non-specific symptoms are certain indications that a woman will be infertile.

Nonetheless, women's fears are not completely unfounded, as there are a number of conditions that will put women's fertility at risk. Most prominent among these is chlamydia. Chlamydia is often asymptomatic and if left untreated can spread into the uterus or fallopian tubes resulting in infertility, ectopic pregnancy (potentially fatal) and chronic pelvic pain.²⁵⁻²⁷ In addition, women infected with chlamydia are five times more susceptible to HIV infection if exposed.²⁶ For some women, the

lack of rapid medical attention to a problem such as chlamydia may have resulted in permanent damage to her reproductive capacity.

Threats to women's fertility are also suggested by reports of ectopic pregnancies during trafficking. Other research has shown that at least one ectopic pregnancy places a woman at an increased risk for future ectopic pregnancies and infertility, depending upon the extent of the damage caused by the first.²⁸

The potential for trafficked women to experience an ectopic pregnancy may be significant. The symptoms and medical history reported by trafficked women are similar to many of the characteristics of women with a history of ectopic pregnancy, including a history of multiple partners, induced abortions, pelvic inflammatory disease (PID), STIs, and miscarriage.²⁹ STIs and PID are a common complaint of trafficked women, and other research suggests that the likelihood of infertility increases with the number and severity of PID episodes.³⁰

Individual sexual and reproductive health symptoms

Similar to the trends seen within the domain scores, individual sexual and reproductive health symptoms show a sharp decline in their number and severity between Interviews 1 and 2.

For example, pelvic pain is reported by more than half of the women surveyed (59%) at the first interview, with 79% of the women rating these problems in the upper severity levels ('quite a bit' or 'extremely'). The prevalence of reported pelvic pain decreases at Interview 2 (24%), with a corresponding decrease in severity (37%). By the third interview, the number of women reporting pelvic pain is 17%, yet 36% still rank this problem as very painful.

Vaginal discharge was the most commonly reported sexual and reproductive health symptom at the first interview (and among the most commonly reported symptoms 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 bothered and worried by this symptom, in particular.

By Interview 2, the percentage of women reporting vaginal discharge symptoms fell dramatically to 11%, with only 17% of women reporting it in the upper severity levels. (Table 7.2.)

As previously noted, early symptom reduction was likely attributable to the rapid gynaecological care women received, accounting for the changes in women's perception of their sexual and reproductive health.

Table 7.2. Percentage of women reporting sexual and reproductive health symptoms by interview and upper severity level.

Sexual and reproductive health symptoms						
Symptom	Interview 1		Interview 2		Interview 3	
	Yes (%)	Upper severity* (%)	Yes (%)	Upper severity (%)	Yes (%)	Upper severity (%)
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

*Upper severity indicates that women rated the symptom as bothering them "quite a bit" or "extremely/very much", versus "not at all", or "a little". The values represent the proportion of women who reported the presence of any symptom.

I had an ectopic pregnancy while trafficked and I am afraid I will not be able to have children.

Self-reported sexually transmitted infections and reproductive tract infections while trafficked

At the first interview, 44% of the women reported having received a previous STI diagnosis. Among the women reporting an infection, the three most common infections were candidiasis (31%), trichomoniasis (11%) and bacterial vaginosis (10%). (Figure 7.4.)

It was beyond the scope of this study to collect clinical samples to measure the prevalence of STIs/RTIs or HIV among the study sample. However, the prevalence and trends of these symptoms are suggestive of common symptoms that service providers are likely to see among women who have recently left a trafficking situation of forced prostitution.

When interpreting data on self-reported infection in this study, it is worth noting that while self-reported STIs can be a viable data collection method,³¹ the results reported are likely to underestimate the actual prevalence of STIs/RTIs and HIV among this population. Reasons for under-reporting may include an undiagnosed asymptomatic infection (e.g., gonorrhea and chlamydial infection are often asymptomatic),³² misunderstanding of an earlier diagnosis or simply an inability to recall a specific diagnosis made while trafficked.

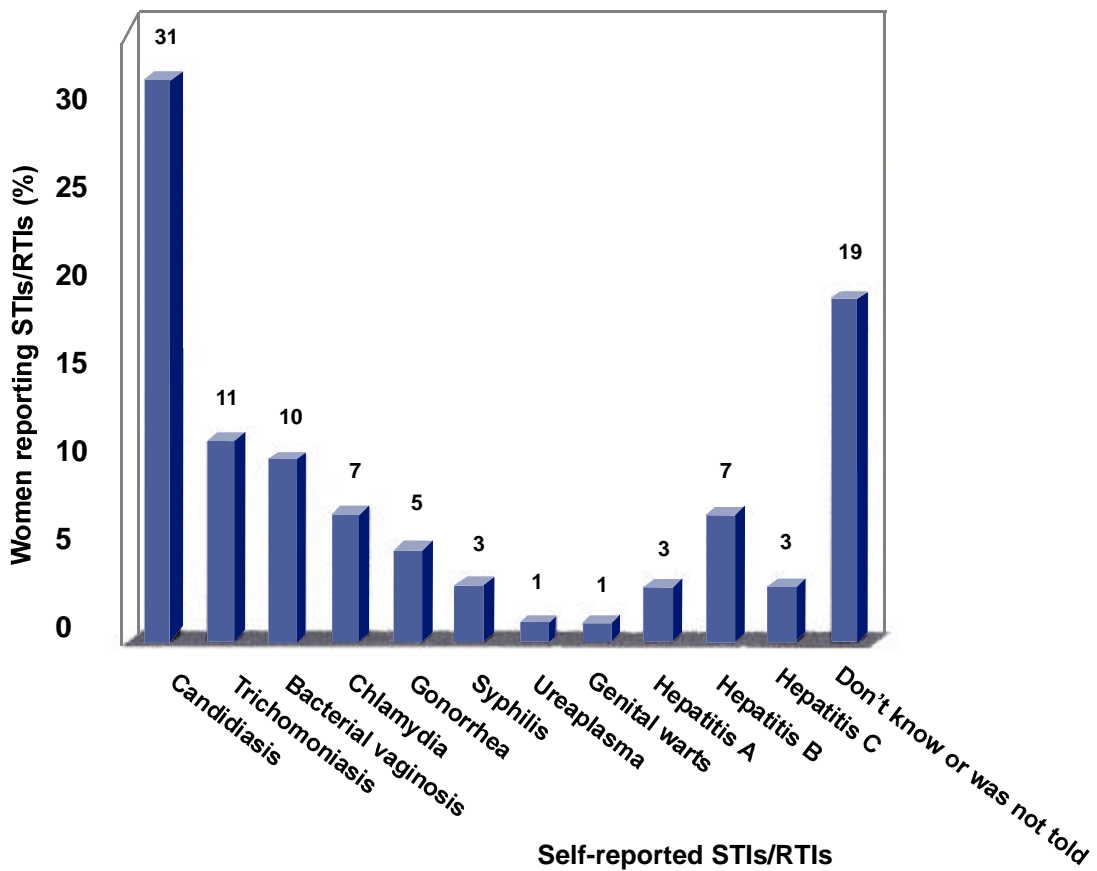


Figure 7.4. Prevalence of reported STIs / RTIs at Interview 1. (n=106)

While laboratory diagnostic testing was unavailable for this study, aggregate laboratory data systematically collected among a larger population of trafficked women by one partner organisation suggests a high STI prevalence among their clients and provides further evidence that STIs/RTIs were likely to have been underreported in this study. Many of the STIs/RTIs reported by the partner organisation correspond to some of the most commonly reported sexual and reproductive ill-health symptoms among the women in this study, including vaginal discharge, pain during urination and pelvic pain. Although non-specific symptoms, these are common symptoms of bacterial vaginosis, trichomoniasis and chlamydia.^{26, 27}

HIV and co-morbidity

Trafficked women are at an increased risk for acquiring HIV through sexual violence, unsafe sex, the presence or history of STIs and behaviours that may facilitate transmission.

HIV was of great concern to many of the women in this study. They were aware that the high-risk sex they were forced to engage in may have led to HIV infection. For some women, this was the issue foremost in their mind.

Women were asked whether they knew their HIV status at the first interview. A positive HIV diagnosis was self-reported by 2% of the women. Questions regarding STIs/RTIs and HIV were only asked at the first interview, therefore the numbers reported likely underestimate the true levels of HIV infection, particularly as HIV testing often occurred following the first interview.

There can be little doubt that a positive diagnosis for HIV can make a woman's attempt to regain her life more arduous, if not impossible. 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 shows 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.

This new and permanent health fact increases and intensifies the difficult emotions that women are already facing.

While in the trafficking situation, women were at an increased risk for HIV infection. Epidemiological studies have shown an association between the presence of STIs and an increased risk of acquiring or transmitting HIV infection.³³⁻³⁵ For example, reproductive tract infections resulting from abnormal flora or severe bacterial vaginosis (BV) have been shown to be associated with an increased risk for HIV acquisition.³⁶ PID and cervicitis [which may be caused by *Chlamydia trachomatis*, *Neisseria gonorrhoea*, *Trichomonas vaginalis*, herpes simplex virus (HSV), or human papillomavirus (HPV), or local trauma or malignancy] are also possible risk factors for HIV acquisition.^{37, 38}

Where the appropriate facilities and confidential and sensitive procedures are available, women benefit from prompt counselling and testing for HIV. Testing is of particular importance during the re-integration process because for HIV infected women, the effects of HIV on the immune system may alter the diagnosis, evaluation, treatment and follow-up of other diseases.³⁸

Among the women interviewed only one HIV infected woman reported a co-infection with TB. Globally, TB is the opportunistic infection occurring

The most life disturbing problems are related to gynaecology– I am tired of vaginal secretions.

I have worrying thoughts about my health. Problem number one: HIV testing.

most frequently among HIV infected individuals.³⁹

Women in this study were asked whether they had ever received a diagnosis for hepatitis. At the first interview, 7% reported a diagnosis of Hepatitis A, B or C. Although no cases of co-infection of HIV and Hepatitis B were identified in this study, co-infection with Hepatitis B (HBV) or Hepatitis C (HCV) with HIV is common and represents a significant cause of mortality and morbidity among HIV infected individuals due to liver damage.⁴⁰ Both HCV and HIV share a common route of transmission (sexually transmitted and injecting drug use), and it is estimated that 70-90% of HIV infected individuals globally are co-infected with HBV.⁴¹

In a previous study on trafficking, it was noted that vaginal douching is a common practice among trafficked women, as women feel a strong desire to cleanse themselves and to feel unsoiled.¹ Unfortunately, rather than lowering women's risk to infection, this practice may enhance HIV transmission by (1) irritating the vaginal mucosa resulting in a proliferation of lymphocytes which are HIV target cells; and (2) dehydrating the vaginal mucosa, resulting in a vaginal epithelium that is vulnerable to local trauma.³⁷ In addition, there is some evidence that douching may increase the risk of Pelvic Inflammatory Disease (PID), as the physical pressure of douching may encourage the ascension of pathogens beyond the vaginal tract.^{8, 23, 30}

One case in particular highlights the range of medical and psychosocial care issues that trafficked women face, especially when they are co-infected with HIV and other STIs. One 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. She explained:

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 counseling. I thought that this was the same infection name. 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...I think constantly of being HIV positive and of my pregnancy and my child.

When asked about her future at the first interview, this woman 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 of what others would think if they knew her HIV infection status.

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.

This woman's story is an important case example illustrating the need for HIV testing, pre and post-test counselling and appropriate referrals to service settings capable of managing the clinical conditions as well as trafficked women's psychological and social challenges.

Induced abortion, pregnancy and miscarriage

Induced abortions are not uncommon for women who are trafficked and sexually abused.^{17, 42} 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. In addition, at the time of the first interview, 7% of women said they were pregnant and 1% did not know.

Women's lack of control over their bodies undoubtedly contributed to the number of unintended pregnancies. Factors such as rape, broken condoms, contraceptive problems or unsafe sex with clients or pimps add significantly to women's risk of unwanted pregnancy.¹

Previous research suggests that women want to access abortion services if they become pregnant in the trafficking setting.¹ Unwanted pregnancies reflect an urgent health issue. Pregnancy may also have been a reason that women were permitted to leave a trafficking situation: *I was released because of pregnancy. I had the abortion done immediately when I returned home.* For women in this study, induced abortion was a common first request among those who recently left the trafficking situation.

Trafficked women share many of the characteristics of women who are most susceptible to undergoing an unsafe abortion—particularly in countries where abortion is illegal,^{1, 43, 44} which highlights the importance of service providers helping the women gain access to safe and professional abortion services. Women who are forced to seek such services on their own may terminate an unintended pregnancy using untrained practitioners in unsafe and unhygienic conditions, thereby increasing their risk for numerous complications. Complications may include sepsis, haemorrhage, genital and abdominal trauma, or a perforated uterus. Secondary complications which can also be fatal include acute renal failure and gas gangrene. Long-term consequences of unsafe abortions can include chronic pelvic pain, pelvic inflammatory disease (PID), tubal occlusion and secondary infertility. Moreover, for women with untreated STIs (which is likely to be the situation for many trafficked women), they are at an increased risk for future infections following an unsafe abortion.^{43, 45} Immediate complications from induced abortions are rare if performed by a trained provider at an early gestational age,⁴⁶ providing further evidence for the recommendation that women be provided swift and confidential access to professional services.

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.

These comments make it clear that women had very little access to appropriate reproductive health services. Reproductive health problems such as these are best addressed in a professional medical setting that directly communicates with each woman in a confidential and sensitive manner.

Implications

Not surprisingly, this study found that immediately after being trafficked and exploited, women presented in service settings with numerous sexual and reproductive health symptoms that caused them significant pain and distress. Moreover, as research on survivors of other forms of violence suggests,^{2, 9} it is likely that for many of the women in this study, their future sexual and reproductive health problems will be greater than for a general female population.

Simultaneously however, the findings also demonstrate that when in a care setting, many of the women experienced a striking reduction in symptoms within the first six weeks. This provides significant evidence of the importance of rapid and professional gynaecological care, with prompt testing and treatment. A programme of services that include clinical examinations, diagnostic testing, syndromic management and presumptive treatment of common STIs/RTIs, will be of immediate benefit to trafficked women.⁴⁷ Efficient care appears not only to alleviate pain and discomfort quickly, but also allays fears about infertility, unintended pregnancies, and prevents further transmission of infections to intimate partners.

For the women in this study who were not among the lucky ones for whom the majority of their symptoms dissipated—such as those who tested positive for HIV—it is of the utmost importance that service providers are prepared to treat infections and to

I got pregnant in trafficking and had one abortion.

I want to see the gynaecologist because first of all, I have to have an abortion.

The problem that bothers me most is the vaginal discharge. I think this was caused by being forced to have sex. I had never had sex before.

provide the psychological support women require before, during and after diagnoses. Again, this highlights that sexual and reproductive health is an integral part of overall health, rather than an independent medical concern.

A comprehensive care package is not only necessary, but is also clinically 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.⁴⁸⁻⁵²

While the women participating in this study each received some level of post-trafficking care, the global reality is quite different. The vast majority of women who are trafficked do not receive care after being sexually exploited. For these women, untreated infections are likely to cause serious and long-term problems. Syphilis, gonorrhoea, HPV, Hepatitis B, and chlamydia are examples of often mild or asymptomatic infections that may not be recognized by the patient, and may be missed by the provider.⁵³ Infertility and other resulting complications, including cervical cancer may be unalterable personal legacies of their nightmare.

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“ My wounds are inside. They are not visible. ”

“ My inner world has changed. The things around me have a different colour; everything seems to be dark grey. ”

In the aftermath of a trafficking experience, a woman's psychological difficulties are perhaps among the most intransigent and painful health problems. The physical and psychological control tactics used by traffickers, combined with the physical and sexual abuses that are perpetrated leave a deep and enduring imprint. Table 8.1. offers a summary of the types of psychological risks and abuse that trafficked women may experience, and a range of the potential mental health consequences.

A primary aim of this study was to better understand women's psychological reactions following a trafficking experience, and how their symptoms might change over time.

The research explored several trauma-related reactions, including symptoms associated with post-traumatic stress disorder, depression, anxiety and hostility. These psychological responses have been identified frequently in individuals who have experienced one or more traumatic events.¹⁻⁴ This chapter presents data collected using two validated psychological scales. No structured clinical interviews were performed for this study, and thus the extent to which self-reported symptoms would match a clinical diagnosis is unclear.

I wish to forget, but this is impossible. These memories will stay for the rest of my life.

Table 8.1. Mental health risks, abuse and consequences.

Mental health	
Forms of risk and abuse	Potential health consequences
Psychological Abuse	Mental Health
<ul style="list-style-type: none"> ■ Intimidation of and threats to woman and her loved ones ■ Lies, deception and blackmail to coerce women, to discourage women from seeking help from authorities or others, lies about authorities, local situation, legal status, family members ■ Emotional manipulation by boyfriend-perpetrator, or other exploiters ■ Unpredictable and uncontrollable events and environment ■ Forced subordination and disempowerment ■ Isolation and alienation ■ Mental defeat ■ Restrictions on movement, time, and activities, confinement, surveillance, and manipulative scheduling in order to restrict contact with or support from others 	<ul style="list-style-type: none"> ■ Suicidal thoughts, self-harm, suicide ■ Depression, frequent crying, withdrawal ■ Chronic anxiety ■ Sleep disturbances, frequent nightmares, chronic fatigue ■ Post-traumatic stress disorder symptoms ■ Acute stress disorder ■ Hostility, irritability, outbursts, aggression ■ Memory problems, dissociation, peri-traumatic dissociation ■ Decreased cognitive functioning ■ Somatic complaints (e.g., chronic headaches, stomach pain, trembling, heart palpitations) ■ Immune suppression ■ Substance misuse, addiction ■ Loss of trust in others or self ■ Identity and self-esteem problems, stigma, guilt, shame ■ Difficulty developing and maintaining intimate relationships

Before reviewing the data, it is useful to consider the psychological theory that explains how a number of these reactions may have developed.

In *Trauma and Recovery*, Judith Herman offers a uniquely appropriate description of psychological trauma and the effects of 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.⁵ (p.33)

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".⁶ As traffickers made women believe that they were in imminent danger, women existed in a heightened state of alert, recognising the limits to their ability to protect themselves. In response to this type of lethal danger, the normal human reaction triggers integrated physical and psychological responses that prepare the individual to either flee the situation or to defend herself from imminent danger.⁷ When the threat is chronic, individuals are often unable to "turn off" their "basic biological and safety alarm mechanisms"⁷, and remain constantly prepared to defend themselves against life-threatening events.⁸ (See Chapter 6: *Physical health*)

Some experts 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.⁷ Moreover, research on post-trauma psychiatric morbidity is increasingly demonstrating that trauma exposure may precipitate symptoms such as depression, anxiety, hostility and post-traumatic stress disorder (PTSD).^{2, 3, 9}

In contrast to discussions of clinical diagnoses, many of those working with survivors of trafficking frequently explain that the symptoms manifested by many trafficking survivors may best be described as normal reactions to extremely abnormal circumstances.¹⁰

Post-traumatic stress disorder

The diagnosis of post-traumatic stress disorder (PTSD) (from the Diagnostic and Statistical Manual of Mental Disorders (DSM IV)¹¹ has been repeatedly applied in discussions of the mental health outcomes of trafficked women. A concise definition of PTSD is offered by the United States National Institutes of Health (NIH):

... 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.¹²

PTSD is mental health disorder 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.² The three symptom groups that define the PTSD syndrome include: (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. It is important to recognise however, that PTSD has been questioned by numerous experts in the field of mental health for cultural, clinical, and contextual reasons.^{13, 14}

While PTSD is frequently mentioned in discussions on post-trafficking psychology, 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. Major depression or anxiety disorders may be an equally or more common reaction to trauma.¹⁵

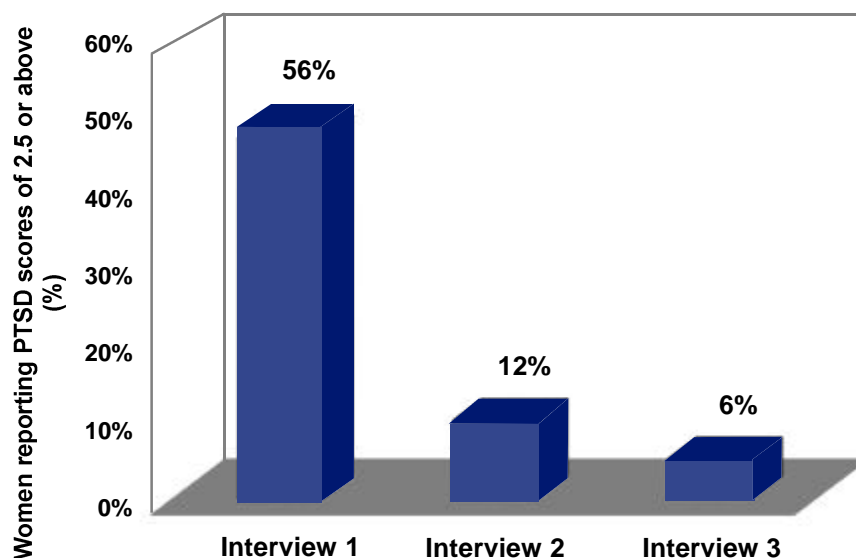
Research suggests previous exposure to trauma may influence the emergence and the severity of the symptoms of PTSD including, childhood trauma.^{2, 12, 16, 17} In addition, the type of violence appears to affect chronic PTSD. Writing on the development of PTSD, Yehuda, et. al., explain:

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.¹⁵ (p.1305)

The effect of past trauma is of particular importance when considering that 60% of the women in this study reported experiencing physical or sexual violence prior to being trafficked. (See Chapter 4: *Violence before trafficking*) Not only do external factors play a role in the emergence of PTSD, but biological factors or changes in the way the body reacts to stressors have also been significantly correlated with PTSD.^{9, 15} Moreover, gender differences have been identified in the prevalence of PTSD. 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%).²

The cognitive, emotional and social consequences of PTSD are multiple. 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.¹⁸



It's not so much that I don't feel emotions, but I feel inappropriate emotions. I would feel like crying and tears would flow but I would be inappropriately smiling.

Figure 8.1. Percentage of women reporting symptom levels suggestive of PTSD at each interview.

Summary trend of PTSD symptoms over three interviews

At the first interview, 56% of women entering post-trafficking services showed symptom levels suggestive of PTSD.* (Figure 8.1.) This symptom level compares with levels found among survivors of war-time trauma,²⁰ and near levels identified in torture victims.²¹ The percentage of women showing these symptom levels decreased at each interview interval. The greatest reduction took place between the first (56%) and second (12%) interviews, with a smaller decline occurring between the second and the third (6%).

At the first interview, symptom severity was extreme for many women. For example, five women ranked each and every symptom at its highest severity level.

It is worthwhile to note an alternative diagnosis linked to PTSD: Acute Stress Disorder, which is a response to trauma that has many of the same symptoms as PTSD, but are of shorter duration.²²⁺ While this psychological effect was not explored in this study, it is possible that for a number of women, their initial symptoms were associated with acute stress disorder—which also has predictive value for PTSD.

By the second and third interviews, 12% and 6% of the women, respectively, scored above the cut-off,⁺⁺ or had symptom levels of PTSD. This decline in post-trauma symptom levels is hopeful, but 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.²³⁻²⁵ Moreover, women who have been exposed to trauma, even without showing PTSD symptom levels, may be at high risk of developing major depression, anxiety disorders, and substance abuse disorders.²

Unfortunately for women who are in the process of re-establishing their lives, stressful events are often 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. 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.

Symptoms suggestive of PTSD

Table 8.2. 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. Although this symptom-by-symptom perspective is not a standard way of reviewing the HTQ results, we believe it offers a valuable, in-depth way to consider women's reactions. A discussion on each of the symptom dimensions of the HTQ is provided, which is highlighted by women's qualitative comments.

Re-experiencing traumatic events

Recurrent thoughts or memories and sudden emotional or physical reactions

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 can smell his deodorant in the room.

* 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 be present after one month following the traumatic event. Because 89% 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.

+ 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 reexperiencing, avoidance, and hyperarousal. (American Psychiatric Association, 1994 Diagnostic and statistical manual of mental disorders. DSM IV. Fourth Edition. Washington D.C.: American Psychiatric Association).

++ Most second interviews took place one month or more after the first interview.

Table 8.2. Percentage of women who ranked individual symptoms of the Harvard Trauma Questionnaire (HTQ) as "quite a bit" or "extremely" severe.

Symptoms in the post-traumatic symptom scale of HTQ	Percentage of women who ranked symptom in upper severity level		
	Interview 1 %	Interview 2 %	Interview 3 %
Recurrent thoughts / memories of terrifying events	75	35	16
Feeling as though event is happening again	52	18	8
Recurrent nightmares	54	16	13
Feeling detached / withdrawn	60	26	14
Unable to feel emotions	44	10	2
Jumpy, easily startled	67	20	16
Difficulty concentrating	52	15	8
Trouble sleeping	67	35	24
Feeling on guard	64	20	6
Feeling irritable, have outbursts of anger	53	19	16
Avoiding activities that remind of traumatic or hurtful event	61	11	13
Inability to remember part of most traumatic or hurtful events	36	6	3
Less interest in daily activities	46	10	6
Feeling as if you don't have a future	65	36	10
Avoiding thoughts or feelings associated with the traumatic events	58	17	23
Sudden emotional or physical reaction when reminded of the most hurtful or traumatic events	65	16	14

High 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.

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 [those thoughts] 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. Some women had begun to change psychologically, and for them, putting memories behind them was more likely than re-experiencing them:

The worst memories are gone. I am emotionally healthy.

...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.

It comes every time when I close my eyes... Always in dreams I see that I am still taken to clients.

Sometimes when I am washing up, I feel like someone is standing behind me.

Recurrent nightmares

Sleep difficulties are a common post-trafficking problem, nightmares in particular. 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, for others, it was less defined:

I have nightmares nearly every night. I dream about my father or like I'm being pulled down in a whirlpool.

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.

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%). 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.

Necessary to understanding and caring for trafficked women is recognising the reality that many women have genuine reasons for feeling ill-at-ease, for perceiving that they are in danger from traffickers or others. (See *Anxiety*)

Valid fears and anxiousness may be compounded by hyper-arousal symptoms that are typically associated with the aftermath of trauma. It is notable that feeling "jumpy" was among the most reported symptoms 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", and "I am waking-up all the time and having trouble falling asleep". One explained that she frequently "wakes up crying".

Sleep disturbance is associated with the after-effects of trauma, such as rape,²⁶ and has also been linked to depression and potential suicidality in rape victims with PTSD.^{27, 28}

Moreover, having sustained such high levels of abuse, injury and illness, it is also likely that women's physical pains, such as headaches, backaches or abdominal pain, also contribute to sleep problems.

A high proportion of women in this study were prescribed sedatives, and the positive effects of medication on their sleep was recognised and appreciated by the women during the interviews.

Serious "difficulty 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, watch television, and they 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.

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.²⁹

The "future" was a subject towards which women felt empty or trepidation. The symptom, "feeling as if you don't have a future" was among the most highly ranked symptoms throughout the interview periods (65%, 36%, 10%), ranking first at the second interview. (See Chapter 9: *Mental health: Special issues*)

After having resolved their most basic and pressing needs (i.e., during the crisis intervention stage), it is not surprising that after approximately one month in care, women would then have more mental space to begin worrying about the longer term future. Confronted with their future, 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 they left—and many had few safe places to go. For these women, positive hopes for the future were inconceivable:

I have only negative thoughts. All future life scenarios are so bad.

I can't even imagine how [the future] should be.

For some women, their thoughts of the future were more existential. They 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 considering 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.

When the research partners gathered for the data analysis stage of the study, the psychologists and support workers attempted to describe this paralysis. Psychologists from the Czech Republic and Bulgaria explained that:

For some period, women can't think past where they are at that moment...it is difficult for them to look to tomorrow. It's like a hole. This reflects depression and a condition of lacking internal resources.^{30, 31}

The psychologist from Italy noted that "feeling as if you don't have a future may also reflect a realistic comprehension of one's state as a social outcast."³²

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:

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.

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.

I don't know how to live in this life. What I am supposed to do or how to survive.

I strive for the future and force myself into planning it.

To avoid giving trust I have learned to be hard and to distance myself.

It is not uncommon for individuals who have been trapped in slavery-like circumstances to feel unable to reclaim the process of making decisions, and to have the confidence to take them.³³

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 perception of the future is discussed further in Chapter 9: *Mental health: Special issues.*

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 past:

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.

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". By the second interview, 10% of women still reported being unable to feel emotions. Emotional numbing is likely to have been a psychological defence strategy to protect against highly emotive events that occurred on a daily, sometimes hourly basis while they were exploited.

Memory issues are a component of the "avoidance and numbing" dimension and, as previously discussed, are an area of great significance. 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, 3% of women said they had problems recalling these events.

As previously noted in Chapter 6: *Physical health*, reactions such as peri-traumatic dissociation can contribute to memory loss or unclear or distorted recollections, which can in turn cause other practical problems (e.g., asylum claim, access to social benefits) that might depend on women's credibility with authorities. 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.³⁴

Also of relevance to our study population are findings from a study of sexual assault survivors which 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.

Memory difficulties appear to be a common component of a portrait of a trafficking survivor.

Implications of post-traumatic stress symptoms

The data show that the prevalence of scores suggestive of post-traumatic stress disorder (PTSD) diminished over the period of time women were in care. While further statistical analysis is required to fully understand the meaning of this decrease, these findings indicate that PTSD is not an inevitable diagnosis for all women who have been trafficked, but that a significant portion are likely to show symptoms suggestive of PTSD.

Moreover, the reduction in symptom levels demonstrated here do not by any means indicate that women who scored above the cut-off for PTSD at the first interview, but whose scores decreased at the second or third interview will be free of PTSD or other post-trauma symptoms in the future. As women encounter future traumatic or stress-inducing events, having experienced such chronic and severe trauma, and having manifested such strong post trauma symptoms (either in the form of PTSD or Acute Stress Disorder), they may in fact, be more vulnerable to more severe psychological responses or PTSD later.

Depression, anxiety and hostility symptoms

Depression, anxiety and hostility were symptom domains of key interest in this study, and were investigated using three subscales of the Brief Symptom Inventory. As outlined in the *Methods* section of this report, the Brief Symptom Inventory (BSI) was developed as a short screening tool for the assessment of psychological distress.³⁵ Similar to the other sections of the questionnaire, for this portion of the mental health inquiry, women were read a set of symptoms and were asked to rank the severity of each symptom (0 to 4). Women were then given an average score that indicated the positive association for that psychological domain. The symptoms that were measured were described as follows in the BSI manual:³⁶

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.

Even if I try hard, I may never remember it, probably, because the memory is lost.

The following section presents the symptom domain scores for depression, anxiety and hostility, and describes individual symptoms that comprise these domains. In addition, to gain a broader understanding of the implications of women's psychological state, trafficked women's symptom levels are compared to those of an average US female population. This comparison provides a relative perspective of the psychological status of women who are attempting to re-gain their lives and to re-enter mainstream social interactions.

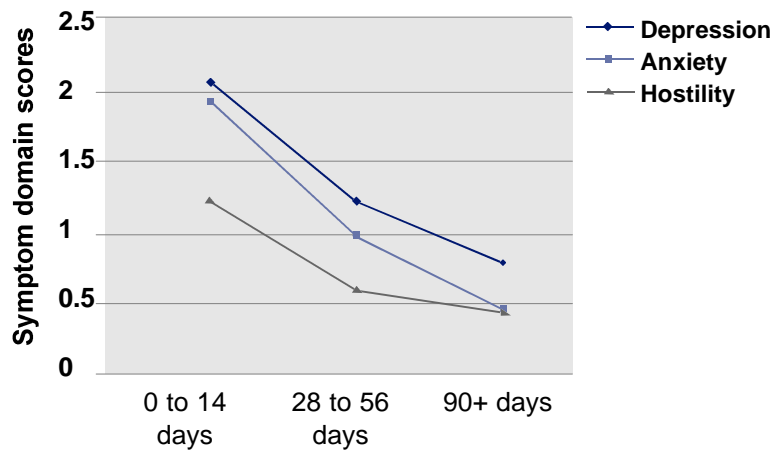


Figure 8.2. Average depression, anxiety and hostility scores for all women over three interviews.

Overview of BSI subscale scores

Figure 8.2. presents 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 worksheet³⁶). 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.

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 are likely to closely reflect women's actual feelings.

Comparing trafficked women's symptoms to a general adult female population

While Figure 8.2. provides a promising view of women's recovery, a less hopeful picture emerges when women's symptom levels are compared to published norms for a general female population (non-psychiatric patients). (Figure 8.3.)

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*. Using these norms, it is possible to achieve an important perspective on trafficked women's psychological health. (Figure 8.3.)

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 interview, women's depression, anxiety and hostility levels were all within the top tenth percentile of a general population (98th, 97th, 95th percentile), i.e., comparable to the 10% of women in a general population with the most severe symptoms of depression, anxiety and hostility.

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 particularly high compared to a general female population.

This comparative perspective is informative in several ways. First and foremost, this comparison highlights that when women emerge from a trafficking situation their mental health is comparable to some of the most distressed women in a general population. Moreover, it indicates that these symptoms are not likely to subside until after at least three months in care. From this perspective, it becomes clear just how poorly prepared women are psychologically 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 re-establishing a "normal life" was the most commonly stated desire, this goal may prove elusive for many women, particularly for those who are not provided support that is of an appropriate duration.

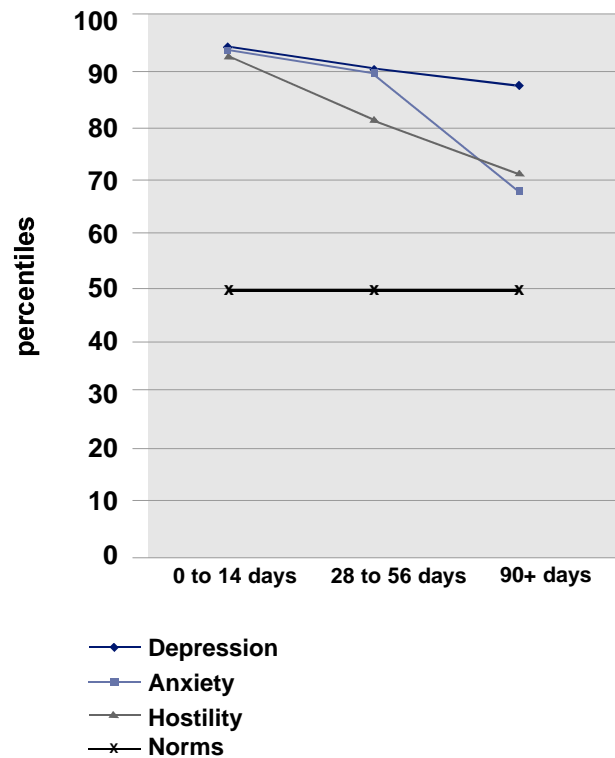


Figure 8.3. Depression, anxiety, and hostility levels compared with these symptom levels for an average female population.

Second, this overview emphasises the severity and duration of depression symptoms. In contrast to the changes over time seen for anxiety and hostility, importantly, depression levels do not seem to adhere to this pattern. The mean depression level for the women in this study remained within the upper 80th percentile of women in an average population even after several months with professional assistance. This finding on depression will not be surprising to those providing longer-term support to women who have been trafficked. 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.³⁷ 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.³⁸

* 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 scores for other female populations from Eastern or Central Europe.

Again, this indicates the importance of ongoing support, both from formal (i.e., professionally trained) and informal resources (e.g., family, friends). 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.

Third, this comparison shows that anxiety is a symptom that can dissipate significantly in a service setting. While it is not clear whether this is a causal relationship (i.e., care = reduced anxiety), it can be easily speculated that women's sense of security under the care of professional service organisations contributed significantly to this decrease. 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.

Fourth, this comparison shows that hostility symptoms may decrease along with anxiety, but even after several months in care, one might expect survivors of trafficking to display levels of anger that are in the top 30th percentile of an average female population. For service provision, this implies that anger management techniques might prove helpful to women trying to move beyond a trafficking situation.

To better comprehend the meaning of these symptom dimensions, the individual indicators within each dimension, "depression", "anxiety" and "hostility", are discussed below.

Individual symptom dimensions: Depression, anxiety, hostility

Below is a description of each of the BSI symptom dimensions asked about in this study. While this is not a traditional manner for presenting symptoms detected using the BSI, it was believed that the reported prevalence levels for individual symptoms, along with women's comments provide important and deeper insights into women's psychology after a trafficking experience.

Depression

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 individual's ability to take care of his or her everyday responsibilities. At its worst, depression can lead to suicide...³⁹

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.³⁸ 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.^{4, 16, 28, 38, 40}

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.⁴¹

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.^{2, 4} Some experts have even warned that with the emergence of PTSD as a diagnosis, symptoms indicating major depression may be lost within this diagnosis.^{4, 42}

Table 8.3. Reported prevalence and high severity levels of depression symptoms for three interviews.

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 indicates that women rated the symptom as bothering them "quite a bit" or "extremely/very much", versus "not at all", or "a little". The values represent the proportion of women who reported the presence of any symptom.

Table 8.3. contributes to this picture, detailing the six specific indicators in the depression symptom domain, most of which 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).

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.

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.

As noted in Chapter 6: *Physical health*, women also linked "thinking too much" to their headaches, as well as several other physical symptoms.

Loneliness was a highly prevalent emotion that many women associated with being away from their family. The following were sentiments uttered by numerous women:

I miss my family. I feel so alone.

and,

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.

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 feeling is feeling far away from my mother. Above all, now that I'm not well, I wish that she were here.

I have lost my last hope—I feel I have no way out.

I would like to finish my education and work as a psychologist and have my own place to live.

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.

Presence of others, even boyfriends, was not necessarily balm 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.

In fact, 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, longing for boyfriend-clients who had facilitated their escape, but whom they had left behind.

While many women spoke of the practical 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.*

Studies suggest that coping in the aftermath of violence may depend significantly, inter alia, on the quality of women's support networks.⁴³⁻⁴⁵ As such, for women expressing this feeling of absolute isolation, overcoming depression is likely to be a very long and difficult process.

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".

"Hopelessness" and the inability to control events in the future hold a significant place in the literature on gender-based violence and depression. Some experts have posited a "hopelessness theory of depression". The 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".^{46, 47}

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.⁴⁸ 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. In the previous study, one

Romanian woman concisely explained:

*I felt like I was only a piece of meat with two eyes. I thought I will end up like nothing.*⁴⁸ (p.63)

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 their perceptions of themselves had changed; that 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. In contrast, numerous women also described feeling as if they had gained maturity, independence and strength. Identity, stigma and maturity 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 or social relationships is an area that would benefit from further investigation to learn what type of support most effectively contributes to positive change.

Suicide

Suicide is among the most extreme expressions of depression. Suicide was, and continued to be 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, 38% of women stated that within the past week they had these thoughts. (Figure 8.4) Sixteen percent ranked these feelings in the upper end of the severity scale ("quite a bit" or "extremely").

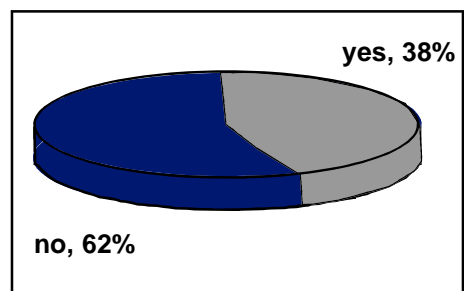


Figure 8.4. Percentage of women reporting suicidal thoughts at Interview 1. (n=203)

By the second and third interviews, suicidal ideation remained a consideration for 9% and 6%, respectively.

Suicide reporting levels 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 have a feeling of disquiet, like something bad is going to happen.

The strongest feeling is that of wanting to die. I feel tired of fighting and I feel alone.

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.

I am afraid that the traffickers will come after me. Because I prosecuted them, I am afraid of revenge.

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.

Many 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.

Some experts have termed this sense of overwhelming futility, "mental exhaustion".³ Researchers working with torture survivors have described the way that individuals internalise a sense of helplessness, which ultimately undermines their self-efficacy, and their belief in their ability to cope or to strategise for positive outcomes.

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 succeeded in killing herself.

Women who are showing signs of both PTSD and depression should be

of special concern to service providers. 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.⁴²

Suicidal ideation is a subject that requires further analysis to better understand the characteristics of those women still reporting suicidal thoughts after 12 weeks in care.

Anxiety

Anxiety is a 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. This is particularly true of women who have had contact with authorities, who are participating in a criminal prosecution, those who are returning to the place from which they were trafficked, and for those who still "owe" sums of money to their traffickers. It is necessary 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 someone known to a family member 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, protection by authorities has been extremely limited.⁴⁹ It is therefore crucial to recognise that manifestations of fear and anxiety very often represent women's 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'm 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.

Although most trafficked women may not necessarily reach anxiety levels that are of the magnitude of a disorder, some may. Extreme forms of anxiety generally fall under the label "anxiety disorders", which includes "post-traumatic stress disorder". Anxiety disorders are "chronic, relentless, and can grow progressively worse if not treated".⁵⁰ Anxiety can be triggered by an event, sign or sensory observation that reminds the person of past trauma. Symptoms of anxiety include nightmares and sleep problems, restlessness, nervousness, being easily startled, and having persistent frightening thoughts. Some sufferers experience panic reactions, such as heart palpitations sweating, dizziness, or faintness. It is not uncommon for anxiety disorders to co-exist with other disorders, such as depression.⁵¹

I am thinking about where I will go. My mother is in Italy and my father is very aggressive. He even tried to rape me.

After the interview with police I was really nervous. I wasn't quite panicking, but I felt very insecure.

Table 8.4. Reported prevalence and high severity levels of anxiety symptoms for three interviews.

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 indicates that women rated the symptom as bothering them "quite a bit" or "extremely/very much", versus "not at all", or "a little". The values represent the proportion of women who reported the presence of any symptom.

Much has changed inside, I'm scared, something has snapped inside.

I "explode" at everything and at everybody. I hit my daughter.

The worst part is that I cannot do anything back to that person.

Table 8.4. 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".

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 events associated with trials or testimonies as having caused deep 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.

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 explained 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.

It was beyond the scope of this study to investigate how women's psychological status impacted children, however this appears to be an area that would benefit from further attention.

Hostility

Symptoms of hostility have been linked to PTSD, and are aspects of post-trauma symptomatology that have been studied primarily in Vietnam War veterans.^{52, 53} 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.⁴³ Research has also connected a history of childhood violence with hostility.⁴²

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).⁵⁴

Table 8.5. Reported prevalence and high severity levels of hostility symptoms for three interviews.

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 indicates that women rated the symptom as bothering them "quite a bit" or "extremely/very much", versus "not at all", or "a little". The values represent the proportion of women who reported the presence of any symptom.

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 8.5) 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.

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.

Support workers at shelters also noted the problems associated with tension and hostility that frequently erupts 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".

Research on forgiveness, hostility and PTSD suggests that forgiveness has a "mediating effect" on hostility-related PTSD among survivors of childhood sexual abuse.⁵⁴

...there were moments when I was throwing the food from the table and breaking different things.

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.⁵⁴ (p.415)

The focus of the forgiveness was of primary 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.⁴²

Implications

However women's psychological reactions are labelled, 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 long been known to support workers in post-trafficking centres.

The information in this chapter shows that there is an extraordinarily high prevalence of psychological morbidity when women first enter a support organization. The constellation of symptoms identified among the women in this study strongly indicate that at this point in time, they are deeply in need of professional psychological assistance and the practical support services that assure the safety required by trafficking survivors. For example, it is possible that the decrease in symptoms associated with anxiety are partly attributable to the security measures offered by the NGOs assisting the women in this study.

In addition, using the broadest lens and comparing trafficked women's symptom levels to those of a general female population, it appears that women who are trafficked are plagued by symptom levels that are comparable to some of the most distressed members of society—even after four months of care.

As such, these symptoms may 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 psychological symptom patterns observed also indicate that women's cognitive functioning may be negatively affected.⁵⁵ Cognitive impairment has serious implications for women's health, as well as 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, i.e., to return home or seek asylum. In particular, as discussed in Chapter 6: *Physical health*, the prevalence of memory problems at this time may affect women's credibility with authorities. While women may be haunted by memories of their past in their waking moments and their nightmares, this does not mean that they are immediately able to provide clear details of events.³⁴ If women are not given sufficient time for the worst symptoms to wane, cognitive distortions or memory lapses may 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 symptoms that are most likely to affect their cognitive functioning. 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 three months.

The chapter has attempted to outline mental health trends, but not to categorise all women, as 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 the data are able to offer is information upon which service providers may

* Approximate number of days from women's entry into a service setting, based on the time span over which Interview 3 was conducted with women remaining in the study.

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 pursue their desire to carry on a 'normal life' will depend on their access to appropriate mental health support that enables them to cope with the psychological aftermath.

Policy makers should put into place measures that help women manage their individual psychological symptoms, and implement policing and immigration laws and procedures that account for and accommodate the changes in trafficked women's emotional and cognitive capacity.

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**“ I feel guilty. I blame myself
that I was not able to foresee
this tragedy. ”**

**“ I always feel a ‘sediment’ or
‘dirt’ inside of me. ”**

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 included: (1) loss of trust; (2) self-condemnation, guilt and feelings of worthlessness; (3) self-disgust, shame and stigma; (4) maturity, self-reliance and empowerment. This chapter also describes women's hopes for and worries about the future, and their thoughts about remaining in a destination location and returning home.

Identity and self-perception

Among the most revealing expressions of women's state of mind after the trafficking experience were those that emerged in response to the question: "Do you think that being trafficked has changed the way you feel about yourself?"

For the majority of women in this study, the experience of having been deceived, marketed and sold, having endured work they found degrading, and having lost control over who did what to their bodies, had altered their perception of themselves.

At each interview, more than half the women in the study felt that trafficking had changed the way they felt about themselves. (Table 9.1.) Upon entering the care of the service organisation, 63% of the women said that trafficking had changed their self-impression. The prevalence of this feeling did not alter significantly over time, as 52% and 55% at the second and third interviews reported having a different perception of themselves.

Identity is a subject of great significance for women who have been trafficked. In the previous study on trafficking and health, this problem for women returning home was summarised as follows:

While a returnee's experience has altered her in many and often invisible ways, she re-enters a family and community context that has not changed with her. In the eyes of her family, she may be perceived as essentially the same wife, daughter or mother as before. For the woman however, she has undergone life-defining events that may never be understood by those around her.¹ (p.84)

This experience will remain an eternal burden.

I was tricked once and will never trust anyone again.

I went to Turkey because somebody promised me a good job, but I was tricked and sold. I was too trusting.

Table 9.1. Percentage of women reporting that trafficking changed how they felt about themselves.

	Interview 1	Interview 2	Interview 3
Has being trafficked changed the way you feel about yourself?	% (n=196)	% (n=155)	% (n=55)
Yes	63%	52%	55%
No	37%	48%	45%

I hate myself that I allowed this to happen to me.

I consider myself a person unable to achieve anything. Everything I start gets ruined.

As will be discussed below, women had many altered self-perceptions that caused them to feel that they could not easily slip back into their former roles, and many believed that even if they were to try, others' views of them might prevent it.

Post-trauma identity problems have been discussed in the literature on political prisoners.² Studies with survivors of rape also offer insights into the effects of trauma, identity and psychological outcomes. One study suggests that women whose memories of the traumatic event 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.³ They were also less likely to respond well to common forms of treatment for PTSD (e.g., exposure treatment).

For some of the women in this study, the negative changes they felt were complete and overwhelming—particularly at the first interview. For some, positive and negative self-impressions coincided. Often these different impressions related to the time that had lapsed.

Loss of trust

Profound mistrust was a common 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 lose all faith in their fellow human beings. A significant portion of the women in each country repeated similar refrains:

I don't trust people anymore.

I have become less communicative, less trustful, more isolated.

I do not believe in anyone and I am afraid of everyone.

(A woman who was trafficked twice)

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:

At the beginning I thought that my fiancé didn't know anything. Then I found out that I had been sold by "my husband."

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.

Women recognised that this loss of faith in others had changed the way they now related to people:

To avoid trusting, I have learned to be hard and to distance myself.

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.

Self-condemnation, guilt and feelings of worthlessness

Women's repeated phrases of self-condemnation supports service providers' contentions that they frequently blame themselves for what happened. Women often perceive that they were liable for their fate from beginning to end: they were responsible for having fallen prey to a dubious offer; they were at fault for having 'agreed' to do work that was odious to them, and were 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.⁴ 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. 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.*

Studies on post-trauma coping suggest that emotions such as self-blame are likely to impede recovery, whereas 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.⁵ 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.⁶ (p.993)

For a number of women this was not their first sense of 'defeat'. As previously discussed, many women came from difficult backgrounds of abuse, neglect or family dysfunction that had previously damaged their confidence and self-esteem.

Feelings of worthlessness accompanied and exacerbated women's sense of shame and guilt—and vice versa. It is worth recalling that at the first interview, nearly eight in ten women reported feeling a sense of "worthlessness" (78%), and that these feelings remained prevalent even by the third interview (52%). (See Chapter 8: *Mental health*)

Defeatism, often associated with feelings of worthlessness, has been proposed as a predictable consequence of abuse. According to researchers on psychological coping:

...repeated 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.⁷ (p. 232)

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.

Maybe some people could call me 'dirty whore', but for others I might be a girl who can give them good advice.

I am bad and dirty.

I feel that everybody knows about my experience, I feel ashamed and I hate myself.

Social care professionals and psychologists explain that an initial focus of their work with women who have been trafficked is to assure the women that what happened to them is not their fault, that they are victims of, rather than responsible for, the deceptive and cruel behaviour of others. Support workers contend that additional psychological and social support work, such as building women's confidence and self-esteem or helping them plan for their future, is most effective once women are relieved of the burden of self-blame.

Shame, self-disgust and stigma

Women's sense of culpability was compounded by their shame and self-disgust. Women repeatedly stated that what they had done while they were trafficked had deeply and irreparably tainted them. They were repulsed by what had taken place, felt contaminated, and believed that this contamination was visible to others. The term "dirty" was uttered numerous times by women from various countries. The following comment is emblematic of numerous women's feelings of disgust*:

You always remember what has happened to you, you are not clean like you were before.

Research experts on shame and stigma suggest that how a person perceives the reasons that the abuse occurred, or the causal inferences she makes, can directly affect her subsequent feelings of shame. Three primary dimensions are said to be influential:

- (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).⁸

That is, 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'.⁸ Moreover, models on stigmatization suggest that "shame" (versus guilt) is a core element leading to stigmatization.⁹

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.

For many of the women in this study, there appears to be an amplifying interplay between the various ways that stigma manifests following a trafficking experience. Stigmatisation, not being or feeling accepted in family or community can impact existing relationships (e.g., marital, parent-child), her ability to enter or re-enter healthy intimate partnerships (e.g., future boyfriends, husbands), and her psychology (e.g., powerlessness, anxiety, loneliness). These isolating responses may converge in ways that persuades a woman that she is an undeserving social outcast—and she, in turn, makes this her reality.

* 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.

Women regularly referred to their "low self-esteem". When asked what she most wanted in the future, one woman replied:

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, respectability, appeared to incapacitate numerous women.

Because abuse and prostitution are highly stigmatised,¹⁰ it was important to learn how women anticipated the reactions of others.

Interviewers asked women: "Do you think that being trafficked will change the way others feel about you?"

Among the women arriving at assistance centres, 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 9.2.) A significant number of 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 view them any differently:

It has not changed the way others feel because no one knows.

Because no one knows and I hope no one will ever find out.

Among the women who believed others' views of them would change, numerous 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 think I am a dirty person and I cannot look in anyone's eyes.

People consider me a prostitute and keep asking me disgusting questions.

Table 9.2. Percentage of women reporting that being trafficked would change the way others felt about them.

	Interview 1
Do you think being trafficked will change the way others feel about you?	% (n=195)
Yes	37%
No	46%
Don't know	17%

If anybody on the streets was to know I had been a prostitute they would just think I am cheap, worthless.

I'm from a Muslim home. They stone prostitutes to death.

Women repeatedly said that they would be thought of as prostitutes or whores:

Even my relatives think I am a prostitute.

My neighbours think I am a prostitute.

My friends think I am a prostitute.

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:

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:

My father and other relatives hate me and don't want to see me ever again.

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 into prostitution. He thinks I did it voluntarily.

It appears fairly common for women to avoid telling spouses or boyfriends the truth about their ordeal for fear of losing them.

My hope is that my boyfriend never finds out. He is the type of man who will never touch me if he finds out I've been with someone else.

For many, the challenges associated with not telling are difficult:

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.

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. Survivors of trafficking exist alongside family members who may or may not notice women's seemingly inexplicable physical and sexual health complications, mood swings and psychological manifestations of what they have been through. Weighing the perceived likelihood of rejection

versus appearing to be difficult or distant, anxious or angry, many women choose to maintain their secrets and wait for their 'old self' to return.

Survivors' mental health repercussions can place great stress on their relationships. Findings from one study of Bosnian immigrants in the U.S. indicated that post-traumatic stress disorder (PTSD) had a significant effect on marital satisfaction.¹¹ 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.

For many of the women in this study, the stigma had so deeply infiltrated their thoughts and identity that a number had the impression that 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.

When I returned I had the feeling everybody knew everything. For three months I did not go anywhere. I thought they all were staring at me as at a "dirty, spoiled woman" –even my mother, but in fact, my mother does not know anything.

A number of women expressed this sense of heightened visibility—the impression that others were staring at them. This hyper-sensitivity to other people'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.

One support worker confirmed women's observations. She stated that when she accompanied women to service appointments, she had also noticed that men seemed to be paying particular attention to the women—even though their appearance (e.g., dress, make-up) did not warrant it. When asked to theorise why men might take particular notice of these women, she speculated that perhaps women's vulnerability or psychological need was perceptible, and maybe this vulnerability was appealing to some men.¹²

When asked about other's perceptions of them, a few women had complimentary descriptions of the care provided 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.

Maturity, self-reliance and empowerment

While many of women's descriptions of the changes that had occurred in themselves were primarily or completely negative, there were numerous exceptions. During the second and third interviews, it was not unusual for women to recognise the strengths they had gained as a result of what they had endured. Some understood that they had become wiser, more mature and more self-reliant:

I learned a lot about myself and about my mistakes. I feel matured, anyway. I think more rationally. I have life experience.

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.

My husband told me that I am a prostitute.

Once back home, I returned with Trichomoniasis (STI). My husband found out. I told him that I was raped.

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.

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.

I became smarter. I am confident of not getting into such a situation again.

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 for many women, their self-confidence had gotten lost amidst the degradation, for some women, reclaiming their sense of self and their self-esteem was readily possible. In the most positive sense, they took pride in their forbearance:

I am not afraid of anything, after all that happened to me, nothing scares me anymore.

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.

Disclosing their experience to others

Women were asked whether they would tell anyone outside the assistance centre about what had happened to them. For most women, their anticipation of ostracism and negative reactions by others caused them to feel unsafe to disclose their stories.

Less than a third of women during the first two interviews felt they would be able to disclose their experience to others. (Table 9.3.) 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 blame. 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 and "re-traumatise" themselves. Actively deciding to put traumatic memories in the past and to be more forward-looking is considered a positive form of cognitive processing that is associated with better coping and greater resilience to trauma (when it is not manifested as the negative response of "avoidance" often associated with PTSD).⁵

Table 9.3. Percentage of women who thought they would talk to someone outside the assistance centre about their experience.

	Interview 1	Interview 2	Interview 3
Do you think you will talk to someone outside the assistance centre about your experience?	% (n=193)	% (n=158)	% (n=62)
Yes	29%	26%	53%
No	71%	74%	47%

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 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.

Women's fears of sharing their innermost thoughts, their memories of what happened, and their fears for the future have significant implications for possible professional and informal psychological support. Unable to connect with others, women are likely to experience greater isolation, closely-held distressing emotions, and face a difficult and long process of social integration.

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.

Several women reported that they could tell others because they had also been trafficked:

It's made me stronger—I don't know how I'll be feeling in the future, but for now I feel stronger.

I will pretend like nothing happened.

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.

Time is the best doctor.

I will tell my cousin because she lived through the same experience as me.

Women were more reluctant to tell their boyfriends. Many explained fears 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.

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.

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, for some, they 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 them to know that.

Some women were simply incapable of, or felt an aversion to, imagining their future, to having dreams of what might be possible.

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 feet, 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.

Independent decision-making, confidence and control are important factors in relation to women's mental health. For example, studies on battered women have shown that self-blame and lower capacity for problem-focussed coping are 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.¹³ Self-blame thus appears also to influence coping, as women who believe that they themselves are the cause for negative outcomes are likely to have poorer coping abilities.

Women's feelings about men

Time and again when women were asked about their future, numerous women voiced their disdain for and mistrust of men. The following are a sample of the many comments expressing women's rejection 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 a 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 to marry, to have children, to have a normal life.

I worry most about having no future. I don't know where to go from here.

The best future I can imagine is work, higher education studies, a place to live. Just three wishes!

I want to show the men who raped me that they haven't broken me...I want them to know that.

I am afraid of people, especially of men.

I'm so scared of my illness [HIV].

[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 of the women in the study, 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-building and sexual maturing.¹⁴

Women's Worries

Over the course of the three interviews women were asked: What are your worries and fears? At the first interview, a majority of women included high on their list of worries, 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 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 discussed in Chapter 7: *Sexual and Reproductive health*, many women understood that it was highly

likely that they had contracted a sexually transmitted infection (STI), and some were recovering from an illness. As noted, 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.

For women who had been diagnosed with HIV, this was the overwhelming focus of their fears:

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 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.

For the very, very few, strength and independence eliminated expressed fears: *I am not afraid of anything.*

Home or away

Among the women who were trafficked, there were a portion who wanted nothing more than to be at

home, while others fervently wished to reside in the country of destination. The responses of the women who were in a destination setting reflected this mixture.

As many women remarked, going home posed numerous and often very serious risks. First and foremost, a number of women warned that they were worried about being found and harmed by the traffickers. This was particularly true for those who participated in a criminal proceeding. (See Chapter 8: *Mental health*)

For many women, the traffickers were not the only individuals they feared. Recalling that 60% of the women in this study reported a history of physical or sexual abuse prior to departure, it is likely that women often had much to fear within their own households from fathers, step-fathers, and husbands. One woman explained her dual concerns about where she would reside in the future:

I do not know where to go. My father is very violent...and about my boyfriend, I am not sure he will forgive me.

The subject of violence at home is an extremely important issue around return and re-integration. For many women, particularly adolescents, returning home is an unsafe option.

Moreover, not only were women fearful for their physical safety, but as has been discussed, many felt the stigma associated with what had happened to them would make it impossible to return home. They would be unwelcome and alienated from their families and their community.

I am scared of returning to [country] and that no one will believe me. I am scared of not being free, of being judged.

I am always reminded of the things I have done and think "who would want a cheap, worthless person?"

I fear for my sister because she is still a virgin and young. My exploiter could hurt her.

My worry is not managing to punish the one who sold me.

Women's limitations to returning home is a subject of the utmost importance and a matter for urgent further investigation.

Implications

After a trafficking experience, women must grapple with a wide range of emotions, memories of the past, and apprehension about the future. Women must often deal with these issues alongside a variety of physical pain and/or infection. These problems cannot help but exacerbate one another, as one anxious or depressing thought recycles itself continually through a woman's mind, giving her very little psychological peace. Whether women are attempting to adjust to a destination setting or they are trying to reintegrate in a home country, their tumultuous inner world is set amidst an environment that is often stress-filled and alienating.

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.

Psychological response patterns observed among the women in this study suggest common issues women are likely to face after a trafficking experience. However, these patterns do not necessarily indicate how symptoms will affect different women, nor the recovery time or resources necessary for individual cases. As suggested by the qualitative data, the capacity and timing of women's ability to take control of their emotional and physical health, and their social integration will vary vastly. It is for this reason, that assistance cannot be prescriptive, and support should be based on professional assessments of women's individual needs, including their experiences of past violence and their prospects for safety and well-being in the future.

I understand that I have a 'myself' – that I have survived and haven't lost myself. I survived!

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General recommendation

Recognise trafficking as a health issue.

Recommendations to States

1. States should approve national legislation that requires provision of healthcare for women who have been trafficked.
 2. Implement a recovery and reflection period of a minimum of 90 days to ensure that women's cognitive functioning has improved to a level at which they are able to make informed and thoughtful decisions about their safety and well-being, and provide more reliable information about trafficking-related events.
 3. Recognise the rights of trafficked persons to compensation and reparation funds to address the range of health consequences of human trafficking and trafficking-related crimes in all national legislation that affects trafficked persons. Specifically:
 - a. Accord women in destination and transit settings immediate legal rights to state-supported recuperative health services. This right should be specified in all national legal instruments, regardless of women's legal status or ability to pay.
 - b. Do not remove or detain women from destination or transit country settings without providing appropriate medical care to meet their immediate healthcare needs.
 - c. Do not return women to States where the healthcare services are inadequate to meet their health needs.
 - d. Provide specially designated health services for trafficked women upon their return home, where existing services are not adequate to meet their healthcare needs, regardless of their ability to pay.
 - e. Accord women returning to their home country the same rights to state-supported health services as other citizens of that country, regardless of the period of time that they have been out of the country or any break in contributions to healthcare schemes.
 4. Develop policies and designate budget items aimed at meeting the urgent and the longer-term healthcare needs of trafficked women.
 5. Foster the provision of in-house medical care within assistance organisations and shelters.
 6. Ensure trafficked women are not unjustifiably denied medical care by informing relevant health care organizations of women's full range of rights and entitlements to services, and by discouraging racism and bias to prevent refusal of services based on nationality, language, ethnicity, or stigma. Monitor regularly to ensure that women's rights to services are respected.
 7. Implement legislative measures that avoid delays in according trafficked women the legal status that enables them to access healthcare services.
 8. Working with international organisations (e.g., WHO, IOM, Unicef), develop and make available health promotion booklets designed for distribution to women at risk of trafficking or women in situations of exploitation. Booklets should include, at a minimum:
 - A clear definition of trafficking and its estimated magnitude;
 - An overview of the health complications commonly experienced by trafficked women, including descriptions of signs and symptoms of illness and options for treatment; and
 - A summary of the rights to health services of non-residents in known countries of destination, and the rights of women who have been trafficked to health services in receiving and/or countries of origin.
- Booklets should be translated into a variety of languages and drafted to be relevant for distribution in different countries.
9. Resources on trafficking should be developed that can be used by health professionals providing care for women who have been trafficked. These should be based on existing models of good practice established for other

forms of violence against women, and for care of migrants and refugees, and should include, at a minimum:

- a. Sensitisation information on trafficked women;
- b. A summary of common morbidity patterns;
- c. Guidelines on appropriate treatment protocols;
- d. Guidelines on privacy, confidentiality, safety and care ethics;
- e. Up-to-date referral information for other necessary assistance (e.g., legal assistance, educational opportunities, etc.).

Regional or country specific documents should include a list of locally available emergency assistance resources.

10. Law enforcement agencies should:

- a. Require police and immigration personnel to ensure that women who are suspected of having been trafficked are asked about their health concerns and pain at the first point of contact. Ensure that questions about health and well-being are posed in private and in a language the woman can understand.
- b. Require police and immigration personnel to respond to urgent medical needs and serious discomfort by referring women to professional medical care - prior to conducting questioning or interrogation.
- c. Offer forensic exams to women who have been trafficked for prosecution of traffickers, where appropriate. Informed consent in the woman's native language should be obtained prior to the conduct of any exam, and results should be made available to her.
- d. Institute good practice guidelines for interviewing trafficked women based on existing models of good practice for victims of sexual assault, vulnerable witnesses, and victims of domestic violence.
- e. Conduct training and sensitization activities for all law enforcement personnel who are likely to encounter trafficked women. Information provided should include, at minimum, the following subjects:
 - Understanding violence and other health risks experienced by trafficked women;
 - Recognising the range of urgent and non-

urgent health complications sustained by trafficked women;

- Responding appropriately to reported urgent and non-urgent health complications;
 - Understanding and responding to distress, anxiety, hostility and other psychological reactions;
 - Understanding how different health outcomes might affect a woman's behaviour and reactions in official settings or during official procedures, in particular, learning about the negative effects of trauma on memory.
- f. Make available to trafficked women the option of having a support person from a non-governmental organisation or a state-sponsored victim support service present when women are in custody of law enforcement personnel.
 - g. Ensure measures are in place to regularly monitor the health and well-being of women who are detained and are suspected of having been trafficked.

Recommendations for donors (States, international organizations, and private donors)

Designate funds to support:

1. Emergency and longer-term health and medical care for women who have been trafficked, and encourage the implementation of programs that include healthcare. Specifically, provide funding to support:
 - a. Safe housing and good nutrition;
 - b. Full sexual and reproductive health diagnosis and treatment;
 - c. Diagnosis and treatment for injuries;
 - d. Medications to alleviate symptoms of pain and distress (e.g., headaches, backaches, sleep problems, anxiety);
 - e. Long-term psychological support, recognising that symptoms of trauma and distress are enduring and recurring among survivors;
 - f. Occupational and educational training to support women's social and economic integration, and to improve their mental health.
2. Advocacy for trafficked women's rights to health and access to health interventions.

3. Training and sensitization of healthcare staff to identify and provide appropriate treatment for victims of trafficking.
4. Interpreting services as needed.
5. The training and sensitization of police, immigration and judiciary officials to enquire about and respond appropriately to trafficked women's health complications.

Recommendations for health service providers

1. Recognise that addressing post-trafficking health problems is a multi-stage process that includes:
 - a. crisis or emergency intervention care;
 - b. support for women's physical recuperation and psychological adjustment; and
 - c. care for long-term symptom management.
2. Ensure that all medical testing is voluntary, and carried out in accordance with international human rights and professional ethical and health standards.
3. Provide physical, sexual, reproductive and mental health support adapted from models of good practice used for survivors of domestic violence, sexual assault, and torture, also relying on good practice guidelines for minority communities and refugees.
4. Respect women's sexual and reproductive health rights by offering access to safe abortion services, counselling for voluntary HIV testing, anti-retroviral drugs, and post-exposure prophylaxis, as required.
5. Carry out safe and linguistically appropriate outreach and mobile clinic strategies to offer care to women still in situations of exploitation.
6. Coordinate closely with local organisations providing assistance to trafficked women to assist them in offering the range of healthcare required by trafficking survivors.
7. Ensure the confidentiality of women's medical records, and respect their rights to all medical and healthcare documents by implementing privacy and file security measures, and by making copies of health-related documentation

available to each woman.

8. Collaborate with NGOs to advocate for the implementation of legislative measures that avoid delays in according trafficked women the legal status that enables them to access health care services.

Recommendations for organizations, such as NGOs, providing services to trafficked women

1. Ensure that assistance programs prioritise women's medical and health needs during intake by:
 - a. specifically enquiring about a range of health complications upon a woman's arrival;
 - b. addressing urgent problems and pain as quickly as possible; and
 - c. working to develop in-house and outreach medical services, where appropriate.
2. Collaborate with key health providers, including general practitioners, genito-urinary medicine, psychiatry, dermatology, abortion services, gynaecology, detoxification services, and emergency services to ensure that women have the full range of care needed.
3. Provide services for trafficked women based on good practices used by assistance programs for survivors of other forms of gender-based violence, such as sexual assault and domestic violence, and culturally competent care practices employed for migrants or refugees. Where appropriate, assistance organizations working in these fields should expand their services to offer care for women who have been trafficked.
4. Train staff to provide written and/or verbal health information for women who have been trafficked, such as information on sexual and reproductive health (including HIV and other sexually transmitted infections), mental health, infection and injury, and pain management.
5. Respect women's reproductive rights by offering access to safe abortion services.
6. Conduct advocacy targeted at improving policies and increasing funding for health and medical care. In particular, advocate for national legislation that does not make healthcare

provision contingent on a woman's legal status, or her ability to pay.

7. Conduct risk assessments to identify safe and viable housing options for women following a trafficking experience.

8. Ensure that women's rights to privacy and confidentiality are respected.

9. Ensure that in addressing health problems, such as sexually transmitted infections, particularly HIV, testing and treatment is voluntary.



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