



Turning Pain into Power: Trafficking Survivors' Perspectives on Early Intervention Strategies



CHILDHOOD

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Family Violence Prevention Fund

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Executive Summary

As I learned more about trafficking, I realized in retrospect, I saw folks who were trafficked (in my practice) and I didn't know to identify them as such. I saw situations with "mail order brides" and their husbands or overbearing employers that refused to leave the exam room, answering questions for the patients. When I learned more about trafficking, it seemed clear that this is another source of adverse lifetime experiences that we (health care providers) have an obligation to help in the same way we help child abuse and domestic violence victims.

David McCollum, MD, Chair of the American Medical Association's National Advisory Council on Violence and Abuse (March 2005)

The study described here is timely and groundbreaking. As Dr. McCollum's remarks indicate, there is a growing understanding that health-care providers can and must play an intervening role in the lives of trafficked women and children. At the time of this report's publication, further evidence has been provided by the development of anti-trafficking toolkits for health-care personnel by the United States Department of Health and Human Services Administration for Children and Families. These materials, which are intended to help health-care providers identify and screen trafficking victims, are strikingly similar to toolkits developed for domestic violence victims over the last decade by the Family Violence Prevention Fund. However, it must be noted that—until now—there has been scant research that supports the notion that trafficking victims even have the ability to access health care providers.

During the last decade, the health care community has improved its response to victims of domestic violence as a result of concerted efforts to increase awareness of societal violence against women. Domestic assault is beginning to be perceived as a public health issue and health care practitioners have begun to screen their patients for signs of abuse and offer them treatment and support.

Building upon the work of domestic violence advocates in the field of health care, this research was undertaken to examine the hypothesis that the health care system might be an ideal place to focus education and intervention efforts on victims of slavery. Human trafficking is without question a health care issue: victims of trafficking suffer a host of health-related problems and are at high risk of injury, illness and even death from the circumstances of their forced treatment and bondage.

In this study, we asked: Is health care a missed opportunity to intervene on behalf of trafficked women and children? Are trafficked individuals able to access any health care information within their extreme situations of abuse? Can they seek treatment at doctor's offices, clinics or hospitals? If health care providers do interact with this population unknowingly, what steps could be taken to enable practitioners to recognize trafficking victims and understand their special needs? What policies might strengthen efforts to

identify trafficking victims, acquaint them with their health care rights and build the community's capacity to provide them with health care and treatment?

In 2004, interviews were conducted with 21 survivors of human trafficking in the San Francisco Bay Area, the Los Angeles area and metropolitan Atlanta. This is one of the largest samples of survivors in trafficking research. Other significant studies heavily rely upon newspaper and media reports on human trafficking to supplement survivor experiences. While we do not argue that this sampling is a representative cross-section, our relatively large pool of survivors underlines the significance of these findings. A key discovery was that there are important differences between victims of domestic violence and human trafficking, although there are also many similarities.

Of the 21 respondents, almost half were children under the age of 18 or on the verge of adulthood (19-21). From these interviews, we were able to glean significant findings about this vulnerable population. In particular, those who were trafficked as children lacked perspective and were less able than adults to recognize the abnormality of the exploitation that they had endured. While it is difficult to talk to trafficked children themselves (due to research constraints and possible re-victimization, etc.), young adults who talk about their experiences as children provide us with an opportunity to understand their ordeal, making this survey one of the few to gather the words of children trafficked through an adult lens.

The research, importantly, confirmed our hypothesis that for some trafficked victims, as for victims of domestic violence, health care was a potential missed opportunity for early intervention. A set of initial steps were identified that could enable the health-care community to respond more effectively:

- **As part of a comprehensive approach to all victimization, health care providers need education about the prevalence and dynamics of trafficking and how to effectively assess and intervene on behalf of trafficked victims.**
- **The health care community must develop protocols to assure the safety of victims.**
- **Specific funding is needed for further research on health care as a point of early intervention for trafficking victims.**
- **Health care providers need education to improve their response to victims, training to help them screen and identify patients, and funding to pay for these new programs.**
- **Culturally-sensitive training to health care providers is needed to address the specific needs of trafficking victims.**
- **Outreach and education is key for the general public. Victims need programs that reach them in all stages of their plight – from identifying them, to acquainting them with their**

rights and available resources, to educating them on leaving captivity and providing them with services after their departure.

- **Targeted education is required to help identify victims, and peer-to-peer outreach programs must be set in motion to reach them.**
- **Specific funding is needed for health care and appropriate services once victims have left the trafficking situation.**

In addition to recommendations for health care, we also identified victims' health care needs and their thoughts on other opportunities for early intervention.

This research was funded by a generous grant from the World Childhood Foundation. The report is intended to serve as a resource for health care professionals and advocates for trafficking survivors. In summarizing the data that emerged from interviews with 21 victims of trafficking who were brought to the U.S. to serve as unpaid domestic and sex workers, sweatshop workers, and in other forms of enslavement, this report is only the beginning. It offers many potential solutions, but it also raises questions, and identifies areas for further research and action.

Background on Trafficking

Definitions and Terminology

“Human trafficking” in this report is understood as the recruitment, transportation, transfer, harboring or receipt of persons for the purpose of subjecting them to sexual exploitation, slavery, forced labor or services, peonage or debt bondage. The methods used may include threats, deception or fraud, abduction, abuse of power, force or other types of coercion and manipulation.¹

While the definition above appears in the United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, some anti-trafficking advocates rely on a simpler formula, “unsafe migration + slavery = human trafficking,” to convey that the most vulnerable victims are immigrants who are held in physical confinement or are too intimidated by their captors to escape even when they are allowed outside alone. In this study, which was particularly concerned with children and young women who had been trafficked, enslavement was, in fact, less often a matter of locked doors than of fear and distrust of strangers, severe demoralization and a lack of knowledge of where to go.

Recent comprehensive reports on trafficking make the important point that consent to trafficking is not possible for children under the age of 18.² Whether or not they have voiced agreement to the intended exploitation, they legally remain victims. Earlier work makes a similar point: whether or not women trafficked into prostitution knew that they were accepting this type of job, they could not have known or consented to the degrading conditions they would encounter as trafficking victims.³

Throughout this report, the terms trafficking “victims” and “survivors” are used to refer to the young women and youths who participated in the interviews we conducted. We rely on these terms because they will be clearly understood even by readers unfamiliar with the subject. However, it is worth noting that not all of our respondents fit the stereotype of helplessness and passivity suggested by the term “victim.” A few engineered their own escapes by calling police. Several others might have done so if they had received contact numbers upon arrival in this country, as interviewees later recommend.

¹ *Protocol to Prevent, Suppress, and Punish Trafficking in Person, Especially Women and Children, Supplementing the United Nations Convention Against Transnational Organized Crime, UN Doc. A/53/383 (2000).*

² *Florida Responds to Human Trafficking.* Florida State University Center for the Advancement of Human Rights: Tallahassee, FL, 2003.

³ See Amy O’Neill Richard (2000), *International Trafficking in Women to the United States: A Contemporary Manifestation of Slavery and Organized Crime.* (Intelligence Monograph on file with Center for the Study of Intelligence).

Scope of the Problem

Because of its covert nature, the international magnitude of the problem is difficult to ascertain. Although estimates vary, the United States government suggests that approximately 600,000 to 800,000 people each year are traded against their will to work in one or more forms of servitude.⁴ The United States government estimates that 14,500-17,500 women and children are trafficked each year into the United States, primarily from Latin America, countries of the former Soviet Union and Southeast Asia.⁵ This figure may be conservative since many trafficked women may not report to law enforcement.

Victims come from many different ethnic, racial, and age groups. One study found that forced labor is prevalent in five sectors of the U.S. economy: prostitution and sex services (46%), domestic service (27%), agriculture (10%), sweatshop/factory (5%), and hotel work (4%).⁶ It should be noted however, that these statistics do not necessarily paint an accurate picture of the types of trafficking that occur in the United States. Many studies rely upon newspaper and government reports that may be skewed to focus on sex trafficking.

The same study cited prostitution as the largest sector in which forced labor occurs in the U.S., followed by domestic service. Monitoring is difficult because the labor does not take place in a formal workplace, and often victims are sequestered in a home.

The length of time in captivity ranges from a few weeks to more than 20 years, with the majority of cases lasting between two and five years.⁷

She said, “Come with me for one year. I will help you with school. America is advanced and life is better. We will bring your child if we stay more than one year.” We went to the United States and she hid my papers. She made me hand wash the clothes even though we had a washer and dryer in the apartment, take care of the child, clean the house, do all of the cooking. She did not give me a day off. She told me I was evil and that I shouldn’t talk to anyone because everybody is with the FBI and will send me back to Kenya. She only paid me \$370 for five months of work even though she promised me \$6 an hour before we left.

Anastasia, trafficked at age 24 from Kenya

⁴ Department of State. (2004). Trafficking in Persons Report, June 2004. Found at <http://www.state.gov/g/tip/rls/tiprpt/2004/>.

⁵ *Ibid.*

⁶ *Hidden Slaves, Forced Labor in the United States*, Free the Slaves and Human Rights Center, Berkeley, CA, September 2004.

⁷ *Ibid.*

In 2000, the U.S. government enacted the Victims of Trafficking and Violence Protection Act, which helps prosecute traffickers and assist victims. The number of identified victims of trafficking has risen since then, as have prosecutions and social service providers working with survivors. This gives us an opportunity to track and research this issue in a deeper way than we could previously, and to develop new solutions.

Victims of trafficking are often subject to the same kinds of abuse as are battered women and children: restrictions on freedom of movement, isolation, financial control, threats, intimidation, physical and sexual violence, and the fostering of drug and alcohol dependencies due to their situations. In addition, they may be isolated because the trafficker has taken away their passport, or may have physically isolated them. They don't know the language, and they're not connected to any family or community of support. They don't know their legal rights, may not trust the police, and may fear deportation. Some of the lessons learned from the battered women's movement – and in particular, the battered immigrant women's movement – can be applied.⁸

However, their situations have significant differences from that of domestic violence and child abuse victims, which require different strategies. Trafficking victims usually have little to no interaction with the public, and in many cases never visit a health care practitioner at all. Plus, they tend to experience feelings of mistrust and can be under the debilitating psychological control of their captors, limiting their access to services, information and intervention even more.

⁸ Volpp, Leti. 1995. *Working with Battered Immigrant Women: A Handbook to Make Services Accessible*. Produced by the Family Violence Prevention Fund.

Why Is Trafficking a Health Care Issue?

In the comprehensive study, *The Health Risks and Consequences of Trafficking in Women and Adolescents: Findings from a European Study*, researchers argue that

Trafficking harms women in insidious ways that create “messy” health problems. The physical and mental health consequences are not a side effect of trafficking, but a central theme. The aim of laws, funding, and resources should be to address the human consequences of trafficking and to assist women in recovering as much of their well-being as possible.⁹

Trafficking is a health care issue in that health care is central to restoring the well-being of the trafficking survivor. Victims of trafficking are at high risk for health-related problems. They usually come from impoverished areas with limited access to health care, and may arrive with hepatitis, tuberculosis, or sexually transmitted diseases. They may become ill on the journey abroad after traveling in overcrowded or unsanitary conditions. They may arrive without proper immunizations or carrying communicable diseases, since they circumvent formal medical screenings. In fact, a white paper called “Human Trafficking in the United States: A Review of the Problem” produced by the Family Violence Prevention Fund, surveyed trafficking victims and service providers and found that medical needs ranked second after housing and before advocacy and legal help in trafficking victims’ needs.¹⁰ This ranking is not surprising in light of the fact that upon arrival, victims work in unregulated environments.

Furthermore, many survivors endure extreme violence used to control them. They may have broken bones, teeth and or face injuries. Those working in the sex trade are at high risk of contracting AIDS and other sexually transmitted diseases. They may be nutritionally deprived, as food can be withheld or substandard. They frequently face physical and sexual battery: one study found that traffickers repeatedly raped girls in order to initiate them into sexual servitude, and customers also beat the girls.¹¹

If they become pregnant, they may be forced to have unsafe abortions. Those forced to work in the sex industry are at risk for gynecological problems. Most victims are of child-bearing age and have limited access to birth control or prenatal care. Because they lack access to health care, medical conditions tend to become more severe.

⁹ Zimmerman, Cathy et al. (2003) *The Health Risks and Consequences of Trafficking in Women and Adolescents, Findings from a European Study*. London: London School of Hygiene and Tropical Medicine. Found at www.lshtm.ac.uk/hpu/docs/traffickingfinal.pdf.

¹⁰ Family Violence Prevention Fund, 2004. Forthcoming.

¹¹ *Hidden Slaves*, citing Sean Gardiner and Geoffrey Mohan, “The sex-slaves of Mexico: teenagers tell of forced prostitution”; *Newsday*, March 12, 2001.

Victims also suffer psychological damage, including post-traumatic stress symptoms, panic attacks, nightmares, depression, and feelings of fear, shame and isolation. With no support from friends or family, they may develop a learned helplessness and unhealthy dependency on their captors.

Once freed, they still may endure health consequences, from psychological trauma, repetitive stress injuries, back pain or other chronic pain, respiratory illness, and sexually transmitted diseases. Health care intervention and access to health care post-release is key.

While the European study described above is an excellent starting point, more research must be conducted over time to quantify and explore the long-term health consequences of human trafficking on its victims in the United States.

Research Methodology

This report analyzes the data that emerged from interviews with 21 victims of trafficking who were brought to the U.S. to serve as unpaid domestic and sex workers, unpaid restaurant helpers, sweatshop workers, and in one case, as a wife forced into a servile marriage.

Supplementary information came from an Advisory Board of experts in the field of human trafficking, migration and domestic violence. The Board assisted in developing an interview tool and helped arrange meetings with trafficking survivors. In some cases in which clients were considered too fragile to speak to outsiders, the Board members conducted the interviews or delegated them to co-workers who had the appropriate linguistic expertise and familiarity with the client. As a result of the Board's participation, the study was able to supplement the qualitative data collected with professional expertise from: a human rights lawyer whose work focused on trafficking victims, a health outreach worker who was in daily contact with immigrant sex and service workers in San Francisco, a social worker whose agency had assisted dozens of trafficking victims, staff from different domestic violence shelters in the San Francisco Bay Area, and an anthropologist who had completed research among trafficking survivors who had returned to their village of origin in the Philippines.

The study set out to determine if the health care setting was an appropriate place to screen and intervene with trafficked women and children. It also sought to find ways to help survivors of trafficking understand their health care rights and have their health care needs met. A related aim was to identify public policy opportunities and recommend strategies to improve the health care of trafficked women and children.

It should be stated at the outset that researchers wanted to ensure that interview questions would take into account the psychological fragility of our respondents and avoid re-traumatizing them. As we argue in a later section on health care rights, the best interests of the trafficking victims should be the primary consideration in interventions by health care practitioners, non-governmental organizations (NGOs), government staff and others providing services to these individuals. Their rights to privacy and confidentiality should also be respected.

At the same time, the study's researchers wanted the thoughts and voices of the trafficking victims to be included in the design of strategies and recommendations for health care intervention. Thus, a delicate balance had to be maintained between obtaining data and avoiding questions that would probe too deeply into experiences that were still distressing to some of our informants, even after five or more years of therapeutic support and other help from the NGOs that were providing them with services. Respondents who were willing to be interviewed were told at the beginning of

these meetings that they could decline to answer any questions that provoked discomfort and/or that they could decide to stop the interview at any time. Interviewees were also read a protocol that reaffirmed that they had complete control over what they chose or chose not to answer. In a few cases, interviewers verbally checked on the emotional state of the respondents and asked permission to continue. It is worth noting, too, that several respondents were eager to tell their stories and in one case, an interviewee asked to return to the interview site because she had more ideas about how helpful information could be provided to people in captivity.

Despite the constraints on the type of data that could be obtained, we did glean insights into the victims' conditions of captivity, the tactics of the traffickers, the victim's coping strategies, the health consequences of the trafficking situation and the psychological needs of the victims for culturally-sensitive service provision. Respondents also provided important data on their points of contact with the outside world and the type of interventions (e.g., signage, information cards provided at airports) that would have helped them escape or summon the assistance of law enforcement.

Sample Size

Several excellent reports published in the last few years reaffirm the difficulty of obtaining informants from a population that has endured severe abuse, betrayal of trust and social isolation, is often prevented by legal order from discussing the details of captivity, may speak a language that is not easily understood by available translators and may be barely past childhood or in a regressed child-like state. Thus, our sample of 21, while not large enough to generate percentages in discussing most of our findings, fell in the upper mid-range of sample sizes when compared with three other recent research projects that have contributed substantially to the scholarship: *Hidden Slaves, Forced Labor in the United States*, op. cit. (which collected data from 8 respondents); Florida State University's "*Florida Responds to Human Trafficking*"¹² (which did not specify its sample size but reported in detail on interviews with several survivors from a particular case of sex-trafficking); and the two-year, multi-country European study sponsored by the London School of Hygiene and Tropical Medicine,¹³ which drew upon interviews with 28 trafficked women and adolescents.

Demographics of the study's 21 informants

Ages: 12 to 53 at the time they were trafficked

Percentage of children: more than half were under the age of 18 or on the edge of adulthood (19-21).

¹² Florida State University Center for the Advancement of Human Rights. (2003) "Florida Responds to Human Trafficking." Tallahassee, Florida.

¹³ Zimmerman, Cathy et al. (2003). p. 111.

Genders: female and two male youths (one of whom sat in on an interview but did not speak).

Marital status: Several interviewees were married, with children.

Regions of origin: South and Southeast Asia, East and West Africa, Mexico, Caribbean, Latin America, Eastern Europe.

Countries of origin: Mexico, Thailand, Sri Lanka, Indonesia, India, Cameroon, Kenya, Nigeria, Puerto Rico and Virgin Islands, Chile, Hungary.

Class origins: Working-class, lower-middle-class and at least three of probable middle-class origin.

Types of unpaid labor: domestic work; domestic work combined with restaurant work and forced sex; forced prostitution; servile marriage; sweatshop work.

Referrals (i.e., how victims were identified): community-based organizations (CBOs), law enforcement, concerned citizens, commonly referred to as Good Samaritans.

In terms of age and national origin, the subjects interviewed were representative of the people trafficked to the U.S. every year. Their gender was also representative, since women and girls are the majority of trafficking victims. With respect to class origin, however, the interviewees were more diverse than expected, indicating that poverty is only one of the vulnerabilities that place people in the path of traffickers. As stated earlier, it should also be emphasized that not all the interviewees fit the common image of a helpless victim awaiting rescue. Not all victims self-identify as trafficking victims. A few contacted police, who arranged their escape or were able to leave because of a police raid.

Findings

Background on the Model of Health Care Practitioners as Interveners

This study initially conceptualized the health care setting as an appropriate place to screen and intervene on behalf of trafficking victims, based on a successful model of identification and treatment of domestic violence survivors. That model is based on the assumption that because virtually every woman interacts with the health care system at some point in her life, health care practitioners are ideally positioned to intervene and help prevent further injury.

Most women visit health care providers for routine medical care, and victims of domestic violence also seek treatment for their injuries. (The U.S. Department of Justice, for example, reports that 37 percent of all women who sought care in hospital emergency rooms for violence-related injuries were injured by a current or former intimate partner.) This puts health care providers in a unique position to help victims of abuse, if they know how to detect domestic violence and provide victims with referrals and support.

Health care administrators have started to recognize that screening for domestic violence and giving women treatment, information and referrals are essential aspects of effective health care. The movement to recognize domestic violence as a preventable health issue is gaining acceptance from the medical community: health care leaders such as the American Hospital Association, American Medical Association, American College of Obstetricians and Gynecologists and the American Nurses Association have all spoken out to say that domestic violence is an epidemic that requires a stronger response.

Clearly, health care practitioners continue to see the significant role that they can play in both the lives of domestic violence and trafficking victims. Since publication of this report, the U.S. Department of Health and Human Services has released an online toolkit aimed at health care providers as a part of their *Rescue and Restore* anti-human trafficking campaign. The toolkit provides resources on how health care practitioners can identify and communicate with trafficking victims, should they suspect they have encountered a trafficked person.¹⁴ While now these useful materials exist, until recently, they have not been firmly grounded in primary research. This is in contrast to similar health care provider toolkits that the National Health Resource Center on Domestic Violence (housed by the Family Violence Prevention Fund) has developed for domestic violence victims over the last decade.¹⁵ While many lessons may be learned from the work of health care practitioners as interveners in domestic violence, it is critical to develop more research specific to the realities of trafficking survivors and tailor those tools toward these realities.

¹⁴ Department of Health and Human Services, Administration for Children and Families, *Rescue and Restore* website. March 10, 2005. Available at http://www.acf.hhs.gov/trafficking/campaign_kits/tool_kit_health/overview.html

¹⁵ For more information, please see <http://www.endabuse.org/health>

The Study's Hypothesis

Is health care a missed opportunity to intervene on behalf of trafficked women and children? Although many victims were not able to leave captivity, we learned that several victims visited dentist or doctor's offices despite their imprisonment. In a few cases, the victim's ill health made it impossible to work—or her visible symptoms threatened to expose the trafficker.

One time I had a very bad stomach ache. I couldn't breathe because of the pain and the gas. So my trafficker took me to the doctor, a Thai doctor. The trafficker stayed in the examination room but the trafficker tried to answer all of the questions the doctor had asked me. The doctor eventually chased her out of the room saying, "No, no, no, I'm asking her not you." That kind of stuff. The doctor said, "No, you are not the sick person, she's the one that's sick. *She* is supposed to answer me." (emphasis added)

Mona, age unknown trafficked from Thailand

In this situation, the doctor did not talk to the patient about victimization, but clearly was unhappy about the trafficker trying to control the conversation about the victims' medical history. What we don't know about this situation is whether the physician considered the possibility of trafficking as s/he became aware of the controlling situation. This is a good example of how essential it is for providers to receive training and have protocols for screening and intervention. This situation underscores the necessity of separating patients from caregivers, partners, and employers in order to screen safely.

Although the trafficker brought Mona to the provider, the trafficker remained in the exam room, attempted to answer all the questions, translated or otherwise monitored the victim so closely that there was no opportunity for meaningful communication between the victim and health care staff.

Mona's experience illustrates a familiar dynamic to the domestic violence community. Perpetrators of domestic violence also insist on being with the patient during hospital/clinical visits in an effort to isolate their victims from the provider. *It is essential that health care providers screen for violence in privacy and insist that the patient be alone at some point during the visit, assuring safe disclosure if victimization is occurring.*

In all, 28 percent of the trafficking victims that we interviewed came into contact with the health care system during their time in captivity—each one of those visits represents a missed opportunity for potential intervention or education about trafficking.

After her fellow trafficking victim had pulled out a tooth that was paining her, at her request, her face became so swollen that the trafficker's own friend told her: "You cannot take this risk anymore. You have to go to the doctor. It's getting worse." The trafficker took the victim to the dentist. The trafficker charged the victim \$120 for a \$60 doctor's visit. The trafficker also never left the room where the victim was being treated. Her threatening presence and the victim's lack of English-language skills prevented any meaningful communication with the dentist.

Pattida, trafficked from Thailand

Other Barriers to Intervention in the Health Care Setting

The victim's freedom to communicate was not the only barrier to intervention in the health care setting. Additional barriers operate to keep victims' situation hidden. In one well-known case, a group of teenage girls and young women trafficked from an Indian village to Berkeley, California did not fully comprehend their situation while in captivity. Because of the wealth and power of the trafficking family in their place of origin, the trafficking victims had difficulty reconciling the cultural belief that they were being taken care of with their actual experiences of labor exploitation and sexual abuse. Similarly, one of our respondents who was taken to see an eye doctor because of bad headaches could not have explained her situation to the doctor, even if she had had the language skills to do so. The trafficker, in addition, never left the examining room and translated all the doctor's questions. Later, the trafficker informed her that she was fine despite her persistent symptoms.

Protocols for identifying victims have been developed by anti-trafficking advocates and research projects.¹⁶ But even if funding were available to train health care personnel in the use of these tools, recognizing a victim would only be the first step. Training is also needed in ways to aid the victim without compromising her safety. Intervention must also include medical, housing, legal and social welfare assistance.

The data reported above and throughout this report suggest that the health care setting may be prime terrain for early intervention, and trafficking in the U.S. should be recognized as a health issue. Health care providers are critical in the healing process of

¹⁶The Florida State University project, already cited, and the training materials developed by the Bay Area Anti-Trafficking Task Force (BAAT) and published in "Regional Approaches to a Global Dilemma: The Greater Bay Area Anti-Trafficking Training" (2003). San Francisco: BAAT, in collaboration with the California Department of Social Services.

trafficking survivors. In particular, given the age of more than half the respondents in this study, trafficking should be recognized as a children and youth issue.

Children as Trafficking Victims

Interviews with these young respondents highlighted some of the problems in accessing child trafficking victims and providing them with adequate services. As the Florida State University study points out, child victims of trafficking are more vulnerable and face far greater obstacles in getting their distinctive psychological, medical and legal needs met than unaccompanied refugee and immigrant children. A dramatic illustration of this point was provided by one respondent in our study, who managed to summon police to help her and her younger brother. The younger brother was removed to a shelter as a minor, but because she was 18 and considered an adult, the police left the sister in the home, in captivity. Even more dangerously for her, she was faced with the ordeal of having to concoct a story as to why her brother had been taken away, while still attempting to protect herself from the trafficker's fury.

This is but one example of the vulnerability of children and teenagers. The study also showed that:

- **Children are less able than adults to recognize the abnormality of the exploitation that they have endured.** Children, especially, have difficulty conceptualizing their experience as trafficking. For example, one victim, now 18 but 12 years old when trafficked, insisted that he could not be angry at the trafficker. Indeed, he felt that the trafficker had been the person who helped him most by bringing him to the U.S. Unlike the 12 year old who felt helped by his traffickers, other trafficked children do recognize their plight but, as one young victim said, "I never considered leaving [my trafficker] because I did not know where to go or what to do."
- **Children feel responsible for their victimization.** The respondent above felt that she didn't have any future, that there was no way out. "You don't feel like leaving, you don't feel like everything is going to be alright. ...It's crazy, it's bad." She also felt that the situation was her own fault and wondered what she had done to be punished in this way.
- **Children may suffer great psychological distress because of separation from their families or because families, unwittingly or intentionally, have been involved in the trafficking.** Betrayal of trust then becomes a painful issue. In at least three cases in this study, families did act as facilitators to the trafficking or were themselves the traffickers. In one, the father of a young Indian woman worked in a low-level job for the trafficker and could not refuse the much more powerful man's request to transport his daughter to the U.S. for a promised job. In another, members of

a teenage girl and her younger brother's extended family trafficked the pair to the U.S. with promises of sending them to school. They were then severely and continually terrorized and abused, even in the presence of their visiting father, who was too ill and distraught to do more than give his daughter a number to contact and warn her that she risked death if she did not leave her situation immediately.

- **Children may have special difficulty in providing coherent or consistent stories to social service, health care or law enforcement personnel trying to assist them.** Telling their stories in an organized way was difficult for most trafficking victims, but children in particular seem to need help in recounting what happened to them in a step-by-step, chronological sequence. This became apparent during interviews, even though project staff did not try to elicit stories of how the victims were trafficked or what they endured. In some cases, however, many details came spilling out.
- **There are barriers in the current system to identifying child victims of trafficking.** All of the respondents under the age of 18 who were trafficked into the United States were accompanied by adult citizens of the U.S. who were also (or purported to be) family members. Furthermore, the ages of several trafficked children were misrepresented on visa applications.

Conditions of Captivity

- **Threats and isolation.** Many of the victims were not allowed to go outside or were isolated from guests in the house when the trafficker opened the home to outsiders. In cases in which the victims had been trafficked into sex work – and necessarily had contact with outsiders – they were threatened by pimps that if they tried to leave or go outside alone, they would be hit or killed, jailed and/or deported. They were also warned that they could not survive alone because it was “bad out there.”
- **Disorientation, subjection to a distorted social reality, battery and other abuse that amounted to torture.** Another teenager, who had been trafficked by members of her own extended family, was subjected to beatings with a shoe, starvation, forced labor for as many as 19 hours a day and a sense of menace so extreme that whenever she and her trafficked younger brother were sent out to Safeway to buy water, they never attempted escape. Rather, since they knew that their trips outside were being timed by the trafficker, they put all their energy into carrying the heavy water and other bundles as quickly as they could back to their house of confinement. In addition, although she spoke English and knew how to contact police, the teenager was afraid to call law enforcement because the trafficker had changed the victim's name and her age on her passport and “told so many lies that I didn't know who I was any more.”

- **Shame, distrust.** A 16-year-old Mexican teenager forced into prostitution was allowed outside to go to a bar, wash clothing or buy groceries. Fear and shame at telling anyone what was happening to her prevented her from escaping. Her sphere of social contact had become so narrow that she was unsure if there was any person or information that could help her.
- **Geographic isolation.** Several trafficking survivors were entrapped in residential areas where public transportation was lacking and a person on foot would be all too noticeable. They also did not know their own addresses. In the case of a Chilean woman, for example, a Spanish-speaking janitor she met in a mall while out with her trafficker offered to help her. Although she took down his phone number, she didn't know where she lived and she was scared of alerting the trafficker.

Tactics of Traffickers

- **Threats of retribution.** Trafficker's tactics have been suggested above and are also detailed in other, comparable studies cited in this report (e.g., violence, forced dependency, relentless uncertainty, physical deprivation, psychological degradation, etc.) What may be added here is that victims' fears of traffickers' threats of retribution (which are common in most trafficking situations) should not be regarded as exaggerated or misplaced. For example, in a case of two Thai women who had been trafficked, one man engineered their escape, with the help of two other people who wished to be silent supporters. However, the trafficker apparently discovered the role of this latter couple and sent someone to burglarize their house. According to the trafficking victims, it was not a mere break-in, but a "search and destroy" operation that was sufficiently frightening to convince the couple to move and "become incognito" (in the words of the translator.) They nevertheless remained helpful, bringing the trafficking victims money and food after they had left the trafficking situation and moved to a shelter. The victims were also very shaken and became extremely fearful after this warning.
- **Maintaining an appearance of normality or "gaslighting."** "Gaslighting" is a term (based on a classic film) that refers to an abuser's attempt to make a victim doubt her own sense of reality and accept the abuser's standard of normality. Several traffickers in this study "gaslighted" their victims into compliance by avoiding outright refusal of their requests for medical care and instead claiming, with some reasonableness, that it was difficult to get timely medical appointments or was expensive. Or, they promised to take the victim to a doctor, but never followed through. Alternatively, one trafficker took his victim to a doctor to preserve the illusion that the trafficker "was taking care of

everything,” but he monitored the examination process so thoroughly that the victim had no opportunity to find out for herself whether anything was wrong with her.

General Barriers to Health Care Accessibility

Although many trafficking victims were isolated from the outside world, they'd lived in places where hardly anyone walked the streets. Hence, they'd had virtually no possibility of speaking to strangers. Most had rarely been able to get out of the house.

Did you tell anyone when you were sick?

No one. When I felt sick, there was no one I could talk to or tell or ask to go to the doctor to. I would just have to swallow it by myself.

Thalia, trafficked from Nigeria at 22

Even if they were able to leave during captivity, victims didn't have money, didn't know how to use public transit, couldn't speak English, feared authority, and feared deportation. They didn't know who to trust, and believed the lies their captors had told them about dangers and consequences of escape.

I was sick so many times. And when you're sick, you know what they tell you? They go, "You can die if you want to." They tell you that straight up. They just let you stay there and be sick and suffer.

I got sick a couple of times, and it was serious, and the last time I go, "God, you can't let this happen because I'm in the camp of my enemies, and if I keep getting sick, I will die because they don't care about me."

Did they take you to hospitals and clinics?

I don't think that'll work because if they consider you as slaves, they don't want to waste their money on slaves. But some of them might be fortunate; they probably will take you to a hospital because they don't want you to die in their house.

Emilie, trafficked from Cameroon at 17

In the case when a victim is brought to see a health care practitioner by her trafficker, she may be unable to speak privately with the health care provider, as the trafficker tries to control the interaction.

Many victims were subject to conditions of near-complete captivity, rendering their communication with anyone in the outside world almost impossible.

Victims of sexual trafficking had minimum access to any kind of health care. Respondents were restricted from using condoms and some had sexually transmitted diseases. If they were allowed to leave their residence/place of employment, they were allowed to do so only with an escort, usually to purchase makeup or clothing related to their job. They were also not allowed to talk to neighbors. In one case, a pregnant worker was sent back to Mexico. There was no attempt to address health issues that came up. No health worker visited them.

Additional barriers involved survivors' notions about health, based upon their experiences with health care services (both formal and informal) in their home countries, and their specific cultural ideas about illness. One Mexican respondent, 16 at the time of her captivity, had been trafficked repeatedly back and forth from Mexico. She was taken to a doctor in Mexico, when her ovaries were so infected that, as she said, "I was in an extreme situation. I looked like I was six months pregnant." The doctor, apparently, did not intervene beyond providing sufficient medication to enable her to be forced back into sex work. It was not an experience that enhanced her trust in formal health care settings.

Equally problematic for the victims' recovery were a sense of shame, distrust of people, culturally-based fears that the trafficker could continue to exercise power even from afar and, for some, despair at being unable to help themselves. As one young woman commented, "You don't have money, you look at your dress, your hair, you feel horrible about yourself."

Age, too, factored into decisions by respondents to tolerate their ills—or in some cases, to complicate their situations—rather than seek health care in a formal setting. A young woman who had had at least one abortion while trafficked into a servile marriage became pregnant by a new boyfriend shortly after leaving her situation. She was most concerned, not about the pregnancy itself, but about finding a well-paying job and qualifying for Medicaid so that, as a single mother, she could take care of her baby. She had agreed to seek medical care on the advice of her new boyfriend's mother, only because the older woman had also been abused by men and therefore understood her experiences.

A Nigerian 21-year-old found it "scary" to admit to her initial interveners that she needed help. According to her, those who released her from captivity told her to go

back to Nigeria, which she could not do without money or documents. Not only the trafficking situation but her initial period of rescue seemed to her “stressful and also crazy.” She felt that no one could help her except herself.

Other Points of Intervention: If Not Health Care, Then Where?

Although our respondents were usually confined to a house or allowed out only under close supervision, some did have opportunities for contact with the outside world, when they were taking children to school or parks, or when they were permitted to shop for groceries, do laundry or accompany the trafficker to a restaurant or shopping mall. Because of fear of the trafficker, language barriers, lack of money and documents, severe depression and/or other obstacles, the victims could not have escaped their circumstances on their own on these occasions. But those who came to the U.S. by plane were close to unanimous in stating that information could have been provided at the airport, perhaps in the form of a card or flyer that gave contact numbers of police or immigration officials, and that information at this time would have been useful.

Because the study considered it important to include the thoughts and voices of trafficking survivors in the design of interventions, they were asked for specific suggestions about how victims could be reached and assisted in escaping their situations.

Following are some of the victims' thoughts about other opportunities for intervention:

- Signage could be placed on cleaning supplies and detergents that would both acquaint victims with their rights and give them phone numbers to call for help, using “Missing Child” advertisements on milk cartons as a model.
- Because of the diverse language groups victims represented, graphics instead of text could appear on varied informational media to show an employer hitting a worker (or refusing to pay her). Graphics could indicate that such treatment was not allowable and phone numbers could be provided.
- Any signage or other text in English should also be printed in other languages, particularly Spanish in U.S.-Mexico border areas.
- Because traffickers often allowed the victims they were accompanying to use restrooms by themselves, helpful numbers and other information could be placed inside the restrooms of fast-food stops along freeways, ethnic-food restaurants, discount shopping malls and other places likely to be frequented by trafficking victims. Telephones outside such restrooms would be another appropriate site for awareness and contact information.
- Information could be posted in taxicabs and other forms of public transportation

such as buses and bus stops in the cities known to be transit and destination points for trafficking (e.g., Los Angeles, San Francisco, Miami, Atlanta and other major cities¹⁷).

- Information could also be posted in public parks in areas where there are many immigrant domestic workers and nannies; elementary schools, both for targeting trafficked children as well as those children who are cared for by trafficked women; grocery and discount stores; Laundromats; places of worship; and hospitals or clinics.
- Ads and public service announcements could be included in periodicals, ethnic press, radio, and television (especially Spanish-language programs, such as telenovelas), as well as in phone books.

Additional Findings

At the personal level (i.e., assistance provided by sympathetic supporters), interviewees expressed gratitude at nurturance and continuity of support that made them feel like cared-for individuals.

Interviewees spoke of greatly appreciating acts of concern that indicated a personal interest in their well-being (e.g., one interviewee was taken to a museum, which she greatly appreciated; another interviewee noted being invited to eat dinner at her supporters' house a year after her escape).

The majority of respondents were appreciative of help that enabled them to become independent and self-sufficient. Several of the women were reunited with their families, found jobs, and continued their education through language and life-skills classes. One woman who had experienced severe abuse is studying to be a licensed vocational nurse because of the assistance of her friends and advocates.

Well-trained cultural and language interpretation was helpful to gaining trust with the trafficking survivor. Those respondents who had limited English skills were able to more easily forge relationships with advocates who spoke their native tongues or had access to a well-trained interpreter. In cases where the trafficker used language as a mode of isolation, speaking her native language interrupted feelings of isolation and brought about feelings of familiarity and independence from the trafficker.

Some respondents found it difficult to seek assistance for services, especially immediately following departure from captivity. Some interviewees were moved around, forced to rely on a variety of

¹⁷ The specific cities identified by The Protection Project of Johns Hopkins University include those already cited, as well as Chicago, New York, Seattle, Dallas/Fort Worth, Boston, Tucson, Minneapolis/St. Paul, Washington, D.C., Detroit, Honolulu, Las Vegas, New Orleans, Newark and San Diego. See "Training Service Providers on Effective Methods to Provide Services to Victims of a Severe Form of Trafficking," (2003) San Francisco: The Protection Project of the Johns Hopkins University, School of Advanced International Studies.

people they did not know and otherwise remained under stress for months after receiving help to escape their traffickers. It does not seem an exaggeration to compare the fear and collapse of trust experienced by some victims, particularly those who had been sex trafficked, to the psychological disabilities experienced by torture survivors. This may or not be the case for other victims of human trafficking.

Interveners ranged from well-meaning and helpful neighbors or even friends of the trafficker to the Federal Bureau of Investigation (FBI). In one case, a trafficker accompanied by an unrelated 12-year-old was arrested at the airport. In another, fellow traffickers of the initial trafficker offered help. In several other cases, the trafficking victim herself called the police. Intervention in a trafficking situation presented certain dangers to the Good Samaritans (as is not uncommon for kindhearted strangers who offer assistance). As mentioned, the house of one couple was burglarized in what was described as a “search and destroy” operation. Furthermore, fear on the part of some interveners caused them to urge the trafficking victim to return to her native country.

General Recommendations

There are many avenues that can be pursued to assist victims of trafficking. For the general public, outreach and education is an important starting point. For victims, programs need to target them in all stages of their plight – first to identify them, then to reach out to them and educate them on their rights and resources, to help them escape from captivity, and finally to provide them with services after their departure. For health care providers, education is needed to improve their response to victims, training is critical to help them screen and identify patients, and funding is needed to pay for these new programs.

- 1. Use formerly trafficked persons to inform public policy and intervention strategies.**
- 2. Train health care providers to assess and intervene on behalf of trafficked victims.**
- 3. Raise awareness of trafficking for the general public.** Several interviewees were helped by neighbors who saw them trapped in their homes, and in one case, a stranger who was approached by a victim in a shopping mall. Since victims are isolated and prevented from accessing social services, it is likely that individuals will have a better opportunity in some cases to intervene. In order for this to happen, citizens need to be educated about trafficking and know that it exists in order to recognize it when they see it, and know what resources exist that can help. It is also worth noting that although Good Samaritans have been an important source of help to trafficking victims, caution needs to be exercised in alerting the public to take action. The lives of those who helped the Thai victims in Los Angeles, for example, have been complicated—even endangered—because the Thai community in the U.S. is so small that individuals can easily be identified.

The police helped me to come out from my employer's house. I was always scared. I did not trust anybody. I was very scared, [at] that time I don't have anybody from my country. Neighbors could see it, but two years I did it, and only they –

Nobody said anything until two years later, when the police came out of nowhere, and you don't know who called?

Yes.

So what I think you might be saying is maybe trying to get information out to neighbors, if they notice something {would help}?

Yes. Maybe there are like 25 people who say it is right, but there may be one person who will say that it is wrong.

Lana, trafficked from Sri Lanka at 21

[A friend of my employer said to me] to leave this house. Because you work here like a dog and you don't have anything and that you don't have a life like other people. They say that. And then maybe you just try to leave from this house and then you can find a better job outside and have a better life. They say that. So they try, they tell me to leave and then I'm going to give you some information to find a job and they give you leaflet... And then I was asked them to please can you please let me borrow money 'cause I don't have any penny with me. So he done let me borrow like for a couple hundred.

Josie, trafficked from Indonesia at 17

4. **Peer-to-Peer Outreach: Health care workers need to reach out, not just to victims of trafficking, but to the victims' peers.** Peer-to-peer outreach is a vital area to explore, so that others who may not be trafficked themselves but who may come in contact with trafficking victims can relay the education and assistance to the victim. Given the preponderance of domestic workers/nannies among the interviewees, this was not a population with access to a workplace where health outreach workers might go (e.g., massage parlors, nail salons). The workplaces are informal and unregulated, so traditional intervention models, such as an Employee Assistance Program, are completely absent. Health care workers could liaison with domestic workers groups, sex workers groups, health care outreach staff who work in migrant communities, and/or HIV/AIDS outreach workers in neighborhoods at high risk.
5. **Fund and promote health outreach services and other social services such as English as a Second Language programs or farmworker organizations that are able to reach sectors known to employ trafficked women and children.**
6. **Outreach through Strategically-Placed Information: Interviewees had many practical suggestions about placing signs and other information alerting trafficking victims to their rights and to phone numbers where they could get help, such as bathroom stalls, public telephones and airports.**
7. **Offer training in the dynamics of trafficking and the differences between trafficking and domestic violence.** Today, many health care providers do not know the problem exists and so they do not recognize it when they see it. The first step to intervention is identifying victims. They are often mistaken for victims of domestic violence or sexual assault and referred to battered women's shelters or rape crisis centers, which lack the expertise to respond adequately to their needs.
 - The training should target health care providers, CBOs and law enforcement

- Training should also be provided to health care educators on a peer-to-peer education model.
- Information about trafficking should be supplied to pharmacists, dentists, low-cost clinics and to other sites where traffickers might bring victims who are still captive.

8. Fund protocols to develop culturally-sensitive service provision for health care and trafficking service providers. Culturally-sensitive service provision entails understanding the hierarchies of power that are part of the everyday context for particular groups.

The popular media has already reported the circumstances of the Lakireddy Reddy case in Berkeley, CA, in which a wealthy Indian family, headed by Lakireddy Reddy, trafficked young women and girls from a rural village where Reddy continues to be treated with tremendous reverence. The young women and girls were from low-caste, poor families whose adult members could not refuse Reddy's request to transport their daughters to what he claimed were "jobs" in the U.S. The patron/client relationship carried over into the trafficking situation, so that one of our interviewees did not realize how abnormal her circumstances were while she was in captivity. Even years later, she still believed that Reddy had "helped" her. Health care aimed at addressing psychological consequences of the trafficking must be sensitive to the social/cultural context that the victims came from and take into account the degree to which they have been socialized into particular expectations and beliefs.

Furthermore, food preferences are deeply cultural. For trafficking victims who have recently left captivity, often in a state of severe depression and disorientation, eating unaccustomed foods – or lacking the comfort foods they are used to – may be distressing. Or, the victims may have culturally-specific ideas about what constitutes the correct food for symptoms of stomach pain and other ills linked to their stressful experiences.

A related point concerns culturally-specific discomfort that trafficking victims may feel at being alone, without the company of other, familiar people. In many countries, people share the same bedroom or live in a room where many sleeping mats are laid out and do not feel comfortable eating or sleeping unless they are in the company of other people. Thus, in a shelter, they may be reluctant to be alone.

In many immigrant communities, those who want to help the victims endure stigmatization because of the widespread feeling that the community's "dirty laundry" should not be aired in public.

9. Fund post-release health care access to provide the trafficked person with immediate access to health care. After the trafficking victim leaves, she should immediately be given

health care assistance – including mental health and dental health. She will need screenings to test for health problems. Doctors should be familiar with the health issues of her home country, so they recognize illnesses and conditions not commonly known here. Psychiatric referrals to culturally and language appropriate counselors are key for mental health, and special care should be arranged for victims who are children.

10. **Set aside pre-certification funding for health care.** Given the health care deficits endured by the victims, they cannot wait for months for health care, as is often the case while waiting for legal documentation. It should be noted that free clinics are already at full capacity, so funding needs to be reserved for access to immediate emergency medical services provided outside a hospital setting. Trust issues may preclude taking the trafficking victim to a hospital.
11. **Coordinate and collaborate among all agencies that serve victims of trafficking,** including law enforcement, the judicial system, outreach workers, health care providers, and social service agencies.¹⁸
12. **Create more housing specifically for trafficked women and children.**¹⁹ Our research substantiated a recent report's finding that housing trafficking survivors in homeless or domestic violence shelters is problematic.²⁰ The legal, psychological, social and economic situations of trafficking victims differed from the residents of these types of shelters, resulting in their increasing demoralization when they lived for long periods of time in limbo while their co-residents seemed to be receiving help much more quickly. Interviewees expressed frustration at having no place to go and no money to spend when they were required to leave shelters during the day. It was also demoralizing for them to bond with their shelter co-residents, only to have these new acquaintances leave after a few months. As one social worker commented, "At first, they're open and friendly to the other shelter residents, but by the third turnover of people, they're withdrawn and don't feel like speaking to any of them." Efforts have begun to create housing specifically for trafficking survivors.²¹ These should be

¹⁸ *Improving Collaborative Response to Trafficked Victims of Domestic Violence and Sexual Assault: Trafficking Handbook.* Family Violence Prevention Fund, 2005. Forthcoming. This curriculum is based upon a series of trainings funded by the Violence Against Women Office (VAWO) of the Department of Justice conducted to build understanding and collaborations among VAWO grantees, domestic violence, sexual assault, immigration organizations, law enforcement and INS to improve their capacity to respond to the complex needs of trafficked women and children.

¹⁹ The Coalition to Abolish Slavery and Trafficking opened the first national shelter dedicated to housing victims of human trafficking.

²⁰ *Hidden Slaves*, 2004.

²¹ The Coalition to Abolish Slavery and Trafficking (CAST) in Los Angeles, CA has started the first-ever shelter specifically for trafficked women and children. CAST is the only organization in the United States dedicated exclusively to assisting victims of trafficking.

encouraged, so that victims' emotional, social and economic needs can be addressed with the appropriate level of counseling and other support.

- 12. Fund research to understand how service providers can collaborate to overcome barriers to helping child victims of trafficking.**

Health Care Rights as Human Rights

This study operated under the assumption that health care rights and human rights are inextricably linked to each other, taking the lead from several health and human rights organizations such as the World Health Organization,²² the United Nations,²³ and Physicians for Human Rights, among others. These organizations argue that the protection and promotion of human rights is inseparable from health, understood as a state of physical, mental, and social well-being as well as the absence of illness and infirmity.

This study also reaffirmed that trafficking survivors are victims of a complicated and extensive set of violative acts, ranging from psychological assaults on their well-being to forms of social deprivation and gender-related abuse.

While significant attention has been paid by the United States government through laws such as the Trafficking Victims Protection Act (2000) and the Trafficking Victims Protection Reauthorization Act (2003), their attention remains on investigation and prosecution of traffickers and legal remedies that the victim may pursue. However, the health consequences of human trafficking persist long after they have been released and treatment of these health effects are essential to their re-integration into society.

In the conclusion to the European study on the health risks and consequences of trafficking in women and adolescents, the authors state:

The damage to individual lives cannot be solved solely by tighter border controls, criminal trials, or awareness posters. Those who work towards improving support for trafficked women must aim for more than stronger laws, policies, and human rights provisions on paper. They must recognize that each individual woman has survived an experience of extreme violence and life-changing intimidation that requires the utmost individual attention and care. Service organizations carrying the human toll of this crime need recognition, funding support, and gratitude.²⁴

²² A description of their health and human rights platform can be found at <http://www.who.int/hhr/en/>.

²³ “Everyone has the right to a standard of living adequate for...health and well-being of himself and his family, including food, clothing, housing, medical care and the right to security in the event of...sickness, disability” *Universal Declaration of Human Rights*, Article 25.

²⁴ Zimmerman et al., 2003. p. 111.

Conclusion

Human trafficking affects tens of thousands of women and children each year in this country, yet it is virtually unseen by most Americans and largely unaddressed by the health care community, even though its health consequences are immense. There is much more that health care providers can do to screen and treat this vulnerable population. More research is needed on the health consequences of trafficking and potential health care interventions. More education, more outreach, more collaboration, and more funding of these efforts are also needed.

Trafficking is a complex issue and the role of health care may play in early intervention remains largely untapped. Human trafficking is an important health care issue that should be addressed with sensitivity, urgency and innovation.

Appendix

Sample Survivor Stories

Anastasia²⁵, Kenya

Anastasia came to the United States at age 24 with the same family that she had been working for in her native Kenya. She was using her wages to support her daughter, her mother, and younger siblings.

Although Anastasia had been hesitant to leave her family, her employer had promised to pay the U.S. minimum wage (\$6-6.25 per hour). She also offered her the chance to go to school if she accompanied them to clean the house and take care of the young child.

Upon arrival, however, Anastasia found herself working a minimum of 16-hour days, cooking according to menus drafted by her employer, washing clothes by hand even though the employer had a washer and dryer in their apartment, and tending to the needs of a young child. Her employer forced her to sleep on the floor of the child's bedroom so that she could attend to his needs at all hours of the night. She was unable to leave the house except to carry the child on her back to a school, which was about a mile away. She was occasionally permitted to attend church on Sunday for a few hours.

Rather than being paid the minimum wage and given a chance to attend school, Anastasia received verbal abuse, intimidation, and meager wages: a total of \$370 for five months of labor. Since her employer was also Kenyan, she understood how to use cultural threats to terrorize Anastasia. This intimidation included making claims about what she could do to Anastasia's family. In addition, she said that if Anastasia died in her employ, she would not bury her in her hometown -- a possibility considered to be worse than death itself. When Anastasia found the courage to ask for higher wages to send to her family in Kenya, her employer responded in a rage, pushing her to the ground and shouting, "I can beat you, kill you. You are from bad blood and arrogant. I can call my husband to beat your uncle if he goes to the house. God will punish you because you don't know how to appreciate what I have done for you."

That night and several nights thereafter, Anastasia was too frightened to sleep, thinking that her employer was going to kill her. Outwardly, she pretended to be happy but privately, she felt severely depressed and sad. She cried herself to sleep at night because she felt so alone.

When the employer left the country for one month to attend a funeral, she left Anastasia alone without money for food and locked her in the house. She told Anastasia that

²⁵ Names identifying trafficking survivors have been changed throughout this report for their safety.

everybody in the U.S. was an FBI agent, ready to deport her if she talked to them. As a result, she never talked to neighbors.

Fortunately, one of her employer's friends came to check on her a few times during this desperate month. He told her about a Worker's Center in a nearby city to help her find work while her employer was away. It was there that she ended up, ultimately finding the will to trust people who wanted to help her leave her situation.

Anastasia had never been able to see a health care professional while she was with her employer. She had experienced headaches, but did not otherwise become sick. She was aware that if she had told her employer that she was sick, the woman would do nothing. Anastasia was only able to see a doctor after she had received her visa months after she left her employer. At that point, she learned she was anemic and had other illnesses.

Emilie, Cameroon

Emilie arrived in the U.S. at the age of 17 from Cameroon. She was accompanied by her 13-year-old brother. Her trafficker was her half-sister, related to her and her brother through a common father.

Emilie's father was Chief of Police of her hometown and her mother was a businesswoman. Emilie had thought she would eventually come to the U.S. for college anyway, but her sister convinced her parents to let Emilie and her brother come with her to the U.S. so that they could attend American schools at a younger age.

Emilie's trafficker arranged the papers for her and her brother, claiming that they were actually younger than they were: 12 and 9 respectively.

When they arrived in the U.S. they found themselves put to work for several people in the sister's house—cooking meals and hand-washing clothes from 4 or 5 in the morning until late at night. When Emilie realized that several months had gone by, she asked the trafficker why she and her brother were not attending school. The trafficker responded with lies, saying that school had not yet started or that they were too old to attend school.

The trafficker wrote letters home to Emilie's parents claiming that they were attending school and that everything was going very well. The reality, however, was that Emilie and her brother had been sustaining severe, regular whippings in the living room in front of the other occupants of the house. Often, Emilie had bruises and cuts on her face and head. Once the trafficker held her down on the floor and sat on her stomach until she could not breathe.

Emilie and her brother worked long hours with very little food and were beaten if the trafficker suspected that they had eaten without permission or been insubordinate in

other ways. If Emilie was allowed to leave the house, it was only to buy groceries at a supermarket fifteen minutes away by car. She was forced to run or walk quickly with the groceries because the trafficker would time her. If her arrival exceeded this time limit, the result was a beating. She was too frightened to talk to anybody because her trafficker had told her that “If you talk to anybody, they’ll put you in jail.”

Emilie eventually sought help after reading an article about another Cameroonian girl in Washington, DC who had experienced similar abuse. According to her, if she hadn’t read that article, she would still be in servitude, because she would not have realized that it was not she who was at fault but her trafficker. It was through reading about the girl that she summoned the courage to go to a neighbor’s house to call the police.

Emilie was rarely sick during this time, but she did constantly worry about her health. She did not come into contact with a health care professional while in captivity, but one of the house’s occupants was a certified nurse’s assistant who worked in the hospital.

Alan, Hungary

Alan arrived in the U.S. at the age of 12 with his brother and an American man. For the two to three years that he lived with this man and his wife, he was a victim of sexual assault by the man. Eventually, as the man came through an airport in the U.S., he was arrested and jailed.

During our interview with him, Alan was asked who had helped him in the U.S. He answered, “the American that brought (him) here.” A little later, he added that the people who had assisted him in attaining legal citizenship had helped him.

When the interviewer asked about the time he had spent with the trafficker, he remarked that someone had told him that his trafficker had now been arrested at the airport and that he should never have been left alone with him. When asked about his trafficker’s arrest, he expressed discomfort, saying, “It doesn’t matter to me anymore, you know? It’s not something I’m happy about...If it hadn’t been for him, I wouldn’t be here right now. I can’t get mad at him.”

Alan attended school while living with his trafficker from the middle of seventh grade until the end of eighth grade. Few more details were forthcoming, however, because Alan preferred to focus on his present life. The advocate working with him also knew very little about his history because Alan did not feel the need to talk about it and chose not to.

With respect to his health, Alan recalls going to the doctor for occasional checkups. But he generally did not tell his trafficker when he felt ill. Instead, he just “dealt with it.” The trafficker’s wife was employed as a nurse but Alan did not reveal whether or not he had consulted her for help.

Carmen, Mexico

Carmen came to the United States when she was 18 with her boyfriend, Marco. Over the period of time she was with him, he forced her to have sex with strangers for money. She later discovered that Marco also had other girlfriends whom he coerced into prostitution.

Marco would take her to a discount strip mall to be picked up by men. Or, she was driven by taxi to various apartment complexes to perform sexual acts with several men throughout the day.

Carmen stayed with Marco because she believed that she could not survive without him. He controlled her by simultaneously telling her how much he loved her and threatening to leave her if she did not bring money home. He was the only person she knew in the U.S. and she depended on him for “everything.” At times she would decide to leave Marco, but fear held her back. He constantly terrorized her, resorting to physical beatings when she resisted going to work.

Carmen was constantly worried about her health. She knew the risks she faced but was too scared to ask for help. She felt she had no choice but to remain with her trafficker.

Carmen never came into contact with a health care professional while in captivity. She was often ill with chronic gynecological health problems, but her trafficker only gave her pills for her infirmities. When she became pregnant, Marco would give her pills to “make her have the baby.” She was simply told that she “could not be pregnant then.”

Carmen did not see a doctor until she was put in contact with an anti-trafficking advocate.

Liza, Sri Lanka

Liza came to the U.S. as a domestic worker, after answering an ad in her local newspaper in Sri Lanka. She was hired by two wealthy doctors—a husband and wife—who told her that she would perform housework for the minimum wage. Upon arrival, her trafficker confiscated her passport, claiming that she was not allowed to have it.

Liza cooked, cleaned, and took care of two young children from sunrise until very late at night. She was forced to sleep on the floor of the children’s bedroom to attend to their needs 24 hours a day. She was not allowed to write letters or communicate with her family in Sri Lanka. Liza rarely left the house, but when she did, it was to take care of the children or bring them to a park.

For one month’s work without a day off, she was paid \$250—far less money than she had been promised. If Liza bought items for herself, like much-needed shoes or a gift for her son in Sri Lanka, her trafficker deducted those expenses from her monthly salary.

Some of the employer's friends and family noticed that Liza was being treated as a slave and attempted to help her. One person close to her employer's family bought her pre-paid calling cards so that she could surreptitiously phone her family in Sri Lanka without her employer's knowledge. Another person eventually helped her escape by finding service providers in the area who could attend to her legal and personal needs.

Liza was able to go to a doctor twice during captivity. The doctor whom she visited appeared to be a friend of her employer. Liza suspected that the doctor thought something strange was going on, but did not feel comfortable intervening. For one of the visits, her employer deducted \$35 from her already-meager salary.

Notes

For more than two decades, the Family Violence Prevention Fund (FVPPF) has worked to end violence against women and children around the world, because everyone has the right to live free of violence. Instrumental in developing the landmark Violence Against Women Act passed by Congress in 1994, the FVPPF has continued to break new ground by reaching new audiences including men and youth, promoting leadership within communities to ensure that violence prevention efforts become self-sustaining, and transforming the way health care providers, police, judges, employers, and others respond to violence.

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