Stolen smiles: a summary report on the physical and psychological health consequences of women and adolescents trafficked in Europe

London School of Hygiene & Tropical Medicine

Poppy Project

International Organization for Migration

On The Road

Animus Association Foundation

La Strada

Pagasa

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

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Contents

1. Introduction

Trafficking in women is a severe form of violence against women and a serious violation of human rights. Although reliable statistics are difficult to obtain, it is widely acknowledged that thousands of women are trafficked each year within and to the European Union. Women* who are trafficked suffer unspeakable acts of abuse, exploitation and degradation. The damage to women's health and well-being is often profound and enduring. Yet, despite the global condemnation of the pain and injury caused by traffickers, relatively little action has been taken to identify and meet the health needs of survivors.

Trafficked women have very different experiences while in the trafficking setting. Some are held captive, unremittingly assaulted and horribly violated. Others are less abused physically, but are psychologically tormented, and live in fear of harm to themselves and their family members.

A fraction of women escape on their own, and an even smaller fraction are able to obtain medical, psychological, and social assistance from dedicated service agencies. In these cases, assistance is generally coordinated by non-governmental organisations (NGOs) that provide shelter, counselling, economic assistance, and medical care or referrals. Women may receive support in the country to which they were trafficked, a transit country, or their country of origin, depending on where they escape or are freed from traffickers, and whether or not they feel safe returning to their country of origin.

To date, there has been little quantitative evidence about the physical and psychological health needs of women who have been trafficked in Europe. This study gathered statistical evidence on the health needs of women who had recently escaped from a trafficking situation.

This report presents some of the first-ever statistical data on trafficked women's health outcomes. It also provides evidence on violence and health risks that may have influenced these outcomes. The findings are startling in the breadth and depth of the harm women sustained. The level of harm caused to so many aspects of women's physical, sexual, and psychological health was all-encompassing, posing a massive challenge to care providers. The organizations that assist women who have been trafficked frequently have their economic and human resources stretched to the maximum.

With this study, we hope not only to call attention to the health implications of trafficking in women, but to provide fact-based information on the range of health consequences of trafficking, which can lead to better, more holistic care for women who have been trafficked. To this end, our research team and the women who were trafficked joined together to provide a full set of data on many discrete aspects of women's health. From this evidence-base, we hope that improved policies and well-planned and resourced services will be available for the many women who will be requiring assistance in rebuilding their health and well-being.

"I feel like they've taken my smile and I can never have it back."

Lithuanian woman trafficked to London

* The use of the term "women" in this report is meant to refer to women and adolescents age 15 and older.

2. Recommendations

General recommendation

Recognise trafficking as a health issue.

Recommendations to States

1. States should approve national legislation that requires provision of healthcare for women who have been trafficked.

2. Implement a recovery and reflection period of a minimum of 90 days to ensure that women's cognitive functioning has improved to a level at which they are able to make informed and thoughtful decisions about their safety and well-being, and provide more reliable information about trafficking-related events.

3. Recognise the rights of trafficked persons to compensation and reparation funds to address the range of health consequences of human trafficking and trafficking-related crimes in all national legislation that affects trafficked persons. Specifically:

    a. Accord women in destination and transit settings immediate legal rights to state-supported recuperative health services. This right should be specified in all national legal instruments, regardless of women's legal status or ability to pay.
    b. Do not remove or detain women from destination or transit country settings without providing appropriate medical care to meet their immediate healthcare needs.
    c. Do not return women to States where the healthcare services are inadequate to meet their health needs.
    d. Provide specially designated health services for trafficked women upon their return home, where existing services are not adequate to meet their healthcare needs, regardless of their ability to pay.
    e. Accord women returning to their home country the same rights to state-supported health services as other citizens of that country, regardless of the period of time that they have been out of the country or any break in contributions to healthcare schemes.

4. Develop policies and designate budget items aimed at meeting the urgent and the longer-term healthcare needs of trafficked women.

5. Foster the provision of in-house medical care within assistance organisations and shelters.

6. Ensure trafficked women are not unjustifiably denied medical care by informing relevant health care organizations of women's full range of rights and entitlements to services, and by discouraging racism and bias to prevent refusal of services based on nationality, language, ethnicity, or stigma. Monitor regularly to ensure that women's rights to services are respected.

7. Implement legislative measures that avoid delays in according trafficked women the legal status that enables them to access healthcare services.

8. Working with international organisations (e.g., WHO, IOM, Unicef), develop and make available health promotion booklets designed for distribution to women at risk of trafficking or women in situations of exploitation. Booklets should include, at a minimum:

    - A clear definition of trafficking and its estimated magnitude;
    - An overview of the health complications commonly experienced by trafficked women, including descriptions of signs and symptoms of illness and options for treatment; and
    - A summary of the rights to health services of non-residents in known countries of destination, and the rights of women who have been trafficked to health services in receiving and/or countries of origin.

Booklets should be translated into a variety of languages and drafted to be relevant for distribution in different countries.

9. Resources on trafficking should be developed that can be used by health professionals providing care for women who have been trafficked. These should be based on existing models of good practice established for other

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

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

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

10. Law enforcement agencies should:

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

- Understanding violence and other health risks experienced by trafficked women;
- Recognising the range of urgent and non-urgent health complications sustained by trafficked women;
- Responding appropriately to reported urgent and non-urgent health complications;
- Understanding and responding to distress, anxiety, hostility and other psychological reactions;
- Understanding how different health outcomes might affect a woman's behaviour and reactions in official settings or during official procedures, in particular, learning about the negative effects of trauma on memory.

f. Make available to trafficked women the option of having a support person from a non-governmental organisation or a state-sponsored victim support service present when women are in custody of law enforcement personnel.
g. Ensure measures are in place to regularly monitor the health and well-being of women who are detained and are suspected of having been trafficked.

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

Designate funds to support:

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

2. Advocacy for trafficked women's rights to health and access to health interventions.

3. Training and sensitization of healthcare staff to identify and provide appropriate treatment for victims of trafficking.

4. Interpreting services as needed.

5. The training and sensitization of police, immigration and judiciary officials to enquire about and respond appropriately to trafficked women's health complications.

Recommendations for health service providers

1. Recognise that addressing post-trafficking health problems is a multi-stage process that includes:
   a. crisis or emergency intervention care;
   b. support for women's physical recuperation and psychological adjustment; and
   c. care for long-term symptom management.

2. Ensure that all medical testing is voluntary, and carried out in accordance with international human rights and professional ethical and health standards.

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

4. Respect women's sexual and reproductive health rights by offering access to safe abortion services, counselling for voluntary HIV testing, anti-retroviral drugs, and post-prophylaxis, as required.

5. Carry out safe and linguistically appropriate outreach and mobile clinic strategies to offer care to trafficked women still in situations of exploitation.

6. Coordinate closely with local organisations providing assistance to trafficked women to assist them in offering the range of healthcare required by trafficking survivors.

7. Ensure the confidentiality of women's medical records, and respect their rights to all medical and healthcare documents by implementing privacy and file security measures, and by making copies of health-related documentation available to each woman.

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

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

1. Ensure that assistance programs prioritise women's medical and health needs during intake by:
   a. specifically enquiring about a range of health complications upon a woman's arrival;
   b. addressing urgent problems and pain as quickly as possible; and
   c. working to develop in-house and outreach medical services, where appropriate.

2. Collaborate with key health providers, including general practitioners, genito-urinary medicine, psychiatry, dermatology, abortion services, gynaecology, detoxification services, and emergency services to ensure that women have the full range of care needed.

3. Provide services for trafficked women based on good practices used by assistance programs for survivors of other forms of gender-based violence, such as sexual assault and domestic violence, and culturally competent care practices employed for migrants or refugees. Where appropriate, assistance organizations working in these fields should expand their services to offer care for women who have been trafficked.

4. Train staff to provide written and/or verbal health information for women who have been trafficked, such as information on sexual and reproductive health (including HIV and other sexually transmitted infections), mental health, infection and injury, and pain management.

5. Respect women's reproductive rights by offering access to safe abortion services.

6. Conduct advocacy targeted at improving policies and increasing funding for health and medical care. In particular, advocate for national legislation that does not make healthcare

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

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

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

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

3. Study Design

Study aims & objectives

The purpose of this study was to gather statistical evidence on women's health needs with the aim of fostering better care policies and strategies to improve women's chances of regaining their health and well-being. The objectives of the study were:

- To gather quantitative and qualitative data on the perceived physical, sexual and psychological health symptoms of women attending post-trafficking services.
- To examine women's health needs over three stages: (1) crisis intervention stage; (2) adjustment stage; (3) long-term symptom management stage.
- To identify symptom patterns and health priorities of trafficked women in post-trafficking service settings.

Study methodology

The study was implemented by a research team consisting of both research professionals with expertise in the area of women's health and violence, and seven highly experienced service organisations who work with trafficked women across Europe. Women in contact with support services in Chisinau, Kiev, Sofia, Prague, London, Martinsicuro (Italy) and Brussels were interviewed during 2003 and 2004. Following strict ethical and safety guidance provided by the *WHO Ethical and Safety Recommendations for Interviewing Trafficked Women*[1] on the conduct of research with women who have been trafficked, 207 women were interviewed in private by counselling staff of assistance organisations who were experienced at working with this vulnerable population.

Rather than focus on a broad range of women who had been trafficked into different circumstances, the study interviewed adolescents and women who had been trafficked into sex work or who had been sexually abused while working as domestic labourers, and who had entered the integration/re-integration phase under the care of an assistance programme. Women trafficked for other labour purposes require future research.

All women were invited to be interviewed at three different time periods. Interview 1 generally took place between 0 and 14 days after a woman entered a post-trafficking assistance program (Crisis Intervention Stage). Interview 2 was carried out with most women between 28 and 56 days after entry into care (Adjustment Stage), and Interview 3 was usually conducted after 90 or more days (Long-term Symptom Management).

The study questionnaire was developed by the research team, and was translated into Italian, Russian, Ukrainian, Bulgarian, Czech, Polish and Lithuanian. The questionnaire enquired about the woman and her family situation prior to being trafficked (including experiences of physical and sexual violence), details about the duration and circumstances of being trafficked (including risks, abuse and deprivation), and her physical health and mental health status at the time of interview. Women's health status was assessed using self-reported symptoms only, and clinical examinations were not conducted. Women's mental health status was assessed using two established research instruments (the Harvard Trauma Questionnaire[2] and the Brief Symptom Inventory[3]).

Sections of the questionnaire on symptoms that were used at Interview 1 were repeated during Interviews 2 and 3, enabling comparisons between the different time periods. Two hundred and seven women participated at Interview 1, 170 at Interview 2 and 63 at Interview 3. The results presented in this report represent a preliminary analysis of the research data.

4. Women in the study

Home and destination locations

The 207 women interviewed for this study came from a total of 14 countries. (Table 1) Countries of origin included four European Union member states, six other European states, and four non-European states. These proportions generally reflect the numbers of women interviewed in each setting (with the largest percentage of women having been interviewed in Moldova and Ukraine), rather than giving an overall representation of the geographical distribution of trafficked women.

Women were trafficked to a total of 24 countries.† More than half (53%) were trafficked to European Union member states, 38% to other European States, and 8% to non-European States. Other than the women trafficked to the main study sites, Italy (18%) and the United Kingdom (16%), the greatest number of women interviewed were trafficked to Turkey (15%), the Russian Federation (14%), and Germany (8%).

Age

The youngest individual interviewed for this study was 15 and the oldest was 45. The largest age group was made up of women between ages 21 and 25 (42%). Adolescents between the ages 15-17‡ [4] made up 12% of the sample. (Table 2)

Marital status and children

Only 11% of women were married or living as married at the time they were trafficked. Nearly 89% were not living with a husband or an intimate partner at the time they left home.

Nearly 40% of the women reported that they had children. Importantly, of the women with children, 82% said that they were not married or living as married before leaving home. The financial implications of single parenting (or caring for other dependents, such as elderly parents or siblings) are significant, and being a sole carer may put women at risk of being trafficked. In addition, the effects of trafficking on the well-being of women's children and the support needs of children of trafficked women are subjects that deserve further examination.

Table 1. Home Countries of women in the study.

	%	Total responses
EU Member States		
Czech Republic	1.4%	3
Poland	0.5%	1
Lithuania	6.8%	14
Slovak Republic	0.5%	1
	9.2%	**19**
Other European States		
Ukraine	25.1%	52
Russian Federation	1.0%	2
Romania	8.2%	17
Moldova	35.7%	74
Macedonia	0.5%	1
Bulgaria	8.2%	17
Kyrgyzstan	1.4%	3
	80.2%	**166**
Non-European States		
Cameroon	0.5%	1
Jamaica	0.5%	1
Nigeria	5.3%	11
	6.3%	**13**
Not Reported		
n/d	4.3%	**9**

* Responses reported by woman at Period 1 interview. (n=207)

Trafficking situation

Nearly nine in ten (89%) had been in the trafficking situation for more than one month, 10% were there for over two years, and 11% for less than one month.

Women were asked: "How long ago did you stop doing this work?" Almost two-thirds (61%) had been free for less than three months prior to the first interview, and 40% for less than one month. Nearly one-quarter (22%) did not find assistance for more than six months after escaping. Most women had been referred to the assistance center by others (e.g.

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

‡ An adolescent is between the ages of 10 and 19, according to the WHO Department of Child and Adolescent Health. Under the age of eighteen is the generally accepted age to be defined as a child, particularly for legal definitions for statutory rape.

police, clients, other women) or had found their own way there (e.g., hotlines, advertisements).

Women's relationship to the trafficker

Almost one in five women reported that a relative knew her trafficker. For some women, this was a case of betrayal by family. For others, relatives were acquainted with the trafficker, but unaware of his/her intentions. Numerous women were recruited by a friend or an acquaintance.

Implications of background findings

Women who are trafficked make up an extremely diverse group. While there are patterns of vulnerability to being trafficked or being targeted by traffickers, trafficked women are anything but a homogeneous population. They differ in age, culture, nationality, personality, marital status, and education level. In addition, the women interviewed were in and out of the trafficking situation for varying lengths of time prior to being interviewed. The majority of women had been out of the trafficking situation for less than three months. The findings presented on health largely represent women who were starting to emerge from an extremely violent, frightening and traumatic period of their lives.

"My mother forced me to have sex with strangers [when I was 11 and 12 years old]. Strangers would force and beat me."

Table 2. Demographics of women in the study.

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

* Responses reported at Interview 1 (n=207). n/d= no data available

5. Violence before trafficking

Women were asked about their experience of physical and sexual violence before trafficking to explore whether there may be common 'risk factors' prevalent among trafficked women that may have made them more vulnerable to being trafficked, or that may have influenced their later health status.

"My mother's half brother raped me when I was eleven."

Experience of physical and/or sexual violence prior to being trafficked

More than half of respondents (60%) reported some form of violence prior to being trafficked, with 32% having been sexually abused and 50% physically assaulted. (Figure 1) Nearly one-quarter (22%) were both physically and sexually abused.

Sexual abuse before and after age 15, prior to being trafficked

One in seven respondents (15%) reported having a forced or coerced sexual experience before the age of 15, prior to being trafficked. Of these women, almost one-quarter (24%) cited more than one perpetrator, with over half (52%) reporting being sexually abused or coerced by a family member, and 28% stating that the abuse was perpetrated by a father (14%) or step-father (14%). Mothers were also implicated in cases of sexual coercion (7%), and women reported abuse by carers in institutional settings, such as orphanages.

Just over one-quarter of the women (26%) reported a forced or coerced sexual experience after the age of 15, prior to being trafficked. The majority of these women stated that the abuse was perpetrated by either an acquaintance or stranger, with only a few women reporting sexual abuse by family members, or boyfriends. Some said that they were physically forced, and many stated that they feared they would be killed if they did not comply.

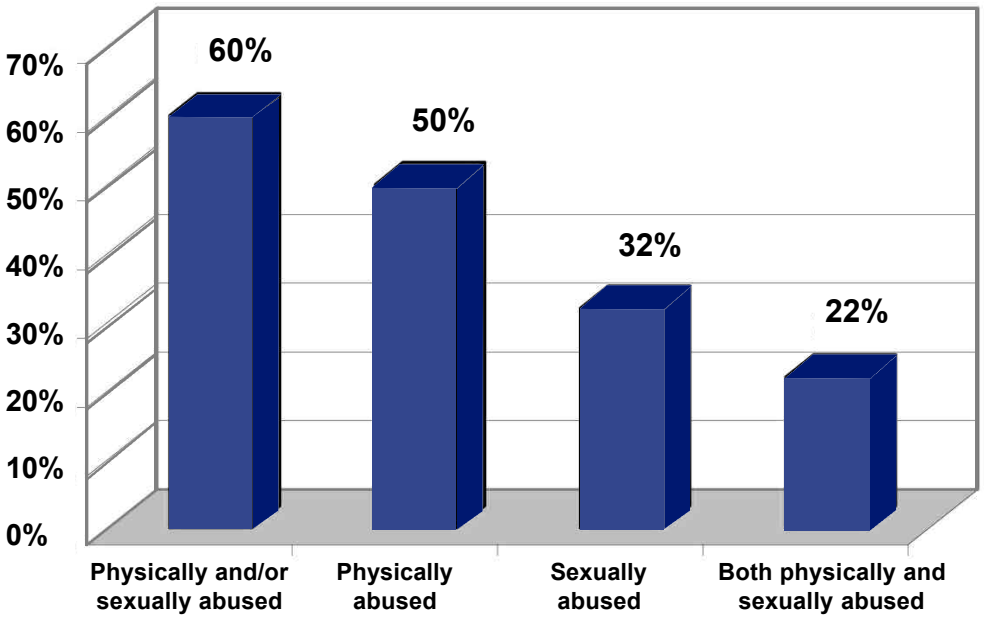
Implications of violence prior to trafficking

The prevalence of violence reported by women prior to being trafficked compares with some of the highest national prevalence levels of gender-based violence in the world. In a recent WHO multi-country study on violence and women's health, the prevalence of sexual abuse before the age of 15 ranged between 1% and 21%, with only three study sites (of the total 15 sites) reporting levels higher than those found in this study sample. Likewise, the WHO study found the prevalence of partner and non-partner sexual and physical violence since age 15 ranged from 18.5% to 75.8%, with most study sites reporting levels below 60%.[5]

Studies with other populations have shown that the negative effects of multiple traumas are greater than those of a single traumatic experience,[6] which suggests that for those women who have been abused prior to departure, trafficking will add to the cumulative deleterious toll on their physical and psychological health.

At the high levels reported in this study, women's history of physical and sexual violence is likely to offer some important insights into the profile of the physical and psychological well-being of women who are trafficked, and have significant implications for their safety if they return home.

Figure 1. Prevalence of physical assault or coerced sexual abuse ever experienced prior to being trafficked.



6. Violence and injury while in the trafficking situation

Women were asked about their experience of physical violence, sexual violence, threats, and restrictions on their movement while they were trafficked. (Table 3) Nearly all women (95%) reported physical or sexual violence, with three-quarters of respondents having been physically hurt, and 90% reporting having been sexually assaulted. The majority of women also reported threats of violence to themselves (89%), and many reported threats to their children and family (36%). Almost three-quarters of women (77%) reported that they had no freedom of movement, and those who reported a degree of freedom generally described being accompanied by minders to prevent their escape.

Table 3. Experiences of violence and movement restrictions during trafficking.

Type of violence	Yes (%) (n=207)	Yes *(n)*
Physical violence	76%	*158*
Sexual violence	90%	*186*
Either types	95%	*196*
Both types	71%	*148*
Threats during trafficking		
Woman was threatened	89%	*185*
Woman's family was threatened	36%	*75*
Woman threatened AND family threatened	34%	*70*
Freedom of movement		
Never	77%	*160*
Seldom	10%	*20*
Occasionally	4%	*9*
Often	2%	*5*
Always	3%	*7*

*4% did not repond to question

Physical violence

Women were asked whether anyone had ever hit, kicked or otherwise physically hurt them while they were in the trafficking situation. Nearly eight in every ten women (76%) had been physically assaulted by traffickers, pimps, madams, brothel and club owners, clients, or their boyfriends. (Table 3) Respondents described being kicked while pregnant, burned with cigarettes, having their head slammed against floors or walls, hit with bats or other objects, dragged across the room by their hair, and punched in the face. Sixty-one women (30%) in the study reported being hurt or threatened with a "knife, gun, or other object".

An indication of the severity of the physical violence can be gained by the extent to which women reported being injured. Over half of the women interviewed (58%) said they had been injured at some point while they were trafficked. Among these women, 57% stated that an injury sustained during that time still caused problems or pain. In addition, in a separate question asking women about problems they experienced in the past two weeks, 12% reported fractures, or sprains, and 8% reported facial injuries. Physical sites of women's injuries spanned their entire bodies and included: head, face, mouth, nose, eyes, back, neck, spine, legs, hands, feet, kidneys, pelvis, abdomen, and the genital area. One woman recalled being beaten so badly that she *was hospitalized in the neurosurgical department [for head trauma]*.

Sexual violence

Women were asked if they were physically forced or coerced by fear or threats to have sex or do something sexual. Nine out of ten women in this study (90%) reported having been physically forced or intimidated into sex or doing something sexual. The majority of women who reported being coerced into sex (83%) were also physically forced (92%). Among the 10% who did not report experiencing sexual violence, 48% reported physical injuries and 71% reported being threatened while trafficked. Eighteen of the women in the study reported that they had no sexual intercourse experience (*i.e.*, were virgins) prior to being trafficked.

Threats to the woman and her family

Traffickers maintained control over women by creating an unpredictable and unsafe environment to keep women continually "on edge". Threats were reported by 89% of the women. These included threats of death, beatings, increased debt, harm to their children and families, and re-trafficking. Among the women who reported being threatened, 82% confirmed that these threats were often carried out *as promised*.

Some traffickers wielded power over women by threatening their family. Thirty-six percent of women reported threats to children and other close relatives. These were not idle threats, as traffickers usually knew where women lived, and often had agents or colleagues in the woman's home town or nearby. Protecting their families affected women's decisions about submitting to sex work, and about escaping. For those who chose to cooperate with authorities, threats from traffickers often continued even once they were free.

Loss of freedom and controls

Loss of freedom is a defining feature of trafficking, as nearly one in nine women were adamant that they were "never free" (77%) or "seldom free" (10%) to do as they wished. Of those reporting being "always" free (3%), their statements commonly revealed a different reality: *I was always [free]…I could go out when I wanted to, but only with somebody*.

"I was locked in the basement with my friend. We were only free to work, and when the boss was drunk he would rape me."

"They told me they would cut me into pieces and send me back like that. Every single day I heard the threat 'I'll kill you bitch'."

Implications of violence while in the trafficking situation

The findings illustrate the degree to which survivors of trafficking have experienced severe and ongoing physical and sexual violence, threats of violence, and severe limitations on their movement and actions. Current evidence of the health effects of physical and sexual violence highlights that when such abuse is frequent and severe, it is likely to result in a host of health problems, including physical injury, sexual health problems, chronic somatic health consequences, and long-term mental health morbidity.[7-9] Research on torture similarly suggests that the lack of "predictability" and "control that an individual has over events can also lead to deleterious health consequences".[10]

7. Concurrent physical and mental health symptoms

At each of the three interview periods women were asked about a range of symptoms indicative of their physical and mental health status.

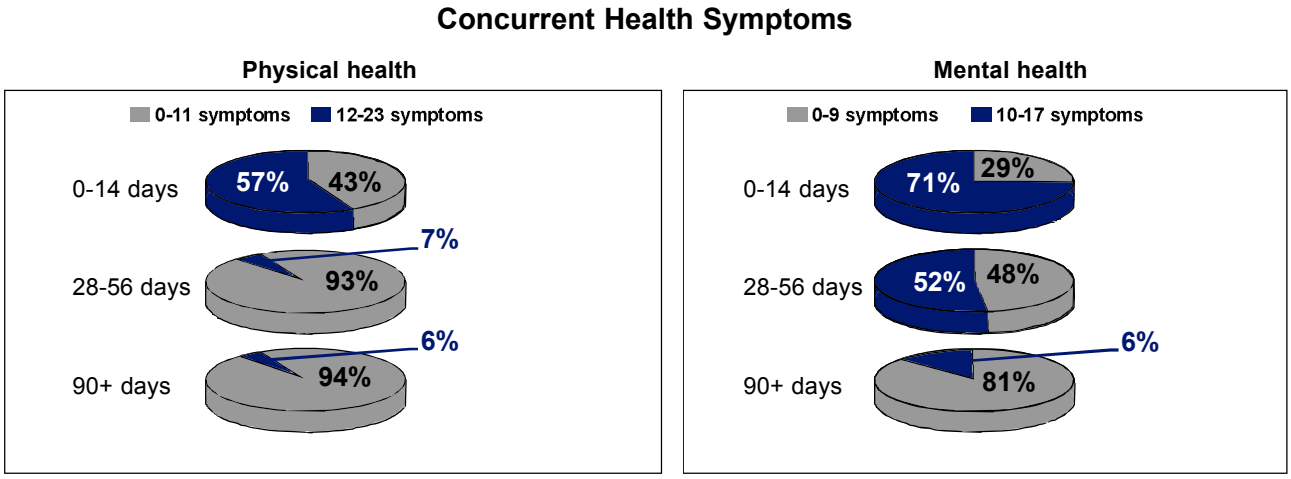


Figure 2a: Percentage of women with concurrent physical health symptoms over three time periods.

Figure 2b: Percentage of women with concurrent mental health symptoms over three time periods.

Concurrent symptoms

Immediately following a trafficking experience most women are burdened with numerous and concurrent physical and mental health problems. At 0 to 14 days, over 57% of women were experiencing 12 or more physical health symptoms that caused them pain or discomfort (Figure 2a). After 28 days, 7% were experiencing eleven or more symptoms, and after 90 days, 6% showed this number of concurrent symptoms.

Multiple mental health symptoms endured much longer. Over 70% of the women reported ten or more mental health symptoms associated with depression, anxiety and hostility within the first 14 days. After 28 days, 52% still suffered ten or more concurrent mental health symptoms, and not until after 90 or more days did this symptom level seem to subside. (Figure 2b) Women's psychological reactions were multiple and severe, and compare to, or exceed symptoms experienced by torture victims.[11]

8. Physical health symptoms

Physical health domains

To assess the prevalence and severity of specific health symptoms, women were asked whether they were currently experiencing any of 26 different physical health symptoms, and how severe, bothersome or painful the symptom felt.** These 26 symptoms are grouped into nine categories. (Table 4) Fatigue and weight loss, neurological symptoms, and gastro-intestinal problems were most commonly reported. Generally, the proportion of women reporting various problems decreased between each interview.

Fatigue and weight loss

Eight of ten women (82%) reported feeling "easily tired" at the first interview. Relative to other symptom domains, symptoms in this domain remained highly prevalent and severely felt. By the second interview, they still represented the second highest symptom scores, and even by the third interview, fatigue was the second most prevalent individual symptom (41%), after headaches. (Table 4)

While fatigue, weight loss, and loss of appetite are frequently associated with depression and stress, for women who are trafficked, they may also be caused or compounded by the deprived conditions, arduous activities, and long work hours most have endured. Respondents who have been forced into prostitution report working as many as 12-14 hours per day, serving as many as 20 to 30 clients and being permitted few hours of sleep or rest.[12] Chronic or prolonged sleep loss not only affects an individual's ability to concentrate and think clearly, but also weakens the body's immune system and ability to endure pain.[13, 14]

Neurological symptoms

Symptoms related to the central nervous system (i.e., headaches, memory difficulty, dizzy spells) were both prevalent and persistent. At the first interview, 81% of the women reported having headaches. Unlike most other symptoms, women reported little relief from headaches over time. Although headaches are often stress-related, the fact that many women may have suffered head or neck trauma cannot be overlooked. Memory problems were reported by nearly two-thirds of the women (63%), and this has significant implications for women's participation in administrative and legal procedures. See Section 10: *Mental health symptoms*.

Gastrointestinal symptoms

At the first interview, 63% of women reported stomach or abdominal pain, and by the third interview, 33% of the women were still affirming the presence of these symptoms. Women reported regular episodes of vomiting, diarrhoea, and constipation. Gastrointestinal problems have been shown repeatedly to be an important part of post-trauma symptomology.[15]

** Severity scale ratings on how bothersome or painful each symptom was, included: (1) not bothersome or painful; (2) a little bothersome or painful; (3) quite a bit; and (4) extremely, which corresponded to a numerical value 1 to 4. A composite score was generated for each woman and compared between periods. Symptoms women ranked as "quite a bit" or "extremely" were catagorised as being "severe".

Cardiovascular symptoms

Cardiovascular symptoms were prevalent at each of the different interview stages. Half of the women at the first interview reported chest and/or heart pain. By the third interview, nearly one-quarter (24%) of the women was still reporting these pains. These symptoms may be symptomatic of a range of different medical conditions, including infection (*e.g.*, tuberculosis), injury, colds and flu, and may also be related to anxiety. Heart palpitations and shortness of breath, in particular, are often associated with acute anxiety and panic attacks.[16]

Musculoskeletal symptoms

Two persistently painful health problems in this category were reported: back pain and dental problems. At the first interview, 69% of women reported back pain and 58% reported dental problems. Back pain may result from many different causes: it is common among women who have been sexually abused or physically assaulted by an intimate partner, and has been associated with stress and depression.[17, 18]

Dental problems also led to serious pain and may be a result of limited access or poor quality care in women's home countries, unattended dental problems while in the trafficking situation, or they may be caused by blows to the face or head.

Eyes

Thirty-five percent of women in the first interview reported eye problems (unrelated to needing glasses). Eye pain was reported as severe, and may have been associated with migraine-type headaches. Vision problems (i.e., blurred vision, eye pain, double vision) have also been identified in survivors of other types of gender-based violence.[17, 19]

Ears, colds, flu and sinus infections

One in six women (15%) reported ear pain at the first interview. Ear pain did not appear to be associated with colds or flu symptoms for most of these women. As many women reported having experienced strong blows to the head during the trafficking experience, this may instead be a lingering effect of previous head trauma.

Table 4. Physical health symptoms.
This table represents the percentage of women reporting each listed symptom.

Physical health domains & symptoms	Symptom (%)		
Fatigue & weight loss	**Interview 1**	**Interview 2**	**Interview 3**
Easily tired	82	55	41
Weight loss	47	27	19
Loss of appetite	64	37	25
Neurological			
Headaches	81	72	67
Dizzy spells	71	36	38
Difficulty remembering	63	42	30
Fainting	22	1	5
Gastrointestinal			
Stomach or abdominal pain	63	30	33
Upset stomach, vomiting, diarrhoea, constipation	45	18	19
Sexual & reproductive health			
Urination pain	17	8	3
Pelvic pain	59	24	17
Vaginal discharge	71	11	17
Vaginal pain	24	7	2
Vaginal bleeding (not menstruation)	10	2	2
Gynaecological infection	60	20	10
Cardiovascular			
Chest/Heart pain	50	30	24
Breathing difficulty	40	17	17
Musculoskeletal			
Back pain	69	50	37
Fractures/Sprains	12	8	13
Joint or muscular pain	36	18	14
Tooth pain	58	43	24
Facial injuries	9	1	5
Eyes			
Vision problems/Eye pain	35	20	10
Ears, colds, flu & sinus infections			
Ear pain	15	8	6
Cold, flu & sinus infections	31	14	27
Dermatolgical			
Rashes, itching, sores	29	15	19

* See section 9 for discussion on sexual and reproductive health findings.

Thirty-one percent of women at the first interview reported colds, flu or sinus infections. Experiencing stressful events has been shown to reduce functioning of the immune system,[20, 21] and studies have demonstrated that abused women show higher rates of infection than non-abused women.[17, 22]

Skin problems

Skin problems affected 29% of the women at the first interview. Women reported boils, dry skin, itching, pimples, sweating and rashes. Reasons for skin problems include sexually transmitted infections, allergies, or skin infections which may be consequences of unhygienic conditions (e.g., scabies, lice), and stress. Associations between skin problems, mental distress or abuse have been noted by other studies.[23,15]

Implications of physical health findings

The findings highlight the range of physical health problems faced by women who have been trafficked. Although injury is an expected consequence of trafficking, the findings demonstrate the degree to which other symptoms of ill-health that could be easily missed cause women pain and discomfort.

Based on the physical health symptoms reported, women clearly require medical attention that not only treats their acute and urgent medical complications (e.g., infections, injury, acute pain, unwanted pregnancy), but that also rapidly responds to their basic needs such as safety, rest, and good nutrition that will foster recuperation from symptoms such as debilitating fatigue, loss of appetite, and many stress-related symptoms.

Women's reported physical pain and discomfort may be either biological or physiological in origin, or somatic. (i.e., non-psychiatric symptoms associated with psychological reactions). Violence and physical harm are hallmarks of trafficking in women, and it is therefore vital that symptoms that appear to be stress-related are not misread and assumed to have solely a psychological cause. Women's physical health complaints should be thoroughly and repeatedly (if necessary) investigated to determine the actual cause. Moreover, it is important to recognise that the absence of a diagnosable cause, such as infection or injury, does not reduce the severity or significance of any given symptom or the impact they have on a woman's quality of life.[24] Services that address symptoms of psychological distress are likely to also reduce physical health symptoms, both in the present and the future.

Most prevalent and severe symptoms over time

Headaches
Fatigue
Dizzy spells
Back pain
Stomach or abdominal pain
Difficulty remembering

Not only are physical health symptoms life-impinging, but they also have the potential to negatively impact women's participation in administrative, legal or other procedures that require intellectual functioning. Some of the most prevalent symptoms, headaches, dizziness, fatigue, and memory loss, caused women considerable pain. Such discomfort is likely to hinder women's cognitive ability and energy levels, which will have significant implications for service provision and law enforcement. Alleviating this pain should be a priority.

For policy and planning, and particularly for budgeting purposes, the data suggest that while women's symptoms subside significantly within the first month to six weeks, deleterious health complications that require medical attention often persist, even after several months of receiving care.

"I wasn't even permitted to sleep. I could eat, but only if very fast, just for a few minutes. I had no right to sleep. If I decided to go to bed, he would beat me, and throw me out onto the street."

9. Sexual and reproductive health symptoms

The adverse sexual and reproductive health complications experienced by trafficked women are typically a result of sexual violence and coercion experienced during the trafficking situation.[12] Nearly the entire study sample (95%) reported being physically assaulted or coerced into a sexual act while trafficked.

Sexual and reproductive health symptoms

More than 60% of respondents reported pelvic pain, vaginal discharge and gynaecological infection, and one-quarter reported vaginal pain at the first interview. (Table 4)

Sexual and reproductive health symptoms were ranked as fourth in importance at the first interview, but quickly fell in ranking by the second and third interviews.

This is likely due to the treatment received, which may have alleviated symptoms and allayed women's concerns about their sexual and reproductive health (e.g., HIV, unwanted pregnancy, loss of fertility).

STIs and HIV among women receiving a diagnosis

Trafficked women are at risk of acquiring a range of STIs through their engagement in commercial sex, sexual violence, experiences of coerced sex, and unsafe sex. Research on sexual violence has increasingly recognised the association between sexual violence and STIs.[12-28] While it was beyond the scope of the study to conduct clinical tests for STIs or HIV infection, women were asked whether they had been diagnosed or treated for any STI during the time they were trafficked.

Nearly half the women (44%) reported having been diagnosed and treated for an STI or RTI. The three most reported infections were candidiasis (33%), trichomoniasis (12%) and bacterial vaginosis (11%). A positive HIV diagnosis was self-reported by 2% of women.

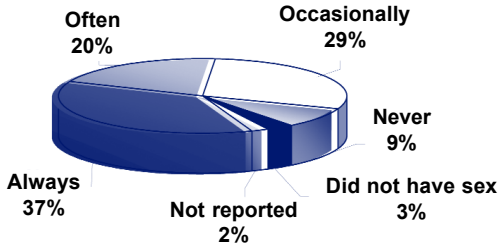
One woman reported being pregnant and co-infected with HIV and other STIs. This case highlights the importance of HIV testing, pre- and post-testing counselling and appropriate referrals to service settings capable of managing both the clinical conditions and the psychological and social challenges that women will undoubtedly confront.

"I had blood tests and the results show that I am HIV positive... I cannot think about anything else, only about my disease. I think I will become crazy. And my parents do not know the truth. I am ashamed and scared to tell them... I have nightmares and cannot rest because of this. I have headaches and am thinking only about my disease. I am very depressed and scared."

Condom use during trafficking

Reported condom usage during trafficking varied from 9% "never" using condoms, to 37% "always" using them. (Figure 4) However, the qualitative responses indicate that condom usage was not uniform, as women may have always been able to use a condom with clients, but may not have had the power to negotiate condom use in their non-commercial sexual relationships (i.e., boyfriends). Studies have suggested that women are most vulnerable to infection during the first six months of

Figure 4. Condom use during trafficking.



Total n=207

work when they have the least bargaining power.[29, 31]

Women's concerns about fertility

Women's attention to sexual and reproductive matters not only represents the reality of the sexual health risks they faced while exploited, but also reflects their deep concerns about fertility and their future ability to have a family. Most prominent among the risks to infertility is chlamydia infection.[31-33]

Induced abortions

Among the women in this study, 17% reported having at least one abortion during the time that they were trafficked. Pregnancy testing and induced abortions were common first requests upon entering a service setting.

Implications of sexual and reproductive health symptoms

Although limited clinical data on the prevalence of STI and HIV infection were available, the study data on the symptoms and abortions highlight the importance of the provision of appropriate and timely sexual and reproductive health services. It is likely that these services will need to draw upon protocols for treatment developed for women working in sex work, and guidelines on counselling and supporting women who have been victims of sexual violence. Given the coerced nature of many women's involvement in commercial sex, specialised care will be necessary to ensure that women are not further traumatised or stigmatised by the provision of such services.

The findings indicate that women who have been trafficked often prioritise their sexual and reproductive health needs, and that women's physical and psychological well-being can be positively affected by addressing these needs. Accomplishing this will depend heavily on agencies being able to offer comprehensive and sensitive sexual and reproductive health services, including clinical examinations, diagnostic testing, syndromic management and presumptive treatment of common STIs/RTIs.[34]

As many women in this study were trafficked to settings where levels of HIV infection were relatively low, few women discussed experiences with an HIV diagnosis. An ongoing challenge for services is how to provide appropriate services to women who test positive for HIV. An obligation for policy makers, particularly in destination countries, is to ensure that women who have been infected as a result of their exploitation are accorded access to appropriate and ongoing support and treatment.

10. Mental health symptoms

A primary aim of this study was to understand women's psychological reactions following a trafficking experience, and how these symptoms change over time.†† The study team elected to assess four specific psychological outcomes associated with trauma: depression, anxiety, hostility, and posttraumatic stress disorder.

Depression, anxiety and hostility

Depression, anxiety and hostility are symptoms frequently detected among torture survivors and survivors of other traumatic events[7,35] and were also identified as prominent psychological reactions in an earlier study on the health of trafficked women.[12]

The Brief Symptom Inventory (BSI)[3] was used to assess these symptoms and create a composite score for all women over three interview periods.

Figure 5 shows women's steady mental health improvements through their declining symptom levels for depression, anxiety and hostility while they were receiving support.

Although the decline in symptoms presented in Figure 5 appears promising, Figure 6 shows how these symptom levels for trafficked women compare

†† No diagnostic clinical assessments were performed, and thus, the extent to which self-reported symptoms would match a clinical diagnosis is unclear.

to those of a general female population. When viewing the symptom levels of trafficked women against the mean symptom levels for a general female population, it becomes clear that trafficking survivors' symptom levels are well-above population norms. That is, it is not until after 90 days that depression and anxiety levels drop below the 90th percentile, and even at this point in time, trafficked women's psychological symptoms remain extremely problematic and are likely to inhibit women from re-engaging in normal daily activities, such as caring for family, employment, or education.

Individual symptoms associated with depression, anxiety and hostility

Further insights into the depression, anxiety and hostility symptoms can be gained by looking at the individual symptoms associated with each domain. Table 5 presents the percentage of women reporting that they experienced different symptoms at each interview period.

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

Figure 5. Depression, anxiety and hostility levels over three time periods.

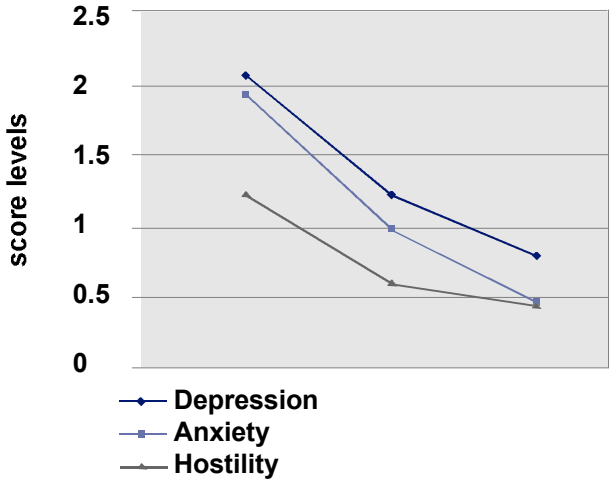
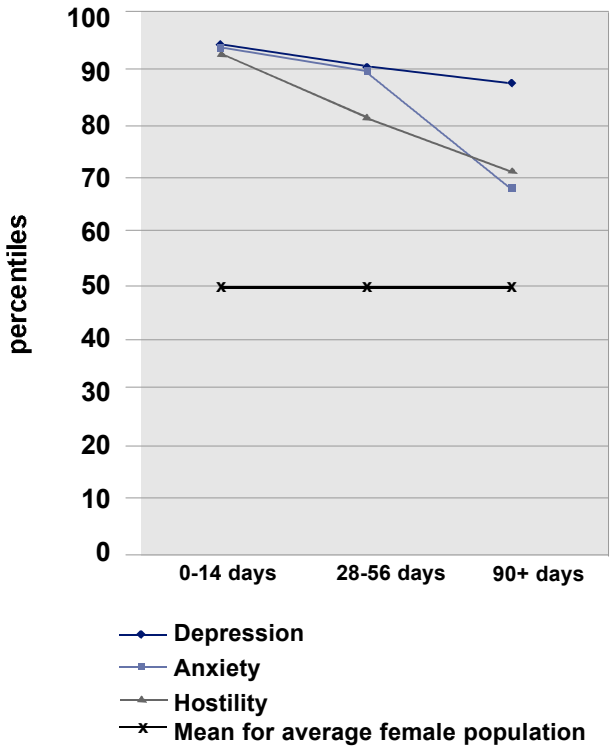


Figure 6. Depression, anxiety and hostility levels compared with these symptom levels for an average female population.‡‡



‡‡ Mean scores for general female population are from U.S. data, therefore cultural differences are not taken into account.

Table 5. Prevalence of women reporting depression, anxiety and hostility symptoms.

	Women reporting any symptoms (%)		
Depression symptoms	Interview 1	Interview 2	Interview 3
No interest in things	73	56	41
Hopelessness about the future	76	72	59
Worthlessness feelings	78	68	52
Loneliness	88	79	72
Depression/ Very sad	95	90	75
Suicidal thoughts	38	9	6
Anxiety symptoms			
Fearful	85	71	43
Tense or keyed up	84	68	37
Terror/ panic spells	61	33	8
Restlessness	67	51	19
Scared suddenly without reason	75	61	24
Nervousness or shakiness inside	91	81	51
Hostility symptoms			
Urges to beat, injure or hurt someone	36	8	8
Urges to break or smash things	29	8	8
Frequent arguments	57	12	8
Annoyed/ Irritated easily	83	27	19
Temper outbursts that cannot be controlled	67	12	10

Depression symptoms

Of the six emotions in the depression domain, the one most commonly reported was: "depression/feeling very sad" (95%). (Table 5) Throughout the three interviews, this emotion remained among the most highly reported symptoms.

Women frequently associated their depression with their loneliness, which was also reported at high levels in the first interview (88%). Many perceived that being alone led to thinking too much, which intensified their sadness. Some women recognised that enlarging their social circle was one way of perhaps avoiding loneliness, their memories and associated sadness. Coping in the aftermath of violence may depend significantly on the quality of women's support networks.[36-38]

The next most commonly reported symptom associated with depression (at the first interview) was "feelings of worthlessness" (78%). For trafficked women, being "bought and sold" and forced to sell their bodies for sex altered their self-perception. They repeatedly described feeling dirty, disgusting and having lost their sense of self—their identity.

Strongly indicative of major depression were the high rates of "feelings of hopelessness about the future" (76%), and "having no interest in things" (73%). Yet, women's lack of interest in things declined from 73% to 41% between the first and third interviews. Access to training and educational opportunities and counselling in many of the service settings may have contributed to this decrease.

Significantly, at the first interview, over a third of women (38%) reported having "suicidal thoughts". In addition, some who denied current thoughts of suicide reported having seriously considered it during the time that they were captive. This figure is very high, but still may be under-reported due to the religious tenets and the stigma associated with suicide. One NGO project stated that over the past year and a half they had six suicide attempts, and a second NGO said that one client had succeeded in killing herself.

Anxiety symptoms

Women were asked six questions about symptoms of anxiety. Among the anxiety-related symptoms reported, "nervousness", "fearful" and feeling "tense or keyed up" were the most prevalent (between 84% and 91% at the first interview). A large proportion also reported "feelings of terror/panic" and "restlessness" (61% and 67% respectively) (Table 5). There was a marked decrease in the proportion reporting feelings of terror/panic over time, and reductions in other indicators of anxiety (between one-half and two-thirds between the first and third interviews). For those remaining in the study at interview three, "nervousness" (51%) remained most

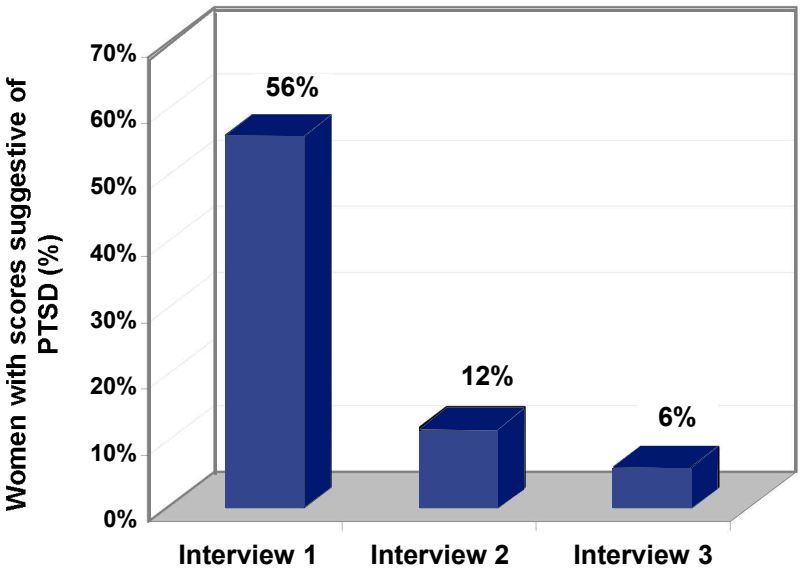
prevalent of the anxiety symptoms, and "fearful" (43%) was second.

Women's anxiety is complex, as many women still face real dangers related to their trafficking experience even once out of the situation. It is necessary here to recall that 89% of the women were threatened while in the trafficking situation, and 36% reported traffickers threatened their family. In addition, many were trafficked by family members or someone from home. Studies have shown that trafficked women continue to receive threats by phone and in-person, both against themselves and their families, and that protection by authorities has been extremely limited.[39] For this reason, the manifestations of fear and anxiety documented may often represent women's practical reactions to actual danger.

Hostility symptoms

Women were asked about six symptoms of hostility and aggression.[§§] (Table 5) The most commonly reported symptom at the first interview was feeling "annoyed or easily irritated" (83%). Women remarked that they were "easily upset", or "irritated by everything". While the prevalence diminished over time, the women still participating at the third interview reported having these feelings to some degree.

Figure 7. Percentage of women with scores suggestive of PTSD over time.



"I wish to forget, but this is impossible. This experience will remain an eternal burden."

The next most frequently reported symptom was "temper outbursts" (67%). Women explained that they had outbursts of temper that they were unable to control or comprehend. Some confessed to being regretful, baffled, and embarrassed by their own behaviour. Women described their irritability and related acts of aggression, such as punching walls, throwing items, and hitting others.

In general, hostility symptoms reduced over time. At the third interview, one fifth of women reported being irritated easily, and less than 10% reported the other symptoms.

Posttraumatic stress disorder (PTSD)

The diagnosis Post Traumatic Stress Disorder (PTSD) (from the Diagnostic and Statistical Manual of Mental Disorders (DSM IV))[40] has been repeatedly applied in discussions of the mental health outcomes of trafficked women. For this study, the Harvard Trauma Questionnaire was used to assess women's potential risk for post-traumatic stress disorder (PTSD).[2]

"[I am] scared for no reason. I think that someone is behind my door, window. Someone will find me, pick me up, beat me and kill me. I have run off and they are looking for me. My mood changes all the time. I cannot control my mind."

[§§] It was recognised that in some cases, women's responses about hostility may have been affected by the wish not to attribute socially undesirable characteristics to themselves.

At the initial interview 56% of women reported having sufficient symptoms to be suggestive of PTSD.[***] (Figure 7) This proportion decreased to 12% at the second interview and to 6% by the third interview. This decline is likely to reflect the value of the support services that women were receiving.

However, despite this promising decrease in symptoms, women nonetheless remain at risk for recurring PTSD, the onset of other psychological problems, and still have the risk of developing PTSD at some later point, particularly when they face other stressful life events that may trigger PTSD, such as when they begin the process of re-integration.[35, 41, 42]

"When I was in the shelter, there were moments when I was throwing the food from the table and breaking different things."

Table 6. Prevalence of PTSD associated symptoms over time.

PTSD associated symptoms	Women ranking symptoms as severe (%)		
	Interview 1	Interview 2	Interview 3
Recurrent thoughts/ memories of terrifying events	75	35	16
Feeling as though event is happening again	52	18	8
Recurrent nightmares	54	16	13
Feeling detatched/ withdrawn	60	26	14
Unable to feel emotions	44	10	2
Jumpy, easily startled	67	20	16
Difficulty concentrating	52	15	8
Trouble sleeping	67	35	24
Feeling on guard	64	20	6
Feeling irritable, having outbursts of anger	53	19	16
Avoiding activities that remind of traumatic or hurtful event	61	11	13
Inability to remember part of most traumatic or hurtful event	36	6	3
Less interst in daily activities	46	10	6
Feeling as if you don't have a future	65	36	10
Avoiding thoughts or feelings associated with the traumatic events	58	17	23
Sudden emotional or physical reaction when reminded of the most hurtful or traumatic events	65	16	14

Individual symptoms associated with PTSD

Table 6 presents the percentage of women reporting symptoms associated with PTSD at severe levels.

Re-experiencing traumatic events

Recurrent thoughts / memories of terrifying events. This was the symptom most frequently rated as severe at the first interview (75%). Numerous women reported having endured disturbing and upsetting memories repeatedly each day and others expressed vivid sensory recollections of their recent past. This symptom declined with time, as 35% reported it in the second interview and 16% by the third, bringing its overall ranking from first to third by the end of the study.

Recurrent nightmares. Severe "recurrent nightmares" were reported by 54% at the first interview and fell to 13% by the third.

Sudden emotional or physical reaction when reminded of the most hurtful or traumatic event. This symptom was reported by 65% of the women at the first interview. For some, this was associated with the perceived dangers of participating in their traffickers' prosecution when asked to recall anxiety-causing events.

[***] Women who scored above the cut-off point (>2.5) at the first interview could be considered at risk of developing PTSD. A PTSD diagnosis requires that the symptoms begin one month after the traumatic event occurred and that these symptoms persist for more than one month at this level. As 88% of the women had been trafficked for at least one month prior to the first interview, these criteria may be applicable for the majority of the women even at the first interview.

Psychological arousal

The second most frequently reported symptoms at the first interview were within the "psychological arousal" dimension: "feeling jumpy or easily startled" (67%) and "trouble sleeping" (67%).

Feeling jumpy or easily startled. This symptom remained within the top three most highly reported symptoms at the third interview. Women expressed that these feelings of nervousness were particularly pronounced when they were "thinking", and many talked about the need to "stop thinking so much".

Trouble sleeping. Women who reported "feeling jumpy" at the highest severity levels also frequently reported having "trouble sleeping" at those same levels. Trauma-related sleep disturbances have been found to be a potential contributory factor to poor physical health symptoms, and depression, and potential suicidal ideation in rape victims with PTSD.[43, 44]

Difficulty concentrating. Just over half of the women (52%) reported having "difficulty concentrating". Women explained how they were unable focus on basic tasks and complained of frequently forgetting what they were doing or where they were going.

Feeling irritable / Outburst of anger. Feelings of irritability are not uncommon among individuals who have endured trauma. Women and social support workers at post-trafficking centres have spoken of the quick tempers and disagreements that often arise among women in shelter settings.

Avoidance and numbing

Feeling as if you don't have a future. Women commonly described their inability to imagine the "future". Fears about the future were particularly pronounced at the second interview, having moved from fourth to first place in importance by the second interview, with more than one-third commenting that they felt indecisive, apathetic and lacked self-determination after their prolonged period of captivity.

It is important to note however, that over the course of the study period, numerous women explained that they believed their experience had forced them to mature, to become more self-confident and independent.

"It comes every time that I close my eyes... when I testified against my traffickers... and when I am at home... always in my dreams. I see myself still being taken to clients."

Feeling detached / withdrawn. This symptom remained among the most highly ranked symptoms throughout the three interview periods. Women often mentioned their concerns around "trust" of others and memories of past betrayal. Some women isolated themselves fearing that their history of forced prostitution would be revealed. Some women, however, gained a sense of independence and self-reliance.

Unable to feel emotion. This symptom was reported by 44% of women at the first interview. Yet, by the last interview, it was reported by only 2% of the women remaining in the study. Numbing is likely to have been a psychological defense strategy to protect against the highly emotive events that occurred on a regular basis during the exploitation period.

Inability to remember parts of the most traumatic or hurtful events. Difficulty recalling details or entire episodes of the worst events was reported by more than one-third of the women, and general memory problems were affirmed by 63% (see Section 8: Physical health symptoms). Problems recalling and reconstructing traumatic experiences soon after the event, and in later discussions have been confirmed by numerous studies.[45-47] Peritraumatic dissociation, or when individuals block out events at the time of trauma, has been closely related to post traumatic stress disorder (PTSD).[46, 48, 49] Dissociation, or "the experience in which a person's normal awareness, memory, identity or perception of the environment is temporarily disrupted", may subsequently result in the "inability to recall important personal information that is not explained by ordinary

"Sometimes I don't see the point in doing anything. It seems useless. When someone has controlled you and made decisions for you for so long, you can't do that yourself anymore.

forgetfulness".[46] Memory loss or unclear or confused recollections can have serious practical repercussions for women whose residency status (e.g., asylum claim) and social benefits might depend on their credibility with authorities, and will likely pose significant challenges during law enforcement and judicial proceedings. Recent studies with asylum seekers indicate that individuals who have experienced trauma commonly have poor recall, or changing memories.[47, 50] Inconsistencies are not likely to be indicative of a lack of credibility. Memory difficulty is a fundamental element of a psychological portrait of a trafficking survivor.

Implications of findings on mental health

The findings on women's mental health illustrate the complex range of psychological problems experienced by trafficked women. At the high symptom levels found in this study, women not only suffer severe distress, but are also likely to experience significantly impaired cognitive functioning. Impaired cognition is a problem of great significance for trafficked women because many, after being released from a trafficking situation are asked, *inter alia*, to substantiate their status as a victim (many do not even know the term "trafficking"), offer detailed evidence related to the crime, make decisions about cooperating in a prosecution against a perpetrator, and determine whether to return home or to complete a petition for resident status.

11. Conclusion

The health trends presented in this summary report suggest first, that immediate assistance and crisis intervention is of benefit to women, and second, that ongoing support, particularly psychological counselling, is important and necessary. Service providers' experiences strongly support these findings, as they describe how physical health problems and psychological distress (depression, in particular) may decrease from initial levels, but, for many women, they remain life-altering remnants of a traumatic period. This aftermath often has the power to affect women's sense of control over themselves, their future and their ability to engage in social settings.

The health problems sustained by trafficked women pose serious challenges not only for the women themselves and for service providers, but also for administrative and law enforcement personnel. A woman's participation in legal proceedings often depends on her emotional and intellectual capacity. Providing appropriate physical healthcare and psychological support can foster health improvements that enable a woman to cooperate effectively in legal proceedings, such as acting as a reliable witness against traffickers.

Women suffer an extremely wide range of health problems, of which many are severe and enduring. It is therefore essential for women to have the appropriate assistance and support available that fosters their well-being, independence and reintegration.

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

Bulgarian woman trafficked to Germany

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