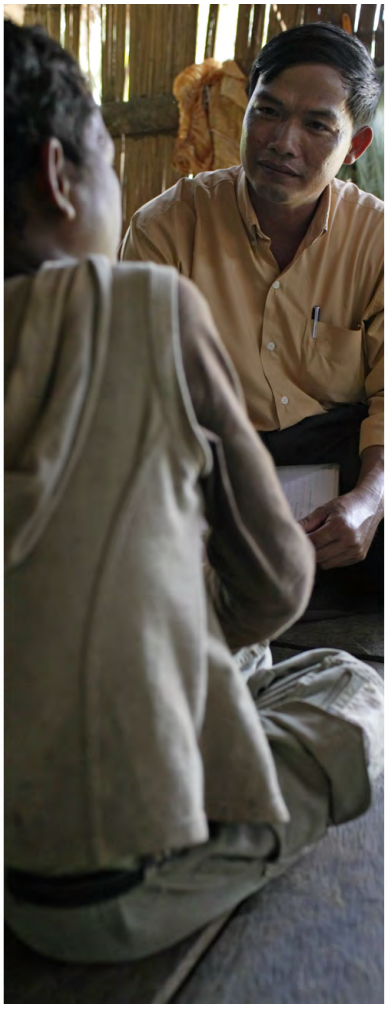
Health and human trafficking in the Greater Mekong Subregion

Findings from a survey of men, women and children in Thailand, Cambodia and Viet Nam

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DEVELOPING CAPACITIES IN MIGRATION MANAGEMENT

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Study on Trafficking, Exploitation and Abuse in the Greater Mekong Subregion (STEAM)

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The greatest contributors to this research were our study participants: the survivors of human trafficking. They generously shared their time and their stories, which too often included descriptions of pain, fear and deep disappointment. We truly hope – and will work to ensure – that their expressions of need are heard by policymakers and service providers, so that fewer people will have to suffer these extreme forms of exploitation, and those who do will receive the help that they require and deserve.

Importantly, this research was made possible by the service providers – and their staff – in each of the participating study countries who took time to ensure that the participants were treated with respect and kindness, and that their service needs were met.

Service providers in **Cambodia** provided the following staff to conduct the interviews with respondents:

- International Organization for Migration (IOM) Office in Phnom Penh: Ms Sous Soksreymom, Mr Keo Korindeth and Ms Hun Leang Ay
- Cambodian Committee for Protection of Child Rights (CCPCR): Ms Ny Channary
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Service providers in **Thailand** provided the following staff to conduct the interviews with respondents:

- Department of Social Development and Welfare, Ministry of Social Development and Human Security: Ms Saowanee Khomepatr
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- Pakkred Reception Home for Boys: Mr Somdech Surawat and Ms Kanoknop Kerdwattana

These service providers in **Viet Nam** provided staff to conduct the interviews with respondents:

- Can Tho Support Centre for Women and Children in Difficult Circumstances
- Social Assistance Centre of Lang Son Province
- Social Protection Centre of Lao Cai Province
- Centre for Women and Development
- Vocational Training Centre, Women's Union of Quang Ninh Province

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Executive summary

Trafficking in human beings is a gross violation of human rights that often involves extreme exploitation and abuse. People are trafficked for various forms of exploitation, including labour exploitation in various low-skilled sectors and sexual exploitation. In these circumstances, trafficked persons are exposed to a multitude of health risks, in addition to violence, deprivation and serious occupational hazards. These dangers frequently result in acute and longer-term morbidity – and sometimes even death. Many, if not most, of those who survive a trafficking experience will require medical care for their physical and psychological health needs.

To date, there has been very limited robust research on the health consequences of human trafficking, and to our knowledge, no surveys have been conducted on the health needs of survivors of trafficking for various forms of labour in the Greater Mekong subregion.

In response to evidence gaps on health and trafficking, a prospective, cross-sectional, multi-site survey was conducted among people in post-trafficking services to identify their health risks and priority health-care needs.

The findings of this survey were based on responses provided by 1,102 people who had been exploited and were willing to share their experiences and voice their health concerns. While these findings illustrate an overwhelming panorama of abuse, at the same time they offer a picture of hope through the opportunity to understand and respond with better health protection and response mechanisms in the future.

Survey background

This study drew on a conceptual framework on trafficking and health that highlights the potential health influences of each of the phases of the migration process and their importance to the cumulative health status of individuals who are trafficked.[1] This research also recognized a "grey zone" constituting the ambiguity and complexities in the definitions of human trafficking, specifically the weak articulation of the level of "exploitation" necessary to define someone as being "trafficked." For this reason, to avoid subjective decision-making by the research team about who is "trafficked," and for important ethical reasons, the study population was defined as 'individuals using post-trafficking services'. In this way, the study population should be viewed as a "service-based" sample, and the findings are intended to inform service providers about client support needs.

Methodology

Study design. This survey on the health of people receiving post-trafficking services was an observational longitudinal study. This report primarily presents frequencies calculated for the first set of interviews (first cross-sectional survey). Data are also reported for the cohort of individuals who were tracked 30 to 60 days after the first interview; however, there was a high rate of loss to follow-up.

Sample. Participants consisted of a total of 1,102 men, women and youth age 10 years or older who were receiving post-trafficking assistance services in Cambodia, Thailand and Viet Nam. A total of 15 post-trafficking services were purposively selected (6 services in Cambodia, 4 in Thailand and 5 in Viet Nam) based on the diversity of their clientele, service relationship with IOM Country Teams or Anesvad Foundation, and their agreements with government. Data collection was carried out from 2010 to 2013 among individuals receiving assistance from post-trafficking services.

Participants constituted a consecutive sample of individuals using these services and were interviewed within the first two weeks (0 to 14 days) of their contact with their selected service. All individuals meeting the following criteria were invited to face-to-face interviews:

(a) Client of one of the participating post-trafficking services, entering the selected service 10 or less days prior to the interview;
(b) Ages 10 or older;
(c) Mentally and physically capable (as assessed by trained support/case workers).

Questionnaire. The survey questionnaire was based on the instrument used in a previous European study with victims of trafficking for sexual exploitation and was adapted for this study's survey population (various labour forms) and the region.[2] It was translated into Khmer, Thai, Burmese, Vietnamese and Lao in several steps: (a) professional translation from English to these languages; (b) group translation and discussion with IOM counter-trafficking staff; (c) pilot testing of the translated questionnaire; (d) adaptation of the questionnaire; (e) back translation and adjustment.

Data collection and analysis. Fieldwork was conducted from October 2011 to May 2013. Interviews were conducted by staff working at the 15 participating services in the three study countries. Data collection and entry were coordinated by IOM Country Offices, with oversight by the London School of Hygiene and Tropical Medicine (LSHTM).

Ethics. A strict ethics and safety protocol was implemented based on the *WHO Ethical and Safety Recommendations for Interviewing Trafficked Women.*[3] Ethical approval for the study was granted by the LSHTM and by local ethics boards in Cambodia (Ministry of Health), Thailand (Ministry of Social Development and Human Security) and Viet Nam (Hanoi School of Public Health).

Summary of study findings and results

Survey population characteristics

Response rate. The response rate was over 98 per cent for all three countries. Study participants included 1,102 men, women and youth age 10 years or older who were receiving participating post-trafficking assistance services in Cambodia, Thailand and Viet Nam.

Participant sex and age. Participants included 637 females (57.8%), 465 men (42.2%) and 387 youth (35.1%) between ages 10 and 17 years old. More specifically, 27.9 per cent were between ages 15 and 17 (*n*=308) and 7.2 per cent (*n*=79) were between ages 10 and 14 years. The majority of children interviewed were female (81.7%).

Country-specific sample characteristics. The largest proportion of the participants were receiving services in Thailand (40.3%, *n*=444), followed by Viet Nam (35.3%, *n*=389), then Cambodia (24.4%, *n*=269). In Viet Nam and Thailand, the majority of the sample was female (72.5% and 73%, respectively); in Cambodia, the sample was mostly comprised of male participants (88.5%), and in Thailand, two thirds of the participants were children (67.3%).

Home countries. Participants' home countries were: Viet Nam (35.2%, *n*=388); Cambodia (28.3%, *n*=312); Thailand (14.2%, *n*=156); Myanmar (11.6%, *n*=128); Lao People's Democratic Republic (10.5%, *n*=116); and China (0.1%, *n*=1). One individual reported not knowing his country of origin.

Education. Fewer than one third (30.8%) of adults and 43.7 per cent of children had completed secondary school (grades 6–8). A small number of adults (8.2%, *n*=59) had completed grades 10 and 11. Nearly one fifth of adults (19.0%) and 8.8 per cent of children reported they did not have any formal education.

Pre-departure occupation. Nearly one tenth (9.7%) of the participants reported having no paid work before leaving home. Agriculture or farming, reported by 42.7 per cent, was the most common pre-departure occupation. One fifth (20.4%) of those under 18 years old reported that they were students before leaving home.

Marital status. One fifth (21.6%) of the participants (over age 15) reported they were married and living with their partner before leaving.

Ever-married participants with children. Of the 287 participants (21.6%) who reported ever having been married, 80.8 per cent had children.

Referral to post-trafficking services. Participants were primarily referred to services by government agencies, police and immigration officials (85.9%).

Pre-departure stage

Awareness of trafficking. Fewer than half (44.1%) of all participants (from the various countries of origin) reported that they had previously heard about "trafficking." Thai nationals were most likely to have heard about trafficking (65.4%), followed by Cambodians (46.2%), the Lao (39.7%), Vietnamese (38.9%) and Burmese (32.8%).

Recruitment. One third (34.2%) of the participants indicated brokers were responsible for getting them into their trafficking situation. More than one quarter (26.5%) said that someone close to them or who should have been trustworthy (i.e. parent, other family member, friend, colleague, boyfriend/girlfriend or neighbour) was responsible for their trafficking. Twenty-six participants said they were abducted.

Violence prior to migration. Among adults, 15.1 per cent had experienced at least one act of physical or sexual violence before leaving home. Almost one fifth (22.0%) of children were exposed to physical or sexual violence. Females (20.6%) reported a higher level of pre-departure physical or sexual violence than males (14.6%).[i]

Pre-departure job information. Nearly half of the participants (44.8%) reported that the job information given to them prior to leaving was "not true at all."

Exploitation stage

Destination locations. There were a total of nine destination countries reported. The largest proportion of the participants were exploited in Thailand (40.7%), followed by China (30.0%), then Indonesia (11.7%). Among the 1,102 total study participants, 87 (7.9%) reported that they were unable to reach their destination. Data for the "exploitation period" represent primarily the 1,015 participants (92.1%) who arrived and began work at the destination.

Labour sectors. Participants were trafficked into 15 different labour sectors, with two thirds (67.2%) trafficked into three sectors: sex work (29.9%), fishing (25.0%) and factory work (12.3%). Just over half of the participants under age 18 were trafficked for sex work (51.9%).

Prevalence of violence at destination. Nearly half of the adult men (49.3%) and well over half of adult women (60.0%) reported experiences of sexual and/or physical violence in the destination location. Experiences of violence were reported by 36.2 per cent of children, ages 10–14 years old, and by 35.3 per cent of adolescents, ages 15–17 years old.

[i] Data for pre-migration violence is presented for 877 (of 1,102) participants only. In Viet Nam, pre-migration violence data for 225 (57.8%) of 389 participants is unreliable due to database problems which were only fixed on 20 August 2012. For Viet Nam, these are coded as missing (*n*=225) until 20 August 2012. Pre-migration violence data for Viet Nam is included only for 164 (42.2%) of 389 participants whose data were entered after 20 August 2012, where we can ascertain that data are reliable.

Violence by sector. Particularly high levels of physical and/or sexual violence were reported by among participants trafficked as brides/wives (88.5%, *n*=46 of 52), for fishing (68.4%, *n*=188, of 275), sex work (50.8%, *n*=167 of 329), domestic servitude (60.5%, *n*=23 of 38) and begging (36.0%, *n*=9 of 25).

Sexual violence. Among those who reached their destination and who answered the question on sexual violence (*n*=1,009), nearly one in six participants (*n*=204, 20.2%) reported being subjected to forced sex while in the trafficking situation. Of these 204 individuals who reported sexual abuse, 198 (97.1%) were female and six (2.9%) were male.

Threats. Almost half of the participants (46.0%, *n*=467 of 1,015) were personally threatened with violence against themselves while in the trafficking situation.

Working days/hours. Over two thirds (67.5%) of the participants reported working seven days per week, with the mean number of hours worked daily at 13.8 (SD[ii]=6.6 per day. Those reporting the greatest number of working hours were in fishing (18.8, SD=5.9), followed by domestic work (15.2, SD=6.6).

Restricted freedom. Over two thirds (67.9%) of the participants reported they were "never" or "seldom" free to "go where they wanted or do what they wanted," with well over half (58.7%) of all participants indicating they were "never" free. Individuals trafficked for domestic work (86.8%) and fishing were most likely (80.4%) to report "never" being free to do what they wanted or go where they wanted.

Restricted freedom and violence. Among participants who were able to reach their destination, those who reported restrictions by their employers were more likely to have also experience violence. Specifically, 60.1 per cent who reported "never" being free also reported physical and/or sexual violence, versus 13.9 per cent of those who reported being "always free" but also experiencing violence.

Forced drug use. Some participants experienced forced drug use while in the trafficking situation, with 6.1% reporting being forced to take drugs or medication. The proportion was higher among children (8.4%) than adults (4.9%).

Alcohol consumption. A small minority (3.2%) of the participants reported drinking daily.

Occupational hazards. By relevant sector of exploitation, the most common occupational hazards were: "repeated bending or lifting" (44.6%, *n*=389), "lifting heavy objects" (39.8%, *n*=347) and "use of sharp instruments" (20.1%, *n*=263). Over 90 per cent of fishermen reported "long hours in the sun, cold or wet without a break" (96.7%), "repeated bending or lifting" (94.9%) and "lifting heavy objects" (93.5%).

Personal protective equipment. Over one third of the participants (37.8%) received no protective equipment for work. Approximately half of the participants reported being given simple protective gear such as gloves (45.9%), or sun hats (50.4%) for outdoor work such as agriculture and fishing.

Condom use. Women who did not experience violence were twice as likely to report "always" using condoms compared to women who reported violence (75.5% versus 35.8%)

Work-related injuries. Over one in five (21.9%) participants reported at least one serious work-related injury, such as deep or long cuts, skin damage and back or neck injuries. Nearly half of those trafficked for commercial fishing (46.6%, *n*=128 of 275) and construction (26%, *n*=5 of 19) in construction reported at least one serious injury. Seven participants (3.2%) each lost a body part. Only 62 of the 222 who reported an injury said they received medical care for the injury.

[ii] Standard deviation (SD) measures the amount of variation or dispersion from the average.

Duration of the trafficking situation. Participants were in the trafficking situation for a median duration of 116.5 days (MAD[iii]=91.5). Those in the following sectors spent the longest median periods in trafficking: fishing (487.3 days; MAD=350.3), bride/wife trafficking (183; MAD=122) and domestic work (122; MAD=107).

Working and living conditions. Nearly all participants who reached their destination (99.9%, *n*=1014 of 1015) reported some form of poor living or working conditions. The most commonly reported adverse conditions were: having "no or very few rest breaks" (56.1%); living/sleeping in overcrowded rooms (44.6%); and having nowhere to sleep/sleeping on the floor (36.4%). Nearly 200 people (19.5%) reported that they were "locked in a room" – this was most commonly reported by participants trafficked for sex work, domestic work and fishing. Importantly, more than one in five people said they did not have enough to eat or enough clean water to drink while working.

Cash payments. Few participants (37.4%, *n*=380 of 1015) received cash payments.

Travel and identity documents. The majority (69.0%) of the participants reported having no travel or identity documents, and of those with documents, 39.4% (*n*=124) said that someone kept their documents from them.

Health care. More than one third of the participants (40.8%, *n*=414 of 1015) reported needing health care while in the trafficking situation. More children (51.7%) than adults (35.2%) reported needing some health care, and a higher proportion of females (49.2%) versus males (30.0%). Nearly thirty per cent (29.7) of the participants who reported needing medical care while in the trafficking situation (*n*=414) said that they did not receive any care, among whom one third (33.7%) said they saw a doctor and 20.8 per cent saw a nurse, while 23.0 per cent reported receiving medication from employers.

Pregnancy and pregnancy termination in the trafficking situation. Thirty-five (7.5%) of the participants reported having been pregnant while in a trafficking situation (e.g., sex workers, *n*=15; brides/wives, *n*=11) and twelve reported having an abortion.

Leaving the trafficking situation. Nearly half of the participants (43.3%) said that they never tried to leave the situation. Reasons participants gave for not attempting to leave included: "I was making money" (44.7%); "I was afraid to get lost" (33.3%); "I feared being arrested" (32.1%, *n*=143 of 445); and "I had no identification documents" (27.0%, *n*=120 of 466). For most participants (71.1%), their escape was facilitated by police, border guards or government officers, and 28.9 per cent said they ran away or escaped without the assistance of others, while 15.4 per cent were assisted by NGOs.

Detention. Approximately one quarter (24.1%) of the participants were ever held in detention. A higher proportion of men (28.5%) than women (20.7%), and more adults (30.3%) than children (12.2%), experienced being detained.

Post-trafficking stage

Physical health. "Poor" health was reported by 15.6 per cent of participants, commonly by those trafficked for fishing (26.9%) and domestic work (18.4%). Most participants (64.3%) identified at least one area of their body where they felt pain or injury. The most common areas of the body where participants reported feeling pain or injury were: head (26.2%); stomach (19.5%) and back (13.6%).

Post-trafficking medical care. Nearly half (49.6%) of those who reported pain, injury or a recent health problem said they wanted to see a doctor or nurse for the problem.

[iii] Median absolute deviation (MAD) is a measure of the variability of a univariate sample of quantitative data.

Pregnancy. Twenty-one women (4.5%) who were of reproductive age reported being pregnant at the time of the interview. Among the 21 pregnant women, 14 (66.6%) reported having experienced sexual violence.

Mental health. Symptoms associated with depression were reported by 59.7 per cent of participants. Symptoms associated with post-traumatic stress disorder (PTSD) were reported by 35.6 per cent of participants and 41.9 per cent met the symptom criteria for an anxiety disorder. A higher proportion of adults reported symptom levels associated with a mental health disorder than among those under 18 years old. More females than males reported symptom levels associated with depression, while more males reported symptom levels of PTSD and an anxiety disorder . Although subsample sizes to compare labour sectors were limited,, depression symptoms were most prevalent among participants trafficked for factory work (67.7%, *n*=92 of 136), domestic work (81.6%, *n*=31 of 38) and construction (79.0%, *n*=15 of 19). Anxiety symptoms were more common among those trafficked for domestic work (63.2%, *n*=24 of 38) and agriculture (62.1%, *n*=36 of 58). PTSD symptoms were prevalent among participants trafficked for agriculture, domestic work, construction and factory work (52.2% to 65.8%).

Suicidal ideation. One in six participants (14.9%, *n*=164) reported having 'thoughts of ending their life' (suicidal ideation) within the past week prior to the interview.

Common post-trafficking concerns. The most commonly reported post-trafficking concerns were: money-related problems in the family (44.6%); health-related problems in the family (43.1%); and guilt or shame (41.2%).

Fear of the trafficker. Nearly half of the participants (43.1%) perceived they *might* still be in danger from a trafficker even if they were no longer in the trafficking situation, with 34.3 per cent stating they believed they *were* still in danger and a further 8.8 per cent reported being unsure if they were in danger.

Treatment by family or community in the home country. Over half of participants (56.3%) were worried about how they would be treated by people upon arrival at home. These concerns were higher among those who reported an experience of sexual violence while they were in the trafficking situation (74.9%, *n*=158 of 211) than among those who did not experience sexual violence (52.0%, *n*=459 of 883).

Residence upon exiting the services. When asked who they planned to live with when they left the post-trafficking service, 79.6 per cent said they would live with parents or other family members.

Post-trafficking disclosure. Participants were more or less evenly divided between those who planned to speak to others about their trafficking experience (42.2%, n=465 of 1,102) and those who did not plan to speak about it (45.1%, *n*=497 (of 1,102)). Women trafficked for sex work were less likely to intend to discuss their experience (29.9%, *n*=98 of 328) than females trafficked for other purposes (43.6%, *n*=105 of 241) or males (49.2%, *n*=262 of 533).

Hopes for the future. When asked about their hopes for the future, not surprisingly most (60.5%) men and women reported wanting to "have a job." Overall, participants appeared to maintain their hopes for the future, as only few (5.1%) said that they had "no hopes" for the future.

Experience of the interview. When asked to comment on how easy or difficult participants felt the interview was, most (70.2%) stated the interview was an "easy" experience, while 20.5 per cent found it "a little bit difficult" and 9.1 per cent found it "difficult."

Second interviews

Second interviews were conducted between 30 and 90 days after the initial interview with participants who could be contacted. Second interviews were conducted in order to learn how the respondents' physical and mental health and concerns changed over time. Comparing their symptoms and situations at Time 1 (T1, i.e. during the first interview) and at Time 2 (T2, during the second interview,) may offer insights on survivors' service needs once their basic needs have been met and they have had some time to recover from their acute health problems and consider their future.

Second interviews were conducted with 353 of the 1,102 participants, or 32.0 per cent of the original sample. In Thailand, second interviews were conducted with 48.5 per cent (*n*=215) of all participants; in Cambodia, with 39.0 per cent (*n*=105) of the original participants; in Viet Nam, only 8.5 per cent (*n*=33) of all participants were interviewed a second time. While this would represent significant loss to follow-up for most other types of studies, we believe that this is a relatively reasonable retention rate given the highly mobile nature of this population.

Mental health comparison between first and second interviews

Comparing symptom levels at the first and second interviews showed that participants experienced a reduction in symptoms of depression (from 46.1% down to 39.3%), anxiety (37.3% to 26.0%) and PTSD (28.5% to 23.7%). It is not possible to determine what may have influenced these changes.

Summary of regional recommendations

General recommendations

(a) Recognize human trafficking as a health issue.[iv]
(b) Recognize the health rights of people who have been trafficked.

Recommendations to States

General government and legislators, in particular, entities responsible for responding to human trafficking

(a) States in the Greater Mekong subregion should develop regional accord(s) on the health rights of trafficked women, men and children.
(b) States should develop regional and national referral mechanisms to ensure that the health of trafficked persons is prioritized through safe and supported referrals between agencies, transfer of medical information and measures to assure the continuity of necessary care. Referral mechanisms should recognize the need for informed consent, confidentiality and privacy of all individuals.
(c) States should approve national legislation, or amendments to existing legislation, that require provision of health care to people who have been trafficked. Care should be funded by the State and coordinated within strategies of the lead agencies addressing human trafficking. Services should be age- and gender-sensitive and offered on a voluntary basis, with informed consent. The following specific recommendations are made:
    (i) Ensure State-facilitated access to health services for trafficked persons in the location where they make their claim.
    (ii) Provide health services by practitioners trained to care for trafficked persons.

[iv] "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." – Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference in New York on 19–22 June 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

(iii) Dedicate budget lines to subsidize health care, either from national anti-trafficking funds or from the ministry or department of health.
(iv) Accord trafficked persons in destination, transit and return locations immediate legal rights to State-supported recuperative health services. This right should be specified in relevant legal instruments, regardless of individuals' legal status or ability to pay.
(v) Do not hold trafficked persons in detention.
(vi) Do not return trafficked persons to locations where their health and safety may be at risk.
(vii) Ensure trafficked persons' health care needs can be met in their home location, with coordination between places of origin and destination.
(viii) Ensure that return policies and procedures for trafficked persons prioritize individuals' safety and health and that consent and return should be voluntary.
(ix) Do not return trafficked persons from destination or transit locations without providing appropriate and voluntarily accepted medical care to meet their immediate health-care needs.
(x) Ensure assistance funding to provide specially designated health services for trafficked persons (who are either trafficked domestically or abroad) upon their return home, where existing services are not adequate to meet their health-care needs, regardless of their ability to pay. Establish a national or Ministry of Health fund specifically to subsidize the health care of trafficked persons.
(xi) Accord persons who have either been trafficked domestically, or who are returning to their home country from a trafficking situation abroad, the same rights to State-supported health services as other citizens of that country, regardless of the period of time that they have been out of the country.
(xii) Recognize health, safety and labour rights in national legislation addressing protection within labour sectors, including mechanisms to compensate trafficking victims for harm, disability or distress, and provide assistance to recover reparation funds to address the range of health consequences of trafficking-related abuses.
(xiii) Advocate for assistance for victims to recover reparation funds and compensation for harm, disability or distress through regional mechanisms, national labour and industry associations and health institutions.
(xiv) States should facilitate collaboration between lead counter-trafficking agencies and the health ministry/department to establish coordinated health responses to human trafficking.
(xv) States should approve legislation to mandate targeted and regular labour health and safety inspections of industries commonly associated with the exploitation of workers and human trafficking. They should include strong legal mechanisms to protect workers and penalties for exploiters. Labour inspection personnel should be trained to identify and refer possible victims of trafficking.
(xvi) States should establish health indicators to monitor, at a minimum: (a) health risks experienced by people identified as trafficked; (b) health consequences reported by or diagnosed among trafficked persons; (c) health service responses and treatment received by trafficked persons. These data should be anonymous and integrated into national and regional data collection mechanisms and reported publicly (e.g. the national special rapporteur).
(xvii) Ensure that the authorities leading national counter-trafficking responses include health providers as first responders in the identification and referral of possible trafficked persons and that health professionals are included in strategic planning and training activities.

Introduction

The data from this survey were provided by 1,102 people who had been exploited and were willing to share their experiences and voice their health concerns. Participants offered information so that service providers and policy decision makers would use this evidence to find better ways to protect people from becoming exploited and to respond to the health needs of those who fall prey to this extreme form of exploitation. While the findings illustrate an overwhelming panorama of abuses – which we know is exponentially larger than represented in this sample – at the same time they offer a picture of hope through the opportunity to understand and respond with better health protection and response mechanisms in the future.

This report offers rare quantitative findings about patterns of risks, abuses, occupational hazards and the health consequences experienced by people who are trafficked into various labour sectors. While we have presented much of these findings as statistics – percentages of the total 1,102 participants – in the end, each person has his or her own individual experience. Therefore, we encourage readers to also look at and think about the actual numbers of individuals (the "*n*="s) who reported these experiences. Looking at the numbers of individuals who have experienced the various risks, abuses and hazards enumerated in this report gives a striking impression of just how many lives have been adversely affected – sometimes destroyed – among the participants of this study alone. This study's sample is undoubtedly just a tiny segment of the larger population of exploited migrant workers in the Greater Mekong subregion, and, of course, a much tinier proportion of those affected by exploitation globally.

To our knowledge, there are few, if any, other studies to date that provide similarly large data-driven findings on health and trafficking in the Greater Mekong subregion. The implications of these findings are wide-ranging and offer important insights for the health sector, as well as other sectors. These results also demand an urgent call for action.

Background

Trafficking in human beings is a gross violation of human rights that often involves extreme forms of abuse. People who are trafficked are exposed to a multitude of health risks, including violence, deprivation and serious occupational hazards. These dangers frequently result in acute and long-term morbidity – sometimes even death. Many, if not most, of those who survive a trafficking experience will suffer the physical and psychological aftermath for years, and, some, forever.

Despite widespread international dialogue and documentation of severe trafficking-related abuses and exploitation, there has been disappointingly little evidence about survivors' health and the medical and psychological services they require. Indeed, there has been very limited robust research focussing on the health consequences of human trafficking in general and, to our knowledge, no rigorous studies on the health needs of trafficking survivors in the Greater Mekong subregion.

To date, studies have been carried out primarily in Europe, predominantly among women who have been trafficked for sexual exploitation, while there has been extremely limited attention to the health needs of survivors in other regions or those who are exploited in other sectors.

The Greater Mekong subregion has a notably high incidence of individuals entering situations of forced labour, often as a result of human trafficking. Women, men and children in the Greater Mekong subregion are trafficked for forced sex work and various forms of forced labour, including commercial fishing, domestic servitude, agriculture, food processing, hospitality, street begging and factory work. In these situations, victims often endure violence and abuse from trafficking recruiters, employers and other individuals, such as co-workers, in addition to being exposed to a range of serious occupational health and safety hazards and poor living conditions. Trafficked labourers are likely to work incredibly long hours with few breaks, be given little to no job training or training in a language they cannot understand. Exploited workers are rarely provided personal protective equipment and commonly work in settings that irregularly or never undergo health and safety inspections. In the face of this risk-laden environment, people who are trafficked suffer acute and chronic physical and mental health problems and emerge with a range of medical support needs. Research-based evidence is urgently needed to inform medical and other health-related interventions and local and regional policy responses to ensure trafficked people have the greatest chance of regaining their health and well-being.

In response to evidence gaps on survivor health and well-being, a prospective, cross-sectional, multi-site survey was conducted to identify the health risks and priority care needs of trafficked persons in Cambodia, Thailand and Viet nam. Data collection was carried out between 2010 and 2013 among men, women and adolescents receiving assistance from partner services after being trafficked. This research project was a ground-breaking initiative carried out by the London School of Hygiene and Tropical Medicine and IOM, and co-funded by Anesvad Foundation and the IOM Development Fund with the cooperation of local post-trafficking support organizations (see Table 1) and the survivors themselves.

In addition to recognizing the health influences of the different stages of the migration process, this research also acknowledged the "grey zone," ambiguities and complexities in applying a single definition of "human trafficking." Specifically, the study recognized the poor clarity related to an operational definition of "exploitation," which is a core concept in most definitions of human trafficking. That is, it remains unclear what level of exploitation is required to define someone as being "trafficked." For this reason, to avoid subjective decision-making by the research team about who is trafficked, and for ethical reasons, the study population was defined as "individuals using post-trafficking services" (i.e. to avoid interviewing people still in trafficking situations). In this way, the study population might be considered similar to a "service-based"

sample, and the study is intended to inform service providers about their client support needs. Findings pertain to the clients of the services included in the study during the study period, and may not necessarily be generalizable to the larger population of post-trafficking service users. At the same time, we hope that these findings offer information on patterns of health risks, outcomes and service needs, to inform services and policies for people trafficked for different purposes in the Greater Mekong subregion and beyond.

This report presents the main research findings and suggests recommendations that we hope will foster the development of integrated health policies for more informed responses, strategies for specialized health service provision and individualized care for trafficked persons in the Greater Mekong subregion.

Study objectives

Aim

This research aimed to measure the prevalence and patterns of health outcomes, and describe health risk factors associated with migrant labour exploitation among people using post-trafficking services in the countries of the Greater Mekong subregion: Thailand, Cambodia and Viet Nam.

Objectives

Specifically, this research aimed to:

(a) Document the trafficked persons' health outcomes throughout the trafficking process;

(b) Examine changes in reported physical and psychological health symptoms over time;

(c) Compare living and working conditions, violence and health indicators by sector of exploitation, country, age group and sex;

(d) Describe social responses (e.g. guilt, shame, empowerment and stigma) to human trafficking;

(e) Examine risk factors associated with severe physical and mental health outcomes;

(f) Document individual perceptions of care needs;

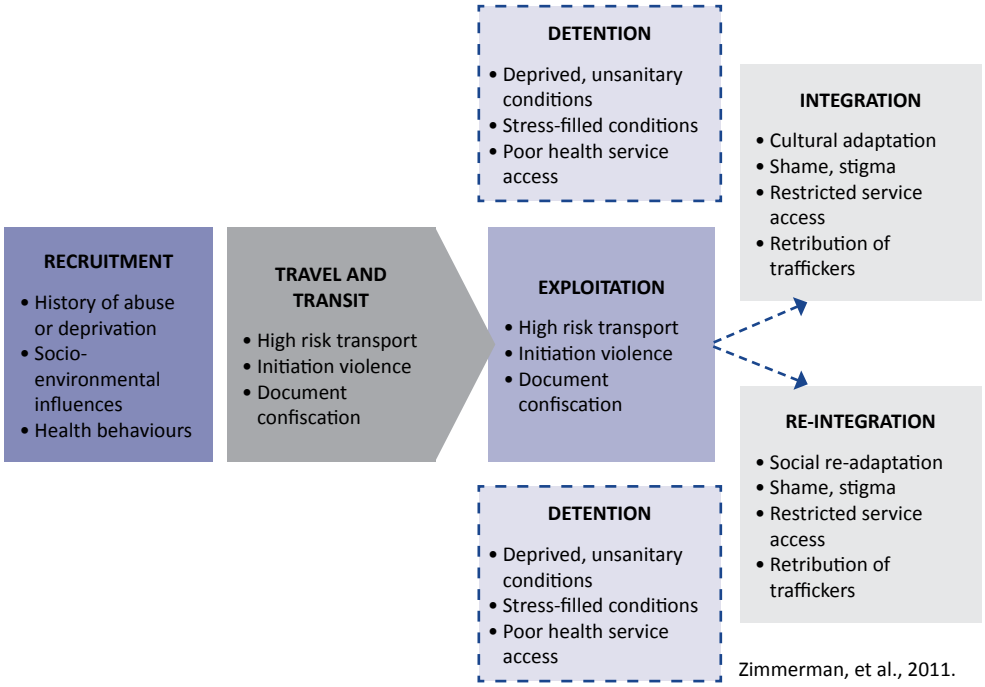
(g) Explore gender dimensions and types of exploitation-related risk, symptoms and care needs.

This report presents frequencies for health outcomes and conditions of exploitation, including living and working conditions, violence, social responses and individual perceptions of care needs.

Recognizing that migration is often part of the experience of trafficked persons, this report presents the findings by migration stage: (a) pre-departure and recruitment; (b) destination and exploitation; and (c) post-trafficking integration or reintegration phase.

Conceptual Framework

Figure 1: Stages of the trafficking process



Zimmerman, et al., 2011.

This study was designed based on the conceptual framework, "Stages of the Trafficking Process" (see Figure 1), which recognizes people's migratory movement and the health risks and the corresponding opportunities for intervention which may emerge at each phase of this migration cycle.[1] This framework underpinned our formulation of the study aim and objectives, and guided the development of the study instrument and analysis. This framework can also serve as a guide towards a theory of change that takes into account each of the geographical and chronological stages where interventions might be implemented to offer greater protection to migrants at risk.

Study Methods

Study design

The Study on Trafficking, Exploitation and Abuse in the Mekong (STEAM) was an observational longitudinal study. This report presents mainly the frequency counts for the first set of interviews (first cross-sectional survey). Data are also reported for the cohort of individuals who were contacted 30 to 60 days after the first interview, despite a high rate of loss to follow-up.

Sample

The participants were men, women and children aged 10 years or more (n=1,102) enrolled in post-trafficking assistance services in Cambodia, Thailand and Viet Nam.

The sample was selected in two stages. In the first stage, post-trafficking services were purposively selected in each country (six services in Cambodia, four in Thailand and five in Viet Nam; see Table 1) based on the diversity of their clientele, service relationship with the IOM Country Teams and Anesvad Foundation, and agreements with government institutions. These services assisted trafficked persons (men, women and adolescents) who were trafficked for a variety of purposes (e.g. sexual exploitation, forced labour and begging) and who were receiving assistance in the Greater Mekong subregion after a trafficking experience.

Table 1: Overview of participating services in Cambodia, Thailand and Viet Nam

Cambodia	Thailand	Viet Nam
Four NGO shelters in provincial locations and two service providers in Phnom Penh: International Organization for Migration (IOM) Phnom Penh, which assists with the voluntary return of trafficked Cambodian men, women and children Healthcare Centre for Children (HCC), which operates Good Day Centres in Kandal and Koh Kong Provinces Cambodian Center for the Protection of Children's Rights (CCPCR), which runs shelters in Svay Rieng and Siem Reap Provinces Acting for Women in Distressing Situations (AFESIP Cambodia), which runs a shelter for women and children in Phnom Penh Children without Borders (KNK) Shelter for Children in Battambang Province Poipet Transit Centre (PTC) in Banteay Meanchey Province, which faciliates Government-to-Government return from Thailand of minor victims of trafficking and vulnerable women	Four government shelters located in provinces in the Central (three shelters) and Southern(one shelter) Regions: Kredtrakarn Protection and Occupational Development Centre (women and children) Patumthani Protection and Occupational Development Centre for Men (men) Srisurat Protection and Occupational Development Centre (women and children) Pakkred Reception Home for Boys, a.k.a. "Phumvet shelter" (boys)	Three government social support centres and two shelters run by non-governmental organizations located in different regions in Viet Nam: Can Tho Support Centre for Women and Children in Difficult Circumstances (AAT) Lang Son Social Support Centre Vocational Training Centre, Women's Union of Quang Ninh Province Social Protection Centre in Lao Cai Province Centre for Women and Development (Peace House)

In the second sampling stage, a consecutive sample of individuals was invited to participate within the first two weeks (0 to 14 days) of their admission by one of the selected services. All individuals meeting the following criteria were invited to face-to-face interviews:

(a) User of one the participating post-trafficking services, entering the selected service ten or less days before the interview;

(b) Age 10 or higher;

(c) Mentally and physically able (as assessed by trained support or case workers).

The target sample size was determined to estimate the prevalence of three study outcomes: depression, anxiety and violence. We also took into consideration the need to produce country-level data.

Calculations indicated that a target sample of 384 completed interviews per country would give sufficient power to achieve the study objectives.

Second interviews were conducted with the same sample of individuals between 30–90 days after the first interviews.

Questionnaire

The questionnaire outline was based on the instrument used in a previous European study with victims of sex trafficking.[4] It was further refined by the core team at the London School of Hygiene and Tropical Medicine (LSHTM) in consultation with IOM teams, the STEAM study steering group and trafficking experts in the region and globally. It included questions on socioeconomic background, pre-trafficking exposure, living and working conditions in the trafficking experience, violence, health outcomes and post-trafficking plans and concerns.

Mental health outcomes were measured using a screening questionnaire for depression and anxiety (Hopkins Symptoms Checklist 25), and another for posttraumatic stress disorder (Harvard Trauma Questionnaire).[5–7] These instruments are intended to detect symptom levels associated with these disorders, but are not diagnostic tools. Findings represent symptoms suggestive of each of the disorders versus a clinical diagnosis.

The items on violence were based on behaviour-specific questions on physical and sexual violence developed by the World Health Organization.[8] These items asked about acts of violence that participants may have experienced before and when they were being trafficked. The acts that these items pertained to were supplemented with acts commonly reported by survivors in trafficking services and shelters. Questions about the relationship of the perpetrator(s) to the participants were asked separately for physical and sexual violence. The participants were also asked about threats against themselves or family members and people they cared about.

The questionnaire was translated into Khmer, Thai, Burmese, Vietnamese and Lao through discussions with professional translators and the IOM counter-trafficking teams in each country. Translations were reviewed during the training and the pilot tests of the questionnaires. Lastly, the revised versions were back-translated into English and final adjustments were made.

Data collection and analysis

For ethical and logistical reasons, interviews were conducted by service staff in the three participating study countries. Data collection and entry were coordinated by the IOM Offices in each country, with oversight by the LSHTM team.

Fieldwork was conducted from October 2011 to May 2013.

First and second data entry were consolidated and data were cleaned by the LSHTM team. Data was analysed using STATA 13.

This report presents descriptive statistics from the study. Significance tests for comparisons described in the text are not presented here, as these more extensive analyses will be available in later publications on specific topics.

Please note that in the computation of percentages and rates, the number of missing values is included in the denominator unless otherwise stated.

Ethics

A strict ethics and safety protocol was drafted and implemented based on the *WHO Ethical and Safety Recommendations for Interviewing Trafficked Women* (which was written by one of the study leads for STEAM). The ethics protocol included, for example, guidance on informed consent, anonymity, confidentiality, privacy, responding to distress, knowing when to terminate an interview and referral procedures. Ethical approval for the study was granted by LSHTM and by local ethics boards. In Cambodia, ethical approval was granted by the National Ethics Committee for Health Research (Ministry of Health). In Viet Nam, the Hanoi School of Public Health's Institutional Ethics Review Board approved the STEAM study. In Thailand, approval was obtained from a board of experts at the Ministry of Social Development and Human Security.

Overview of post-trafficking services and referral in Cambodia, Thailand, and Viet Nam

Referral processes

Cambodia

In Cambodia, the main government agencies responsible for the referral and protection of victims are the Ministry of Interior and the Department of Anti-Trafficking and Juvenile Protection (whose main role is to interview victims, conduct investigations and provide protection), and the Ministry of Social Affairs, Veterans and Youth, which provides direct assistance and reintegration, family tracing for unaccompanied minors and vocational training).

Other government agencies involved are the Ministry of Foreign Affairs and International Cooperation and relevant embassies and consulates overseas who work with local authorities and international agencies in destination countries to identify and repatriate Cambodian victims of trafficking.

Thailand

In Thailand, government agencies that are responsible for referrals include the Royal Thai Police (specifically, its Anti-Trafficking in Persons Division), the Ministry of Justice (Department of Special Investigation), the Immigration Bureau, and the Ministry of Social Development and Human Security (Department of Social Development and Welfare). The referral process for victims of trafficking in Thailand is carried out through the "Multi-Disciplinary Team" (MDT) on anti-trafficking. The MDT is composed of a group of professionals from diverse disciplines who come together to perform a comprehensive assessment and consult on all human trafficking cases. The group, which includes government and non-governmental organizations at the local, national and bilateral levels, works at each stage of the process, including intake/incident reporting, rescue, victim identification, legal assistance, protection, and return and reintegration. In Thailand, the MDT approach is reflected through the establishment of memorandums of understanding between concerned agencies, for example, between government and non-governmental organizations (NGOs).

Under the framework of the MDT, when the victims of trafficking are found or rescued by the police, immigration or NGOs, they are referred to the Department of Social Development and Welfare for further assistance.

Viet Nam

In Viet Nam, government agencies responsible for referrals of victims of trafficking include: the Ministry of Public Security, in particular the Immigration Department and Criminal Police; Border Guards; the Ministry of Foreign Affairs, in particular Viet Nam's embassies in destination countries; and the Ministry of Labour, Invalids and Social Affairs, in particular the Department of Social Evils Prevention. Subject to the needs of trafficked persons, individuals are referred to governmental social support centres or non-governmental services, or receive assistance in their communities.

Characteristics of participants

The response rate among study participants was very high for all participating services: above 98 per cent for all three countries. We believe that the interviewees' willingness to participate in the study was related to the settings in which the interviews were conducted (i.e. services where the participants were residents) and familiarity with interviewers (service staff). Material incentives for participation were not offered, and interviewers made it clear that no negative consequences would arise from declining to be interviewed.

Females, males and children

There were 637 females in this study, representing 57.8 per cent of the overall sample. Males numbered 465, representing 42.2 per cent of all participants (See Table 2).

Table 2: Sex of participants

Sex	*n*	%
Male	465	42.2
Female	637	57.8
Total	1,102	100.0

Over one third (35.1%) of the participants were children (i.e. those under 18 years old) (see Table 3).

Table 3: Age of participants

Age group	*n*	%
Children (<18 y/o)	387	35.1
Adults (≥18 y/o)	715	64.9
Total	1,102	100.0

Most of the males in the study were over age 18, and there were approximately equal numbers of adults and youth under age 18 (see Table 4).

Table 4: Sex of participants (n=1,102) by age group (adults and children)

	Male (*n*=465)		Female (*n*=637)	
Age group	*n*	%	*n*	%
Children (<18 y/o)	70	15.1	317	49.8
Adults (≥18 y/o)	395	84.9	320	50.2
Total	465	100	637	100

There were 79 children (7.17%) between 10 and 14 years old and 308 adolescents between the ages of 15 and 17, who together comprised 27.9 per cent of the overall sample. Four in five children (80.5%) were female. The youngest participant interviewed was 10 years old (See Table 5).

Table 5: Sex of participants (n=1,102) by age group

	Male (*n*=465)		Female (*n*=367)	
Age group (years)	*n*	*%*	*n*	*%*
10–14	30	6.5	49	7.7
15–17	40	8.6	268	42.1
18–24	174	37.4	214	33.6
25–34	154	33.1	59	9.3
≥35	67	14.4	47	7.4
Total	465	100.0	637	100.0

The adult sample was relatively young, with the mean age of women (25.2 years; SD=8.7), slightly lower than that of men (27.5 years; SD=7.3). Three quarters of the women were below 28 years of age, and 75 per cent of men were below 32. Conversely, among participants younger than 18, the vast majority (90%) were older than 14 years of age, with a mean age of 15.8 (SD=2.0). The proportions by sex and age differed between study sites. In Cambodia, 88.5 per cent of participants were male, while the majority of participants receiving post-trafficking services in Thailand (73.0%) and Viet Nam (72.4%) were female. To a large extent, these proportions reflect the target populations of the participating post-trafficking services. For example, between 2011 and 2012, IOM Cambodia saw a larger trend of male labour trafficking cases repatriated through its regional repatriation programmes than females (who were commonly domestic workers returning from Malaysia). In Thailand, two of the four services included in the study cater specifically to women and children, and one shelter is specifically for boys.

The largest proportion of all participants in this study were receiving services in Thailand (40.3%, *n*=444), followed by Viet Nam (35.3%, *n*=389) and Cambodia (24.4%, *n*=269). In Cambodia, adults composed 92.2 per cent of the sample and the majority were male (88.5%). In Thailand, the majority of the sample comprised children (67.3%) and females (73.0%). In Viet Nam, the majority of the sample comprised adults (82.8%) and females (72.5%) (See Table 6).

Table 6: Participant characteristics by country of access to services

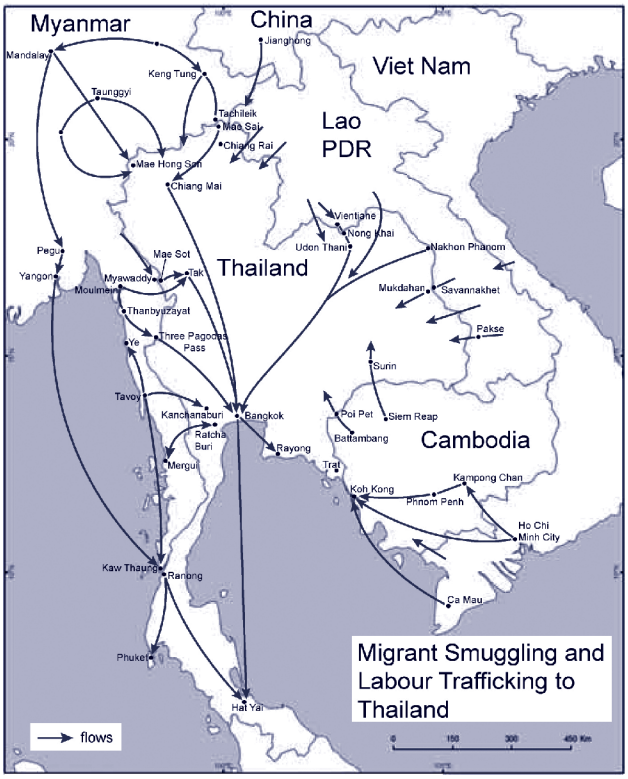
	Cambodia (*n*=269)		**Thailand (*n*=444)**		**Viet Nam (*n*=389)**	
Age group	*n*	*%*	*n*	*%*	*n*	*%*
Children	21	7.8	299	67.3	67	17.2
Adults	248	92.2	145	32.7	322	82.8
Sex						
Male	238	88.5	120	27.0	107	27.5
Female	31	11.5	324	73.0	282	72.5

Age and gender

Age and gender can have a significant influence on the ways that individuals are exposed to and experience health risks associated with human trafficking. For example, females and males are often trafficked into sectors related to gendered employment (e.g. more females enter domestic work; more males are recruited for fishing or construction). Moreover, age and gender can also influence the ways health risk exposures affect individuals. Physical and psychological abuse and deprivation, for example, may affect an adult differently than a child, for whom the effects of abuse are often related to his or her specific developmental stage. For this study, the researchers, where relevant, disaggregated findings by age and sex to reveal any differences in people's experiences, exposures and outcomes.

Country of origin

Individuals in this study may have been accessing services in: (a) their home country after having been returned; (b) the country of destination awaiting return or release; or (c) a transit country, in cases where they did not reach their destination.



UNODOC, Transnational Organized Crime Threat Assessment – East Asia and the Pacific, 2011.

More than one third (*n*=388, 35.2%) of all participants using the services in this study were Vietnamese nationals, and over one quarter (*n*=312, 28.3%) were Cambodian, which, combined, comprised more than half of participants (63.5%). Only 14.2 per cent were Thai nationals (See Table 7).

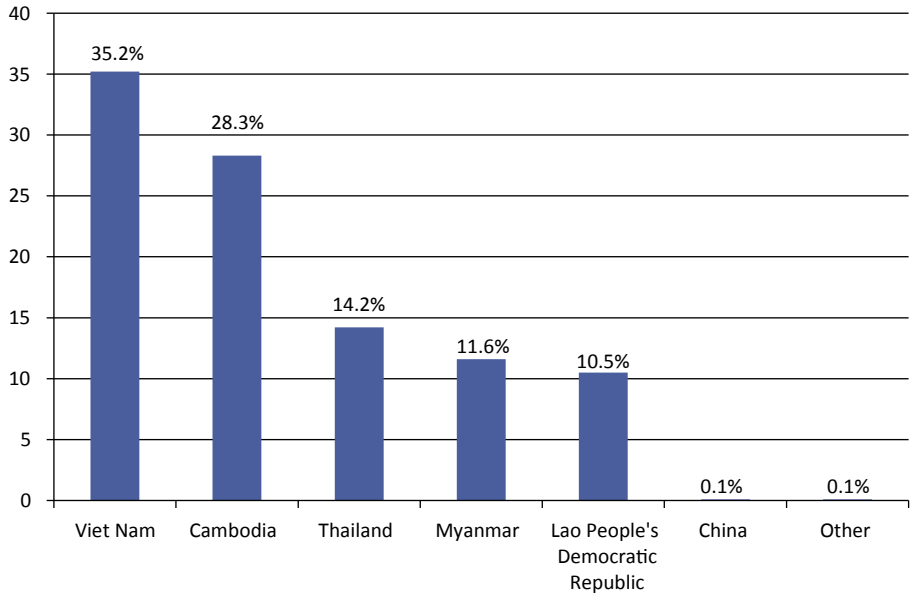
Of the participants receiving services in Thailand (*n*=444, or 40.3% of the overall sample) – which is primarily a regional transit or destination location – the largest proportion consisted of Thai nationals (34.7%), and approximately one quarter each were from the neighbouring countries of Myanmar (28.8%) and the Lao People's Democratic Republic (26.1%), and 10.1 per cent from Cambodia.

Table 7: Participants by country of origin

Home country	*n*	%
Cambodia	312	28.3
China	1	0.1
the Lao People's Democratic Republic	116	10.5
Myanmar	128	11.6
Thailand	156	14.2
Viet Nam	388	35.2
Missing data/responses	1	0.1
Total	1,102	100.0

Among females, the largest group were those from Viet Nam (44.1%); more than half of male participants were Cambodian (55.9%); and more than one third of children were Thai (37.5 %).

Figure 2: Participants by country of origin



Education

The average education levels of participants appeared to be low, particularly when compared to reported national averages.[9] However, by no means are all trafficked people uneducated or are all people who are less educated vulnerable to being trafficked. Notably, several study participants reported achieving higher education.

Over one third (39.8%) of all participants reported they had completed primary school.

Primary school (grades 1–5) had been completed by approximately the same proportions of adults and children (40.5% and 39%, respectively). However, among adults from Viet Nam, where the population average for completion of primary school is reportedly near 100 per cent, the percentages of participants completing primary (39.8%) and secondary education (35.3%) were relatively low[10] (See Table 8).

Among adults, fewer than one third (30.8%) had completed secondary school, while 43.7 per cent of children reported they had completed secondary school (grades 6–8). A relatively small number of adults (*n*=59, 8.2%) had completed grades 10 or 11.

Almost one fifth of adults (19.0%) and 8.8 per cent of children reported not ever participating in any formal education.

Four participants who were trafficked had attained a university degree, indicating that it is not solely the least educated who are trafficked.

Table 8: Education levels of adult and child participants

Educational attainment	Adults		Children (<18 y/o)	
	n	%	*n*	%
Primary (grades 1–5)	282	39.4	157	40.5
Secondary (grades 6–8)	220	30.8	169	43.7
Higher secondary (grades 10–11)	59	8.2	19	4.9
University degree or higher	4	0.6	0	0.0
No formal schooling	136	19.0	34	8.8
Don't know	0	0.0	1	0.3
Missing data/responses	14	2.0	7	1.8
Total	715	100	387	100

Occupation before migration

There were very few participants who were entirely without some source of income prior to the trafficking experience. Small proportions (e.g. 4.6% of adults and 19.1% of children) reported having no paid work before leaving home.

Agriculture (or farming), reported by 42.7 per cent of participants, was the most common pre-departure occupation; the next largest groups consisted of those who were not working (9.7%) and students (9.0%). Six participants (0.5% of the overall sample), all of whom female, reported working as sex workers before migrating.

Only one fifth (20.4%) of all youth under 18 years old reported that they were students before leaving home; 24.6 per cent of children were engaged in agriculture; and 19.2 per cent were not working. Of children between 10 and 14 years of age, 31.7per cent reported that they were in school before leaving home.

Marital status

Participants over the age of 15 were asked about their marital status prior to leaving home. Most (67.4%) of those aged 15 years or older were single prior to migrating. Only 21.6 per cent of participants reported that they were married and living with their partners before leaving home. Thirty-two women and 12 men reported being divorced, separated or widowed (See Table 9).

During migration, 7.5 per cent of participants had a change in marital status. Of these 77 participants whose marital status changed, more than a fifth (23.4%, *n*=18 of 77) started out single and then married and were living with their partners.

Table 9: Pre-departure marital status of participants over age 15

Pre-departure marital status	*n*	%
Single and never married	689	*67.4*
Married, but not living with partner	46	*4.5*
Married and living with partner	221	*21.6*
Separated or divorced	31	*3.0*
Widowed	13	*1.3*
Others	2	*0.2*
Unreported	21	*2.0*
Total	1,023*	100

* Of those ages 15 and older.

Participants with children

Participants who reported having ever been married (before or after being trafficked) were asked whether they had children and where their children were currently residing. Of the 287 participants who were ever married, most (80.8%) had children. As a transit/destination country, Thailand had the fewest participants living in the same country as their children. Only 12 of 51 (23.5%) participants with children and receiving services in Thailand were in the same country as their children, whereas nearly all participants with children and receiving services in Viet Nam (91.8%, *n*=135 of 147) and most in Cambodia (76.2%, *n*=93 of 122) reported that their children were in the same country.

Referral to services

It is often speculated that only the smallest proportion of trafficking survivors are likely to reach post-trafficking support services. Self-referral is rare. Access to services is frequently facilitated by government or NGOs, which is reflected in the data. Participants were referred to the post-trafficking services participating in the STEAM research mainly by government agencies, the police and immigration officials. The greatest number of participants was referred by police, immigration or another government agency (See Table 10).

Table 10: Participants by type of referring organization/agency

Referring entity	*n*	%
Police	316	*28.7*
Immigration	162	*14.7*
Self	4	*0.4*
NGO	74	*6.7*
Government agency	469	*42.6*
Another individual	1	*0.1*
Others	76	*6.9*
Total	1,102	100.0

Recruitment stage

Awareness of trafficking

Over the past decade, significant resources have been invested in "awareness raising" to prevent human trafficking. Participants were asked: "Before you left home, had you ever heard about "human trafficking?" Less than half (44.1%) of all participants (from the various countries of origin) reported that they had previously heard about "trafficking." (See Table 11).

Thailand was the country with the highest proportion of nationals who had heard about trafficking (65.4%), followed by Cambodia (46.2%), the Lao People's Democratic Republic (39.7%), Viet Nam (38.9%) and Myanmar (32.8%).

Table 11: Participants' awareness of the term "trafficking" prior to the trafficking experience

Awareness of the term "trafficking"?	*n*	**%**
Yes	486	*44.1*
No	559	*50.7*
Doesn't remember/Doesn't know	56	*5.1*
Unreported	1	*0.1*
Total	1,102	*100*

Reasons for leaving home

People often have multiple reasons for migrating for work – generally related to financial difficulties, such as unemployment, personal crises and "shock" (e.g. family illness) – to support children or other families and with hopes of investing in a better future. Participants were asked about the reasons they opted to seek work away from their home villages and were given the opportunity to offer multiple responses. The most common reasons cited were that "I didn't earn enough money in my job" (42.5%), "I know others who left and earned money" (37.9%), and "I could not find a job nearby" (23.8%).

Thirty-five participants (3.2%, *n*=35 of 1102) reported: "I was abducted." Nineteen of the 35 were under 18 years old, and 27 of the 35 were female.

Recruitment

Participants were asked, "Who do you think is responsible for getting you into the trafficking situation?" and were invited to offer more than one answer. Just over half (50.7%) stated that they themselves were responsible. When participants implicated others, "brokers" or recruitment agents (33.9%) were most commonly cited.

Of the 420 participants who offered more than one response, participants were most likely to name themselves (65.7%, *n*=276 of 420) and a broker (52.6%, *n*=221 of 420) as the individuals who were primarily responsible for the trafficking.

Table 12: People who participants reported as responsible for their most recent trafficking situation, by gender

Person responsible for the participant's most recent trafficking situation	Female		Male		All participants	
	n	%	*n*	%	*n*	%
Self	322	*50.6*	238	*51.2*	560	*50.8*
Broker	143	*22.5*	234	*50.3*	377	*34.2*
Friend	78	*12.2*	37	*8.0*	115	*10.4*
Someone unknown to participant	84	*13.2*	29	*6.2*	113	10.3
Acquaintance not near my home	49	*7.7*	24	*5.2*	73	*6.6*
Other family member	36	*5.6*	24	*5.2*	55	*5.0*
Acquaintance in my village	30	*4.7*	19	*4.1*	49	*4.5*
Boyfriend or girlfriend	46	*7.2*	2	*0.4*	48	*4.4*
None	39	*6.1*	9	*1.9*	48	*4.4*
Parent	22	*5.0*	23	*3.5*	45	*4.1*
Employer	21	*3.3*	14	*3.0*	35	*3.2*
Was abducted	23	*3.6*	3	*0.7*	26	*2.4*
Participant does not know	15	*2.4*	8	*1.7*	23	*2.1*
Neighbour	11	*1.7*	11	*2.4*	22	*2.0*
Agency/Recruitment company	13	*2.0*	5	*1.1*	18	*1.6*
Ex-boss	2	*0.3*	8	*1.7*	10	*0.9*
Colleague	1	*0.2*	5	*1.1*	6	*0.5*
Others	2	*0.3*	6	*1.3*	8	0.7

* As multiple responses were possible, totals exceed 100 per cent.

Approximately one in four (26.5%, *n*=291 of 1,099) implicated someone who was close to them or who should have been trustworthy (i.e. parent, other family member, friend, work colleague, boyfriend/girlfriend or neighbour) as responsible for their trafficking. Of the 45 people reporting a parent as the responsible party, 21 (46.7%) were under 18 years of age.

It is not unusual for people to be trafficked or introduced to traffickers by someone who is known to them – including even close family members. This is one of the fundamental challenges to the prevention trafficking, as it is logical for people seeking to improve their lives to trust friends, family members or acquaintances to provide reliable advice and assistance.

Twenty-six participants, of whom 14 were under 18 years old, reported that they were abducted. Twenty-three of the 26 participants reporting abduction were female.

More females than males appeared to be recruited by a friend (12.2% versus 8.0%, respectively) or by a boyfriend or girlfriend (7.2% and 0.4%, respectively). More males than females reported being recruited by a broker (50.3% versus 22.5%). Eighty per cent (*n*=4/5) of participants in animal farming were trafficked by a parent, followed by 16.7 per cent of street sellers (*n*=3/21). The sectors with the highest proportions reporting recruitment by a broker were "other" sectors (75%, *n*=9 of 12), construction (57.9%, *n*=11 of 19) and agriculture (56.9%, *n*=33 of 58). Other sectors included chopping sugar cane and loading and offloading goods.

Eighty-seven people offered other answers, of which the most common responses included: "the boss or employer or owner," "no one" and "I don't know."

Violence prior to migration[v]

Participants were asked about any physical or sexual violence that occurred before they left home. Among participants who answered the question, 15.1 per cent reported having experienced any violence (physical or sexual) before leaving home (See Table 13).

Females were more likely to have experienced either physical or sexual abuse prior to trafficking (20.6%, versus 14.6% for males), as were those under 18 years of age (22.0%, versus 15.1% for those over 18 years). Among females who were trafficked for sex work for whom we have data (*n*=265), 23.8 per cent reported experiencing physical or sexual violence before leaving home.

Table 13: Reported pre-departure physical or sexual violence

	n	%
Female	97 (of 472)	*20.6*
Male	59 (of 405)	*14.6*
<18 years old	76 (of 346)	*22.0*
18 years old or above	80 (of 531)	*15.1*
Total	312 (of 1,754)	17.8

Previous studies in other settings, nearly all with women, have found much higher levels of pre-trafficking abuse. Early abuse is an important risk factor for increased vulnerability to later abuse and longer-term health consequences, especially mental health problems.[11] It has also been suggested that pre-migration abuse may be a strong contributing factor to an individual's decision to leave home.[12]

Pre-departure physical violence

Among adults, 12.2 per cent had experienced at least one act of physical violence before leaving home. One fifth (20.2%) of children were exposed to physical violence. Women (16.1%) reported a slightly higher level of physical violence than men (14.6%).

The most commonly reported acts of pre-departure abuse was slapping or having something thrown at them (22.2%); being pushed or shoved (18.1%); and being hit with a fist or another object (17.8%). Additionally, approximately one in 18 persons (*n*=50 of 877) reported being choked, tied or chained up or threatened with a weapon.

There was a high proportion of missing responses for four of the items on violence prior to migration: (a) "pushed or shoved you"; (b) "used a knife to cut you"; (c) "burned you on purpose"; and (d) "released a dog to bite or scratch you" in the Viet Nam sample (please see footnote above). There were no data on these questions for 225 participants from Viet Nam, constituting 20.4 per cent of all participants (*n*=225 of 1,102). The frequencies reported for these items should, therefore, be interpreted as representing a smaller sub-sample of participants in the study.

Sexual violence before trafficking

Sexual violence prior to migration was reported by 31 participants (3.5%), of whom 30 (96.8%) were female. Among the participants reporting sexual violence, nine (29.0%) were under the age of 18 at the time of the interview.

[v] Data for pre migration violence is presented for 877 (out of a total 1,102) participants only. In Viet Nam, pre-migration violence data for 225 (57.8%) of 389 participants are unreliable due to database problems. For Viet Nam, these data are coded as missing (n=225). Pre-migration violence data for Viet Nam are included only for 164 (42.2%) of 389 participants whose data were entered after 20 August 2012, when we can ascertain that data are reliable. Missing data are not included in the denominator for pre-departure violence figures.

Viewed alternatively, among females, 11.1 per cent of adults and 3.2 per cent of children reported having been sexually abused prior to leaving home. (See Table 14. Note: These data do not indicate whether adults who reported sexual violence were abused before or after age 18.)

Table 14: Prevalence of pre-departure sexual violence, by age group (adults and children)

Age group	n	%
Children (< 18 y/o)	9	*2.6*
Adults (≥ 18 y/o)	22	4.1

No boys and only one adult male reported experiencing sexual violence prior to being trafficked. Again, it is unclear at what age this pre-departure sexual violence occurred.

Exploitation stage

Not all participants in this study arrived at their intended destination and exploited there. Among the 1,102 total study participants, 87 (7.9%) reported that they did not reach their destination. This section focuses mainly on the 1,015 participants (92.1%) who arrived in their intended destinations and began forced work in the various sectors described below. However, where relevant (e.g. violence and threats), the levels experienced by those who "did not reach the destination" are also included in the text (results for the overall sample, N=1,102).

Country of exploitation

A total of nine countries were reported as destination locations. The largest proportion of participants were exploited in Thailand (40.7%), followed by China (30.0%), and then by Indonesia (11.7%). Cambodian fishermen are commonly in Indonesian waters on Thai-owned fishing boats (and in Mauritius) (See Table 15).

Table 15: Destination countries where participants were exploited

Country of exploitation	*n*	%
Thailand	448	*40.7*
China	330	*30.0*
Indonesia	129	*11.7*
Malaysia	52	*4.7*
Mauritius	33	*3.0*
Cambodia	7	*0.6*
Russian Federation	6	*0.5*
South Africa	6	*0.5*
Viet Nam	3	*0.3*
Other	1	*0.1*
Did not reach destination	87	*7.9*
Total	1,102	100.0

The main destinations where adult men were exploited were Indonesia (31.4%), China (25.1%) and Thailand (23.3%). Adult women were trafficked mainly into China (56.9%) and Thailand (21.9%). The majority of children were exploited in Thailand (73.9%).

Internal migration was infrequent among participants from Cambodia (1.6%, *n*=5 of 132), Viet Nam (0.8%, *n*=3 of 388), China, the Lao People's Democratic Republic and Myanmar (0% each). In contrast, nearly all of the study participants who were Thai nationals were trafficked within Thailand (88.5%, *n*=138 of 156).

Sector of exploitation

Over 15 different labour sectors were reported by study participants, with 72.9 per cent of all participants having been trafficked into three sectors: sex work (32.4%), fishing (27.1%) and factory work (12.4%). Factory work included, for example, garment, electronic goods and toy manufacturing, and shrimp and meatball production. Of those trafficked for sex work, all but one were female. All who were trafficked for fishing were male. Of the 136 participants trafficked for factory work, 62.5per cent were male (See Table 16). Although "entertainment" is frequently associated with sex work, the researchers made a distinction between the two to reflect the responses offered by participants about the sectors into which they were trafficked.

Fifty-three women were trafficked for marriage or to be brides/wives and all accessed post-trafficking services in Viet Nam. In this type of bride trafficking, women (often from ethnic

minorities in northern Viet Nam) were frequently lured by Vietnamese men who had migrated to China and were connected with local traffickers. Trafficked brides/wives were commonly required to help with farming, cleaning and other domestic work. For brevity, the researchers have included "brides/wives" as a "sector" throughout this document.

Youths were commonly trafficked for sex work (58.4%, *n*=201), karaoke or entertainment (6.7%, *n*=23) and street begging (6.4%, *n*=22).

Eighty-seven individuals (7.9%) reported that they did not reach their intended destination. For the remaining tables in this section, unless otherwise specified, data are presented for the 1,015 individuals who reached their intended destination.

Table 16: Participants who reached their destination reporting exploitation in the different sectors (n=1,015), by sex

Sector or type of exploitation	Male		Female		Total	
	n	%	*n*	%	*n*	%
Sex work	1	*0.2*	328	*57.6*	329	*32.4*
Fishing	275	*61.7*	0	*0.0*	275	*27.1*
Factory work	85	*19.1*	51	*9.0*	136	*13.4*
Agriculture/farming/plantation	21	*4.7*	37	*6.5*	58	*5.7*
Brides/wives	n.a.	-	53	*9.1*	53	*5.2*
Domestic work/cleaning	2	*0.5*	36	*6.3*	38	3.7
Entertainment/karaoke/massage/nail care	0	*0*	29	*5.1*	29	*2.9*
Begging	23	*5.2*	2	*0.4*	25	*2.5*
Construction	16	*3.6*	3	*0.5*	19	*1.9*
Street selling/shop	5	*1.1*	13	*2.3*	18	*1.8*
Restaurant/hospitality/tourism	0	*0*	7	*1.2*	7	*0.7*
Home business	5	*1.1*	1	*0.2*	6	*0.6*
Animal farming/meat preparation	3	*0.7*	2	*0.4*	5	*0.5*
Car care	5	*1.1*	0	*0*	5	*0.5*
Others	5	*1.1*	7	*1.2*	12	*1.2*
Total	446	*100.0*	569	*100.0*	1,015	100.0

Participants receiving services in Cambodia were trafficked primarily into the fishing sector (83.3%); Thai service users were commonly trafficked for sex work (55.6%); and in Viet Nam, the greatest proportion of post-trafficking service users were trafficked for sex work (28.5%) and factory work (27.6%).

The main destination countries across all labour sectors – except for fishing and domestic work – were Thailand (40.7%) and China (29.9%) – . The waters around Indonesia were the main destination for fishermen (46.9%), while Malaysia was the main destination for the largest portion of domestic workers (44.7%).

Table 17 shows a more detailed breakdown by sector of participants who were exploited in Thailand and China.

Table 17: Participants reporting exploitation in the different sectors: China and Thailand

Sector or type of exploitation	Working in Thailand		Working in China	
	n	%	*n*	%
Sex work	227	*50.7*	95	*28.8*
Factory work	39	*8.7*	89	*27.0*
Fishing	77	*17.2*	2	*0.6*
Brides/wives	0	*0.0*	51	*15.5*
Begging	25	*5.6*	0	*0.0*
Entertainment/karaoke/massage/nail care	23	*5.1*	2	*0.6*
Animal farming/meat preparation	5	*1.1*	0	*0.0*
Agriculture/farming/plantation	4	*0.9*	53	*16.1*
Car care	5	*1.1*	0	*0.0*
Domestic work/cleaning	9	*2.0*	12 (	*3.6*
Construction	13	*2.9*	6	*1.8*
Home business	0	*0.0*	5	*1.5*
Restaurant/hospitality/tourism	6	*1.3*	0	*0.0*
Street selling/shop	15	*3.3*	3	*0.9*
Others	0	*0.0*	12	*3.6*
Total	448	*100.0*	330	100.0

Looking at participants by country of origin, Cambodians were mainly trafficked into fishing (70.9%), factories (6.9%) and domestic work (5.9%). Participants from Thailand, whether nationals of the country or not, were trafficked mainly into sex work (79.3%). Vietnamese were exploited in a variety of sectors, especially the sex industry (28.5%), factory work (27.6%), agriculture/farming (15.7%) and as "brides/wives" (15.4%).

Sector of exploitation: Children and adolescents

Among those under 18 years old (including those who did not reach their destination), the majority were exploited in sex work (51.9%), followed by factory work (5.2%) and entertainment (5.9%). Among the 25 individuals trafficked for begging, 22 were less than 18 years old, 16 of whom were from Cambodia, with the rest from Thailand.

Table 18: Participants reporting exploitation in the different sectors , by age group

Sector or type of exploitation	10–14 years old		15–17 years old		18 and above	
	n	%	*n*	%	*n*	%
Sex work	23	*29.1*	178	*57.8*	128	*17.9*
Fishing	1	*1.3*	12	*3.9*	262	*36.6*
Factory work	2	*2.5*	18	*5.8*	116	*16.2*
Agriculture/farming/plantation	0	*0*	3	*1*	55	7.7
Brides/wives	2	*2.5*	13	*4.2*	38	*5.3*
Domestic work/cleaning	4	*5.1*	6	*2*	28	*3.9*
Entertainment/karaoke/massage/nail care	2	*2.53*	21	*6.8*	6	*0.3*
Begging	18	*22.8*	4	*1.3*	3	*0.4*
Construction	1	*1.3*	7	*2.3*	11	*1.5*
Street selling/shop	10	*12.7*	4	*1.3*	4	*0.6*
Restaurant/hospitality/tourism	0	*0*	7	*2.3*	0	*0*
Home business	0	*0*	1	*0.3*	5	*0.7*
Animal farming/meat preparation	2	*2.5*	1	*0.3*	2	*0.3*
Car care	3	*3.8*	0	*0*	2	*0.3*
Other	1	*1.3*	0	*0*	11	*1.5*
Did not reach destination	10	*12.6*	33	*10.7*	44	*6.8*
Total	79	*100.0*	308	*100.0*	715	100.0

Participants who did not reach the destination

Eighty-seven participants in post-trafficking services (7.9%) were detected before they reached their destination. Among participants assisted by services in Viet Nam, 45 individuals were identified before reaching their destination. Thirty-six individuals in Thailand and six in Cambodia were identified before reaching their destinations.

Expectations at the destination

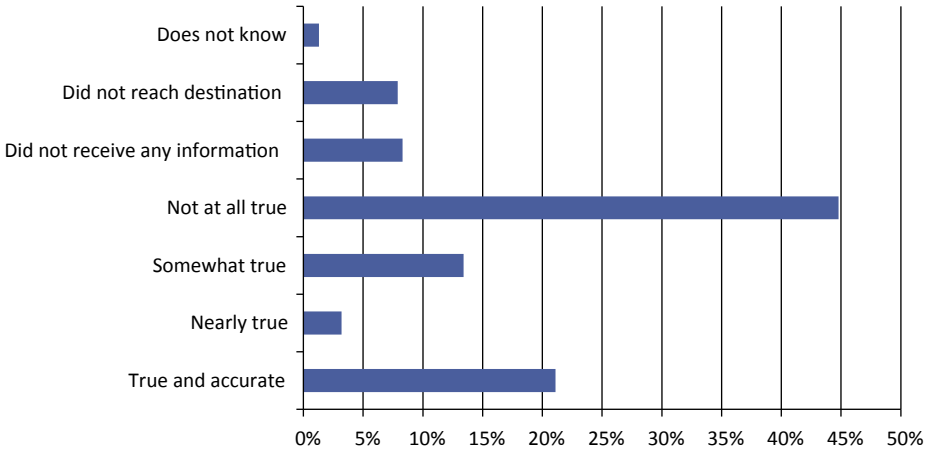
Participants were asked how they would rate the accuracy of the information they received prior to leaving home (i.e. "true and accurate," "nearly true," "not at all true," and "no information") (See Table 19). Most participants (66.5%) thought the information they received before starting work was not accurate; 44.8 per cent reported information was "not true at all"; and 13.4 per cent reported that the information they received was "somewhat true" or that they did not receive any information at all (8.3%).

Sectors with the highest proportions of respondents reporting that the information they received was "not at all true" were brides/wives (92.5%) and construction workers (68.4%). Among sex workers, 45.9 per cent reported that the information they received was not at all true, as did 56.4 per cent of fishermen.

Table 19: Accuracy of information provided to participants prior to starting work

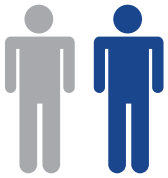
Accuracy of information	*n*	%
True and accurate	233	*21.1*
Nearly true	35	3.2
Somewhat true	148	*13.4*
Not at all true	494	*44.8*
Did not receive any information	91	*8.3*
Did not reach destination	87	*7.9*
Does not know	14	*1.3*
Total	1,102	100.0

Figure 3: Accuracy of information about the situation at the destination prior to starting work



Physical and/or sexual violence while in the trafficking situation[vi]

Violence is a common and defining feature of human trafficking. Violence may be used to intimidate, as a punishment for perceived errors or disobedience and to dissuade escape. Moreover, abuses operate as implicit and effective threats to others who may witness the violence.



Nearly one in two participants experienced violence.

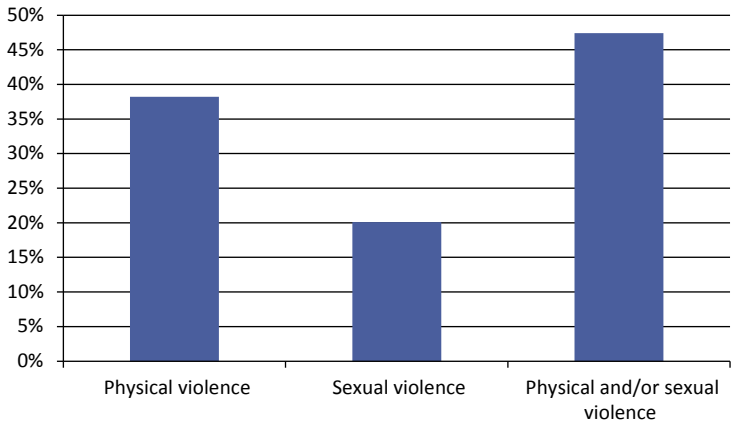
Nearly half (47.4%) of the 1,015 participants – adults and children – who reached their destination reported experiencing physical and/or sexual violence during the time they were trafficked (See Table 20).

Table 20: Violence experienced by trafficked participants who reached their destination (*n*=1,015)

Type of violence experienced	*n*	%	95% CI
Physical violence*	388	*38.2*	35.3–41.4
Sexual violence**	204	*20.1*	17.8–22.8
Physical and/or sexual violence***	481	*47.4*	44.5–50.8

* Two responses missing.
* Six responses missing.
*** Five responses missing.

Figure 4: Prevalence of physical and/or sexual violence among the trafficked participants



Among participants who did not reach their destination (*n*=87), data on violence were collected for 85 persons. Among these participants, 16.5 per cent (*n*=14) experienced physical violence; 8.2 per cent (*n*=7) experienced sexual violence; and 20.0 per cent (*n*=17) experienced physical or sexual violence during transit.

Of those who reached their destination and answered the questions on violence, nearly half of male (48.4%) and female (47.0%) participants reported experiences of sexual and/or physical violence while they were in a trafficking situation. Experiences of violence were reported by 36.2 per cent of children ages 10 to 14 and by 35.3 per cent of adolescents ages 15 to 17.

[vi] For consistency with pre-migration violence, we present figures, excluding missing data from the denominator in this section, with the number of missing values stated in below tables.

Table 21: Experience of violence by men, women and children who reached their destination (*n*=1,015)

	Male		Female		Adult male		Adult female		Children 10– 14 years old		Children 15–17 years old	
Experience of violence	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
Any violence*	215	*48.4*	300	*47.0*	188	*49.3*	171	*60.0*	25	*36.2*	97	*35.3*
No violence*	229	*51.6*	266	*53.0*	193	*50.7*	114	*40.0*	44	*63.8*	178	*64.7*
Total	444	*100.0*	569	*100.0*	381	*100.0*	285	*100.0*	69	*100.0*	275	100.0

* Five responses missing.

To measure the prevalence of violence, participants were asked about a series of specific abusive acts they may have experienced. Approximately half of those who reported abuse reported being slapped, shoved or hit with something that could hurt. However, many participants also reported what are generally considered more severe acts, such as being choked (*n*=54), being cut with a knife (*n*=39) or having a gun shot at them (*n*=14) (See Table 22).

Table 22: Participants who reached destination and experienced specific acts of violence (*n*=1,015)[#]

Act of violence committed against the participant	n	%
Slapped, shoved or thrown something that could hurt *	288	*28.4*
Pushed or shoved	265	*26.1*
Hit with a fist or with something else that could hurt	227	*22.4*
Kicked, dragged or beaten up*	199	*19.6*
Tied or chained *	26	*5.3*
Choked on purpose*	54	*3.6*
Burned on purpose	9	*0.9*
Released a dog upon to be bitten or scratched	11	*1.1*
Forced to have sex***	204	*20.2*
Threatened to use a gun, knife or other weapon against**	156	*15.4*
Used a knife to be cut*	39	*3.9*
Shot a gun at *	14	1.4

* One response missing.
** Two responses missing.
*** Six responses missing.
[#] Multiple responses possible: totals will sum up to >100%.

Particularly high levels of physical and/or sexual violence were reported by participants trafficked as brides/wives (88.5%, *n*=46 of 52) and for fishing (68.4%, *n*=188 of 275), sex work (50.8%, *n*=167 of 329), domestic servitude (60.5%, *n*=23 of 38) and begging (36.0%, *n*=9 of 25).

More than one in four participants (26.3%) witnessed their boss or trafficker physically assault another person. Reports from study participants – in addition to descriptions in another study on Cambodians trafficked for commercial fishing – feature detailed accounts of murders by employers, for example, boat captains, when men and boys become too ill or injured to work, often by throwing the individual overboard. Among a sample of 49 trafficked men interviewed, 59 per cent witnessed the murder of a fellow crew member by the boat captain (although it is not known how many men were on the same boats and might have witnessed the same acts).[13] In another study – which involved 24 trafficked fishermen in Thailand – 33 per cent witnessed physical abuse committed on others by their superiors, while 50 per cent were physically abused themselves.[14]Among fishermen in our sample, 52 per cent (*n*=143 of 275) witnessed their boss or trafficker physically harm someone.

Violence commonly occurs at the destination location, when individuals are engaged in the exploitative work, but abuses may also occur en route to the final destination. As noted above, 20.7 per cent of those who did not reach their destination reported experiencing one or more acts of violence. Among them (85 of 87 participants who answered the question), 12.9 per cent reported being slapped or shoved, 8.2 per cent being hit with a fist or something that could hurt them, and another 8.2 per cent being forced to have sex.

Sexual abuse

Among those who reached their destination and who answered the question on sexual violence (*n*=1,009), nearly one in six participants (20.1%, *n*=204) reported being subjected to forced sex while they were in a trafficking situation. Of these 204 individuals reporting sexual abuse, 198 (97.1%) were female and six (2.9%) were male.

Among participants who answered the question (*n*=1094 of 1102), 32.2 per cent of the females and 1.5 per cent of the males reported sexual violence. Among those aged under 18 years, 8.9 per cent (*n*=7 of 69) of those aged 10 to 14 years old reported sexual violence, as did 21.8 per cent (*n*=67 of 275; 1 response missing) of those aged 15 to 17 years old.

Women trafficked as "brides/wives" (*n*=53) were the most likely to experience sexual abuse, with 44 of the 52 who answered the question (84.6%) reporting that they were forced to have sex.

Among women trafficked for sex work (*n*=327), almost half (43.1%, *n*=141 of 327; 1 response missing) reported sexual abuse. Sexual abuse was also reported by women in other sectors, such as domestic work (16.6%, *n*=6/ of 6) and agriculture (13.5%, *n*=5 of 37).

The seven males who were sexually abused were trafficked for either fishing (*n*=5) or sex work (*n*=1); one did not reach his destination (*n*=1).

Sexual abuses were also reported by those who were not able to reach their destination: six of the 68 female participants (9.0%; 1 response missing) who did not reach their destination were forced to have sex.

Perpetrators

Participants were asked to categorize the perpetrator who physically or sexually abused them into one of the following: (a) those who owned or managed their workplace ("employer"); (b) those who recruited and/or transported and sold them ("trafficker"); and those who do not fall under either (a) or (b) (e.g. co-workers, police, clients, etc.). Among those reporting physical and/or sexual violence who reached their destination and gave information on the perpetrators (*n*=481), the perpetrator of the violence was most frequently the employer (35.8%, *n*=172 of 481) or the trafficker (28.1%, *n*=135 of 481).

Participants who reported forced sex were asked to identify their abusers. Among those who reached their destination and reported being forced to have sex (*n*=204), most said the abuser was "a client" (56.9%, *n*=116), followed by "an employer" (31.8%, *n*=64), a "husband/partner" (21.6%, *n*=44) and "the trafficker" (21.1%, *n*=43). These figures on perpetrators reflect, to a certain extent, the proportions of women trafficked into certain sectors (e.g. sex work, brides/ wives), as most of those experienced sexual violence at the destination were female (*n*=198).

Among the seven participants who experienced sexual violence and did not reach their destination, six were forced to have sex by the trafficker and one was forced by another person.

Frequency of abuse

Among the participants who reported violence during transit and at the destination (*n*=498) and who gave information on frequency, violence was "regularly" experienced by those who were abused by a husband (77.1%, *n*=37 of 48), a client (69.2%, n=65 of 94,) or a bouncer (40.9%, *n*=36 of 88,).

Threats

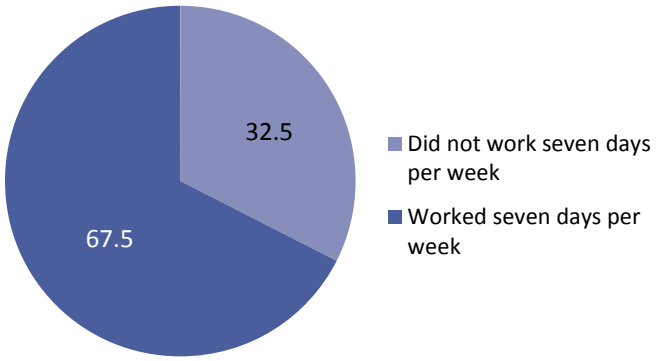
Nearly half of the participants who reached their destination (46.0%, *n*=467 of 1,015) were personally threatened with violence while in the trafficking situation. Additionally, 12.9 per cent of participants (*n*=131 of 1015) reported that someone threatened to harm a family member or another close relation.

Threats – especially those to harm an individual's family – and intimidation are a particularly effective method of maintaining control over people in trafficking situations. People who are trafficked understand that those who have trafficked them are frequently well-aware of their home location or may even be from the individual's village and can easily make problems for their family. In this way, a trafficked person's sense of entrapment may seem insurmountable. It is also worth noting that in many trafficking cases, threats relate to the repayment of usurious debt arrangements.

Working days and hours

When asked about their work schedules, the great majority (67.5%) of participants who reached the work destination reported working seven days per week (see Table 23). Among those reporting working every day and who could recall their working hours (*n*=449), the mean number of hours worked was 13.8 (SD=6.6) per day. Those reporting the greatest number of working hours were in fishing (18.8, SD=5.9), followed by domestic work (15.2, SD=6.6). Among the 1,101 participants who answered the question on the number of working hours, over one third (39.8%) reported having no fixed work hours. A small percentage (2.2%) did not know how many hours they worked on a daily basis.

Figure 5: Percentage of those who worked seven days per week



Among adults, the mean number of hours worked per day was 15.1 (SD=6.4); the mean number of hours worked by children was 7.9 (SD=4.8).

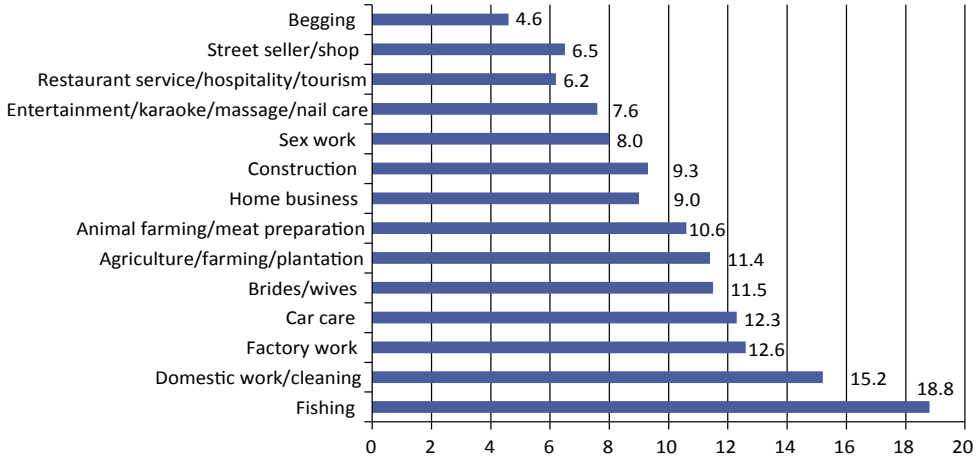
On average, men worked longer hours than women, 15.6 hours (SD=6.7) and 9.2 hours a day (SD=5.2), respectively. The men's high average is likely due to the large number of fishermen among the respondents, who reported working nearly 19 hours per day, 7 days per week. Children were often assigned to street "begging" and reported working fewer hours than respondents in other sectors.

Table 23: Mean hours of work per day, by sector or type of exploitation

Sector or type of exploitation	Mean number of hours worked in a day (hours)	*SD* (Hours)
Fishing	18.8	5.9
Domestic work/cleaning	15.2	6.6
Factory work	12.6	3.2
Car care	12.3	1.0
Brides/wives	11.5	4.7
Agriculture/farming/plantation	11.4	2.5
Animal farming/meat preparation	10.6	0.9
Home business	9.0	--
Construction	9.3	1.1
Sex work	8.0	4.5
Entertainment/karaoke/massage/ nail care	7.6	4.7
Restaurant service/hospitality/ tourism	6.2	2.2
Street seller/shop	6.5	4.1
Begging	4.6	3.0

When asked if they could change their working hours if they were "feeling ill or wanted to take a holiday," 60.7 per cent (*n*=616) of participants stated that they could not.

Figure 6: Mean number of hours worked by sector/type of trafficking



Abusive working hours are a well-recognized feature of exploitative trafficking work conditions and a demonstrated contributor to workplace risk and poor health. It is difficult to overestimate the physical and psychological effects of abusive work hours such as those associated with human trafficking. Especially for those who live and work in the same physical space, such as fishermen and domestic workers, with both groups reporting working up to 24 hours, the psychological stress is likely to be chronic and unrelenting, potentially resulting in severe mental health problems. The risk of physical injuries is highly dependent on the type of work, and is particularly pronounced in jobs that involve hazardous tasks or equipment will generally pose greater risk of more severe physical injuries. At the same time, jobs that keep people in situations of isolation for long periods, such as domestic work, may pose greater risk of poor mental health outcomes.

Restricted freedom

When asked "How often were you free to do what you wanted or go where you wanted?", 67.9 per cent of participants reported that they were "never" or "seldom" free to go where they wanted or to do what they wanted. It is notable that well over half indicated they were "never" free.

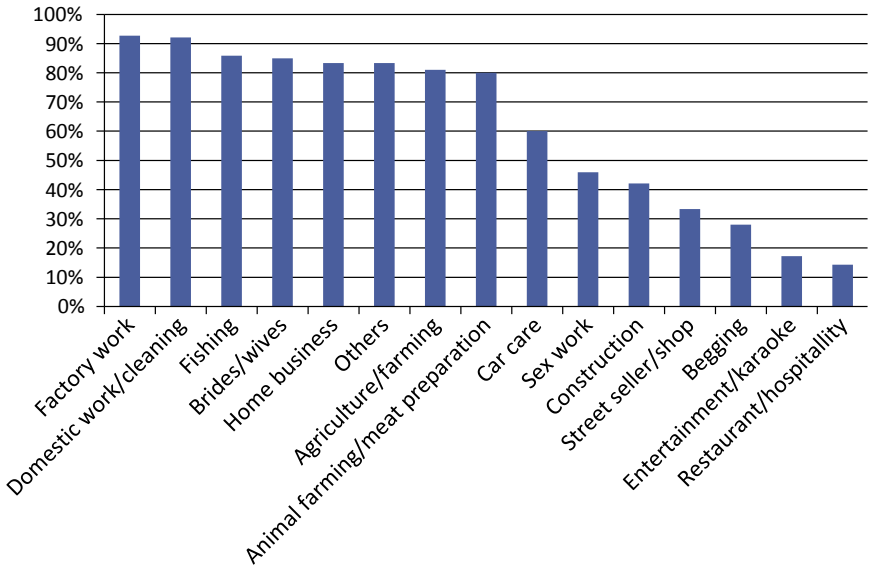
Table 24 shows the proportion of individuals reporting that they were seldom or never free. It is notable, however, that in many sectors, the majority had reported that they were "never" or "seldom" free. Those who reported "never" being free, specifically those individuals trafficked for domestic work (86.8%) and fishing (80.4%), were most likely to report "never" being free to do what they wanted or go where they wanted (data not shown on the table). In many ways, this level of restriction is logical because domestic workers are often confined to the employer's home, and fishermen are out at sea and physically confined to a vessel. However, the figures indicating the average number of hours they worked – 15.2 hours among domestic workers and 18.8 hours for fishermen – perhaps suggest a deeper truth: they never had time for rest or leisure.

Participants trafficked for sex work tended to report somewhat greater freedom than other females, but still a high proportion (45.9%) indicated they were "never" or "seldom" free and 53.8 per cent said they were "occasionally," "often" or "always" free. This differs from a previous study conducted in Europe, where 87 per cent of women trafficked for sex work reported they were "never" or "seldom" free.[4]

Table 24: Participants reporting they were "never" or "seldom" free to do as they wanted or go where they wanted while in a trafficking situation, by sector or type of exploitation

	Number of participants who reported being "never" or "seldom" free to do what they wanted or go where they wanted	
Sector or type of exploitation	***n***	**%**
Domestic work/cleaning	35	92.1
Fishing	236	85.8
Brides/wives	45	84.9
Factory work	126	92.7
Animal farming/meat packing	5	80.0
Agriculture/farming	47	81.0
Home business	5	83.3
Sex work	151	45.9
Car care	3	60.0
Construction	8	42.1
Street seller/shop	6	33.3
Begging	7	28.0
Restaurant/hospitality	1	14.3
Entertainment/karaoke	5	17.2
Others	10	83.3
Total	689	67.9

Figure 7: Participants reporting being "seldom" or "never" free, by sector of exploitation



Restricted freedom of movement, physical confinement or detention by threat – implicit or direct – are core indicators of a trafficking or forced labour situation. Based on participants' reported restricted levels of choice and movement, one may surmise that few felt able to leave their situation, whether temporarily or permanently. The distinction between the actual level of physical restriction or confinement versus implicit restrictions (e.g. threats, intimidation and debts) remains unclear, however.

Participants whose movement and choice were restricted were also much more likely to experience violence. Of the 594 participants reporting "never" being free and who answered the questions on violence, 60.1 per cent (*n*=357) reported experiencing physical or sexual violence. This is in contrast to the 13.9 per cent (*n*=19) of the 137 participants who reported that they were "always" free to move *but* reported being subjected to violence while they were in the trafficking situation.

This type of abuse-related confinement or "traumatic entrapment" has been studied in association with Stockholm Sydrome and the concept of "appeasement."[15] Appeasement – which comprises "pacification, conciliation and submission," – is an important survival defence strategy in the face of traumatic entrapment.[15] These situations and concomitant psychological reactions are associated with poor mental health outcomes, specifically complex post-traumatic stress disorder.

Forced drug use

A small proportion (6.1%, *n*=62 of 1,015) of participants who reached their destination were forced to take drugs or medication during their trafficking experience. Forced drug use was more likely to be reported by children (8.4%) than adults (4.99%). Females (6.5%) and males (5.6%) reported similar experiences of forced drug use. Reports of forced drug use was higher among those trafficked for begging (24.0%) and sex work (10.3%); however, forced drug use was also reported among participants working in entertainment (6.9%), fishing (5.8%) and factories (1.5%).

Alcohol consumption

For only a small minority of participants did alcohol appear to be a serious health hazard, as a mere 3.2 per cent (*n*=32) reported drinking daily. Nineteen participants (1.9%) reported they

drank more than five drinks on most days. The majority (63.1%) of participants reported never consuming alcohol while in the trafficking situation. Those trafficked for sex work were more likely to drink daily (6.4%) or binge drink (4.9%), as were the 29 participants trafficked into the entertainment sector (17.2% drink daily; 10.3% binge drink) (See Table 25).

Table 25: Frequency of drinking while in the situation of exploitation (*n*=1,015)

Frequency of drinking	*n*	%
Never drank alcohol	640	*63.0*
Drank a few times per year	106	*10.4*
Drank a few times per month	102	*10.1*
Drank a few times per week	70	*6.9*
Drank every day	32	*3.2*
Drank more than five drinks most days	19	*1.9*
Refuses to answer	29	*2.9*
Doesn't know/Doesn't remember	17	1.7

Occupational hazard exposures during trafficking situation

Participants who reached their destination (*n*=1,015) were asked about multiple occupational hazards specifically associated with their jobs. Large proportions of the participants trafficked into sex, domestic, restaurant/hospitality, construction and factory work, and agriculture and fishing (*n*=873) reported that their jobs involved "repeated bending or lifting" (44.6%) and "lifting heavy objects" (39.8%).

Table 26: Occupational health hazards experienced while in the trafficking situation

Occupational hazard	*n*	%
Repeated bending or lifting	389 (of 873)	*44.6*
Lifting of heavy objects	347 (of 873)	*39.8*
Use of sharp instruments	263 (of 873)	*30.1*
Working with harsh chemicals (e.g. cleaning solutions)	163 (of 873)	*18.7*
Working with dust or fibers	55 (of 161)	*34.2*
Operating big or heavy machinery	25 (of 155)	*16.1*
Working high off the ground	15 (of 155)	9.7
Working with raw meat	3 (of 63)	*4.8*
Working with or near pesticides	7 (of 63)	*11.1*
Unstable or heavy work platforms	226 (of 275)	*82.2*
Working along rocky coasts or in remote offshore locations	179 (of 275)	*65.1*
Working in a small, unstable or poorly maintained fishing vessel	94 (of 275)	*34.2*
Using poorly maintained or no fishing equipment	77 (of 275)	*28.0*
No safety/poor or no survival equipment	170 (of 275)	*61.8*
Working long hours in the sun, and cold or wet without a break	266 (of 275)	*96.7*
Working near road traffic	46 (of 111)	*41.4*
Working long hours in the sun without a break	51 (of 111)	*46.0*
Working long hours in the cold or wet without a break	31 (of 111)	27.9

*Multiple responses possible; totals can reach >100.

There were patterns of specific occupational hazards reported for the most common sectors of exploitation. Individuals working in fishing were highly likely to report spending "long hours in the sun, cold or wet without a break" (96.7%), working on "unstable or heavy work platforms" (82.2%) and "working along rocky coasts or in remote offshore locations" (65.1%). Looking specifically at individuals trafficked for fishing, most reported "repeated bending or lifting" (94.9%) and "lifting heavy objects" (93.5%).

The majority of domestic workers reported occupational hazards such as "repeated bending or lifting" (68.4%) and "lifting heavy objects" (55.3%). Participants trafficked for agricultural work reported "long hours in the sun without a break" (53.5%) and "repeated bending or lifting" (22.4%). Factory workers reported "working with dust or fibres" (33.8%), having to "work with harsh chemicals or cleaning solution" (33.1%) and having to "use sharp instruments" (23.5%). When asked about protective equipment, many females trafficked for forced sex work reported risks associated with not having condoms and/or contraception (See Table 27).

Trafficking for forced labour generally involves low-skilled and often high-risk tasks, accompanied by inadequate training, poor personal protective equipment and limited or no health and safety standards for work premises. While there is little to no research on occupational health risks among a general population of migrant workers in the Greater Mekong subregion, exposures to work-related hazards and dangerous work settings are likely to be common. It can easily be estimated that the occupational hazards in these already risk-laden sectors are exponentially worse for people who are trafficked and in extremely exploitative and abusive circumstances—circumstances where their safety and lives are probably even less valued.

Personal protective equipment

Table 27: Personal protective gear given for work

Personal protective gear	*n*	%
Sun hat	171 (of 339)	50.4
Helmet	32 (of 155)	20.7
Gloves	247 (of 538)	45.9
Life vest	74 (of 275)	26.9
Protection mask	36 (of 268)	13.4
Safety goggles or eye protection	15 (of 155)	9.7
No protective gear given	384 (of 1,015)	37.8
Shoes or boots*	34 (of 1,015)	3.4
Condoms*	220 (of 1,015)	21.7
Contraceptive pills*	8 (of 1,015)	0.8
Apron*	8 (of 1,015)	0.8
Knife*	9 (of 1,015)	0.9
Shirt*	2 (of 1,015)	0.2
Coat*	2 (of 1,015)	0.2
Pepper spray*	2 (of 1,015)	0.2

* From the "Other, specify" option. Denominator includes everyone who reached their destination, except for "Condoms" (only sex workers included in the denominator).

Participants were asked whether they were given any occupational health and safety gear for their work. Participants were offered a list of basic equipment commonly associated with the type of labour they had undertaken (e.g. helmets for construction workers; gloves and hats for agricultural workers; life vests, sun hats and gloves for fishermen; etc.). Over one third of participants (37.8%) received no protective equipment at all for their work. The most commonly reported protective gear or devices associated with the sectors for which they would be relevant were: condoms (66.9%) (sex workers), sun hats (50.3%) (e.g. agriculture, animal farming and fishing), gloves (45.9%) (e.g. agriculture, construction and fishing), and life vests (26.9%) (fishermen). Only 34 people (12.8%) reported receiving protective masks – despite the high numbers of factory workers (*n*=136), agricultural workers (*n*=58) and construction workers (*n*=19), for example.

It is uncertain how these rates of protective gear use might relate to the general population of migrant labourers working in the same sectors in this region. However, it would be reasonable to

speculate that workers in exploitative situations are less likely to be offered protective gear and are more exposed to workplace hazards for longer periods. There is a large body of occupational health literature that highlights the various potential long-term health consequences (e.g. loss of limbs, pulmonary diseases, pesticide poisoning and drowning) that can be prevented with appropriate personal protective equipment, but little research has been conducted with migrant workers in middle- and low-income countries.[16,17]

Labour sectors that are physically demanding and require high-intensity activities, such as fishing, construction, agriculture, animal farming and sex work, frequently pose serious occupational health hazards – especially in situations of forced labour. As noted above, for individuals in trafficking or extremely exploitative circumstances, these work-related risks are exacerbated by, for example, long working hours; taking few breaks, which leads to exhaustion; having poor or no protective equipment; limited or no training (e.g. for those work involving heavy equipment, hazardous chemicals, repetitive activities and airborne contaminants), in a language that the worker understands ; lack of protection from heat, the cold and other environmental elements; and poor or no health and labour inspections. Additionally, as indicated on the tables on violence, these hazards are frequently accompanied by violence, physical punishment and deprivation, which are likely to place individuals at further risk of dangerous mistakes and accidents.

Condom use among females trafficked for sex work

Over half of females trafficked for sex work reported always using condoms with their clients while they were in the trafficking situation (see Table 28). It is unclear how accurately the women and girls in this study reported regarding the regularity of condom use, as it is possible that a "social desirability" bias may have resulted in over-reporting of "Always." Reported condom use also appeared to be linked to violence. Twice as many women who did not experience violence reported "always" using condoms compared to women who reported violence (75.5% versus 35.8%).

Table 28: Frequency of condom use with clients among participants in forced sex work

Condom use with clients	*n*	%
Occasionally	71	*22.2*
Often	31	*9.6*
Always	179	*55.2*
Never	14	*4.3*
Refused	6	*1.9*
Doesn't know	4	*1.2*
Missing	18	*5.6*
Total	324	100.0

Work-related injuries

Participants were asked how many times they had a "serious injury resulting from their work or accidents at work."[vii] (See Table 29).

One in five participants was ***seriously*** injured while working.

[vii] Note: Participants were asked specifically about serious injuries; therefore, more general (less than severe) injury rates are likely to be higher.

Over one in five (21.9%) participants who reached their destination reported being seriously injured at least once while working. For the 222 participants who reported an injury, the most commonly reported injuries were: deep/long cuts (51.8%, *n*=115); skin damage (38.3%, *n*=85); and back or neck injuries (30.2%, *n*=67). A serious head injury was reported by approximately one in six participants (16.7%, *n*=37). Eye injuries were reported by 8.1 per cent of participants (*n*=18 of 222), and 4.1 per cent reported a broken bone (*n*=9/222). Forty-nine people said they were injured "many times."

Seven participants (3.2%) reported that they lost a body part.

Only 62 of the 222 who reported any injury received some kind of medical care. Treatment was received most frequently for broken bones (36.4%, *n*=4 of 11) and other accidental injuries (29.2%, *n*=14 of 48),

Fishermen were by far the most likely to report an injury. Almost half of men trafficked for fishing (46.6%, *n*=128 of 275) reported at least one serious injury. Those in construction were the next most likely to report injuries, with 26.3 per cent (*n*=5 of 19) having experienced at least one serious injury. Over one in 10 participants involved in sex work (10.3%) or entertainment (10.3%) reported experiencing at least one serious injury as part of their work.

Table 29: Number of times participants were seriously injured as a result of work or accidents at work

Injury reported	*n*	%
Injured once	100	*9.9*
Injured a few times	73	*7.2*
Injured many times	49	*4.8*
No injury	760	*74.9*
Did not work	1	*0.1*
Cannot recall	32	*3.2*
Total	1,015	100.0

Length of time in the trafficking situation[viii]

There was a wide range of time that participants were in the trafficking situation. The median duration of the trafficking situation was 116.5 days (MAD=91.5) – over three months (see Table 30). The median duration for men (193 days; MAD=167) was longer than that for women (91.5 days; MAD=69.3). The high median duration for men is likely due, in part, to the long periods that a large cohort of men spent onfishing boats, as the median duration of exploitation was longest for these men, which was approximately 16 months (487.3 days; MAD=350.3). The next longest median duration of exploitation was for people trafficked for brides/wives (brides/wives (183; MAD=122), and then for domestic workers (122; MAD=107).

[viii] In this section, we use the median and median average deviation (MAD) rather than the mean. The median is the midway value in the distribution of responses (half of the distribution lies below the median and half above it). The mean of time spent in the trafficking situation was significantly influenced by extreme outliers in some sectors (e.g. fishing and domestic work); therefore, the median more accurately reflects the number of days in trafficking for the majority of participants by sector.

Table 30: Time spent in trafficking situation by sector

Sector of exploitation	Median (days)	Median Average Deviation
Fishing	487.3	350.3
Brides/wives	183	122
Domestic work/cleaning	122	107
Factory work	91.5	41
Sex work	91.5	61
Car care	61	0
Agriculture/farming/plantation	61	41
Street selling/shop	61	58
Restaurant/hospitality/tourism	45.8	16.5
Others	34.8	14.8
Entertainment/karaoke/massage/nail care	30.5	21.5
Construction	30.5	23.5
Begging	30.5	26.5
Home business	29	16.5
Animal farming/meat preparation	10	21.5
Total	116.5	91.5

The longest period spent in a situation of exploitation was reported by a woman trafficked to China to work in agriculture (6,605 days, or over 18 years) who received post-trafficking services in Viet Nam. Among the men, the longest time spent in labour exploitation was reported by a man trafficked to Malaysia to work in the fishing sector (3,744 days, or over 10 years), who received post-trafficking services in Cambodia.

Among the youth, a 16-year-old receiving post-trafficking services in Thailand was exploited as a beggar for 3,287 days (or approximately 9 years).

It is important to acknowledge the extreme difficulties associated with escaping a long-haul commercial fishing boat, which undoubtedly contributed to the long periods that fishermen remained in trafficking situations. Typically, long-haul fishing boats do not need to return to shore for years on end, as smaller vessels will operate between the shore and the fishing boat to collect the catch and bring supplies, making escape nearly impossible. Moreover, even when boats come within sight of shore, escape would not be possible for fishermen who come from Cambodia's north-west provinces (which are landlocked) and generally do not know how to swim (surveys suggest that six Cambodian children die each day from drowning, for example).[18]

Working and living conditions of trafficked persons

Participants were asked about various aspects of their living and working conditions in order to explore potential health hazards. Over three-quarters of all participants who arrived at the work destination (78.1%, *n*=793 of 1,015,) reported some aspect of poor living conditions. The most commonly reported adverse conditions were: "no or very few rest breaks" (56.1%); living/sleeping in overcrowded rooms (44.6%); and having nowhere to sleep/sleeping on the floor (36.4%) (See Table 31).

Table 31: Living and working conditions

Living and working conditions	*n*	%
No or very few rest breaks	569	*56.1*
Living and sleeping in overcrowded rooms	453	*44.6*
Nowhere to sleep/sleeping on the floor	369	*36.4*
Overexposure to sunlight or the cold	359	*35.4*
Poor basic hygiene	307	*30.3*
No clean clothing items	302	*29.8*
Insufficient food	241	*23.7*
Inadequate water for drinking	216	*21.3*
Locked in a room	198	*19.5*
Sleeping in dangerous conditions	144	*14.2*
Other hazards	117	11.5

*Multiple responses possible.

The highest proportion of those reporting poor living conditions were participants trafficked in the agriculture/farming and fishing sectors. A total of 144 people said that they slept in "dangerous conditions," which was most commonly reported by men engaged in fishing work (39.3%, *n*=108 of 275).

Importantly, nearly 200 people (19.5%) reported ever being "locked in a room" while they were in the trafficking situation; this was more commonly reported by sex workers (27.7%, *n*=91 of 329,), domestic workers (23.7%, *n*=9 of 38,) and those working in the fishing sector (22.9%, *n*=63 of 275). When asked about availability of food, 23.7 per cent (*n*=241) said they were not given sufficient food. Lack of food was commonly reported by those working in fishing (44.0%, *n*=121 of 275) and domestic workers (47.4%, *n*=18 of 38).

Both the working and living conditions of people who are trafficked are, at the least, unhealthy, and, more often, dangerous, in addition to being filled with multiple stressors, including life-threatening circumstances. Even when not at work, participants often did not feel safe or comfortable. Although "home" is supposed to be a respite from work, people who are trafficked rarely return to a secure and restful residence at the end of the day, but instead often spend their non-working hours in unclean, uncomfortable and overcrowded conditions. Although many migrant workers endure poor living situations, individuals in trafficking circumstances appear to be even more likely to suffer severely deprived and unsafe living conditions.

Trafficking finances

Few participants (37.4%, *n*=380 of 1,015,) had received cash payments while trafficked.[ix] A much higher proportion of children reported receiving some cash payments (66.6%, *n*=229 of 344) compared to adults (22.5%, *n*=151/671). A slightly higher proportion of females received cash payments (43.8%, *n*=249 of 569) compared to males (29.4%, *n*=131 of 446).

The sectors with high proportions of participants reporting that they received no cash payments included: agriculture (96.6%, *n*=56 of 58); brides/wives (96.2% *n*=51 of 53); and factory workers (80.2%, *n*=109 of 136). None of the five participants working in car care were ever paid.

Among those who were paid and could recall the amount (*n*=291), sex workers (*n*=106) took home the most pay, with a mean of USD 37.80 per day (SD=USD 67). The lowest paying sectors were agriculture (*n*=2), at USD 1.70 per day (SD=USD 1.70) (*n*=2), and fishing (*n*=79), at USD 3 per day (SD=USD 5.70).

[ix] Note: Cash payments were measured (versus, e.g. reported remittances or money owed) because cash represents funds that are accessible to meet needs and often more accurately represents whether participants were paid at all (i.e. versus what they may have been told about monies sent home or promised).

Travel and identity documents

The majority of participants (69.0%, n=700) reported having no travel or identity documents.

Among participants who reported having documents, 39.4 per cent (*n*=124) said that someone kept their documents from them. A higher proportion of females reported having documents kept from them (47.5%, *n*=103 of 217) than males (21.4%, *n*=21 of 98), and a higher proportion of adults had their documents kept from them (48%, *n*=85 of 177) than did children (28.3%, *n*=39 of 138).

Confiscation of a migrant's documents is a common indicative feature of a trafficking situation, especially if it involves crossing an international border. Withholding their documents can be an effective tactic to control people and prevent them from trying to escape. Trafficked persons are often warned by traffickers that if they are found without proper documents, they will be arrested and possibly detained for indeterminate periods.

Access to health care while in a trafficking situation

Participants were asked whether they ever needed health care while in the trafficking situation. More than one third of the participants (40.8%, *n*=414 of 1,015) said that they had needed health care while in the trafficking situation. A higher proportion of children (51.7%) than adults (35.2%) reported needing some health care, as did a higher proportion of females (49.2%) than males (30.0%).

The sectors with a high proportion of participants reporting that they needed health care were sex work (59.6%), brides/wives (58.5%), fishing (32.0%) and domestic work (31.6%). Some 52.5 per cent of post-trafficking service users in Thailand, 36.1 per cent in Viet Nam and 28.9 per cent in Cambodia reported having health-care needs while they were in a trafficking situation. These figures may, to a certain extent, reflect the sectors into which the service users were trafficked and people's general perceptions and practices related to medical care, which may lead to underreporting.

Health care received while in a trafficking situation

Around 11.3 per cent of all participants reported seeing a medical professional (i.e. a doctor or a nurse). Among the 414 people who reported that they needed medical care while in the trafficking situation (40.8% of all participants who reached their destination), 39.1 per cent said that they had contact with a doctor or nurse, while 33.7 per cent saw a doctor and 20.8 per cent saw a nurse. Approximately one quarter (23.0%) of those who needed medical care said that the owner or manager provided medication. It is not clear what types of medication the employers offered.

Interestingly, 5.1 per cent of all trafficked participants said they received regular health checks that were organized by their employer or trafficker. These were mainly women in sex work (10.9%, *n*=36 of 329). As such, females were more likely than males to report regular health checks from employers or traffickers (7.2 to 2.5 per cent).

As referral networks emerge for trafficked people, it is increasingly important to recognize the potential role of health providers in both providing post-trafficking medical care and in identifying people who might have been trafficked.

Identification of suspected cases of trafficking in a medical setting can provide an important potential resource for people to escape trafficking situations. However, this is not without certain challenges. For example, for this study, it is unclear how many of those who received care from

a medical professional requested help out of their trafficking situation or were asked about their situation.

Pregnancy and termination of pregnancy during trafficking

Of the 467 female respondents who were over the age of 15, 35 (7.5%) reported being pregnant while in the trafficking situation. Sex workers (*n*=15) and brides/wives (*n*=11) reported pregnancy in the greatest number. Approximately one third of the over-15 respondents (34.3%, *n*=12 of 35,) had an abortion.

Exiting the trafficking situation

When asked if they ever attempted to leave their trafficking situation, 56.7 reported (*n*=583) of all respondents reported trying to leave. Participants who reported never attempting to leave were asked about the reasons they did not seek to leave. The most common reasons reported by the 445 participants who did not attempt to leave were: "I was making money" (44.7%, *n*=199 of 445,); "I was afraid to get lost" (33.3%, *n*=148 of 445); "I feared being arrested" (32.1%, *n*=143 of 445); and "I had no identification documents" (27.0%, *n*=120 of 466).

Most of the participants escaped the trafficking situation through the intervention of police, border guards or government officers (71.1%, *n*=784 of 1,102) (see Table 32). Over one fifth of participants ran away or escaped with no assistance from others (28.9%, *n*=318 of 1,102). Fifteen per cent (15.4%, *n*=170 of 1,102) said their escape was facilitated by a non-governmental organization (see Table 32).

Although trafficking awareness messages to alert the public about the problem of trafficking have increased in number over the past decade, only a small portion of participants exited with help from neighbours (5.1%, *n*=56 of 1,102), or family or friends (4.2%, *n*=46 of 1,102).

Table 32: Means of exiting the trafficking situation

Means of exiting the trafficking situation*	*n*	%
Helped by police/border guards/government officer	784	*71.1*
Ran away/escaped	318	*28.9*
Helped by an NGO	170	*15.4*
Helped by neighbours/people living nearby	56	*5.1*
Helped by family, friend or acquaintance	46	*4.2*
Co-worker escaped and denounced employer/trafficker	20	*1.8*
Manager let participant go/participant's contract ended	14	*1.3*
Others	35	3.2

*Multiple responses possible; total will be greater than 100 per cent.

Detention history

Nearly one quarter (24.1%) of the participants were held in detention (e.g. immigration detention or prison). A higher proportion of men (28.5%) than women (20.7%) experienced detention. A much higher proportion of adults were detained (30.3%) compared to children (12.2%).

It is not uncommon for people to be removed from a trafficking situation, only to find themselves in a situation of further detention. There are regular reports of trafficked persons being arrested and imprisoned for their immigration status or other crimes.

Table 33: Detention in main destination countries (*n*=257)

Country of exploitation	*n*	%
China	88 (of 330)	26.7
Indonesia	62 (of 129)	48.1
Malaysia	40 (of 52)	76.9
Mauritius	2 (of 33)	6.1
Thailand	47 (of 448)	10.5

Even in cases where post-trafficking residential situations might have benevolent intentions, in some cases, they can operate in confining and controlling ways (e.g. in closed-asylum settings, or in refugee or immigration support centres). There are various forms of detention where trafficked people may be held, with practices differing among countries.

Post-trafficking stage

Physical health symptoms

Participants were asked to rank their health from poor to very good over the four weeks prior to the interview. One in six participants (15.6%) reported being in "poor" health. Adults reported worse health than children, with 42.3 per cent of children reporting "good" or "very good" health status, compared to 25.9 per cent of adults. People trafficked for fishing (26.9%, *n*=74 of 275,) and domestic work (18.4%, *n*=7 of 38) reported high levels of poor health; however, many of the sectors have small respondent groups and thus do not present strong conclusions about associations with self-reported health.

Participants (N=1,102) were asked to identify areas of their body where they felt pain or injury. Most (64.3%, *n*=708) identified at least one area of pain or injury; 3.6 per cent (*n*=40) identified at least five. The most common areas of the body where participants felt pain or injury were: the head (26.2%, *n*=289); the stomach (19.5%, *n*=215) and the back (13.6%, *n*=150). Participants were asked to report how much pain or discomfort they felt in various areas of their body. Headaches and back pain were most commonly reported as "severe" or "quite a lot." (See Table 34).

Table 34: Physical health symptoms reported by participants (N=1,102)

Recent health problem	Severity of the problem					
	Not at all/A little		Quite a lot		Extreme	
	n	%	*n*	%	*n*	%
Headaches	875	*79.4*	161	*14.6*	66	*6.0*
Back	906	*82.2*	135	*12.3*	61	5.5
Skin problems	967	*87.8*	81	*7.4*	54	*4.9*
Nausea	963	*87.4*	89	*8.1*	50	*4.5*
Exhaustion	906	*82.1*	145	*13.2*	50	*4.5*
Dizzy spells	887	*80.5*	167	*15.2*	48	*4.4*
Dental problems	999	*90.7*	57	*5.2*	46	*4.2*
Memory problems	937	*85.0*	128	*11.6*	37	*3.4*
Persistent cough	1,008	*91.5*	59	*5.4*	35	*3.2*
Gastrointestinal	1,023	*92.8*	49	*4.5*	30	*2.7*
Significant weight loss	958	*86.9*	117	*10.6*	27	*2.4*
Fainting	1,090	*98.8*	9	*0.8*	4	0.4

The labour sectors with the highest proportions of participants who indicating that at least one area of their body that had been injured or hurt were: "brides/wives" (88.7%), agriculture (75.9%), fishing (74.6%) and construction (73.7%).

Individuals who reported pain, injury or a recent health problem (*n*=990) were asked whether they wanted to see a doctor or nurse for this problem. Of the 957 respondents who answered this question, half (49.6%) did.[x]

This study did not include definitive clinical diagnosis of the respondents' reported injuries or medical problems, so the possible causes of reported pain or injury remain unclear. Given participants' exposure to physical abuse and occupational hazards, a portion of reported injuries may have been directly linked to violence or work-related accidents. In addition, pain and (physical) illness may have been co-morbid symptoms associated with poor mental health. The

[x] It is not clear to what extent there may have been underreporting of requests for medical care, as a portion of participants may have believed that they would have to pay for it.

psychological effects of exposure to chronic trauma may be linked to physical symptoms that emerge quickly after the exposure, and may also be associated with longer-term illness. For example, studies have found that extreme stress that affects an individual's adaptive capacity may be linked to longer-term illness resulting from "allostatic load" or the "wear and tear" on the body in response to repeated cycles of stress.[19]

Pregnancy

Twenty-one women who were of reproductive age reported being pregnant at the time of the interview (4.5%, *n*=21 of 467). Eight of the women who reported being pregnant at the time of the interview were exploited in sex work, one in agriculture, one in domestic work, three in factories, seven as brides or wives, while did not reach a destination. Because women were sometimes interviewed upon arrival at a service or before they had received medical assessments or pregnancy testing, current pregnancies may have been underreported.

Of the 190 reproductive-age women who experienced sexual violence during trafficking, 14 reported being currently pregnant , which was a higher rate of pregnancy than for the 277 reproductive-age women who did not report sexual violence (2.5%, *n*=7 of 277) (See Table 35).

Table 35: Violence among women of reproductive age (15 to 49 years old)* who were pregnant at the time of the interview

Pregnancy and violence*	*n*	%
Pregnant at the time of the interview and experienced sexual violence	14 (of 190)	*7.4*
Pregnant at the time of the interview and did not experience sexual violence	n=7 (of 277)	*2.5*

*Two missing values among women aged 15 to 49 for the question on sexual violence

Mental health: Depression, anxiety and post-traumatic stress

Table 36: Prevalence of depression, anxiety and post-traumatic stress disorder among participants (N=1,102)

	Prevalence levels		
Condition	***n***	**%**	**95% C.I.**
Depression*	658	*59.7*	56.9–62.7
Anxiety*	462	*41.9*	39.1–44.9
Post-traumatic stress disorder**	392	*35.6*	32.9–38.5

* Two missing values.
** Three missing values.

Figure 8: Participants with symptoms suggestive of depression, anxiety and post-traumatic stress disorder

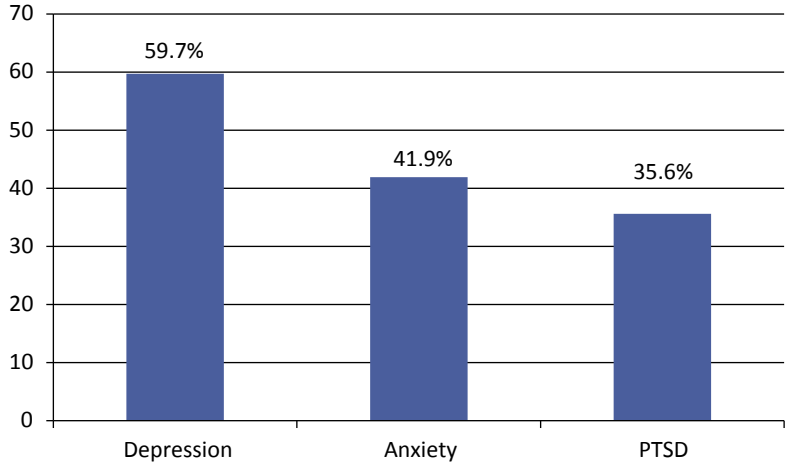


Table 37: Prevalence of mental health outcomes among participants, by age group (N=1,102)

Age group	Depression		Anxiety		Post-traumatic stress disorder	
	n	%	*n*	%	*n*	%
10–14	38	*48.1*	24	*30.4*	17	*21.5*
15–17	180	*58.4*	102	*33.1*	76	24.7
18–24	241	*62.3*	177	*45.6*	154	*39.7*
25–34	130	*61.0*	102	*47.9*	89	*41.8*
≥35	69	*59.8*	57	*50.4*	56	49.1

Of the common mental health disorders that were measured, symptoms associated with depression were highest, with 59.7 per cent of participants reporting levels indicative of a depressive disorder. Symptoms associated with post-traumatic stress disorder (PTSD) were reported by 35.6 per cent of participants, and 41.9 per cent met the symptom criteria for an anxiety disorder.

The prevalence of depression, anxiety and PTSD were similarly distributed between males and females, with depression symptom levels most prevalent, followed by anxiety, and then PTSD. Males reported higher levels of symptoms associated with anxiety disorder (45.7% of males vs. 39.3% of females) and PTSD (40.7% of males vs. 32.0% of females) than females. On the other hand, symptom levels associated with a depressive disorder were higher among females (61.8% of females vs. 57.1% of males) (See Table 38).

Table 38: Prevalence of symptoms associated with anxiety, depressive and post-traumatic stress disorders among males (*n*=465) and females (*n*=637)

	Male		Female		Total	
	n	%	*n*	%	*n*	%
Symptoms of anxiety disorder*	212	*45.7*	250	*39.3*	462	*41.9*
Symptoms of depressive disorder*	265	*57.1*	393	*61.8*	658	*59.7*
Symptoms of post-traumatic stress disorder**	189	*40.7*	203	*32.0*	392	5.6

* Two missing responses.
** Three missing responses.

For each of the three disorders, the prevalence of associated symptoms was higher among adults than children. Some of this difference may have been associated with the possible limitations of the instrument's use with children versus adults. Symptom levels for all disorders were higher among adolescents 15 to 17 years old than for children ages 10 to 14 years old, particularly for depression (58.4% vs. 48.1%, respectively) (See Table 39).

Table 39: Prevalence of symptoms associated with anxiety, depressive and post-traumatic stress disorder, by age

	10–14 years		15–17 years		18 years or above		Total	
	n	%	*n*	%	*n*	%	*n*	%
Symptoms of anxiety disorder*	24	*30.4*	102	*33.1*	336	*47.1*	462	*41.9*
Symptoms of depressive disorder*	38	*48.1*	180	*58.4*	440	*61.7*	658	*59.7*
Symptoms of post-traumatic stress disorder**	17	*21.5*	76	*24.8*	299	*41.9*	392	35.6

* Two missing responses.
** Three missing responses.

There appeared to be a higher burden of symptoms of these common mental disorders among service users in Cambodia and Viet Nam compared to service users in Thailand (see Table 40). It is unclear what factors might have influenced these differences, as this study did not aim to assess the impact of the services.

Table 40: Prevalence of symptoms of mental health disorders among participants in Thailand (*n*=445), Cambodia (*n*=443) and Viet Nam (*n*=389)

	Thailand		Cambodia		Viet Nam		Total	
	n	%	*n*	%	*n*	%	*n*	%
Symptoms of anxiety disorder	117	*26.4*	154	*57.5*	191	*49.2*	462	*41.9*
Symptoms of depressive disorder	227	*51.1*	174	*64.9*	257	*66.2*	658	*59.7*
Symptoms of post-traumatic stress disorder	93	*21.0*	130	*48.5*	169	*43.4*	392	35.6

* Two missing responses.

** Three missing responses.

When symptoms of depression among females trafficked for sex work were compared with those of females trafficked for other forms of exploitation (e.g. domestic work, "brides/wives," factory work, etc.), symptom levels were slightly higher among those who were not in sex work (63.6% for females in sex work; 65.2% for others). Higher symptom levels of post-traumatic stress disorder were also observed among labour trafficked females (41.9%) compared to sex trafficked females (29.1%); as were anxiety symptom levels, with a 49.2 per cent prevalence estimate among other labour trafficked females compared to 34.2 per cent among sex trafficked females.

Table 41: Prevalence of symptoms of mental health disorders among females trafficked for forced sex work (*n*=328) and females trafficked into other sectors (*n*=241)*

	Females trafficked for forced sex work		Females trafficked into other sectors		Total	
	n	%	*n*	%	*n*	%
Symptoms of anxiety disorder*	112	*34.2*	118	*49.2*	230	*40.5*
Symptoms of depressive disorder*	208	*63.6*	157	*65.2*	365	*64.3*
Symptoms of post-traumatic stress disorder**	95	*29.1*	101	*41.9*	196	34.5

* Denominator includes only females who reached their destination.

* One missing response.

** Two missing responses.

Responses to individual psychometric scale items

The scales used to assess survivors' mental health are based on a set of symptoms, many of which are important independent of the combined measure. Participants were asked to describe the level of each symptom that they felt within the week prior to the interview.

Depression and suicidal ideation

As noted above, symptom levels associated with depression were reported by 59.7 per cent of all participants. Feelings of depression have been found to be among the more enduring post-trauma symptoms among trafficking survivors.[4,20]

One of the most important symptoms included in the depression scale is "thoughts of ending your life," That is, suicidal ideation. One in six participants (14.9%, *n*=164;) reported experiencing suicidal ideation within the week prior to the interview. Suicidal ideation is the most extreme expression of depression.

Among the items most commonly reported from the Hopkins Symptom Checklist-25 for depression were: "worrying too much about things (63.3%), "blaming myself for things" (67.9%), and "difficulty falling asleep or staying asleep" (62.7%).

It is also worth noting that many depression-related symptoms can have serious effects on survivors' physical health, for example, appetite problems may lead to unhealthy weight loss or gain and problems related to sleep disruption or insufficient sleep can have negative effects on overall health and immune system functioning.[21] A slightly higher proportion of females reported sleep problems than males (64.8% vs. 59.7%). A slightly higher proportion of adults reported some level of sleep problem when compared to young persons (65.3% vs. 57.9%) (See Table 42).

Table 42: Hopkins Symptom Checklist-25 depression items reported by participants*

Items on depression – Hopkins Symptoms Checklist-25	*n*	% (N=1,101)
Blaming yourself for things**	748	67.9
Worrying too much about things***	696	63.2
Difficulty falling asleep or staying asleep**	690	62.7
Feeling lonely**	674	61.2
Feeling hopeless about the future**	651	59.1
Feeling blue**	648	58.9
Crying easily**	615	55.9
Poor appetite**	563	51.1
Feeling everything is an effort**	549	49.9
Feeling of worthlessness**	543	49.3
Feeling low in energy, slowed down**	520	47.2
Helpless/ Cannot do anything to help myself**	485	44.0
Feeling no interest in things**	440	40.0
Thoughts of ending your life**	164	14.9

* At frequencies of "a little," "quite a lot" or "extremely."
** One missing response.
*** Two missing responses.

Post-traumatic stress disorder

Symptom levels associated with post-traumatic stress disorder (PTSD) were reported by 35.6 per cent of participants. PTSD has been associated with certain core symptoms: "intrusive memories of a traumatic event (or repeated events)," "avoidance of reminders of these events," "emotional numbing and hyperarousal." It is worth noting that there has also been increasing research pointing to the role that neurobiological mechanisms, including previous exposures and genetics, may play in the development of PTSD, that is, there is an increase in the likelihood of developing this disorder upon exposure to traumatic events.[22,23]

The most prevalent symptoms associated with PTSD were: "feeling on guard" (61.0%), having "recurrent thoughts or memories of the most hurtful or terrifying events" (59.7%) and "avoiding thoughts or feelings associated with the traumatic or hurtful event" (59.5%). It is possible that the symptom "feeling on guard" among the participants was a reflexive reaction as a result of past exposure to repetitive dangers, but may have also reflected fears to actual current dangers, such as retribution from traffickers (See Table 43).

The "avoidance" symptom, reported by over half the participants, may indicate that an important portion of these individuals were employing "avoidant coping strategies," which have been linked to detrimental post-trauma recovery, based on studies primarily conducted outside of Asia.[24,25]

Importantly, over one third (34.2%) of the participants reported an "inability to remember parts of the most traumatic or hurtful events." This trauma-related symptom has significant implications for those who may participate in criminal investigations or serve as witnesses in judicial proceedings. Memory problems can hinder investigations, prosecutions and affect an individual's credibility, particularly as more detailed memories return eventually, causing changes in testimonies.

Table 43: Harvard Trauma Questionnaire items reported by participants

Harvard Trauma Questionnaire Item	*n*	% (N=1,102)
Recurrent thoughts or memories of the most hurtful or terrifying events*	657	59.6
Feeling as though the event is happening again*	481	43.7
Recurrent nightmares*	448	40.7
Feeling detached or withdrawn from people**	457	41.5
Unable to feel emotions*	376	34.1
Feeling jumpy, easily startled*	577	52.4
Difficulty concentrating*	559	50.7
Trouble sleeping*	602	54.6
Feeling on guard*	672	61.0
Feeling irritable or having outbursts of anger*	442	40.1
Avoiding activities that remind you of the traumatic or hurtful event*	526	47.7
Inability to remember parts of the most traumatic or hurtful events*	376	34.1
Less interest in daily activities*	407	36.9
Feeling as if you don't have a future*	582	52.8
Avoiding thoughts or feelings associated with the traumatic or hurtful events*	655	59.4
Sudden emotional or physical reaction when reminded of the most hurtful or terrifying events**	582	52.8
Feeling that you have less skills than you had before**	519	47.1
Having difficulty dealing with new situations***	502	45.6
Feeling exhausted***	522	47.4

* One missing response.
** Two missing responses.
*** Three missing responses.

It is notable that over half (52.9%) reported "Feeling as if you don't have a future," as many survivors will have left a trafficking situation and face the same financial and other difficulties as before they left. Indeed, many may be forced to face these hardships with poorer physical and mental health and fewer individual and interpersonal resources as a result of the trafficking situation.

Anxiety

Forty-two percent of participants reported symptom levels associated with an anxiety disorder. Individual symptom items reported by the greatest number of people were: "feeling tense or keyed up" (65.4%), having headaches (55.7%) and feeling "nervousness or shaking inside" (55.2%) (See Table 44).

Service providers, such as counselling staff and health providers (and law enforcement and judiciary officials) may wish to take particular note of this co-morbidity between psychological symptoms and physical pain (e.g. over 20% of participants reported suffering headache pain at the most severe levels). Such combination of symptoms may be debilitating to the extent where they hinder post-trafficking engagement in social activities and integration, family life, employment and practical daily functioning.

As noted above, anxiety-related symptoms may also affect survivors' participation in criminal investigations and judicial proceedings – simultaneously, participation in high-stress procedures, such as testimonies, can increase survivors' anxiety symptoms.

Table 44: Hopkins Symptom Checklist-25 anxiety symptoms reported by participants

Items on anxiety – Hopkins Symptoms Checklist-25	*n*	% (N=1,101)
Suddenly scared for no reason*	540	49.1
Feeling fearful*	570	51.8
Faintness, dizziness, or weakness*	321	29.2
Nervousness or shaking inside*	608	55.2
Heart pounding or racing*	492	44.7
Trembling*	317	28.8
Feeling tense or keyed up*	720	65.4
Headaches*	613	55.7
Spells of terror or panic**	417	37.9
Feeling restless, can't sit still**	556	50.5

* Two missing values.
** One missing value.

Post-trafficking concerns

Participants were asked: "At this time, what are your most important concerns or what problems come to your mind most often?" The concerns reported as most important included: "money-related problems in the family" (44.6%), health-related problems in the family (43.1%) and guilt or shame (41.2%). Participants who reported feelings of guilt or shame were more likely to be symptomatic for depressive disorder (59.0%) than those who did not report such feelings (40.8%) (See Table 45).

When asked about their concerns for their physical and mental health, a greater number of people reported concerns for their physical (33.1%) as opposed to their mental health (23.1%). This difference may be related, in part, to stigma or shame associated with psychological problems.[26]

It is worth noting that while financial worries were certainly among the most common concerns, a large portion of participants also reported concerns for the health of their family and for themselves. This has implications for wider health sector involvement in the service networks for trafficked people.

While it is common for those studying trafficking and mental health to focus on exposures to traumatic events during the trafficking stage, this list of concerns indicates that current and future stressors are also likely to have an influence on people's present mental health status.

Table 45: Common concerns about the future among participants

Main concerns*	*n*	% (N=1,102)
Money-related problems in family	491	*44.6*
Health-related problems in family	475	*43.1*
Guilt or shame	454	41.2
Earning money/having a job/paying debt	433	*39.3*
Physical health	365	*33.1*
Afraid of traffickers, drivers, smugglers, etc.	290	*26.3*
Mental health	255	*23.1*
Documents	185	*16.8*
Housing: having nowhere to live long-term	153	*13.9*
Spiritual, religious concerns, ghosts	136	*12.3*
Housing: having nowhere to stay short-term	81	*7.4*
Other concerns	153	13.9

* Two missing values for each item.

Fear of the trafficker

Over one third (34.3%) of participants perceived that they were still in danger from their trafficker even when they were already out of the trafficking situation. Additionally, almost one in 10 (8.8%) reported that they were unsure if they were in danger, suggesting that, in total, nearly half (43.1%) of all participants believed they *might* be in danger.

A higher proportion of women (42.2%) than men (23.4%) were afraid that that their employer or trafficker would try to hurt them or their families. Approximately one third of children (36.4%) and adults (35.2%) reported fearing harm from their traffickers.

Table 46: Participants' fear of harm to them or their families by their traffickers

Worries that trafficker or employer may hurt her/him or family	*n*	%
Yes	378	34.3
No	625	56.7
Does not know	97	8.8
Missing	3	0.3

Participants who feared their trafficker/past employers were more likely to experience symptoms of post-traumatic stress disorder (38.9%) than those who did not fear their trafficker/past employers (29.6%).

Treatment by the family and community

Over half of participants (56.3%) were worried about how they would be treated when they arrived home. Although sex work is highly stigmatized, lower levels of concern were reported by females trafficked for sex work (60.8%, *n*=200 of 329) compared to domestic workers (79.0%, *n*=30 of 38), brides or wives (83.0%, *n*=44 of 53) and those trafficked for fishing (66.2%, *n*=182 of 275) Over half of the males (51.8%, *n*=241 of 465) reported worries about the kind of treatment they would receive at home.

These concerns were much higher among those who reported experience of sexual violence during their trafficking (74.9%, *n*=158 of 211) than among those who did not experience sexual violence (52.0%, *n*=459 of 883).

Living arrangements upon return home

Participants were asked who they planned to live with after receiving post-trafficking services. Nearly 80 per cent (79.6%) of participants reported they would live with parents or other family members (see Table 47). Only 16.9 per cent reported they would live with a spouse (21.6% of participants reported being married and living with their partners). A small percentage of participants said they would live at their work location and two individuals said they would live at an orphanage. Post-trafficking living arrangements can be difficult for some survivors, particularly those who are concerned about how they will be treated by people at home, as noted above.

Table 47: Who participants planned to reside with*

Response	*n*	% (N=1,102)
Parents/other member of family	877	79.6
Spouse	186	16.9
Alone	29	2.6
Work location	19	1.7
Friends	18	1.6
Boy/girlfriend	14	1.3
Orphanage	2	0.2
Other	36	3.3
Does not know	0	0

*Multiple responses possible; totals sum up to > 100 per cent.

Disclosure to others

Participants (N=1,102) were evenly divided between those who planned to speak to others about their experience in trafficking (42.2%, *n*=465) and those who did not plan to speak about it (45.1%, *n*=497). Women trafficked for sex work were less likely to intend to discuss their experience (29.9%, *n*=98 of 328) than females trafficked for other purposes (43.6%, *n*=105 of 241) or males (49.2%, *n*=262 of 533). The proportions of those intending to disclose to others were similar for those who reported sexual abuse and those who did not.

Hopes for the future

Participants were asked about their hopes for the future. Not surprisingly, the most common responses were to “have money” and “have a job” (see Table 48). Men and women responded in similar proportions in their hopes for a job (60.5% for both). There was a striking difference between men and women in wishing to “go home,” with almost 30 per cent more women reporting that they wanted to go home than men. It is possible that some of this difference reflects the higher number of women interviewed in shelters in Thailand and Viet Nam versus the Cambodian men who were interviewed in services in Cambodia. An equal proportion of men and women mentioned that “getting married” was one of their hopes for the future. Overall, participants appeared to maintain their hopes for the future, as only 5.1 per cent said that they had “no hopes” for the future; a small percentage of males (7.7%) and females (3.1%) reported that they had no hopes for the future.

Table 48: Hopes for the future, by sex*

Hopes for the future	Males (*n*=465)		Females (*n*=637)		Total (N=1102)	
	n	**%**	***n***	**%**	***n***	**%**
Have money	281	60.4	302	*47.4*	583	*52.9*
Have family	110	23.7	164	*25.8*	274	*24.9*
Have job	281	60.4	386	*60.6*	667	*60.5*
No hopes	36	*7.7*	20	*3.1*	56	*5.1*
Go home	166	35.7	398	*62.5*	564	51.2
Get married	82	*17.6*	101	*15.9*	183	*16.6*
Other	53	11.4	109	*17.1*	162	*14.7*
Does not know	0	0	0	0	0	0

* Three missing values for each item.

The most prevalent hopes reported by children were to “have a job” (57.1%) and to ‘go home’ (58.7%) (see Table 49).

Table 49: Hopes for the future reported by children and adults*

Hopes for the future	Child (*n*=387)		Adult (*n*=715)		Total (*n*=1,102)	
	n	%	***n***	%	***n***	%
Have money	145	*37.5*	438	*61.3*	583	*52.9*
Have family	113	*29.2*	161	*22.5*	274	*24.9*
Have job	221	*57.1*	446	*62.4*	667	*60.5*
No hopes	18	*4.7*	38	*5.3*	56	*5.1*
Go home	227	*58.7*	337	*47.1*	564	*51.2*
Get married	43	*11.1*	140	*19.6*	183	*16.6*
Others	91	*23.5*	71	*9.9*	162	14.7

* Three missing values for each item.

Experience of the interview

At the end of the interview, each participant was asked to comment on how easy or difficult they felt the interview was. Most participants (70.2%) felt the interview was an “easy” experience. Approximately one fifth reported feeling that the interview was “a little bit difficult” (20.5%) and 9.1 per cent found it “difficult.” A higher proportion of males found the interview difficult compared to females (10.5% vs. 8.0%), as did a higher proportion of adults to children (11.5% vs. 4.7%).

Second interview

Second interviews were conducted 30 to 90 days later with participants who could be contacted. Second interviews were conducted in order to learn how people’s physical and mental health changed over time. This longitudinal perspective also offered an opportunity to understand how people’s needs, concerns and hopes may have changed from their initial contact with service providers. It is hoped that by comparing participants’ symptoms and situations at Time 1 (T1, during the first interview) with their responses at Time 2 (T2, during the second interview), these findings would offer insights into what survivors want from services, once their basic needs have been met and they have had time to recover from their acute health problems and consider their future.

In total, second interviews were conducted with 353 of the 1,102 participants, or 32.0 per cent of the original sample. While this would represent significant loss to follow-up for most studies, we believe that this is a relatively reasonable retention rate given the characteristics and situations of this migrant population. This is a group that is, by its very definition, highly mobile (e.g. some en route home or returned home), for whom further contact posed logistical challenges (distance) and who have emotional reasons for discontinuing contact with post-trafficking services. Due to service structures, in certain study sites, it was more difficult to maintain contact with participants. Thailand was the country with the greatest retention rate (48.5%, *n*=215), primarily because Thailand is a destination/transit location and many participants were residing in the participating shelters, awaiting return to their home cities. Cambodia was able to conduct the next greatest number of second interviews (39%, *n*=105), often through contact networks with local NGOs around the country. Viet Nam (8.5%, *n*=33) was able to conduct the fewest second interviews (See Table 50).

Table 50: Second interviews: Loss to follow-up by post-trafficking services by country

Country of service access	Total first interviews	Retained for second interview		Lost to follow- up	
	n	*n*	%	*n*	%
Thailand	444	215	*48.5*	229	*51.5*
Cambodia	269	105	*39.0*	164	*61.0*
Viet Nam	389	33	*8.5*	356	*91.5*
Total	1,102	353	*32.0*	749	68.0

Physical health symptoms

People were asked at both time periods about their physical health symptoms. It appears that the symptom levels of those who remained in the study remained similar to those of the whole cohort at the start of the study. Reported physical health symptoms appear to remain similar over the two time periods (See Table 51).

Table 51: Physical health symptoms reported by participants at first and second interviews

Recent health problem	Symptom severity			
	FIRST INTERVIEW "Quite a lot" or "Extremely" (*n*=1,102)		SECOND INTERVIEW "Quite a lot" or "Extremely" (*n*=354)	
	n	%	*n*	%
Headaches	227	20.6	82	23.2
Back pain	196	17.8	62	17.5
Skin problems	135	12.3	44	12.4
Nausea	139	12.6	53	15.0
Exhaustion	195	17.7	63	17.8
Dizzy spells	215	19.6	69	19.5
Dental problems	103	9.4	45	12.8
Memory problems	165	15.0	65	18.4
Persistent cough	94	8.6	17	4.8
Gastrointestinal	79	7.2	36	10.2
Significant weight loss	144	13.0	19	5.3
Fainting	13	1.2	1	0.3

Mental health symptoms: Comparison between first and second interviews

During the second interview (T2), participants were asked about their mental health symptoms in order to explore how levels of depression, anxiety and PTSD may have changed over time. Table 52 shows the proportion of all participants with symptoms of at T1, and then shows the proportions of participants with symptom levels indicative of depression, anxiety and PTSD among the same cohort interviewed at T1 compared to T2.

Table 52: Mental health at Time 1 and Time 2

Disorder symptom	*n*	%
Time 1 (all participants)		
Symptomatic of depression*	658	59.7
Symptomatic of anxiety*	462	41.9
Symptomatic of PTSD**	392	35.6
Time 1 (participants not lost to follow up)		
Symptomatic of depression	191	46.1
Symptomatic of anxiety	132	37.3
Symptomatic of PTSD	101	28.5
Time 2		
Symptomatic of depression	139	39.3
Symptomatic of anxiety	92	26.0
Symptomatic of PTSD	84	23.7

* Two missing values.
** Three missing values.

There are several observations to make from these data. First, comparing the entire study population (T1) with those who remained in the study for a second interview (T2), those at T2 generally had lower symptom levels than the full study population at T1 . Table 53 shows a striking comparison between those who remained in the study versus those who were lost to follow-up (T2). Those lost to follow-up appear to have higher prevalences of symptoms than those retained in the study (i.e. 62.4% vs. 46.1%, respectively, for depression). It remains unclear why individuals with worse mental health symptoms at the start were more likely to have been lost to follow-up. Further analysis is required to explore possible explanations for the difference.

Second, and more important, a comparison of T1 and T2 symptom levels shows that a significant number of participants reported improved mental health. Participants experienced a reduction in symptoms of depression (from 46.1% at T1 to 39.3% at T2), reductions in symptoms of anxiety (from 37.3% to 26.0%) and a lesser reduction in symptoms of PTSD (from 28.5% to 23.7%). As this study is not an intervention trial to assess potential impact of contact with post-trafficking services, it was not possible to attribute these reductions in symptoms to any aspect of contact with the post-trafficking services, or even the fact of having contact with services. Future intervention research should be conducted to explore the effects of various post-trafficking support mechanisms – and psychological support, in particular.

Table 53: Comparison of symptom prevalences of participants who did and did not participate in a second interview

Time 1 (not lost to follow-up)	*n*	%	Time 1 (lost to follow-up)	*n*	%
Symptomatic of depression	191	46.1	Symptomatic of depression[1]	467	*62.4*
Symptomatic of anxiety	132	37.3	Symptomatic of anxiety[2]	330	*44.1*
Symptomatic of PTSD	101	28.5	Symptomatic of PTSD[3]	291	38.9

Post-trafficking concerns: Changes from T1 to T2

Participants were asked about their concerns at the first and second interviews. Among the participants who were interviewed a second time, nearly all concerns appeared to have remained nearly the same or increased from the first interview. Among the concerns that increased the most was "earning money/having a job" (from 45.8 to 50.3 per of participants) . Participants' concern about family-related health problems also appeared to have increased greatly from T1 (43.1%) to T2 (63.6%).

Participants were asked who they planned to live with during the first interview and were then asked again about their prospective or actual living arrangements at the second interview (see Table 54). For those who planned to live with their parents/family/spouse, intended residence did not appear to change very much from T1 to T2. It is worth highlighting that during the first interview, only two children planned to live at an orphanage and by the second interview, three children planned to or were already living in an orphanage. At T1, only two participants expected to live at a work location; by T2, six participants were already residing at a work location.

Table 54: Who the participants would like to live with after leaving the shelter

Response	Time 1		Time 2	
	n	%	*n*	%
Spouse	40	11.3	39	11.0
Boyfriend/Girlfriend	11	3.1	6	1.7
Parents/Other members of the family of origin	304	85.9	286	80.8
Alone	13	3.7	11	3.1
Friends	10	2.8	13	3.7
Orphanage	1	0.3	3	0.8
Work location	2	0.6	6	1.7
Other*	9	2.5	16	4.5
Does not know	3	100	7	2.0

*1 missing values at Time 1.

Discussion: Implications of findings for practice and policy

The findings from this study provide some of the first-ever quantitative evidence on the health of people who have been trafficked into many different labour sectors in the Greater Mekong subregion. These data have implications for both post-trafficking services and policies to protect people from human trafficking and respond to the health needs of people who fall prey to this extreme form of exploitation. Post-trafficking responses can make the difference in whether survivors shift to a road of healing or whether they linger in the painful repercussions of a trafficking experience. We also hope that these results will be used to help people who have been trafficked understand the range of symptoms they might be feeling after a trafficking experience and encourage them to seek the medical treatment and counselling that they might need.

Of course, in most cases, actual health support will depend on the available resources, including the presence of national, bilateral and regional frameworks that allow health systems to work together in addressing the health vulnerabilities and consequences of trafficking. Therefore, we also fervently hope these results are used by advocates, donors and others to ensure that greater resources are invested in the health of people who are trafficked. Investments need to be made in labour protection, immigration realities, and referral and medical care for survivors.

This concluding section aims to reflect on the implications of these findings for different stakeholders, policies and practices.

Clients of post-trafficking services

Among the first, and perhaps most obvious, findings from this survey is that there is no single profile of people who are trafficked and use post-trafficking services. People who are recognized as 'trafficked' and referred to post-trafficking services differ not only in terms of age, sex, marital status, home country and language, but also vary widely by their exploitation experiences and sector-related exposures. Increasingly, as recognition of trafficking for different forms of labour has grown, so has the diversity of the post-trafficking service user population. People who use these services are no longer include only victims of trafficking for forced sex work, but a much wider range of labour sectors. This means that providers have to get better at assessing survivors' health needs. It also means that we need to think more upstream – at a policy level – to promote prevention initiatives, for example, through trade and labour policies to protect migrant workers from becoming trafficked people.

Post-trafficking physical and mental health care

Physical health

Because this study identified prevalence patterns for various health outcomes, it offers important information about priority areas for post-trafficking health care for trafficking survivors. Approximately two thirds of study participants identified at least one area of their body where they felt pain or injury. Post-trafficking medical care should include a medical history-taking to understand the potential exposures that might have caused survivors' discomfort, pain and injuries and a systems review to identify the precise body areas where the individual is feeling pain or injury.

Sexual health

Findings on sexual violence, reported condom use and pregnancy indicate the need for sexual and reproductive health and sexual assault referral services as part of a post-trafficking service

package. Notably, women who reported sexual violence were three times as likely to be pregnant than those who did not report sexual violence. It will be important for practitioners to recognize the links between reported sexual violence and unwanted pregnancies and respond sensitively to victims' clinical sexual and reproductive health needs, as well as potential mental health-care needs. Although the links between forced sex work and unwanted pregnancy have been well-recognized, our findings indicate that women trafficked for other purposes (to be brides or wives, domestic servants, factory workers, etc.) are also at risk of sexual abuse and unwanted pregnancy.

Mental health

While participants reported a wide range of physical health complaints, the most prevalent and severe symptoms were generally associated with mental health. Findings strongly indicate that symptoms associated with depression, anxiety disorders and post-traumatic stress disorder (PTSD) are prevalent and seemingly persistent. As can be observed among individuals who participated in a second interview, symptom levels decreased but still persisted, as has been seen in other studies on trafficking and mental health. [4,27]

For participants in this study, mental health symptoms associated with depression were most prevalent – reported by more than half (59.7%) of the participants. Over 40 per cent reported symptoms associated with anxiety disorder (41.9%), and one third (35.6%) expressed symptoms indicative of PTSD.

These rates are very high when compared to other labour migrants, for example, and are also high or similar when compared to refugee populations. A systematic review and meta-analysis of depression and anxiety among labour migrants and refugees found that among labour migrants, 20 per cent reported symptoms of depression and 21 per cent had symptoms of anxiety, and among refugees, the prevalences of depression and anxiety were 44 and 40 per cent, respectively.[28] Suicidal ideation is an extreme expression of depression or hopelessness, which has been noted among migrant populations, especially among refugees.[29,30] In this study, one in six (14.9%) participants reported suicidal ideation within the week prior to the interview. It is important for post-trafficking service providers to have procedures in place to detect possible suicidal ideation and options to make supported referrals to appropriate resources.[31,32]

Perhaps one of our strongest messages regarding the health of survivors is the clear need for effective ways to respond to the damage that has been done to people's psychological well-being. What do we currently know about post-trafficking mental health interventions? Unfortunately, we have little proven knowledge about what helps survivors heal. While service providers are well-aware of the psychological toll that human trafficking takes on its victims and studies have confirmed survivors' deep emotional distress and poor mental health, to date, there has been very little – if any – robust evaluation research on post-trafficking mental health care. Given our findings, plus evidence from other studies with trafficking survivors, we hope that intervention research will be urgently supported in order to identify effective forms of psychological support – and especially support that can be easily implemented in low-resource settings.

Health service component of post-trafficking care

This study also showed that professional medical care for people in post-trafficking services is a necessary component of post-trafficking care, as at least one in two people – half of all those in services – requested to be seen by a medical professional for physical pain, injury or discomfort. Providers and donors should plan and budget for survivor health assessments and medical treatment as part of a multi-service post-trafficking care package. For some, medical attention to illness, infection and pain will be among their most urgent post-trafficking care needs.

Health and social insurance schemes

In addition to providing evidence about post-trafficking health needs, these data also suggest the need for migrant worker health and social insurance schemes as part of primary prevention in a region of prevalent and growing labour migration. Especially given the severe nature of some injuries and the persistence of symptoms commonly associated with depression and anxiety syndromes, migrant workers would benefit from insurance schemes that can enable them to access health care if and when they need it and to potentially support their longer-term medical care needs resulting from occupational-related injuries or illness.[33]

Prevention of trafficking

These findings also have implications for protection and prevention. Approximately half of the participants said that they had heard of the term "trafficking" prior to leaving home. While these findings about pre-departure awareness of the concept of trafficking cannot be interpreted as indicative of the effectiveness of awareness-raising activities in the general population, they do suggest that greater consideration should be given to the reach and potential impact of prevention programming and investment in anti-trafficking awareness campaigns. If fewer than half (44%) of the study participants reported they had heard of the term "trafficking" before they left home, it is possible that even after a decade of regional efforts to "raise awareness" about trafficking, messages would still not have sufficient reach. At the same time, if over half (50.7%) of the people enrolled in or making use of post-trafficking services had indeed heard about trafficking prior to leaving home, this may indicate that anti-trafficking campaigns or messages about safe migration are not necessarily working – at least among some groups. Before large sums of additional money are invested in campaigns and messages that may not be working to protect people from trafficking, donors and programming decision-makers might wish to achieve better evidence on the role and effectiveness of awareness-raising activities. Again, rigorous mixed methods pre-programming and intervention research may provide more robust insights to inform investments.

Similarly, findings suggest that to improve prevention, we will need to learn more about people's initial recruitment options and how prospective workers make migration decisions and plans. As other research has suggested, it is not unusual for people to be trafficked or introduced to traffickers by someone who should have been worthy of their trust, as more than one quarter of participants said that someone close to them, such as a parent or another family member, friend, work colleague or boyfriend/girlfriend, was responsible for getting them into the trafficking situation.[4] This is one of the fundamental challenges to preventing trafficking, as it is logical for people seeking to improve their lives to trust friends, family members, acquaintances or migrant networks to provide reliable advice and assistance. Anti-trafficking efforts should aim to regulate and identify ethical and trustworthy recruitment mechanisms, and make these known to prospective workers, including migrants, so that they do not have to use potentially untrustworthy, untested means of finding employment outside their home cities or villages.

Although the study did not aim to identify pre-departure vulnerability to trafficking, we did explore people's reasons for migrating and their history of violence prior to departure. Findings did not offer any particularly instructive messages about pre-departure risk factors for trafficking, as a majority of participants sought to migrate for financial reasons, that is, to earn money. Unlike other studies, such as previous research on trafficking of women for forced sex work in which pre-departure abuse was very high (e.g. 60%), in this study, a much smaller percentage of people (11.8% of adults and 18.9% of children) reported pre-departure abuse. While pre-departure violence is unlikely to be predictive of whether someone would be trafficked, it may nonetheless play a role in some people's decision to seek to leave home. Perhaps more importantly, a history of abuse been shown to be an important risk factor for increased vulnerability to later abuse and

longer-term health consequences, especially mental health problems.[34,35] People who have been exposed to multiple experiences or cumulative trauma, especially among children, are more likely to have more complex or worse mental health outcomes.[36]

Role of health practitioners in the identification of trafficked persons and participation in service referral networks

There has been increasing recognition of the role that health-care practitioners can play in the identification and referral of people who have been trafficked.[37] In this study, more than one third (40.8%) of participants indicated they needed medical care while in the trafficking situation – and half of all children wanted medical care for health problems.

Findings showed that some people do indeed have contact with professional medical practitioners (i.e. a doctor or a nurse) while they are in the trafficking situation. Importantly, more than one in 10 participants said that they met with a medical professional while in the trafficking situation and a portion said that they had regular health checks.

Although our findings indicate that health practitioners had a little role in helping identify individuals in trafficking situations, identification of suspected cases of trafficking in a medical setting can provide an important potential resource for people who are trafficked to escape trafficking situations. However, taking on this role will not be without certain challenges. For example, it is unclear how many of the participants in this study who received care from a medical professional might have had private conversations to request help out of their situation or to be asked about their situation. Medical setting encounters comprise an area for further investigation.

Nonetheless, these results confirm the potential role of health practitioners within a network of services identifying and responding to cases of trafficking. In some circumstances, health providers may be more likely than other professionals to have private or semi-private clinical contact with people who are trafficked; if given appropriate training in safe identification and referral procedures, they can play a vital part in helping people leave dangerous and exploitative situations.

In addition to identifying the information and training needs of health practitioners, more needs to be learned about the types of “medical assistance” or medication offered by employers, managers and co-workers. It is not clear how we may interpret the response from the 23.2 per cent of participants who said that the owner or manager provided medication or care, that is, whether this care was safe and appropriate or not.

Finally, health practitioners may also face security concerns and threats to their own physical and mental health well-being while providing identification, care or referrals to trafficked persons. It is of paramount importance that health practitioners not be expected to work in isolation, but as an integral part of a network of services required to support trafficked persons. Safety precautions may be put in place. Further investigations into the medical encounters of trafficked persons should also investigate safety and privacy concerns of health practitioners.[37,38]

Occupational health and safety interventions in low-skill labour sectors

These findings underscore the fact that post-trafficking services support people who are trafficked into a wide variety of low-skilled labour sectors. Study participants were exploited in over 15 different types of work. On the one hand, these results are encouraging because they

indicate that anti-trafficking efforts have advanced from only identifying victims trafficked for sex work, and authorities are increasingly recognizing that people are trafficked for a range of other purposes. On the other hand, it is clear that, sadly, a large number of labour sectors are conducive to exploitative practices akin to trafficking.

Regulation of work hours

Perhaps the most common workplace abuse was the long hours that people were made to work. Over two thirds of participants reported working seven days per week for a mean of 13.8 hours per day, with many made to work many more hours per day, such as domestic workers (15 hours on average) and fishermen (nearly 19 hours on average). Over half reported having few or no breaks. These long work hours without breaks have significant implications for occupational safety and increased risk of injury, as well as longer-term effects of exhaustion, illness and poor mental health. For example, one US national survey showed that individuals in jobs with overtime had a 61 per cent higher injury hazard rate than those in jobs without, and those who worked at least 12 hours per day had a 37 per cent increased injury hazard rate.[39] Moreover, because these figures are from US national statistics, these are likely to be jobs for which the conditions are less hazardous than the often-unregulated situations for migrant labourers in South-East Asia. Studies strongly suggest that greater working hours are associated with higher rates of accident and injuries and injury prevention interventions need to be tailored to the sector and specific tasks.[40]

Injury prevention

Occupational injuries were fairly widely reported. Injuries were reported by one in five people in the study and half of those trafficked for fishing. Even with this high injury rate, we simultaneously suspect that injuries may have been underreported, as people may not have identified smaller, less severe injuries. It is certainly notable that seven people reported losing a body part.

While some participants reported receiving medication from their employers, it is unlikely that work places had on-site urgent care procedures to handle major accidents and few, if any, would have had medical leave (paid) related to job-related injury or illness.

Although our findings on occupational risks are by no means representative of any particular labour sector, among these post-trafficking service users, various risks and abuses were reported consistently for nearly all sectors. This suggests that greater government monitoring and private sector action are needed to institute health and safety measures to prevent workplace hazards, and to detect and punish dangerous and abusive practices in many of these poorly regulated, high-risk sectors.

Bride trafficking

Although women and girls who were trafficked to be brides or wives are not in a recognized "labour sector," it is worth making special note of this form of trafficking because the health of these women has received relatively little attention, to date and women appeared to report some of the worst levels of abuse and most debilitating health problems. In this study, 53 females from Viet Nam were trafficked to China to serve as wives—which included two girls between ages 10 and 14 years old. Bride trafficking certainly must be a priority area for further knowledge-building and a greater focus of prevention and detection.[41]

Minimum standards, inspections, compensation and penalties

While this study is not able to provide evidence on the extent of underregulated sectors, our findings, combined with other research and commentary from around the world, hint at the low-wage, low-skill sectors where health and safety standards do not exist or where even minimum

standards may not be enforced.[42,43] In these settings, where inspections are few or non-existent, some employers appear to have little motivation to invest in worker protection mechanisms – and some actively perpetrate serious criminal abuses. This raises the question of government and sector-specific regulation to maintain minimum standards, establish on-site medical responses to work-related injuries and laws to ensure fair access to compensation – regardless of immigration status. At the same time, greater penalties must be imposed on exploitative employers, and prosecutions need to be pursued for those who commit criminal abuses, including trafficking.

In addition to workplace hazards, trafficked workers in this study were unlikely to report being given personal protective equipment. Relevant personal protective equipment should be part of a basic health and safety package that is offered to workers, especially those working in high-risk situations (as, e.g. in fishing and construction) or those working with hazardous or toxic substances (as, e.g. in agriculture and food processing). It is also probable that workers in these underregulated sectors received little to no training (or training in a language they did not understand) on the use of, for example, heavy equipment or hazardous substances. This poor knowledge-level and inexperience may put individuals at greater risk of injury or illness.

Reducing occupational health risks through pre-departure skills training

Workplace dangers reported in this study suggest the potential benefits of pre-departure training for migrant workers to learn sector-specific skills that may prevent accidents and injury. State-funded or NGO-supported or subsidized pre-departure skills training (e.g. domestic work, fishing and construction) may lead to greater work-related safety, as well as possibly better-paid jobs, more savvy review of employment contracts, and increased ability to seek assistance in destination locations.[44]

Improving use of health services in destinations through pre-departure information on access to health care

In addition to pre-departure skills-building, pre-departure information for migrant workers should also include descriptions of people's rights to health care and various health service options in key destination locations. Even in locations where rights to free services are limited, people can often access free treatment for certain aspects of care (e.g. sexual health and emergency medicine) or services provided by NGOs. Groups working to provide pre-departure information for migrant workers should aim to include health services information for common countries of employment, in addition to contact information for assistance if they find themselves in difficult circumstances.

Violence occurring in destination settings: detection, prevention and responses

Physical, sexual and psychological abuses have been and continue to be signature features of human trafficking. Findings from our study re-confirm that violence both in and outside the workplace are prevalent violations among people who are trafficked. Approximately half of adult and child participants (47.4%) in this study reported that they were physically and/or sexually abused. The levels and types of abuse have important health implications. Decades of evidence from studies on violence demonstrate the multiple and enduring health consequences associated with various forms of abuse.[45, 46] Additionally, one in two participants was threatened or had threats against someone close to them. Threats are an effective means of preventing people from trying to leave trafficking situations.

Prevalence of violence and threats in this study also indicates people's well-founded fears of what might happen to them if they tried to escape – at the same time as these abuses probably persuade them that they should try to flee.

From this study, we were able to detect that among the study participants, people in some sectors appeared to be more exposed to violence than other sectors, such as "brides/wives" (88.5%), fishing (68.4%), sex work (50.8%), domestic servitude (60.5%) and begging (36%). These findings are not necessarily generalizable to the wider sectors.

Study results showing the high prevalence of violence indicate that evident signs of abusive labour situations, such as violence, may be common, which may have implications for labour regulation, and health and safety inspections, in particular – and certainly for law enforcement, as well.

If there were more targeted health and safety inspections in sectors commonly associated with trafficking-like practices (e.g. fishing and domestic work), and if inspections included private, anonymous interviews with workers in particular, inspections might serve as a deterrent to abusive employers and managers, as well as a means to identify and assist people who are trafficked. From a supply chain perspective, the large corporations who are the purchasers of commodities commonly associated with trafficking (e.g. fish and shrimp) would certainly need to make greater efforts to ensure their suppliers are ethical employers.[47] Companies planning to purchase from or invest in sectors known for trafficking must carry out their due diligence to identify those employers who do not adhere to appropriate occupational health and safety standards.

For law enforcement – who will want to work in collaboration with labour inspectors – better detection of violence is likely to lead to greater success in the prosecution of trafficking cases. Violence is a clear and prosecutable crime, whereas it is often more difficult to prove criminal levels of exploitation. An employer, trafficker or manager who commits assault or battery can be readily charged, regardless of whether a case of "trafficking" can be proven.

Findings are also informative for post-trafficking service providers, who will want to be especially cognizant of the prevalence of abuse among survivors and to prioritize trauma-informed care assessments and treatment of injury and acute and/or longer-term psychological reactions.[37]

Recognizing workplace confinement and restrictions

Restricted freedom of movement, physical confinement or detention by threat – implicit or direct – are core indicators of a trafficking or forced labour situation. Two in three participants (67.9%) reported they were "never" or "seldom" free to go "where they wanted or do what they wanted," and more than half of all participants indicated that they were "never" free. Almost half the participants said that they never tried to leave their situation. Not surprisingly, those participants reported that their movement and choices were restricted were also much more likely to experience violence. Of the 596 participants reporting "never" being free, 61.7 per cent (*n*=368) reported experiencing physical or sexual violence. This is in contrast to the 13.9 per cent (*n*=19) of the 137 participants who reported they were "always" free to move and reported violence while trafficked. It is sometimes asked (by police and others) why people do not just leave these situations if they are not physically confined. These levels of abuse and people's perceptions of freedom of movement provide a good indication of why people do not "just run away." This restricted sense of freed 'traumatic entrapment" – is related to "appeasement," and for some, the "Stockholm Syndrome." This natural defensive strategy, while potentially keeping a person safe while in the trafficking situation, can have longer-term effects on his or her psychological functioning, especially if the individual has been in this "entrapped" situation for long periods.

Some participants reported being in the trafficking situation for many years, up to nearly a decade (as in the case of children trafficked for begging), while others were detected before they reached their destination. In addition to the physical dangers of being in a trafficking situation for these

lengths of time, as noted above, the effects of the psychological stress of these indeterminate periods fear, of never really knowing when it would be possible to leave or to go home, are considerable. For those in isolated situations, such as domestic workers, these long periods are likely to have created extreme loneliness and perhaps a sense of profound hopelessness.

In addition to highlighting abusive working conditions, this study also indicated people's unhealthy, often hazardous and stress-filled living conditions. Even when not at work, participants often did not feel relaxed or comfortable in their off-time, or were unable to sleep well. "Home" (or the non-work setting) is supposed to offer a respite from the strains of work, yet people who are trafficked rarely spend their non-working hours in a secure and restful location. Some live and sleep in the same location where they work. Others who live outside the workplace are likely to live in unclean and overcrowded conditions, sometimes deprived of nutritious food, hygiene and unable to get a restorative night's sleep after long, arduous hours of work. Moreover, people were unlikely to be able to use their free time to have meaningful contact with friends or family. This type of social isolation, with poor emotional support (for potential "stress-buffering"), can have important implications for people's mental health.[48–50]

Health and safety inspections to identify occupational health hazards should also aim to identify situations of restricted movement and unhealthy living conditions as part of a comprehensive response to improve conditions for migrant workers.

Addressing the wider effects of poor mental health outcomes on participation and engagement in official processes

Post-trafficking mental health symptoms, in addition to causing deep psychological distress, often lead to practical problems, for example, related to people's daily functioning, somatic physical symptoms, stress in interpersonal relationships and difficulty engaging in income-generating activities. Psychological symptoms can also lead to challenges in participating in official processes, such as criminal investigations and prosecutions.

Mental health service providers, such as counselling staff and health care workers (and law enforcement and judiciary officials), may wish to take particular note of this co-morbidity between psychological symptoms and physical pain (e.g, over 20 per cent of participants reported suffering headache pain at the most severe levels). Physical symptoms may be closely linked to individuals' mental health – however, practitioners should not always assume this, especially given the high levels of violence and injury reported.

As noted, such a difficult combination of symptoms may be debilitating to the extent where reactions hinder post-trafficking engagement in social activities, family life, employment and future planning, which, in turn, further worsens people's mental health.

For example, survivors may find it difficult to "fit" back into their former lives and relationships following an experience that has changed them and their ability to trust others, and which may have altered their capacity to cope with perceived adversities and stress. As noted in the findings, approximately half (45.1%) of participants reported that they did *not* plan to disclose their experiences to others.

Criminal investigations and judicial proceedings may also be affected by survivors' anxiety-related symptoms. Importantly, over one third (34.1%) of participants reported an inability to remember parts of the most traumatic or hurtful events. This trauma-related symptom has significant implications those who may participate in criminal investigations or serve as a witness in judicial proceedings. For a survivor offering information to police or evidence in court, memory problems can affect his or her credibility, particularly as more detailed memories eventually return and cause changes in testimonies.

Simultaneously, survivors may experience increased anxiety as a result of participation in high-stress processes, such as testifying in court, facing their trafficker, and potentially being challenged in such a public forum about the veracity of their accounts.

Similarly, symptoms may be made worse by current and future stressors, such as fears of retribution by the trafficker. The findings indicate that those who feared their trafficker or past employer were more likely to experience symptoms of post-traumatic stress disorder (41.5%) than those who did not (29.6%).

It is important for practitioners to discuss personal security with trafficking survivors, both because of the very real possibility that they might be harmed by people involved with their trafficking and because perceptions that they are at risk will negatively affect their healing process. Where an individual's safety appears to be at risk, practitioners may wish to involve trusted law enforcement officials in protection planning.

Designing reintegration planning, processes and support

While people who are trafficked are likely to have many disturbing memories and struggle with emotional reverberations of past abuses, it is often the future worries that comprise the source of their deepest concern. Not surprisingly, a majority of survivors explained that their post-trafficking concerns centred on how they would find income in the future. However, it is also important to mention that almost half noted health-related problems in their family to be their main concern, while one third reported they were concerned about their own physical health, and one quarter indicated that their mental health was a main concern. Significantly, as suggested above, for many, their safety from the trafficker worried them.

There can be little doubt that survivors' post-trafficking path will benefit from professional support from a variety of service providers working in collaboration. In addition to the practical aspects of reintegration (e.g. return travel, housing, documents), survivors will need support for their health, and for some, advice about how to deal with health problems in their families. Additionally, and especially for children, there may need to be safety assessments before return, to ensure that people are being returned to a place where they can recover and thrive – not to situations of abuse or domestic violence, for example. Some may also benefit from assistance to explain to their families what has happened to them and the effects that these traumatic events might have on their emotions and behaviour in the coming months. Just over 40 per cent reported that they worried about feelings of guilt or shame, which would have been be difficult to overcome without the support of family and/or friends, and would have undoubtedly been made worse by recriminations and stigma. Reintegration support might also include advice to family member about how to support someone who is suffering the physical and psychological aftermath of exploitation and abuse.

Concluding remarks

As increasing global migration numbers suggest, people are not going to stop attempting to migrate to improve their lives and the well-being of their families. As such, criminals and unscrupulous operators are not going to stop trying to take advantage of the opportunities presented by global capitalism and the vulnerability of prospective migrants, whether they migrate within their own country or across international borders. This means that policymakers and service providers must work even harder both to foster safe labour opportunities for migrant workers, as well as ensure health services are in place to help heal those who do end up becoming exploited and abused.

Given the past paucity of evidence on health and human trafficking for different forms of labour, these findings should be used widely to inform service professionals in designing health services

and referral systems to support people who have been trafficked. These results should be used by decision makers, who are in a position to create an informed and responsive policy environment that takes full account of the intervention options to protect people's health.

Human trafficking is a crime of severe and abusive exploitation practices that cause people serious and often long-lasting harm. These damages to people's body and psyche are the reason that health must be at the centre of responses to address human trafficking.

Limitations

The main limitation of this study is the potential generalizability of the findings (ability to make inferences about a population based on a sample). People who are still in trafficking situations are extremely difficult to locate and interview safely. Data about trafficked people's experiences, particularly their health, have most commonly come from post-trafficking settings, and even this body of evidence remains quite small. There have been few studies and very limited quantitative analysis and reporting of service setting data. Therefore, we still have very little "generalizable" information about the situation of a 'larger population' of trafficked persons. In order to increase this study's external validity (i.e. the potential to generalize findings to broader population of trafficked persons), we included numerous services with different programming scopes in the three countries. The findings in this report represent the health risks and experiences of people who were using post-trafficking services in the study countries during the fieldwork period running from October 2011 to May 2013. Although the demographics of this population are likely to differ from what might be deemed the "larger population of trafficked people in the Mekong," their experiences of risk and the associations with various health and safety needs are likely to be comparable to others trafficked for similar purposes. Moreover, these findings offer important insights into the patterns of post-trafficking service needs of trafficking survivors.

Participating services were selected using non-probability sampling. Selection criteria used to determine who is eligible for services vary between countries and sometimes between service providers. STEAM study findings must be interpreted with caution. For example, in Thailand, STEAM data come from individuals using government-operated services – accepting assistance is a requirement of the repatriation process, and trafficked persons may be in these government services until the legal processes are completed. In Viet Nam, data are from individuals using government-related services, with the restriction that only citizens who are identified as trafficked are referred to these services. In Cambodia, data are from individuals repatriated from countries in the region through IOM services and a wider network of NGOs, which are not all affiliated with the government (Note: Poipet Transit Centre is managed by Cambodia's Ministry of Social Affairs).

It must also be mentioned that not all trafficked persons receive assistance.[51] The STEAM study provides data on individuals who undergo a screening process with immigration officials, police or other agencies, and, thus, it is not possible to know the potential effects of possible selection bias. This is a known problem with surveying trafficked persons.

Despite potential selection biases in data from service client populations, for ethical and safety reasons, researchers acknowledge that individuals who are out of the trafficking situation and in the care of service providers are the most suitable population with which to conduct primary research.[3,51] In shelters and post-trafficking services, individuals can be safely and ethically identified and invited for interviews. Should individuals need assistance during or after the interview, services staff are on hand to provide support.[51] In contrast, attempting to access individuals while they are still in a trafficking situation may be dangerous for both the individual and the researcher. Additionally, seeking out formerly trafficked persons once they have returned home poses other problems – such as the risk of stigmatization in the community

if the individual concerned does not want his or her experience to be known. Even the most careful and well-intentioned researcher may put the individual at risk of harm if he or she is currently in a trafficking situation.[3]

Another frequent challenge in research is related to missing data. Missing values in the dataset are inevitable in research and can sometimes affect reliability of results.[52] Data can be missing for a variety of reasons, including unwillingness of respondent to answer particular questions, interruption of interviews, mistakes in questionnaire application or data entry procedures. In our study, we tried to prevent errors in the questionnaire application by having intensive two-week training of interviewers in each country, and opted for double data entry procedures to avoid missing entries. Nonetheless, we still had some missing values in some variables in our study, including the violence and mental health outcomes. It is possible that not all participants felt comfortable answering these questions. We opted to report missing values where appropriate and not use any statistical methods to deal with missing values at this stage. This decision was made in order to facilitate interpretation of the results by a non-academic audience. In this report, the missing values are included in the denominator for data presented, unless otherwise stated.

Finally, the sample size was calculated to achieve enough power for estimation of prevalence of our main outcomes (violence and mental health variables described in the “Methods” section) among the entire sample and by country. The breakdown of these percentages by sectors of exploitation should, however, be interpreted with caution as the study was not designed to measure prevalence among those subgroups.

Recommendations

General Recommendations

Recognize human trafficking as a health issue.[xi]

Recognize the health rights of people who have been trafficked.

Recommendations to States

General government and legislators, in particular, entities responsible for responding to Human Trafficking

(a) States in the Greater Mekong subregion should develop regional accord(s) on the health rights of trafficked women, men and children.

(b) States should develop regional and national referral mechanisms (transnational and national), along with the requisite legal frameworks on public health security that support enforcement of such mechanisms to ensure the health of trafficked persons is prioritized through safe and supported referrals between agencies, transfer of medical information and measures to assure continuity of necessary care. Referral mechanisms should recognize the need for informed consent, confidentiality and privacy of all individuals. These mechanisms should be implemented along with requisite legal frameworks on public health security to support the enforcement of such mechanisms.

(c) States should approve national legislation, or amendments to existing legislation, in relevant sectors such as labour, immigration, and public health that require provision of health care for the health needs of people who have been trafficked, including the needs of trafficked persons who are cross-border migrants. Care should be funded by the State and coordinated within strategies of the lead agencies addressing human trafficking. Services should be age- and gender-sensitive and offered on a voluntary basis, with informed consent. Specifically:

  (i) Ensure State-facilitated access to health services for trafficked persons in the location where they make their claim.

  (ii) Provide health services by practitioners trained to care for trafficked persons.

  (iii) Dedicate budget lines to subsidize health care, either from national anti-trafficking funds or from the ministry or department of health.

  (iv) Accord trafficked persons in destination, transit and return locations immediate legal rights to State-supported recuperative health services. This right should be specified in relevant legal instruments, regardless of individuals' legal status or ability to pay.

  (v) Do not hold trafficked persons in detention.

  (vi) Do not return trafficked persons to locations where their health and safety may be at risk.

  (vii) Ensure trafficked persons' health-care needs can be met in their home location, with coordination between places of origin and destination.

[xi] "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.)

(viii) Ensure that return policies and procedures for trafficked persons prioritize individuals' safety, health and that consent and return are voluntary.

(ix) Do not return trafficked persons from destination or transit locations without providing appropriate and voluntarily accepted medical care to meet their immediate health-care needs.

(x) Establish assistance funding for victims to provide specially designated health services for trafficked persons, who are either trafficked domestically, or trafficked abroad upon their return home, where existing services are not adequate to meet their health-care needs, regardless of their ability to pay. Establish a national or health ministry's fund specifically to subsidize the health care of trafficked persons.

(xi) Accord trafficked persons who have either been trafficked domestically or who have returned to their home country the same rights to State-supported health services as other citizens of that country, regardless of the period of time that they have been out of the country.

(xii) Recognize health, safety and labour rights in national legislation addressing protections within labour sectors, including mechanisms to provide compensation to trafficking victims for harm, disability or distress and assistance to recover reparation funds to address the range of health consequences of trafficking-related abuses.

(xiii) Advocate for assistance for victims to recover reparation funds and compensation for harm, disability or distress through regional mechanisms, national labour and industry associations and health institutions.

(d) States should facilitate collaboration between lead counter-trafficking agencies and the health ministry or department to establish coordinated health responses to human trafficking.

(e) States should approve legislation to mandate targeted and regular labour health and safety inspections of industries commonly known for the exploitation of workers and human trafficking. Strong legal mechanisms must be put in place to protect workers and impose penalties for exploiters. Labour inspection personnel should be trained to identify and refer possible victims of trafficking.

(f) States should establish health indicators to monitor, at a minimum: (i) health risks experienced by people identified as trafficked; (ii) health consequences reported by or diagnosed among trafficked persons; (iii) health service responses and treatment received by trafficked persons. These data should be anonymous and integrated into national and regional data collection mechanisms and reported publicly (e.g. by a national special rapporteur).

(g) Establish health indicators to monitor, at a minimum: (i) health risks experienced by people identified as trafficked; (ii) health consequences reported by or diagnosed among trafficked persons; (iii) health service responses and treatment received by trafficked persons. These data should be anonymous and integrated into national and regional data collection mechanisms and reported publicly (e.g. by a national special rapporteur).

(h) Ensure authorities leading national counter-trafficking responses include health providers as first responders in the identification and referral of possible trafficked persons and ensure health professionals are included in strategic planning and training activities.

Ministry of Health

(a) Participate in national human trafficking strategy groups and contribute to national plans of action and invite relevant professional health service representatives, as needed. The Ministry should participate actively with counter-trafficking authorities to ensure that provision of health care for trafficked persons is integrated into legislation, referral networks and service provision.

(b) Work closely with other key relevant service providers (in the areas of e.g. sexual violence, domestic violence, refugee and migrant services) to integrate health responses for trafficked persons into existing specialized services, protocols and referral networks.

(c) Develop policies and designate budget lines to a specialized pooled victim assistance fund aimed at meeting the urgent and the longer-term health care needs of trafficked persons.

(d) Maintain policies and budgets to foster outreach services provided through existing health networks, including local clinics, village health volunteers or occupational health focal points for sectors where human trafficking is common.

(e) Help establish and promote in-house medical care within assistance organizations (civil society) or easy referral options from post-trafficking organizations and shelters.

(f) Ensure trafficked persons are not unjustifiably denied medical care by informing relevant health care stakeholders of trafficked persons' rights and entitlements to services, and by discouraging prejudice so people are not refused services based on nationality, language, ethnicity or stigma. Monitor regularly to ensure that individuals' rights to services are respected.

(g) Coordinate with relevant authorities and non-governmental groups to develop and disseminate health promotion multi-media materials designed for distribution to: (i) individuals at risk of trafficking; (ii) individuals possibly in situations of exploitation; and (iii) trafficking survivors. Materials should be developed with the financial support of national budget, international organizations and/or donors and materials should be designed to inform literate and non-literate individuals. Multimedia materials should include, at a minimum:

    (i) A clear definition of "trafficking" so victims can be identified by service professionals and victims themselves will recognize a "trafficking situation" and can self-identify;

    (ii) A hotline or other indication of where to call for help;

    (iii) Description of health complications commonly experienced by trafficked persons, including descriptions of signs and symptoms of illness and options for treatment;

    (iv) Information on rights to health services of both residents and non-residents in known countries of destination, and the rights of trafficked persons to health services in receiving and/or countries of origin;

    (v) Materials translated into a variety of relevant languages and offering relevant details for distribution in different countries.

(h) Develop guidance resources and conduct trainings for health professionals to identify and refer individuals they suspect have been trafficked and provide treatment to trafficking survivors. Resources should be developed in coordination with counter-trafficking agencies and non-governmental organizations. Multimedia guidance materials should be based on existing models of good practice established for other forms of interpersonal violence, care of migrants and refugees, occupational safety and health medicine, and be age- and gender-relevant. Resources should include, at a minimum:

  (i) Sensitization information to inform providers about the health, protection and safety issues associated with human trafficking;

  (ii) Descriptions of common morbidity patterns;

  (iii) Recommendations on appropriate service approaches that take account post-trafficking physical, psychological, safety and protection needs;

  (iv) Guidance on privacy, confidentiality, safety and care ethics;

  (v) Up-to-date referral information for other necessary assistance (e.g. legal assistance, educational opportunities, etc.);

  (vi) Regional- and country-specific materials that include a list of locally available emergency assistance resources.

(i) Overall, Ministry of Health should put in place a migrant health policy and legal frameworks, as well as migrant health monitoring systems that also provide the framework for addressing health needs of trafficked persons. These should be based on a public health approach that respects relevant international standards on protection for migrants and their right to health, and promote ethical information sharing on standardized health data across countries and sectors.[53]

Law enforcement, immigration and agencies leading on human trafficking responses

(a) Do not require trafficked persons to participate in intelligence-gathering, criminal investigations or judicial proceedings as a condition of medical or other care or as a condition of asylum.

(b) Ensure trafficked persons are not unwillingly hosted, accommodated in closed shelter facilities, or jails or migration detention centres.

(c) Ensure trafficked persons in government or non-governmental accommodation and support services have freedom of movement and informed and voluntary decision-making.

(d) Offer the legal right to employment to trafficking survivors in destination locations.

(e) Establish a national referral system that includes the participation of government and non-governmental services to ensure comprehensive support and protection.

(f) Collaborate with and support health sector staff to be able to identify, treat and/or refer trafficked people. Ensure health sector representatives are included in policy discussions, especially practitioners responsible for responding to violence and for care of vulnerable populations.

(g) Require police and immigration personnel, and embassy personnel overseas, to ensure that individuals suspected of having been trafficked are asked about their health concerns, pain and urgent medical needs at the first point of contact. Ensure that questions about health and well-being are posed in private and in a language the individual can understand.

(h) Require police and immigration personnel, and embassy personnel overseas to respond to urgent medical needs and serious discomfort by referring individuals to professional medical care prior to conducting questioning or interrogation.

(i) Offer forensic exams to people who have been trafficked to support the prosecution of traffickers, where appropriate. Obtain informed consent prior to the conduct of any exam in the individual's native language and make results of exams available to her/him.

(j) Institute good practice guidelines for law enforcement officers, including consulate officers deployed in the region for interviewing trafficked people based on existing models of good practice for victims of sexual assault, vulnerable witnesses, and victims of domestic violence to ensure interviews are safe and non-stress-inducing.

(k) Conduct training and sensitization activities for law enforcement personnel and consulate officers deployed in the region who are likely to encounter trafficked people. Information provided should include, at minimum, the following subjects:

  (i) Knowing where to refer a suspected victim of trafficking;

  (ii) Understanding the range of violence and other health risks experienced by trafficked people;

  (iii) Recognizing the range of urgent and non-urgent health complications sustained by trafficked people;

  (iv) Responding appropriately to reported urgent and non-urgent health complications;

  (v) Understanding and responding to post-trauma reactions, including distress, anxiety, hostility and other psychological reactions;

  (vi) Understanding how different health outcomes might affect an individual's behaviour and reactions in official settings or during official procedures, in particular, learning about the negative effects of trauma on memory and recall;

  (vii) Restriction or termination of interviews with individuals suffering severe distress, pain or discomfort and urgent supported referral for medical care.

  (viii) Special attention should be given to staff who may be involved in assessing medical needs or undertaking forensic exams.

(l) Make available to trafficked persons the option of having a support person from a non-State actor, NGO or an independent, State-sponsored victim support service (e.g. social workers and child protection officers) present after individuals are identified by or when they are cooperating with law enforcement personnel.

(m) Ensure measures are in place to regularly monitor the health and well-being of individuals who have been identified by or cooperating with police or immigration services, or participating in an investigation or judicial proceeding.

(n) Delay investigative interviews until an individual's physical pain and cognitive functioning has improved to a level at which she/he are able to make informed and thoughtful decisions about their safety and well-being, and provide more reliable information about trafficking-related events.

Labour Ministry and Labour-related Organizations

(a) Develop and dedicate budget lines to strategies that include regular inspection of industries and specific labour sectors in which exploitation and human trafficking commonly occur.

(b) Train labour inspection officials and labour attachés to identify and respond to situations where human trafficking is suspected and report suspected perpetrators.

(c) Develop coordinating mechanisms between labour inspectors and criminal justice sector to ensure perpetrators of labour trafficking, including enterprises or entities, is reported, investigated and punished.

(d) Conduct training and sensitization activities for relevant labour inspection personnel, including any informal occupational safety focal points and volunteers. Information provided should include, at minimum, the following subjects:

  (i) Recognizing, recording and reporting situations of exploitation and human trafficking;

  (ii) Recognizing, recording and reporting health and safety risks associated with labour trafficking, including work-related risks, living conditions, dynamics of exploitation, violence and threats and abuse of documents, contracts, payment arrangements and legal status;

  (iii) Recognizing, recording and reporting the range of urgent and non-urgent health complications posed by various industry-related practices and conditions;

  (iv) Recording and reporting violations of health and safety standards to specifically recognize situations of potential exploitation and human trafficking;

  (v) Supporting labour inspection personal and workplace volunteers as members of multi-disciplinary team to refer potential victims of trafficking from the workplace for further assistance;

  (vi) Responding appropriately to reported urgent and non-urgent health complications;

  (vii) Safe approaches for addressing situations of human trafficking.

(e) Monitor sectors at high-risk of trafficking and make the results of regular inspections publicly available.

(f) Monitor foreign and local recruitment agencies to ensure they maintain the standards as registered recruitment agencies and do not use deceptive, coercive or debt-bondage practices. Recruiters should be obligated to:

  (i) Assist clients to obtain free or affordable health insurance or access to affordable services;

  (ii) Provide easy access for workers to contact and receive assistance in cases of abuse or exploitation by employers;

  (iii) Facilitate compensation payment for work-related harm and to obtain medical care for physical and mental health consequences.

Recruiters that do not adhere to regulations or are abusive should be penalized and/or closed.

(g) Allow and facilitate access for migrant workers to join national trade unions to strengthen migrant workers' advocacy for healthy working conditions, access to medical care and compensation when abuses occur.

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

(a) Allocate funding to support emergency and longer-term health and medical care for people who have been trafficked, and encourage the implementation of programs that include health care. Specifically, provide funding to support:

  (i) Safe housing and good nutrition;

  (ii) Voluntary health needs screening, including diagnosis and treatment for sexual and reproductive health, injuries, mental health;

  (iii) Medications to alleviate symptoms of pain and distress (e.g. headaches, backaches, sleep problems, anxiety);

  (iv) Long-term psychological support, recognizing that symptoms of trauma and distress are commonly enduring and recurring among survivors;

  (v) Occupational and educational training to support individuals' social and economic integration, and to improve their mental health.

(b) Advocate for trafficked persons' rights to health and access to health interventions.

(c) Train health care staff to identify and provide appropriate treatment for victims of trafficking.

(d) Train shelter or service provider staff to identify and respond appropriately to trafficked people's health complication, either directly or through the referral mechanism.

(e) Train labour inspection staff to identify, record and report situations of labour exploitation and associated occupational health and safety risks.

(f) Train and sensitize police, immigration and judiciary officials to enquire about and respond appropriately to trafficked persons' health complications.

(g) Provide interpreting or translation services, as needed.

(h) Carry out rigorous research to inform health responses to human trafficking (see section *Research community* below).

(i) Advocate for more countries to ratify the Migrant Worker's Convention, the Palermo Protocol and other relevant international conventions relating to the safety of the migrant worker, for example, the Seafarers' Act.

Recommendations for health service providers

(a) Develop and promote strategies and programming that address post-trafficking health problems though a multi-stage process that includes: (i) crisis or emergency intervention care; (ii) adjustment period support for individuals' physical recuperation and psychological stabilization; and (iii) symptom management care to address longer-term symptoms.

(b) Foster collaboration between health professionals, relevant NGOs and State actors to advocate for the implementation of legislative measures and implementation procedures to ensure trafficked people the right to state-supported health services.

(c) Develop or identify existing training tools to ensure relevant health professionals are informed about human trafficking and able to implement safe approaches to care for trafficked persons. See *Ministry of Health* recommendations, above.

(d) Establish and/or maintain a referral network of trusted services, linking into the national and transnational referral mechanisms, as appropriate.

(e) Establish and/or maintain supported referral procedures for suspected trafficked persons, as well as those already receiving care and identified, prioritizing individual security, confidentiality and ease of service access throughout the referral processes. Specifically, ensure that identification and referral are conducted in safe, voluntary and linguistically appropriate ways that prioritize providers and trafficked people's safety.

(f) Establish and implement mobile health outreach services to labour sectors commonly recognized for exploitation and human trafficking.

(g) Ensure medical assessments and treatment are voluntary and carried out in accordance with international human rights and professional ethical and health standards. Specifically, ensure that procedures for informed consent are implemented in service settings.

(h) Provide physical, sexual, reproductive and mental health support adapted from models of good practice used for survivors of, for example, domestic violence, sexual assault and torture, while also relying on good practice guidelines for minority communities and refugees.

(i) Coordinate closely with local organizations providing assistance to trafficked individuals to assist them in offering the range of health care required by trafficking survivors.

(j) Ensure the confidentiality of individuals' medical records by implementing privacy and file security measures and respect for their rights to access their medical and health-care documents by making copies of health-related documentation available to them free of cost.

(k) Respect males' and females' sexual and reproductive health rights by offering access to safe pregnancy termination services, counselling for voluntary HIV testing, anti-retroviral drugs, and post-exposure prophylaxis, as required.

Recommendations for the commercial and business sector

(a) Ensure that the production of goods or services does not involve forced labour or trafficked persons and producers have appropriate health and safety standards.

(b) Implement mechanisms to ensure that main contractors and subcontractors do not use forced labour and have appropriate health and safety standards.

(c) Promote and fund regular health and safety inspections of businesses, contractors and subcontractors.

Recommendations for organizations (non-health-specific), such as government shelters, NGOs and other statutory services to or advocating on behalf of trafficked people

(a) Ensure assistance programs prioritize individuals' medical and health needs from intake onwards—especially urgent health needs. Individuals' health should be prioritized by:

    (i) Implementing specific procedures to inquire about a range of health complications upon an individual's arrival into services;

    (ii) Addressing urgent problems and pain as quickly as possible;

    (iii) working to develop in-house and outreach medical services, where appropriate.

(b) Conduct advocacy in coordination with relevant policymakers and health providers to improve policies and increased funding for health and medical care for trafficked men, women and children. In particular, advocate for health-care provision regardless of the trafficked person's legal status or ability to pay.

(c) Establish and/or strengthen and monitor a referral service network in coordination with law enforcement, immigration officials and labour inspectors and define specific communication mechanisms and limitations for coordination.

(d) Collaborate with relevant health providers to ensure key professionals are trained and prepared to identify, refer and treat individuals who have been trafficked. Relevant medical service specialties may include, at minimum: genito-urinary medicine; mental health and psychological counselling, accident and emergency services, pregnancy termination services, antenatal care, detoxification and drug and alcohol rehabilitation services, and mobile outreach services.

(e) Provide services for trafficked persons based on practices that prioritise health and safety, such as procedures used by programs for survivors of sexual assault and domestic violence, migrants or refugees, occupational health and safety. Where appropriate, assistance organizations working in these fields should be encouraged to expand their services to offer care for trafficked persons.

(f) Train relevant social workers, psychologists, counsellors and medical, shelter and other service staff to provide written and/or verbal health information to trafficked persons, such as information on post-trauma mental health, sexual and reproductive health (including HIV and other sexually transmitted infections), communicable and non-communicable diseases, violence and occupational-related injury, and pain management.

(g) Conduct risk assessments to identify safe, hygienic and healthy housing options for individuals following a trafficking experience.

(h) Ensure that trafficked persons' rights to privacy and confidentiality are respected in all information related to their health and security – and ensure that individuals are informed of this right and measures are taken to protect their privacy.

(i) Inform and support trafficked persons to use medical services and identify and articulate their care needs.

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

Research community

(a) Include an assessment of health and safety in research on human trafficking.

(b) Conduct rigorous evaluation research (e.g. randomized controlled trial, experimental and quasi-experimental designs) to identify effective post-trafficking mental health support approaches.

(c) Conduct policy research, mapping and analysis to identify opportunities and challenges to establishing transnational and national referral mechanisms that include a strong, regularly implemented health services role.

(d) Conduct research with providers and patients to identify health service provider training needs and the most feasible and effective modes of delivering information and training.

(e) Conduct research with workers in high-risk labour sectors known for human trafficking to identify range of health and safety risks.

(f) Conduct research to identify pre-recruitment risk reduction opportunities, including assessing factors assessing migrant decision-making.

(g) Conduct research on the legislative and operational areas associated with occupational health and safety to identify barriers and challenges to improving the protection of exploited workers and trafficked persons.

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