



Sex Trafficking of Women and Girls in Eight Metropolitan Areas around the World

Case Studies Viewed through a Public Health Lens

This report was written by, in alphabetical order: Roy Ahn, Elaine Alpert, Thomas Burke, Elizabeth Cafferty, Judith Palmer Castor, Wendy Macias-Konstantopoulos, Anita McGahan, Nadya Wolferstan and Timothy Williams for the Division of Global Health and Human Rights, Department of Emergency Medicine, Massachusetts General Hospital.

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**Division of Global Health and Human Rights
Department of Emergency Medicine
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PROLOGUE

This report was written by, in alphabetical order: Roy Ahn, Elaine Alpert, Thomas Burke, Elizabeth Cafferty, Judith Palmer Castor, Wendy Macias-Konstantopoulos, Anita McGahan, Nadya Wolferstan and Timothy Williams for the Division of Global Health and Human Rights, Department of Emergency Medicine, Massachusetts General Hospital. The report's graphics and cover illustration were designed by Division staff member, Hao Dinh. The mission of the Division is to care for the world's most vulnerable by developing and facilitating health-care delivery, research, education and capacity- building initiatives. The principal investigator of this project was Thomas Burke, Chief of the Division of Global Health and Human Rights, Department of Emergency Medicine.

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CHAPTER 1: INTRODUCTION

Study Goals

This report presents the principal findings from eight case studies of sex trafficking of women and girls in metropolitan areas of five countries.

- New York City and Los Angeles, United States
- London, England
- Manila, Philippines
- Mumbai and Kolkata, India
- Rio de Janeiro and Salvador, Brazil

Our research team conducted these case studies between October 2008 and October 2009.

Collectively, these case studies were designed to: (a) examine the issue of sex trafficking through an integrative, public-health lens; (b) identify current, local health-system responses to sex trafficking; and (c) determine the potential role of local health systems* in addressing sex trafficking, alone and alongside other anti-trafficking stakeholders, in affected communities.

Rationale

The sex trafficking of women and girls[†] is a significant global health concern, because of the scope of the practice worldwide as well as the severe health consequences associated with sex trafficking. The 2009 U.S. *Trafficking in Persons* (TIPS) report cites UNICEF data that “as many as two million children are subjected to prostitution in the global commercial sex trade.”¹ The 2005 TIPS report estimated that eight out of ten trafficked persons were women and girls, with the “majority” in the sex trade.² A report of the UN Global Initiative to Fight Human Trafficking (UN GIFT) cites International Labor Organization estimates of nearly 2.5 million trafficking victims worldwide, with nearly half of these victims in “commercial sexual exploitation.”³ The accurate tabulation of the scope of global sex trafficking is difficult; the lack of consensus on the prevalence of these practices is a major concern for the field. Hence, estimates of these practices have varied significantly.^{4,5} However, as indicated by the TIPS report and the UN GIFT

* In this project, we defined “local health system” as the collection of health-focused institutions in a given community, including, but not limited to: hospitals, clinics or health centers, public health departments/ministries of health, health professional schools, and medical societies.

† We recognize that the trafficking of men and boys is also a significant societal problem—the TIPS report¹ cites ILO and UNICEF statistics that state that men and boys comprise “two percent” of the sex trade. However, the focus of this project was women and girls.

Report, sex trafficking, by any estimate, is a major, global social problem – one that affects many women and children worldwide.

Definition of Sex Trafficking

Studying sex trafficking is challenging for a compendium of reasons, but the lack of consensus on a definition of sex trafficking is a significant challenge for researchers. At the core, people generally agree that the trafficking of human beings to sexually exploit them is a harmful activity—some even note that it violates one’s basic human rights. Beyond that, however, opinions diverge about the parameters of trafficking; the field has produced a muddy amalgamation of definitions that diverge in key areas. A wide range of organizations, from governments to anti-prostitution groups, have staked out positions on what should be included—and excluded – in definitions of sex trafficking and more broadly, human trafficking.

The U.S. State Department offers one definition of sex trafficking:

When a person is coerced, forced or deceived into prostitution, or maintained in prostitution through coercion, that person is a victim of trafficking. All of those involved in recruiting, transporting, harboring, receiving or obtaining the person for that purpose have committed a trafficking crime. Sex trafficking can also occur alongside debt bondage, as women and girls are forced to continue in prostitution through the use of unlawful ‘debt’ purportedly incurred through their transportation or recruitment—or their crude ‘sale’—which exploiters insist they must pay off before they can be free.¹

Despite significant efforts, broad consensus on critical trafficking definitions has not materialized. Part of this definitional issue centers on the unclear, sticky relationship between “sex trafficking” and prostitution or sex work. That is, some organizations view all prostitution as “trafficking,” while others argue that some women willingly engage in sexual activity in exchange for money. The polarization of definitions reflects an ideological division in the field, which is encapsulated in the following history of trafficking:

The merging of these issues is not new, nor confined to the USA. In Asia, where human trafficking (both for prostitution and for bonded labour) has a longer history than in Europe, responses by governments and feminist groups alike have often been to call for eradication of prostitution, and therefore trafficking.

But this approach overlooks an important fact; millions of women have made the decision to sell sex, usually but not always, on economic grounds. Selling sex is a pragmatic response to a limited range of options.⁶

These divisions have led some researchers to refer to trafficking data with suspicion, labeling them as “often contaminated with ideological and moral bias.”⁷

Certain domains of sex trafficking have garnered more universal agreement. For example, definitions of child sex trafficking appear to be less controversial; many organizations argue that children who are sexually exploited for money are tantamount to trafficking victims. Yet other aspects of the definition remain problematic for many organizations. For instance, should a woman who entered the sex industry in a trafficking situation but escaped and began to work for herself as a sex worker still be considered a “trafficking victim?”⁶ Where is the dividing line between sex trafficking and labor trafficking with sexually exploitative elements?⁸ Some researchers have navigated the troublesome definition issue by relying on self-reports. In other words, they have defined trafficking victims if, and only if, a victim has come forward and identified herself as a trafficking victim.

The struggle to clarify what sex trafficking is, represents more than an intellectual tangle among academics. Definitions shape and influence how trafficking prevalence is calculated, and therefore inform how public and private resources are deployed to shunt these types of activities worldwide. Therefore, the definitional disagreements in the field are problematic in significant ways. In Chapter 2, we describe how we addressed trafficking definition-related issues in our study.

Framing Sex Trafficking through Public Health Lens

Much of the early literature on sex trafficking has been viewed through a legal/criminal justice or sociological lens. Such research provided useful insights into the range of factors that could foster trafficking. The field of public health was notably absent in the early development of the field of trafficking research. However, the multi-disciplinary field of public health is well-suited to studying complex, controversial topics like sex trafficking. Effective public-health interventions are predicated on comprehensive understandings of social issues and their root causes; they go beyond traditional biomedical explanations and treatments for disease and injury. For instance, public health has made significant inroads into the understanding of, and the development of systemic interventions for the mitigation of violence in America during the past two decades. Public health has emphasized prevention, community involvement, and an epidemiologic approach to understanding the individual- and community-level risk factors for violence⁹:

Public health brings a tradition of integrative leadership, by which we can organize a broad array of scientific disciplines, organizations, and communities to work together creatively on solving the problem of violence. This approach is in direct contrast with our society's traditional response to violence, which has been fragmented along disciplinary lines and narrowly focused in the criminal justice sector. In addition, communities have not been given a voice in fashioning and implementing prevention policies and programs.⁹

We believe the public health approach can yield important insights into the dynamics and root causes of, and social/cultural conditions underlying slavery and trafficking—and not just on the health effects of these practices. Public health comprises myriad disciplines, including economics, medicine, psychology, sociology, biology, and chemistry, among others.¹⁰ Within public health, the field of social epidemiology has made significant contributions to the understanding of fundamental *social* determinants of health (e.g., poverty, education, income inequality, discrimination).¹¹ Similarly, the field of health and human rights has emerged over the past several decades, and made these important connections.¹²

Theoretical frameworks from public health inform our study design as well as the recommendations drawn from our study findings. Specifically, the “Social-Ecological Model,”¹³ which is used extensively in the violence prevention field, is instructive for studying sex trafficking of women and girls, and ultimately for developing prevention strategies. This model posits that the risk factors are myriad, and operate at multiple levels: “This model considers the complex interplay between individual, relationship, community, and societal factors. It allows us to address the factors that put people at risk for experiencing or perpetrating violence.”^{13, 14} The wide breadth of this theoretical model also allows for inquiry into both the supply and demand aspects of sex trafficking. The model also mirrors existing theoretical frameworks used outside public health to study child trafficking. An International Labor Organization publication on the dynamics of child trafficking in the Philippines similarly describes the importance of “a reciprocal influence between and among the child and other individuals, families and social contexts.”¹⁵

Taking a public health approach, or “lens,” to understand trafficking is expansive and integrative rather than atomistic, and can be, therefore, useful for framework- and/or theory-building. In practice, this approach involves much more than asking local health workers if and how they encounter trafficking victims in the health-care setting. The public health approach, in its quest to identify the underlying etiology of disease and illness in a population, accommodates the examination of fundamental social causes like poverty in depth, through anthropological, economic and other lenses. In effect, the health setting serves as an *entry point* in communities of interest through which the trafficking and slavery problem can be examined and illuminated. Ultimately, the

project will contribute to our understanding of how the health community can directly intervene, and how the health community fits within a larger multi-sector response to trafficking and slavery around the world.

Existing Literature on Sex Trafficking

The research literature on human trafficking is growing, especially with respect to legal and political strategies for prosecution of traffickers, and methodological debates center on how best to obtain accurate prevalence figures of trafficking.* Also, a small body of social science and health research has proposed various social and cultural determinants of human trafficking. For example, the 2008 UN Global Initiative to Fight Human Trafficking (UN GIFT) report cites “economic crisis in the trafficked person’s home country, social exclusion, gender discrimination...and a weak legal or social protection system” as underlying factors for human trafficking.^{5, 17} Elsewhere, with respect to sex trafficking of women and girls, factors such as lack of education and poverty have been posited as important ones for explaining how girls end up being trafficked.¹⁸ A review article of trafficking of women added, beyond the factors described above, “political instability,” “government corruption,” and “increasing demand for commercial sex...” as other determinants of trafficking.¹⁹ New anthropological evidence also suggests that birth order and “parental marital instability” may also play roles in trafficking among girls in Thailand.²⁰ Cultural norms placing girls in lower social strata than boys within familial structures have also been proposed as risk factors for sex trafficking among girls in India.²¹ As one noted sex-trafficking researcher summarized, “Push factors, such as gender inequity, social deprivation and poverty, or civil and political unrest are said to cause women to migrate, while images of good jobs, political freedoms and media images of wealth pull women toward what they hope will be a better life.”⁸ This initial wave of research provides useful insights into the wide range of factors that could foster trafficking, and there is ample room for researchers across disciplines to add to this existing body of work, especially studies that illuminate how all these factors work within specific local communities where trafficking is known to be problematic.

Within the health sector, the emphasis on sex trafficking has taken on urgency, because of research showing an association between these practices and the spread of HIV/AIDS.²² A recent study in India suggests that sex-trafficking victims are severely restricted in their ability to seek health care services.²³ Given the plethora of physical and mental health problems facing sex-trafficked women and girls, at different time points in the trafficking experience,^{24, 25} understanding the health sector’s role in mitigating sex trafficking in communities is both timely and important. A landmark 2003 qualitative study of trafficking in the European Union produced a conceptual framework describing the various trafficking “stages” (e.g., “predeparture,” “detention, deportation, and

*See, for example, an overview of the types of research reports available on National Institute of Justice’s “International Human Trafficking Research” link on the NIJ website¹⁶

criminal evidence”) at which victims’ health can be compromised. This study provided an early window into health, NGO and policymaker perceptions of sex trafficking and health.²⁶

Recently, increased attention has been paid to examining the role of health-care providers in the identification and treatment of human trafficking victims. In 2007, the U.S. government’s Administration for Children and Families launched the “Campaign to Rescue and Restore Victims of Human Trafficking,” which included an entire section of the campaign targeting health-care workers and how they can help.^{27, 28} Calls for health-care workers, especially emergency medicine clinicians and mental health workers, to help identify and treat human trafficking victims, have intensified.^{19, 27} Intervening in sex trafficking is a natural fit for the hospital and health community, and it could serve as a useful template for how the health community might assist in other types of human trafficking, such as bonded labor.

This Report: Case Studies of Cities/Metropolitan Areas

The small but expanding literature on sex trafficking of the health and non-health sectors offers valuable insights into the macro-level factors that place women and girls at risk for trafficking; the types of health issues facing trafficking victims; and recommendations on policy and advocacy levers involving the health sector. However, in-depth studies examining *local* sex trafficking through a public-health lens, those that elucidate local health system engagement in anti-trafficking work, are decidedly lacking.

Given the plausibility of the health setting offering a safe harbor for women to talk about abuse and violence in general,²⁹ studying local sex trafficking trades through a health lens differs from a legal system-led perspective. In practical terms, putting the *local health system* at the center of a comprehensive, multi-sector solution for communities, and giving health workers a leadership stake, allows local health systems to engage at a deeper level: one that goes beyond treating trafficking victims, and facilitating an earlier entry to the sex trafficking solution than health currently enjoys.

We are working under the hypothesis that starting with health workers as our entry point into the communities makes sense, because physicians and allied health workers may be: (a) highly credible, high status and influential in these communities; (b) have professional expertise in handling sensitive and confidential topics like trafficking in a discrete manner; (c) may be viewed as advocates for the poor and vulnerable without being “political”; and (d) intersect with a wide range of public and private actors that could inform our understanding of the local trafficking and slavery situations.

For these reasons, community-specific, local case study research—an approach that can provide in-depth inquiry that examines community-level contextual factors (in addition

to individual and macro-social factors)—in suspected sex trafficking hotspots can contribute significantly to the existing literature on underlying social and cultural determinants. Our study contributes to the literature eight in-depth case studies of sex trafficking in metropolitan areas where sex trafficking is reported to occur. These case studies, which focus on cities as the primary units-of-analysis, provide insights into the mechanisms by which international and internal trafficking take place; describe existing responses of local health systems to sex trafficking; and posit the potential nexus between local health systems and non-health anti-trafficking stakeholders in future strategies that address sex trafficking.

These case studies represent a first phase of research towards the eventual development and refinement of theories on slavery and trafficking—leading ultimately to theory-grounded interventions to combat these practices worldwide. These case studies describe various health communities' current responses to sex trafficking and slavery, and offer insights into how health organizations might intervene in trafficking and slavery in the future.

Report Roadmap

The remainder of this report is organized in the following way. Chapter 2 describes how we chose our cases, and what methods we used to arrive at our findings. Chapters 3 through Chapter 10 describe the major findings from each of the eight case sites.

Countries with multiple case study sites are presented back-to-back, so that readers can understand national contexts within which the cases are presented. For example, Chapter 3 covers New York City and Chapter 4 covers Los Angeles. Chapter 11 is a concluding chapter that summarizes the cross-cutting findings from the case sites, describes how the cases contribute to theory development and proffers concrete recommendations for action.

CHAPTER 2: STUDY DESIGN

This chapter identifies our eight case study cities, and provides an overview of the project study design. Overall, we employed a multiple case-study design approach, which has been used extensively in such fields as education, management science and public health.³⁰ A hallmark of the mixed-method case study is the methodology's utility in addressing "how" and "why" questions related to a particular topic of inquiry.³⁰ This methodology is particularly useful in exploratory studies, "when little is known about a phenomenon, current perspectives seem inadequate because they have little empirical substantiation, or they conflict with each other or common sense."³¹

We elected to use case study methodology to characterize how trafficking occurred in discrete metropolitan areas; identify key determinants of sex trafficking; and describe the current and potential role of local health systems in addressing sex trafficking in affected cities. The primary methods used in these case studies were: semi-structured interviews with key experts ("interview respondents") on sex trafficking in the case study cities, supplementary review of documents provided by interview respondents (e.g., annual reports, brochures, other publications), and literature reviews on sex trafficking in each of the case study cities (and respective countries).

The remainder of this chapter outlines our study questions, working definition of sex trafficking, case selection, data collection and analytic methods, and limitations.

Research Questions

The eight case studies were designed to produce information on the following broad questions:

- How can a public-health lens characterize the underlying conditions that permit and foster sex trafficking of women and girls?
- How can local health systems* directly intervene in order to assist sex-trafficked women and girls?
- How can health systems contribute to multi-sector strategies for ending sex trafficking of women and girls?

* In this project, we defined "local health system" as the collection of health-focused institutions in a given community, including, but not limited to: hospitals, clinics or health centers, public health departments/ministries of health, health professional schools, and medical societies.

Study Definitions

Before describing our study methods, we must initially define sex trafficking. As described in Chapter 1, the field has produced a confusing, often contradictory lexicon of terms and definitions on human trafficking and sex trafficking. While mindful of the lack of agreement in the field, our research team searched to identify a well-known definition that could bound our study. After considerable deliberation, we settled on the United Nations' *Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children* definition of human trafficking, and specifically, the phrase "exploitation of the prostitution of others or other forms of sexual exploitation."

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

The recruitment, transportation, transfer, harbouring or receipt of a child for the purpose of exploitation shall be considered "trafficking in persons" even if this does not involve any of the means set forth in subparagraph (a) of this article.³²

The UN protocol, also known as the Palermo Protocol, is not without its critics, especially as it applies to sex trafficking and prostitution, yet it provided us with a definitional anchor from which we could examine the phenomena in our case studies.

The Palermo Protocol recognizes the existence and possibilities of both voluntary and forced prostitution and indeed leaves 'prostitution' intentionally ambiguous to allow for different interpretations. Participants noted that the Palermo Protocol includes but does not define the phrase 'exploitation of prostitution of others or other forms of sexual exploitation' because delegates to the Palermo negotiations could not reach a consensus on the meaning of the phrase. While all delegates agreed that involuntary participation in prostitution constitutes trafficking, the majority of delegates rejected the idea that voluntary participation by adults in prostitution amounts to trafficking.³³

We were aware that any definition of sex trafficking would be controversial with some interview respondents in our study. Given that ours is an exploratory, largely inductive study, the Palermo Protocol definition took primacy over other definitions, but we also

kept the door open to competing definitions or descriptions of sex-exploitation phenomena offered by our interview respondents. Nor did we take a firm position on whether all prostitution was or was not trafficking.

Hence, we reported on activities that fall under the Palermo Protocol definition of sex trafficking. In instances where interview respondents disagreed with the Palermo definition or even the use of “sex trafficking” as a descriptive term, our research team adheres as closely as possible to the descriptive terms (e.g., survival sex) used by each respondent. In these instances, we clearly demarcate the respondent’s term from “sex trafficking” in the report, and note any key differences in interpretation of results or recommendations that arise from these definitional differences. In other words, we also report on sex trafficking-related topics, such as so-called survival sex, sex work, prostitution and gender-based violence.

Selecting Case Studies

Number of Case Studies

The goal of the study was to develop information-rich cases in each city, and, collectively, to generate enough case studies to attain a preliminary understanding about constructs and relationships related to sex trafficking. At the outset, we chose to conduct eight case studies during the study timeframe. The selection of eight case studies is consistent with the literature on case study and theory development; some researchers proposed four to ten cases as a reasonable amount from which to build conceptual frameworks, while others have argued for adding cases until subsequent cases fail to present new findings.

The Cases: Inclusion Criteria and Final Selection

We undertook a systematic review of candidate cities. Table 2.1 (below) highlights the case selection criteria; the first two criteria were the most critical in terms of study inclusion. Our selection criteria reflect the overarching goals of our case research—to build a rich conceptual understanding on sex trafficking through a public-health lens, one that describes many settings and geographic locales and health systems, and also capture “complementary aspects of a phenomenon”³¹ (e.g., origin, destination, transit areas for sex trafficking). As such, the case selection process was dynamic and iterative.

Case studies on human trafficking are rare in the published literature. Therefore, we drew extensively from Bales’s seminal case research for *Disposable People: New Slavery in the Global Economy*, which employed the following criteria for case study (country) selection:

- “[S]ignificant amount of slavery” and “distinctive economic activities using slaves”
- “[D]ifferent types of slavery”
- Researcher access
- Inclusion of Pakistan and India [as well-recognized hotspots for slavery]
- “Within each country...one area of economic activity that could be effectively studied”³⁴

Table 2.1. Case Selection Criteria

- Significance/magnitude of sex trafficking problem in country and city/metropolitan area
- Adequate public health infrastructure to be studied in country and city/metropolitan area
- No, or little, potential for entrenching trafficking and slavery problem by conducting research
- Access to local social scientists
- Sufficient security for case researchers
- National government commitment* to address trafficking and slavery

Our case screening process was multi-fold: we screened candidate countries, then candidate cities within the selected countries. First, we screened for countries that had a *significant sexual slavery and trafficking problem* among women and girls.[†] Case study methodologist Robert Yin argues that the purpose of case studies is to examine “contemporary phenomenon.”³⁰ In this study, sex trafficking represents the “contemporary phenomenon,” and therefore must be present to a sufficient degree in each of our case study sites. Second, we determined whether the candidate city had a strong enough *public health infrastructure*[‡] to apply our public health “lens” to the analysis of trafficking. We then applied the remaining four criteria to the list of candidate countries.

We identified Brazil and India as the countries that best satisfied the full set of selection criteria. Within Brazil and India, we selected two cities each, with the rationale that studying multiple cities within each country would allow us to make appropriate comparisons within each country. For example, studying multiple cities in one country could help controlling variation in terms of health systems. In effect, the second city in each country could add to theory by “replicating” or disconfirming findings from the

* Of course, local government commitment is critical, too, but as a selection criterion, national government actions made sense, given the importance of central government support to local government initiatives.

† Magnitude and significance are difficult to assess, given the paucity of trafficking data. We relied on widely-available sources, such as the U.S. Trafficking in Persons Report,^{1, 35} and others, to determine the significance of the problem in the candidate cities.

‡ We used World Health Organization (WHO) and World Bank indicators of health capacity (e.g., physicians, nurses, and pharmacists per 1,000 population, hospital beds per capita) to determine the strength of a country and sub-national region’s public health “infrastructure” relative to its neighbors. We stratified case site candidate cities by strength of country- and local public health infrastructure.

first. Therefore, we selected Rio de Janeiro and Salvador, Brazil, and Mumbai and Kolkata, India, as the first four cases.

For the remaining four cases, we selected cities that satisfied our selection criteria and could also increase our breadth of understanding of sex trafficking along several domains. Because the research field on trafficking is still growing, our approach to theory-building was necessarily inductive and iterative. Therefore, guided by the principle of theoretical sampling, we sought to sample case study sites that could, in Eisenhardt's words, "extend theory by filling conceptual categories."³¹

The salient, theoretically-driven categories included:

- Type of sex trafficking (origin, destination, transit)
- Robustness of public health system/infrastructure
- Geography (e.g., urban vs. rural, representation of continents)
- State of development (developed country vs. developing country)

For example, given that our research questions related to sex trafficking through a broad public-health lens, we needed to understand the trafficking phenomenon in a similarly holistic way—i.e., understanding the phenomenon at origin, destination, and transit sites would provide a more complex understanding of sex trafficking than, say, limiting our study exclusively to origin sites. Also, from a downstream perspective, a health systems-focused, theory-based intervention, would be better served if we understood origin, destination, and transit phases of trafficking.

Therefore, we added two cities in the United States (New York, Los Angeles), and one in Europe (London). These three cities were chosen to help address our research questions in the context of major ports-of-entry for sex trafficking. These cities also had extremely robust public health systems in the developed countries. As major destinations of the international sex trafficking trade, findings from these three cities could complement our cases in Brazil and India, which contain origin, destination, and transit sites. The inclusion of these three major international cities also represented "extreme cases" of sorts: one could argue that the conditions for understanding and addressing sex trafficking were *optimal* in New York City, Los Angeles and London, given the robustness of public health system/infrastructure, and advanced state of economic development. These three cities also served as politically-important cases, given their high visibility, and the potential to inform policy action on human trafficking worldwide.

The two U.S. sites were paired in order to allow in-country comparisons, and serve, in as much as can be done in case studies, as control groups to one another. The selection of London was an important counterpart to the two US cities, because the health-care

system in the U.K. differed from that of the U.S. Differences in health systems in the two countries might have implications for the health response to sex trafficking.

We selected Manila, Philippines as the eighth case, because it met all our selection criteria, and also added geographic diversity to our sample of cases (i.e., covering a different part of Asia aside from India).

Overall, the cases filled salient categories for building a conceptual framework on sex trafficking through a public-health lens. The eight cases were chosen to generate a more concrete picture of the extent of the sex-trafficking problem, driving factors, root causes, permissive conditions and possible areas of entry for anti-trafficking work, on four different continents. They allowed us to examine several types of sex trafficking sites with respect to origin, destination, and transit sites for sex trafficking. Some cities were known for international sex tourism, while others harbored significant within-country (i.e., internal) sex trafficking trades. The cities also had a range of health systems. Because our cases were paired in three of our case study countries, there was considerable opportunity for “replication” (i.e., confirmation, disconfirmation) of case studies in each of these countries, and reduction of possible “extraneous variation.”³¹

Unit of Analysis

The unit of analysis in research case studies can be individuals, organizations, industries, policies, or other measurable units. We used the **city/metropolitan area**^{*} as the primary unit of analysis for the case studies. By bounding our cases by geography, we believe the study findings accurately characterize sex trafficking in each city, and in turn, facilitate comparisons among the case studies.³⁶

Data Sources

Our study data came principally from interviews with experts in the field of trafficking, plus supplementary analyses of published and unpublished literature on sex trafficking in the case study cities. The research study and protocols were approved and exempted from further review by the Institutional Review Board (ethics) of Partners Healthcare, the parent organization of Massachusetts General Hospital, in Boston, Massachusetts.

^{*}We use the terms “cities” and “metropolitan areas” interchangeably in this report. For instance, two of our case sites, Los Angeles and Mumbai, are sprawling, and the sex trafficking phenomenon were described as creeping outside the city limits into suburban areas, but not far enough to extend geographically to a different major city.

Key Informant Interviews

We completed semi-structured interviews with 274 key informants (“respondents”) across the eight cases. We identified respondents using a “snowball sampling” method, whereby an individual knowledgeable about sex trafficking in her/his city referred our researchers to other individuals. This “snowballing” continued until researchers felt that theoretical saturation had been reached in each city. We sought to interview a wide range of types of trafficking stakeholders in each city. For example, because of the nature of our research questions, we interviewed health-care workers in each city, but we also interviewed people outside the formal health sector—anti-trafficking advocates, law enforcement officers, program directors of shelters that assist trafficking victims, and so on. By interviewing people beyond the health-care sector, we attempted to increase the internal validity of our findings by working across disciplines to corroborate and refute evidence.³⁷

Tables 2.2 and 2.3 (below) summarize the interview respondents by type of organization, and by occupation. While there are no established benchmarks for an optimal number of interviewees for a given case study, we aimed to conduct at least 15 interviews in each case—to assure that multiple perspectives on sex trafficking were covered.

Table 2.2. Case Studies’ Interview Respondents, By Occupation

Occupation Type	Number of Key Informants
Physician	47
Nurse	9
Social Worker	27
Mental Health Provider	15
Program Director	42
Administrator	48
Government Officer	19
Foundation, Philanthropy Officer	2
Researcher	40
Law Enforcement Official	2
Legal Professional	7
Other	16
Total	274

Table 2.3. Case Studies’ Interview Respondents, By Organization Type

Organization Type	Number of Organizations
Health Care Organization	31
Social Service Providers	58
Advocacy	29

Academic or Research	34
Government (Health)	11
Government (Non-Health)	17
Foundation, Philanthropy	4
Total	184

Data Collection

Key Informant Interviews

A team consisting of eight health researchers (master’s degree-level or higher, including five clinicians*), all of whom were trained in case study methods prior to the field work, conducted the key informant interviews. Teams reviewed available literature on sex trafficking in the case cities prior to their departure, to better familiarize themselves with local trafficking contexts and the major anti-trafficking stakeholders in the cities. Most interviews were conducted in-person by pairs of researchers.† The decision to pair researchers was made in order to minimize potential single-investigator bias in the interviews. All interviews took place in English. In Brazil, a translator accompanied our researchers to many interviews where English posed difficulties for the respondents.

While most interviews took place with a single respondent, our researchers conducted some group interviews. Generally, interviews were between 45 to 60 minutes in duration, but interview times varied significantly, based on the direction the interviews took. Researchers took extensive notes during the interviews, and audio-taped the interviews in most instances.‡ The interviews were transcribed verbatim, or in the Brazil cases, transcribed verbatim in Portuguese, then professionally translated into English.

The interviews asked respondents their perceptions about the scope and nature of sex trafficking in their respective cities; the key social, cultural, political, economic determinants of sex trafficking; the current local health system response, including partnerships between health and non-health anti-trafficking stakeholders; and potential opportunities for local health systems to increase their impact in anti-trafficking work in cities.

To this end, we developed a semi-structured interview guide (Appendix A). As in other case research, especially in inductive theory-building research, the interviews needed to be flexible and, to some degree, open-ended. The research team reviewed several drafts

* By clinicians, we mean two emergency physicians, one internist/sexual violence expert, one social worker with a master’s degree in public health, and one social policy PhD with experience in counseling psychology of adolescents. The remaining interviewers were: a senior health care attorney, an international relations/women’s rights researcher and a researcher with a doctorate in public health.

† Research team members conducted, but rarely so, telephone interviews with respondents when it was logistically implausible to conduct face-to-face interviews.

‡ Some respondents asked that we not audio-record interviews, and in a very small number of instances, we experienced difficulties with the digital voice recorders, and did not retain the interview contents.

of this interview guide before finalizing the guide. Researchers in the organizational behavior field have used free-form techniques that elicit people's stories rather than asking rigid questions.^{38*} Our researchers added questions that addressed different domains of trafficking and slavery when interviews took on a particular direction.

Our approach to the interviews sought to maintain a balance between purely inductive inquiry and deduction. As an exploratory study, we were open to lines of questioning and themes emerging organically in the interviews.³⁹ While open to emergent constructs and relationships, we also went into these cases with some "a priori constructs" that could be useful guideposts in our inquiry.³¹ For example, we were interested in exploring whether health stakeholders worked in collaboration with other anti- trafficking stakeholders.

Supplementary Data

The study relied on the key informant interviews as the main data source, but also collected supplementary data. As mentioned earlier, researchers searched available literature on sex trafficking in each case city (and country). Researchers searched peer-reviewed health databases such as the U.S. National Library of Medicine's PubMed, and searched the Internet using keywords related to sex trafficking and human trafficking to identify salient articles, websites, and other data. Because the literature on sex trafficking was patchy and inconsistent in quality, researchers used their experience and discretion to identify articles that were credible, and in some cases, reached out to trafficking experts (e.g., academic health researchers studying trafficking) to identify prominent authors or articles in the field.

Additionally, the research team asked interview respondents if they could provide general documents (e.g., organizational annual reports, brochures, newspaper articles) illuminating the sex trafficking trade in their cities. Respondents provided a wide range of documents, including reports on sex trafficking, annual reports, brochures and leaflets, service providers' data on client case load, and other documents.

Together, these supplementary data provided a rich counterpart to the key informant interviews, and effectively triangulated findings from the interviews.

Data Analysis

We used specialized qualitative research software (NVivo 9, QSR International) to organize our interview data. All interview audio files were transcribed by a member of the research team. To assure accuracy, at least one other team member reviewed the transcripts, and the team members then reconciled any differences in the transcripts.

^{**} Also, personal communication with Anita McGahan, PhD, Professor of Strategic Management, Rotman School of Business, March 2008.

Once all interviews were transcribed, they were uploaded to NVivo project files for each of the eight case cities.

Our analysis of the interview transcripts was both iterative and collaborative. The fact that our research team was multi-disciplinary facilitated considerable, rigorous discussion about the key conceptual codes and themes in the cases. Additionally, research team members triangulated interview transcripts with the notes taken during the interviews.

We primarily used “grounded theory” methods to develop key codes, and subsequent categories of findings. In other words, our codes were developed through induction. However, given our concrete research questions, we did not adopt a purely “grounded” approach in our analysis. We took a hybrid approach to developing a code book, one that has been described by Bradley et al. as an “integrated approach”: “An integrated approach employs both inductive (ground-up) development of codes as well as a deductive organizing framework for code types (start list).”⁴⁰ Once the research team reviewed a sizable subset of the interviews, it developed, over several iterations, a code book that could be used across the eight cases. Table 2.4 documents the conceptual codes we used in the study. To assure a place for data that did not fit cleanly into one of the categories, researchers also used “free nodes” in NVivo (akin to an “Other” category) to place findings. In many instances, portions of interview transcripts fell into multiple categories, and were coded as “co-occurring codes.”

Table 2.4. Coding Schema in NVivo

- Access to health and other services (facilitators and barriers)
- Health provider awareness of trafficking
- Collaboration/partnerships
- Domestic trafficking
- International trafficking
- How trafficking occurs in the city
- Identification of trafficking victims
- Trafficking legislation
- Prevalence and composition of trafficking in the city
- Social determinants
- Trafficking as a research construct
- Emerging constructs

Pairs of researchers were involved in coding the interview transcripts for each case, to strengthen inter-rater reliability and also validity. Research teams also met to discuss similarities and differences in the major themes that emerged from the transcripts, and to resolve any discrepancies in their findings. This constant iteration and use of multiple researchers provided opportunities to debate interpretations of interviews, and to thoughtfully begin to establish the logic (i.e., establishing the case “chain of evidence”) case key finding outlines that informed chapter-writing.

As the project evolved, the research team met often to discuss inter-case common themes and differences, and to discuss any difficulties in coding, or in approaches to identifying emerging themes in the individual cases. This group approach added considerable rigor to our findings. As noted case study theorist Eisenhardt notes, “Different cases often emphasize complementary aspects of a phenomenon. By piecing together the individual patterns, the researcher can draw a more complete theoretical picture.”³¹

Case Study Strengths and Limitations

Overall, our multiple case study approach offered several benefits from a methodological standpoint:

- Multiple case researchers strengthened inter-rater reliability in coding and analyzing case data;
- Triangulation of data sources strengthened internal validity;
- Focus on a single type of trafficking—sexual—among women and girls strengthened internal validity; and
- Multiple case-study design, arrayed by geographic diversity, could improve external validity.

Some of the limitations of our case study approach were:

- Our emphasis on women and children excluded consideration and examination of boys and men who are exploited, trafficked and/or enslaved;
- Cross-sectional nature of the study provided a single snapshot in time, rather than longitudinal changes in sex trafficking in a city;
- Limited access and security prevented us from potentially studying salient trafficking and slavery areas (e.g., North Korea, Thailand, Burma, Iraq); and
- Our inability to interview enslaved and trafficked victims and their perpetrators may limit our internal validity (i.e., getting the “real story” first-hand).

CHAPTER 3: SEX TRAFFICKING OF WOMEN AND GIRLS IN NEW YORK CITY

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Introduction

Study Setting

According to the 2006 U.S. Census, New York City has the largest population among U.S. cities: 8.2 million. The city is diverse, with whites comprising only 44.7 percent of the city's population; the Hispanic and black populations make up the largest minority groups in the city.⁴¹ Several sources cite New York City as a major destination for sex trafficking.⁴²⁻⁴⁴ Furthermore, a 2006 U.S. Department of Justice report noted that fully eight percent of suspected human trafficking cases in the U.S. took place in New York State.⁴⁵

The United States is primarily a destination and transit area for trafficking victims; an estimated 17,500 people are reportedly trafficked to the U.S. each year.⁴⁶ The country's federal legislation is the Victims of Trafficking and Violence Protection Act (TVPA). Enacted in 2000 and reauthorized in 2008, the TVPA is designed to prosecute traffickers and also to ensure services for victims. Trafficking victims are issued a T-visa, which, pending victim's cooperation with law enforcement, offers benefits and services via the federal Department of Health and Human Services.⁴⁷

Health care in the United States functions through a privatized system* that operates largely through employer-sponsored insurance programs.⁴⁸ However, despite a robust public-health care infrastructure, an estimated 20 percent of Americans remain uninsured,⁴⁹ including a disproportionate number from non-White minority groups.⁵⁰ The high number of uninsured partially accounts for a high infant-mortality rate (6.89 per 1,000 live births) compared with other developed countries.⁵¹ Recently-proposed health care reforms in the United States have attempted to address issues of access, efficiency, and cost for citizens.

In June 2007, New York State passed a law recognizing human trafficking as a criminal offense; it also convened a task force to oversee the State's efforts related to trafficking.

* Exceptions to privatization include Medicare, Medicaid, Veterans Health Administration, and Children's Health Insurance Program

The New York State Interagency Task Force on Human Trafficking noted three purposes of the 2007 State human trafficking statute:

- Criminalizes sex and labor trafficking
- Toughens penalties
- Establishes services for victims⁵²

The city's public-health infrastructure is robust. For example, the city's public hospital and clinic system, known as the New York City Health and Hospitals Corporation (HHC), consists of a vast network of facilities (e.g., hospitals, clinics). The HHC has more than 7,500 patient beds, and its hospital emergency departments had over 1 million patient visits in 2008.⁵³

This chapter describes sex trafficking among women and girls in New York City, viewed through a public-health lens. Specifically, we explore key determinants of sex trafficking as well as the health needs of victims, characterize the current, local health system response; and identify potential roles for the health system of New York City in addressing sex trafficking.

Summary of Field Work

Pairs of researchers conducted field work in New York City during three short trips in late 2008 and early 2009. In the preceding months, researchers generated a list of potential key informants by contacting physicians, nurses, local service providers, social scientists and advocates who subsequently referred us to other colleagues who could speak to the issues of sex trafficking and/or healthcare in New York City. Using a snowball method, we interviewed respondents until we reached theoretical saturation of our research questions. We used direct quotes from respondents to arrive at categories and themes. Quotes from multiple respondents, supplemented by existing literature were used to triangulate findings.

A total of 21 interviews were completed in New York City. Our case study methods are described in greater detail in Chapter 2.

Characterization of Sex Trafficking in New York City

Prevalence of Sex Trafficking

Few people agree on the prevalence of sex trafficking in New York City. To illustrate this discord in the field, estimates of the number of *children* commercially exploited for sex in New York City vary dramatically, from 15 to 5,000.⁵⁴ Two recent studies have estimated between 2,000 and 4,000 commercially, sexually exploited children in the

city.^{42, 43} The estimates are even less reliable for adult women victims; the literature fails to provide a well agreed-upon prevalence estimate for women and girl victims in New York City. One large NGO service provider in the city estimated it helps “an average of 75 human trafficking individuals and their families each year,”* but such data aggregated across service providers, or other proxies for prevalence, are lacking.

Our interview respondents similarly noted that it was virtually impossible to determine incidence (new cases) and prevalence of sex trafficking with any confidence due to difficulties with the definition of sex trafficking and with locating victims. Furthermore, some expressed skepticism about law enforcement’s ability to identify minor victims.

As one respondent explained,

So, if a 15-year old girl has been trafficked into prostitution, and is arrested for prostitution, brought into the police station to be booked and says, ‘I’m 18’; because she looks 18, she’s dressed like she’s 18, she’s hardened by her life, what New York City cop is going to doubt that she’s not 18? Plus, they say they’re 18 because the John can bail them out and get them back on the street.

Another respondent corroborated this point:

I think that law enforcement will tell you that even if somebody is under 18, they can’t prove that unless they tell them. If she gets picked up, and they ask, ‘How old are you?’ and she doesn’t have identification but says ‘I’m 18; I’m doing this on my own,’ they have no way of proving that she’s under 18.

Respondents identified both domestic as well as international trafficking as problems in New York City. Domestic victims (i.e., internally trafficked) were predominantly underage girls from poor neighborhoods, while international trafficking victims came predominantly from Russia, the Balkans, Mexico, India and China.

How Women and Girls Are Trafficked: Mechanisms

Our interview respondents suggested that psychological manipulation is a hallmark of the recruitment and retention strategies used by traffickers of vulnerable women and girls within New York City. Traffickers are typically male, several years older than their victims, and may portray themselves as “boyfriends” of their prospective victims. They prey on girls who they perceive as vulnerable due to low socioeconomic status or chaotic home lives. These boyfriend-traffickers befriend them first to earn their trust;

* This estimate included all forms of human trafficking, including sex trafficking.⁵⁵

then, over a period of time, they would introduce and then ratchet up demands to generate revenue, usually through sex acts with others. Several respondents portrayed traffickers as calculating and tactical in their recruitment and retention of young women for prostitution. One social worker observed similarities in the tactics used by traffickers for luring girls and reflected, “[I]t is almost like they have a trafficking manual.”

One NGO provider spoke about the process by which domestic trafficking occurred.

The vast majority either ran away from home, or were [*sic*] walking home from school... already incredibly vulnerable because of all the prior abuse... meets a guy who acts like their boyfriend and seduces her, and becomes sold. I mean, that is pretty standard. There are a percentage of girls who were straight kidnapped – there was no seduction element. I mean, they were literally walking home from school and someone grabbed them from the street, but even in those cases the trauma bond often ends up developing. Those girls don’t actually run away afterwards.

Another respondent explained that traffickers frequent well-known transit areas for vulnerable girls, wherein the process of psychological manipulation commences.

These girls run away, they go to shelters, train stations – and this is where the guys are that pick them up and tell them what they want to hear. Then there is what I call the honeymoon period of about two weeks, and this is when these men collect as much information as they can about the girls, their lives, and their families. This is how they can keep their hold over the girls, and create fear in them – they know where to find their families, and how to harm them if the girls don’t do what they say. They talk of threatening family members if they ever do run away.

Whereas the initial recruitment emphasizes kindness, traffickers soon introduce psychological and physical abuse tactics to control their new victims and keep them enslaved. One respondent familiar with international trafficking cases in New York described how traffickers play to victims’ empathy before resorting to other tactics: “He’ll first try to get her to do it willingly – like ‘We really need food, we really need to pay the coyotes [smugglers who transport undocumented persons across borders for a fee],’ and if she says no, then there’s an escalation of violence or threats until she agrees to do it, or then is forced to do it.”

Sex Trafficking: Key Determinants

The interviews, with corroborating support from the literature,⁴² revealed a plethora of determinants of sex trafficking in New York City. Some determinants related to general societal norms regarding sexuality for both males and females, while others focused on individual, family and neighborhood conditions that rendered some girls particularly vulnerable to being trafficked.

At the individual (i.e., victim) level, personal and family financial instability emerged in our interviews as two distinct trafficking determinants: absolute poverty and relative lack of sufficient income. In other words, respondents distinguished between conditions of abject poverty and less severe forms of economic deprivation. For example, some spoke about absolute poverty in terms of a victim family's chronic privation--being poor for several generations, or failure to have basic daily requirements met for food and/or shelter.

By contrast, relative lack of income was described in terms of a girl's inability to purchase certain goods and services felt by the girls to be necessary, although often viewed by others as discretionary, such as a cell phone, manicure, or hair style. One health-care respondent illustrated how trafficking clients s/he worked with compared sex work against alternative economic opportunities: "Well, a job at McDonald's is fabulous. But, you know what? I can go out one night and get money for food, a hotel room. I can get my nails done, I can get my hair done, and I can buy myself an outfit." Several respondents also mentioned women's and girls' lack of formal education as a determinant of sex trafficking.

Prior sexual abuse in a trafficking victim's life resonated as an additional key determinant. One service provider estimated that "75 to 80 percent" of the organization's trafficking-victim clients "have been victims of sexual abuse," while a health-care respondent noted that "approximately 80 to 90 percent of young people who are involved in the commercial sex trade have a history of sexual abuse."

Individual-level trafficking determinants were expressed along a time-continuum. For example, some respondents reported how early exposure to poverty, sexual violence and other forms of domestic violence in a victim's life create contextual conditions favorable to trafficking, while others described factors (e.g., social isolation, psychological abuse) that could prevent a women or girl from *escaping* once she has been trafficked (Table 3.1). Several respondents described the pressure traffickers could exert on victims through threats to harm family members. Coupled with obligations that victims feel to provide financial support to their families, traffickers' success in using psychological tactics to harm victims was viewed as a determinant of whether victims could leave their trafficking situations. Psychological abuse tactics also serve to muddy reality for victims, who may not even have recognized the extent of their victimization.

One health-care respondent described the relationship between victim and trafficker in the following way:

I mean, they knew something bad happened. They knew the person [trafficker] had done bad things. But even, you know, a lot of the women – this pattern of women coming from Mexico who were involved in a romantic relationship – it’s very thorny because this person has this involvement, but the person is also threatening them and there’s all these other issues –untangling domestic abuse from trafficking and how it crosses the line....

Traffickers also lead their victims to believe they will be deported if they approach law enforcement, social service or health authorities. In other words, victims fear seeking help from law enforcement, social service organizations or health care because they believe they would be deported.

Table 3.1. Statements Related to Key Determinants of Sex Trafficking

Key Determinants of Sex Trafficking of Women and Girls

So poverty, childhood sexual abuse and actually involvement with the child welfare system. So that’s indicative of childhood sexual abuse in the home, neglect in the home, physical abuse in the home, domestic violence in the home... Those are the three biggies. (Hospital social worker)

Determinants of whether Victims Remain in Trafficking Situations

For some [trafficking] clients depending on where they are from, their papers were either stolen from them; a lot of them were tortured or beaten. They are threatened physically, mentally, emotionally, and they are isolated...everything we can think of just so they won’t escape. [Speaking about traffickers] Break the human spirit down so they do what they need them [victims] to do. So after a while it’s a lot. And also you know [traffickers are] threatening their family back home because there is always someone there and someone here that are part of the trafficking group. And you know we [speaking about traffickers] will do harm to your family or your children or what have you, so it makes it very difficult to escape. (NGO respondent)

At a macro-level, several respondents reported media depictions of sex in society as an important factor that contributed to gender inequality, which thereby could lead to favorable conditions for sex trafficking. One respondent implicated society’s need to “glorify the pimp culture” as a factor, which could then undermine messages to young people about “healthy relationships” between men and women.

Another respondent placed the issue in the following context:

A culture that increasingly glamorizes sexual exploitation is a huge barrier [to eliminating trafficking], particularly directed at people of color and youth. Pimping is supposedly now a good word, a culture that continues, as I say, to glamorize sexual exploitation of women. (NGO advocacy director)

A nurse implicated the Internet as a conduit through which depictions of “really violent” sex could influence relationships between women and men, noting, “I have friends who are GYNs [gynecologists] and the females that they’re seeing, across social, ethnic and educational lines, are beginning to say, ‘My male partner is asking me to do things that I’m uncomfortable with. Am I normal?’”

Existing Responses to Sex Trafficking in New York City

Health Services for Trafficking Victims in New York City

Overall, the interviews suggested that sex-trafficking victims in New York City have a wide range of health needs, ranging from primary care to obstetric care to dental care to mental health treatment. Despite these myriad health needs, the health system response in New York City to sex trafficking victims was characterized as being extremely limited. Health care services are paid for, only if a rescued victim is in the process of becoming certified or has attained “continuing presence” status. Free outpatient medical services are reportedly extremely limited, as there is one free clinic in each borough. Respondents noted the lack of a dedicated health facility in the city, or coordinated system of care, to meet the health needs of trafficking victims. One respondent said, “There are no specific, unique providers of health care to victims. There are no specific hospitals.”

As is the case for the general public, emergency departments were the primary source of health care for sex-trafficking victims, especially in the event of severe illness or injury. However, emergency departments were not viewed by respondents as facilities of choice for routine health issues:

Basically, it [the emergency department] is the one place that is mandated to take care of anyone and everyone, at any time. I think probably for that reason, we just end up seeing a more vulnerable population. I’m sure community health centers also do – maybe even more so, but as a rule of thumb anywhere, anyone can walk in anytime, wherever you are – the wealthiest city in the world, and you have to take care of that person as a federal mandate. I also think that people present for all sort of things. If

someone has a lot of pain or has a very bad infection, I think the perpetrator would bring the person in, and would want them to be healthy and work. They wouldn't bring them in for other basic care; check their cholesterol; or general medical exams. (Emergency physician)

Another respondent described a medical "no-win" situation facing trafficking victims in the city.

When a 16-year old girl just comes out of a sex trafficking situation we immediately want STD [sexually transmitted disease], OB-GYN, blood work, everything, and we have two choices. One is to send them to the emergency room, but you can't really send them to the emergency room for comprehensive care; and the other option is to wait, sometimes for months, for a free clinic. (NGO service provider)

Instead, the locus of responsibility for coordinating health care services falls largely on the shoulders of the NGO service providers working with trafficking victims. In other words, service providers seek health care services on victims' behalf, through various and often ad hoc mechanisms. Some of these routes are part of the formal health care delivery system (Noted one respondent: "We are very lucky here in New York City. We have a lot of immigrant-friendly, sliding scale facilities."). For example, one service provider formed a working relationship with the children's health center of a major New York City hospital, such that the same hospital social worker visits the provider's facility on a weekly basis to meet with victims. In contrast, another service provider uses a much less formal mechanism for arranging health care for victims: "What I do basically is hustle and get people that I know to do favors for me. Luckily, I know a few people who have medical backgrounds that I basically beg for favors."

Beyond treatment, the health system in New York was not perceived as a visible stakeholder in anti-trafficking activities in the city. Several respondents pointed to the evolution of anti-trafficking work in the city, and the fact that law enforcement and social service organizations, rather than health institutions, are at the forefront of this work. Our interviews uncovered only one exception: The New York State Nurses Association's Committee on Ethics and Human Rights helped draft a resolution declaring trafficking to be an important nursing issue, which the national nursing body, the American Nurses Association, adopted in 2008.*

*See also: Glickstein B. The tragedy of human trafficking. *Am J Nurs*. Nov 2008;108(11):11.⁵⁶

Barriers to Health-System Response to Trafficking

Our interviews identified barriers that prevent a more robust response from the local health system. These barriers included: low baseline awareness about trafficking among health care workers, mistrust of health providers among sex-trafficking victims and lack of health insurance for victims.

One frequently-mentioned barrier is a lack of basic awareness about sex trafficking among health-care workers: the issue is not part of basic education or in-service training for health-care workers.

You know, in all honesty, it isn't something that is on the forefront of our radar, I would say, here. And...we have a very good, supportive department that has very good learning opportunities and very good trainings and in-services, and trying to keep us knowledgeable about whether there are changes in child abuse laws and what is going on, and having trainings and updates. And I would have to say that, you know, trafficking isn't something that is as present... (Hospital social worker)

An emergency physician echoed the sentiment that trafficking is a relatively new topic for health-care workers: "I never think about it [trafficking], and I'm probably the most aware person in our department. I think about domestic violence sometimes...."

Related to the low level of awareness was the view among several health care respondents that trafficking victims, like torture survivors and domestic violence survivors, do not tend to self-identify as trafficking victims. Therefore, health-care workers could not confirm having seen trafficking cases. Noted one physician with extensive experience treating victims of torture, "You know, I think there is probably a lot of fear there, too, so as with survivors of torture, they [sex-trafficking victims] don't necessarily wave a flag for you to identify them." Another respondent put it another way: "People don't say, 'I'm a victim of trafficking, or I'm a survivor of trafficking.' They might say, 'I had some domestic violence, my labor rights were violated, I was sexually assaulted.' But to have it all come together as trafficking takes a lot of work."

The lack of self-identification frustrated one emergency physician, who described being unable to help a potential victim.

I had one that I thought the person may have been trafficked. It was a very bizarre interaction – there was a nanny and the mother of the house. The woman was very sick, so she brought her to the ER. I stepped out with the woman and I just asked her, 'Are you okay there? Is this a choice for you? Are you allowed to leave?' It just seemed very abusive, and she was like, 'Yeah, yeah, yeah.'

The interviews suggested that victims' lack of self-identification to health care workers could be due to several factors. One common theme among the respondents was that international trafficking victims feared that hospital workers would turn them over to immigration authorities for detention and subsequent deportation. Part of the fear resulted from stories spread by traffickers. Noted one respondent: "[Victims] are afraid to go to the hospital to seek any kind of care, or they have been threatened by the traffickers [who say], 'Never go to the hospital. They'll ask you for your SSN [social security number]. They'll ask you for your passport, so just do not even go to the emergency room.'"

Another factor is that trafficking victims feel marginalized by health workers they encounter. As one respondent characterized, "What I hear the most from these young women is that when they've gone to pursue health care, they feel judged. They feel like nobody really understands what they're going through. Social workers or clinicians that they meet don't understand the issue."

An additional factor related to victims not seeking health care is the lack of health insurance coverage for sex-trafficking victims—especially those who are international victims. Respondents noted the quandary of international victims who lack the legal status to qualify for Medicaid, and could only qualify if they cooperate with law enforcement to testify against their traffickers. The process of becoming "certified" as a trafficking victim by the federal government was described by respondents as cumbersome. As described earlier, victims fear retribution against family members abroad if they cooperate with authorities.

Opportunities for Local Health-System Response to Sex Trafficking

Our interview respondents, both health and non-health, overwhelmingly believed that the local health system could be an effective stakeholder group in anti-trafficking work in New York City. Some respondents maintained that health care workers could directly engage in anti-trafficking activity, whether by identifying victims or by creating greater awareness about trafficking in the health field. Other respondents recommended general improvements in health care provision for vulnerable populations that could indirectly, yet profoundly, improve services for sex-trafficking victims.

Education and Awareness-Building among Health Professionals

The interviews suggested that raising awareness about sex trafficking among hospital emergency department personnel—physicians, and non-physicians alike—could be effective, because the emergency room is one of the only places where victims are not physically accompanied by their traffickers. One NGO service provider described how

difficult it was for victims to move freely, and how vital a patient encounter at the hospital could be:

So even if the trafficker isn't there, they have a series of associates and enforcers, and so the person is rarely ever alone. And so, to be able to have that person be able to be alone and share part of their story, health care facilities are one of the only places where that can happen.

Respondents offered suggestions for providing education about sex trafficking to hospital workers. Several NGO service providers suggested trainings on how health care workers could identify trafficking victims and make appropriate referrals to service providers specializing in serving trafficking victims (Table 3.2). One of these respondents described having conducted such trainings at some of the "HHC" [New York Health and Hospitals Corporation] public hospitals. The potential impact of closer collaboration with hospitals was described by one service provider this way: [I]t would be great to feel that every hospital in this city knows our number, knows how to reach us 24 hours a day, knows the signs, and feels comfortable calling. This isn't the case right now, though." A hospital social worker suggested that emergency department staff be trained on immigration laws, so that medical providers could reassure undocumented immigrant patients that the providers would not call immigration officials about them.

One NGO service provider cautioned that training health care workers could only succeed if more funding became available.

Right now there's almost no funding for outreach, so right now any outreach that we do is being done in our spare time. If I had just one grant focused on outreach, we would be in the hospitals a lot. Right now we get invited when we can. One of my suggestions would be to train all social service providers, nurses, social workers.

Table 3.2. Suggestions for Training Health Care Workers about Sex Trafficking

From NGO Service Providers

It's usually just general information sharing, presentation type work. You know, 101: 'These are the signs of trafficking, and these are some of the questions you can ask, and if you ever have a case, please call us.'

So on health issues, we would target every single hospital - emergency rooms particularly, so they know what are the five top indicators of trafficking, what are the three steps they would take protocol-wise in terms of calling a social worker. [Also], social workers being trained in making sure to make sure that person is treated...with respect.

I...don't think it has to be a long and elaborate training. You know, trafficking takes place, and this is what it looks like.

Another type of recommendation involved the development of checklists or algorithms on trafficking identification for health care workers. However, respondents were divided on whether a trafficking checklist in hospitals would be useful.

Remarked one health researcher,

...I think the cases are so unique that there is not a checklist that you could give an ER nurse and be like, "Look for these things." You can give people information, but I think a lot of times you'd have so many people identified as being potentially trafficked, or they're overlooking something, because the signs are too subtle and [they are] looking for the worst case scenario.

Yet other health respondents drew parallels to domestic violence and sexual assault screening at hospitals, and how such tools could be adapted to sex trafficking.

...I would imagine – people (the "handlers") often accompany these victims of sex trafficking to the hospital to ensure they say the right thing – that has been seen in rape cases. It is important that the physician tries to allow some independent time with the person and I to ensure the appropriate questions are asked – perhaps incorporating some of the standard questions regarding abuse, sexual abuse, and those specific to sex trafficking. (Emergency physician)

Another emergency physician commented, "I think just having set protocols like we do for domestic violence, which you are required to ask every person at triage, you know, a few questions."

Beyond health facility settings, some respondents argued that medical schools could play a role in trafficking awareness and identification by educating students about the prevalence, indicators and intervention regarding sex trafficking. One social worker talked about incorporating sex trafficking into domestic violence or family violence modules for medical students.

Two physician respondents described different tactics that could raise awareness and understanding regarding trafficking in medical schools:

I think people need to know outside of reading on page 16 of the New York Times that sex trafficking exists. Dedicated time in medical school teach future physicians how to address these problems is imperative. Sex trafficking victims are not easily identified during a routine H and P

[history and physical]. Training is necessary to develop the skills to identify these people.

If you got it [a question about trafficking] on the boards [medical licensure examinations], then there'd be a trickle-down effect. If you can get it into the boards, then people have to prepare their students for the boards, so it's a no-brainer that they're going to have to put it into the curriculum.

Beyond medical schools, some respondents also called for trafficking training for other health-related professionals, such as social workers. One emergency physician described below the need for social workers to work in tandem with physicians to form a cohesive health team.

I think a lot of the things that this population needs can be provided much more effectively by a social worker than a doctor *per se*. Certainly we may be able to see some of the psychological consequences of *this*, and we might be able to do something to treat *that*, but I think a lot of what they need is help to develop connections in the community. If there is a person known to the community, that has roots there, they would be a natural go-to person for victims. Victims of sexual trafficking would look to them for help to separate from the criminal ring that is trying to prevent them from making these community connections.

Improve Health-care Services for Trafficking Victims and Other Vulnerable Populations

Lack of access to health care for victims was a concern among many respondents. Many respondents denounced the *quid pro quo* of federal trafficking "certification," whereby, in order to obtain Medicaid and other benefits, victims needed to cooperate in law enforcement investigation and prosecution of their traffickers. Some respondents embedded the plight of trafficking victims in the broader context of immigrants. In other words, society needs to do more to make health care services available to immigrants, of which international trafficking victims represent one small but important subset. Other respondents observed that youth who may be susceptible to trafficking are likely to lack health insurance.

Many respondents reflected on the need for providers, both health care and social service, to be mindful of the trust issues that challenge trafficking victims who need health care. Respondents used such phrases as "You have to get beyond the armor that these girls have built up" and "removing the judgment and the stigma is going to be critical" to describe the challenges in working with this population of victims. Another respondent argued for patience among mental health care providers, maintaining that trafficking victims may not be open to receiving "trauma counseling" for a year or

longer, until they are fully ready to participate on their own terms. Furthermore, one respondent noted that some international trafficking victims may have come from a country where the traffickers or their associates actually pose as doctors or policemen (and in some cases actually were doctors or policemen), only to bring them harm. In these situations, a well-founded lack of trust of health care providers may be a stubborn complicating factor.

A physician that serves at-risk youth described the importance of utilizing approaches that offer examples of healthy relationships, thus teaching and empowering young people in their daily interactions, in order to prevent them from becoming vulnerable to sex-trafficking and other victimizing situations:

So, for example, along the lines of this sort of broad definition of trafficking, most of the kids in our program have had unhealthy relationships with adults – either abuse or manipulation. ... [O]ne of the driving principles of our program is that the relationship is the primary intervention. Not anything that I do, like [treating] strep throat or even anti-retrovirals. Like it's all good stuff, but I'm having with them a healthy relationship that's appropriately boundaried, that encourages them to have an internal locus of control, that sort of creates, especially among younger people, the ability to think longitudinally, to create a context for decision making.

The importance of building trust was echoed in respondents' comments about health care providers as needing to be viewed by victims as *trustworthy*. As one emergency physician summarized, "If they do not see any trustable qualities in the caretaker who is supposed to be taking care of them, then I do not think they are going to open up and expose this extremely horrific episode in their life."

Another respondent described how a health care provider could earn a victim's trust:

Let them know that immediate assistance is going to be offered. ... Present it with an immediacy of help. We can take care of this for you now. We can get you shots of whatever or we can get you feeling better now, and then we can talk about other things we can offer you. (NGO service provider)

An emergency physician suggested that the physical configuration of a busy hospital emergency room be changed in order to accommodate private conversations with at-risk patients.

There's so much crowding, that the idea of privacy is kind of a joke. So if someone identifies themselves to us as domestic violence, we'll actually put them in one of the isolation rooms – you know, one of the rooms we

keep for patients – but if they don't identify themselves that way, most of the conversations we're having, they're here, and the other patient's right there.

Discussion

Overall, the case of sex trafficking in New York City, and the role of health care in addressing the issue, yielded several important findings. The key determinants (e.g., poverty, childhood sexual abuse, family dysfunction) for sex trafficking operate at multiple levels, from the individual, all the way up to the societal level. Thus, because the factors that facilitate sex trafficking are complex and multifaceted, the interventions must be correspondingly rich and integrative. These findings imply the need for a deliberate role for health-care institutions in New York City in prevention activities (and in turn helping to obviate the social conditions that make trafficking possible), and in the systematic identification and treatment of victims. Put in a different way, the health system, predominantly through emergency departments, has responded to victims' acute health problems, yet has the potential to make a deeper, more lasting impact on the lives and well-being of trafficking victims as well as on the prevention of trafficking itself.

Unfortunately, the problem of sex trafficking remains a peripheral issue to the health system in New York City. Despite a fairly impressive track record in related issues such as domestic violence, torture survivor care and sexual assault, the problem of sex trafficking is new, and in many cases completely foreign to many health care workers, including clinicians specializing in the aforementioned areas. The definitional stew of trafficking, prostitution and other conditions of exploitation obfuscates the issue for health care workers, and in turn may present barriers to intervention. We encountered little evidence, other than the New York State Nurses Association's efforts to advance trafficking as a policy issue, that the health system plays any major role in coalitions or other city-wide efforts to combat sex-trafficking. As such, the current health system response to sex trafficking is weak, episodic and reactive. The hospital emergency room remains the primary locus of health care for many victims, and given competing demands of hospital staff, is poorly positioned to be a satisfactory venue to meet the full range of health needs of sex-trafficking victims.

Of course, the health sector can only respond to the needs of victims if they can be identified, or if victims themselves present for care. This chapter described victims' numerous fears about seeking health care, and reluctance to trust health care providers. Trust issues such as these, and, in addition, access, payment and certification issues present major barriers to care. Efforts need to be made to address these barriers, for example, finding a way to provide health insurance or free care for undocumented immigrants and to change survivors' perceptions of health care providers. In other

words, health care workers need to be trained to function – and survivors need to be able to view them - as advocates and trustworthy professionals who will assist them in a sensitive, compassionate and confidential manner. Interview respondents emphasized the need for compassionate health care workers to listen patiently and attentively to the stories and needs of victims. This request was a universal recommendation, not only for trafficking victims, but also for all at risk and vulnerable patients. Most importantly, notions of “respect” for patients were felt to be critical to build the trust that is required between patient and provider.

Additionally, hospitals’ and clinics’ outreach to victims via improved coordination with the city’s leading trafficking service providers could make hospitals and clinics locations in which trafficking victims could feel secure, cared for and able to talk about their experiences. Several examples of trafficking service providers collaborating with social work departments of hospitals have been documented; such programs could be expanded. One health respondent went so far as to recommend opening a trafficking health center in the city that would tailor its services to meet the needs of victims, drawing on the lessons of centers focused on treating domestic violence victims or torture survivors.

The practical issue of how health care workers can become more effective agents in anti-trafficking activity is not simple, nor is there a single turn-key solution. Our interview respondents made clear that targeting physicians alone is insufficient. Nurses, social workers and allied health professionals need to be involved in anti-trafficking work, too, in order to generate any real impact in communities where trafficking takes place. The frequently described notion of raising awareness about sex trafficking among health professional trainees (i.e., medical students, social work students) was viewed by respondents as a sustainable strategy for assuring greater engagement in addressing sex trafficking among health professionals in the future.

Short-term strategies for awareness-building among hospital personnel, for example, may be most effective by identifying health audiences that may already be sympathetic and/or predisposed to take on sex trafficking as an issue.

As one hospital social worker commented,

...I’m not sure you would really want, nor would it be feasible, to have all primary care docs feel comfortable treating, or addressing this. Because the issues, I think legally, and socially – medically probably is the easiest – are just so, so, so complex. And the safety issues are even I think far more complex even than DV [domestic violence]. I would think at least to start, you would want to start with specialized centers that could do this and then you kind of see where it goes from there.

Interview respondents generated a multitude of ideas for a stronger health system response, many of which involved strengthening existing systems within hospitals. For example, the notion of adding sex trafficking questions on to existing domestic violence screening checklists, or introducing trafficking as a topic for the Sexual Assault Nurse Examiner (SANE) programs, or creating more private spaces for provider-patient encounters, were each suggested repeatedly in our interviews. Furthermore, as stated earlier, taking steps to improve health access for vulnerable populations as a whole, such as for undocumented immigrants, may have beneficial ripple effects for sex- trafficking victims.

This chapter provided some additional lessons about sex trafficking in New York City. Our interview respondents cited a wide range of social and other determinants of sex trafficking that corroborates the published literature on the topic.^{43, 44} Such evidence points to the need for intervention at multiple points in a woman's life-course, rather than solely focusing on treating victims once they are already victimized, and the need for action at multiple levels—individual, interpersonal, communal and societal.

Our interviews raised questions about the scale and scope (e.g., prevalence) of sex trafficking in the city. In particular, identification of minor victims was noted to be very difficult, given the incentives young girls have to fabricate their age. It is therefore likely that child sex trafficking victims could be undercounted.

In spite of the many challenges described here, the interviews described a significant potential role for health care workers in anti-trafficking work—in identification, treatment, advocacy and other areas. The fact that health systems are intrinsically multidisciplinary (i.e., comprising medicine, public health, nursing and social work), and that New York City is such a resource-dense area in this regard, suggests that the local health system can contribute in many areas—not just short-term treatment of victims' acute illnesses and injuries.

CHAPTER 4: SEX TRAFFICKING OF WOMEN AND GIRLS IN METROPOLITAN LOS ANGELES

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Introduction

Study Setting

With 4 million residents,⁵⁷ the city of Los Angeles has one of the largest populations in the United States. Metropolitan Los Angeles (Metro L.A.) has over 13 million residents, and is sprawling, covering nearly 5000 square miles.* Los Angeles has been noted as a major destination for international sex trafficking victims in the U.S.⁵⁸

The public health system in Metro L.A. is extensive. For example, the Los Angeles County Department of Health Services (DHS) is one of the largest public health systems in the nation, and provides treatment and care to the majority of the uninsured in Los Angeles County.⁵⁹ In 2007 it received nearly 300,000 emergency room visits. DHS operates four hospitals, two ambulatory care centers, and six comprehensive health centers.⁵⁹

This chapter describes sex trafficking among women and girls in Metro L.A. Specifically, we describe what is known about the mechanisms of sex trafficking, explore key determinants of sex trafficking, describe the current local health-system role in anti-trafficking activities, and elucidate potential roles for the health system in anti- trafficking work in the future.

Summary of Field Work

Researchers conducted most field work in Los Angeles during a March 2009 trip. In the preceding months, researchers generated a list of potential key informants by contacting physicians, nurses, local service providers, social scientists and advocates who subsequently referred us to other colleagues who could speak to the issues of sex trafficking and/or healthcare in Metro L.A. Using a snowball method, we interviewed respondents until we reached theoretical saturation of our research questions. We used direct quotes from respondents to arrive at categories and themes. Quotes from respondents, supplemented by existing literature were used to triangulate findings.

*In this chapter, we define Metro L.A. as covering both Los Angeles and Orange County. The U.S. Census Bureau similarly defines the metropolitan area as "Los Angeles-Long Beach-Santa Ana CA Metro Area."⁵⁷

A total of 19 interviews of 21 respondents were completed for this case study.* The respondents comprised 5 physicians, 1 nurse, 1 mental health provider, 11 social service providers (program director or administrator), and 1 social worker. Chapter 2 provides an in-depth description of our case study methodology.

Characterization of Sex Trafficking in Los Angeles

Prevalence of Sex Trafficking

Two themes emerged from our interviews that relate to the prevalence of sex trafficking in Los Angeles: (1) no reliable city- or metropolitan area-wide estimates of sex trafficking currently exist; and (2) sex trafficking victims in Los Angeles come from within the U.S. as well as from other countries.

While maintaining that sex trafficking occurred throughout the Metro L.A., the interviews did not produce a reliable estimate of the number of sex trafficking victims in the area.

Respondents were unable to venture either city-wide or metropolitan area-wide estimates. Respondents offered a number of reasons why such estimates remain elusive. First, trafficking was viewed as a clandestine activity that makes identification of victims extremely difficult. One respondent noted that while labor trafficking victims could be readily identified, sex-trafficking victims are much more difficult to locate: “Sex trafficking is so underground.” Traffickers reportedly work hard to keep victims out of sight of authorities. Furthermore, sex-trafficking victims do not identify themselves as victims, *per se*, because they are fearful that immigration authorities will deport them; view their circumstances as “a secret and...a shame”; or do not recognize that they are being exploited by their traffickers.

One respondent, a mental health provider, described such apprehensions as follows:

So they will hide, they will not go to any police officer or anyone because they are very, very afraid. On top of that, the traffickers make them think they are scared of the police, and they tell them, ‘No, you have to be very careful of the police, because if you don’t do this or you do that, I’m going to call the police on you, or I’m going to call immigration on you, and this is what is going to happen.’

* Due to audio-recording difficulties, we re-interviewed one respondent, by telephone.

Finally, some NGO respondents noted prevalence estimates are hampered by the lack of organizational capacity required to rigorously document and track victims. Prevalence estimates are also impeded by the porous definitional borders between “sex trafficking” and other forms of sexual exploitation, which led some respondents to reframe, redefine, or expand the issue. For example, one pediatrician maintained that, among youth, “survival sex” is a more accurate depiction of “the predominant” phenomenon in Los Angeles, rejecting the term, “sex trafficking” as describing only a small minority of cases:

I think that [sex trafficking] happens some. I don't think that's the predominant thing that happens. ... It's not only that kids are taken, kids go to conventions. People that are into this, you know, when they get into it, you don't have to have a slave master, okay? So, again, I think that it's a complex phenomenon, many different types of behaviors occur.

Another physician noted that some women and girls are lured into pornography, a trafficking-related form of sexual exploitation, in the hope of eventually finding work in “mainstream” acting. Another respondent cited that, within the larger field of human trafficking, there is the perception that cases of labor trafficking that have sexually exploitative components should be part of the total calculation of “sex trafficking” prevalence. Finally, some respondents argued that the experience of having been trafficked can have adverse collateral effects on women's health and social welfare in the long term. For example, a woman could have been trafficked early on in her life, escaped from her trafficker or “aged out” of the initial trafficking situation, only to remain in or return to the sex industry as an adult. One respondent summarized, “The female prostitutes we see on the streets today are the children we failed to protect 20, 30 and 40 years ago.”

While prevalence estimates are difficult to find, respondents were nonetheless able to shed light on the predominant source areas from which sex-trafficking victims come. Respondents described both domestic victims as well as victims from a wide range of countries outside the U.S., a finding corroborated by existing literature on sex trafficking in California^{60, 61} (Table 4.1).

Table 4.1. Source Countries of Sex Trafficking Victims in Los Angeles

Domestic Sex Trafficking into Los Angeles

We've heard stories that they met their pimp in San Francisco and they've been taken to Las Vegas, they track all up and down California, from San Diego to San Francisco, to Fresno, across state lines, yeah, most definitely state to state. (NGO service provider)

And of course we have many trafficking victims that are coming out from other countries, but with what we're doing and our level of outreach, it's been U.S born. I have seen some girls, some young girls that I believe are from South America or Mexico that are out, but our connection has been U.S. born. (NGO service provider)

International Sex Trafficking into Los Angeles

We have clients from Nigeria, we have clients from Samira, we have clients from the Philippines, we have clients from Russia, we've, we have a client from Vietnam, we've had a couple, one from Singapore. (NGO service provider)

I know sex trafficking is happening in LA because just recently, a couple of weeks ago, five people were in a criminal case and have been sentenced because they trafficked how many, I think it was eight Guatemalan girls. They brought them over with the idea that they were going to be nannies. Once they got here to this area, right here, they were prostituted. They were forced to prostitute and work in that capacity. So, I know that's happening here. (NGO service provider)

In L.A. we have survivors from all over the world. I mean my [clinic] patients are from Central America, South America, Asia, Africa and Europe. (Physician)

How and Where Women and Girls Are Trafficked: Mechanisms

Several respondents emphasized the importance of relational aspects of sex trafficking in Los Angeles. That is, traffickers are able to recruit victims by first establishing relationships, or strong ties, with them. As one respondent recalled,

[A] lot of times these girls call them 'Daddy.' It's a pseudo-family that they create. He's the daddy, the other girls are wifeys, so they refer to each other as that, and, you know, many times these girls are coming from such a broken home situation....

The notion of traffickers as older men providing succor to victims, treating them with kindness prior to exploiting them, was a primary theme in interviews. Respondents identified attributes that make traffickers effective at recruitment of victims, using such terms as "very smart" and "master manipulator" to describe traffickers. While most respondents who spoke about traffickers identified men as perpetrators, one respondent expressed the contrary view that women who were formerly trafficked comprise a substantial subset of traffickers.

Seduction was noted as a key tactic used by traffickers to draw in young women: “The lover boy scenario...is very, very prevalent here, especially with marginalized kids who don’t have anybody watching out for them, and somebody comes in and says you’re really beautiful.” Furthermore, according to an NGO service provider, relationships between traffickers and victims are carefully cultivated: “These guys know how to come in and take a girl that’s in that vulnerable place and just groom her to the point that she’s all of a sudden out there working for him and has no problem with what she’s doing....”

Some respondents described the paradoxical “attachment” between victim and trafficker in these abusive relationships. As one physician described, “For girls who have been involved in pimp-controlled prostitution, they have formed a kind of traumatic attachment to that person, and that’s where their emotional center is.” The psychological control of victims can manifest in the form of financial control over victims, too: “It’s, ‘\$2,500 goes to the pimp.’ If the pimp decides you need a new dress, he’ll spend for the new dress. If he decides you need toothpaste, he’ll spend for that. But he makes all the decisions...so there’s no ‘How much do they get back?’”

Traffickers also recruit victims—international victims—through transactional means. In other words, they promise women and girls better economic opportunities in Los Angeles. Several respondents asserted that false job offers lead international victims (e.g., from Mexico) into sex-trafficking situations in the Los Angeles area. Many of these purported jobs in Los Angeles are domestic work-related, such as housekeeping or child care positions that ultimately turn into sex-related work.

One NGO service provider respondent provided the following example of a trafficker’s false promise:

Even if they’re not found out in a raid or it’s not on TV, I think that it happens all the time that people are trafficked all the time that people are trafficked as maids and nannies but end up as sex workers. So someone might say to us, ‘I was working as a nanny,’ but be too ashamed to actually tell us that they had to be a dancer at these men’s clubs.

One NGO service provider asserted that concerns about profitability lead many traffickers to push victims into sex work, because it is more lucrative than labor trafficking: “People are starting to traffic them for labor, and when they find out they cannot make enough money on them on labor then they move them into sex trafficking.”

Sex trafficking takes place in a variety of settings, and across a wide range of locations (Table 4.2). Respondents described sex-trafficking victims being forced to engage in sex work in both indoor as well as outdoor locations. Furthermore, collectively, our

respondents indicated that these activities are taking place in far-flung parts of Metro LA. Rather than a single red-light area in the city, respondents noted that trafficking occurs in urban neighborhood hotspots (aka “tracks”) as well as the suburbs of Southern California: Compton, Hollywood, Pico Union (all in the City of Los Angeles), plus the San Fernando Valley, San Gabriel Valley, and Orange County, among other places.

Table 4.2. Venues of Sex Trafficking Activity in Metropolitan Los Angeles

Venue	Quote
Private homes	<i>Another thing that was found in that same town of Arcadia [in L.A.’s foothills], was a very nice upscale, affluent home being used as a brothel. (NGO service provider)</i>
School grounds	<i>The school psych [nurse] said that every week there are pimps on the sidewalk intercepting these little girls on their way home from school saying I know your families are having a very difficult time but we can show you how to make an extra \$100 a week. \$100 a week means that we get to eat everyday. (NGO service provider)</i> <i>The main time for most of these girls to come out is, actually, when school’s getting out, because the dads will drive by and see the girls working, drop their kids off, and come back and pick up. And she talked about seeing some of her classmates then out working, you know 14 or 15 year old girls that were working in prostitution. (NGO service provider)</i>
Massage parlors	<i>So we believe that a lot of sex trafficking is happening in the spas and massage parlors, right? No surprise there. (NGO service provider)</i> <i>[I]’m thinking a lot of trafficked women from other countries are not put on the street. I may be wrong about this, but I think they may be put indoors, in massage parlors and escort services, or trafficked in that arena, more so than maybe on the street. (NGO service provider)</i>
Business conventions	<i>If there’s a big Asian conference and they want Korean women, they’re going to find all the Korean women, which is why we know it’s organized crime. They’re going to find all the Korean women to come in and make a lot of money. (NGO service provider)</i>
City streets	<i>We had one young woman...who became sort of a pawn among a bunch of pimps, who took pleasure in who had her in the moment ,and would kidnap her, put her out on her stroll on a different street, then somebody would recognize her and kidnap her, and so they were fighting over her, to control her, so she clearly had a trafficked experience. (NGO service provider)</i>

Sex Trafficking: Key Determinants

As described earlier in this chapter, many factors contribute to women and girls becoming, as well as remaining, trafficked. At the victim level, lack of sustainable income emerged as a salient determinant in our interviews, both for domestic as well as international victims. In the words of one NGO service provider, “They don’t have

options to make the level of money that they need to support their families.” As described earlier, lack of income can drive unwitting victims into labor trafficking, which can eventually turn into sex-trafficking situations. Lack of education (e.g., dropping out of school during or prior to high school) is also described by some respondents as an important risk factor for trafficking.

Additionally, respondents mentioned family instability as a key factor in whether women or girls end up in trafficking situations. This instability is expressed in various ways: as “young women who come through foster care who then end up in prostitution,” or girls in “a broken home situation” being targeted by traffickers. A majority of respondents who talked about social determinants described childhood sexual abuse as a major risk factor for girls becoming sex-trafficked.

One NGO respondent described the profile of a young victim:

Our primary intervention in terms of treatment is psychotherapy because most of these women have a history of domestic violence. About 85 percent of them were molested as children. Upwards of 90 percent have dropped out of school and by the time they come to us for services with us they pretty much have lost interest in humanity, and they have an odd mix of street smart coping skills to have survived out on the street juxtaposed against some sort of adolescent frozen judgment and coping mechanisms. (NGO service provider)

Finally, the role of folklore beliefs also play a role in keeping some international victims from seeking help, once they are trapped in trafficking situations. Respondents noted that some traffickers threaten to have curses placed on victims or their families, should victims try to escape their trafficking situations. One anti-trafficking advocacy NGO respondent described the role of folk healers in terrorizing victims from Latin America:

Not only do [some] *Curanderos* and the *Botanicas* give them [victims] botched-up health care, they also instill in them fear. They also help the traffickers threaten them and keep them enslaved. Because these people come from places where *Curanderos* and *Botanicas* are very powerful. They threaten their families and themselves with curses.

At the trafficker-level, several key factors emerged that explain why perpetrators engage in sex-trafficking activities. The desire for money is a key factor; additionally, some traffickers are engaged in sex trafficking in order to purchase or sell illegal drugs.

Respondents also described society-level factors that contribute to women and girls being commercially sexually exploited. Societal norms about the sexual objectification of women were mentioned by several respondents. One respondent said, “The hip hop

culture has a sub-factor of glamorizing pimping that needs to be addressed in some way,” while another described the “pornification” of “women and children.” Furthermore, respondents cited the significant “demand” among men for purchased sex as a major factor behind sex trafficking. One physician, on why sex trafficking occurred, put it simply: “I think it exists because you have a demand and you have vulnerable youth that will fill that demand, respond to that demand.”

Existing Responses to Sex Trafficking in Los Angeles

Health Services for Trafficking Victims in Los Angeles

Overall, respondents were divided in their opinions about the L.A. health system’s current response to anti-trafficking. While some respondents noted examples of excellent care from individual health providers, others suggested that the health system could play a larger role in meeting the health needs of sex trafficking victims. On the latter, a physician respondent who treats victims characterized their overall access to health care in Los Angeles as “fairly limited.”

Our interviews suggested that when sex-trafficking victims are able to access health care, which is not always the case, they do so in various ways: at free clinics, in hospital emergency rooms, via mobile clinics, at drug rehabilitation centers, or through unlicensed providers. Several respondents cited non-profit community health clinics (aka “free clinics”) as major sources of health care for sex-trafficking victims in Los Angeles. Some respondents also cited hospital emergency rooms as primary sources of health care for victims. However, no respondents identified any hospital-based centers that specifically address the health needs of sex-trafficking victims.

The interviews also stressed the central role of anti-trafficking service provider staff (e.g., case managers) and of advocacy organizations as connectors between victims and health care providers. These NGOs provide a wide and often creative array of services for victims, including temporary shelter, transitional and permanent housing, education, job training, food assistance, medical care, and legal services. The organizations work energetically to establish and maintain relationships with health care providers and health care sites, including clinics, individual physicians, and hospitals. The degree of formalization of relationships, as well as the scope of services offered by health care providers, varies significantly from NGO to NGO.

One NGO service provider noted their “network of providers...both Western methodologies and non-Western,” and the impact of these stable relationships on victims:

Before, we had clients sitting in wait rooms in free clinics; we had people sitting in the ER for 18 hours. I mean, it was just awful. And so this is just a perfect example of filling a gap. And it hasn't you know, it hasn't been easy. It's been a bumpy road, but I think we've worked it out so that this is an effective system. Clients get to see the same doctor now. They still wait, it's not perfect, but then, they're not waiting an undetermined amount of time, you know. And just knowing that there is a relationship that they can have between themselves and the doctor is just so key.

In contrast, another social service provider described a very limited, *ad hoc*, set of health care options for victims.

Right now it's just, okay...we can send you to the.... [non-profit clinic] We can get you the mobile clinic when they come here. We can give those services, but other than that, we can't really do anything else. If it's emergency services, obviously we've got to call 911, and they handle that on their own. But we don't have anything formalized in terms of healthcare stuff.

The issue of state and federal requirements to receive health benefits for international trafficking victims came up repeatedly in our interviews, as both facilitators and as potential barriers, to health-care access. Some respondents described a detailed and often complex sequence of steps that must be followed in order to establish eligibility for these benefits, especially surrounding federal "certification" as a victim of trafficking, along with concerns about requirements to cooperate with law enforcement regarding investigation and prosecution of their traffickers. By contrast, some respondents noted that the California state law relating to victim benefits allows victims to receive Medi-Cal benefits immediately, for a period of up to nine months, until federal certification can be determined.*

Aside from direct treatment of victims, respondents provided examples of other anti-trafficking activities in which health care workers are engaged. Some health care workers are involved in anti-trafficking coalition work in the city. Some NGO service provider staff conduct awareness-raising activities at health facilities in the metropolitan L.A. area. However, there was considerable sentiment among respondents that health-care workers could and should become more involved in activities such as these.

* These respondent comments are corroborated by existing literature: "Under the federal TVPA, individuals who are federally certified as victims of severe forms of trafficking are eligible to receive federal benefits, but the certification process can take as long as two years. On September 29, 2006, California became the first state in the nation to enact a law providing a 'bridge' of temporary services to offer immediate assistance to victims as they await federal certification."⁶⁰

One NGO service provider described the grass-roots nature of their outreach to health facilities:

So, we do quite a number of different forms of outreach, one of which is to medical clinics. We've mapped all the medical clinics that we can find in our area, and then we are slowly visiting them all. Sometimes, we go to an area, and we find medical clinics that are not listed on the Internet or not listed in phone directories, in which case we'll just visit them. We usually go in with a packet [of educational materials] in hand. These usually have a letter with them. They provide basic resources. We give them a human trafficking fact sheet, a poster for their waiting room, some brochures for their waiting room, some little cards for how to identify victims cards and we ask to speak to the center manager to explain who we are, offer a training for their staff members, and that's it, really.

Victims' Health Needs

Victims face an enormous array of health issues. Health and non-health respondents alike identified the major illnesses and injuries seen in sex-trafficking victims:

- Malnutrition
- Sleep deprivation
- Rape
- Physical injury such as bruising, broken bones or teeth, mouth injuries, cuts, burns
- Emotional manipulation
- Persistent sexual exploitation
- Gastrointestinal distress
- Sexually transmitted infections
- Forced or unsafe abortions
- Anxiety, post-traumatic stress disorder, depression, suicidality
- Somaticized symptoms and other sequelae of abuse (e.g., headaches/migraines)
- Muscular-skeletal disorders, dizziness, nausea, vision disturbances
- Dental-related disease and/or injury
- HIV/AIDS
- Substance abuse related morbidity
- Lack of immunization

The literature on trafficking corroborates respondents' descriptions of the profound health effects experienced by sex trafficking victims.^{61, 62}

One respondent described the interaction between physical and mental health problems facing some victims:

We focus on the effects of the trauma in intervention, in therapy. So when you're dealing with anxiety disorders, sleeping disorders, PTSD [Post-Traumatic Stress Disorder], most of the symptoms are very similar: lack of sleep, we've had a lot of people with hallucinations, , we've had a lot of people with schizophrenia, or what appears to be schizophrenia, but they're just now going through the anxiety and the fear. They're just finally in a safe place where they can finally feel what they were holding back on.

Barriers to Health-System Response to Trafficking

Respondents identified a number of ongoing barriers trafficking victims face with respect to health care. Some of these challenges relate to victims' inability to access health care, while others relate to structural or attitudinal barriers within the health system.

The traffickers themselves serve as obstacles to a greater health-care response to sex trafficking. Respondents described situations in which traffickers seek health-care services for their victims, but game the system to avoid detection by authorities.

Two respondents shared examples of the problems encountered when traffickers accompany their victims to health facilities:

The uncle brought the 12-year-old in for a pregnancy test. They thought something was little off, so they thought they'll do some follow-up. So they went to the address, and it was not even a residence. So, typically then, you begin to see that they go to a different ambulatory clinic every time they go for services, if they take them in for service. (NGO service provider)

We had a client go into the ER. Her traffickers finally agreed to bring her, because I think her health was getting so poor, and she spoke not a word of English, and they let the trafficker interpret for her, and she spent another year in the trafficking situation before she was able to escape. (NGO service provider)

These situations highlight a broader theme in our interviews: many trafficking victims are not being identified as victims, and health-care providers lack even basic awareness about trafficking. Therefore, victims may not be receiving the full range of health services they need.

As one physician respondent noted, the difficulty of victim identification is a major stumbling block:

I think that from my perspective as an in-the-trenches-doctor in community health centers in L.A., the biggest issue, the biggest obstacle to... trafficking victims in receiving appropriate care is identification. It's all identification, identification, identification. And I think that even for the small subset that may actually be identified, there's such a knowledge gap among providers in Los Angeles, and I would say it not just specific to the issue of trafficking.

Our interviews offered different explanations for this lack of connection between providers and victims. First, several respondents asserted that many victims have no idea of the resources available to them. One emergency physician commented about trafficking as well as sexual violence victims, "The part that doesn't work in terms of taking care of them is letting them know that services are available. Victims don't know that services are available."

Second, some trafficking victims may be apprehensive about seeking care, because: (1) they fear that their traffickers may find out, and punish them; (2) they cannot afford to pay for health care; or (3) they hold negative views about the health profession, particularly with respect to formal mental health treatment. For example, two respondents specifically identified the "stigma" attached to mental health services as a significant barrier for victims. Also, victims' personal attitudes about "Western medicine" as a whole may influence their willingness to seek care at traditional health facilities. As one physician reported, "Probably the ones [victims] I see the most don't have this bias, but some of them do have a bias against Western medicine, against taking pills, against the whole system that we base our healthcare on." Along those lines, one anti-trafficking advocacy worker suspected that victims in Downtown L.A. turn to informal providers, and that "false doctors" in and around MacArthur Park in Los Angeles are providing "botched abortions" and other services to victims.

A pediatrician respondent cast the broad issue of youth perceptions of health-care workers in terms of "survival sex" rather than sex trafficking:

One thing that is in the health-care system, which is as it is in much of society, is this sense of stigma and prejudice of girls or boys, for that matter who are involved in survival sex. And we have all kinds of epithets that we call girls, 'Call Girls' being one of them. And people who look in hospitals and health care settings, many of them have the same internalized bias, and that this is a major barrier in creating environments where young people will come in for care where they feel they can be approached and accepted and not judged.

Third, respondents said that health care providers in Metro LA, by and large, have only minimal awareness of sex trafficking as an issue. As the following quote from a physician attests, sex trafficking falls outside the mainstream of most health-care workers' practices: "[Human trafficking] should be part of the general healthcare streaming for our patients, and it's really not, and I think that some of that has to do with provider awareness, education, understanding."

Victim-belief and provider-awareness factors contribute to difficulty acquiring good quality health care for sex trafficking victims. As a result, one physician hypothesized that many health care workers miss the opportunity to ask questions that could indicate a potential sex-trafficking situation: "I don't think it is something that would come up in a regular medical interview, because it's not always something we think of, and the patients themselves aren't always going to offer it up."

Opportunities for Local Health System Response to Sex Trafficking

Overall, our interviews indicated a high level of support for greater participation in anti-trafficking work by the health sector of Los Angeles. Respondents saw opportunities for education and training for health care workers and trainees, increased health-sector engagement in local anti-trafficking initiatives; research regarding screening and identification; and engagement in public awareness and prevention activities.

Education and Awareness Building among Health-care Professionals

Respondents recommended a top-down approach to educating and training health care workers about the sex-trafficking issue—from hospital physicians, nurses, social workers, and allied health professionals, to medical, nursing, social work and public health students.

Respondents singled out the importance of training personnel in hospitals, including those staffing emergency departments, about trafficking identification. The hospital is viewed as a critical location for victims, as the following quote from an NGO service provider suggests: [T]raining on what to be looking for so that the health care system could be a main point for victim identification, because really, when women are in these situations, it's kind of the last stop. You know, at some point either she may be in a place where she's going to actually die."

A social worker described the need for training multiple staff, rather than for a focused few, on such topics as identification and referral.

So when you go into the hospital, you're going to see twelve people by the time you leave that hospital, at least. All of those people need to be trained, because maybe this guy is having a bad day, or maybe that person just didn't see it, or maybe this person just still hasn't had the training. So you need to build up some kind of defense to make sure that you are compensating for human error so that some person catches it at some point before that person leaves the hospital. And then the next piece is connecting that person with appropriate services. They can't just know about trafficking, that it exists. They have to know what to do. They have to know where to send this person.

In terms of identification, our interviews generated ideas about how health-care workers could provide compassionate, trauma-informed care to potential trafficking victims at the first patient encounter (Table 4.3).

Table 4.3. Respondents on Helpful Tips for Workers on Treating Trafficking Victims

Physician respondent

I see them alone in a room, I don't let an accompanying friend stay in the room with them, and I always take an in-depth social history, in terms of who are you living with, what kind of work are you doing, a general depression screening, and then I start to look for red flags through that. But I don't yet have a formal, easy quick way where I feel like I can screen this patient and feel like I know yes or no, what's the likelihood. But those are the things that I look for. That's how I approach them.

NGO respondent

The first step would be if someone comes in and they are a trafficking victim, it's very likely they're coming in with someone who is controlling them. It may not be the trafficker, but it is part of the trafficking ring. So the first step is to gently, discreetly keep them away from...say we need to see the patient alone, just make up something. Then once they have the patient alone ask, 'Where do you work? Do you sleep and eat in the same place? Do you have your documents in your possession? Are you ever afraid for your life? Are you threatened? Are you calm or at peace? Is there anything else bothering you?' Those would be key questions.

Table 4.3. (Continued) Respondents on Helpful Tips for Health Care Workers on Treating Trafficking Victims

NGO respondent

You never ask a victim anything when they are with their traffickers. But when that person is alone, you can go and ask that person, 'What can I do for you?' or 'What's your name, where do you live, do you have family?' Little questions that might make that person feel a little bit comfortable. I notice that you're sick... 'How can I help you?' Those things a person [does] builds trust, because a victim has no trust. So if you start making that person feel comfortable, that person is going to feel that freedom and know, 'Okay, I have somebody on my side. This person might help me.'

Respondents identified a range of training resources and strategies that could be useful for health-care providers. One emergency physician suggested the development of a sex-trafficking segment in existing training videos on sexual assault examinations. This physician also urged that any training on sex trafficking begin with a working definition, because of the learning styles of physicians:

I think that the education has to start with the very basics. ... This is the definition, even if you don't like definitions, this is what trafficking is, you know. It's not necessarily picking up some little girl in India and taking them to the Middle East or whatever. ...Health care providers largely work off definitions.

Another physician recommended the establishment of "a very clear protocol" on referring victims to appropriate service providers once a victim has been identified by a health provider. In addition to training, respondents called for greater hospital-based resources to help victims who cannot speak English. Two respondents specifically noted the need for more medical interpreters in the hospital setting, so that victims can be kept out of earshot of their traffickers in order to speak directly to health care providers in a confidential setting. An NGO service provider wondered if hospitals could elude traffickers and "admit someone under a false name, like they do for movie stars...and get all the services you get in social work in that kind of setting"

A predominant theme in our interviews was the need to raise awareness about sex trafficking among medical, nursing, social work, and other health professional school students. Respondents suggested the fields of domestic violence and child maltreatment be used as templates for how sex trafficking could become a mainstream issue among health-professional school students over a long period of time. Specific recommendations ranged from allowing medical students to complete their OB/GYN clinical rotation at clinics known to treat sex-trafficking victims, to inclusion of sex trafficking modules in medical school curricula.

Another physician believed that students at public health schools could also be effective audience for education on sex trafficking, because the field of public health, in general, needs to work in tandem with medicine on this issue:

I think public health has to become integrated into addressing both the identification and the treatment of survivors. Once victims are identified, they all need TB screening, they all need other communicable disease screening, they need STD screening, and those are all public health issues, not to mention shelter, food, and the social services and legal services and the education services.

A third physician called for training health workers to be general advocates for all their patients, including those who may be trafficking victims.

I personally think that there needs to be a broadening of what it means to be in healthcare, period. And that, the training needs to empower and expect all of us to be advocates

Improve Health-care Services to Trafficking Victims and other Vulnerable Populations

Respondents offered suggestions for a more expansive health system role in improving victims' access to health care. First, several respondents urged health care professionals to become more visible in the city's anti-trafficking coalitions, with the ultimate goal of bringing about "more of a coordinated effort in L.A." Increased engagement in these coalitions, one NGO respondent maintained, could advance the work of coalitions and service providers:

We need to be in collaborative groups, but working collaborative groups, not groups where you just go and sit in a meeting and everybody just kind of toots their own horn, [saying] 'Look at how great I am.' True collaborative meetings. Having, maybe a liaison with the hospitals and the clinics..., so that when you have someone, when somebody is in doubt in the health profession, whether it be a doctor or a nurse or a physician's assistant, they know when to call someone and say, well 'What do you think about this?' without obviously violating confidentiality....

Next, respondents noted that the health community could play a larger role in preventing sex trafficking in the first place. In terms of prevention, several respondents called on the health sector to foster greater public awareness about sex trafficking: "So I hope that sometime in the future the health department can also get involved with outreach and engagement. And the health department goes and does PSAs [public service announcements]: PSAs on TV and PSAs on radio."

Some respondents also noted that media outreach campaigns could be effective at reaching trafficking victims who might have access during the day to television and radio. One service provider offered the following suggestion: "Even having signs around clinics in public areas talking in very simple language, using pictures. We developed a domestic violence poster that has no words and then just a phone number-- something like that for low literacy."

The idea of utilizing the health community to help reduce demand for commercial sex, especially among young boys, was raised by respondents. One respondent called for a health program that asked the following questions, "How do we socialize boys, how do

we train boys, how do we create an idea or an ideal of masculinity?" Another respondent suggested that mental health could design prevention programs aimed at girls in the foster care system

Discussion

This chapter has provided an overview of the sex trafficking issue in Metro LA through the lens of health. Our interviews in Los Angeles center on the following themes: the difficulty of accurately counting sex-trafficking victims; the key determinants driving sex trafficking at the individual victim- and societal levels; and continued discomfort in the field over the definition of "sex trafficking" and its closely related concepts, and its consequences on services for victims. Notably, the close and sometimes overlapping ties between "sex" and "labor" trafficking argues for a careful examination of key constructs going forward. The chapter has also described Los Angeles as an international and domestic destination for trafficking activity.

Overall, the interviews indicate that the health system in Los Angeles is at an early stage with respect to its response to sex trafficking. As one NGO respondent noted, "[T]his movement with trafficking has been compared to the domestic violence awareness 25 years ago. We're still in the beginning stages of that, but the mindset I think is really similar." No respondents noted that the current health system has a model or comprehensive strategy, or coordinated system, for addressing the full range of health and non-health needs of victims and at-risk individuals in Los Angeles. To the contrary, respondents described a small but estimable group of nonprofit free clinics that provides health care to victims, and a safety-net of swamped hospital emergency departments that, while knowledgeable and skillful in treating sexual violence and vulnerable populations, has yet to integrate sex trafficking into their organizational repertoires.

Respondents emphasized the importance of improved collaboration and coordination among health care providers, anti-trafficking coalitions, and service providers. Trafficking coalitions and service providers welcomed greater representation from the health-care sector in anti-trafficking activities. In terms of raising awareness regarding sex trafficking among health care workers, it appears that the road from fringe to mainstream issue is lined with some substantial, but not insurmountable, challenges.

Furthermore, for the issue of sex trafficking to move beyond the hospital-based emergency care into widespread medical practice, one respondent offered an innovative proposal:

So I guess I'm thinking that your average physician or community health center hears that there's an anti-trafficking coalition and immediately they think, 'Oh, that's scary, or, 'Oh that's narrow.' But if we're are talking about some kind of

human rights coalition, it is a less frightening way for people to enter the issue, especially when it is partnered with issues that have some commonalities.

Beyond already-practicing health-care providers, the importance of health professional schools' engagement in teaching trafficking topics to trainees emerged as a major theme in our interviews; respondents believed that introducing trafficking in the formative years of health workers' training could yield large dividends down the road in terms of facilitating the identification, referral and treatment of victims. The emphasis on the need for proactive rather than reactive responses was a related theme. Aligning prevention activities with target populations (e.g., school-aged girls and boys) could provide traction in addressing some of the social conditions that make sex trafficking so widespread in the first place.

CHAPTER 5: SEX TRAFFICKING OF WOMEN AND GIRLS IN LONDON

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Introduction

Study Setting

London is one of the developed world's largest (7.4 million residents)⁶³ and most affluent cities. It is home to a diversity of ethnicities. The city has historically been a center of migration from the rest of the United Kingdom (UK), other parts of Europe, and its former Empire. It is also a major port of entry to the UK, and is home to five international airports. London Heathrow Airport is the world's busiest international airport; in 2006 it handled 1.4 billion passengers, on over 14 million flights.⁶⁴ The UK's population was estimated at 61,383,000 in mid-2008, with a high growth rate in the previous 12 months attributed to new births and immigration.⁶⁵ The U.K. and London, specifically is considered a trafficking hotspot.⁶⁶ The U.K. is called a "significant" destination for trafficked women, children and men, and ranked as Tier 1 in the U.S. State Department's *Trafficking in Persons Report* as a result of the U.K. government's efforts to combat this crime.¹

Various pieces of U.K. central government legislation address trafficking and set obligations for different local and central government departments and agencies with respect to services for victims. Internal and international trafficking for sexual exploitation was criminalized in the 2003 Sexual Offenses Act. The *Update to the U.K. Action Plan on Tackling Human Trafficking* was agreed in 2008.⁶⁷ The Council of Europe Convention (CEC) on Action Against Trafficking in Human Beings became operational in the U.K. on April 1, 2009 and raised minimum standards of care and social entitlements for individuals officially identified as victims, or potential victims, of trafficking. Trafficking is addressed by several government departments, primarily guided by an Inter-Department Ministerial Group led by the Home Office, and whose membership includes a Department of Health (DH) minister. As of April 1, 2009, all potential cases of trafficking are supposed to be submitted to the U.K. Human Trafficking Center (UKHTC) and U.K. Border Agency (UKBA), the newly named "Competent Authorities" that verify whether an individual in question meets the criteria for trafficking under the CEC.⁶⁸ This referral process is described as the National Referral Mechanism (NRM). Additionally, under Section 11 of the Children

*The original U.K. Action Plan on Tackling Human Trafficking⁶⁷ was released on March 2007.

Act 2004, local governments (“local authorities”) in England and Wales have a statutory duty to “safeguard” all children resident in their areas whenever there is a concern regarding their safety. This work is carried out by the Department of Children, Schools and Families at local levels, through Local Safeguarding Children Boards (LSCBs).

The National Health Service (NHS) provides free health care for U.K. and other European Union (EU) citizens, members of the European Economic Area’s (EEA) citizens, as well as recognized legal residents, including asylum seekers. The majority of Britons who have private insurance also utilize the NHS’ primary care system. As of April 1, 2009, all formally-identified victims of trafficking, those who have been identified through the NRM as potential victims of trafficking, and the victim’s spouse/civil partner or dependent child are eligible for NHS care and prescriptions –free of charge.⁶⁹ Accessing the majority of NHS services require individuals to obtain an NHS number and register with their local general practitioner office (GP “surgery”).

Specialized care is accessed only by referral. Health services that can be accessed by anyone, without an NHS number and on a walk-in basis, include Accident & Emergency Rooms (A&Es) at hospitals, compulsory psychiatric treatment, sexual health clinics (also known as genito-urinary medicine (GUM clinics) and Sexual Assault Referral Centres (SARCs).^{70, 71}The NHS is also the largest employer in Europe, with 1.3 million staff providing services to over 57 million people.⁷²

This chapter describes sex trafficking among women and girls in London. Specifically, we explore key determinants of sex trafficking as well as the health needs of victims; characterize the current health system response; and identify potential roles for the NHS in London in addressing trafficking.

Summary of Field Work

Pairs of researchers conducted field work in London during two short trips in April and June of 2009. Interviews were scheduled prior to these trips after contacting potential key informants including physicians, nurses, local service providers, academics, law enforcement officials, lawyers, advocates and central and local government workers who subsequently referred us to other colleagues who could speak to the issues of sex trafficking and/or health care in respect to London. Using a snowball method, we interviewed respondents until we reached theoretical saturation of our research questions. We used direct quotes from respondents to arrive at categories and themes. Quotes from multiple respondents, supplemented by existing literature, were used to triangulate findings.

A total of 17 interviews with 20 key informants were completed in London.* The respondents included two nurses, six government officials, five academic researchers, one law enforcement official, two legal professionals and four service providers.† One interview took place off the record. Our study methods are described in greater detail in Chapter 2.

Characterization of Sex Trafficking in London (and wider U.K. context)

Prevalence of Sex Trafficking

Our interviews, as well as the trafficking literature,⁷³⁻⁷⁶ suggest that it is very difficult to calculate accurate estimates of trafficking victims in London and, more broadly, in the U.K. Estimates of trafficked women, girls and victims in general were reported to vary widely. One U.K. central government respondent commented on the wild fluctuations in estimates: "...I've got numbers, from...over 4,000 women trafficked into prostitution to, I don't know, 30, 40, 50, 80 [thousand women]."

Table 5.1 provides government statistics on human trafficking in the U.K. Numerous respondents maintained that the number of officially-recognized trafficking victims is an undercount of the actual number of victims; a number of respondents called government estimates "the tip of the iceberg," because they believed that trafficked victims were largely not being identified and even when identified were not reported to the authorities for reasons discussed below. Other respondents believed that estimates developed by nonprofit organizations overstated the phenomenon.

* As described elsewhere, new trafficking legislation on April 1, 2009, set out new obligations with respect to health-care provision and trafficking-victim identification. Therefore, many respondents' comments reflect previous practice and experiences, and others, the fact that awareness of the issue was not yet widespread.

† For reasons outside researchers' control, we were unable to obtain NHS clearance to interview more health-care providers, including physicians, during the time frame of this study.

Table 5.1. U.K.-wide Government Estimates of Human Trafficking*

United Kingdom Human Trafficking Center (UKHTC)⁷⁷

- **National Police Operations**

Pentameter I (2006) identified 88 victims.

Pentameter II (2007) identified 167 victims of sexual trafficking, 13 of whom were children.

- **National Referral Mechanism (NRM) (2009)**

April-June: 107 of 148 referrals were female. Of these, 54 women and 10 girls were trafficked into sexual exploitation.

July-September: 150 of 199 referrals were female. Of these, 64 women and 22 girls were trafficked into sexual exploitation.

U.K. Child Exploitation and Online Protection Center (CEOP)

2007:⁷⁴

- 330 cases of children who were potentially trafficked.
- 86% of cases identified were girls.
- 65% of these were trafficked for sexual exploitation.

2009:⁶⁶

- 325 cases of children who were potentially trafficked.
- 68% of cases identified were girls.
- 56% of these were trafficked for sexual exploitation.

Our interviews suggested two other barriers to estimating prevalence: (1) lack of consistency in data collection of trafficking cases; and (2) competing definitions of trafficking. Respondents noted that no local government agency collected data in a single, centralized place. The National Referral Mechanism (NRM) took effect in April of 2009, with the goal of serving as a central data collection function. All “front-line” workers from law enforcement to local government agencies to non-profits who come across a potential victim of trafficking are now supposed to report victims via the NRM.

Respondents’ opinions varied as to whether the new NRM would improve the accuracy of estimates of reported victims.

As noted by one respondent,

They’re [central government policy makers] very well aware, they’ve got a good understanding...and they forget that actually so little is known in local areas. You know, you go into local areas and people are still asking the most basic of questions. You know they’re imposing this National

* These government agencies do not provide city specific data.

Referral Mechanism, etcetera, without actually thinking at the most basic level about what's going on in local areas.

The definitional controversy surrounding human trafficking poses a significant problem in estimating prevalence. Many respondents expressed concern about the contentiousness and complexity of existing definitions of human trafficking and sex trafficking. When discussing the definition of sex trafficking, the majority of respondents pointed to the close relationship between sex trafficking and prostitution/sex work, as well as with sexual exploitation, interpersonal violence and child abuse. Many respondents referred to the challenges of clearly bounding these definitions and therefore how to accurately count the number of sex-trafficking victims.

One academic respondent discussed these definitional difficulties:

There are some women who are horribly controlled, and it is brutal and it is sexual slavery. But I think in the majority of cases it's more complicated than that. And so what they think is happening to them and what is happening to them are not necessarily the same thing... Trafficking is not so clear cut, because you might not know that the exploitation part has happened until you've actually said, 'Actually, I want to go home now and I want all the money that you've been putting away for me so that I can take.' And they don't give it to you. That's the point when you know you've been exploited.

Respondents also reported that many trafficked women and girls did not view themselves as trafficked, because victims had been involved in relationships with their traffickers and had histories of abuse and exploitation. As a result, respondents maintained that many trafficked women and girls may not recognize they have been exploited, thereby under-counting the true number of victims.

How Women and Girls Are Trafficked: Mechanisms

London has been described as a destination for trafficked women from abroad, notably Asia and Africa,⁷⁴ as well as a transit point and point of origin for women and girls from both the U.K. and overseas. Our interview respondents similarly cited London as a point of origin, transit, and destination for both British and foreign females. Girls and women were reported to be trafficked into the U.K. from Eastern Europe, East and West Africa and China.

Women and girls trafficked from abroad were described by respondents as arriving in London on airplanes, Eurostar*, ferries and trucks. Several respondents noted that foreign

*Eurostar is the high speed train connecting Paris, Brussels and London.

girls were trafficked into airports in the north of England, due to the vigilance of immigration officials at London's international airports. This finding is consistent with literature suggesting a move away from London airports as initial ports of entry, because of stricter immigration enforcement at London's Heathrow and Gatwick airports.^{75, 78, 79}

There were strong similarities in the mechanisms by which women and girls were trafficked, as well as how overseas and domestic victims were trafficked. The literature cites outright abuse to more subtle manipulation, mostly by family or other individuals close to victims, as leading to women and girls being trafficked.^{8, 74, 75, 80}

Our interviews revealed that, in the majority of cases, women and girls are trafficked by someone known to them. A number of respondents described a similar scenario whereby a new "boyfriend" reportedly provides a victim with gifts, money or attention, and often moves them to another location. The trafficker's behavior then changes, and the victim is pressured into sex with other men for money, and finds her movements and money under the trafficker's control.

[T]he quote unquote boyfriend scenario is very prevalent...it's similar to trafficking in women, where you have a person agent trafficker who grooms a young person pretending to be the boyfriend and spends a lot of time with her in their local community before even bringing them outside the country. And in one case certainly I'm familiar with that young person even to this day- and she is now safe and away from the trafficker. She's been sexually exploited, [but] she still looks at the trafficker as her boyfriend even though they have no contact, which she talks about in terms of my boyfriend, my boyfriend. So that is a very powerful thing.

Other respondents attributed entry into trafficking to the families of victims. In other words, girls from abroad may be sold by their parents and "hidden" within large immigrant communities once in London. British girls were believed to be "pushed" into prostitution by family members*. Respondents also contended that some foreign women and older girls know they are going to work in prostitution, but do not think they are going to be exploited or enslaved.

Girls from outside the U.K. are also understood to be trafficked into the U.K. for labor and for "benefit fraud." Traffickers claim to be the girl's parent or custodian, which enables them to file an application with a local government social service department for income support and housing to care for the girl. Respondents believed these two situations made girls highly vulnerable to sexual exploitation.

* As minors, this qualifies them as trafficked.

Sex Trafficking: Key Determinants

In the interviews, prior childhood abuse, domestic violence and family instability resonated as key individual- and family-level determinants of sex trafficking. Prior studies have similarly pointed to early exposure to violence, including sexual and physical abuse, as risk factors for trafficking.^{26, 75, 76} Respondents described women and girls' desire to escape what one termed "atrocious childhoods," which involved difficult and abusive family lives. Many respondents noted that trafficked girls had lived in homes that lacked two adults exercising parental responsibility, and/or households where violence took place. These difficult home lives led women and girls to leave home, be turned over to traffickers by family members or be taken into the foster care system.

As described by a legal expert with expertise studying child sexual exploitation:

For some young women, you know the older man may well be offering kinds of corruptive care... [T]hat kind of older man...may actually be a rational alternative to their actual peers, who [live] in a kind of culture which is very accepting of young women being disempowered in their sexual health.

Some women and girls from outside the U.K. were also believed to be seeking a means of escaping either the general living conditions in their society, or armed conflict. Other respondents reported that many women migrate to the U.K. for sex work to earn money to meet family obligations back home, but did not realize the harsh conditions that would face them in London.

At a societal level, respondents cited gender inequality and the constant demand for commercial sex workers as important determinants of sex trafficking.

One academic respondent commented:

I don't believe we can have a country or a world where women and men are equal when a proportion, and it's only a proportion, of men think that it's absolutely fine – not only is it fine but it's their entitlement to buy sex from women. And the majority of men, not all, but the majority of men collude by not questioning that in other men...But it does mean that you have to have the issue of demand and you have to have the issue of men who pay as part of your equation. And the human-rights perspective demands that we do that, too.

Although poverty was referenced as a risk factor for sex trafficking, a number of respondents were careful to qualify this opinion. Some did not believe that poverty was the prime risk factor, and that notions of poverty were relative and difficult to measure.

Existing Responses to Sex Trafficking in London

Health Services for Trafficking Victims in London

The literature on sex trafficking describes victims' numerous physical,^{25, 73, 75, 76, 80, 81} sexual⁸¹ - and mental^{25, 73, 76} health conditions. Two recent studies highlighted the necessity of long-term support for mental health problems stemming from trafficking.^{25, 73, 75, 76} In the interviews, respondents noted women and girls had substantial physical, sexual health and dental care needs as a direct result of being trafficked. Mental health- care, from trauma counseling to dual-diagnosis, was also deemed a significant need.* Our interviews revealed that the public-health system, other government departments and non-profits have all increased their involvement in anti-trafficking work in an effort to meet these needs.

As of April 1, 2009, any individual formally identified through the NRM as a potential trafficking victim, or officially certified by a Competent Authority as a trafficking victim, is eligible for free NHS services and prescriptions under new DH regulations.^{†69} These women and girls may also access support to help navigate the NHS system of referrals, appointments and specialist clinics and providers. Health assessments of victims are conducted immediately after identification as part of the initial trafficking assessment overseen by a 'front-line' practitioner.‡ In the autumn of 2009, the DH convened a Taskforce on Violence Against Women and Girls, which will consider the NHS' role in trafficking – among other issues – and recommend how health-care workers can better respond to victims' needs.§ In addition to this policy work, two government officials noted that there is ongoing NHS trafficking training for SARC staff. Finally, the DH has a number of commitments in the U.K. Action Plan to improve provision of health-care for victims.⁷⁵ However, awareness of these policies and efforts was not reported to be widespread. Many respondents believe that the NHS as a whole, as well as health-care workers themselves, is a minor player in the larger anti-trafficking response in London, despite the efforts just described.

* Also named were psychotherapy, psycho-sexual counseling, dual-diagnosis, trauma counseling, depression, untreated bipolar disorder, as well as day to day coping strategies.

† British, EU and EEA nationals already have this right as described in the Introduction. For others, the right to free NHS services is based on the purpose of residency in the UK, as well as the length of time of residency.

‡ This is done using the NRM guidance and documents, and is then submitted to the Competent Authority which will then determine whether an individual is a victim of trafficking.

§ The Taskforce is due to report in January 2010. The overarching cross government strategy on Violence against Women and Girls Strategy is being launched in November 2009.

Other government bodies as well as non-profits were described as playing a key role in facilitating health-care access for identified victims or suspected victims. As different legislation and different bodies help to facilitate this access, how victims receive health-care services post-trafficking was reported to depend on whether they are adults or children. A government-funded non-profit facilitates women's access to health-care and other social services as a result of partnerships with local NHS and National Dental Service (NDS) services. According to respondents, these partnerships allow women to access care more quickly, receive longer appointments, and receive respectful treatment. By comparison, girls have access to a wide range of social services, including health care and an assigned support worker through local, multi-agency government child-protection bodies called Local Safeguarding Children's Boards (LSCBs).^{* 82}

One respondent, who is an expert on child trafficking, noted the difference in access to services for girls, compared with women:

One of the things that really strikes me is the split between what's going on for children and what's happening for adults...It's easier, frankly, to work in the children's sector and produce very tight guidelines and ensure that people do get the training on it. I think once you call it 'Safeguarding Children' then you enter a whole different ball game. So it's a new idea to have women and girls; Completely new to us, where as usually you say safeguarding children.

Respondents explained that a number of non-profit trafficking experts are providing one-off training sessions to health-care workers. Additionally, the pan-London LSCB was reported to have begun piloting trafficking training in the summer of 2009 for all government employees with responsibilities to safeguard children (from school nurses to social workers). This guidance was published in 2009.⁸³ The training was described as targeting those identified as frontline health-care practitioners who would be trained to use matrices containing indicators (e.g., physical abuse, abuse of pets, expensive clothing) that could signal that a child is at risk for trafficking. Respondents stated that trainings of hospital-based nurses and trainee doctors have already begun.

A majority of respondents believed that some women and girls still in trafficking scenarios access a range of public-health facilities, from GP surgeries and sexual health clinics, to A&E and maternity wards, while still in situations of trafficking. This understanding is also reflected in recent literature.⁷⁵ Despite this, most respondents reported that health-care workers, even those who possessed some awareness of trafficking, overwhelmingly do not identify victims (Table 5.2).

* All children considered "separated", whatever their nationality or where they are domiciled, become "looked after" children under the 2004 Children's Act. The relevant local authority then fills the role as guardian, and their responsibilities are carried out by social care staff who follow guidance set out by Local Safeguarding Children Boards. As of March 31, 2008, 59,500 children in England and Wales were looked-after.

Table 5.2. Quotes from Respondents about Health-care Workers and Victim Identification

In terms of reporting and onward referral, that's probably been almost nil...through the health service. (Central government official)

I've come across no health-care workers...not to my memory that have successfully identified and sort of safeguarded a child. (Trainer in child trafficking)

Identified a trafficked child? Gosh, not as far as I know. (Nurse with special administrative responsibility for safeguarding children)

Most women are not identified by health-care workers, but instead through police raids and checks of brothels. Girls are identified by immigration staff at airports as well as after coming to the attention of a local child protection team – sometimes as “troubled” children, asylum-seeking children, or a child in private fostering arrangements.

A few respondents described stories related to them by health-care workers who, only *after* trafficking training, recalled specific patients they had treated that they now suspected could have been victims of trafficking. This missed opportunity, which has been noted in prior studies of trafficking,⁷⁵ was articulated by one respondent in the following way:

It's a conceptual issue, because when you're working with young people...they are not identified because they're trafficked. They're identified because they've come into the service in another way. For example, they've come into children's services because either they're an unaccompanied child, an asylum seeking child, an abandoned child. So the very first entry point is classified as something else, not 'trafficked.'

Only a couple of respondents were able to identify a few instances of health-care workers identifying trafficked children. A respondent working for the government in child protection described one case she knew of:

The A&E staff... [in an area of London with a high proportion of immigrants] spotted a woman who'd come in over a period of time with different children at the same address. And they thought this is rather odd, certain children of a similar sort of ages all turning up from the same woman. And yes, they were being trafficked.

Finally, one respondent—a child protection officer—suggested that some minor girls may be accessing underground reproductive-health services:

We have the experience of some of these young people returning to our care, and we know that they've been in brothels: They've had surgically-implanted contraceptives, they have their body hair shaved off. But that's not resulted in, sort of prosecution, because it's very difficult...I doubt that if any of the surgical implants have gone through any NHS service. I think that would be foolish if traffickers do that. But we don't know the answer to that.

Barriers to Health-System Response to Trafficking

Our interviews identified three major barriers to a greater health-system response in London: (1) the problems that the term “trafficking” creates for health-care workers, including lack of awareness of the term, confusion in regards to its definition and disagreements as to who constitutes a trafficked victim; (2) lack of clarity about health care and residency entitlements for victims of trafficking; and (3) absence of clear policy directives from senior levels of the NHS or DH as well as lack of uniform, widespread, and mandated training for health-care workers. These were mostly discussed as significant barriers to identification of victims, though they were also noted as contributing to lack of appropriate care for victims post-identification, which was characterized as not tailored enough to meet the needs of women and girls.

The majority of respondents, as well as the trafficking literature, suggested that most health-care workers in London were unaware of, or confused by, the definition of trafficking.^{75, 84}

As one respondent noted,

Palermo Protocol [UN Definition of Human Trafficking]. That's not how most practitioners define it. There is a lot of confusion as to what is trafficking...We've had cases where it has taken us over a year to get into a local authority. Then when we finally got access,] they gave us a stack of case files that didn't match the database, which they used for recording whether or not a child was 'trafficked.' So, basically you're thinking, 'What definition are these different people working to? They've said 5 people, but I have about 50 on my desk.'

According to respondents, some health-care workers are reluctant to identify women as trafficking victims, because they view sex workers as individuals who make the decision to engage in sex work of their own free will. As such, some health-care workers viewed victim identification as an intrusion into the lives of these women. Two respondents

noted how funding for HIV/AIDS in the U.K. set the context for such “harm reduction” approaches to sex work.

As an academic described it,

There’s been very little resources for work around prostitution and the sex industry and the only pot of money that’s seemed like it might accommodate it was the HIV/AIDS money in the late 80s, 90s. And that was framed as harm reduction. Especially the bits that were associated with drug use, which was the easy way to link prostitution into it, so the funding source actually ended up framing the approaches, I think.

Another barrier to health-care workers identifying trafficked victims is believed to be concern over violating a patient’s confidentiality, compromising a patient’s immediate personal safety, or initiating a process that would lead to a patient’s deportation.*

One central government official reported that without having knowledge of resources and next steps, health-care workers may choose not to act.

They [health-care workers] need to have that understanding of the dynamics and what they can do, and what their role is. Because often times, staff don’t want to open up Pandora’s box or ask a question, because they didn’t know what to do to respond to it, whether it’s a child or an adult.

Finally, many respondents attributed health-care workers’ lack of awareness and confusion to a general dearth of trafficking training for health-care providers. A respondent who trains health-care workers on child trafficking commented:

Level of awareness: really quite low. They’ve all had basic child protection training, but within that, trafficking was not included as part of the hospital-based, across-the-board, that-everyone-gets training.

Some training for NHS workers on child trafficking exists, but it was believed to be ad-hoc, delivered upon request, or brand new. Developing the training components, including screening tools for trafficking, were noted by some respondents to be a challenging task. Additionally, respondents reported that most training is not delivered by health-care workers. Low participation in training was attributed to time pressures on health-care staff and hospital hierarchies.

* A trafficking victim must file an asylum claim to receive legal residency in the UK. In 2007 70% of asylum claims were rejected.⁶⁵ Individuals whose asylum applications are rejected are expected to leave the UK, or a removal process will be put in place.⁶⁸

According to a respondent that conducts training on child trafficking with health-care workers in two London boroughs,

For the emergency department, for example, that's all gone through the Training and Development Nurse...and the nurses that took part in that training said to us, 'You really do need to find a way to engage with the doctors, as well, because it's all very well; us recognizing and having this knowledge, but really the doctors are in there as well, and we often have to answer to them. So they really need to be on board and be up to speed and know what to do.' But it's just proving really difficult to sort of engage them...in a hospital in another borough...that's the same issue, 'How do you get the doctors?' You know, they feel they're so busy, it's not part of their role, the nurses can do it. But it's very hierarchical. And so we're just struggling with that really at the moment.

At the governmental policy level, respondents articulated several barriers to a more effective anti-trafficking response from health stakeholders. Several respondents noted that health-care workers and policymakers often do not attend multi-agency meetings on trafficking. Some government respondents suggested that the absence of robust data on trafficking prevalence remains a barrier to the DH, NHS and Primary Care Trusts's (PCTs) greater involvement in anti-trafficking efforts.

One respondent familiar with government multi-agency work noted,

[I]t was very, very difficult to engage with Department of Health, despite the fact that they had strong policies on teenage pregnancy and strong policies on provision of sexual health. And it was hard to get to the bottom of that. But it meant that we didn't have any leaders to try and drive this forward.

Although women and girls are able to access NHS services, respondents noted that no special provisions are made for women who have been trafficked.

As one service provider commented,

Some GPs have been great, some GPs have been awful. Just in terms of, you know having a 15 minute appointment; and we have tried to book double appointments with interpreters even though they're [GP offices] supposed to book the interpreter but we often end up bringing our own because it's not always been possible to get...I've used a couple of services which are actually for homeless populations who've not been registered because they don't have any documents and I've found it to be a *lot* better and they've got a psychiatric nurse present. They're used to dealing with substance use

and I found them to be *much*, much better than the average GP surgery where you've got to go in really quickly and you've got one problem only, you're only allowed one problem. We're working with women with multiple kinds of health needs who may be having to make appointment after appointment after appointment.

Mental health-care access was portrayed as a significant blind spot for many trafficking victims in London. All respondents who worked directly with trafficked women and girls found it extremely challenging to identify a local Child and Adult Mental Health Service (CAMHS), a service that is responsive to partnership requests or to otherwise find a straightforward way to help victims access mental-health services (Table 5.3).

Table 5.3. Respondents' Quotes about Mental Health-Care Assess in London

I think at a policy level, it's [provision of mental health-care for trafficked children] not a priority. So structurally it's not funded as such. And it would be seen as needing to be integrated into mainstream services around psychotherapy so it's not really seen as a specialist area yet within, I think within mental health services where you tend to get bespoke psychotherapy for that purpose. (Local government worker)

I've worked with a few women who had really quite serious mental health cases...but getting a diagnosis is almost impossible...If you're registering with the GP, if you're waiting for an assessment with the community mental health team, it's really not realistic. It takes too long. So the only other option is to take them to A & E and...there've been a few cases where it's worked and a lot of cases it hasn't worked. You don't go to A & E unless you made a serious suicide attempt or unless you are really a danger to somebody else. (Social service provider)

[P]hysical health generally is very good and [children can get] fast access to clinics for a physical check-up type stuff. The problem comes with the access to mental health care services, because also there's such long waiting lists, and it's really difficult to support things like trauma counseling or even things like support for coping with day-to-day challenges. (Non-profit advocacy director)

Opportunities for Local Health-System Responses to Sex Trafficking

Respondents overwhelmingly believed that the health-care sector could play a greater role in anti-trafficking efforts. Our interviews strongly suggest that with appropriate education and training, the health sector could more effectively assist trafficking victims by identifying trafficked girls and women in a variety of NHS settings, as well as by providing more comprehensive and better tailored health-care treatment for victims.

Table 5.4. Respondent Quotes about Potential Health-System Role in Anti-Trafficking in London

Because the one thing is, many victims, no matter what type of trafficking it is, are bound to engage at some point with the health services. (Senior law enforcement official)

It's probably endless, the roles that health can play. (Researcher)

[E]veryone we're working with says, 'They're our key. They're our eyes and ears, you know. We really need to get them on board.' They see so much, and I'm sure so much of that is not being documented or passed on. (Non-profit worker conducting child trafficking training)

I think it's about understanding that health is a context where you can find out things, you can do certain kinds of protective interventions, but you can also enable someone to access a different kind of support. (Academic)

Education and Awareness-Building among Health-Care Professionals

Awareness-raising was reported to be the key to greater participation by the NHS in anti-trafficking efforts. Many respondents recommended training. Others suggested issuance of clear guidance and protocols by the NHS and the DH. As stated earlier, it was proposed that health-care workers in A&Es, GUM clinics, SARCs, maternity units, GP surgeries, termination clinics, as well as mental health professionals, health visitors, community nurses and school nurses, be targeted for training. Given the high staff turnover in hospital A&Es, one respondent noted that constant training is required.

As one researcher argued:

They [health-care workers] need to know what the indicators are if a child presents with more than one mobile phone, if the child has expensive clothes on, a lot of money but doesn't speak the language of if a child is accompanied by an adult whom he or she appears to be uncomfortable with or scared of...I think GPs in this country have ten minutes to look at a patient, if they're lucky. That [indicators] needs to be internalized, it needs to be part of medical training. If you have a gut feeling, you think, 'Hang on a second, something wasn't quite right.' And we found a lot of practitioners said, 'In hindsight, I thought I had a bad feeling.' or 'I couldn't just put my finger on it.' A lot is intuition, you know, it's intangible....No child presents a 'Listen I've been trafficked, so can you help, please?' It doesn't happen like that, you know?

The need to clarify what services are available, and appropriate, for victims was seen as crucial. It was argued that there was a direct link between staff understanding of next steps and their willingness to identify victims.

A central government health official stated:

It's not enough just to tell frontline staff what they should be doing. They need to have that underpinned by the dynamics and what they can do and what their role is. Once you equip them with that and you help to explain what their role is, then you find that staff are much more willing to lend support and much more willing to try and work more closely with victims and also with other agencies.

Some respondents also argued that any training for health-care workers around identification or prevention strategies should take into account social determinants. Others believed a broader assessment of patients was needed. As a respondent involved with the new London LSCB guidance on child trafficking described,

They [NHS workers] need to have a much wider [frame of reference]: Am I living in an area where trafficking is likely and is regular or current? What are the police telling us about what's going down at the moment? What's the wider family circumstances? Where are the other siblings, how many children come from that address?

A few cautioned against oversimplification of trafficking or how trafficking might present.

[H]ow do we enable people in health settings, and everybody else, to have complex enough understanding of this issue that they can ask about it in a way that enables those who need to be identified to be identified?...If we haven't got the questions right in the first place then we are never going to identify anybody because they are all going to say, 'No I wasn't forced, no'. Because they think they agreed to be, the contract they think they're making is they agree to be smuggled...there are some women who are horribly controlled and it is brutal and it is sexual slavery. But I think in the majority of cases it's more complicated than that. And so what they think is happening to them and what is happening to them are not necessarily the same thing. So, I think it's a huge challenge, how to translate something that is very complex into, into the kind of screening questions that are used in health settings.

Improve Health-Care Services for Trafficking Victims and other Vulnerable Populations

Nearly all respondents noted the need for much greater participation of mental health trusts and workers to meet the health needs of trafficked women. Several respondents also named mental healthcare as the most difficult health-care service to procure.*

As a respondent with special responsibility for safeguarding noted,

But if I had my wish granted, my wish would be to have all of these children who are coming through any process outside the norm, i.e. within safeguarding, to have a mental-health assessment, a mental, psychological health assessment. Because we know that the journey of children to this country or to any country outside their own; being trafficked is horrendous. And you want to do something about their experiences in terms of their mental health.

Some non-health respondents contended that health-care should more broadly increase its engagement in preventing violence against women, addressing migrant health issues or improving child protection work.

As one researcher argued:

[W]e might need to be smart in how we do this, and not think that in every hospital you've got to have an advocate for domestic violence, an advocate for sexual assault, an advocate for trafficking. Actually, there're enough commonalities across these things, not least that men use the women, when it's effect, for all three of these things.

Another respondent explained how work advocating for better care for trafficked children would indirectly help other vulnerable children.

So it's [advocating for child trafficking victims] challenging the existing structures. But we've got a legacy of...an almost punitive approach to supporting asylum and immigration. So, by trafficking coming, we're really challenging what was, in the past, quite a low level support for some children.

*This was echoed by those who worked with prostitutes/sex workers.

Build Trust with Victims

Also, many respondents suggested that health-care workers have a unique opportunity to identify women and girls who were not presenting in other situations where abuse or crimes were typically picked up. As one researcher explained:

So that you've got that extra bit of space to ask a few more questions to be seen as someone who you could tell something to. I mean some of this is about trust, isn't it?...Some of it's about permission, you know? We know if we give people permission to talk about these things some of them will, immediately. And some of them will take longer and that's an issue about trust. And you can't do that, if you're in a kind of factory, get as many people through as possible...So if you are going to enable those sentences to be spoken you have to create a conducive context that's not...the traditional way you deal with any health situation.

Improved Inter-Agency Collaboration

Respondents believed that local anti-trafficking efforts would be more successful if more health-care workers participated. As described by one non-profit child trafficking expert,

[W]hat we would like to see is a more integrated approach so that...you've got all the working relationships across a broad range of professions...[and] everybody working to almost to the same framework and be able to work in a multi-agency environment, cause the pieces of the puzzle can at different times be in different places.

Respondents expressed a desire for clear guidelines and protocols from the NHS. Several respondents suggested that any guidance on trafficking be situated in a wider context (e.g., violence against women and girls) to help health workers better understand the issue. One central government official suggested inclusion of trafficking as a priority in the NHS' Operating Framework, to assure that any issues raised by the DH are implemented by the NHS.

One central government official argued,

[I]f you start to look at the needs of migrants anyway in terms of health care, you'll probably address some of the kinds of issues of trafficked women. And even in terms of, some of the needs of victims more generally, again, you'll hit trafficked women.

Discussion

This case suggests that the health system of London can play a significant role in combating sex trafficking in London. Respondents enthusiastically discussed the possibility of health-care workers becoming a substantial force in local efforts to address sex trafficking in London. They articulated numerous opportunities and potential roles for the local health system, including identification, treatment and prevention of sex trafficking.

A key emphasis of the interviews was the need for the health system to address social determinants of trafficking. That is, prevention strategies may be effective in mitigating the social conditions that allow trafficking to occur. The NHS could, for example, develop programs to address the problem of sexual and physical abuse in childhood and adolescence. Furthermore, a clearer and easier path to mental health services must be made for victims, which were noted by respondents as a critical, yet extremely difficult, set of services to procure. Mental health services may be critical resources at the port of entry, given recent literature suggesting that girls from abroad trafficked into the U.K. are being identified by airport immigration staff, taken into care as unaccompanied minors, disappear, and then re-appear.⁷⁵ When these girls “re-appear,” they are identified as trafficked, and show signs of sexual exploitation.

With the introduction of the U.K. Human Trafficking Centre and the National Referral Mechanism, as well as new local policies and guidelines providing victims improved access to social and health services, the government has taken strides to address the issue of trafficking. Despite these efforts, sex trafficking remains a phenomenon not well-known or understood by health-care workers. The fact that multiple government departments, agencies and nonprofits are involved in these efforts makes coordination even more challenging. Health-care workers need clarity regarding their responsibilities and victims’ rights to health and other social services.

U.K. health-care workers in London look to the NHS to guide their work. Directives from the NHS could eliminate confusion around health and residency entitlements for trafficked victims, particularly women. Training could also clarify to what health-care services trafficked women should be referred. The DH and the NHS are the most appropriate governmental bodies to issue training packages with protocols, which may eliminate confusion among health-care workers and encourage them to engage in anti-trafficking work.

To be successful, training should be prioritized for health workers most likely to identify and treat victims – as well as treat women and girls at risk of being trafficked. Therefore, school nurses, sexual health clinics (SARCs and GUMs), A&Es and health visitors are positioned to take on leadership roles in anti-trafficking work. Trainings for these groups also need to be mindful of health workers’ time constraints and internal

hierarchies. Health-care workers, especially doctors, should be more involved in the trainings, i.e., as trainers. As described earlier, some training programs are currently being piloted with health-care workers on child trafficking; these trainings include matrices of indicators that raise red flags about suspicious cases. Further refinement of victim-identification tools may be an area where health-care workers can also contribute.

Furthermore, respondents called on health-care workers to collaborate with non-health stakeholders to address trafficking in local communities. For example, some suggested health-care workers' increased participation at local multi-agency child protection strategy meetings, in order to add knowledge and tools to groups seeking to increase identification of girls, and how to keep them safe once in care.

Finally, several respondents suggested that more research is needed to illustrate the trafficking problem, highlight potential solutions and to convince policy makers to allocate resources to tackle trafficking.

Overall, these conclusions are consistent with recently published literature, including a 2009 report on child trafficking in the U.K. published by the University of Bedfordshire/NSPCC.⁷⁵ Recent reports suggest that increased efforts by the health sector would make a difference in fighting trafficking and assisting victims. Literature from the U.K. calls for more policies and systems that can effectively meet the immediate and long-term health needs of formerly trafficked women and girls.^{73, 76} Studies argue that awareness-raising of health-care workers would lead to improved identification of victims^{8, 26, 73, 76} particularly in A&E and other walk-in settings⁷⁵ and that health-care workers could provide more comprehensive, immediate and long-term health-care treatment for victims.^{8, 26, 75, 7}

CHAPTER 6: SEX TRAFFICKING OF WOMEN AND GIRLS IN METRO MANILA

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Introduction

Study Setting

With a population of 11.5 million,⁸⁵ the Manila metropolitan area (“Metro Manila”, also known as the National Capital Region) is highly urbanized and densely populated.

Metro Manila encompasses 16 cities* including Manila, the capital of the Republic of the Philippines. It is an emerging hub of global commerce,¹⁵ and a known “tourist and entertainment hotspot.”¹⁵ Metro Manila is also a major source, destination, and transit area for trafficked girls and women in the Philippines¹⁵

Metro Manila is situated between Manila Bay to the west and Laguna de Bay to the southeast, Bulukan to the north, Cavite to the southwest and Laguna to the southeast. The most commonly spoken language in Metropolitan Manila is Filipino/Tagalog (94%), though English is also widely understood. The primary religion in the Philippines is Catholic (83%), followed by Protestant (5%), and Islam (5%).⁸⁶

In 2009 the Philippines was downgraded by the U.S. State Department to a Tier 2 Watch-List country ¹ It is considered by UNICEF to have one of the world’s worst track records with regards to child trafficking.⁸⁷ While trafficking prevalence figures vary, the International Labour Organization (ILO) cites 100,000 as an often quoted figure for the number of children trafficked in the Philippines – a substantial proportion of whom are reported to be in Metro Manila.¹⁵

The Philippines is a member of the Association of Southeast Asian Nations (ASEAN), which adopted the Declaration Against Trafficking in Persons Particularly Women and Children in 2003.⁸⁸ Also in 2003, the Philippines passed its own Anti-Trafficking in Persons Act (No. 9208), out of which emerged the Inter-Agency Council Against Trafficking (IACAT). Comprising heads of government agencies as well as selected representatives of non-governmental organizations (NGOs), IACAT is tasked with the coordination and implementation of the Philippine’s anti-trafficking law.⁸⁹

* Metro Manila includes the cities of Manila, Quezon City, Pasay, Caloocan, Malabon, Mandaluyong, Marikina, Paranaque, Valenzuela, Makati, Pasig, Muntinlupa, Taguig, San Juan, Navotas and Las Piñas.

In 1991 the National Department of Health (DOH) transferred decision-making and management of health care to local units of government through a decentralization process known as devolution.^{90, 91} In accordance with the devolved system of governance in the Philippines, local government units are largely responsible for operating and maintaining hospitals in their areas.⁹² Designed to give autonomy to local governments with regards to resource allocation, this effort has been hampered by chronic under funding, poor management, allegations of widespread corruption, and a decline in infrastructure maintenance.⁹¹

Health-care delivery in the Philippines is a mosaic of private and government run services. The Philippine Government funds a social insurance scheme that operates in conjunction with the DOH. The eventual goal is to provide universal coverage for all citizens.⁹³

The Metro Manila Development Authority reported the existence of 3,730 health-care facilities in Metro Manila, including 1,509 hospitals and clinics, in 2003.⁹⁴ According to the Philippine Department of Health, there are approximately 1 physician and 3 government nurses or midwives per 20,000 residents of Metro Manila.⁹⁵ At present, the infant mortality rate for Metro Manila is 20 per 1,000 live births.⁹⁵ Approximately 35% of the population of Metro Manila live in one of the city's 500 slums.⁹²

In this chapter we attempt to characterize sex trafficking in Metro Manila; uncover the factors and mechanisms through which trafficking occurs; examine current health-care responses to sex trafficking; and elicit how health care could play a larger role in addressing sex trafficking in the local context.

Summary of Fieldwork

A list of potential key informants in Metro Manila was generated by contacting local service providers, doctors, social scientists, and advocates who subsequently referred us to additional individuals and organizational representatives who could speak to the issues of sex trafficking and/or health care. Fieldwork took place over a two week period in June 2009 until theoretical saturation of our research questions was reached. Direct quotes were analyzed to arrive at themes and triangulated using multiple respondents and existing literature.

Fieldwork yielded a total of 24 individual interviews and group interviews with 51 key informants including 17 program administrators,* 12 social workers, 9 program directors, 3 mental health providers, 2 government officers, 3 researchers, 4 physicians, and 1 legal professional.*

* Our sample included two interviews with five individuals in neighboring Subic Bay who could speak to the issue of sex trafficking in Metro Manila.

Characterization of Sex Trafficking in Metro Manila

Prevalence of Sex Trafficking

As a known source, destination, and transit point for trafficked women and girls,^{15, 87, 96-98} respondents characterized sex trafficking in Metro Manila as a pervasive and progressively worsening problem.

Accurate prevalence figures on sex trafficking are extremely challenging to generate due to the underground nature of human trafficking.¹⁵ Several respondents emphasized that published prevalence estimates for sex trafficking in Metro Manila and the Philippines are little more than educated guesses and cannot be considered reliable. The country's Department of Social Welfare and Development (DSWD) reported entry of over 3,000 children into prostitution each year in the Philippines.¹⁵ A 2007 study described 287 individuals nationwide who were rescued from sex trafficking situations over a one year period, of which 40 percent were minors.⁹⁶

Existing data on known victims of sex trafficking has been collected by a number of government agencies and NGOs working on anti-trafficking initiatives. Documentation from one anti-trafficking service provider in the Philippines indicated that since 2001 it had intercepted approximately 10,000 incipient trafficking victims at major seaports and airports en route to situations of forced labor and prostitution.⁹⁹ Several respondents reported providing social services for between 20 and 100 victims of trafficking in Metro Manila per year.

One physician who treats victims of child abuse pointed to national census figures as one source of data, but quickly cautioned, "You know we barely look [at government data] because we know how inaccurate it is." This physician continued by stating that in the last year, her/his organization had treated more survivors of child abuse than the total nationwide figure reported to the Department of Social Welfare and Development.

Consistent with recent studies,¹⁵ the age at which girls are trafficked into prostitution reportedly ranges from 12 to 23 years, with the vast majority trafficked as minors.[†] Girls trafficked to Metro Manila were reported to come from rural regions of the Philippines including Samar, Cebu and Mindanao as well as different areas within Visayas.

* One interview was not fully transcribed due to the poor quality of the recording. This interview was therefore not included and not used in our analysis.

† While the problem of sex trafficking in Metro Manila was also thought to extend to women over age 18, we reflect language used by most of our respondents who more frequently referenced sex trafficking as a problem facing girls.

Metro Manila reportedly serves as a source as well as a transit area through which girls are sent to Japan and Singapore. Several respondents in Metro Manila also reported treating rescued girls and young women who had been trafficked through the province of Mindanao to Malaysia, though it was unclear how many of these girls originated from Manila.

Two respondents also characterized Metro Manila as a transit area where girls receive “training” before becoming dancers or entertainers elsewhere. “They get recruited in the rural areas and then train in Manila. And once they [have completed] training preparation they are ready for international exposure,” noted an anti-trafficking advocate. The characterization of Metro Manila as a source, destination, and transit area for sex trafficking is well supported in the literature.^{15, 87, 96, 97}

How Women and Girls Are Trafficked: Mechanisms

The mechanism by which girls enter sex trafficking in Metro Manila was reported to involve elements of force, deception, economic desperation, and psychological manipulation. Trafficked girls often do not realize they will be entering prostitution and are deceived with promises of decent jobs in areas such as domestic help or restaurant work. Published literature supports this finding¹⁰⁰ while also describing how children may be trafficked at first for forced labor, but later transferred or sold into commercial sexual exploitation.^{15, 96}

Families were perceived as playing a complicit role in trafficking at times, by approving or pressuring their daughters, nieces, or neighbors to seek work in Metro Manila to support the family. In return, family members have reportedly received cash advances and other gifts from traffickers and recruiters.

Several respondents described impoverished families in remote rural areas as operating in “survival mode.” As one doctor reflected “... So there are girls who say ‘What’s wrong with that [prostitution] if we can fill up our stomachs?’”

One NGO respondent described how such dire circumstances open the door to traffickers:

... the very force of poverty and lack of choices, you don’t even have to whip them; you don’t even have to tie them down in the brothels so that they’ll keep coming back to you. Because they will, because they don’t have anything to go back to.

Traffickers who lured girls from their home communities often were described as “middle men,” “headhunters,” “canvassers,” or “recruiters.” Some traffickers were thought to operate via large networks; others described traffickers as working as solo operators on a smaller scale by recruiting and transporting two or three girls at a time.

Victims frequently are moved through seaports or international airports, successfully passing through security checkpoints with forged or stolen birth certificates or other seemingly legal documents.

One NGO respondent who works to identify and intercept trafficking victims in transit areas described features of a typical trafficking case identified in a port area:

... you could detect a group of very young women ... the average age of those that are being trafficked ... is from 12 to 23 years old. If you look at that age range and you see a group of women emerging, it should already raise a red flag to start thinking about it. Second thing that you need to look is that there is always some kind of a mother hen who holds all of the documents; she has the tickets; she has the personal documents ... [T]hird ... these young women are usually constrained in their movements. Once inside the ship, they are not allowed to talk to any other passengers, they are not allowed to talk with the crew, even the crew of the boat, and if you ask them where they are going, some of them have no idea, most of them really have no idea what will be their jobs ...

Upon arrival in Metro Manila, girls are promptly sold to a brothel, bar, or “casa.” In particular, casas and brothels were commonly thought to be the most hidden, restrictive, and heavily guarded destinations for sex-trafficking victims.

In past years, local government administrations permitted “adult entertainment establishments” to operate in specific, circumscribed districts known as “red-light areas.” More recently, some local mayors have taken steps to restrict or eliminate red light areas, which has resulted in the dispersal of adult entertainment venues, such as videoke bars, beer houses and the like, across the city. While current local governments have officially banned prostitution in Metro Manila, they reportedly tolerate and sometimes even promote a culture of tourism and entertainment that employs young women as “guest relations officers” or GROs in establishments throughout the city. GROs are hired to entertain clients, many of whom pay for supplemental sexual services. Some GROs enter this line of work by choice, while others may have entered as a result of deception or frank coercion. As a result, one NGO respondent reports the perception that “the red light district is almost everywhere.” In Metro Manila, the term “guest relations officer” is a euphemism for sex worker or prostitute. Several respondents who work directly with rescued trafficking victims reported that girls often experience psychological manipulation by brothel owners as a means of control. As one respondent described,

“Their traffickers or their pimps or whoever’s operating the system has already brainwashed them that ‘the [Department of Social Welfare and Development] is going to put you in jail; they won’t let you go.’ It’s part of the brainwashing process.”

Upon rescue, the reintegration process in the Philippines was thought to be, as one policy advocate stated, “quite questionable.” There was reported to be a lack of established systems or services to absorb trafficking victims back into their communities of origin. This was believed to lead children returning to their village likely to face the same set of social and economic conditions that led them to be trafficked in the first place, leaving them particularly vulnerable to re-trafficking. “She might just be re- victimized again, or worse, encourage other children to be,” reflected one social worker.

Sex Trafficking: Key Determinants

A wide range of key determinants for sex trafficking reportedly place girls at risk for sex trafficking.* These range from individual factors of clinical significance to broader social ecological determinants.

Many respondents explicitly associated a girl’s prior history of sexual abuse as a major risk factor for sex trafficking. As many as 80 to 90 percent of girls forced into prostitution were estimated by respondents to have been victimized by a family member or someone close to the family. One doctor who treats victims of child abuse reflected, “I always say especially if you have a history of abuse at home, you know, you’re thinking ‘anything else would be better. It cannot be worse than this.’”

Other individual determinants include neglect, emotional abuse, physical abuse, and poor self esteem. Being a prior victim of trafficking, as well as being at a critical stage of socio-emotional development were also cited as determinants. As one respondent who treats trafficking victims described, a vulnerable girl has “a brain of [a] teenager that’s not yet fully developed and is mainly emotion based,” which heightens her vulnerability to peer pressure, an observation corroborated in other trafficking studies.¹⁵

Being raised in a large and/or dysfunctional family was also suggested as a risk factor for sex trafficking. Parents of trafficked girls may be uneducated, working far from the city, or have a history of prostitution themselves. Some parents were thought to have psychiatric problems. Two respondents noted how family members may literally force girls to go with a local recruiter or trafficker.

* Throughout interviews respondents did not differentiate between domestic trafficking and those trafficked out of the country.

A 'culture of migration' was widely reported to exist among families and communities in the Philippines. Particularly in source areas, cultural pressure exerted on girls to support the family by moving to urban areas or overseas for work was thought to lead to victimization. One social services administrator recounted a conversation with the sibling of a trafficking victim:

Respondent: [We] ask[ed] them "What is your dream?"

Child: "I want to become a nurse so that I can go to the United States."

Respondent: "If you can't, for some reasons, if you weren't able to graduate the centers, what would you do?"

Child: "I am a very good singer and dancer so I would go to Japan as an entertainer."

Families in rural areas may lack knowledge or awareness about the realities of sex trafficking in their communities. Lack of access to education was also cited as a socio-cultural factor that led to girls being trafficked. School fees are often prohibitive, and educational and financial resources are disproportionately allocated to boys.¹⁵ A social worker who treats victims in a residential facility reported observing an influx of trafficking cases during the summer months when children are out of school. "It is also seen as an opportunity. It's vacation time so children have nothing to do, they are very easy to encourage. So that's the thing of peak season..."

Consistent with recent literature on child trafficking,^{15, 87} profound poverty and economic desperation in rural areas were cited by respondents as major risk factors. Economic circumstances in some areas were believed to be so dire that families would give up a daughter out of a need for survival. "The people, the families in the rural areas are just wanting to survive and out of desperate measures lend their young," noted one policy advocate. A doctor who treats trafficking victims postulated that poverty and abuse interact to form a "perfect storm" of factors leading to sex trafficking.

Maintaining a sustainable livelihood through traditional forms of labor such as agriculture and fishing was believed to be increasingly difficult, with environmental degradation leading to decreased crop yields and declining fish harvests. In addition, recent agricultural policies and practices have reportedly contributed to forced displacement and subsequent migration to urban centers. "We're having difficulties with so much pesticides dumped, you know, in the farms. The yield for each hectare of land is now reduced because they have destroyed the... the fertility of the soil" noted one respondent. Some mountainous regions of the Philippines are particularly vulnerable to typhoons and landslides, increasing the likelihood of migration to urban areas to pursue viable livelihood options.

A lot of them are from Samar province or that region, and it's because that region is very poor, very low, almost no infrastructure development in that region. It's typhoon stricken, educational levels are low, the drop out rates, the school participation rates are low, and even the irrigation levels are low. (Social worker)

An increased likelihood for re-trafficking occurs when rescued girls are returned to their home villages, only to discover that the conditions of extreme poverty from which they sought to escape remain unchanged.

My fear is that once they go back into their hometown...the whole situation that pushed her into that situation, into the trafficking scenario in the first place, is...[still] present [in] their hometown. You could imagine waking up early and seeing nothing has changed from when you left three or four years ago. It's kind of depressing and sometimes it even deteriorates, the situation... (NGO respondent)

Another major theme of our interviews was corruption, complicity, and denial of the extent of sex trafficking by local government officials as a contributing factor that allows sex trafficking in Metro Manila to persist unchecked.

[I]f only we could get local governments to sign up and agree that they have to fix the problem [of sex trafficking], encourage local governors, mayors, whoever, just to be less corrupt, skim off a little less money off each thing, let some more money trickle through these places, you could actually make some incremental improvements in all sorts of governance or social issues... (Policy advocate)

Demand for young girls in Metro Manila was also described by many as a major contributor to sex trafficking. Two respondents who provide treatment for trafficking victims observed that many customers are foreign businessmen, some of whom sought out virgins to provide them strength. Demand for virgins is reportedly so high that when girls are first brought to Metro Manila they are taken to a private doctor to verify their virginity. Regardless of the results of the "inspection", traffickers were understood to increase their profit by employing various tactics to trick customers into believing they are receiving the services of a virgin.

Existing Responses to Sex Trafficking in Metro Manila

Health Implications of Sex Trafficking

Victims of sex trafficking reportedly suffer from a number of health problems. Unwanted pregnancies and subsequent medical complications resulting from forced and

often unsafe abortions* were described by a number of respondents as frequent problems for victims. Physical and sexual abuse was also pronounced for trafficked girls. As a senior government official noted, "Some would not be fed, some would be raped, and some would be asked to work from dawn until night ... and I suppose these will have some effect on how they will be able to cope." A high prevalence of sexually transmitted diseases, and vulnerability to HIV/AIDS, was also related by several respondents.

Traumatic and post-traumatic stress were frequently cited as mental health problems in girls rescued from trafficking situations. One NGO representative specifically pointed to the compounded trauma experienced by devout Catholics forced to have abortions. Other behavioral issues identified include tobacco smoking, alcohol abuse, illegal drug use, and a variety of behavioral and emotional problems.

Many respondents working with rescued victims also pointed to profound anger and mistrust, which girls develop in response to the brainwashing that occurs while trafficked. One respondent who provides services to rescued girls reported that some girls even refer to their traffickers or brothel owners as "uncle" or "mommy."

As a recent report by the ILO summarized the health effects of child trafficking:

They suffer long term emotional, physical and social problems. Girls may have reproductive problems due to the immaturity of their bodies when they become sexually active, resulting in greater reproductive health morbidity.¹⁵

Health Services for Trafficked Victims in Metro Manila

Citing the illegality of sex trafficking and prostitution, trafficked girls held in casas and brothels were reported by service providers and advocates alike to have extremely limited access to health care of any kind. One policy advocate recounted an interaction she had with a rescued girl on her life in a casa:

[She] was really confined... she can't go out...and right there and then, the first night she had I think eight men. She was not treated. She had a severe STD with fever and shivers. And according to her, actually she was asked to take antibiotics on her own without seeing a doctor. And then they used a stick into her vagina to get a specimen of her then put it in a slide ... it was brought to outside, but she was never allowed to go to see a doctor.

* While abortion is illegal in the Philippines, the estimated abortion rate in Metro Manila is 52 per 1,000 women, including nearly 30,000 women hospitalized with abortion complications in the year 2000.¹⁰¹

Trafficked girls' only access to medical attention was reported to be at private clinics favored by the pimp or bar owner. Given that abortions are illegal in the Philippines,¹⁰¹ terminations were thought to be carried out through private, unlicensed, and often poorly trained abortionists. Alternatively, some girls were believed to be given herbal or pharmaceutical medications to induce abortion.

There are rescued victims who shared their story that their [trafficked victim's] employer will give them some kind of medicines to prevent them from getting pregnant or to abort their baby so that they will continue working as sex workers, and this information is based on the cases documented and testimonies of those rescued already... (Social service provider)

Immediately following rescue,* trafficking victims are reportedly sent to a forensic examiner in a government facility for age verification. If the individual is declared both underage and a trafficking victim, she is either sent back to her family or placed in a rehabilitation home, according to respondents. This process was described as "critical" by one landmark report on child trafficking, "since [it] may spell the difference between the child overcoming the initial trauma and developing into a healthy adult or [instead] going back into the cycle of victimization and abuse."¹⁵

The Department of Social Welfare and Development (DSWD) is responsible for the coordination of policies and services for trafficked girls who have been rescued. Resource allocations for the Philippine Government's anti-trafficking efforts were reported to focus largely on the prosecution of traffickers. As a result, the government was understood to look to NGOs to coordinate health care and mental health support for victims.

Government and non-government respondents alike pointed to the active presence of NGOs as critical stakeholders in the delivery of health-care services to victims of sex trafficking. Government run residential facilities for survivors of rape, abuse, domestic violence, and trafficking were described as having been established for the purposes of rehabilitation and social reintegration of the girls back into their communities of origin. NGO run residential services were also said to have been established in and around Metro Manila. Compared to their government counterparts, most respondents thought NGO provided services were more sensitive and less discriminatory, and indicated that they often made referrals to private hospitals that offer what several respondents described as "child friendly" services, appropriate for young victims.

* Three primary mechanisms were reported for the identification and rescue of sex trafficking victims: (1) NGOs working with seaport and airport authorities to identify and intercept victims en route; (2) NGOs working undercover in bars and brothels; and (3) local law enforcement conducting rescues on their own.

Noted one NGO respondent who coordinates aftercare services for rescued trafficking victims;

... and for the government, because of budgetary constraints, their least priority is the medical checkup ... of the kids, so we come as an NGO helping these kids. So we are the ones responsible for bringing ... them to a private hospital ... and the government cannot afford that.”

Another major theme described by respondents was the existing community based grassroots initiatives that relied on formal and informal partnerships and collaborations among providers, advocates and governments to ensure effective service delivery to sex trafficking victims. One frequently mentioned example of collaboration was the Child Protection Unit Network (CPU),¹⁰² thought to be the country’s major service provider on issues related to child trauma and abuse. The CPU reportedly receives the majority of its resources for services through private foundations, but is also endorsed and supported through a partnership with the Department of Health. The CPU Network was said to have evaluated and treated more than 7,000 abused children through 28 CPU facilities across the Philippines in 2008. In addition to providing services for child abuse and trafficking victims in Metro Manila, several respondents described how anti-trafficking organizations link with CPUs in rural source areas for medical expertise and for abuse and trafficking prevention activities.

Efforts to involve health-care service providers and related professionals in anti-trafficking training exist in some source areas.* In addition to providing anti-trafficking awareness and education in *barangays*,[†] respondents reported working with local leaders to ensure that service providers, community educators, and social workers were made aware of available resources regarding child protection and trafficking prevention, including how to make referrals. “If you start doing community education, you’ll get [trafficking] cases, you have to know where to go...” observed one respondent.

Another anti-trafficking expert and community educator reflected:

[We] ask [local service providers] to...link up with the local Child Protection Unit if it exists in that area because...we don’t have expertise as medical professionals, so we have to learn how to link up locally as well. And some of our greatest advocates are actually medical practitioners, you know, medical municipal health officers for example, who take on the issue of trafficking in addition to what they’re already doing.

* A detailed description of trafficking and local services response in source areas can be found in the International Labour Organization’s 2007 report, *Child trafficking in the Philippines: A situational analysis*¹⁵

[†] *Barangays* are the smallest unit of administrative government in the Philippines. There are 1,695 *barangays* in Metro Manila.¹⁰³

Barangay health workers were reported to provide community outreach and education on issues of local importance to the community such as child abuse, HIV/AIDS, and, in some cases, trafficking. “They know that trafficking is an issue and is a reality in the areas they work in,” commented one advocate.

[*Barangay* health workers] used to be mothers who were not doing anything so they just decided to volunteer for a commune. So it is a pool of people engaged in the health-care system who could be of help and they’re the ones who are usually trusted, because in every *barangay*, there is usually ... one registered nurse, then they have this doctor who goes there once a week, full moon; yeah, so it’s not really that much, but they’re the ones that are trusted by the people and by the health professional himself or herself. (NGO service provider)

Barriers to Health-System Response to Trafficking

Overall, respondents suggested that combating sex trafficking was not a public health priority for the government. As reported earlier in this case, the Philippine Government’s coordination for anti-trafficking initiatives occurs through IACAT. It is chaired and co-chaired by representatives from the Department of Justice and Department of Social Welfare and Development, respectively.⁸⁹ IACAT’s priorities have been interpreted as mainly prosecution focused rather than centered on services to victims. “The [anti-trafficking] law was passed ... without any appropriation for its implementation,” noted one anti-trafficking policy expert. Consequently, members of IACAT are responsible for allocating funds from their own budgets to carry out IACAT related duties. As a result, the government reportedly defers administration of most public health and some social welfare services for sex trafficking victims to NGOs.

Respondents specifically pointed to the absence of a representative from the Department of Health (DOH) on IACAT. Observed one advocate active in anti-trafficking policy, DOH “hasn’t even figured into any discussions that I’ve had over the past year on trafficking.” Possible reasons offered by respondents for DOH’s lack of involvement include DOH wanting to avoid more responsibility given its current budget limitations; or the government lack of recognition of trafficking as a health issue.

Public-health care in general was not thought to be of high priority for the local or national government. Existing health and mental health services reportedly suffer from chronic funding shortages. Two respondents thought that such shortfalls are used to justify the public health system’s lack of involvement on issues around social medicine such as child abuse prevention or trafficking. While NGOs attempt to address this gap by offering their own services to marginalized and vulnerable people in Metro Manila, one NGO respondent cautioned that NGO run services are susceptible to funding cuts and shifting priorities from their own funding sources. “I mean we’re really depending on grant to grant. What happens if the world ‘flavor of the month’ changes?”

The country's devolved system of governance⁹¹ was reported as presenting challenges for health-care delivery and administration. While the DOH coordinates regional hospitals, responsibility for services administration is diffused to local government units, which presents challenges for coordination, accountability, and follow-up of services. One foreign government respondent specifically noted the difficulties of finding funding for anti-trafficking work amidst so many different competing priorities at different levels of government.

Respondents described existing public health facilities as lacking in both materials and human capacity, and thus unable to deliver effective medical treatment on a population wide level. The "brain drain" phenomenon was thought to be particularly pronounced in the medical professions. In addition, there were believed to be insufficient numbers of social workers and mental health professionals able to provide care. As a one psychiatrist described, "Some [hospitals] don't have mental health services for children ... Some of them try to encourage volunteers, so if they get volunteers, that's the only time that the children get mental health services. So if they don't have volunteers...they don't offer the services."

Long queues were reported to be commonplace at government run health facilities; patients often line up in the early morning hours in hopes of being seen. Patients' needs were thought to be prioritized by seriousness and immediacy, meaning a rescued victim suffering from trauma may endure a significant wait time if she does not have a life threatening ailment. One respondent recalled the case of a newly rescued sex trafficked girl who waited nearly all day for treatment.

While the Department of Social Welfare and Development is responsible for ensuring that rescued girls receive health-care and social services, respondents reported serious deficiencies in a systematic response to the health-care needs for sex trafficked girls in Metro Manila. When newly rescued girls are taken to a government hospital, they are described as often traumatized and upset; yet treatment was perceived as judgmental and often not child friendly. Clinical care for women at government facilities in Metro Manila was generally described as insensitive and "emotionally distant." Stigma and discrimination were reported to extend particularly to sex trafficking victims. Two respondents posited that the number of patients waiting for treatment overwhelms government hospital staff and they develop insensitive treatment routines as a protective mechanism. "They've developed numbness for this. And then they shout, they shout at these women: 'Oh you're here again!'" said one respondent. A social worker expanded on this sentiment: "Sometimes they are being labeled as willing victims; that they came willingly and they should accept the fact that they have been victimized there because they consented."

When NGOs are not present following a police only rescue of a trafficked girl, there is reportedly an increased likelihood that a victim's health-care needs will be neglected. Two

respondents attributed this to a lack of knowledge and priority for the prosecution focused police. "Sometimes the police don't even record the case, especially if it is something they can't solve," noted one respondent.

One respondent described an interaction with a law enforcement representative who was managing the case of a newly rescued trafficked girl:

The NBI [National Bureau of Investigation] agent who was handling the case was complaining that he didn't have money to pay for the health tests that this girl needed. Basically he said that, 'You know we have to do HIV, pregnancy, etcetera, etcetera, so many tests,' but he said 'I don't have any budget for, you know to help the girl undergo all these other tests that are necessary, not just the medical, legal examinations.'
(Advocacy respondent)

The provision of health-care services to girls in residential rehabilitation facilities was described as extremely expensive. Noted one social worker, "You have to pay for it, so that the girl will have access to it. Even the check, the HIV test, the HIV/AIDS testing, we have to pay for that. So it's not for free."

Rehabilitation services offered at government rescue homes (also known as government crisis centers) are reportedly intended to help survivors of child abuse, domestic violence, and trafficking. However, many respondents indicated that workers at these centers lack the required technical skills and training to effectively respond to the health and mental health challenges specific to sex-trafficking victims. "I think doctors may know about trafficking but responding to a trafficking victim is different from responding to a child sexual abuse victim," commented one advocate.

It also depends on when you rescued them, you know. When you rescued them on the way to being trafficked, they've not yet been trafficked, it's just en route, ... so they have not yet experienced being raped. 'You're in the way, you're not being helpful; what can you offer us, you know, because we're being promised a job and a livelihood. What can you offer us ... because you're preventing us from ... helping our families.' (Physician respondent)

Similarly, a major barrier identified by respondents was a lack of awareness and basic education on the part of doctors, psychologists, and nurses regarding the particular needs facing victims of sex trafficking and how these needs differ from abuse survivors.

Handling trafficking victims is somehow more challenging compared to handling victims of child sexual abuse or interfamilial abuse ... how [forensic doctors] interview or how they draw out the situation of child

sexual abuse ... is very different from getting information about the trafficking incident ... so, I think its not yet as, it's not within the awareness, even of child trafficking practitioners or even child protection practitioners to really get more involvement of the medical profession.
(Advocacy respondent)

“Most medical curricula [in the Philippines] often capacitate medical professionals to diagnose the biomedical aspects of illness but lack child and gender friendly protocols” noted a recent report from the ILO.¹⁵ Indeed, two senior level health-care administrators also thought that curricular material about trafficking did not exist in schools of nursing, public health, or medicine in the Philippines.

Opportunities for Local Health-System Response to Sex Trafficking

Priority and Policy

Collectively, interview respondents called for coordinated anti-trafficking efforts at local and national levels of government which would explicitly involve a health-care component. DOH representation on IACAT was seen as an essential and practical step that could begin to infuse a public health framework into national policies and services.

As one doctor who treats survivors of abuse and trafficking in a hospital based setting reported:

The way that the Department of Health is acting is that they really look at child trafficking, child abuse, as not a health problem ... they really look at it as a problem mainly belonging to the hands of either the Department of Social Welfare or the Department of Justice. I think we were lucky ... when we decided that [our child abuse center] was going to be hospital based because it more or less forced ... the hand of health to look at it as, to take ownership, that it is a health problem too, that its not just social welfare and, and justice.

Many respondents held fast to a belief that an effective public health response to address sex trafficking could be achieved through improved utilization of existing resources, despite current low levels of government funding and the inherent challenges of a devolved system of governance. For example, one respondent thought the government could provide tax incentives for hospitals that demonstrate competency in treating trafficking survivors and victims of violence or abuse.

This same respondent also advocated for an enhanced coordinated effort for service delivery for communities:

[T]he social welfare offices should really devote the resources, not entirely in coming up with their own programs, but in mapping programs that are already in the community and finding links and helping them improve those programs. Because ... we have community health centers that are available and that we utilize as some kind of focal point for stability for the social workers ... they should have more rational process of allocating funds, there are a lot of actions, so, we have funds for livelihood programs but usually the livelihood programs that could be accessed by trafficked victims and their families are usually given to municipalities or to *barangays* that are politically connected with the, either the decision maker from that agency, so...

Mental Health Services for Trafficking Victims

Immediately following the rescue of a trafficked girl, respondents pointed to the need for survivor centered, rights based systems of care and support. One NGO respondent working with rescued children thought that many existing barriers to service delivery in Metro Manila could be resolved by offering a “one stop shop” for sex trafficking victims “where all services can be accessed” to meet a girl’s immediate forensic and mental health needs following her rescue. “You go there, you don’t have to be transferred from one agency to another; you get your initial medical exam; you get dental aging there ... that’s where they could also meet psychologists and social workers who can help out in counseling ...”

The Philippine government’s current policy of absorbing rescued trafficked girls into existing services and infrastructure for survivors of other forms of abuse was thought to be ineffective, as it fails to account for the bio-psychosocial and ecological complexities that are specific to victims of sex trafficking.

Respondents called for curriculum development for training and sensitizing doctors, nurses, forensics specialists, mental health professionals and social workers on the specific health and mental health needs of sex trafficking victims. In particular, respondents emphasized how the needs of sex trafficking survivors may differ from the needs of survivors of other forms of abuse. As one advocate observed, “I think doctors may know about trafficking but responding to a trafficking victim is different from responding to a child sexual abuse victim.”

Several respondents suggested the possibility of integrating sex trafficking into medical or nursing schools through existing social medicine modules covering child abuse, domestic violence, or sexual assault.

Prevention and Community Education

Another recommendation from respondents was for health interventions to engage in primary prevention of sex trafficking by piggyback on existing community based health projects in known source areas for trafficking. “Livelihood, transport, housing, clean water shed, and all that. I mean that’s a holistic view to address the problem,” noted one advocate.

Respondents clearly differentiated between the service needs of sex trafficking victims and other survivors of abuse. However, since childhood abuse was identified as a hallmark determinant of sex trafficking, respondents suggested linking local *barangay* health workers’ ongoing efforts to identify and prevent child abuse with trafficking prevention activities in order to identify cross cutting signs of abuse and establish systems of referral to anti-trafficking service providers.

We’re finding that a lot of the trafficking victims have already been victims of abuse within the home or in their community before they are trafficked, so if we can find ways to assist them at an early stage, you know when the family is not protecting enough, you know, to put in the protective mechanisms early enough then maybe we can prevent trafficking in the long run. (Policy advocate)

I also would like to see trafficking, migration, and violence against women and children’s issue integrated with the training that’s being provided ... we have *barangay* health workers. These are volunteer health workers, so they should also at least receive information about this; they should be able to detect, because they’re at the community levels, so we could detect whether a house is being used as a prostitution den or suspected recruitment or trafficking situation that’s being initiated, so they should be part also of the solution. (Service provider)

Discussion

Collectively, our interviews maintained that Metro Manila is a major source, destination, and transit area for sex trafficking victims in the Philippines. This case provided an overview of sex trafficking in Metro Manila. It used a public health lens to describe the current landscape of health service for sex trafficking victims and explore possible avenues for local health systems to play an increased role in anti-trafficking efforts.

Gender inequality, childhood sexual abuse, and profound levels of poverty, coupled with an ingrained ‘culture of migration’ and sense of familial duty, functioned to form the “perfect storm” of social forces that drive girls into sex trafficking. Girls were

typically lured from rural areas with vague promises of a job in Metro Manila only to find themselves forced into prostitution. Psychological manipulation is one of the primary means of control used by traffickers and brothel owners. Sexually transmitted infections (STIs), abortion complications, and high levels of trauma were frequently reported health consequences of sex trafficking.

Our interviews found sex trafficking victims have minimal access to health services while being held in *casas* or brothels. In the event that girls are rescued from trafficking, the subsequent health-care response was characterized as unsystematic. NGOs were regarded as the primary facilitator of access to health services; in the event an NGO is not involved in the post rescue treatment of a trafficked girl, access to necessary health-care services is not guaranteed.

A lack of public health investment, a devolved system of governance, poverty, natural disasters,* and corruption were all cited as barriers to health-care delivery. Many of our non-government respondents perceived endemic corruption on all levels of civil society – a perception corroborated in the most recent Trafficking in Persons report by the US State Department.¹

As a recent ILO report recommended, “Communities must be empowered to address abuse and exploitation of children and capacitate them to address those situations.”¹⁵ Respondents expressed confidence that health care could play an increased role in addressing sex trafficking in Metro Manila. Rather than building vertical, standalone anti-trafficking interventions, respondents endorsed an integrated health-care model for anti-trafficking initiatives that would build off existing resources and strengths in communities. For example, despite the fundamental differences in services needs for survivors of sex trafficking and those of child abuse, the latter was pointed out as a key determinant of sex trafficking. For this reason, respondents recommended forming an alliance between anti-trafficking programs and existing child abuse health-care services at the *barangay* level to help prevent and address sex trafficking.[†] In a similar vein, upon reintegration, *barangay* level health systems could be enhanced and engaged to receive a victim girl back into her community and provide appropriate follow-up health and mental services

Respondents expressed frustration that current government rehabilitation services for trafficking victims are often packaged into existing services for survivors of other forms of abuse without catering to the wide range of health issues specific to sex trafficking victims. A number of health consequences were reported to disproportionately affect sex trafficking victims (e.g. STIs, abortion complications, etc). Many respondents,

* In September/October 2009, Metro Manila was the epicenter of a series of devastating floods that reportedly wiped out as much as 80 percent of existing health care infrastructure.¹⁰⁴

† See the renowned model designed by David Olds for preventing child abuse and neglect through nurse home visitations.¹⁰⁵

particularly those who provide direct services to rescued children, additionally painted a complex picture of the profound psychosocial problems specifically facing trafficked children (depression, anxiety, self-harm, psychological manipulation) that warrant care and support by trained mental health professionals. Our interviews characterized the current mental health response as variable; some institutions treating victims have psychologists and trained counselors on hand; others have volunteers or no one at all.

Due to these differences in provision of care for trafficking victims, our interviews made a general call for increased sensitization and levels of awareness for those providers who come into contact with rescued girls. While social medicine modules reportedly exist for child abuse, domestic violence and sexual assault, we found no evidence to suggest that sex trafficking was currently included into existing educational curricula.

Citing the absence of DOH participation on IACAT, respondents largely thought that sex trafficking was not perceived as a public health priority for the Philippine Government. While IACAT's 2004-2010 Action Plan¹⁰⁶ reports on the need to provide social services to survivors of trafficking, no explicit reference is made for strategies to promote or supply health care. With IACAT's strategic plan coming up for reauthorization in the near future,¹⁰⁶ the inclusion of the DOH on IACAT, as well as clarification on role of health care in the next Strategic Plan, could serve as two pragmatic steps toward creating an integrated response for sex trafficking prevention and treatment in Metro Manila.

This chapter provided some important insights into sex trafficking in Metro Manila that serve to extend our understanding of conventional risk factors for sex trafficking at multiple levels: individual (*e.g.*, childhood abuse), socio-cultural (*e.g.*, gender inequality and a "culture of migration"), and macro (*e.g.*, profound poverty caused, *inter alia*, by environmental degradation disrupting traditional forms of labor). This evidence points to the need for an integrated response at multiple levels of a girl's social ecology that serves to complement survivor-centered, sensitive treatment of rescued girls in a health-care context.

CHAPTER 7: SEX TRAFFICKING OF WOMEN AND GIRLS IN MUMBAI

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Introduction

Study Setting

Mumbai (formerly Bombay) was recently characterized as “India’s largest city and largest concentration of victims of commercial sexual exploitation” and the most common sex trafficking destination within India.⁴⁶ With a population in excess of 18 million,¹⁰⁷ Mumbai is one of the most populous cities in the world: a burgeoning economic center that has advanced India’s positioning within the global economy. It is characterized as a city of stark contrasts where culture and tradition are confronted by globalization and modernity. A changing infrastructure magnifies the existing disparities within the population as development slowly displaces slum settlements and street children, fostering an environment that allows sex trafficking to flourish.¹⁰⁸

Mumbai is situated in Maharashtra, India’s second most populous state. Located on the western coast of India, Maharashtra is bordered by Goa, Karnataka, and Andhra Pradesh to the south, Gujarat and Madhya Pradesh to the north and Chhattisgarh to the east. There are approximately 96 million people living in Maharashtra with 922 females per 1000 males.¹⁰⁹ The literacy rate for the general population is approximately 77 percent.¹⁰⁹ The most commonly spoken languages within Maharashtra include Marathi (69%), Hindi (11%), Urdu (7%) and Gujarati (2%).¹¹⁰ Hindu (81%) is the largest religion in Maharashtra, followed by Islam (13%), Christianity (2%) and Sikh (2%).¹¹¹

As a major source, destination and transit country for sex trafficking in women and children, India has been labeled a Tier 2 Watch-List country by the US State Department for six consecutive years.¹ While estimates of sex trafficking prevalence tend to fluctuate considerably, the following numbers, as cited by the Asian Development Bank¹¹² are often referred to in the literature: 225,000 persons are trafficked from Southeast Asia each year; an estimated 100,000 to 200,000 Nepali girls are currently in Indian brothels, 25 percent of whom are under 18; and an estimated 300,000 Bangladeshi women have been trafficked into India. In 2009, the Ministry of Women and Child Development stated there are 3 million sex workers in the country, 40 percent of whom are children.^{113, 114}

India's legal response to trafficking is through the Immoral Traffic Prevention Act (ITPA). At present the ITPA is primarily focused on penalizing brothel owners and pimps, though recent reforms would also target clients of sex workers.¹¹⁵ India also subscribes to regional anti-trafficking legislation through the South Asian Association for Regional Cooperation (SAARC) Convention on Trafficking in Women and Children.¹⁷

India's health-care system extends from national to village level and consists of national, state, district, community, primary health care, and sub-center levels. Less than 20 percent seek outpatient services and fewer than 45 percent seek inpatient treatment within public hospitals. This sub-optimal level of utilization is attributed to inadequate levels of public health infrastructure.¹¹⁶ Recent prevalence figures indicate that approximately 2.5 million adults in India are living with HIV,¹¹⁷ 10 to 20 percent of whom are commercial sex workers.¹¹⁸

Mumbai's urban infrastructure has struggled to match the rapid economic expansion exacerbating problems in housing, sanitation, and health, particularly for the poor.¹¹⁹ Over one-fifth of Mumbai's population lives in urban slums¹²⁰ consisting of formal and informal communities characterized by poor sanitation facilities, inadequate water supply and abject poverty. HIV/AIDS in Maharashtra accounts for over 12 percent of the overall prevalence in India¹²¹ with recent surveillance data showing over 42 percent of all female sex workers in Mumbai are HIV positive.¹²²

Brihan Mumbai Municipal Corporation (BMC) is Mumbai's major provider of public healthcare services. In 2004, Mumbai contained 3 teaching hospitals, 14 municipal general hospitals, 26 maternity homes, 185 municipal dispensaries, and 176 health posts.¹²⁰

In this chapter we attempt to characterize sex trafficking in Mumbai; identify the factors and mechanisms through which trafficking occurs; examine current healthcare responses to sex trafficking, and elicit how healthcare could play a larger role in addressing sex trafficking in the local context.

Summary of Fieldwork

Fieldwork in Maharashtra was initially planned for early December 2008 but due to the November terrorist attacks in Mumbai, was postponed until February 2009. In the preceding months, a list of potential key informants was generated by contacting local service providers, doctors, social scientists, and advocates who subsequently referred us to other colleagues who could speak to the issues of sex trafficking and/or healthcare in Mumbai. Prior to the fieldwork, discussion with several local individuals active in anti-trafficking revealed the emerging link between trafficking in Mumbai and that of neighboring Pune.¹²³ For this reason, we considered Mumbai and Pune as a single

metropolitan area* and several interviews with key informants occurred in Pune. Field work was conducted until we reached theoretical saturation of our research questions. Direct quotes were used to establish themes and triangulated using multiple respondents and existing literature.¹²⁴

Interviews yielded a total of 25 individual and group interviews with 34 key informants including 10 physicians, 7 program directors, 4 administrators, 3 government officers, 3 researchers, 3 social workers, 2 mental health providers, 1 legal professional, and 1 nurse.

Characterization of Sex Trafficking in Mumbai

Prevalence of Sex Trafficking

Mumbai is comprised of several red-light areas, the largest being Kamathipura, a multi-cultural center for commerce and activity. Described by one respondent as “an umbrella of smaller red-light areas,” Kamathipura is comprised of 14 lanes,¹²⁵ about 6 of which are known sources of prostitution.[†] These lanes are narrow side streets with multi-story brothels or bungalows on either side. Several respondents noted that multiple languages are spoken in the area, and that lanes are generally divided on a linguistic basis. “In the 13th lane they are mostly Nepali women. In the 11th lane we have all women from Kolkata, West Bengal and other parts...” noted one service provider to women in the area. Kamathipura’s red-light area is also associated with brothel cages, tiny rooms measuring 10 square feet with a wooden bed in the corner and “barricaded by a thin, cheap, and colorful nylon curtain.”¹⁰⁸ Brothel cages obtain their name from the bars on the windows¹²⁵ but a woman’s confinement to the bungalow or brothel is often characterized by an impenetrable sliding iron accordion gate: a manifestation of the girl’s actual incarceration.¹²⁵

A 2005 report estimated that Kamathipura generated at least \$400 million, with 100,000 prostitutes servicing men 365 days a year, averaging 6 customers per day, at \$2 per customer.¹²⁸

* Pune, India’s eighth largest city is located 102 miles southeast of Mumbai.

[†] Throughout this chapter, reference to “sex work” is not an attempt by the study authors (nor our key informants) to conflate sex work with sex trafficking. We do not favor “sex work” over “prostitution” but rather attempt to reflect language used by many of our respondents (and peer-reviewed literature^{126, 127}). In the course of many of our interviews, respondents drew from their own experience and insight treating and caring for sex workers to speak to our research questions of focus as it related to sex trafficking. For example, many respondents identified sex trafficking as being a point of entry into sex work; doctors and social workers providing treatment and services to sex workers described points of contact with sex-trafficking victims; and sex workers’ children were recognized as being particularly vulnerable to sex trafficking. These points and others supported in the literature, are expanded upon in subsequent sections of this chapter.

Respondents reported unequivocally that the dynamics and trends of sex trafficking in Kamathipura have undergone dramatic changes in recent years, impacting upon the present day characteristics of sex trafficking in Mumbai, including prevalence and composition of this population.

Several respondents expressed skepticism about the validity and accuracy of existing figures for Mumbai, cautioning that any numbers are rough estimates at best and fabricated at worst.

I have seen [prevalence figures] getting quoted and quoted in the worldly literature ... it is a great recreation for me to read some of those statements because I know the birthplace ... my neighbor said ... 'I can make a statement.' And this statement then gets circulated ... (Direct of social services agency)

One source of prevalence data can be found in existing figures of girls rescued from sex trafficking. The Mumbai Mass Raids took place between 1996 and 1999, during which local police removed 487 minor girls from the city's red-light areas¹¹² while the United Nations Global Initiative to Fight Human Trafficking (UN-GIFT) reported 250 trafficking victims had been identified in the state of Maharashtra between 2005 and 2007.³

Several respondents reported providing direct care and support for rescued trafficking victims. One service provider working with local law enforcement in Mumbai indicated that his organization has rescued approximately 250 girls in Mumbai since the year 2000, while a doctor affiliated with a non-governmental organization (NGO) indicated she has treated 500 rescued trafficking victims during the past six months.

While the difficulty in ascertaining accurate prevalence figures results from the clandestine nature of trafficking,^{112, 129} one potentially helpful proxy for conceptualizing the size of the sex trafficking problem in Mumbai stems from the documented link between sex work and sex trafficking.^{128, 130} The literature suggests that a significant percentage of women in Mumbai's red-light areas are minors^{112, 125, 128, 129, 131} and an estimated 30 to 90 percent of women are under the age of 18 at their point of entry into prostitution in India.^{125, 128, 130} Respondents reported that girls are trafficked into prostitution from 8 to 14 years of age or at least by the time they reach puberty.

In a recent study conducted with sex workers (all over age 18 at time of interview), researchers found that not only were many of the women under 18 at the point of entry into the trade, but nearly 25 percent reportedly entered through trafficking.¹³⁰ Several respondents who work directly with sex workers in Mumbai and Pune contended that many sex workers do not enter the trade voluntarily but rather through some form of force, fraud, and/or coercion.

Prevalence figures for female sex workers in Kamathipura offered by respondents ranged from 5,000 to 10,000, while two local government officials pointed out that these figures were once upwards of 50,000. These estimated figures contrast with those in the literature in recent years, which place sex worker prevalence in Kamathipura between 20,000 and 100,000.^{35, 112, 129, 132} Respondents estimated 5,000 female sex workers in Pune, a figure corroborated by public health literature.¹³³

Consistent with recent studies,¹²⁵ a number of factors reportedly explain the shrinking female sex worker population within Kamathipura. Factors include the city's redevelopment of Mumbai Central and the resulting displacement of current residents (including sex workers). Frequent brothel raids, coupled with a crackdown of minors in the area, as well as stigma and fear associated with the areas with a markedly high HIV prevalence rate also contribute to this decline. One service provider to sex workers and their children in Kamathipura anticipated the red-light area there will vanish within several years. This reduction in Kamathipura was generally not perceived as a reduction in prostitution or sex trafficking in Mumbai; rather, respondents maintained that the population has become increasingly hidden, shifting to different parts of the city like New Bombay and dispersing to neighboring areas such as Pune. Perceptions and observations about composition and demography of sex trafficking closely reflects existing literature, indicating that victims come largely from rural parts of Maharashtra and different states within India, as well as India's neighboring countries of Nepal and Bangladesh.^{46, 112, 125}

While much attention in existing literature and policy reports focuses on the global phenomenon of trafficking across international boundaries,¹ an estimated 9 out of 10 victims of commercial sexual exploitation are thought to be trafficked within India's own borders.¹¹²

In Mumbai, girls are reported to be trafficked from poor, rural villages throughout India, both inter-state and intra-state. The most commonly referenced source states included the southeastern states of Andhra Pradesh and Karnataka. Specific source cities included Kolkata, Chennai and, within the city of Mumbai itself. Respondents pointed out that Kolkata, in the northeastern state of West Bengal, was used by traffickers as a transit city for girls coming to Mumbai from northeastern India as well as Bangladesh and Nepal.

[On girls forced into sex work] ... the first lot comes to Kolkata. There they are picked and chosen, and the best ones are sent to Delhi and Mumbai because that is where the most money lies. Then the second lot stays in West Bengal – that is Kolkata and maybe to Pune and all of those places. Or Bangalore or some such places. And the worst lot – they are to fend for themselves. (Medical anthropologist)

[On girls coerced into sex work from Nepal] ... the route is that they would come through the villages of Kolkata, which is on the borders of Bangladesh, because they will get smuggled into the villages of Bengal. From there to Kolkata, and from there in Kolkata, they probably have some sort of connections with the people already there in that city who would then offer them the opportunity of coming to Bombay... (Director of social service agency)

An influx of Bangladeshi girls into Mumbai over the past several years was pointed out by several respondents, yet one service provider to women in the area cautioned that it is often difficult to distinguish a Bangladeshi girl from someone from the Indian state of West Bengal due to their shared physical characteristics, linguistic, and cultural similarities.

Many respondents described a sharp decrease in Nepalese girls trafficked to the red-light areas, and attributed their observed decline to AIDS-related deaths among current Nepalese sex workers coupled with an absence of new Nepalese girls entering Kamathipura.

Now, in today's time, we are not seeing too many girls coming from Nepal as there were, say about 15 years back. But you would find slightly older women who are still in the trade because they have been in Bombay for 10-12 years and they have no place to go back. But by and large you won't see too many younger Nepali girls now coming into the brothels. (Director of social service agency)

... the Nepalese have reduced, because the Nepalese have died by HIV so they are now less. They used to come to that area in larger numbers. But now from Nepal they are not coming... They come to know that this disease is [in Mumbai] and because of that a smaller number are coming. (Government official)

Several reports have also noted the recent decline among Nepalese girls trafficked into Mumbai for commercial sexual exploitation,^{125, 134} while the reported recent surge in Bangladeshi girls has yet to be corroborated by the literature.

How Women and Girls are Trafficked: Mechanisms

Interview respondents suggested that girls did not enter prostitution on their own accord, but rather through an assortment of factors that often involved force, fraud, and/or coercion. Girls were duped or cheated through false promises such as domestic work or false marriage. Family members, friends, or neighbors often had a complicit role in trafficking by selling the girl to a pimp or agent. Even "legitimate" marriages were

cited by respondents as a potential mechanism for forcing girls into prostitution - a situation that is particularly difficult to challenge under the law.¹²⁹ Deception as a leading mechanism for sex trafficking in India has been consistently documented in the literature.²³

128-130, 135

Respondents noted that upon arrival in Mumbai, girls are quickly sold to a brothel keeper for anywhere between 5,000 and 50,000 Indian Rupees.* Due to increasing brothel raids, girls are initially placed off-site and out of sight until they physically mature and near age 18, at which time they are then brought to the brothel. As one service provider in Pune described, "They have their houses in the outskirts of the city so they keep the girls, the new girls over there. They make them used to sex work, and then they bring them [to the red-light area]."

As a 2005 report on sex trafficking of Nepalese girls to Mumbai and Kolkata further explained, "girls are now kept up to several months in outside 'homes,' during which time they are taught Hindi, taught to wear saris and makeup, and prepared to present themselves as 'older girls' if questioned by the police."¹²⁵

In addition to being held off-site, new girls may find themselves in slave-like conditions where they are not allowed to exit the brothel or bungalow; they receive limited contact with the outside world and have no contact with service providers or NGOs. The girls – typically minor - are "usually locked up in rooms and boarded with secured doors," noted one respondent, "... you have to go through secret doors." An anthropologist respondent observed that "hardly any girls under 18 can be found" in Pune, "because they are placed in isolation and secrecy." Brothel owners and pimps also reportedly work to ensure girls remain hidden from the outside world by forcing them to provide false ages to police.

One respondent noted:

In the brothel the girl essentially lives in captivity under the brothel madam and cannot step out. The madam has paid money to get her into the brothel and the girl is not free until she has paid off the debt. She is not free to move in and out of the brothel. (Director of social service agency)

Once in a brothel, respondents described that girls are required by brothel owners to pay back the expenses incurred over the course of their stay in the brothel including medical costs, room and board, and utilities. A service provider to women and children in Kamathipura also pointed out that a brothel owner would further exploit a girl's lack of

* At the time of the drafting of this report, 100 rupees = \$2.17(USD)

education for more profit: “[If] she owes 10,000 [Indian Rupees] the owner will take 20,000 as well because the woman [trafficking victim] doesn’t know the math.”

After a girl has paid off her “debt” to the brothel owner, respondents noted that she may remain in sex work pressurized by the perceived need to support her family in her community of origin. She may also stay in sex work due to a lack of other opportunities to support herself or her children, though several respondents noted that these children may be at heightened risk for second-generation trafficking.

Some girls rescued from sex trafficking were also identified as being at significant risk for re-trafficking due to levels of trauma and manipulation, poor rehabilitation services, discrimination or rejection by their family or community of origin, and lack of follow-up support following reintegration into their community.

These factors, corroborated in the sex trafficking literature,^{125, 128} were thought to contribute to profound vulnerability on the part of the girl child.

Sex Trafficking: Key Determinants

Interviews elicited a number of key factors and determinants spanning the social-ecological spectrum,¹³ which explains why women and girls are particularly vulnerable to sex trafficking.

A ‘broken background’ – including histories of incest, physical, and sexual abuse - was widely regarded by respondents as increasing a girl’s vulnerability to sex trafficking. High levels of pre-trafficking abuse have been documented in other studies of sex trafficking in India.^{128, 136}

Following a rescued girl’s rehabilitation; stigma and discrimination on the part of her family and community may prohibit successful social reintegration, thereby increasing her vulnerability to re-trafficking.

There is no way to go out. Once she is in Kamathipura she loses all contact with family members. Because the moment her family comes to know she is in prostitution, they will not have her back or show her face ever in life again ... She can’t go back home. (Social service provider)

While the literature is scant on the post-rescue outcomes for rescued girls, one study of 561 rescued trafficking victims in India found that over 24 percent had been rescued on a prior occasion, insinuating they had been re-trafficked.¹²⁸

Being the child of a sex worker in a red-light area was widely cited by respondents as a predisposing factor for second generation trafficking. As a service provider noted, children of sex workers are born “without a place, property, or proper maternal support.”

A government official commented:

They are at the mercy of the pimps or whoever is available in the house. And they are subject to listening to all that goes on [in the brothel], so it really warps their attitude to life. It really almost marks them; if they are girls they go back into the system [of prostitution] and if they are boys they become pimps and things like that.

Class, caste, and social status were reported as socio-cultural determinants of sex trafficking. Gender inequality and a patriarchal environment were perceived as limiting women’s rights and livelihood opportunities. When opportunities do become available, such as education or health-care treatment, boys are given priority.

The *devadasi** system was reported by several respondents as a cultural factor that permits trafficking. Similarly, two respondents described how some families and villages have traditionally supported themselves by sending girls into large cities for prostitution, an observation corroborated by existing anthropological research.^{137, 138}

Many respondents reported poverty as the major factor driving women and girls into sex trafficking, and described how women often needed a job as a means of survival, or to support their family. A growing body of research also reports poverty as a major determinant of sex trafficking in India.^{23, 128, 129, 139} In a study of 561 trafficking victims in India, more than half of the girls and women indicated that they were lured by traffickers with promises of a job or money.¹²⁸ Another study that reviewed case records of 61 sex trafficking victims found that 57 percent were trafficked under the pretense of false economic opportunities, while no girls reported their traffickers as informing them they would be entering sex work.²³

While lack of opportunities for girls and women is partially a socio-cultural determinant of trafficking, their resulting illiteracy and lack of education were also described by several respondents as having economic implications that contribute to the desperate situations in which girls and women find themselves.

* The *Devadasi* system, officially banned in 1982, is a system a system of marrying off a girl to a deity or goddess. The root causes of this system have been cited to be acute poverty and gender inequality; thus, by marrying their youngest daughter off to the goddess *Yellamma*, a family avoids paying a dowry while also providing a pension scheme for parents into old age. One ethnographer found that more than half of *devadasis* are sex workers, and since they are dedicated as children, they may be at a particularly high risk of HIV.^{108, 137}

Respondents also indicated that the lure of a glamorous life in Mumbai, such as that portrayed in the media and the Indian film industry, coupled with an absence of opportunity in desperately poor rural areas, leave girls and women particularly vulnerable to sex trafficking.

Another case is that they would bring a young girl into the city who has not seen a city, give her all possible pleasures she wants - be it five-star hotels, finest of dresses, make up, hairstyles, massages, parlors, etcetera. Let her get used to it for a month and take her back to her remote village where she came where she didn't even have food to eat, so she says 'Why the hell am I back? That [was] a much better lifestyle!' Then she would tell the person who had taken her 'I will like to go back to that lifestyle' but he says 'You have to pay a price for that' and she is now coming willingly.' (Physician)

Demand for commercial sex was seen as a key component of sex trafficking in Mumbai. Sex trafficking is a lucrative enterprise and Mumbai is considered, as one respondent described, the "most desirable and profitable destination for girls who come from all over the region... where top price can be gained." Clients were thought to fuel a demand for young and new girls. Recent literature also described how demand for new girls partially stems from an increasing preoccupation with HIV/AIDS in Mumbai as well as demand for virgins.¹²⁵ Two respondents noted the migration of men seeking work in factories or construction in Mumbai led to many seeking companionship in Mumbai's red-light areas.

Existing Responses to Sex Trafficking in Mumbai

Health Consequences of Sex Trafficking

A number of negative health consequences are associated with victims of sex trafficking.* Respondents highlighted the increased risk of girls and women facing infectious diseases, including tuberculosis, HIV/AIDS and other sexually transmitted infections (STIs). They also described issues around reproductive and mental health, sexual violence and other forms of abuse.

Referred to by one respondent as "the most common opportunistic infection," tuberculosis was mentioned as a particular problem among sex workers. HIV/AIDS, STIs, and subsequent co-morbidities (including tuberculosis) were also frequently

* When asked about health consequences, services and recommendations, several respondents drew from their knowledge and experience of working with sex workers. As was noted in prior sections of this chapter, the point of entry into sex work in India for many women is through trafficking. A richer discussion of ideology and definition is located in Chapters 1 and 2.

associated with sex trafficking victims. A rapidly expanding body of literature further details the association between infectious disease and sex trafficking in girls in South Asia.^{23, 35, 125, 128, 130, 140-143}

Mental health and psychosocial well-being were discussed by many respondents both in general and specific terms. Examples of specific mental health problems associated with trafficking and sex work include trauma, post-traumatic stress, and substance abuse including alcoholism and tobacco chewing.

Numerous respondents pointed to the issue of unwanted pregnancies and abortions as being a particular health concern for sex trafficking victims. Others reported deficiency diseases, unhygienic living conditions, and general colds, coughs, and fevers. Several respondents described the routine violence and sexual violence women and girls experience from brothel keepers and clients in the context of the sex trade, a phenomenon that has also received attention in other empirical studies.^{23, 130}

Sex workers' children were also reported to experience health problems, including vulnerability to sexual abuse, HIV/AIDS, malnourishment, and poor living conditions.

Health Services for Trafficking Victims in Mumbai

Due to the clandestine nature and illegality of trafficking, health-care access for sex trafficked women and girls is reportedly restricted. For girls held by a trafficker or brothel owner, contact with public health-care services, such as government hospitals or clinics, was reported to be very limited. Noted a social work researcher, "I think women who are trafficked are young, minors. I wouldn't think they would access any health care, because [trafficking is] illegal. There are a lot of raids in the area, a lot of police try to go from brothel to brothel trying to identify women if they're hidden. So, I don't think they would access health-care at all."

Several doctors and nurses in government health facilities that provide routine treatment to sex workers reported having never knowingly treated a trafficking victim in the context of their work.

Two doctors who treat rescued trafficking victims indicated that the girls may also not be clear as to whether any medical treatment they received while in the context of trafficking was performed by a licensed doctor. "For them, a doctor is a doctor," noted one physician at a government hospital. "Which category he belongs, she doesn't know. She would just go by the name 'doctor.'"

The notion of victims' restricted access to health-care is also supported in the literature. One recent study examined levels of health-care access for 61 rescued sex trafficking victims in India. The researchers concluded, "Considering the illegal nature of sex

trafficking, brothel managers are likely to ensure that sex-trafficked victims remain hidden from authorities, including health-care professionals.”²³

At present, the role of government hospitals in treating trafficked girls appears to center largely on post-rescue activities, including the collection of forensic evidence for age verification and documentation of sexual trauma.

Table 7.1. Identification of Sex-Trafficking Victims in Mumbai

Several NGOs, some of whom provide health-care services, were mentioned as playing an important role in the identification and rescue of sex trafficked girls and women, including:

- ⊙ A peer-to-peer based model to register sex workers and track health outcomes; the NGO will not register girls under 18 and make efforts to send girls back home if possible
- Community health workers in Pune’s red-light area will respond accordingly if trafficking victims self-identify and/or express a desire to leave the red-light area
- ⊙ Peer workers educate brothel owners about why it is wrong (and illegal) to have minors in their brothel
- ⊙ An NGO identifies trafficked girls in brothels through undercover work and partnering with local police in Mumbai

According to our interview respondents, brothel owners do not take recently-trafficked girls to NGOs because they want to avoid detection, and they have the resources to bring them to private clinics and doctors. Brothel owners were described as exercising complete control over girl’s access to medical care.

As one social service provider in Pune explained:

See, these brothel keepers, they have their own private practitioners, doctors whom they associate with. They never go to government centers and hospitals because otherwise, if they go to government centers that means it is going to be a medical-legal case. In order to avoid all those things they have regular contacts with their own private practitioners and they are on call for them because they get huge money. (Social service provider)

One frequently reported mechanism for how trafficked girls receive health-care services is through private or informal providers. The pimp or brothel keeper either accompanies girls to private medical facilities or brings a private doctor into the brothel to provide treatment. One respondent whose organization employs peer educators to monitor the health of women in brothels noted how educators may be turned away from helping minors by brothel keepers. The respondent described why it was in the economic interests of the brothel owner to have the girl treated by a private practitioner:

Even when they are in the red-light area, then our peer educator goes to brothel and brothel, and if somebody is not feeling well then the peer educator will ask the brothel keeper to send that particular girl away to the government hospital. The brothel keeper will first say, 'No, we have our own doctor and she should go to that doctor.' Because if you try to understand, what happens to the girl as she is getting sold into the brothel – that money, plus interest, which will range from 12 to 25 percent – becomes her loan on that girl ... and a single rupee the brothel keeper is spending on a girl gets added into her debt. So this cuts practice, you know. Whenever she is going to a private practitioner, whatever fee she is giving to the doctor, that fee plus interest gets added into her debt. That's how the brothel keeper will get more money.

Respondents noted that private providers often operate in close proximity to the red-light areas and may have existing arrangements with brothel owners to provide services per request of the brothel owner. If a trafficked girl has an unwanted pregnancy, for example, she will not be taken to a government hospital for termination. Instead, the brothel owner will take measures to have the abortion performed by a private provider, sometimes within the brothel itself.

Although private providers were reported as a source of medical treatment for trafficked girls, one respondent who works to rescue girls through law enforcement questioned whether private providers would be willing to identify trafficked minors:

If you are talking about detecting and reporting trafficking, I mean, what [doctors] would tell you and scream at you, 'If you start doing that, they're not going to let us in.' They've done their best to convince the traffickers that that [treatment] is what they're going to do.

Following a government-sanctioned raid or rescue by local law enforcement, rescued trafficking victims are typically brought to a government hospital* to undergo age verification to determine whether the victim is less than 18 years of age.† One hospital was cited by several respondents as providing treatment to sex trafficking victims following rescue.

If a rescued survivor cannot be immediately sent back to her family or community of origin, she is often placed in a rescue home run by either the government or an NGO. The delivery of health services within this context are reportedly provided either inside the

* Government hospitals are noted for their close proximity to Kamathipura.

† Girls were reported to experience threats and manipulation on the part of brothel owners, pimps and traffickers and therefore it is not always possible to rely on a girl's stated age. Age verification is required in the successful prosecution of traffickers while also giving the government legal jurisdiction to remove the girl from prostitution.

home by medical professionals, while more complex medical cases are referred out to government hospitals or private providers.

Health-Care Services to Sex Workers and their Children

In contrast with the narrow scope of any health services available to girls and women in trafficking, respondents described several ongoing efforts and strategies by NGOs to deliver health services for sex workers (many of whom were believed to have entered sex work through trafficking) and their children. Within this context, respondents described how NGOs work to build relationships with powerful members of a government health facility, such as a hospital dean or superintendent, to help sex workers receive effective and non-discriminatory treatment. As one service provider in Pune described, if a doctor at a local government hospital mistreats or refuses to attend to a sex worker, “complaints will go up” through an informal mechanism in which women complain to a health worker, who relays the complaint to the NGO, which then informs a senior administrator at the health-care facility. Table 5.2 describes the role of several key stakeholders thought to play important roles in facilitating health-care access for sex workers.

Several service providers also reported providing services to sex workers’ children - a group identified as particularly at risk for trafficking. Many services described by respondents included a residential component, including group homes, crèches, boarding schools and drop-in centers. These facilities emerged out of a collective observation by providers in red-light areas that, as one service provider described, “... often their sleeping room is in the brothel rooms at night.” Routine health checkups, medicines and mental health supports were frequently reported components of services provided to sex workers’ children. Several respondents noted that neither stigma nor discrimination act as obstacles to sex workers’ children accessing health-care in government facilities.

Table 7.2. Key Stakeholders for Facilitating Access to Health Services for Sex Workers

Stakeholder	Facilitator	Example
Non-government organizations (NGOs)	Several NGOs employ peer educators* to identify and reach out to other sex workers and help ensure the delivery of health-care services. Services may include informal visits to brothels, health education, psychosocial support and referral, and accompaniment to government hospitals for treatment. Trafficking victims have reportedly been identified by peer educators within this context.	<i>They may give us, as outsiders, socially acceptable answers but to the peer, totally different. She cannot fudge, she cannot fib – the peer educator knows exactly what she is doing ... typically, a peer educator in an area will be working with about 40 to 50 sex workers. (Director of social service organization)</i>
Government health-care providers	Government health facilities are proximal to red-light areas and reportedly provide medication at nominal costs to women. Informal systems of referral were reported between NGOs and government hospitals, where NGOs act as an intermediary to ensure treatment occurs. Some NGOs provide basic health services in red-light areas and will refer women to government hospitals for complex medical cases.	<i>Generally, organizations which are catering for these sex workers – they have an internal mechanism. Suppose there is somebody who has an immediate serious medical concern – they make arrangements for the transport of these sex workers to the nearest government health facility. (Director of social service organization)</i>
Quacks and informal providers	Quacks† were thought to offer convenient, non-discriminatory services; they may know symptoms of certain sexually transmitted infections and can provide medication. Some respondents characterized quacks as having a negative influence on the health of sex workers and thought they may interfere with complicated treatment regimens for tuberculosis or HIV. Trained, but unlicensed doctors were thought to operate as quacks by practicing outside the scope of their medical training.	<i>Patients want medical treatment. They want tablets and injections ... They keep practicing because of demand ... Quacks play a large role for India's poor, as they are a source for alternative medicine and homeopathy. By stopping quacks, you are withdrawing services and not providing alternatives. People have the right to go to a quack if nothing else is available." (Physician)</i>

*Peer educators were also referred to by respondents as “paramedics”, “community health workers,” or “animators.”

† According to USAID: “Quacks provide various treatments and medicines to slum residents, usually of an allopathic variety. Many operate small clinics but previously worked (or even continue to work) as assistants at established doctors’ clinics or hospitals, picking up a smattering of skills. They often seek to reinforce an image of professional competence by making use of stethoscopes and thermometers. While lacking much formal training or obvious technical competence, these providers do not operate in an entirely separate sphere from the formal-sector health providers. In defending their use of allopathic approaches (a departure from the more formal medical training some had acquired), the quacks described their approach as a response to demands for such treatments on the part of the slum residents themselves.”⁹² While little formal research has been done on quacks in Mumbai, one study of sex workers in Kolkata found nearly half preferred to go to quacks for treatment.¹⁴⁴

Barriers to Health-System Response to Trafficking

Respondents reported a wide range of challenges associated with the delivery of health-care services to victims of sex trafficking. Some barriers were thought to be attitudinal in nature, while others were related to existing policy and allocation of resources. Many of these barriers were specifically associated with government hospitals where rescued trafficking victims are reportedly taken for post-rescue treatment and care.

While several respondents pointed to positive interactions with select health-care providers and systems, insensitivity and discrimination were reported on the part of many medical providers, counselors, and nurses as well as institutional policies. These attitudinal barriers were regarded as pervasive, particularly within government health facilities that treat rescued trafficking victims.

A general discriminatory attitude towards poor women on the part of medical providers in India was reported to profoundly affect access to care and services, particularly if women are impoverished. "Gender sensitivity in medical education is terrible" and uses "language that is essentially anti-women," noted a physician and medical ethicist. Two respondents commented on the inherent gender biases and insensitivities contained within medical education textbooks in India, a topic that has received recent attention in the social science literature.¹⁴⁵⁻¹⁴⁸

Another major barrier included obstacles related to a lack of resources and capacity to provide effective care. General overpopulation of Mumbai coupled with unfilled medical posts was described as contributing to long queues at government facilities.

Others noted a lack of qualified mental health professionals in government hospitals to treat issues of trauma facing sex trafficking victims. Respondents also noted a lack of trained counselors to address the social dimensions of receiving an HIV diagnosis. One government official observed that even when hospitals have the technical capacity to provide HIV testing, because test results mandate counseling, tests will not be conducted at all or results will not be revealed if a counselor is not available.

The Indian Government was perceived by some respondents as increasingly withdrawing funds from the public health-care sector; that is, the population is increasingly reliant on paying privately and to a large extent without insurance ("out of pocket" medical expenses). As a recent review of healthcare in India reported, "The decreased public health spending is leading to incapacitated public health facilities, where, due to insufficient funding, the staffing levels are far below acceptable norms, there is a constant shortage of consumables and all this is housed in dilapidated buildings."¹⁴⁹ Because the private sector may have less incentive to promote health access and equity in their work, market-driven, health-care services may be of particular

concern for poor or marginalized populations in India, such as brothel-based female sex workers.¹⁵⁰

Compounding the general challenges of outreach to women in the red-light areas are ongoing police raids of brothels by local law enforcement. Reported to occur as frequently as several times per week, respondents indicated that brothel raids impair NGO access for women, push sex trafficked girls further underground, and undermine any trust and rapport which had developed between service providers and brothel owners. Noted one service provider, following a raid: "... the madams or the brothel owners, they clam up" out of fear that the NGO was working with the police. "[We] have to go back to the whole circuit of starting at square one: building rapport with them again, convincing them that we are not really reporting against you."

Respondents also identified a number of challenges around post-rescue health-care services for sex trafficking victims. In addition to the issues of sensitivity described above, respondents described a lack of specialized services in hospitals and lack of systematic follow-up in government rescue facilities. Health-care services and supports in government rescue homes are thought to be insufficient and are perceived as lacking essential medicines, services and infrastructure; are overcrowded and lack adequate hygiene and sanitation. One policy expert felt that rehabilitation homes (both government and NGO) operate with little oversight, accountability, or accreditation to ensure minimum standards of quality of care and support.

Opportunities for Local Health System Response to Sex Trafficking

Our interviews provided a number of recommendations for how health could better respond to sex trafficking in Mumbai. Respondents identified different strategies ranging from training and sensitization to policy and research.

Education and Awareness-Building among Health Professionals

Respondents asserted a belief in the potential of the local health system to provide better health-care services and support to trafficking victims and sex workers. These respondents pointed to the need for advocacy and sensitization within the public health community. Several respondents suggested that local hospitals within a short distance of red-light areas should coordinate with local services providers in order to develop a deeper understanding of the issues faced by sex workers and potentially trafficked women and girls.

Medical education and curricula was considered to provide an opportunity for improvement of health-care professionals' receptivity toward working with vulnerable populations such as victims of sex trafficking. Several respondents believed that doctors'

communication skills with patients could be improved. For example, doctors, counselors, and nurses could develop skills for taking a trafficking victim's history in a sensitive, uniform way and learn how to gently probe into difficult topics such as violence or abuse.

Mental Health Services

Several respondents pointed to an underdeveloped system of mental health services in India and noted that current psychiatric services, if they exist at all, focus largely on diagnosing and labeling rather than providing care. Respondents suggested that sensitive mental health treatment be developed to respond to issues facing women around trafficking, trauma, and abuse. It was also recommended that counselors who provide voluntary counseling and testing for HIV concurrently be sensitized to the situations facing marginalized populations, such as trafficking victims and sex workers.

Professionally trained counselors were thought to be particularly needed for post-rescue mental health services in government hospitals and rescue homes.

Rehabilitation Homes

Systems that ensure the successful rehabilitation of sex trafficked girls and women were thought to be largely underdeveloped. Respondents called for marked improvements in levels of oversight, accountability, regulation, and accreditation in order to ensure high-quality of care and support in the rehabilitation homes. Healthcare's contribution to rehabilitation efforts was characterized as unsystematic, e.g. there was lack of routine follow-up treatment and care to attend to the physical and mental health needs of sex-trafficked girls. Specific recommendations offered by respondents included extending access to a primary care doctor in a rescue home who could refer girls to an outside specialist as needed; developing individualized care plans that cater to the specific needs of the girl, and improving the planning and coordination for home investigations prior to repatriation.

Priority and Policy

To ensure the development of sustainable systems of support for anti-trafficking initiatives, respondents called for a strengthened response from the local and national government. Several respondents characterized Mumbai's current public health response to issues facing sex workers and sex trafficking victims as largely focused on containing the spread of HIV/AIDS and not accounting for the myriad other health problems facing women and girls in red-light areas.

Go and see the area [Kamathipura] and imagine how people must be living there, look at the hygiene, look at basic needs are not met. There

are two public toilets and that's all. Two or three at the most that people survive on – it is extremely dirty and it all builds onto your health agenda. There is so little talk about violence and drug abuse and substance abuse ... [HIV] is very well funded. I think it is good, but I think it is given so much attention because I don't know of any one organization that is not given money for this area of HIV prevention...
(Social work researcher)

Respondents described several strategies for government to make sex trafficking a higher policy priority, including the development of partnerships with community-based programs to establish trust with community members and local government; engaging multiple stakeholders in the development of pilot programs for trafficking victims and sex workers' children in government hospitals; and developing a mechanism to ensure the delivery of health services to sex trafficking victims in government rescue homes.

Data and Research

Respondents considered how further research could help shed light on how health-care systems may work to better address the situation facing trafficking victims, including conducting assessments to better understand the on-the-ground situation facing sex trafficking victims, and to evaluate targeted, culturally-sensitive interventions by health-care professionals.

Discussion

Using a public health lens, this case provided an overview of sex trafficking in Mumbai and builds on an emerging literature examining the health implications for sex trafficking victims in India.^{23, 130, 141, 143} Our interviews clearly suggest that sex trafficking of women and girls remains a problem in Mumbai. Sex trafficking victims were reported to come from other parts of India as well as neighboring countries. Numbers of Bangladeshi girls being trafficked into sexual exploitation in Mumbai were thought to be increasing, while those from Nepal were decreasing. A common trafficking scenario relayed by respondents involved a desperately poor, illiterate, adolescent girl from a rural village, sold by her family to an acquaintance who promised a good job for her in Mumbai. In Mumbai, the girl discovers she was duped into forced prostitution in a red-light area. The complicity of family members and friends in the trafficking of girls was noted by several respondents.

The definition of sex trafficking proved to be problematic in this case study. At times, respondents had difficulty disaggregating sex trafficking victims from sex workers.

Many asserted that sex workers' point of entry into the trade was typically when they were minors and often included elements of force, fraud, or coercion.

The case reveals that sex trafficking victims are vulnerable to a wide range of health problems, ranging from mental health disorders and sexual violence, to infectious diseases and malnutrition. Prior to rescue or being freed from the brothel owner, sex trafficking victims are thought to have limited or no contact with government hospitals or NGO services, a finding corroborated by recent research on trafficking victims' healthcare access in India.²³

Several NGOs in Mumbai and Pune described coming across sex trafficking victims in the context of providing health-care and other services to sex workers in red-light areas. These NGOs were characterized as community-based (e.g., located in red-light areas), typically employing peer educators and providing multi-pronged services to women and their children; they reportedly do not discriminate against a woman because of her status as a sex worker, though several programs offered opportunities for women to transition out of prostitution. One director of an HIV prevention intervention for sex workers provided a rationale for employing sex workers as outreach workers, "[We] don't really need to try and test this out, because it has proven a number of times all over the world. The best approach is through [a] peer educator approach." It is also within this context that a wide range of services are often offered to sex workers' children in red-light areas, a population regarded as highly susceptible to "second-generation" trafficking due to vulnerabilities at multiple levels of the child's social ecology. Our interviews suggest that local health-care systems can work to strengthen a comprehensive response for this subset of children, and thus participate in trafficking prevention efforts.

Our interviews also revealed a number of other opportunities where health-care workers could play an increased role in addressing the needs of sex-trafficking victims in Mumbai. For example, doctors, nurses, and counselors working in forensic or gynecology departments in government hospitals could develop competencies for how to provide care and support to sex trafficking victims with increased sensitivity.

Furthermore, health and mental health services could be made available to trafficking victims in rescue homes and administered in a sensitive and systematic way.

The problem of sex trafficking in Mumbai does not appear to be a public health priority. For example, it is noteworthy to compare and contrast the targeted, systematic response associated with HIV-related services in red-light areas with the generally ad hoc, unsystematic response associated with the delivery of health-care services to trafficked women and girls in government rescue homes. Trafficking victims currently fall under the care of India's Department of Women and Child Development (DWCD) for rehabilitation and subsequent repatriation. DWCD has developed a comprehensive manual for social workers involved in the rehabilitation and repatriation of trafficking victims,¹⁵¹ including

a detailed chapter on the health-care needs facing sex trafficked girls. Respondents indicated that local health systems could play an increased role in providing comprehensive, systematic, and sensitive care and support to trafficked girls throughout the process of rescue and rehabilitation.

CHAPTER 8: SEX TRAFFICKING OF WOMEN IN GIRLS IN KOLKATA

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Introduction

Study Setting

With a population of approximately 14 million,¹⁰⁷ Kolkata (formerly Calcutta) is a major destination, source, and transit point for sex trafficked women and girls.^{128, 129}

Kolkata is regarded as the major trade and cultural hub for northeastern India. It serves as the capital of the northeastern state of West Bengal, which shares international borders with Nepal, Bangladesh, and Bhutan, and has state borders with Sikkim, Bihar, Orissa, Jharkhand, and Assam.¹²⁸

The population of West Bengal is approximately 80 million with a sex ratio of 934 females per 1000 males. The literacy rate for the general population is approximately 69%.¹⁵² The primary languages spoken in West Bengal are Bengali (85%), Hindi (7%), Santali (3%) and Urdu (2%).¹¹⁰ The most common religions in the state are Hindu (73%) and Islam (25%) with less than one percent identified as Christians, Sikhs, or Buddhists.¹¹⁰

The Kolkata Municipal Corporation (KMC) oversees the local public health infrastructure.¹⁵³ Despite the presence of four medical colleges and several government hospitals, health-care services for Kolkata's poor remain underdeveloped, and struggle to keep pace with a growing urban center whose population density is nearly 25,000 people per square kilometer.^{153, 154} While private health facilities for Kolkata's upper and middle class are improving, government hospitals catering to the poor* reportedly suffer from issues of insufficient governance and accountability.¹⁵⁴ Statewide HIV surveillance data indicates West Bengal as a low prevalence state; less than 6% of female sex workers are HIV positive.¹²²

In this chapter we attempt to characterize sex trafficking in Kolkata; review the factors and mechanisms through which trafficking occurs; examine current health-care responses to

* In 2001, one third of the city's population was reported to live in Kolkata's registered and unregistered slums.¹⁵⁵

sex trafficking; and elicit how health care could play a larger role in addressing sex trafficking in the local context.

Summary of Fieldwork

A list of potential key informants was generated by contacting local service providers, doctors, social scientists and advocates, many of whom subsequently referred us to other colleagues who could speak to the issues of sex trafficking and/or health-care in Kolkata. Key informant interviews in Kolkata occurred over a three-week period in April 2009. Fieldwork was conducted until theoretical saturation of our research questions was reached. Direct quotes were analyzed to establish themes, and were triangulated using multiple respondents and existing literature.

Fieldwork yielded a total of 27 individual interviews and group interviews with 49 key informants including 15 physicians, 14 program administrators, 6 researchers, 5 program directors, 3 social workers, 2 government officers, 2 mental health providers, 1 law enforcement official and 1 legal professional.

Characterization of Sex Trafficking in Kolkata

Prevalence of Sex Trafficking

Kolkata consists of 29 red-light areas¹²⁹ including Sonagachi, which is known as one the oldest and busiest brothel areas in India. As one recent account of sex trafficking in Kolkata described, "The business of the area is evident during the day as well as the evening, and sex workers freely move about conversing and conducting off-work activities. In the evening, the area is congested and businesslike. Many pimps present themselves at the entrances to the brothel area."¹²⁵

Due to the clandestine and illegal nature of sex trafficking, reliable prevalence figures remain elusive.^{112, 128, 129} "Anybody's guess is as good as anyone's," remarked one respondent. However, many characterized the problem of sex trafficking in Kolkata as getting worse.

Some suggested a significant presence of underage girls involved with sex work in Kolkata but that the girls will not disclose they are of minor age. "So within Sonagachi we hear that there are a lot of minor girls" said one respondent. One doctor reported, "So even if they are fifteen years old, if you ask them they will go, 'My age is 18 or 19.'" Trafficked children were reported by respondents to enter the trade as young as eight or nine years of age.

One policy advocate described the inherent challenge for documenting accurate prevalence figures for sex trafficking in red-light areas:

Most people claim that there are only children in the red-light areas 'in that house,' but nobody has ever gone inside the house to find out how many girls are there and how frequently these girls are coming in. So data regarding that is not possible.

One source of data can be found in existing services for girls rescued from sex trafficking. A number of respondents reported providing services for trafficked girls (Table 8.1).

Table 8.1. Number of Sex Trafficking Victims Served by Respondents in Kolkata.

- Government rescue homes cater to approximately 1,500 trafficked girls at any given time
- Three NGO-run rescue homes provide services for between 80-160 trafficked girls in each home
- An NGO that works with law enforcement to identify trafficking victims reported rescuing 34 girls in 2008
- A government official estimated that one police unit rescues between 16-19 girls per year
- Using a community-based screening system, an NGO reported having rescued over 600 women in the last 7 years, 85% of whom were minors. In 2008, it reported rescuing 150 women, half of whom were minors.¹⁵⁶
- One government psychologist estimates receiving referrals for four of five newly rescued trafficking victims per month

Note: Figures are not mutually exclusive

Another useful proxy for conceptualizing the size and scope of Kolkata's sex trafficking problem can be found through the documented link between sex work* and sex trafficking.^{128, 130} Existing literature describes the sex worker population for Kolkata as roughly between 12,000 and 25,000 women, including approximately 6,000 sex workers in Sonagachi.^{126, 127, 129, 130} Recent empirical studies have suggested that many commercial sex workers in Kolkata enter the sex trade through trafficking. A sample of 146 commercial sex workers (25% of whom were under age 18) in Kolkata found that 25% were originally sold into prostitution and 37% reported having been driven into sex

* Throughout this chapter, reference to "sex work" is not an attempt by the study authors (nor our key informants) to conflate sex work with sex trafficking. We do not favor the term "sex work" over "prostitution" but rather attempt to reflect the language of our respondents (and peer-reviewed literature^{126, 157}). In the course of many of our interviews, respondents drew from their own experience and insight gained treating sex workers to speak to our research questions of focus as it related to sex trafficking. For example, many respondents discussed sex trafficking as being a point of entry into sex work; doctors and social workers providing treatment and services to sex workers described points of contact with sex trafficking victims; and sex workers' children were recognized as being particularly vulnerable to sex trafficking. These points and others, supported in the literature, are expanded upon in subsequent sections of this chapter.

work due to poverty.¹⁴⁴ Similarly, a study of 580 adult female sex workers in Kolkata found nearly one quarter had entered sex work through some form of force or deception.¹³⁰

Respondents endorsed the trafficking-sex work link but differed on the extent to which girls were thought to enter sex work through trafficking; several posited that nearly all entered through the mechanism of trafficking, while others thought this proportion was considerably less.

As reflected in recent literature,^{112, 128, 129} respondents reported that the vast majority of sex trafficking in India occurs within the country's own borders through intra- and inter- state trafficking. Girls were reported to come to Kolkata from poverty-stricken rural villages in West Bengal. As one advocacy respondent described, "Seven districts [in West Bengal] have been identified as source areas, for the trafficking of girls to other states, or to the other districts within West Bengal." The most commonly referenced source states for trafficking into Kolkata included Andhra Pradesh and Bihar, while recent literature also noted the neighboring states of Orissa and Madhya Pradesh as major sources.^{125, 128, 129}

Sex trafficked girls were also reported to come from neighboring countries, particularly Bangladesh, due to its shared porous border with West Bengal. However, several respondents commented on the difficulty in differentiating between individuals from West Bengal and Bangladesh, due to cultural and linguistic similarities.

Nepal was also reported as a source country for trafficked girls. One respondent from a private rescue home for trafficking victims reported that 16 of the 135 girls under the care of her organization were Nepalese.

One police respondent described the process of determining victims' country of origin following a rescue or raid:

We see the teeth structures. We tell them to speak. When they speak, we find out she's from Bangladesh. Like her speech pattern holds the key. Somebody is very new—Nepali. This kind of importation of girls from Nepal, they cannot speak Hindi so soon, they cannot talk so soon. And their legs, their feet patterns, their feet, I mean their toes are separated like that, because in Nepal it's a very hard terrain, they have to walk for a long time. They get hold of the terrain, they walk like that, so when they come to India, at least for the first one year, their feet go like this. And now here is comfort. They do not get to walk on that kind of a terrain, so gradually their feet comes to be very close. In the very first time when you see the impression, it tells you she may have come very soon from other places.

Kolkata's geographic positioning also permits it to serve as a gateway for girls ultimately destined for other major urban centers such as Mumbai, Delhi or Dubai. One trafficking report describes Kolkata as a "transit point for many girls who are 'initiated' into the business before being resold to other brothels."¹²⁹

How Women and Girls Are Trafficked: Mechanisms

The primary mechanisms through which girls and women were reported to enter the sex trade include force, deception, false marriage, and profound desperation.* As described by respondents with corroboration from the literature,^{125, 128} a typical case of sex trafficking in Kolkata would involve an adolescent girl from a rural, impoverished village in West Bengal. Enticed by promises of a job in a big city, the girl travels with a recruiter only to realize that upon arrival in Kolkata, her occupation is prostitution.

Families were widely reported to play a complicit role by selling their children or encouraging false marriage.

So in the name of work, someone comes to their home and says, "If you go to Kolkata you can earn 2000 rupees."[†] So they come for the rupees and that person who is telling them is in the red-light area. Somebody goes to their house and says that, "I will marry your daughter. And they are not giving me anything." So their mother says "Okay, I have 5 or 6 daughters, so I can give one daughter for marriage." ... And that person lives in a red-light area. So in the name of marriage, in the name of work, in the name of love they get into the red-light area. (Social service provider)

Upon arrival in Kolkata, respondents noted that girls are not immediately brought to brothels. Rather, they are kept off-site under the watchful eye of the brothel owner before eventually being taken to the major red-light areas. "They have an initiation process, described one respondent, "and they are initiated into smaller red-light areas from where they are groomed gradually to come to the areas which are like Sonagachi, high priced red-light areas."

Our interviews portrayed traffickers and brothel owners as maintaining control of girls using a number of different strategies including social control, deprivation, and/or physical brutality.

* While existing literature generally corroborated our findings that girls do not enter sex work on their own accord,^{125, 128} several respondents interpreted girls' circumstances differently, suggesting that desperately poor women and girls willingly entered sex work. Given this group's circumstances, sex work was a legitimate livelihood. For example, women from Bangladesh reportedly sometimes choose to enter sex work over garment work due to levels of income, sense of autonomy, and working conditions.

[†] At the time of the drafting of this report, 100 rupees=\$2.17(USD)

It is usually pimps and hooligans; they are just like you and me and absolutely normal guys hanging around in the red-light areas in certain strategic points, and they know all the new girls. New girls cannot escape the red-light areas. So it is simple; it is kind of like a vigilante system. (Advocacy respondent)

...she's subject to being beaten and she's subject to having her food withheld. You will find that she will become very compliant after about a year or two, if not just 6 months... people have to survive, and people adapt to the most hellish circumstances. (NGO program director)

One recent report on sex trafficking of Nepalese girls to Kolkata and Mumbai described the effort and investment made by brothel owners to watch over the trafficked girl:

Considerable effort and expense are taken by the brothel owner to protect her investment, that is, to ensure that the *tsukri* [enslaved girl] does not run away. This includes guarding the *tsurki* 24 hours a day for the years of her confinement, renting a (usually more expensive) house or flat that can be physically secured, paying police not to raid the brothel and 'rescue' the investment, and paying local politicians, landlords and others to 'turn a blind eye' on the activities.¹²⁵

This report also noted that in the event that girls pay off their 'debt' to the brothel owner, they often remain in the sex trade. "While she can choose to leave prostitution, few women, particularly Nepalese, have the option to do so."¹²⁵ This was corroborated by many of our interview respondents who reported that girls do not have other economically viable livelihood options to sustain themselves or their families other than to remain in sex work.

One doctor working in a clinic in Sonagachi recalled interviewing 60 sex workers, during which time he asked, "If you were being offered a huge amount of money, what you are going to do?" The doctor described how the women "spontaneously react[ed]" and said that all the women indicated, "We want to leave this place."

In the event that a trafficking victim is rescued from trafficking, pervasive stigma, discrimination, and subsequent rejection are among the many barriers that may prevent a young woman from successfully reintegrating back into her community of origin. One doctor maintained that police, government and media continue to focus on the number of girls rescued from raids but pay little attention to follow-up services for the girls, permitting them to be re-trafficked or re-enter sex work in the future.

Sex Trafficking: Key Determinants

Our interviews painted a complex picture of sex trafficking determinants in Kolkata. While some key determinants centered on women and girls seeking better economic opportunities, others were rooted in long-held cultural norms and beliefs about the role of women in society.

At the individual level, several key determinants emerged from the interviews. Abject poverty, especially in rural villages of India, was the most-cited determinant of sex trafficking in our interviews. One respondent noted that for as little as “10 to 25 rupees, the girl will be willing to sell herself [to traffickers].” Another respondent said that girls from Bangladesh and Nepal view India as a prosperous nation relative to their own, and the lure of the big city and economic opportunities pulls them into sex trafficking. Often, the poverty of individual victims was viewed as inseparable from that of their families. That is, a family’s levels of financial despair often played a role in whether a girl was trafficked. The following example illustrates how families may be dependent on girls to survive, and the duplicity involved in families entering into agreements with traffickers:

[I]nitially, agents actually mobilize the parents saying that we will be able to give you so much of money. The parents only realize the moment the money stopped coming. So that happens for two or three months. After three months, only when the money doesn’t come for three months, then they only realize that ‘My child has been trafficked.’ (Advocacy respondent)

Aside from poverty, girls’ illiteracy and lack of education also emerged in interviews as major risk factors for sex trafficking. Two respondents also noted that some sex trafficking victims have experienced sexual harassment in prior blue-collar jobs, such as agriculture and construction.

The importance of victims’ families in facilitating girls’ entry into sex work, and sometimes directly into trafficking situations, was emphasized in many interviews. Some respondents noted that female children of sex workers in Kolkata, and girls living in the city’s slums or red-light areas, were at significant risk for being trafficked. As a service provider to sex workers’ children observed, “When she is 10, 11, or 12 then it is dangerous to keep [the girl child] with the mother in the evening. Normally what happens, when the customer comes they refuse the mother and they, all the time, demand the child...”

Overall, respondents described a range of familial contributors, from child neglect and failure to report a missing daughter to the authorities, to more pernicious activities. For example, several respondents cited childhood physical or sexual abuse by family members as contributing factors to sex trafficking, while others noted that some family members of victims had pressured their daughters to enter prostitution. Some reported that victims were shunned by their families and communities of origin when they attempted to return

to their villages. Victims were stigmatized as a result of having been trafficked to the brothels in Kolkata.

The other day they rescued a girl, but the repatriation was difficult because this girl says, 'My community will not accept me, and where is my income? I have to have an income.' She herself wanted to be rescued. She called, and then her parents said, 'What are we going to do with her? She is useless to us.' (NGO social service provider)

A number of macro-level forces also reportedly place girls at risk for sex trafficking in Kolkata. For example, respondents suggested that social discrimination was a trafficking determinant. That is, gradients based on skin-tone (i.e., darker skin as less desirable) or caste, or certain religious affiliations (Muslim girls, in particular, who may be targeted for discrimination), predisposed girls to sex trafficking. One respondent also voiced the opinion that certain culturally-accepted practices, such as dowries and child marriage, set a favorable context within which trafficking could take place in Kolkata.

The interviews also implicated the demand for commercial sex as a macro-level factor in sex trafficking. Respondents described different facets of demand: men seeking to have unprotected sex (assumed to be free from HIV-risk) with young girls or virgins; the current global recession fueling brothel visits as a form of escapism; or, by contrast, a booming, information-technology industry in the suburbs of Kolkata leading to greater demand for paid sex among professional men with few social outlets. These observations on the male-centered culture in and around Kolkata were substantiated by respondents' views that gender inequality plays a major role in sex trafficking in the city. Risk factors described earlier, such as lack of access to education for girls, represent one type of manifestation of gender inequality. Some respondents also specifically noted the dearth of programs in rural villages that empower women.

One respondent summarized how a perfect storm of social inequalities could ultimately determine whether girls become sex trafficked into Kolkata:

You know the concept of 'no-choice' is not a choice? Like, if you have only one choice, that due to your social status, due to your educational level, due to your financial level, you can only do sex work to support your family? And then if you join sex work, then it's not really a choice. It's a 'no-choice.' One choice is no choice. (Advocacy respondent)

The socio-political context of India was also described in various ways as contributing to the sex trafficking trade in Kolkata. Ease of migration between West Bengal and Bangladesh was described by several respondents as a facilitator of international trafficking into Kolkata. As a recent report on trafficking described:

Crossing the border between Bangladesh and West Bengal is a daily routine for many. Thus, keeping track of the movement of people is very difficult. Illegal entries by traffickers are a matter of common knowledge, and there is a perception that they are protected.”¹²⁸

Other respondents expressed similar views about the India-Nepal border, noting the lax procedures for border control (e.g., no visa or passport required for entry into India). “The border is most porous between India and Nepal,” noted one advocacy respondent, “because you don’t have... that many checks right? It’s not fenced.”

One doctor viewed the historical frictions between India and neighboring countries as a contributing factor to sex trafficking:

The root cause of trafficking is the poverty, is the illiteracy, is the international migration issue, is the conflict terrorism, is the fight between Pakistan and India, is the fight between Bangladesh and India, is the [lack of] international dialogue.

Existing Responses to Sex Trafficking in Kolkata

Health Consequences of Sex Trafficking

Our interviews, as corroborated by the literature,^{23, 24, 140, 143, 158} revealed that victims of sex trafficking suffer from a long list of physical and mental health issues (Table 8.2).^{*} HIV/AIDS and complications of unsafe abortions were most frequently cited when respondents were asked about the adverse physical health consequences of sex trafficking. Furthermore, nearly all respondents cited mental health issues, particularly psychological trauma, as serious health consequences arising from trafficking. Some respondents noted that victims resort to substance abuse as a method of coping with their lives.

These health consequences can have long-term ramifications. For example, one service provider who works with rescued trafficking victims described mental health issues that emerge with many girls:

They are just so anxious about getting back to their parents, but sometimes the parents are rejecting them or community or society rejects them. That is the main problem. Then anger management is another

^{*} When asked about health consequences, services and recommendations, many respondents drew from their knowledge and experience of working with sex workers; as it was noted in prior sections of this chapter, the point of entry into sex work in India for many women is through trafficking. A discussion of ideology and definition is located in Chapters 1 and 2.

thing, they are so impulsive and so aggressive at times, they get so aggressive. The main things is the trauma, they are not able to handle the trauma, their traumatized situation. (Service provider)

Table 8.2. Health Problems of Sex Trafficking Victims and Sex Workers in Kolkata

Physical health	Mental health
<ul style="list-style-type: none"> • Tuberculosis • HIV/AIDS and other sexually-transmitted infections • Fever • Skin problems • Headaches • General ailments • Pregnancy and unsafe abortions • Violence and sexual torture • Malnourishment and anemia 	<ul style="list-style-type: none"> • General / non-specific mental health issues • Psychological trauma and mistrust • Self-harm (cutting) • Anxiety and fears of rejection about being returned home for rescued girls • Substance abuse including drugs, alcohol and tobacco • Depression and suicidality • Care needed for providers, doctors, and counselors

Identification of Trafficked Women and Girls in Kolkata and Role of Health System

In light of the health consequences of trafficking, it is critical to understand how victims are identified, and to what extent the Kolkata health system plays a role in identification. Overall, our interviews indicate a strong police and NGO partnership in victim identification activities. Respondents reported three primary mechanisms through which victims are found: (1) NGOs partnering with police on raids (e.g., accompanying police), or alerting them to possible under-age sex workers; (2) raids or rescues conducted by police acting on information collected from reports or surveillance of suspicious activity; and (3) health workers from a Kolkata-based sex workers union screening for trafficking victims in the course of outreach work.*

One respondent depicted the collaboration between NGOs and police in Kolkata in the following way:

[NGOs] are there in the communities and in the red-light areas, so they get the first-hand information of minor girls being brought to the red-light areas, or girls forcefully brought into the trade. So they inform the police, and it's with the NGOs and the police together they conduct the raids and they rescue the children. (Advocacy respondent)

* Durbar Mahila Samanwaya Committee (DMSC) is a sex workers' union with a reported membership of 65,000. India's National AIDS Control Organisation (NACO) funds DMSC to provide HIV testing and treatment to sex workers through a community-based peer-to-peer model. Respondents and program documentation^{156, 159} also describe DMSC as having a "Self Regulatory Board" to screen for potential sex trafficking victims who have arrived in Kolkata's red-light areas.

Regarding the role of health-care in the identification process, respondents described in detail the post-rescue process, and some of the tools used to help identify the age and origin of individuals found in raids. These individuals, especially young females, reportedly undergo forensic examination and bone ossification tests to help determine whether they are under the age of 18.* Women and girls identified as trafficking victims are then sent to a government home or NGO rescue home, or repatriated to their home villages. However, some women or girls are reportedly shunned after returning to their home villages, and later found working in Kolkata's brothels.

Health Services for Trafficking Victims in Kolkata

Prior to rescue, respondents noted that health services for trafficking victims in Kolkata are extremely restricted, a finding consistent with recent empirical studies.²³ Several major themes emerged around health-care access for sex trafficking victims: (1) health-care access for victims is tightly controlled by brothel owners; (2) NGOs play a unique role as intermediaries between victims and health-care providers, and as direct providers of health services; and (3) government plays an important, albeit not central, role in delivering health care for rescued trafficking victims.

One major theme that emerged from our interviews was the control exerted by brothel owners in mediating trafficking victims' access to health-care services. In order to evade law enforcement, brothel owners act as gatekeepers to a wide range of health providers, ranging from physicians to informal medical providers known as quacks.[†] Due to the high-control nature of the brothel owner-victim relationship, victims reportedly do not have the freedom of movement to seek health care on their own. Brothel owners control health-care access by contracting with private providers or physicians to deliver treatment in brothels. As one service provider observed, "[R]egarding the minor girls who are trafficked, the brothel keeper wouldn't want to let her come out. So for that reason they hire a doctor, and the doctor will not say anything against it."

The following quotes describe how owners restrict victims' access to several types of health care:

They don't want the girls to go out for any kind of medicines, or injections or any kind service, or whatever they provide, so the doctor brings it himself. He comes and brings it to the girls or to the brothel keeper. (Service provider)

* Girls were reported to experience threats and manipulation on the part of brothel owners, pimps, and traffickers to not reveal their age, and therefore respondents did not believe it was always possible to rely on a girl's stated age. Age verification is reportedly required for the successful prosecution of traffickers and gives the government legal jurisdiction to remove underage girls from prostitution.

[†] One study of commercial sex workers in Kolkata found nearly half preferred to go to quacks for treatment.¹⁴⁴ Chapter 5 defines and describes the role of quacks as health providers.

The brothel owner will get these midwives, or an older prostitute who has some experience handling these abortions. And they might have picked up the knowledge here and there... A lot of the women die of pregnancy-related complications. (Researcher)

Another major theme is that NGO service providers such as DMSC reportedly play a central coordinating role for health-care services for sex workers. Several respondents characterized NGOs as legitimate stakeholders that have established, over a long period of time, working relationships with groups on all sides of sex work and trafficking related issues in Kolkata: brothel owners, hospitals, individual physicians, sex workers and trafficking victims, children of sex workers and trafficking victims, police, and government health agencies.

The reach of NGO service providers' services in health is extensive, ranging from direct treatment for women and girls, to mental health counseling and HIV prevention activities. For example, doctors commissioned by an NGO-run HIV/AIDS project visit local brothels each week to treat patients and to provide health education to brothel owners; or coordinate with NGO-run rescue homes to provide medical treatment to victims. Some NGOs hire former or current sex workers as peer health outreach workers who work in the red-light areas and help identify the health needs of other sex workers, providing referrals to clinics and hospitals as necessary. Some NGOs operate clinics in red-light districts that cater to sex workers and their health needs; these local clinics serve as *de facto* primary care centers for sex workers who may not want to go to a government hospital for care.

Through India's National AIDS Control Organisation (NACO),¹⁶⁰ NGOs also implement government-funded health programs designed to reduce sexually-transmitted infection (STI) prevalence among sex workers in Kolkata. These programs provide testing for HIV and other STIs in red-light areas, as well as other "targeted intervention" activities and services aimed specifically at female commercial sex workers.¹⁶⁰

Several respondents also noted that NGOs are critically important in facilitating health-care access for *rescued* trafficking victims (i.e., women and girls identified through raids and other means). One respondent spoke to the natural role assumed by these organizations: "These trafficked girls, they...are identified usually by the NGOs first. So the NGOs... try to facilitate, and they try to ensure that they get the requisite health-care." According to respondents, the ability of NGO workers to help navigate trafficking victims through the health-care system is largely relationship based; some NGOs have worked with hospital providers for years.

A government hospital physician reported working with NGOs to ensure health-care for victims, once they have been identified and placed in shelters:

We are typically doing an HIV clinic here [at the hospital]. Each and every doctor's phone number is there with Sanlaap [shelter home for rescued trafficking victims] and the DMSC [sex worker union]. Okay, whenever they are in a position to contact us, they contact us that we [the NGOs] are rescuing one girl, so we say that we are too full tonight. Come tomorrow morning, and we will help you out.

An NGO respondent who provides social services for sex workers' children described the process of facilitating girls' access to emergency medical treatment:

[T]here is never a bed available for them, there's never, every time one of these girls has called me when there is an emergency and each time had to use a contact to get them into the hospital ... I have to get them some connection somewhere, I make calls here, there, everywhere and ensure that within a couple of hours a child gets admitted.

One respondent suggested that familiarity with specialized health providers often results in more timely, personalized care for trafficking victims: "[T]he NGO's home superintendents, what they do, they have rapport with the doctors in the outpatient departments, and whenever they take girls to the hospital, maybe they don't always wait in the queue... They are given some privilege of being treated by the doctor." The NGOs that provide these services argued that the coordinating function they serve is necessary, especially in obtaining care at the crowded public hospitals of Kolkata.

Two respondents illustrate the need for their staff to accompany sex trafficking victims to government hospitals, as advocates for the victims.

[W]e don't leave the girls alone with the doctors, we reassure that the girl is are not feeling uncomfortable sharing the problem with the doctor, if she does, we take the permission whether she can share the problem, but many cases like STD [sexually transmitted disease], girls are shy to share the problem then she is there to help. (Social service provider)

Respondents specifically described the importance of NGOs working with trafficking victims. One government hospital physician offered a vignette of NGOs' work facilitating health care for trafficked girls:

From her mother's lap she was put in a brothel, she was assaulted by many men for three to four years. To her, the life is rising up in the morning, and start having sex with many men. So they [child victims] don't just start trusting, yes, and we being male doctors in this setting, they just come and just sit like this, not in a position to talk. Those Sanlaap [NGO] people, they say, 'Talk with the doctor, he is a very nice

person, just talk once, and we will get rid of all the fears you are having.’
And we just brought her to talk. ...And gradually she speaks up.
(Government hospital physician)

Some NGO service providers in Kolkata provide comprehensive services for children of sex workers – a cohort thought to be at particular risk for “second generation” trafficking. Respondents reported that some children receive health services at clinics in red-light areas. Two respondents described integrated child development service programs in red-light areas where children of sex workers can receive education, nutrition, and life-skills training.

Our interviews suggest the provision of health-care services for trafficking victims is multi-faceted. As described earlier, government hospitals provide treatment for trafficking victims referred by NGO service providers. For example, some rescue homes send HIV-positive girls to government hospitals for anti-retroviral treatment and counseling. Government hospitals also reportedly provide HIV testing for recently identified victims.

Yet, as one physician summarized about the government role, “In a nutshell, there is no specific health-care system from the government side for trafficked girls. There are some homes for the shelter of trafficked girls, there are doctors, but there are no specific health-care programs from the government side.”

Barriers to Health-System Response to Trafficking in Kolkata

In addition to brothel owner control as a limiting factor for accessing health-care, respondents revealed barriers to a comprehensive local health system response to trafficking in Kolkata. Some barriers were attitudinal, while others were financial or structural in nature.

Discrimination by hospital personnel against women believed to be in the sex trade emerged in interviews as a major theme. Many respondents voiced concern that hospital workers’ negative attitudes towards sex workers and trafficking victims created a hostile environment, which led to a perception that women and girls would be treated poorly and could therefore not trust health-care workers at these facilities.

A physician from an NGO that works with sex workers summarized the impact of these attitudes on women’s health-seeking behaviors:

It’s not that they [sex workers or trafficking victims] don’t want their services but they want it non-discriminatory, and that is why they are not very inclined to go to medical colleges and other [hospitals]...

A different physician who has worked with sex workers placed these discriminatory attitudes in the larger context of the mistreatment of any woman who has a sexually-transmitted disease:

If you go to the government hospital you will see, many of the people there with sexually transmitted disease are waiting outside in a public place for treatment from the doctors, they have stigma, the doctors have the stigma, and paramedic staff have the stigma, and policy makers have stigma – ‘Oh, sexually transmitted disease.’

One researcher noted that the stigma attached to these women and girls has the potential to fuel a rise in HIV/AIDS incidence:

[T]hey don't want to acknowledge that they've been trafficked, because they are afraid that the society will reject them, they don't want to go in for HIV testing because they are afraid of the stigma - that once they are stamped if they are positive that they won't be accepted back into society. This is what makes it a very different job with this population, to take any steps, even the trafficked girls, even if they are offered that they can go back, even if they are rescued and they are offered that they can go back into society they refuse to go back because they know that they won't be accepted there.

Another physician who also conducts research added:

So they remain in this work, this sex work profession. ... They remain in this work and take up high risk activities, become HIV-positive, get STDs... So this is what helps this spread of HIV. So I think if you have the power, we should first try to decrease the stigma that is associated with this HIV positivity and associated with this trafficking thing. And we should reach out to the population and try to tell this population that these girls are just vulnerable, they have become victims, they were not trafficked by their own will.

Following the forensic and age verification services a victim receives upon being rescued, respondents provided little indication that follow-up testing and treatment occur in a systematic manner if the girl is placed in a government rescue home. While NGOs were understood to utilize their established medical contacts and advocacy skills to ensure that the girls under their care receive necessary treatment, these services were not thought to be available for girls in government homes. As an advocacy respondent surmised, “[A]t present I don't think there's any mechanism to begin with to ensure that these children or these girls get some preferential or quick thing so they can get examined... unless the NGOs take special effort.”

Throughout the process of post-rescue treatment and rehabilitation, respondents pointed to a shortage of qualified mental health professionals to provide effective care and support for the specific needs facing trafficking victims.

One advocacy respondent reflected on the lack of standardized training for individuals providing counseling services to trafficking victims:

I'd like to make a complaint that they are not trained properly ... You will have one counselor train like seven others who are not trained at all – but they will say 'Yes, she's a counselor; he's a counselor,' but [they] don't know what a counselor is. Maybe one week's training, maybe fifteen days training, maybe at the best three weeks or one month. Maybe no training at all.

Our interviews also suggest other reasons why health-care providers are not more involved in anti-trafficking work. With respect to victim identification in a clinical health-care setting, several physicians expressed concern that intervening in a sex trafficking situation could have deleterious effects on victims' access to health-care, which is often mediated by brothel owners. One physician who treats girls in Kolkata brothels was concerned that alerting authorities to victims would lead brothel owners, with whom the physician had cultivated relationships, to ban the physician from the brothel altogether. Such action, the respondent argued, would deny both trafficking victims and other women in the brothel all access to health services.

Another major barrier to health-care responses to trafficking centered on the lack of resources (human and financial) for public health services in the city. Several respondents commented about the overcrowding and long waits at government hospitals in Kolkata, and the intense time pressures physicians face to keep up with the demand for services. Specifically, some physician respondents said that they simply lacked the time, given their competing responsibilities, to intervene on behalf of trafficking victims. For example, a physician who staffed a government health clinic noted that, due to the high volume of patients at the clinic, she did not have time to discern trafficking victims from other patients in the general population, and described what she would do if a non-biomedical problem (e.g., trafficking) was suspected:

In government centers the load of patients is so much that...as a medical professional, everybody is the same to me. Medical care, whatever is needed, if she is trafficked or not, that is not my concern. Medical care, what I have to give, I have to give to every patient... so if I think that any health, any other health, any other issues are required, if I talk to her then any other help is required I can refer.

Another respondent blamed the workload and the system under which government hospital physicians' work for the lack of attentiveness to victims: "Most of the mistreatment, maltreatment is committed by the doctors. How can you blame a doctor when that person has to take care of 90 patients in 2 hours? How can you expect him or her?"

One respondent summarized the factors that lead to a disconnection between potential sex trafficking patients and providers at local government hospital.

So that is why maybe some of the people are losing faith, because they don't feel like they are adequately treated at the government establishments. They are not provided free medications, not a doctor over there is very much interested, so it is something like that, and that is why the NGO sector, when it is working in this health field, they have made a lot of impact. (Social service provider)

The lack of public resources in Kolkata for health was described by respondents as a broader city problem (i.e., not just a problem for sex workers and trafficking victims). By "health," respondents referred to the lack of resources for health services, but also for non-health services that support basic living conditions within which health can thrive. Comments from respondents on the topic of lack of government resources ranged from "We don't any social security in this country" to "So when 80 percent of people [in Kolkata] are deprived, how can we think about the sex workers alone?"

One physician summarized the multiple challenges for people living in poverty in India:

In one day you cannot change the economy of India, Pakistan, Nepal, and Bhutan, the economy - this poverty - is there - but regarding health-care issues, not only the trafficked girls but the general people. Also, health-care issues are not the prime importance of their life. Basic things, food, shelter, clothing, that is the most important thing. They do not have these things.

Opportunities for Local Health System Response to Sex Trafficking

Our interviews suggested several lines of activity in which the local health system could be more responsive to the problem of sex trafficking in Kolkata. Respondents identified gaps in health-care services for sex trafficking victims and offered several suggestions to address these gaps. Furthermore, respondents recommended actions that task the health system to move beyond merely treating victims, and to work with non-health stakeholders to prevent trafficking in Kolkata.

Assure Health Services for Trafficking Victims

Respondents made a general call for government to develop health initiatives specifically targeting sex trafficking. In the absence of explicit policies and procedures for the delivery of health services to rescued trafficking victims (or as one doctor described, “lapses in government strategies”), the extent to which victims receive effective treatment and care was thought to vary. As described earlier, respondents called on government hospitals to reduce the logistical barriers to care for sex trafficking. For example, government hospitals could develop a unit dedicated to caring for rescued victims, and guarantee these women and girls access to hospital beds.

Interview respondents also reported the dearth of mental health and psychosocial supports for trafficked girls and saw this as reflecting the broad, societal neglect and stigma of mental health services throughout India – an observation consistent with recent literature.¹⁴⁸ Respondents specifically suggested that mental health-care systems of support should be strengthened in both government and NGO rescue homes for trafficking victims.

One respondent summarized the large gap in mental health services for trafficking victims:

Nobody is sort of willing to talk about mental health. I find mental health is quite a big issue. But people are so much occupied with the physical problems. They do not find the time to focus on mental health. But I find these girls go through trauma, stigma, and maybe imbalance sometimes, but the physical problems of getting beaten by the customer and the police, doing abortions, getting infected with HIV or STDs is so high that you forget about the tears. (Advocacy respondent)

Several respondents argued for a greater mental health role in working with newly identified trafficking victims (e.g., increase capacity for mental health services in rescue homes), because most post-rescue policies are law enforcement centered rather than victim health centered.

Yes, the trauma reduction is the most important area to these women. If you give medicine, if one has trauma, and if you give medicine, they depend [on] you, but then their mind never cures. Because they told her, “No, you are a prostitute.” Yes, you can feel better with the medicine, but still you are a prostitute. So it is very important to that lady to start with the trauma reduction. (NGO program director)

An expansion in the role of mental health providers, one respondent maintained, should include training programs for counselors who work with newly-trafficked victims.

[S]ome specific trained people should be there who can give the psychosocial counseling so that she can come back to normalcy. Both psychosocial counseling and clinical treatment should be available to her along with adequate food and nutrition, and people should be empathetic to her. (Program director)

Prevention Activities

One doctor made a general call for anti-trafficking initiatives to take actions not only to improve the quality of treatment for victims who have been trafficked, but also to reduce the number of women and girls who are trafficked. To this end, several respondents offered strategies for how health-care systems can have an increased role in anti-trafficking prevention efforts. For example, one policy expert thought existing efforts to raise HIV awareness for out-of-school youth and vulnerable families could also be extended to include a trafficking awareness component. This same respondent also described the existence of several pilot support groups for girls to raise awareness of trafficking.

Interventions targeting sex workers' children – a vulnerable population at particular risk for sex trafficking¹²⁸ – were also noted as a strategy to prevent “second generation” trafficking. Respondents suggested that health care could play an increased role in wider prevention efforts directed at this population through treatment and referrals, as well as working in concert with other sectors to provide a comprehensive trafficking prevention response. This may include targeted interventions such as mental health counseling; after-school activities including art therapy; or health-care services in conjunction with a crèche where children can safely stay while their mothers are working.

One doctor of an NGO clinic for sex workers described how his clinic's holistic prevention strategy includes services for sex worker's children as a form of prevention:

So prevention is when we talk about the children – that's education, vocational training, computer lessons, giving them jobs, in fact we even employed some of our girls from Khidderpore [a major red-light area in Kolkata] into an all girls petrol pump which is very close by. There are two women going to the petrol pump every day, they have a job there. So this is all part of our ... prevention program.

Training and Awareness-Raising Activities of Health-care Workers

In order to mitigate potential discrimination against victims, respondents also proposed sensitization and training for health-care workers providing care to victims post-rescue in Kolkata.

To remove attitudinal barriers, many respondents called for the training of all government hospital staff—from physicians and nurses to hospital administrators and security guards—to assure fair and sensitive treatment for sex workers and trafficking victims. For example, one respondent proposed the development of in-depth training for social workers on sensitization around HIV and children of sex workers. Physicians were specifically targeted as potential leaders in calling for improved care for women in sex work. As one respondent surmised, “[D]octors sometimes have the roles of policy makers in the hospitals, at least in their department. So doctor[s], medical care providers, should have internalized this thing in their mind, thus they can change the society – society of medical people...”

Respondents also called for increased coverage of sexual violence related issues during medical training, a topic that has received considerable discussion in recent social science literature.^{145, 148, 161, 162} One physician who treats sex workers recommended that medical interns receive sensitization and training to the situation facing marginalized women through hands-on experience working at STI clinics in red-light areas.

Research: Improve Evidence Base on Sex Trafficking

Numerous respondents offered ideas for further research on sex trafficking in Kolkata. For example, one respondent noted that while police raids of brothels generate potentially valuable outcome data (e.g., number of victims rescued), measuring and reporting on the efficacy of any type of prevention related program is inherently challenging.

To raise awareness and promote health and hygiene will be the recommendation, but the problem is the impact is very slow ... I can very easily evaluate your [health awareness raising] program and say that it has no impact. But if you do a raid its impact in your hand: You rescue.
(Advocacy respondent)

Other research activities proposed by our interview respondents included: developing evidence-based approaches to rehabilitation and repatriation by evaluating current services for girls in rescue homes; conducting longitudinal follow-up health outcomes studies of sex workers’ children; and examining the inter-relationship between young sex workers, violence, and susceptibility to HIV.

Discussion

Overall, this case on the nature and context of sex trafficking and health-care access for sex trafficking victims in Kolkata yielded several important findings that complement an emerging public health literature on trafficking in India.^{23, 130, 143}

Our respondents contended that Kolkata remains a major source, destination, and transit area for sex trafficked girls. Victims often enter Kolkata through elements of force and deception such as false marriage or promises of a job. Some families were thought to be complicit in sex trafficking. Respondents described a wide range of key determinants across a girl's social ecology that may heighten her vulnerability to becoming a sex trafficking victim, including illiteracy, abuse, porous international borders and chronic levels of poverty, among others.

Our interviews included a diverse sample of key informants with varying experiences and perspectives. Interviews revealed ideological and philosophical disagreements among stakeholders. This tension stems largely from disagreements about the degree of agency and choice exerted by sex workers. For example, DMSC's community-based care and peer-based work largely rely on HIV funding channeled through NACO. While DMSC objects to sex trafficking, those who align with its guiding principles endorse the prospect of a poor woman willingly opting for the "profession" of sex work out of desperate (but not coerced) measures; therefore, DMSC advocates for sex work to be recognized by the state as a legitimate form of work. Other respondents hold a decisively opposite view on this issue, however, and argue that poor "prostituted women," by definition, exercise extremely limited agency. They, therefore, advocate against the legalization of prostitution in India. Specifically, these respondents note that many adult sex workers in India entered under the auspices of sex trafficking as minors – an observation supported by the literature^{128, 130, 163} – and point to efforts to legitimize sex work as promoting gender-based violence and exploitation of girls and women while failing to address the underlying inequalities that may drive women and girls into the trade.

Regardless of these persistent ideological tensions, collectively, interview respondents shared in the fundamental belief that sex trafficking remains an under-addressed problem in Kolkata, and that prostitution of underage girls, regardless of agency, was to be unequivocally condemned.

Our respondents presented a strong case for enhancing the role of health in anti-trafficking initiatives. Our public health framework allowed us to describe the nature and context of health-care access for sex trafficking victims and explore possible avenues for health to play an increased role in anti-trafficking efforts in Kolkata.

Despite the growing literature on its negative health effects,^{21, 135, 140} sex trafficking was not thought to be a public health priority by local and national levels of government, but rather an issue that falls under the jurisdiction of justice and social welfare. Existing policies and procedures on health-care services and support for rescued survivors of sex trafficking were largely folded into existing services for other marginalized groups such as children living with HIV or adult sex workers. Consequently, health-care programs and

the staff who carry them out may lack the resources or training to attend to the particular circumstances that face trafficking victims.

Consistent with recent research on sex trafficking and health-care access in India,²³ interactions between trafficked girls and health-care institutions was largely restricted, as brothel owners often arrange for private providers to address the victim's medical needs inside the brothel.

Our interview respondents offered a number of specific suggestions and innovative strategies for how health could play a more effective role in anti-trafficking initiatives. Any health-led intervention, program, or initiative should be tailored to meet the particular socio-cultural circumstances and behavioral complexities that manifest in trafficking. In some situations, health-care systems may be more effective as part of a comprehensive, integrated response; while in other instances, a vertical, health-led response may be more appropriate.

Our interviews shed light on how the health sector could contribute to an integrated prevention response to sex trafficking. For example, ongoing HIV awareness programs that reach particularly vulnerable girls and their families in known source areas for trafficking could also incorporate a trafficking awareness module. Integrated health-care prevention efforts could also extend to sex workers' children by offering comprehensive wraparound health, social welfare and educational services. In this way health care could make important contributions toward comprehensive efforts to prevent "second generation" trafficking for this particularly vulnerable population.

In contrast to the integrated nature of trafficking prevention efforts, respondents proposed that other services to trafficking victims should subscribe to a vertical focus for addressing the specific needs of trafficking victims. One doctor borrowed language from NACO to suggest that a framework akin to the "targeted intervention" programming for sex workers could also be applied to ensure that sex trafficking victims receive treatment and care catered to their specific circumstances. This is particularly relevant for the delivery of health-care services to trafficked girls in government rescue homes. As a social services respondent suggested, "... on a scale out of 1 to 10, I would say ... they are given right now about three." While several NGO rescue homes utilize their existing resources and networks to ensure girls receive necessary health testing and treatment, this same level of diligence with regards to health-care treatment was not reported to occur in government homes.

Many respondents described a general insensitivity on the part of many doctors, nurses, and others who provide treatment and care for marginalized populations such as sex workers, persons living with HIV, and rescued victims of sex trafficking. While some of these prevailing attitudes may be attributed to general deficits in gender sensitivity within medical education,^{146, 161} respondents also pointed to the specific situation facing

trafficked girls as necessitating specialized training for providers. For example, due to the trauma, manipulation, and subsequent maladaptive behaviors on the part of a girl forced into sex work, she may be angry, mistrustful, and resistant to services by police, health providers, and counselors. These specific circumstances faced by trafficking victims differ from those of other vulnerable or marginalized populations. A psychologist in a government hospital contrasted the differences in working with rescued trafficked girls compared with adult sex workers or children living with HIV: "The purpose is totally different; the lifestyle is totally different; so the counseling purpose is totally different." For these reasons, training and sensitization on the specific mental health needs facing sex trafficking victims would be beneficial.

This chapter provided insight into sex trafficking and health care in Kolkata. Respondents identified numerous challenges they face in anti-trafficking work, and subsequently articulated opportunities where they envisioned health could play a greater role through prevention, treatment, advocacy and other avenues that extend beyond biomedical approaches to treatment and care.

CHAPTER 9: SEX TRAFFICKING OF WOMEN AND GIRLS IN RIO DE JANEIRO

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Introduction

Study Setting

In this chapter we attempt to characterize sex trafficking in Rio de Janeiro, including the mechanisms through which trafficking occurs and the factors that facilitate this practice; develop an understanding of the current health system response to sex trafficking; and identify means by which the health system can play a larger role in addressing sex trafficking within the local context.

Rio de Janeiro is the capital city of the southeastern Brazilian state of Rio de Janeiro. The city had a population of just over 6.1 million inhabitants in 2007, making it the second most populous city in Brazil, behind Sao Paulo.¹⁶⁴ Rio de Janeiro was the capital of Brazil from 1763 to 1960 when it was succeeded by the Federal District of Brasilia. The city is one of the most popular tourist destinations in Brazil. Yet alongside its famed scenery and wealth, exists some of its poorest and most violent slums, *favelas*, directly adjacent to, or overlooking, some of the wealthiest areas. The city is also home to one of the country's major airports, the Galeão-Antônio Carlos Jobim International Airport, and connected to the northeast and south regions of Brazil via federal highways BR-101 and BR-116, respectively.

Overall, the country of Brazil has a total population of over 198 million. The country's population is nearly three quarters Roman Catholic.¹⁶⁵ Regarding its human trafficking profile, the U.S. State Department's *Trafficking in Persons Report* placed Brazil as a "Tier 2" country in 2009.¹ In terms of key health statistics, Brazil's infant mortality rate is 22 deaths per 1,000 live births.¹⁶⁵ According to the Pan American Health Organization, Brazil spent approximately eight percent of its GDP on healthcare, in 1998, and had nearly 8,000 hospitals, country-wide, in 1999.¹⁶⁶

The main system of health care in Rio is public, and the city is home to various teaching hospitals, state hospitals, maternity clinics, state dispensaries, and health posts. Also, the national school of public health, *Escola Nacional de Saúde Pública Sérgio Arouca* (ENSP), which forms part of the various academic units that comprise *Fundação Oswaldo Cruz* (Fiocruz), is located in Rio. Fiocruz is considered a major component of the nation's

public health fiber, and contributes significantly to the field of public health research as well as the formation of national public health policy.

Summary of Field Work

Fieldwork in Rio de Janeiro was conducted by researchers during three visits in November 2008, February 2009, and August 2009. Prior to these trips, a list of potential key informants was generated by contacting local service providers, doctors, social scientists, and advocates who subsequently referred us to other colleagues knowledgeable on the issues of sex trafficking, sexual violence against women, child sexual abuse, sexual exploitation, sex work, and sex tourism, as well as the local health-care structure. In total, 37 respondents were interviewed in Rio de Janeiro.*

During the first trip, 11 individual and 4 group interviews were conducted with a total of 22 respondents that included 9 public health researchers, 6 social service providers, 3 advocates, 2 state government officials, 1 health, and 1 mental health provider.

During the second trip to Rio de Janeiro, a total of 4 individual interviews were carried out, one with each of the following: health provider, mental health provider, public health researcher, and state government official. Of note, this 2-day visit to Rio de Janeiro was completed as part of the trip to Salvador during which a 1-day visit to Brasilia and a 2-day visit to São Paulo were also carried out to interview key informants at the level of the federal government (2 respondents), as well as researchers who study the phenomenon of sex trafficking from a countrywide perspective (6 respondents).

During the last trip to Rio de Janeiro, 1 respondent from the second trip was re-interviewed. This respondent referred us to 4 other key informants and the remaining 8 respondents resulted from the snowball effect or our background pre-fieldwork research. Five individual and 4 group interviews were conducted with a total of 13 respondents (12 in Rio de Janeiro) that included 6 health providers, 3 mental health providers, 3 public health researchers, and 1 federal government official in Brasilia interviewed by phone.

An interpreter fluent in Portuguese and English with both local and international experience facilitated communication in interviews and transcribed a number of interview recordings.

* During this trip, we experienced audio recording difficulties in nine interviews. Extensive notes were taken during these interviews. One interview respondent fluent in English was re-interviewed over the phone; another was re-interviewed on our final trip to Rio de Janeiro.

Characterization of Sex Trafficking in Rio de Janeiro

Prevalence

The overwhelming majority of respondents referred to sex trafficking of women and girls as either a phenomenon restricted to the North and Northeast regions of Brazil, or at least more visible or worse in those regions compared to Rio de Janeiro. Once in Rio de Janeiro, these women and girls were mostly referred to as sexually abused, sexually exploited, and/or prostitutes. This terminology was used even in the case of women and girls whom respondents described as having been recruited and transported from other Brazilian states into Rio de Janeiro.

Respondents did not provide an estimate of the magnitude of sex trafficking in Rio de Janeiro, stating instead that “information is very general” and there is “no specific information on sex trafficking in Rio de Janeiro.” One state government respondent noted the controversy in Brazil regarding the national number of trafficking victims. Referring to a 2001-2002 national landmark study on sex trafficking in women and girls, *Pesquisa sobre Tráfico de Mulheres, Crianças e Adolescentes para Fins de Exploração Sexual* (PESTRAF), this government official commented, “There’s a big-small conflict between the PESTRAF report and the numbers the NGOs give. NGOs say that there’s a much bigger number than this 700,000. But again, it’s hard to measure; it’s hard to say that it’s bigger or smaller.” An NGO respondent questioned the report’s method of counting victims, noting that “the methodological error is that sexual tourism, migration, sexual exploitation of children, and consensual prostitution are lumped together,” and expressed concern that “people tend to use the issue of sex trafficking to bring prejudice to bear on sex workers such that working against sex trafficking is the same as working against prostitution.” This sentiment was shared by an academic researcher. Yet another public health researcher warned that prevalence studies of sex trafficking should be interpreted with caution, as “this real problem can itself be exploited in the direction of controlling frontiers and populations.”

The Brazilian system was described as relying almost exclusively on victims’ self-presentation and self-identification. As noted by a federal government respondent, “Generally, the victims don’t approach the social assistance and protection services.” Overall, respondents alluded to difficulties in victim identification due to a lack of consistent methodology, infrequency of victims coming forward to authorities, and definitional differences as to what constitutes sex trafficking versus exploitative sex work, or even voluntary migration abroad for sex work. As one respondent said, “This very fuzzy line between exploitation and trafficking and self-decisions of working in another country is very delicate.”

One federal government respondent shed further light on one of the factors contributing to data collection challenges in Rio:

Rio de Janeiro has a number of features that camouflage people trafficking. Why? Because it's a town with a high volume of drug trafficking and arms trafficking and where prostitution of adult women is more conspicuous than sexual exploitation of children and adolescents... that conceals it. Nonetheless, Rio de Janeiro is an excellent conduit for recruiters and for those who exploit children and adolescents sexually and traffick people and who come from other regions of Brazil. Rio de Janeiro is the main entry point to Brazil for tourists, it's the destination most offered as the first option and unfortunately receives visitors who come for sex tourism.

Composition

Many interview respondents cited the city of Rio de Janeiro as one of the main destination sites for internal sex trafficking within Brazil, particularly for women and girls from the rural regions of the state of Rio and the poorer North and Northeast regions. While many of the adult women may end up walking the beaches or working in 'exploitative' nightclub bars (*boites*) or spa massage parlors (*termas*) that cater to tourists, adolescent girls were described as being less visible in the sex tourism industry.

Although some older-looking 16- and 17-year old adolescent girls may work in nightclubs and massage parlors, several respondents argued that the commercial sexual exploitation of minor girls is not out 'in plain sight'." A few respondents described situations where young girls trafficked into Rio de Janeiro from other states are "confined" in apartments, "ordinary apartments," like those in the tourist area of Copacabana, and which clients frequent for sexual services. Vila Mimosa, a famous red- light brothel district in Rio de Janeiro, as well as an area referred to as "downtown" where sexual services are offered at "\$1 *reais** a minute for a minimum \$5 *reais*," are two places where adult women and adolescent girls are reportedly commercially sexually exploited. Two respondents, a health worker and an NGO provider, identified the area surrounding CEASA-RJ, *Centrais de Abastecimento do Estado do Rio de Janeiro* (a commercial goods wholesale market with heavy inter-state truck traffic) as another location in Rio where adolescent girls are being trafficked. Additionally, one medical doctor respondent, who maintained that sex trafficking is more of an issue in the northern regions of Brazil, described caring for adolescent girls who "go with adults inside the hotels" for "commercial exploitation" in Rio de Janeiro. Finally, some respondents described both the sexual exploitation and commercial sexual exploitation of adolescent girls and women in the city's *favelas* as being related to narco-trafficking. These types of exploitation were depicted as occurring within and across *favelas*, with movement of girls "from one *favela* to another *favela*." One respondent described the drug traffickers in the *favelas* as a "network of pimps."

* 1 Brazil Reais is equivalent to US \$0.59, at the time of this report.

Several respondents also identified Rio de Janeiro as an origin and transit city for international migration and trafficking, mostly to European countries, given its major international airport. However, respondents argued that international trafficking involves adult women or older-looking adolescent girls who could produce false travel documents. Younger girls and adolescents were mostly described as vulnerable to domestic trafficking and land-based international trafficking across Brazil's borders, to neighboring countries.

Acknowledging that Brazil's data on trafficking is "very precarious," one federal government official indicated that of all human trafficking in Brazil, "85 percent of the victims are women trafficked for the purpose of sexual exploitation." A state government official in Rio de Janeiro qualified that sex trafficking involved, for the most part, "women between 15 and 25 years [old] in Brazil." Overall, our interviews revealed three distinct sex-trafficking victim profiles: (1) a woman or girl already working in prostitution who accepts a recruitment proposal for higher earnings and better conditions in the sex industry abroad; (2) a woman or girl not engaged in sex work in Brazil who accepts a recruitment proposal to work in the sex industry abroad, as a temporary means of income; and (3) a woman or girl not engaged in sex work who accepts a recruitment proposal for an opportunity that is purportedly not related to sex work.

How Women and Girls are Trafficked: Mechanisms

Most respondents talked about mechanisms of sex trafficking in terms of moving women and girls across international borders. Several mechanisms by which women and girls are trafficked were cited. Respondents commented that foreigners come to Rio de Janeiro to recruit women for prostitution abroad – with false promises. These include promises of higher wages and better working conditions, or attractive, but false job opportunities such as waitressing and modeling. Other respondents described foreign recruiters who manipulate and seduce women with love affairs and marriage proposals, only to force them into the sex trade once abroad, or keep them "locked in their apartment" as sexual and domestic servants.

Others identified the recruiter as someone close to the victim, often another female, a family member, friend, or neighbor. This close connection between victim and recruiter was reported for both internal and international trafficking cases. Truckers and taxi drivers were implicated by some respondents as participants in the recruitment, transportation, or exploitation of women and girls.

One federal government official in Brazil described the following scenario:

[P]rostitutes end up giving priority to foreign customers. In that way, they meet a lot of people from other countries and often they get proposals to go and work in the country of origin and with lots of facilities. That is, the fare is paid by the customer, they have somewhere to stay, and often the proposal is for them to work only for him. Very often it is camouflaged as a love affair and then there are proposals of marriage and they end up agreeing even knowing that they will end up in prostitution, sometimes. Others thinking that – no – they are going to get married and their lives are going to change and they go abroad with a false impression that the situation overseas is better than here in Brazil. And when they reach their destination what a waits them is a situation very different from what they expected. If they go into prostitution, they have no autonomy at all to decide on the sessions, prices, conditions, use of condoms, the number of sessions per night. They are always in increasing debt, which includes everything from the fare through to meals, personal hygiene, and accommodation. The sessions are never enough to pay their costs and they end up in a situation of veritable modern slavery and both those who go to work as prostitutes and those who go to get married and end up serving just one person, but serving not just sexually, but as domestics.

Those respondents who spoke directly about sex trafficking in Rio believed that women remain in trafficking situations as a result of traffickers' constant threats of harm, confiscation of victim's travel documents, and the isolation of victims.

Several factors were identified by other respondents as contributing to women and girls remaining in commercially-exploitative situations. These situations were labeled as "sex trafficking" only by a few respondents who described them. According to several respondents, women earn a significantly larger monthly wage working in the sex industry than as receptionists, secretaries, domestics, or cashiers, for example. This financial incentive reportedly drives women and girls into sex work as a "rational" alternative for income. According to some respondents, this incentive is also the reason given why some middle-class women in Rio de Janeiro enter the sex industry, as well as why some women choose to remain in exploitative situations:

I mean workers' rights are violated every day in every job you want in Brazil. And they are certainly violated in the kind of jobs that these women would be doing otherwise: check-out counter girls, beauticians, maids. Maids' rights are notoriously violated in Brazil, notoriously violated. The difference being that if you are having your rights violated as a prostitute, you are at least making two to three thousand *reais* a

month, whereas if you're having your rights violated as a maid, it is 400 a month. When you talk to these women about their workers' rights being violated, they just laugh. They will say "I've never had a job where my rights have been respected, why should my rights be respected." There are things that they understand to be okay. Violations that they don't like but they are willing to accept. For example, they have to pay for their work clothes in some *termas*, which means the bikinis with the house name on it or the robe. They might have to pay for the rubbers that they use, they don't like that. They have to pay the fine if they don't come to work, they don't like that but they are willing to accept that. (Academic researcher)

A state government official, who described this situation as trafficking, echoed this assertion: "They don't see that they have been trafficked. For them it's better to be there under an exploitation situation, but making money." Another reason identified for women remaining in the exploitative *boites* and *termas* is the opportunity either of being recruited to work abroad where they could earn more money or of finding their "Prince Charming," as one respondent called it, who would provide for a better life – a scenario propagated by the media and by word-of-mouth among the women.

It [is] difficult to recover a woman or girl once she has a taste of the money, glamour, love, and opportunity associated with sex work. The circulation of positive stories associated with sex work is what 'keeps the dream alive' and keeps the girls coming back for more even after having a negative experience. There is also strong peer pressure in urban centers like Rio de Janeiro among girls to lure other girls into the sex work industry. (Social service provider)

Sex Trafficking: Key Determinants

As described earlier, many respondents did not speak directly about sex trafficking per se. Instead, respondents identified determinants that increase women and girls' vulnerability to domestic and sexual violence, sexual exploitation, and commercial sexual exploitation, as well as facilitate entry into sex work, all of which may create favorable conditions for sex trafficking.

Individual Factors

Several respondents identified certain beliefs held by women and girls that increase their vulnerability to sexual exploitation and trafficking. These beliefs include: (1) living abroad or marrying a foreigner as a means to a higher quality of life; (2) women are subordinate to men and meant to serve their sexual needs; (3) relationships between

minor girls and adult men are acceptable; and (4) sex work is a legitimate means for generating income.

Recognizing the pressure placed on girls from an early age to live up to the Brazilian female image of sexuality propagated by the samba culture, the media, and advertisements for the sex-tourism industry (further discussed in below), some respondents suggested that this early socialization can contribute to women and girls’ inability to see themselves as victims of objectification and violence.

Similarly, low self-esteem was reported as another factor contributing to vulnerability. For example, one health-care respondent working with youth explained that lack of income is often the source of high levels of stress in families. This stress may, in turn, precipitate violence and dysfunction in the home, which then engenders the low self- esteem among young girls that contributes to their overall vulnerability. Finally, “ambition”, “desire for more”, and “dreams for a better life” were identified by respondents as increasing vulnerability. Some respondents noted that these psychosocial factors have also facilitated the entry of middle-class women into the sex industry as a means of making money to pay for school or material goods that they otherwise would not be able to afford.

Situational Factors

Economic deprivation of communities, coupled with limited opportunities for income and education, were factors identified by multiple respondents as either facilitating entry into prostitution or increasing the vulnerability of women and girls to commercial sexual exploitation and/or sex trafficking. Respondents also described numerous other community-level, as well as family-level factors particularly relevant to young girls.

These are included below in Table 9.1.

Table 9.1. Community and Family-level Determinants

Community	Family
<ul style="list-style-type: none"> • Substandard living conditions • Culture of violence • Lack of employment opportunities • Lack of formal education • Need to migrate for work • Lack of protective schooling and child care • Lack of community support 	<ul style="list-style-type: none"> • Lack of child rearing skills • Single-parent, female-headed households • Absent working parents • Weak family bonds • Inability to provide for basic needs • Physical, sexual and psychological abuse • Exploitation of children within the community by family

One child mental-health provider observed that “93 percent of the cases of sexual abuse and violence are incestuous” and that “having been abused, their parents will sell them.” Another child mental-health provider noted accounts of cases in which girls were repeatedly forced by their mothers to leave their home at night and told not return without money

until the next morning. In these cases, the girls would sell sex to earn this money, and it was implied that the mothers were aware of this. One medical doctor provided anecdotal accounts of pregnant girls ranging from 10- to 12 years of age. These girls presented for prenatal care, and, upon further investigation, the doctor discovered that the mothers regarded the girls as “married” or “dating” adult men (sometimes drug traffickers) who fathered the babies, as these men had assisted with paying for family expenses.

Respondents explained that the strong presence of drug-trafficking rings in the poor communities of Rio, particularly in the *favelas*, is also a factor that increases the vulnerability of women and girls, to what some labeled sexual exploitation and others called sex trafficking by drug traffickers. They explained that women and girls became involved with drug traffickers as a means of accessing power, wealth, and status, as well as escaping the violence in their homes. The two quotes below illustrate the influence of drug traffickers.

For the girls, this is a way of moving up. Associating with these drug traffickers is a way of their having power too, and access to the income generated by the sale of drugs that they manage through that activity. And so, you see, there's that issue that you have to look at: you have these underprivileged, economically disadvantaged classes, it's a way of surviving, a way of ascending socially.... The second thing was the presence of domestic violence, which often generated the need for the child to go to the street, either because he was beaten or because they were sexually abused by the adults, particularly the girls were sexually abused by their stepfathers. So recurrent cases in the families that we visited, where one daughter had got pregnant, so the other one left so that it wouldn't happen to her. So the presence of violence is a fundamental factor in these children's leaving to look for other... another life... and often the other life that is offered them is prostitution. (Academic researcher)

I would say about 20 to 25 percent of the population within the state is considered extremely poor... girls who live in the *favelas*, and the boss of the drug traffick come to them, and offer them like one *reais* or two *reais* so they can come and stay like 8, 9, 10 hours a night, and work as [prostitutes]. (State government official)

Contextual Factors

Economic inequalities between the rich and the poor in Rio de Janeiro were identified as major societal-level determinants that lead women and girls into vulnerable situations.

One health respondent remarked, "Brazil is one large *favela*, with small pockets of wealth scattered about."

Another respondent explained:

Here, we have poverty with inequality. The poor are living side-by-side with the rich. There are more than 600,000 people who live under the poverty line in Rio de Janeiro. Here, geography plays a large role in the socioeconomic disparities in Rio – *favelas* are located up on the mountains, with the poor looking down on the rich. (Social service provider)

Some respondents identified gender inequality as a factor that leaves women and girls vulnerable to violence, in general. Several respondents also perceived the "sex-driven" media as creating international demand as well as the societal conditions favorable to sexual exploitation, sex tourism and sex trafficking.

Using some of the following phrases, respondents credited the media, the samba culture, and the sex tourism advertising industry with a prominent role in shaping a "highly sexualized society" by targeting the youth and "bombarding" them with "sexual scenes" that "glamorize sexuality and prostitution," and depict the Brazilian woman as a highly desirable and sensual being meant for "men to see, and to touch, and to use." Along the same line of reasoning, other respondents commented on the sex-tourism industry acting as an "enhancer" for sex trafficking by creating a culture that allows it to be objectified by foreigners as a means to an opportunity for love, glamour and a better life.

One federal government official noted,

The traffick for sexual purposes in Rio is also very much related to – and here I am talking about the international traffic – with sex tourism, that situation of foreigners who come to Brazil for the specific purpose of having access to women, not just for the purpose of declared exploitation, but also to have... There's a very distorted view that here in Brazil sexuality is experienced very freely. So, tourists come here to enjoy that sexual freedom. There's this myth that that [sexual freedom] can be had here in Brazil. And on the other hand we have a population of vulnerable women who end up having this great dream of marrying and falling in love with a foreigner to go and live abroad and in some way to improve their lives through that marriage. So there's a situation of vulnerability associated with sexual tourism, but also another reality associated with the sexual exploitation network, which includes prostitution too, so I think that Rio de Janeiro is very much seen from

outside – and also because of its climate, the beaches – as being an appropriate place for this kind of traffick.

Several respondents cited public corruption as a facilitating force in the commercial sexual exploitation of women and girls. Some respondents indicated that a number of police officers are complicit with the management of *boites* and *termas* in Rio de Janeiro and, so these establishments’ activities are well-protected. One social service provider concerned with child protection stated, “There is a network of commercial sexual exploitation of children that includes the corrupt participation of police, government officials, and weak internal investigations of sex crimes to identify corrupt officials. They operate with impunity and, as a result, the scale to which it exists is unknown.”

Existing Response to Sex Trafficking

Health Implications of Sex Trafficking in Rio de Janeiro

Table 9.2 (below) contains respondents’ list of health consequences of sex trafficking as well as physical, psychological and sexual violence; incest, child sexual abuse and sexual exploitation; survival sex, commercial sexual exploitation, and sex tourism; and prostitution.

Table 9.2. Health Implications

Type	Health Consequences
Physical, psychological & sexual violence	Chronic pain syndromes; mental health issues.
Incest, sexual abuse, & sexual exploitation	Sexually transmitted infections; repeated unwanted pregnancies; mental health issues including low self-esteem and depression.
Survival sex, commercial sexual exploitation & sex tourism	Sexually transmitted infections including HIV; unwanted pregnancies; unsafe abortions; chemical dependencies.
Sex work / prostitution	Sexually transmitted infections including HIV; complications from maneuvers, medications and devices to arrest menstrual flow; unwanted pregnancies; unsafe abortions; mental health issues; chemical dependencies.
Sex trafficking	Sexually transmitted infections including HIV at higher incidence rates; unwanted pregnancies; unsafe abortions; mental health issues (i.e.; Stockholm Syndrome and suicide); and chemical dependencies.

Process of Identification of Sex Trafficked Women and Girls

Respondents described self-identification and public notification as the main mechanisms by which victims of violence are identified in Rio. Identification is accomplished through specialized women's police stations known as *Delegacias de Atendimento a Mulher* (DEAM), specialized child and adolescent police stations known as *Delegacias Especial de Repressão a crimes contra a Criança e Adolescente* (DERCA), child protection agencies called *Conselhos Tutelares*, and an anonymous national 1-800 call center for reporting crimes of violence called *Disque Denuncia-100*. In the case of public notifications or policing activities, would-be victims are still required to self-identify and verify their status as victims.

Within the Rio health system, no widely-practiced protocols for screening or identifying victims of violence exist, and the burden rests largely on the woman or girl to self-identify in order to receive any services. Several health respondents stated that when encountering a female patient with signs of trauma, any probe into how the injury was sustained is highly dependent on the health provider, how knowledgeable and receptive the provider is to the issue of violence against women and girls, and how empowered the provider feels to assist victims.

It's going to depend on the health worker. A health worker who feels capable, who's been trained to deal with, to work with that, he will have that outlook, will have that concern to approach this woman, to talk to her, to take her in and refer her to the psychology service or social service. So it's going to depend on that professional. If it's someone who's not sensitized to provide care on this subject, who is resistant to working with this problem, they're going to pretend they don't see it. They're going to give the care necessary for the wounds, but they're not going to address the question of violence, to find out what happened, 'Why are you bruised?' (Public health researcher)

Existing Health Services for Sex Trafficked Women and Girls in Rio de Janeiro

Respondents noted that under the Brazilian system of universal health care (the *Sistema Único de Saúde* (SUS) created in 1988) all Brazilians have access to public-health services. However, no specific health-care facilities for sex trafficked women and girls exist in Rio de Janeiro. As one respondent noted, "We still don't have a structured network of services." Additionally, there is no special system of referral and counter-referral to expedite care for victims of sexual violence within the existing public-health system. Female victims of any type of violence seek medical assistance in the same manner as any other person would at basic health posts, primary health care centers, maternity clinics, hospital emergency units, university-based psychotherapy programs, and centers for psychosocial services called *Centros de Atenção Psicossocial* (CAPS).

Respondents did note the existence of two maternity clinics in Rio de Janeiro where safe and legal abortion services are available, and staff have received some training on the issue of violence against women and girls. However, a few respondents noted that victims and trafficking service providers are not always aware of available services. In fact, a social service NGO provider working with sex trafficked women was unable to identify a specific clinic or provider to whom s/he would preferentially refer trafficked victims. Respondents also noted that female victims of violence who seek assistance in the public health system encounter the same delays in care as the rest of the population, due to a health-care system that is challenged to meet the demands of such a large population. Some members of the state government were actively seeking to build a referral center that would coordinate a referral-based service network to provide timely and quality assistance for women victims of violence.

One of these state government officials observed:

But you probably heard that it doesn't work like that; that people die waiting for treatment. And here the thing about the health system is the difference between the treatment given to blacks and to whites, and to women and men.... Specifically with regard to women, there are laws, regulations, family planning, [that] also don't work very well. Abortion is a big issue, because a lot of women don't have access to family planning, end up with undesirable pregnancies.

Barriers to Identification and Health Response for Sex Trafficked Women and Girls

As mentioned earlier, respondents said that the current health system in Rio is not screening for domestic or sexual violence. This lack of screening was viewed by some as leading to an "under-identification" of victims, and several factors were suggested as contributing to this lack of action:

- Novelty of violence as a health issue
- Lack of screening protocols
- Lack of protection for health providers who file reports of violence
- Paucity of social services available, and the lack of a referral system for those services
- Low awareness of and training on these issues among health providers
- Over-crowding and high patient turnover rate in public-health facilities

Table 9.3. Barriers to Identification and Health Response

Factor(s)	Quote
Under-identification	<i>They don't want to talk, and if the people in the hospital are not trained to diagnose the problems with a certain sensitivity, that's one more case that remains hidden in the figures.... This has made it extremely difficult to get specific numbers on victims of people trafficking. (Social service provider)</i>
Lack of screening tools and over-crowding	<i>I think what happens is you don't have good screening... I think there are lots of missed opportunities in terms of women coming in for whatever, but I think especially women who might come in, for example, for an STI symptom or one of these health indicators that might be more directly linked. I think there's no protocol that I know that doctors, nurses are taking those opportunities to figure out if there's other things going on especially when a woman comes in with be it signs of violence, something sexual happening. Not taking advantage of those opportunities because of the huge demand that's on the system and there's very little investment that is put into the system. (Advocacy Worker/Educator)</i>
Violence not considered a health issue by all	<i>I think the first barrier that inhibited the response was the lack of an understanding that violence is also a public health problem. So we spent a long time here just caring for the wounded, counting the dead and not thinking that there could be concrete action by the health sector, the services and professionals to deal with this issue... With time, over these 20 years, we have managed to reverse that a little, but to this day, a lot of professionals, health workers in services providing care, think that they don't have to intervene in these cases. As a result, they don't investigate. A child comes in who's been mistreated, an elderly person, a woman who's been sexually abused – they don't investigate... to this day. (Public health researcher)</i>
Paucity of services and lack of referral mechanisms	<i>We have some institutions but not very much and they don't publicize their work. You know, if you have one case [of reportable violence] here, I would have to go invest my time to find out the way, what can I do, what am I – you don't have a real network and clear pathways where you can go to start a process of getting this girl a new house or getting this girl some support in the school or some health, mental support. You don't have this clearly. (Health provider, doctor)</i>
Lack of protection after filing a report	<i>There is still resistance among these health workers to getting involved in these cases, because often this will entail their having to give testimony in court and they want to safeguard themselves, because neither is there any policy in support of those health workers for them to be able to go, but be safeguarded by the service, by the network of services that exist. So they have that resistance.... they allege breach of confidentiality. There's that personal question, of not feeling protected, often of feeling threatened by the fact of having filed a report. (Public health researcher)</i>
Lack of trainings	<i>It's very rare. [Name of organization] has existed for four years now and in four years we have one contact with a hospital that wanted a lecture about trafficking in persons. (Social service provider)</i>
Low level of awareness and comfort with issue	<i>It is very difficult to train professionals to work on this issue, because it's not a subject that calls just for transfer of information. It's not enough to fill them with content, tell them about these forms of violence. You have to convey something that will involve those professionals subjectively too, so that they themselves feel mobilized, sensitized to work with the problem and feel trained for that purpose. So a number of training courses have been given, but when we ask those professionals "Well, do you work on this?" They always say, "No" because they don't feel trained. (Public health researcher)</i>

Several respondents voiced a common theme in our interviews: among all health providers, medical doctors are the least engaged group on the issue of violence against women.

It depends, it depends, but I would risk saying that generally the ones who get most involved with these issues are the nurses, social workers, those are the two who get closer and listen better. The doctors, the training our doctors get is still very much on the bio-medical model: that they have to treat just the wound, and these other issues he refers to the nurse, social worker and psychologist. So I would say that, within the health team, those three professionals are the most sensitized in research studies. In the studies that have been made, they even complain about the doctors who don't participate in these problems. Now, I would say that there is a category of doctor that is more sensitive to these issues, and that is the pediatricians. Generally pediatricians are more sensitive to problems of violence because, in fact, historically they introduced the subject of child abuse into the health sector. (Public health researcher)

The doctor would look at a young girl, 22, and she'll say, 'Oh, I suffered sexual assault.' [To which the doctor would respond], 'Oh, come on, it didn't happen like you were saying; it was different... you were probably you know what.' So we made some sensibilizations, but doctors don't attend to these sensibilization classes. So we could gather 50 people in a room to explain the policy, to talk about the protocol, to explain how medication would be dispensed for every patient, no doctor will show up. The nurses show up? Yes. And social workers, psychologists, these three usually are the professionals that, you know get more involved with women's issues. (Health provider, doctor)

Respondents offered insights on the barriers to greater participation of medical doctors in Rio in anti-trafficking related work (Table 9.4).

Table 9.4 Challenges Faced by Doctors

Factor	Quote
Type of training	<p><i>Our hypothesis is that our services [that] provide care for these people are not sensitized to understanding this process because of their training which involves an ethics of right and wrong; that is a biomedical training, medicalized training, and interventionist training. (Nurse)</i></p> <p><i>Another [barrier], I think is the professional education in the schools. Violence is not a topic that is a very important topic in the schools. I think that formal education is not preparing professionals to be aware and to work with that. The other [barrier], the technocratic model and the humanistic model. The technocracy: I have to have a diagnosis for pathology.... this is the main importance in the technocratic model. So the mind and body's keep apart. It doesn't matter for the whole thing. This is the way of understanding the health, the body. And the person in society, in [his/her] historical and cultural context, it doesn't matter. (Nurse)</i></p>
Over-crowding	<p><i>The emergency of a general hospital with a line of 30 or 40 people waiting to be assisted and you suffer sexual assault and you get into this hospital to be assisted and it's very difficult. So what we try to do to the general hospital, ask, who could be the professional who would receive these women first? It wouldn't have to be necessarily a doctor. It could be a nurse, it could be a social worker and they could receive if a woman was really hurt. I mean broken legs, broken arms or head concussion, something like that, she would need to see a doctor. But if she had only sexual assault, not other kinds of health problems, she could be assisted by another professional because we don't have many professionals. Usually the emergency hospitals, they are crowded with hundreds of people waiting. (Physician)</i></p> <p><i>You have to have some time to develop this kind of confidence. And then if this woman feels that she can trust me, probably she will tell me something and if I ask about these things that are happening that I can see in their bodies then probably the first time she will lie. She'll say that she fell from the stairs, that something happened, not sexual abuse or violence. But I'm worried for them, so I will bring this woman again for another consultation and then to allow her to feel better to tell me what is happening. So this is a kind of conduction that takes time and the doctors or the professional has to have time and he doesn't want, or they don't want, to spend time with this woman. They have to attend 20 women in 4 hours... so there's no time for listening to these women. (Nurse)</i></p>

Respondents suggested that preconceived notions among health providers about public-health system patients, especially women seeking reproductive care, serve as barriers to health-care provision for this vulnerable population.

Below are some of their insights:

We used to say here that if you are white, ok. If you are black, black or not white, not so well. If you are a woman, worse than if you're not. So, poor, black and woman they have less chance. Officially in Brazil there's no racism... The difference is not only because you are white or black or not white. It's because here, mostly poor people are not white, so these

things are together, it's not because you're black or white, it's because you're poor or you have no money to pay for health insurance, if you have a health plan you can go wherever you want, black or white, it doesn't matter. But here because blacks are the poorest people, they are submitted to the public health system. (Nurse)

But as a result of our social history, we can see that it exists even if it's symbolic, subliminal, it's a symbolic violence. For example, a black woman has the same access to prenatal care, to the health services as a white woman. But if you evaluate how many appointments, access to family planning, a white woman manages to get an appointment for family planning after she's had two children, a black woman will only manage to get it when she's having her fifth child. (Public health researcher and nurse)

When you really look at how classes are divided across Brazil, it's clearly linked to race. But it's almost like this indirect way of being racist really... That kind of goes back to the [public] health-care system where the users are predominantly people who are coming from *favelas*, lower-income settings and the providers are coming from another class, the middle class. And you have that interaction in a society where there's very strong, almost violent, classist beliefs. It doesn't make for very positive interactions. Lower-income [people] come into health services, often there's a whole power dynamic that goes beyond class. When you come in as a patient and the doctor... I mean there's a whole vulnerability and there's a power relationship that could be easily manipulated when you throw in class and all these other prejudices. And then again, when you have lots of these women who are probably most affected by sexual trafficking are from these lower-income settings. So if you already have a context where there's not lots of sympathy, lots of respect and then these women are involved in these kind of very taboo behaviors, networks, context, that of course puts up all the more barriers. (Advocacy Worker/educator)

One physician/public health researcher placed these beliefs into context.

More or less, 75 percent of the population who depend exclusively on the public services and are of the lowest-income class, lowest level of schooling and were also the non-white population – let's put it that way – that is the black and brown population is more represented.... A white, middle-class woman... would seek out another type of service that unfortunately ends up offering more quality than a public service. Despite our having a universal public-health system, in fact the services

are used most or exclusively or regularly by the people with least income... Although we have substantial problems of quality in the private health sector, on average, the middle-class consumer manages to bring another type of pressure to bear, manages to have more choice, more autonomy in choosing her doctor, her hospital, etc.

So discrimination comes in because the subject, the person is poor, a woman, has aborted, has little schooling, she categorizes as 'ignorant'. Their experience is... a very standard approach characterized by lack of privacy of the kind, 'Oh, it's an abortion. That room there.' Generally these women go either to maternity hospitals or to general hospitals, but to the general emergency department, so a waiting room: 'Oh, this one here aborted. You go in that door there.' And the most typical story is that they treat – if it's a maternity – all kinds of births, other obstetric emergency first. That's typical. Even the health professionals themselves criticize this – those who study this criticize the delay in giving care, the lack of privacy, and the intention to expose the woman, as a punitive mechanism. And well, typically, the women do not go through a good physical and laboratory examination, good anamnesis. It's as if there were no need to ask anything of women who have aborted, because they are in sin, they are already wrong, they are illegal... So there's no need for medical anamnesis, nothing. It's not done. People who have analyzed even medical records, no history is taken to see if she's been taking contraceptives, why she decided to interrupt the pregnancy, whether there's a known partner who lives with her who's her lover or her husband....

Opportunities for Local Health System Response to Sex Trafficking

Overall, interview respondents agreed that the health system in Rio de Janeiro, in collaboration with other sectors, could play an important role in the city's anti-violence and anti-trafficking efforts.

Education and Training among Health Trainees and Professionals

Several respondents suggested that health-professional schools should address the issue of violence against women and girls as part of the formal curriculum, and recommended that the Ministry of Health collaborate with the Ministry of Education and the schools to accomplish this goal.

One respondent, a public health researcher, traced the epidemiological history of how violence has become a salient public-health topic in Brazil in support of this recommendation:

So a number of training courses have been given, but when we ask those professionals, 'Well, do you work on this?,' they always say, 'No,' because they don't feel trained. So we have tried to act by investing in the need to, right from the undergraduate level – the courses, training of doctors and nurses and so on – to be picking up this subject and working with those professionals. Because in Brazil, until very recently, we had a profile in our morbid-mortality where the main causes were infectious or parasitic diseases, and our health workers were trained to deal with those problems. But since the 80s, our profile has changed. We have gone through the epidemiological transition, so the new main causes now are degenerative diseases, neoplasms, the circulatory system and so on, and accidents and violence... So they need to start to train professionals to work with these problems, which is something that hasn't been completely incorporated yet.

In addition to changes in the formal curriculum for health-professional trainees, multiple respondents alluded to the need for increased training around issues of violence against women and girls for health providers already in practice. This training would serve not only to increase awareness and provide information on proper treatment and referral for these patients, but also to engender sensitivity towards the issue, overcome any reluctance to engage in the issue, and increase the rates of victim identification and notification to the proper authorities.

I think that health is an important gateway, because when people need a health service they approach the health system, unlike other activities like social assistance and protection and care needs, where they don't approach the public services. In health, we see that people go to the health system to get care. So we regard the health system as an important gateway. Nonetheless, we have still not managed to sensitize health workers to identify and to be sensitive to those issues. So very often they see the care for the physical pathology resulting from the situation of trafficking and sexual exploitation, for example, from that kind of violence and, on that approach, the other issues that are also important end up not be addressed. So it's in that direction that we have been working: partnerships to have those health workers gain that more sensitive, more humanized view of care. We would very much like health professionals to know how to identify these people from their signs and, on that basis, to do specific work not just to cure, but to refer them so that the other services can work to restore their autonomy and self-esteem, so that they can find other paths to solving their problems and their lives. (Federal government official)

Improved Health Care for Victims of all Forms of Violence

Several respondents suggested improving the delivery of healthcare through Brazil's Family Health Program*, *Programa de Saúde da Família* (PSF). One respondent, a medical doctor, explained that budget restrictions have led to decreased funding for Rio de Janeiro's PSF, and as a result, "less than 5 percent" population coverage as compared to São Paulo, where "70 percent of the population are covered." The respondent described this as "a lost opportunity to improve the community health" and further explained the potential preventative role of PSF teams:

If you look at the health family program with its full potential, I would have a health professional who would come into every house of the community and ask about the health problems of the family and how they are and is there anyone pregnant, are you in school and all these different things. The health family program would be a nice start for identification of these situations: violence, malnutrition, teenager pregnancy, you know...

The PSF teams were described as uniquely positioned to be the first line of victim identification, because of their close contact with communities and families. Although one government official admitted there is still much work to be done, the "community health agents" who form part of the PSF health care teams and visit families in their homes, will be receiving teaching materials that offer "some of the conceptual thinking on people trafficking, so that the agents have a broader idea of the problem, as well as specific proposals for how health agents should act." One health provider who had worked with PSF teams in Rio suggested that medical doctors could conduct greater outreach in the communities (e.g., visiting families in their homes), rather than working exclusively in their clinics. The respondent noted that this tendency to remain based at the clinic, also described by a different health provider, has been responsible for creating a system of healthcare within the PSF similar to that seen in any other public health facility – "with long lines of people waiting to be seen" and "appointments for 3 to 4 months later."

The need for greater collaboration between social services and health services emerged as a major theme in the interviews. For example, in addition to forming a network of services, some respondents recommended a system of referral and counter-referral to better assist and protect victims of violence.

* Launched in 1995, the *Programa de Saúde da Família* (PSF) is a government effort to improve primary healthcare by providing a comprehensive range of preventive and curative health-care services delivered by a team composed of 1 doctor, 1 nurse, 2 nurse assistants, and 4-6 community health workers. The team is responsible for the care of all families within a catchment area, usually about 600-1,000 families (about 3,500 people per team). The PSF teams are responsible for conducting health assessments, providing direct assistance, and serving as a gateway to the public health system.

A federal government respondent offered the following perspective:

The Ministry...seeks to harmonize concepts, technical standards, procedures, and the environment where victims are to be received, so that all the work we can offer to benefit these people's health is done in a qualified, balanced manner and brings the health system as a whole to bear on what we call the 'network to address violence.' The way the health system can contribute is to provide care for violence-related health problems, support prevention of disease – mental diseases, STDs, and other diseases connected with exploitation and trafficking – and prepare people always to report cases of violence. In Brazil's health system, it is compulsory for health workers to report violence or suspicion of violence whenever a case is encountered.... The doctor doesn't know how to identify the signs, because he's been trained for another specialty. So what we do is to call on them to acquire other skills, so as to be able to listen, to look differently at the symptoms, so they can be a source of support in addressing this situation.

Finally, respondents who spoke about mental health services argued for more resources in this regard, including an increase in the number of trained mental-health providers. One medical doctor illustrated the existing gap by pointing out that only 4 mental health providers work in a 150-bed hospital with a maternity ward that cares for a large number of infants. A state government official noted that, "Mental health is important to women and children who have been trafficked. I don't know of any work being done, I can't see of any concern over this."

Discussion

This case presents numerous opportunities for the local health system of Rio to intervene in sex trafficking, as well as related practices, such as domestic- and sexual violence and child abuse. The interviews, however, reveal financial and socio-cultural challenges that need to be addressed in order to bring about an effective and rigorous multi-sector response to sex trafficking of women and girls in Rio.

Overall, the issue of sex trafficking is not mainstream among the public in Rio. Issues such as sexual violence, sexual exploitation and prostitution – rather than sex trafficking per se – dominated our interviews. Interestingly, the overwhelming majority of respondents spoke of sex trafficking as a phenomenon existing in the northern regions of Brazil, more so than in Rio. The tendency to perceive sex trafficking as occurring elsewhere (i.e., not in Rio) may be a product of several factors, including: (1) trafficking is a surreptitious activity; (2) while considered by the international community as having a significant sex trafficking problem, Brazil is primarily a source/sending country for sex-trafficked women

and girls; and 3) the fusion of the sex and tourism industries may function as a “camouflage” for sex trafficking.

Brazil has enacted comprehensive legislation for addressing sex trafficking, at least international sex trafficking. While some respondents expressed some points of contention with the legislative language, Brazil’s government has demonstrated a significant commitment to the anti-trafficking effort and to the ‘prevention, protection and prosecution’ approach. The problem emerges when these laws, policies and guidelines must be translated into practice. Our interviews strongly suggested that budget constraints impede adequate on-the-ground responses to violence against women and girls, as well as sex trafficking. These budget constraints, along with current structural limitations in the Rio health-care system, have implications on the health system’s and the individual provider’s ability to respond to the issues of sexual violence and sex trafficking.

Despite these challenges, many respondents believed the local health system had an important role to play in sexual violence prevention and care of victims. This suggests a potential key role for the health system in Rio de Janeiro in prevention and care of trafficked victims without the need to overhaul the entire system of health-care delivery, but rather using the resources that are already in place. The health system should place more resources in prevention activities that identify potential and ongoing situations of trafficking. This would mainly be accomplished by escalating the Family Health Program (PSF) to increase coverage and expanding the mandate of the PSF team to include assessments of the social well-being, not just the medical well-being, of families. Such a mandate would call for an extensive program of competency training for the PSF team members regarding potential indicators of at-risk populations, strategies for brief impromptu interventions, mechanisms for reporting and referral of confirmed victims, as well as ongoing surveillance of evolving situations. This effort should also increase the number of social workers that are recruited to participate in the Family Health Program.

Simply increasing identification of victims or would-be victims is not sufficient though. As suggested by our interviews, barriers to a proper health response are still in play even with increased identification. In order to maximize the benefits of intensive prevention and identification efforts by the Family Health Program, the public health system must be prepared to adequately handle the referrals from PSF teams. To this end, the public health system must be capacitated in the following ways:

- Provide timely, quality healthcare, including mental health services
- Train health providers to engage in supportive, compassionate and non-judgmental interactions with patients
- Increase awareness and recognition of potential indicators of violence and vulnerability

- Empower health providers with the tools to further probe, identify victims and report cases under a veil of confidentiality and protection
- Facilitate referrals for further social services through the implementation of a network system that could be easily coordinated through a social worker so as to free up the health provider at this step

In the case of victims of violence or trafficking referred into the health service through this network system, the goal would also be to provide some counter-referral information back to PSF or other referring service. Ideally, each unit within the network system would ultimately report and submit data to a central organ whose sole purpose would be oversight, coordination and data collection for the system.

Such a deeply-entrenched scheme would be considered pro-active, rather than reactive, and would send the message to victims that they can find supportive services within the health system. Limitations to achieving this high standard of care for vulnerable populations (such as over-crowding of the public health system), however, must be taken into account, and there are several socio-cultural factors that also pose a challenge to this role for the Rio health system.

For one, some of the social determinants of violence against women and girls themselves double as barriers to the health response. For example, gender inequalities that increase the vulnerability of women and girls also surface in patient-health provider interactions and pose a significant challenge to effective provision of care, even during one of their most fragile moments as when experiencing complications of unsafe abortions. As previously noted, one medical doctor described that, "...those who study this criticize the delay in giving care, the lack of privacy, and the intention to expose the woman, as a punitive mechanism." Another determinant that doubles as a barrier is the hyper-sexual role that society imposes on women and girls through various media outlets and cultural traditions. Some women and girls unconsciously accept these expectations, which leave them vulnerable to exploitation. This hyper-sexual image of women and girls was suggested not only to play a role in increasing their vulnerability to sexual violence and sex trafficking creating a cycle not easily broken, but also to undermine their ability to receive quality, non-discriminatory health-care. Again, these interviews have raised questions as to whether such deeply-ingrained socio-cultural challenges can be easily overcome. One respondent argued this change in the cultural mindset could take decades or even centuries to achieve.

Violence is a recognized as a leading cause of death in Brazil, particularly in its major cities. There are municipal-level interventions aimed at address violence that involve health groups.¹⁶⁷ Anti-violence and anti-trafficking interventions require careful planning, and entail more than simply infusing money into the health system or conducting purely technical trainings of health and social providers. Rather, interventions have to be robust and comprehensive enough to overcome many of these

socio-cultural barriers identified in our interviews. It is critical that any and all conceived interventions consider and account for the historical and socio-cultural context in which they are implemented in order to assure programmatic success.

In the case of Rio de Janeiro, the health system stands to play a substantial preventative and interventionist role in the anti-trafficking movement, as part of a broader multi-sector effort. The question that remains unanswered is whether health providers in the public-health system can be the agents of change. Providing quality and compassionate health care to populations that normally have been institutionally marginalized and discriminated against requires a complete change in mindset by those who deliver this care. Such a transformation would ensure that the groups that need it the most, such as the *favela*, street adolescents and sex worker populations, receive the healthcare and social assistance they need.

CHAPTER 10: SEX TRAFFICKING OF WOMEN AND GIRLS IN SALVADOR

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Introduction

Study Setting

In this chapter, we attempt to characterize sex trafficking in Salvador, including the mechanisms through which trafficking occurs and the factors that facilitate this practice; develop an understanding of the current local health system response to sex trafficking; and identify means by which the health system can play a larger role in addressing sex trafficking in Salvador.

Salvador is the third most populous city in Brazil, behind São Paulo and Rio de Janeiro, with nearly 3 million residents.¹⁶⁸ The capital city of the northeastern Brazilian state of Bahia, Salvador was the first colonial capital of Brazil and remained so until 1763, when it was succeeded by Rio de Janeiro as the country's capital. One of the oldest cities in colonial Brazil, Salvador became the country's main seaport and a major center for the transatlantic slave trade. It served as the port of arrival for many of the estimated four million African slaves sent to Brazil. Today, with over 80 percent of the population having black African ancestry, Salvador is considered the epicenter of Afro-Brazilian culture and is the second most popular tourist destination in Brazil. It is connected to major northern and southern Brazilian cities, including Rio de Janeiro via federal highway BR-101 and to the rest of the world via the Deputado Luís Eduardo Magalhães International Airport. The northeast region of Brazil, where Salvador is located, has received attention as an area where sex trafficking reportedly occurs.³⁵

As in our other Brazil case city, Rio de Janeiro, the health-care system in Salvador is mainly public, and comprises several types of health facilities, ranging from municipal general hospitals to health posts. In addition to the *Centro de Pesquisa Gonçalo Moniz*, the Bahia research branch of Fiocruz,* Salvador is also home to the *Instituto de Saúde Coletiva Coletiva* (ISC) at the *Universidade Federal da Bahia* (UFBA), which is nationally recognized for its significant academic contributions to the Brazilian literature in various fields of public health.

* See Rio case chapter introduction for more complete description of Fiocruz.

Summary of Field Work

Fieldwork in Salvador was conducted during a 1-week period in February 2009 just prior to the *Carnival* festivities. Prior to the trip, a list of potential study respondents was generated by contacting social service providers, doctors, advocates and gender studies academics, many of whom were able to refer other colleagues as potential key informants. Respondents included those knowledgeable, not only on the issue of sex trafficking, but also about sexual violence against women, child sexual abuse, sexual exploitation and sex tourism, as well as the local health-care system for women and adolescents.

In total, 16 respondents were interviewed in Salvador including 4 health providers, 2 mental health providers, 1 hospital-based social worker, 3 social service providers, 2 university-based public health researchers, 2 foundation-based researchers, 1 international NGO-based social program director and researcher, and 1 local NGO-based advocate/researcher. Additionally, a group interview comprised of community outreach workers at a hospital-based social service NGO was conducted in a manner similar to a focus group. A total of 13 of those present at the interview were actively and directly engaged in the discussion, and offered the majority of the information elicited.*† An interpreter proficient in Portuguese-English translation was employed to facilitate communication.

During the trip to Salvador, a 1-day visit to Brasilia and a 2-day visit to São Paulo were also carried out to interview respondents at the level of the federal government (two respondents) and researchers who study the phenomenon of sex trafficking from a countrywide perspective (six respondents). The information from these interviews helped set the national context of trafficking.

Characterization of Sex Trafficking in Salvador

Prevalence of Sex Trafficking

While several respondents identified Salvador as one of the main “enticement hubs” for sex trafficking in Brazil, no interview respondents could estimate the local prevalence of sex trafficking. In general, respondents identified both methodological difficulties in identifying victims (fear of retaliation by traffickers or mistrust of the authorities) as well as differences in the definition of sex trafficking.

* We estimate that approximately 25 attended the group interview, but only 13 engaged. Therefore, for purposes of the total number of respondents, we note a total of 29 respondents (13 from the group interview, and 16 individual interviews).

† During this trip, we experienced audio recording difficulties in two interviews. Extensive notes were taken during these interviews.

Respondents that spoke about the definitional differences that hinder victim identification also noted several reasons for these differences and ways in which these are differences are expressed (Table 10.1).

Table 10.1. Respondent Quotes Regarding Definitional Differences

Reasons for:	Ways expressed:
<p><i>Women suffer so much violence at home that when they suffer a less physical violence, they don't recognize themselves as victims. This is particularly true in the poor class, and this is why exploitation of the female body by sex tourism is not recognized by women as a violence, but rather as a love for the Brazilian woman. (NGO respondent)</i></p>	<p><i>The problem is that women who are trafficked abroad as sex workers are not considered as trafficked; they are simply seen as 'prostitutes' and as 'immoral'. This is because of our machista and patriarchal society. What defines trafficking as such are the living and working conditions, not whether she went voluntarily. (NGO respondent)</i></p>
<p><i>A diagnosis of the problem... has been very difficult to establish, to make, because people don't recognize, people don't speak, people don't feel like being [involved]... and the women don't feel they are being trafficking unless they are suffering the effects of trafficking. [sic] The answer is there is a problem, but no one knows how to measure it. (Physician)</i></p>	<p><i>What we see the most is registers of abuse – sexual abuse, so even sexual exploitation is not being registered properly. And trafficking, worse. There is sexual violence and then there is abuse and exploitation and then there is trafficking or prostitution under exploitation, but all cases are being registered as abuse wrongly. (Researcher, referring to a review of police and organizational registries)</i></p>
<p><i>If you say 'trafficking', people will not understand, first because the legislation in Brazil about trafficking is very recent. So, it has not been absorvido [absorbed], it has not been understood yet. The standard answer is, 'There's no trafficking in Bahia. There's no trafficking here. I haven't seen anyone trafficked. I haven't been in contact with anyone who has been trafficked.' It's something of another country, or it's only for children or people who have been abroad. They tend to think that it's international trafficking. And most of the trafficking is actually domestic trafficking, it's internal trafficking, but it's seen as either sexual exploitation or abuse. It's not identified [as sex trafficking]. (Researcher)</i></p>	<p><i>And we are training people to better identify victims and understand the sexual violence categories and collaborating with government's efforts to improve databases and track cases. (Research program director)</i></p>

One NGO researcher observed that, with the exception of the *Centro de Referência Especializado de Assistência Social (CREAS)** in Salvador, which has been able to identify and register a handful of children as victims of sex trafficking, this definitional confusion posed “one of the main challenges” in identification and proper registration. Finally, one NGO respondent pointed out the lack of a central system of data collection, which contributes to the difficulty in estimating prevalence. This respondent noted the underlying difficulty in merging data from various sources: “The health has their data, and social services has their data. The police has a separate set of data.”

Composition

Two respondents described trends in child sex trafficking in the Bahia and the Northeast region. One NGO respondent noted that while some children are taken to other countries like Paraguay and Argentina, most children do not leave the state. The respondent said, “They just go from one city to another in Bahia,” including Salvador, Camaçari and Feira de Santana. This respondent also cited research from the *Universidade de Bahia* noting that trafficking of children occurred in one-third of the Bahian cities included in the study, and that Salvador was prominent among the cities. Another NGO respondent noted that trafficking within the state of Bahia is occurring from the “rural areas to the urban areas.” Referring to this movement as an “internal migration” and to the “sexual exploitation of children” as “one of the worst forms of labor,” this respondent observed, “There are lots of kids coming from the rural areas, ‘interior municipalities,’ as we call them, and they end up here in Salvador, and they end up involved in sexual work.” Additionally, truck and taxi drivers were cited as either recruiters for the traffickers or facilitators in the domestic migration of children and adolescents.

Prefacing their interview with a statement that they see survival sex (but not sex trafficking) in their client population, multiple respondents from an NGO working with at-risk youth agreed that about 98 percent of the population they serve are involved in commercial sex. Girls as young as 9-years-old make up the majority, and many engage in commercial sex for survival under the physical and psychological control of a pimp.

Speaking about international trafficking originating from Salvador, one NGO respondent noted that victims are brought to Salvador from the “interior” of Bahia, where they remain until they are taken out of the country, mostly to Europe. Another NGO provider experienced in working with women victims of international sex trafficking also described trafficking routes between Salvador and Europe. This provider added that Madrid is the major “European port of entry;” women cite Spain as their destination, based on what is

* Reference Center for Specialized Social Assistance, part of the Unified Social Services (SUAS – *Sistema Unico de Assistência Social*), is a government agency under the Ministry of Social Development and Hunger Alleviation that is responsible for providing specialized attention, support, guidance and counseling to individuals and families with one or more of its members in situations of threat or violation of right.

printed on their plane tickets, but many times they are transported long distances by car to other European countries, and “women have no idea where they were located.”

A federal government respondent explained that international trafficking in Brazil is much more common among adult women, while children and adolescents are more likely to fall victim to domestic or internal trafficking. The difficulty of moving children and adolescents through the country’s major international ports without proper documentation was cited as the reason for this phenomenon. According to this official, in some cases of older adolescents, falsified documents are used to facilitate migration to Europe through major ports, such as the Salvador international airport, but for the most part, international trafficking of children and adolescents originates as land-based trafficking, i.e., across Brazil’s borders to neighboring countries such as Suriname, Paraguay, Bolivia and Argentina, where unrestricted movement of people and goods is much easier.

How Women and Girls are Trafficked: Mechanisms

Respondents suggested that the most common tactic used to recruit victims was the promise of a better life – mainly through employment or educational opportunities, but in some cases, through marriages to Europeans.

One NGO respondent described this vulnerability as follows:

You are in a poor situation, right, and then... you are promised a better job, you are promised a better life. And that’s how they end up going, because they are looking for other opportunities. So, even though it’s not a lot of money for us, or for most people, but it is significant when you compare for a minimum wage or for less than a minimum wage. But also the opportunity of going and working in the big city or doing some other type of work in another country. Even sometimes they go expecting to even do some of the work that they do here, like being a domestic worker, and then they’re there and it’s another different type of work. So, this, for Brazilians or for poor community, there... you know, being in a different country, going to a different place, being promised the opportunity... because job here is a question of survival.

A common theme in the recruitment process was the inadvertent involvement of families who, deceived by false promises, actually encouraged the recruitment process. In other words, family members believed “something good” would happen for the girl. A “lack of information” or “understanding of the potential risks” for the victim and the family therefore facilitate the trafficking process. While one NGO respondent described false employment advertisements in the newspapers that turn out to be “traps,” other

respondents described a recruitment process that is mediated by an individual working with the trafficker.

Two main profiles – the smuggler and the trafficker – were most commonly described by respondents. The recruitment process appears to originate with a Brazilian national, someone either known to the victim, or known to a friend or family member of the victim who is assumed to be trustworthy, such as a relative, close family friend, or an individual well-known in the community. One respondent referred to the recruiter as a “smuggler,” noting that a smuggler may be female. This female recruiter may either be married to an intermediate Brazilian smuggler working with the end-destination trafficker or traffickers, or married to the trafficker himself. In other cases, the female recruiter may be a trafficking victim herself; may be under duress or threat to assist in the recruitment of other women from her community; or may be receiving payment for each successful recruit. Nonetheless, the smuggler is in charge of engendering the trust of the victim and her family, getting to know the family’s particular vulnerabilities for potential use at a later date as leverage for threatening a victim who may want to opt out, and making promises that are likely to result in a successful recruitment. On the receiving end is a foreigner, in cases of international trafficking, a Brazilian national who is-most likely a stranger to the victim, in cases of domestic trafficking.

Why Women and Girls Remain Trafficked

Three main profiles of women and girls trafficked to work in the commercial sex industry emerged from our interviews: (1) sex workers seeking higher wages; (2) women and girls who are not sex workers, but are willing to work temporarily in the sex industry in order to earn higher wages; and (3) women and girls who have been deceived with promises of other economic or educational opportunities. According to one respondent, in all three cases, women are not aware of the “dehumanizing, exploitative and deceitful” conditions in which they work until they are already trafficked.

Respondents referred to several factors that contribute to women and girls remaining in their trafficking situations, including: language barriers, confiscation of travel documents, false promises by the trafficker that once victims repay their debt they will be able to keep their earnings, and fear of retaliation against victims and/or their families.

The need to provide financial support for their families may be a factor for keeping victims in trafficking situations. One NGO respondent explained that traffickers may sometimes allow money to be sent home in order to avoid raising suspicion, especially in cases where the recruiter or “smuggler” remains in contact with the victim’s family. This respondent noted that in the case of women who are able to send money home, failure

to do so would be viewed by the family (and children) as “abandonment,” and “this is why women have to accept whatever the trafficker proposes.”

Another NGO respondent working with youth engaged in survival sex explained that girls who migrate from the rural areas of Bahia to Salvador to work as domestic help, then end up in the sex industry. This respondent explained that some of the girls send money to their mothers to assist their families financially and “to justify that they are really working on a decent work [career].” Furthermore, another respondent from the same NGO reported that many victims come from violent homes, and rather than going back to being “mistreated” or “sexually abused,” they exchange sex for money or subsistence needs.

Finally, the women and girls who remain in trafficking scenarios were reported to do so under the threat of physical and psychological violence.

One NGO provider spoke about the control of pimps over adolescent girls:

I met many of the adolescents between 12 and 15 years of age, and they sold themselves in streets where they have many truck drivers and cab drivers. And they had a pimp, a woman or a man, so they had to share their profit with the pimp – they were under their control. If they tried to leave or if they tried to escape this control, they were beaten.

Sex Trafficking: Key Determinants

Due to the definitional and ideological differences discussed earlier, not all respondents spoke specifically about sex trafficking determinants, but they did address the determinants that increase the vulnerability of women and girls to other practices, such as domestic violence, sexual violence, commercial sexual exploitation, sex tourism, and survival sex. These determinants fall into the following categories: (1) contextual factors (macro-society level); (2) situational factors (micro- family and community level); and (3) individual factors (internal).

Contextual Factors

The Brazilian economy, and specifically that of the Northeast region, plays an important role in shaping the factors of vulnerability at the family and community level in Salvador. International and domestic trafficking routes from the Northeast, including those via the Magalhães International Airport and federal highway BR-101, reflect the migration that occurs from this economically disadvantaged area, to more economically prosperous areas in Brazil. The greater proportion of poverty in the Northeast region as compared to the Southern regions is thought to be a remnant of the complex interplay

between the region's history of slavery, the high population density of Afro-Brazilians, and the exodus of non-Africans from this region.

In turn, our interviews suggest that the rise of the sex tourism industry in Brazil in the 1980s facilitated the exploitation of women. Several respondents noted that sex tourism industry exploits Brazilian women by selling the image of the sensual Brazilian or exotic Afro-Brazilian woman; trivializes sex in everyday media and advertisements; and attracts foreign tourists whose intention it is to reap the benefits of this exploitative system.

Respondents offered different insights about this industry:

I was saying that during a period, especially before the '80s, I think that Brazil sold that image, of the Brazilian woman as sensual, different as a way of attracting tourists. And it was only recently, as of the 1990s, that is, about ten years to twenty years ago, that Brazil realized that it was bringing a type of tourist that was coming here with the intention of exploiting women. The tourist industry, for those networks that infiltrate themselves into tourism to broker and make money in that way [exploiting and trafficking], it was a perfect space. (Mental health provider)

This [sex tourism industry] is a model of development that exploits the female body. Being a beautiful Brazilian woman is valuable. On one hand, the Brazilian woman is made to feel beautiful, but she doesn't realize what she is being submitted to. The tourists come looking for exactly that – women who will allow themselves to be exploited and not even realize that this is what is happening to them. This is not [an] accident; the model is geared towards exploitation. (Advocacy worker)

Even prior to the sex tourism boom, respondents noted the existence of profound gender inequalities in Brazilian society. Brazil ranked poorly in a 2005 study comparing countries based on gender inequalities (e.g., on measures such as “economic opportunity” and “educational attainment”).¹⁶⁹ All interview respondents addressed the power differential between Brazilian men and women, noting that women are “submissive” to men, stereotyped into “anonymization” as “mothers” or “reproductive beings,” confined to the domestic sphere of the household, and objectified as bodies of pleasure over which men have property rights.

These power dynamics manifest in violence against women, which was characterized by a mental health provider as being “so banal” that it is not even recognized as violence. Echoing this sentiment, a physician pointed out that domestic violence is considered a

“private matter” in Brazilian society, and that interference is seen as meddling in the business of others.

Women are reportedly reluctant to denounce male perpetrators of gender-based violence for multiple reasons, including: their lack of self-recognition as victims, the instinct to protect the family image, and the fear of losing status in their social circles. One NGO provider described the common situation of a girl who is sexually abused, raped, and/or impregnated by the father or uncle, and then blamed and thrown out on the streets by the mother upon discovering the situation.

One health-care respondent noted that while Brazil’s creation of the Special Secretariat for Women’s Policies was a major achievement for women’s rights, the government and people of Brazil have not yet “put those actions into practice.” Another physician who works with sex trafficked victims said, “Brazilians also believe or have been taught to believe that sexual exploitation is commonplace in humanity. There is a lack of understanding of human rights and that these rights can provide for a better life. Instead, women and girls walk away [from a violent situation] thinking, ‘Well, I’m alive; I’m okay.’”

In addition to gender inequality, several respondents touched on the low value placed on children by Brazilian society, and how that value serves as a permissive factor of vulnerability of children – despite legislative tools like the *Estatuto da Criança e do Adolescente*. According to respondents, tolerance of sexual violence against children and the normalization of sexual relationships between older men and girls as young as 9 to 13-years-old have led to an “adult-centered society” in which “children are worth very little” and girls embark on a “process of vulnerability” from a very early age.

Respondents offered many supporting examples: auctioning virgin girls to the highest bidder for the right to her first sexual encounter, the selling of children as young as eight years old who are then trafficked for sexual purposes, the sexual abuse of children as young as one year old that require medical attention for injuries sustained from the abuse, and the diagnosis of HIV in children as young as six years of age that have a history of sexual abuse and/or exploitation.

One health-care provider working with an NGO that serves adolescents engaging in survival sex illustrated the power disparity between pimps and girls:

So if she wants to go away, sometimes they beat this girl, but it’s not very strong control. It’s not a slave or something like that. Sometimes in our culture, the person [pimp] it’s a ‘good father’ or ‘good mother’ – it’s a protection to them because they are very young when they came to the streets in not so great condition who needs someone that occupies the place of the father or the mother. They got money off these girls, but they provide protection to them.

Situational Factors

Family dysfunction, unsafe homes, sub-standard living conditions, history of sexual abuse or rape by a family member, or sexual exploitation in communities were identified by respondents as important determinants for commercial sexual exploitation, or sex trafficking.

One NGO respondent provided an example of these situational determinants:

Their families are generally families where the parent is either an absent person or an abuser; so the children, most of them have been abused when they were children. They are abused, and sometimes they were also already in sexual exploitation in this original community. So, all this sexual violence makes them also more vulnerable to trafficking. Their home is not a safe place or a reasonable place where you can have at least food and a bed to sleep. There is either domestic violence in the home and also the families are torn apart and there are problems of alcohol, all kinds of things.

Furthermore, the age at which individuals have children (“teenagers or 20 years at maximum”), parental unemployment, parental involvement with alcohol and drugs, and lack of basic community services were identified by respondents as increasing the risk of the children and adolescents becoming victims of domestic/familial violence, and, some respondents argued, sex trafficking.

Individual Factors

Respondents noted that many women and girls view foreign life as exciting and high status. Respondent comments, such as; “there is a perception among Brazilians that everything outside of Brazil is better;” “women think that is something that is better than marrying Brazilian;” and “[girls’] strong desire for a better quality of life” exemplify these attitudes, which in turn facilitate traffickers’ recruitment of these girls.

Also, multiple respondents made a connection between Afro-descendants and poverty in the Northeast, pointing out that the majority of women and girl victims of sexual violence, and women and girls sex trafficked or engaged in the commercial sex industry, come from this impoverished population. These observations are in line with estimates that 70 percent of women and adolescent victims are of African descent.¹⁷⁰

Another theme in the interviews was that women and girls, due to the gender inequalities described earlier, experience guilt, shame, and low self-esteem, which contribute to vulnerability at the individual level. As part of a psychological defense mechanism, their long-term experiences of abuse and violence harden these women and girls to the point

that they, according to a respondent, “don’t see themselves as victims” anymore. As one mental health provider explained, “Because of prolonged maltreatment, there comes a time when these children and adolescents become desensitized and they no longer protect themselves. They don’t care anymore to escape the vicious cycle of victimization and they give in to the situation of sexual violence, sex traffic, and so on.”

Furthermore, the socially-accepted view of sensuality and eroticism of the Brazilian woman was reported to play into the low self-esteem of women and girls. This complex web of psychosocial factors allows women and girls to accept and adopt the idea that they are valued and empowered by the sex tourism industry. As explained by a health provider, “The need for valorization by society as a woman who is beautiful and can offer joy and pleasure” is a strong incentive for women and girls with low self-esteem. The sex tourism industry offers these vulnerable women and girls the sense of being “elevated from non-value to value, and there it falls into the idea of the dream.”

In particular, the Afro-Brazilian woman and girl were reported to be particularly vulnerable to this. One social service provider described one of their programs designed to empower Afro-Brazilian youth:

And so they talk about vulnerability factors such as poverty, and myth that talks about Black women and women from Bahia from Brazil; there is a whole myth around this woman, [this] profile. [They talk about] this very hot Black woman with a critical, a very critical understanding of the whole issue and how Brazil shows itself to the foreigners and to abroad using the image of Black women to attract tourism.

Respondents noted that these factors leave Afro-Bahian women and girls particularly at risk. One NGO respondent noted, “Women who tend to be trafficked are Afro-descendants and are the poor underclass with little access to legal support.” Discussing a sample group of trafficked adolescents, another NGO respondent noted, “The majority are black, Afro-Bahian with poor education – they stopped in primary school, at some point.”

On the latter point, respondents affirmed the role of lack of education (“most had stopped before the fourth grade”) as a salient factor in increased vulnerability among girls in the area. The reasons why girls drop out of school include; the need for these children and adolescents to assist in generating income, as well as the lack of information regarding the potential risks in migrating for employment and “safe migration options.” Such factors, said respondents, may lead to a “precarious socioeconomic situation” in the Northeast and “a situation where survival is very difficult” and vulnerability increases.

A social service provider summarized this complex interplay of determinants at different levels:

This population has no access to quality education, to health assistance of quality. They do not have a good livelihood in their community, within their families either. These vulnerabilities are individual when this adolescent, when they're not using a condom in the case of sexual relation, but it could also be social vulnerability when they do not have access to these quality services; and it can also be institutional vulnerability when there are no public policies within a structural support to really attend to the different kinds of vulnerabilities that they have to face. It's a set of vulnerabilities that makes up the picture of this adolescent or child to become a victim of sexual tourism or sexual exploitation or sexual commerce or even sexual trafficking.

Existing Responses to Sex Trafficking in Salvador

Health Consequences of Sex Trafficking

While many respondents were not comfortable addressing the health consequences specific to sex trafficking, they commented on the health implications of domestic violence, sexual violence, sexual exploitation, commercial sexual exploitation, sex tourism, survival sex, and prostitution. Among the most frequently cited health sequelae were: sexually transmitted diseases (including HIV), psychological trauma resulting in guilt, shame and low self-esteem, pregnancy and unsafe abortions, drug addictions; injuries resulting from physical violence (fractures); and wounds resulting from sexual violence.

Victim Identification

Currently, victim identification was not reported to be carried out systematically within the health-care system of Salvador. The process that leads to identification of any victim of sexual violence, including trafficking victims, functions through the DEAM*, Tutelary Councils†, CEDECA-BA‡, CREAS* and DERCA.† Most victim identifications are initiated

* *Delegacia de Atendimento a Mulher* (DEAM) – specialized police stations for addressing violence against women.

† *Conselhos Tutelares de Salvador* – Tutelary Councils are child protection agencies responsible for protecting the rights of children and adolescents and enforcing the 1990 Statute for Children and Adolescents.

‡ *Centro de Defesa da Criança e do Adolescente Yves de Roussan* – non-governmental agency founded in 1991 that provides legal and psychotherapeutic assistance to child and adolescent victims of sexual abuse and exploitation. It is ECPAT's official representative in Brazil since 1997.

initiated by the victim herself or the victim's family, who presents to the agency seeking assistance. Once the victim presents to one of the above agencies, an investigation is opened, and any necessary services or measures of support are provided. Part of this service is a referral to obtain a medico-legal examination at the office of the coroner in Salvador. Respondents reported that for victims requiring more specialized medical attention, referrals are made to one of the hospitals or clinics collaborating with the network of services for victims of violence to provide comprehensive care.

Victim identification, when it does occur within the health system, is more likely to occur in the pediatric population, because medical providers are mandated to adhere to a system of reporting for suspected cases of violence against children. Despite this mandate, respondents stated that it is "rare" or "sporadic" that the health-care system successfully identifies and/or provides a referral to the available social services. By and large, respondents agreed that the process of screening and identification is not always happening as it should, and that little is being done to correct this problem. Although legislation exists to impose a penalty for failure to report, no system is believed into be in place to enforce this mandate on negligent health-care providers.

Two respondents articulated the problems with victim identification among children:

[T]here is a protocol - like if you identify that that person has been through sexual violence, you have to report it, but that...doesn't happen. That is one of the black corners, you know, one of the gaps. (NGO respondent)

Look, sincerely, the health centers are not sending children or adolescents, because there is a specialized police station. It's the tutelary councils, the specialized police stations that handle these situations more. It's not the health centers. It's the specialized police stations, public prosecutors, the juvenile courts... and it's not the health centers. They [the children] get to the specialized police stations through the family itself, the neighbors, and the tutelary council, they know... and the council members. The specialized police station, DERCA – a specialized police station for children and adolescents. They come here for protection of their violated rights, so it's not medicine that sends them. Here we can send them there, but unlikely [the reverse] – only when it happens in providing care. That they said before... when they identify and then they

* *Centro de Referência Especializado de Assistência Social (CREAS)* – provides specialized attention, support, guidance and counseling to individuals and families with one or more of its members in situations of threat or violation of right.

† *Delegacia Especial de Repressão a crimes contra a Criança e Adolescente (DERCA)* – specialized police stations for addressing crimes against children and adolescents.

send, but I don't have it recorded... it's sporadic. It's one of those things that isn't constant. (Social service provider)

Health Services for Sex Trafficking Victims in Salvador

According to our interview respondents, health services specifically for women and girl victims of trafficking are non-existent in Salvador. There are currently no medical facilities or clinics dedicated to serving sex-trafficking victims. However, a small number of health units (maternity hospitals, pediatric hospitals, adolescent health clinics and CAPS^{*}) are used by the NGO and government-run social services. These health service units receive victims identified through the above mentioned agencies – DEAM, Tutelary Councils, CEDECA-BA, CREAS, and DERCA – and subsequently refer those clients that require medical attention to one of the health units. These health units are considered to be collaborating with the network of social services, but they are not a part of the network. These referral health units are chosen based on the staff's willingness to attend to this underserved population and to participate in education and trainings on the subject. Some of these medical units have their own internal awareness-raising activities, while others rely on NGO providers to plan and execute these awareness-raising activities.

For women and girl victims of violence and trafficking who fail to present to any of the above social service gatekeepers, but instead present directly to the health system, the portal of entry is the same as for any other health-care patient in Salvador. These women and girls are more likely to present with their complaints directly to a public health clinic or the emergency ward of a public hospital. At that point, a woman may choose to identify herself as a victim of violence and/or trafficking – or not. Even if victims do identify themselves, one mental health respondent argued that difficulties remain: “In practice, we have lots of gaps. Among them for us to manage, to qualify, to notify correctly a situation of trafficking for sexual purposes involving children and adolescents – our legislation doesn't provide for that.”

Barriers to Identification and Health System Response for Sex-Trafficked Women and Girls

The interviews suggest that identification of victims of sexual violence rarely occurs in the health-care system. The reasons behind the medical community's lack of victim identification are myriad, according to respondents: (1) the medical community's failure to “recognize violence as a health problem” deserving of their immediate attention; (2) low level of awareness regarding sex trafficking; (3) lack of training; and (4) deeply-rooted socio-cultural attitudes toward sex and gender-based violence.

^{*} *Centro de Atenção Psicossocial (CAPS)* – under the Municipal Secretary of Health (*SMS – Secretaria Municipal de Saúde*), the centers around the city of Salvador are intended to provide psychosocial services for mental health.

According to our interviews, a disinterest among physicians in Salvador in addressing issues that are not directly related to a medical condition represents an attitudinal barrier to victim identification and provision of health services. Physicians' technical or pathophysiological approach to health and the practice of medicine appears to stem from Brazil's system of medical education and training. This mind-set, in turn, likely hampers the ability of the medical community to recognize and accept interpersonal violence as a public health matter that merits their immediate attention or intervention. Overall, respondents echoed the sentiment that health professionals are "prepared to make a very precise and specific diagnosis in order to medicate the person. But violence has no specific or precise diagnosis... the doctors will treat those wounds [resulting from the violence], but they do not know how to treat the other parts of the wound that are related to violence or to all kinds of abuses."

Even at a hospital attending to a large pediatric population of victims of physical and sexual violence, a physician respondent acknowledged that the hospital's list of screening questions does not ask about whether the child or adolescent was subjected to any form of sexual violence, other than domestic child sexual abuse. Hence, children that may be subjected to sexual exploitation, commercial sexual exploitation, or trafficking remain largely undetected. Furthermore, this physician thought that the likelihood that health professionals at other hospitals are actually asking about any sort of abuse is quite low. A low level of awareness among health providers was stressed by multiple NGO providers.

The consequences of a lack of systematic training for health professionals around identification and treatment of sexual violence and sex trafficking victims was summarized by one respondent:

The whole issue of violence is very much pushed under the carpet and health workers, health professionals on the whole, even if they suspect something, they are often... they don't know where to refer the women, they would rather not deal with the issue. The same I think may be with prostitution. (Gender studies academic professional)

This respondent also noted that Brazilian health professionals are not immune to socio-cultural norms that tolerate or fail to recognize violence against women and girls as an important issue. In fact, advocates of women's rights in health care note that, due to the powerful political position enjoyed by physicians in Brazil—the membership of doctors is traditionally viewed as "a conservative group" – advocates' efforts to promote women's rights in healthcare have been hampered.

Many NGOs working to raise awareness and provide training on sexual violence against adolescents among health-care professionals explained that they have been unable to engage physicians, because, as one respondent said, doctors "are not available to work

with adolescents or work on their relationships,” or claim they do not have the time to attend trainings. In fact, some NGO respondents noted that most training attendees are social workers, psychologists, and nurses, who were described as “very available and sensitive to the adolescent’s situation” and “really engaged in the whole issue of sexual violence.”

One physician noted that some efforts to teach medical students how to interact and treat child and adolescent victims of violence have been successful. By immersing these trainees during their formative years in clerkships or rotations during which a high proportion of their patient load is comprised of victims of physical and sexual violence, these trainees are sensitized to these issues and learn how to deal with the health of their patients using a more holistic, rather than technical, approach.

Another cited barrier to physicians assisting women and girl victims of violence is their fear of retaliation by the perpetrators of violence. One NGO provider whose client population is comprised mostly of women and girl victims of violence explained that health professionals working in high-risk area health posts fear getting caught up “in the whole chain of violence.” This fear is further validated by their belief that perpetrators of sexual violence and exploitation against women and girls are often involved in drug-trafficking mafias, or have other legal problems. A physician coordinating a project that aimed to strengthen the services network and social opposition to child and adolescent sex abuse and exploitation further expounds that “they do not want to become involved because then they have to denounce and this is, one, too much trouble, and two, they fear the immediate retaliation. Health professionals are not trained to consider that violence or sex trafficking are health problems and they – in general – are afraid of being involved..”

Beyond fear for personal safety, our interviews identified other attitudinal barriers among health professionals against certain patient populations (e.g., women and girls presenting with sexual and/or reproductive health issues, poor people). For example, one NGO respondent explained that “typically, medical professionals are the elite class and don’t want to be bothered with this problem of the poor – this is irrelevant in the face of other health problems in Brazil.”

This attitude toward “problems of the poor” among doctors was confirmed by a physician respondent who described the profession’s reluctance to get involved in the following way:

That's the point I wanted to get to: but even at this hospital, undergraduate students can have this discussion – a minor discussion, but it is among what they discuss – and people from the day-hospital and nursing sometimes take part in these discussions with them. But here it's also an area of internship in postgraduate and specialization studies in

gynecology and obstetrics. And doctors who have already qualified and who are doing that specialization, they are terrified of getting involved in this. They keep a strict distance from this issue; they don't want to be part of this story. And this is reinforced by most of the tutors and professors who are teaching or supervising. I would like this to be... I would like to think that this was something unconscious, but, for some, I'm certain that it's conscious.

These negative health professionals' attitudes have consequences on women and girls' health-seeking behaviors. For example, adolescent girls engaging in survival sex on the streets of Salvador reportedly prefer either not to seek medical attention, or do not reveal what they do, because, as respondents noted, "they are mistreated" and "they are not seen as victims."

Furthermore, a physician and mental health provider described the "power relations" that are reinforced in the health system between health professionals and their patients as a form of institutional violence. One respondent noted some health professionals "belittling" and "disqualifying" female patients, as well as possessing negative attitudes toward "badly behaved" pregnant adolescents or adolescents with sexually transmitted diseases.

An illustrative example from a mental health provider follows:

Well, in the case of a maternity unit, for instance, where the woman arrives pregnant, showing that she had sex. It's something that you shouldn't do, it's something prohibited. A mark that there has been sex and so she comes and she feels pain and when she cries out in labor, people ignore her. They tell her not to yell, say that she's exaggerating. If she's an adolescent, they say things to her like, 'When it was time to have sex, you didn't call out for your mother. Why, now that it's time to give birth, are you calling for your mother?' What else? Women who are aborting are treated with difficulty, because 'at the time you did it you didn't think, but now you are in pain from aborting you'll have to put up with it.' And then force her to do family planning. That's another kind of violence for her own good. These are good evidence of violence that is an institutionalized violence.

Finally, a number of respondents suggested that negative attitudes on the part of health professionals are even harsher towards Afro-Brazilian women and girls.

Opportunities for Local Health-System Response to Sex Trafficking

The overwhelming majority of interview respondents, both health and non-health, were in agreement that the health-care system has an important role to play in Salvador's anti-trafficking efforts. Given the current state of health-care for women and girl victims of violence, there was a strong collective sense among respondents that there exists yet untapped opportunities for the health sector to become involved in anti-trafficking efforts. In the course of research, one NGO provider found that health-care is the service most frequently accessed by trafficked children and adolescents: "So this was one of the first findings that brought to us that these services are very important, that they should be used somehow to either prevent or identify victims."

Education and Training among Health Trainees and Professionals

Respondents agreed that a greater level of awareness among health professionals was needed in order to adequately address the health aspects of sex trafficking. Providing education and training should not be restricted to sex trafficking, but rather should encompass other related forms of violence, such as sexual abuse and exploitation of children and adolescents, physical and sexual violence against women, sex tourism, and prostitution. Some respondents felt that this type of training should aim to directly engage health professionals in anti-trafficking efforts by providing them with the knowledge and tools needed to identify and/or refer victims of violence to NGO and government-run social services.

We're working with different - for this reason - with different professionals from different areas: social workers, psychologists, police, also health workers, too. The ideal would be to give specialized trainings to each one of these so they could identify and know what to do and where to refer the victims. And I think this public [audience] from the health service has been very poorly focused in most of the trainings that have been done in trafficking at least in Brazil. There has been a lot of work as you know with the police. With social workers and psychologists, there has been some work too, but I think the health services... at least this is what we have found also in the research; that we couldn't get information from them because they don't see the problem, so they are not able to identify the situation yet. (NGO respondent)

Others believed that this education and awareness-raising should simply aim to counteract the discriminatory attitudes among health professionals, and thereby improve the quality of health care for this marginalized population, particularly when individuals are referred to medical facilities by social service agencies. Several respondents maintained that this would also serve to increase the number of hospitals and clinics that could collaborate or be affiliated with the network of social services in Salvador.

What we really expect from these professionals is to raise the awareness; to make them more sensitive toward these situations that these adolescents have to face; to see if they can move forward to be more sensitive to when they are in the situation of taking care of an adolescent who is coming with such a picture. (NGO provider)

Numerous respondents alluded to the disinterest among physicians for this type of training. As a result, many recommended focusing efforts to increase and streamline the education and training available to those health professionals that have already shown an interest, such as psychologists, social workers, and nurses. However, two respondents suggested that a way to educate physicians on the psychosocial aspects of these important issues is to target them during their medical training, rather than trying to engage them once they are in practice. An approach that targets doctors in training would not only involve classroom discussions and multidisciplinary group discussions during clinical rotations if and when the occasion arises, but as suggested, could also involve an entire, dedicated clinical rotation in a hospital or clinic with a known propensity to care for these vulnerable populations. Discussions on the psychosocial aspects of caring for these patients would become part of their everyday rounding discussions for many, if not the majority, of their patient load.

Improved Health-Care Services for Victims of all Forms of Sexual Violence and Exploitation

For the most part, respondents recommended increasing health-care services for women and girl victims of violence in general as a way of indirectly improving the health of trafficking victims. However, none of the respondents suggested creating specialized units for these vulnerable populations; the implication was that such services should be integrated into existing hospital and clinic systems.

Despite the opening of various CAPS in Salvador by the Municipal Secretary of Health, the need for increased mental health services resounded as a theme among health and non-health respondents alike. Recognizing that many women and girl victims of trafficking are first victims of violence and abuse in their homes, the need to “strengthen self-esteem and identity” and to assist vulnerable women and girls in finding the “valuable in themselves” was suggested as a preventative strategy.

According to respondents, helping to lift the veil of guilt, shame, and stigma through adequate psychological care would allow these women and girls to regain access to “self-protection factors” that would ultimately reduce their vulnerability to repeatedly “going through these situations of violence” that put them at risk of trafficking. Increased access to mental health services was also suggested for women and girls initially surfacing from a trafficked situation in order to minimize their risk of being re-trafficked as well as to facilitate the recovery process that can ultimately lead to healing.

It's very hard for us who are working to provide care for those victims to work on that point, because they say that we are destroying their dreams, their great dreams. They don't see themselves as victims. We are seen that way to begin with [as destroying their dreams], but after a time of reflection, then they perceive that they really are victims and can change the course of that – they have opportunities to change that trajectory. (Psychologist)

Strengthened Policies around Reporting and Data Collection Mechanisms for Sex Trafficking

Several respondents recommended greater use of the reporting mechanism by health professionals, particularly in incidents that involve violence against children and adolescents. Respondents argued that this system of mandatory reporting, and therefore data collection, is currently not working in the health system. One physician working with adolescents engaged in survival sex commented on the large number of policies in place stating, “We do have them on paper, but they are not implemented the way they should.”

Once these mechanisms of reporting are better enforced, respondents speculated that the authorities could then have the opportunity to investigate these possible cases of sexual violence, sexual exploitation, and sex trafficking, and hence increase the overall rate of victim identification and assistance.

Framing the Issue from a Public Health Standpoint

Although advocates have long addressed violence as a public health issue, the Brazilian medical community as a whole has yet to adopt the issue, except as it concerns treating physical symptoms of violence. The majority of respondents felt that sex trafficking and related forms of sexual exploitation and violence should be addressed by the medical community, as an issue of public-health significance.

As one physician noted,

When I say it's a health problem, I meant the health system. It's not a problem of doctors, psychologists, nurses, social workers: it's a public health problem, a problem that involves government policies – or better, which involves policy of State, because with government policy, governments change and the policies change. The problem has to be addressed as a public health problem, where it is necessary that the State be involved, and the State... the constitution of the country – constitution, as is the case here in Brazil – that it be framed as a problem of the population, in the same way as hunger, the lack of education, unemployment, so as the country recognizes, the State recognizes, that the problem of violence is involved with all this.

Discussion

According to the 2003 U.S. Bureau of International Labor Affairs (ILAB) report on Brazil, child labor is more prevalent in northeastern Brazil than in any other region. Children are victims of internal trafficking networks that transport them to tourist areas for the purpose of commercial sexual exploitation.¹⁷¹

The 2008 ILAB report on the Worst Forms of Child Labor describes the situation in Brazil as follows:

Children are engaged in commercial sexual exploitation, pornography, and drug trafficking. Trafficking in children is a problem. Girls are trafficked domestically and internationally for commercial sexual exploitation. Child sex tourism is a problem, which often involves a ring of travel agents, hotel workers, taxi drivers, and traffickers. Children are sexually exploited by foreign pedophiles, mostly from Europe and North America.¹⁷¹

These findings have also been corroborated by the national landmark 2001/2002 PESTRAF study coordinated by the Center of Reference, Studies, and Actions for Children and Adolescents (CECRIA), which reported that exploitation networks were active in all regions of Brazil, with the largest concentration of them in the north and northeast regions of the country. This study also found that most of the victims of trafficking are women and girls between 15- and 25-years of age, with the group most affected being girls between 15- and 17-years-old.¹⁷²

Despite Brazil's relatively comprehensive set of federal laws and policies to combat the various forms of human trafficking, the understanding of sex trafficking by greater society appears to be in its infancy. While this broadens the opportunities for potential interventions, it also presents a major challenge in identifying the most strategic levers for intervening.

Overall, this case suggests several ways in which Salvador can address sex trafficking. As described earlier, part of the challenge is addressing the larger issue of violence against women in Salvador. While the many government agencies, social services, and policies that are in place to assist these vulnerable populations clearly indicate that the government has prioritized addressing violence against women and children in Salvador, changing societal views about violence will take considerable work. For example, laws and policies on domestic violence must be enforced and implemented. One gender studies academic argued that although the Maria de la Pena law is "in the books, there is a lot that's still lacking for it to actually work properly. For example, they have to set up a particular tribunal and a justice system." Similarly, one NGO respondent with extensive knowledge and international experience in sex trafficking of

women and girls commented on the overall strategy adopted by Brazil and individual states, such as Bahia: “Brazil has no public policy specifically geared toward trafficking – we elaborated a National Plan to Combat Human Trafficking, but there are no resources to implement on the ground.”

The potential health-system role in addressing sex trafficking is significant. Given the alarming links between in some countries between sex trafficking and HIV,^{142, 143} sex trafficking is clearly a public health concern. However, in Salvador, the effectiveness of any strategy that addresses sex trafficking, other forms of sexual exploitation, and violence as public health issues must be mindful of health-professionals’ current attitudes towards victims. In particular, the health system needs all health professionals, especially physicians, to take leadership on these issues. The health professional’s ability to establish an inviting, supportive, and non-judgmental rapport with patients can serve as a strong initial step to disrupting the cycle of violence in a woman’s life. If in every human interaction, the woman or girl is violated, be it physically, sexually, verbally, or emotionally, then she is likely to internalize this state of being as normal. However, if in their interactions with health professionals, particularly male health professionals, women and girls are made to feel that they are deserving of respect and compassion, then perhaps this may be the first of the many stepping stones she will need to break the cycle of violence. Health professionals must examine their own personal biases and lack of understanding of these issues; these topics have been covered in many studies in the Brazilian health literature.¹⁷³⁻¹⁷⁵

Health professionals in training (e.g., medical students) may be good audiences for trainings on these important social issues. For example, an approach that targets physicians early on in their training to address these more complex psychosocial aspects of delivering compassionate and “humanistic” patient care could eventually lead to an overall change in mindset. This change in mindset could give rise to opportunities for these health professionals to engage in anti-trafficking activity in the future.

CHAPTER 11: CONCLUSIONS

A principal goal of these case studies was to extract rich, textural data about sex trafficking in eight cities/metropolitan areas of the world where trafficking is reported to occur. In this chapter, we summarize cross-case findings as well as key differences among the case studies; relate these findings to existing theories on sex trafficking; and translate these findings into action recommendations for local health systems and the anti-trafficking field.

Taken together, our cases acknowledge the complexity of sex trafficking in local communities worldwide—its root causes, myriad stakeholders, and lack of a singular “silver bullet” to end this practice. Applying a broad health lens to sex trafficking in these cities allowed our research teams to take a multi-disciplinary view on the issue, and to propose how local health systems can contribute to future anti-trafficking efforts. We interviewed over 270 individuals knowledgeable about sex trafficking in the eight case sites, and have drawn primarily from these interviews to generate conclusions and recommendations.

This study sought to address three questions:

- How can a public-health lens characterize the underlying conditions that permit and foster sex trafficking of women and girls?
- How can local health systems directly intervene in order to assist sex-trafficked women and girls?
- How can health systems contribute to multi-sector strategies for ending sex trafficking of women and girls?

Overall, the case studies suggest that factors at multiple levels (i.e., at the individual, family, community, and societal) work in concert to create conditions that are favorable to the sex-trafficking of women and girls. The cases also reveal that local health systems currently play a minor role in addressing these cities’ sex-trafficking problems, due to various barriers. Assuming such barriers can be lowered or removed, the cases strongly suggest that local health systems can play significant roles in cities’ anti-trafficking activities as partners in identification, treatment, and prevention.

The remainder of this chapter expands on these points.

Five Key Cross-Case Findings

We array the cross-case findings along the following domains: (1) characterization of sex trafficking and its determinants; and (2) current health system role in addressing sex trafficking as well as barriers to a more effective response. The third research question is subsequently addressed in the “Recommendations” section of this chapter.

Characterization of Sex Trafficking and Determinants

1. Difficulty Assessing the Magnitude of Sex Trafficking

The cases indicate that sex trafficking is prevalent in each of the eight areas studied. How prevalent, though, is exceedingly difficult to determine. By and large, respondents could not provide reliable estimates of either incidence or prevalence. Profound definitional and methodological challenges impede accurate estimation. Inconsistent definitions are compounded by victims’ lack of self-identification, fear about the consequences of disclosure, and lack of viable options once rescued.

Vociferous definitional debate was magnified by the fuzzy boundaries among sex trafficking, sex work, and prostitution. Specifically, anti-prostitution and pro-sex worker rights groups disagree, and, for the most part, maintain opposing positions on definitions, prevalence, intervention and prevention. Therefore, other than child prostitution, which most respondents in the cases agreed was a form of trafficking, the interviews found little common ground from which definitions of sex trafficking, and thus basic epidemiologic surveillance, could be developed.

Compounding the difficulties in definition and epidemiology, some respondents objected to the use of the term “sex trafficking” as a solo category of human trafficking, noting that many women and girls are also sexually exploited in labor-trafficking situations. Therefore, using the term “sex trafficking” may under-count the true number of women and girls who are exploited for sexual purposes or with sexualized results.

Finally, respondents in some cities used terms other than “sex trafficking” (e.g., “sexual exploitation,” “survival sex”) to describe local phenomena.

Victims’ reluctance to self-identify also could result in the under-estimation of prevalence, and this emerged as a major theme across the eight sites. Whether due to fear of their traffickers, police or immigration authorities, shame, denial, brainwashing, or simply lack of awareness, trafficking victims often cannot or do not come forward to authorities. Quoting a doctor in the Kolkata case, “So, even if they are fifteen years old, if you ask them, they will go, ‘My age is eighteen or nineteen.’”

2. Sex Trafficking as Homogeneous as well as Heterogeneous Processes

The case studies reveal both homogeneity and heterogeneity in processes related to trafficking. Heterogeneity arises in the mechanisms of trafficking. From city to city, women and girls are recruited in many different ways; traffickers operate different types of criminal enterprises; as a result, the cast of co-conspirators in the recruitment and retention of victims varies. The traffickers themselves were a mixed lot. For example, in the three developed-country port cities (New York, Los Angeles, London), domestic traffickers are typically male and known as a "boyfriend" or "lover boy." This individual typically seduces young girls, first earning their trust over a period of time, and eventually entraps them in commercial sexual exploitation by the use of tactics of physical and psychological coercion. In the India domestic-trafficking cases, by contrast, women play major roles in victim recruitment, as local village intermediaries or as brothel managers. In Manila, a "mother hen" help arrange transport of victims.

Homogeneity arises in the nature of the psychological, social and economic processes of trafficking. In all of the cases, "false promises" of better economic opportunities for women and girls were a predominant theme. In many of the cities, family members of victims or neighborhood acquaintances act as co-conspirators in trafficking with degrees of support that range from vague awareness to active complicity. In all of the cases, the trafficked individual becomes complicit over time in her own involvement in prostitution out of a sense of obligation to send money back to the family, or through psychological processes of dissociation and of affiliation with a peer group or hierarchy. All of these phenomena are manifestations of maladaptive coping strategies. As girls and women in prostitution seek to cope by normalizing their dissociation, over time they become unwitting agents in the perpetuation of their new "status quo."

The social systems in which trafficked women and girls become embedded occasionally provide them with enough personal security and wealth to engender their own active complicity as traffickers. More often, however, trafficking victims are beaten, intimidated and impoverished to the point where they lack the emotional, financial, and physical resources to escape. Inter-relationships between illicit drugs and trafficking were pervasive in the cases we studied. The Los Angeles and Rio cases suggest that sex-trafficking schemes are closely linked with drug- trafficking rings. In Manila, business networks of "headhunters," "canvassers," and other trafficking "specialists" participate in organized trafficking schemes. Truck drivers, taxi drivers, bar and massage parlor owners, are among the many co-conspirators in sex trafficking activities in the case study cities. These associates comb rural villages for new victims; sort out transportation logistics for victims, within and across borders; and collude with corrupt law enforcement officers to evade detection.

Members of the medical community can be complicit in supporting the sex trafficking "industry." In Mumbai, for example, private physicians or quacks who work directly for

brothel owners (and, to maintain access in order to provide health-care services, fail to intervene to release or rescue victims) are complicit in this activity.

The cases also provide insights into the political economy of sex trafficking. The level of organization and fluidity required to carry out these activities is substantial. The model that emphasizes brothels and transactions -- money paid to a single pimp or a madam running an urban brothel in exchange for a single sexual encounter for an individual client -- is incomplete. Brothels and client transactions are just the tip of the iceberg in trafficking and prostitution. The traditional "model" of a pimp controlling a few women engaged in street-based prostitution still exists; overall, however, the business processes underlying trafficking in the case study cities are much more sophisticated than historical models of prostitution suggest. The true underlying business systems of prostitution may involve long, intertwined, carefully managed schemes that take place at many locations and with extensive cash outlays that occur over a long period. Up-front expenditures are construed as investments that will generate rich returns once prostitutes begin to generate revenue as domestic workers, street or brothel-based prostitutes, enslaved mistresses, or conduits for facilitating drug distribution.

Traffickers' communication and mobility appear to play significant roles in the dispersion of prostitution, which suggests that organized decisions are made about geographic diversification from core urban centers. The central coordinators in prostitution and/or trafficking rings are expert at using geographic diversification to evade detection. Reports of the sex-trafficking trade moving outward from central Mumbai to neighboring cities, such as Pune, attest to this phenomenon. As a result, the task of locating trafficking victims and of identifying the places where prostitution is organized is becoming increasingly difficult.

3. Key Determinants of Sex Trafficking: A Multi-level Explanation

Collectively, the eight cases suggest that there are multiple key determinants of sex trafficking of women and girls, including poverty, gender inequality, inadequate education, desire to find economic opportunities, and demand for paid sex, among others. These determinants, arrayed by social-ecological level, range from macro-social (e.g., racism, gender inequality, acceptance of violence, political instability) down to the individual-level (e.g., girls' lack of education, prior history of sexual abuse). For example, at the country-level, negative social attitudes about women may contribute to gender inequalities that manifest in the sex-trafficking of women. Whether "glamorizing pimping" in Los Angeles or viewing Brazilian women as objects for "men to see, and to touch, and to use," deleterious social attitudes towards women emerged as a major implicating factor for trafficking in most cities.

At the family level, many respondents in the cases noted that family instability might create conditions that could lead to trafficking of girls. Particularly in the India case

studies, the role of family poverty in fostering the sex-trafficking of girls was critical. At the individual-level, across the cases, a girl's prior history of sexual abuse emerged as a major determinant of sex trafficking. Respondents tended to group these determinants when describing why sex trafficking occurred in their cities. In other words, a victim's lack of income as trafficking determinant cannot easily be decoupled from her difficult family situation (e.g., need to feed her children, or her parents), a culture of violence in her local community, or the country-wide norms that condone overt or latent discrimination against women.

Societal-level factors appear to play particularly important roles in the India and Brazil cases. The Rio and Salvador cases suggest that discrimination against women in general (viewed as subordinate to men, and objectified), may create permissive conditions for sex trafficking, and more broadly, violence against women. In Kolkata, social discrimination against darker-skinned individuals and lower-caste individuals, serve as risk factors for sex trafficking.

Current Local Health-System Responses to Sex Trafficking

4. Health Systems' Current Response to Sex Trafficking is Weak and Largely Reactive

Overall, the local health systems in the case-study cities have not yet addressed sex trafficking in a significant way. Public hospitals and clinics provide health care treatment for victims, especially in emergency situations—as they do for the general population. However, government health systems have not developed a coordinated system of health care for sex-trafficking victims, in any of the eight cities. Given the absence of a formal, coordinated system of health care, NGO service providers have attempted to fill this extremely sizable gap. Acting as case manager and sometimes, as in the India cases, patient advocates (accompanying victims to the hospital, and meeting with health-care workers to assure non-discriminatory care), service providers have developed relationships with individual health-care workers at clinics and hospitals.

Notably, the cases reveal predominantly informal and personal relationships between anti-trafficking service providers and health-care workers. In other words, as seen time and again in the cases, NGO staff members cultivate relationships with individual doctors and nurses in the city to assure the best possible help for victims. As one service provider noted in New York City, “What I do basically is hustle and get people that I know to do favors for me. Luckily, I know a few people who have medical backgrounds that I basically beg for favors.”

Despite the efforts of NGO service providers and a small number of dedicated health-care workers in each city, victims still experience a profound lack of access to healthcare. Interview respondents largely attributed these barriers to care to traffickers and brothel owners (e.g., in India and Philippines) denying victims access to health-care facilities,

and victims' reluctance to access public or government health facilities because of insensitive and at times abusive treatment. In terms of specific types of health-care services, the cases unequivocally noted the absence, for the most part, of culturally-sensitive mental-health services for trafficking victims. Furthermore, in Kolkata and Mumbai, respondents expressed the need for healthcare for the *children* of trafficking victims and sex workers.

We found little evidence of health systems' systematic involvement in trafficking-prevention activities. Although individual cases produced anecdotal evidence of health-care prevention work (e.g., health education aimed at reducing sexually-transmitted infection incidence among Kolkata commercial sex workers, funded by the National AIDS Control Organisation), local health systems have not, overall, worked in this domain of anti-trafficking work.

5. Barriers Exist to More Effective Local Health-System Responses to Trafficking

In general, the cases suggest that health-care worker's knowledge of sex trafficking is minimal, at best. In fact, despite nearly uniform agreement that trafficking exists and is a serious threat to the health of women and girls, trafficking is still not considered a mainstream health issue. Furthermore, aside from specialized health personnel who routinely work with sexual violence victims, health-care workers have extremely limited knowledge regarding how to identify victims or to whom to refer suspected victims for additional legal or social services. Table 11.1 (below) lists a sample of health-care worker concerns about becoming involved in victim-identification activities.

Table 11.1. Health-Care Worker Concerns about Victim Identification

- Concern that traffickers will avoid detection, regardless of health-care worker attempts to identify suspected victims
- Fear of retribution against health-care worker by trafficker
- Law enforcement officials may be corrupt and punish victims
- Health-care workers' lack of knowledge of immigration laws; uncertainty as to whether identification of victim could lead to her deportation
- Health-care workers' fear of breaching health privacy laws by reporting victims to authorities
- Competing commitments- obligations to other patients, especially in public hospitals with long lines of patients

Notably, Mumbai and Kolkata deviated from the other six cities in terms of awareness. Health-care worker awareness of sex trafficking (and commercial sex work) was highest in Mumbai, Kolkata, due in part to trafficking being reported to be much more prevalent in these cities than others in the study.

In some cities, discrimination by health-care workers emerged as a key barrier to quality health care for victims. For example, several respondents in the Brazil cases noted that some health-care workers' negative attitudes toward certain patients (e.g., poor, black women) can have deleterious effects on women's access to, and experiences with, health care. In Mumbai and Kolkata, respondents perceived that hospital workers pre-judge women in prostitution, and treat them less favorably than other patients. In Manila, multiple key informants reported widespread humiliating treatment of unmarried women presenting for reproductive health problems, and outright hostility toward women who present for care following complications from unsafe abortion.

Implications of Case Study Findings for Theory Development and Refinement

Due to their largely inductive nature, the eight case studies provide new insights into conceptual frameworks and theories about sex trafficking. Existing theories can be categorized into distinct research streams: (1) theories of how and why sex trafficking occurs; (2) frameworks describing health risks for victims; and (3) theories on potential interventions to combat sex trafficking.

As described in Chapter 1, extant research on the determinants of trafficking has identified a number of social, economic, political, and cultural determinants.^{19, 130} Our cases corroborate key determinants (e.g., history of sexual abuse, lack of education) from this existing body of research, and suggest the need for a multi-level understanding of determinants that is synergistic—one that describes how co-occurring determinants at the individual, family, communal, and national levels interact with each other to increase risk for sex-trafficking. The International Labor Organization has described this layered approach as “a reciprocal influence between and among the child and other individuals, families, and social contexts”¹⁵ and the “Socio-Ecological Model” employs similar language to describe the salience of a multi-level approach.^{13, 14} Furthermore, the cases clearly support the existing theory that “push” and “pull” factors explain why human trafficking occurs (i.e., “poverty” pushes women towards trafficking, while “media images of wealth pull women” into such situations).⁸ Among the key determinants, the influence of family members of victims in encouraging—sometimes unknowingly--trafficking of their daughters is an area that requires further theoretical development. It is unclear, for example, whether family members *buffer* girls against trafficking and traffickers; most of our interviews focused on the negative aspects of family influence (e.g., abuse), but as evidenced by trafficked women and girls' sending money home to their families, there is a complex set of family relationships that deserve further examination. And in the case of extended families, especially in small villages, community-level factors that predispose or protect girls against sex trafficking need to be understood more fully.

The case studies also provide rich information on the mechanisms of trafficking—how trafficking happens, who the key stakeholders are, etc. In this report, we have described

the business processes of trafficking in eight cities. Trafficking involves many more roles than only those of the pimp and the prostitute: recruiters, drivers, drug dealers, corrupt police, and health care providers, to name a few. We propose that in some instances the financial systems of trafficking may be much more sophisticated than single transactions between clients and pimps. Thus, the psychological, social and economic processes by which sex workers are trafficked for prostitution are more difficult to identify, disrupt, and eradicate than an atomistic brothel/transaction model might suggest. Further refinement of these propositions is needed.

The mechanisms of sex trafficking trades described in this report are consistent with existing theories on the business processes of human trafficking. Shelley has proposed six “business models” of human trafficking.¹⁷⁶ For example, the “Violent Entrepreneur” model suggest that traffickers use threats of violence against victims and their families and conspire with rogue police in order to sustain their international-trafficking rings.¹⁷⁶

New conceptual models that account for the sophistication of trafficking processes offer better opportunities for intervention and greater hope for the successful release of women and girls from sex trafficking. As Hughes, who has written about the demand- side of trafficking, writes, “There is much to be learned about the dynamics of sex trafficking by analyzing the markets for victims and the exploiters’ methods of operation. Focusing on the marketing and profitmaking of exploiters can provide multiple strategies to intervene to eradicate sexual exploitation. State approaches to prostitution create different cultures and levels of accommodation for the sex industry and its need for victims.”¹⁷⁷ Shelley delineates how understanding such processes may lead to concrete action: “Economic strategies to seize the assets of the traffickers and to find other financial means of support for trafficking victims are key to developing a strategy to reduce trafficking.”¹⁷⁶ Understanding how traffickers and their associates work—documenting their tactics—is critical for theory development. For example, do certain activities, such as city men loitering or trespassing in rural villages, serve as harbingers for trafficking? Do they signal high risk situations for trafficking?*

From a health perspective, our case findings support the conceptual framework on the “Stages of the trafficking process” proposed by Zimmerman and co-workers, in their 2003 landmark study of international sex trafficking in Europe.²⁶ (The Zimmerman study explicitly did not study internal trafficking in European countries, or study individual cities/communities.) The Zimmerman framework posits that trafficking victims move

* This situation may be similar to the controversial “Broken Windows Theory” of policing in New York City, which posited that arresting all petty thieves (e.g., who broke windows or evaded paying fares on the subway) would reduce serious crimes, because these small criminal acts led to more serious ones, and consequently had latent, destabilizing effects on the community at large. This theory’s detractors suggest that such actions do not reduce crime, and that reductions in crime attributed to this theory are confounded by improvements in macro-social conditions. See Kelling GL and Coles CM. *Fixing broken windows: restoring order and reducing crime in our communities*. 1997. Touchstone Books, New York.¹⁷⁸

through a sequence, from “pre-departure” all the way through “Integration, re- trafficking and reintegration,” and at each stage, these victims face serious health risks and adverse health outcomes.²⁶ Our case studies, which examined international as well as internal trafficking, similarly identified a wide range of physical and psychological problems facing sex-trafficking victims.

Further research would address theoretical gaps in knowledge about trafficking. Our case studies suggest some of the many areas that merit further inquiry:

- Understanding the relationship between sex trafficking and labor trafficking – in what ways are they linked?
- Examining the health and development outcomes of children of sex-trafficking victims – what are the determinants of ongoing suffering and of resilience?
- What are the psychological characteristics of traffickers? What is the full set of motivations driving such exploitation?
- In hotspot cities, what role do the media play in producing positive or harmful messaging about women and sex, or in serving as allies for public education and awareness?
- What effect do police raids have on rescued victims’ psychological health?
- Who profits, and how, from the business of trafficking? What opportunities arise to intervene in the business process?
- What are the health outcomes of victims that are repatriated to their home villages?

Recommendations

The case studies identify many challenges for anti-trafficking stakeholders in the health and non-health sectors. Surmounting these challenges will require the participation of local health systems—in victim identification, prevention, treatment, policy, advocacy, education, training, research, and quality improvement. Health systems are well-positioned to take on a greater role in anti-trafficking work, and based on our case studies, their participation is welcomed by health professionals, and by non-health anti- trafficking stakeholders. A key thread in the case studies was the notion that anti- trafficking activities involving health should make use of existing systems and processes, rather than starting de novo.

Key recommendations for the health sector are briefly described below. While recognizing that each local context is unique, we propose a number of general, unifying recommendations for key stakeholder groups.

1. Improve Access to Health-care Services for Victims

The need to lower barriers to health-care access was frequently described by respondents across the eight cities. Currently, the onus of coordinating health care for victims falls heavily on victims or NGO service providers who work with victims. Given the diverse as well as long-lasting health effects of trafficking, the menu and availability of health-care services should be improved. Some fixes could be implemented immediately. In India, for example, government clinics operate during the day, when victims and sex workers sleep. An expansion of hours to accommodate victims could improve health access for this population.

While acknowledging that many types of health care services are lacking, the paucity of culturally-competent mental health services for sex-trafficking victims represents a major concern for the field. Many respondents in the cities noted the strong relationships that develop between trafficker and victim, the dependency of victims on their traffickers and pimps, and the complex psychological trauma inflicted on victims. When victims are ready to seek mental health-care, they need to have access to quality mental health services that are trauma-informed and culturally competent. Local health systems should increase the number of trained mental health professionals who can provide assistance and care to victims. In cities like Mumbai and Kolkata, where rescue homes are present, local health systems should provide comprehensive mental-health services to rescued trafficking victims.

In addition to illness/emergency care and mental-health support, rescued victims need primary care medical services, including reproductive health-care, primary health-care, dental care, and nutritional support. Attention to immunizations and prevention services should be included as well. Many victims of sex trafficking have one or more of their own children to care for. Therefore, children of sex-trafficking victims should receive well baby and child care, immunizations and illness care.

Furthermore, local health systems should more effectively coordinate with NGO service providers who work with victims in affected communities. Time and again, our cases described NGO service providers utilizing personal relationships with medical professionals to secure care for victims. A well-functioning system of coordinated care for victims, rather than an ad hoc one, is needed.

2. Raise Awareness of Sex Trafficking among Health Professionals and Trainees

Efforts to raise awareness about trafficking among existing health-care workers, as well as health profession trainees (e.g., medical, nursing, dental, social work, and allied professional students), could yield sustainable benefits to the anti-trafficking field, and improve health outcomes for victims. Most health-professions students have little awareness and receive no education whatsoever about this topic.

In terms of education and training, the evolution of the domestic violence field as a legitimate arena in health care suggests a template that the trafficking field could follow. Due in part to the emergence of domestic violence, sexual violence, and child abuse as mainstream topics taught in health-professional schools, sex trafficking awareness efforts do not need to start from scratch. As many respondents suggested, sex trafficking can be kneaded into existing topics taught at health-professional schools – e.g., sexual violence in medical and nursing schools, health and human rights in schools of public health. One intriguing idea from a respondent is to push for inclusion of a question about trafficking on national medical board exams, thereby assuring that all medical students take notice of the issue. Curricular innovation should flow from the development of core competencies for each field, and be supported by scholars and community-based experts.

Training health-care workers on identification and referral of victims is very important, but great care must be taken to create clinical tools that assist in the evaluation and management of patients, and do not unduly burden health-care workers. Training related to sex trafficking must be mindful of the time constraints and competing responsibilities facing health-care workers, while not oversimplifying the topic, such that the trainings are rendered useless. Many respondents suggested starting with training specialized health professionals, such as sexual assault nurse examiners, and then branching out to other health professionals who may come into contact with victims.

3. Play a Role in Preventing Sex Trafficking

The case studies' emphasis on multi-level trafficking determinants suggests that community-based health-care workers can apply their knowledge of community-, social-, family- and individual-level disease prevention and health promotion strategies to sex trafficking. One respondent in Kolkata suggested, for example, that youth-targeted HIV-awareness programs could fold sex trafficking awareness topics into these programs. The robust "Socio-Ecological Model" that we explicitly referenced at the start of our study has been successfully applied in the field of violence prevention, and can also be used to inform sex-trafficking prevention activities. As with training of health workers, creating stand-alone "sex trafficking prevention programs" may be impractical, given that in many local contexts, the issue of sex trafficking is still new, not well understood, and lacking a robust evidence base. Instead, introducing basic awareness about sex trafficking – what it is, what the warning signs are, what people can do to prevent it, how and to whom to call if you suspect a case, and how to respond with compassion – could be very effective.

Some respondents in the cases also suggested that the health sector bring its social marketing expertise (e.g., HIV awareness) to bear on the issue of sex trafficking. Public-service announcements targeting the general public, or even victims that may be

confined to homes where television or radio are accessible, may help bring the issue to light, especially in high-prevalence communities.

4. *Raise Profile of Trafficking and Health in Policy*

Health professional membership organizations can raise the profile of trafficking by deeming it an important issue for their members. For example, the American Nurses Association, which represents nearly 3 million nurses, passed a resolution in 2008 declaring human trafficking to be a nursing and public-health issue. Health-care workers in such fields as emergency medicine, pediatrics, obstetrics and gynecology, psychiatry, among others, could take similar stances on the trafficking issue. In policy circles, health systems could draw greater attention to the health ramifications of trafficking by pushing for the inclusion of health indicators in the U.S. State Department's annual *Trafficking in Persons* report. Finally, ministries of health should become more actively engaged in country-wide governmental task forces. Leadership at all levels of health care should play a more significant role in policy and advocacy work around trafficking.

5. *Partner with Local Anti-Trafficking Stakeholders*

A number of partnerships, such as those between health-care workers and NGO service providers that serve victims, have been described in this report. These partnerships, however informal, provide a critical service for sex-trafficking victims in the case study cities. Greater coordination between health-care providers and service providers could therefore improve the health of many trafficking victims in a city.

The cases suggest that health-system involvement in anti-trafficking coalitions is spotty, at best. Many respondents said that health systems would be welcomed in these multi-organization coalitions. Given the significant expertise health-care workers possess in working with victims of crime, local health systems could participate in formulating local strategies for addressing sex trafficking in a comprehensive way. Health workers could also work more closely with law enforcement to assist in identifying suspected victims, but must do so in a way that does not jeopardize their primary responsibility to their patient (e.g., protecting confidentiality).

6. *Advocate for Underserved Populations*

Negative health-worker attitudes, especially among physicians, can quickly erode trust with patients, especially trafficking victims that have been conditioned not to trust formal health-care providers. Discrimination by health-care workers against patients based on their race, class, gender, or occupation (e.g., sex worker) emerged as a major theme in the case studies. As such, while not specific to sex trafficking per se, local health systems should implement sensitivity training programs for physicians and other health professionals that improve their attitudes about, and communication with, vulnerable patients from various parts of society.

In developed-country cities such as Los Angeles, New York, and London, the need to improve health-care access for immigrants was frequently cited. Local health systems should advocate for the rights of underserved populations as a whole, through existing public policy levers, as such actions could improve access for sex-trafficking victims.

Finally, the expression “a rising tide lifts all boats” underscores the importance of better treatment for victims via better treatment for underserved populations in general. Educating health providers to be more sensitive and non-judgmental to patients is not a trafficking-specific recommendation; it applies to all patients.

Appendix A: Case Study Interview Protocol

This following set of interview questions are the major domains of questions for the semi-structured interviews, but deviation from these questions are allowed/encouraged in the social science case research method, as interviews are conducted. Case study method is designed to be iterative, flexible. Hence, this interview guide is simply that: a guide for case researchers to use, allowing for probes and new lines of questioning as interviews progress. New question domains/constructs, for example, may emerge in future iterations of this interview guide.

I. INTRODUCTION AND CONTEXT SETTING

1. Thank subject for agreeing to meet and for allocating time for interview.
2. Review goals and timetable of project, expected outcomes and value of informant's input.
3. Review consent form
4. Explain importance of interviewee's input in context of entire project. Remind interviewee to not reveal personal level health information or to "name names."
5. Provide Palermo Protocol definition of human trafficking.
6. Remind informant to ask questions at any time.

II. LOCAL/REGIONAL GEOGRAPHIC, CULTURAL, SOCIO-POLITICAL CONTEXT AND FACTORS

1. What is your sense of the scope of the problem of sex trafficking of women and girls (STWG) in (your city)?
2. What are the key cultural, political, economic or social issues that contribute to the problem of sex trafficking (ST) in (your city)? How, specifically, do these factors lead to STWG in (your city)?
3. In terms of policies or programs, what is being done in (your city) to address the problem of STWG?

III. ORGANIZATIONAL CONTEXT

1. Does (your organization) work with victims of sex trafficking? If so, how do you come into contact with them?
2. What services does (your organization) currently provide for victims of sex trafficking?
3. What are some of the barriers or challenges (your organization) faces in identifying victims of sex trafficking?

4. What are some of the barriers or challenges (your organization) faces in meeting the needs of sex trafficking victims?
5. What opportunities or untapped potential do you see for (your organization) with regard to combating sex trafficking?

IV: ACCESS TO SERVICES

1. In general, how do women and girls in (your city) who are *not* sex trafficking victims obtain health care?
2. In general, how often do you think health workers encounter sex trafficking victims?
3. How do victims of sex trafficking obtain health care? What are their general experiences?
4. What makes it *difficult* for women and girls who are trafficked to access medical and social services?
5. What would make it *easier* for women and girls who are trafficked to access medical and social services?

V. COLLABORATION

1. Are you aware of any collaborations or partnerships that currently exist in (your city) to address STWG?
2. In what ways might the health care sector in (your city) contribute to a comprehensive approach to STWG?
3. What kinds of partners would make ideal collaborators with the local health system?

VI. FUTURE DIRECTIONS

1. In the *short* term, what steps need to be taken to meet the needs of sex trafficked women and girls in (your city)?
2. In the *long* term, what steps needs to be taken to address STWG in (your city)?
3. Which of these ideas, in your view, would be most achievable?

VII. CONCLUDING THE INTERVIEW

1. Thank interview subject for valuable input and insights
2. Ask for suggestions for others to interview
3. Verify contact information for final report

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