

BREAKING the CYCLE of VULNERABILITY

Responding to
the **health
needs** of
**trafficked
women** in
East & Southern
AFRICA



“The enjoyment of
the highest attainable
standard of health is
one of the fundamental
rights of every human
being without distinction
of race, religion, political
belief, economic or
social condition.”

World Health Organization



IOM International Organization for Migration

Breaking the Cycle of Vulnerability: Responding to the health needs of trafficked women in East and Southern Africa

Pretoria, South Africa, September 2006

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IOM International Organization for Migration

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Every day in many countries of this world women and children are bought and sold, transported against their will and forced into lives of prostitution, of pornography, of slave labour, and of utter misery. The lives of these unfortunate human beings are ultimately cut short because of the disease and the dangers to which they are subjected. The problem is growing. It is becoming more and more organised by criminals with links to drugs and with links to terrorism. It is the downside, the dark side to globalisation and we must tackle all of it.

Mary Robinson, former UN High Commissioner for Human Rights, BBC World Service, 2002

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**He promised
her a home.**



**But put her
in a prison.**

Gabriel told Florence that if she went to South Africa with him, he would find her a husband. But when she arrived in South Africa, Gabriel sold her to Sipho. Sipho kept her in his house and forced her to have sex with other men so that he could make money. Florence is a victim of human trafficking. Don't fall into the same trap as Florence. For information or help call us. It could save your life. In South Africa phone: 0800 555 999. In Zambia: 01 256 701. In Mozambique: 21 310 779. In Zimbabwe: 04 335 044.



IOM's Southern African Counter-Trafficking Assistance Program (SACTAP) offers help and support to victims of human trafficking. SACTAP is sponsored by the US Department of State's Bureau for Population, Refugees and Migration, the Norwegian Ministry of Foreign Affairs, and South Africa's Department of Foreign Affairs. Visit www.iom.org.za

INTERNATIONAL ORGANIZATION FOR MIGRATION (IOM) REGIONAL OFFICE FOR SOUTHERN AFRICA



PART ONE: Background

Abbreviations

- AIDS** Acquired Immune Deficiency Syndrome
- CT** Counter Trafficking
- ESA** East and Southern Africa
- FGC** Female Genital Cutting
- GBV** Gender-based Violence
- GTZ** Deutsche Gesellschaft für Technische Zusammenarbeit
- HIV** Human Immunodeficiency Virus
- ILO** International Labour Organization
- IOM** International Organization for Migration
- LSHTM** London School of Hygiene and Tropical Medicine
- NGO** Non Governmental Organisation
- PTSD** Post Traumatic Stress Disorder
- SABC** South African Broadcasting Corporation
- SACTAP** Southern African Counter Trafficking Assistance Programme
- SGBV** Sexual and Gender-based Violence
- SOLWODI** Solidarity with Women in Distress
- SRMH** Sexual, Reproductive and Mental Health
- STIs** Sexually Transmitted Infections
- SWs** Sex Workers
- UNAIDS** Joint United Nations Programme on HIV/AIDS
- UNDP** United Nations Development Programme
- UNHCR** United Nations High Commissioner for Refugees
- UNICEF** United Nations Children's Fund
- UNODC** United Nations Office for Drugs and Crime
- VCT** Voluntary Counselling and Testing
- WHO** World Health Organization

Foreword

Trafficked persons – regardless of whether trafficking happens for the purpose of labour, sexual or any other form of exploitation – are exposed to a range of health-related problems. Several of the most influential human rights instruments emphasise the relationship between health and human rights. The most significant international instrument recognising the rights of trafficked persons to receive health and social care is the 2000 *United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children*.¹

It is with a human rights-based approach to health that IOM aims to address the needs of individuals who have been trafficked. In other parts of the world, especially in Central and Eastern Europe and Asia where human trafficking is better researched and understood, IOM offices have started to develop and implement sexual, reproductive and mental health (SRMH) programmes to complement the more ‘traditional’ counter trafficking responses to human trafficking.² In comparison, in East and Southern Africa there is little data available on human trafficking in general, and even less on the health implications of human trafficking.

IOM’s Regional Office for Southern Africa welcomes this opportunity to conduct research on the link between human trafficking and SRMH in East and Southern Africa. We hope that this publication will contribute to the body of evidence describing the health needs of trafficked persons and inform a wide range of interventions.

I would like to thank the Swedish International Development Cooperation Agency (Sida) – on behalf of IOM – for its generous financial support for the development of this report.



Hans Petter Boe
Regional Representative
IOM Southern Africa

.....
¹ Commonly known as the Palermo Protocol, which supplements the United Nations Convention Against Transnational Organized Crime, G.A. Res. 55/25, Annex II, 55 GAOR, Supp. (No.49) at 60, UN Doc. A/45/49 (Vol. II).

² Such as training of law enforcement officials, contributing to law development, victim assistance, rescue/reintegration, capacity-building of service providers etc. For more information on IOM’s Counter Trafficking activities please see www.iom.int



1. TRAFFICKER MAKES OFFER

2. VICTIM IS TRANSPORTED

3. VICTIM IS INTIMIDATED

4. VICTIM IS ENSLAVED OR SOLD BY TRAFFICKER

5. RESCUE

Introduction

Trafficking in persons affects women, men and children. However, this study focuses on women and adolescent girls who have been trafficked within, to and from East and Southern Africa (ESA). All reference to women includes adolescent girls.

This is the first study in ESA to focus specifically on the links between trafficking of women and sexual, reproductive and mental health (SRMH). With regard to health, special attention is paid to HIV since all countries in ESA are experiencing generalised HIV epidemics (with the exception of the Indian Ocean Island States).

The main objectives of this study are:

1. To present the links between sexual, reproductive and mental health (SRMH) including HIV, and human trafficking in East and Southern Africa (ESA).
2. To make recommendations on how better to respond to the health needs of trafficked women in ESA.

This study is divided into three parts. **Part One** describes the research methods of the study, main definitions used, and existing policies/principles addressing human trafficking and health. In addition, Part One gives an overview of human trafficking trends in ESA and an in-depth look into three examples of trafficking trends in the region. These three examples are: 1) Ethiopian women trafficked to countries in the Middle East for domestic servitude, 2) Mozambican women trafficked to South Africa for sexual exploitation and 3) Thai women trafficked to South Africa for sexual exploitation.

Part Two discusses the findings of the study, which are based on the literature review and information gathered by the research team through interviews with key informants. IOM uses a four-stage framework (see Figure 1) to identify migrants' health-related vulnerabilities and this framework is also applied to structure the recommendations (page 43). The framework looks at the whole cycle of migration including origin, transit, destination and return. The conclusion is at the end of Part Two.

The bibliography and annexes are found in **Part Three**, which includes references and further readings, as well as related websites and a list of stakeholders in the region.

RESEARCH METHODS

The following research methods were employed:

1. Development of analytical framework
2. Literature review and field visits
3. Structured interviews to gather quantitative and qualitative data. Two different questionnaires were developed and used as the basis for structured interviews. **These were:**
 - a. Questionnaire for medical practitioners working – knowingly or not³ – with trafficked women
 - b. Questionnaire for technical experts working with trafficked women and engaged in counter trafficking work in general

1. Analytical Framework (see Annex 1)

There are various human trafficking trends in East and Southern Africa (ESA), some of which are better researched and documented than others. Following preliminary discussions with IOM counter-trafficking colleagues and an initial literature review, an analytical framework was developed to assess the link between SRMH and human trafficking in ESA. A four-stage framework (see Figure 1) was used to review the degrees of disempowerment and exploitation at each stage and how these impact on vulnerability to health-related problems, and on access to health and social services.

Each trafficking scenario was analysed within the four-stage framework:

1. Origin/pre-departure – where recruitment takes place
2. Transit – travel to destination
3. Destination, including detention/deportation/criminal evidence – where exploitation takes place
4. Return – rescue and reintegration

The analytical framework describes three examples of trafficking to, from and within the region, which are looked at in more detail:

1. Women trafficked from Ethiopia to various countries in the Middle East for domestic servitude
2. Women trafficked from Mozambique to South Africa for sexual exploitation
3. Women trafficked from Thailand to South Africa for sexual exploitation

These examples were chosen for three reasons. First, the purpose of trafficking is different (domestic servitude and sexual exploitation). Second, they are geographically diverse – the first is trafficking of African women out of the region, the second of African women within the region, and the third of non-African women into the region. Third, they are relatively well documented compared to many other trafficking trends in the region.

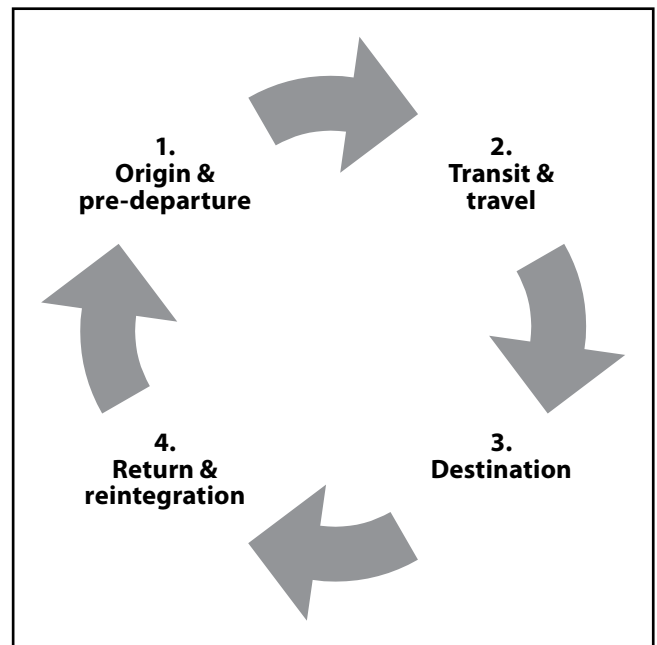


Figure 1: The four-stage migration framework (adapted from Zimmerman et al 2003 and Gushulak and MacPherson, 2000)

³ As can be read on page 11, the definition of human trafficking is complex, and often trafficked persons do not disclose their status as a trafficked person to their health care provider. Therefore, it is likely that health care providers treat trafficked persons without knowing that they are trafficked.

2. Literature review and field visits

The initial aim of the literature review was to gather and analyse existing information about trafficking of women in ESA, and its links to SRMH including HIV. However, it became evident that there is little research available on these subjects in the region.

Figure 2 shows the regional distribution of studies on human trafficking. As can be seen, nearly 80 per cent of all studies on human trafficking are from Europe and the Asia-Pacific region. Moreover, of research carried out in Africa (13 per cent), West Africa has generated the most data.⁴

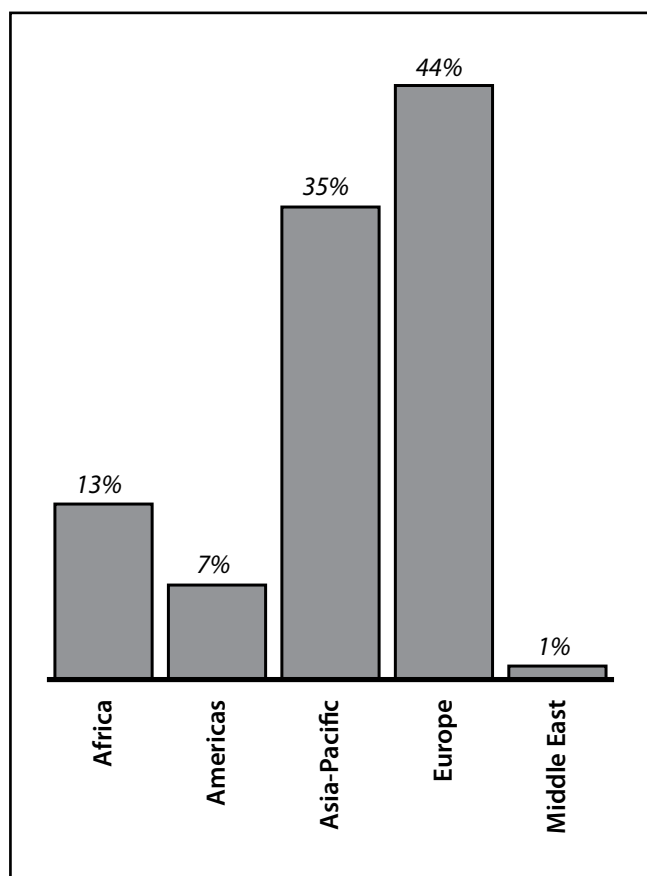


Figure 2: Regional distribution of studies on trafficking (adapted from IOM 2005b)

In ESA some general data on human trafficking is available, although there is little analysis of human trafficking in relation to health. Due to this knowledge gap, literature about health and trafficking in other regions, particularly Europe and Asia,⁵ was used. Existing literature was supplemented with data from IOM colleagues working in counter-trafficking programmes in the region. In addition, structured interviews were conducted during field trips to Addis Ababa, Ethiopia; Nairobi, Kenya; Lusaka, Zambia; and Cape Town, Pretoria and Johannesburg, South Africa. These field visits were undertaken to establish gaps in responses and to identify organisations that are working in the field of trafficking and/or health (see Annex 3).

3. Structured interviews

In order to add qualitative data to information gathered in the literature review, questionnaires were developed to use in interviews with key informants. For many interviewees human trafficking has not been the focus of their work. Most informants are engaged in work with vulnerable women, and it is through this that they come into contact with women who have been trafficked. In general, it was found that very few health practitioners see women who have been trafficked, and non-medical experts in the field of counter trafficking tend not to take the health consequences of trafficking into consideration.

Therefore, the interviewees were people that might provide services to trafficked women without being aware of it – for example through mobile clinics accessing sex workers in brothels, and people working in shelters for abused women. The research team relied a great deal on counter-trafficking programmes within IOM to access key informants. Some organisations that were interviewed are listed in the directory of organisations (Annex 2), however some cannot be named for reasons of confidentiality and security. Information gathered from interviews is referenced in the bibliography under IOM 2006a-e.

⁴ See *Data and Research in Human Trafficking: A Global Survey* (IOM 2005), which lists existing trafficking research per region.

⁵ See particularly Zimmerman et al 2003.

Study Limitations

The following proved to be limitations to this study:

1. Brief time frame
2. Lack of access to:
 - a. Trafficked women
 - b. Technical experts with first hand experience of working with trafficked women

1. Time Frame

The fact that the time frame of this study was relatively brief (March-August 2006) meant that primary research was difficult to carry out. Although the original study was to be a desk review, existing contacts from counter trafficking colleagues made it possible to conduct some primary research.

2. Accessing trafficked women and technical experts

...One of the most challenging problems facing researchers is the fact that most of the populations relevant to the study of human trafficking, such as victims/survivors of trafficking for sexual exploitation, traffickers, or illegal migrants are part of a "hidden populations," i.e. it is almost impossible to establish a sampling frame and draw a representative sample of the population. (Laczko in IOM 2005b)

There has been criticism of the way research into trafficking tends to be undertaken: "interviews with a small number of conveniently selected stakeholders and victims are unlikely to capture the experiences and views of all those about whom claims are being made" (Pharoah 2006). Whilst such criticisms are valid from the point of view of quantitative research methodology, it is currently the only option available when carrying out short-term studies about trafficking such as this one.

Accessing victims and survivors of trafficking is not only difficult logistically – the nature of the trafficking process means that women are not easy to identify – but there are also ethical considerations. In terms of logistics, at present it would be possible to, for instance, interview Thai women trafficked into South Africa about their experiences and health status, since IOM assists many to return to Thailand. However, this would not be representative of the experiences of most women who have been trafficked in the region. In addition, such interviews would be questionable on ethical grounds since the women have been subjected to so much recent trauma that during the brief period in which IOM assists them in South Africa, in-depth health-related interviews could be harmful. Because of these limitations it currently is not possible to obtain quantitative empirical data about the links between trafficking and health.

TERMS AND DEFINITIONS

Trafficking in Persons

The Optional Protocol to the *United Nations Convention on Transnational Organized Crime* (the “Palermo Protocol”) states:

- a) Trafficking in persons shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.
- b) The consent of a victim of trafficking in persons to the intended exploitation set forth in subparagraph (a) of this article shall be irrelevant where any of the means set forth in subparagraph (a) have been used;
- c) The recruitment, transportation, transfer, harbouring or receipt of a child for the purpose of exploitation shall be considered “trafficking in persons” even if this does not involve any of the means set forth in subparagraph (a) of this article;
- d) “Child” shall mean any person under eighteen years of age (United Nations 2000).⁶

A significant number of countries in both East and Southern Africa have signed and/or ratified the Palermo Protocol, which obliges them to develop anti-trafficking legislation and consider government measures to provide adequate support to trafficking victims, including their health needs. Figure 3 (page 17) shows the countries in ESA that have ratified the Palermo Protocol.

Gender-Based Violence

As described by the Inter-Agency Standing Committee (IASC) Guidelines for Gender-based Violence Interventions in Humanitarian Settings, trafficking is a form of gender-based violence, and responses to trafficking must be addressed within this framework: *gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person’s will, and that is based on socially ascribed (gender) differences between males and females. Acts of GBV violate a number of universal human rights protected by international instruments and conventions. Many – but not all – forms of GBV are illegal and defined as criminal acts in national laws and policies. The term “gender-based violence” highlights the gender dimension of these types of acts; in other words, the relationship between females’ subordinate status in society and their increased vulnerability to violence.*

Examples include:

- ⊙ Sexual violence, including sexual exploitation/abuse and forced prostitution
- ⊙ Domestic violence
- ⊙ Human trafficking
- ⊙ Forced/early marriage
- ⊙ Harmful traditional practices such as female genital mutilation, honour killings, widow inheritance and others (IASC 2005)

Sexual Violence

The World Health Organization defines sexual violence as: *any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work. Coercion can cover a whole spectrum of degrees of force [...].*

⁶ United Nations (2000). United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially women and children, supplementing the United Nations Convention Against Transnational Organized Crime, Article 3 (a-d), G.A. res. 55/25, annex II, 55 U.N. GAOR Supp. (No. 49 at 60 U.N. Doc. A/45/49 (Vol. I)).

Sex Work - Prostitution

There is a great deal of debate over the terms “prostitution” and “sex work” and how they relate to human trafficking. As will be discussed, not all women who have been trafficked enter the sex industry, and not all sex workers have been trafficked. Although sexual violence is common in all three examples discussed in this study, there are differences between what women are subjected to. In the case of Ethiopian women trafficked to countries in the Middle East, sexual exploitation is not the primary purpose of trafficking, as it often is for Mozambican and Thai women trafficked into South Africa. Moreover, some women knowingly enter into sex work, and only later find out that the conditions are exploitative.

Sex work means different things to different people. Some argue that all sex work, or prostitution, is essentially an act of violence against women, and an abuse of human rights involving sexual exploitation and psychological trauma (Farley et al 1998). Others believe that sex work is not intrinsically exploitative since women themselves make the empowered decision to enter into the industry – this is a livelihood option that women choose in order to earn a decent wage, and therefore a survival strategy. From this latter perspective, violence against women occurs at the hands of law enforcement officers and legislators who seek to prevent women practising sex work (IOM 2006d).

It is not the aim of this study to enter into this debate, since human trafficking – for whatever purpose – is by definition exploitative in nature. For the purposes of this study, however, “forced sex work” is a useful term to describe the examples of human trafficking in this region when sexual exploitation is the primary purpose of trafficking, and the sex industry is a valuable entry point for conducting research about the health of trafficked women in the region. This includes the southern African women trafficked into sexual slavery and forced marriage in downtown Johannesburg and mining areas in the region (Example 2), and the Thai women trafficked into brothels in the affluent suburbs in Gauteng and KwaZulu Natal Provinces (Example 3).

Human Trafficking and Health

"I left my country, came to Tanzania, and then Malawi. I didn't want to travel anymore but I met a man, a trucker from South Africa who promised he would get me a job – a house in South Africa. When we arrived in South Africa, he started to abuse me, wanting anal sex. When I refused, he got violent and brought his friends to sleep with me through the vagina; only he through the anal sex. He said, 'that woman is a crook. You can use her and pay me certain monies.' I escaped and fled to Cape Town, but in March 2000, I got sick and was diagnosed as HIV positive. My health is...I am weak, but I hope if I get on treatment I will be ok." (Interview with Ugandan trafficking victim, IOM 2003a)

In Europe, more research has been done about the health consequences of human trafficking, and in comparison with East and Southern Africa more comprehensive responses are being implemented.⁷ Most research in Europe has explored the ways in which the risks associated with the trafficking process impact SRMH. **The following table illustrates these links:**

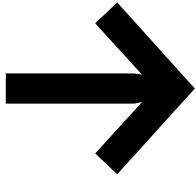
Causes of health risks of trafficking		Areas of health consequences of trafficking
<ul style="list-style-type: none"> ⊙ physical abuse ⊙ sexual abuse ⊙ psychological abuse ⊙ forced, coerced use of drugs and alcohol ⊙ social restrictions and manipulation ⊙ economic exploitation and debt bondage ⊙ legal insecurity ⊙ abusive working and living conditions ⊙ risks associated with marginalisation 		<ul style="list-style-type: none"> ⊙ physical health ⊙ sexual and reproductive health ⊙ mental health ⊙ substance abuse and misuse ⊙ social well-being ⊙ health service uptake and delivery

Table 1: The health risks and consequences of trafficking (adapted from Zimmerman et al 2003)

⁷ For example see IOM's *The Mental Health Aspects of Trafficking in Human Beings, Training Manual, 2004* www.iom.hu/bppublications.html

The health risks associated with each of the four stages of the trafficking process (adapted from Zimmerman et al 2003) are:



The **origin or pre-departure stage** defines some basic mental and physical health characteristics of the trafficked person at departure, which in turn will affect that person's health-related behaviour throughout the trafficking process. Pre-existing illness or diseases reflect the environment present at the migrant's home, including poverty, lack of knowledge about HIV prevention and its spread, lack of education and poor nutrition, present at the migrant's home. Many trafficked persons come from families with a history of violence and abuse. In common with other migrants, trafficked individuals may have pre-existing health conditions, such as malaria or tuberculosis or other conditions prevalent at point of origin.



The **transit or travel stage** is the period beginning with the individual's recruitment and ending with the arrival at the point of destination. Since illicit activities generally begin at the 'travel and transit stage' and the traffickers' primary concern is to avoid detection, the dangers facing trafficked persons are significant. The transit stage is also known as the time of "initial trauma" because it is often here that the individual first notices the deception and realises that she is in life-threatening danger with little or no control. Trafficked persons may be exposed to dangerous modes of transportation, high-risk border crossings and arrest, threats and intimidation and violence, including rape and other forms of sexual abuse. Additionally, in long and complicated journeys, trafficked migrants may be exposed to illnesses and diseases along the route.



The **destination stage** is when an individual is put to work and subjected to a combination of coercion, (sexual) violence, forced use of alcohol and other substances, forced sex work, forced labour, debt bondage or other forms of abuse normally associated with trafficking. In addition, they lack access to health and social care and support. The psychological reactions to these different types of abuse are complex and often enduring. Evidence shows that many trafficked individuals emerge with multiple infections, injuries and illnesses, and complications resulting from lack of adequate medical treatment.



Between the destination and the return stage is the **detention, deportation and criminal evidence stage** when an individual is in custody of the police or immigration authorities for alleged violations of criminal or immigration laws, or is cooperating in legal proceedings against a trafficker, exploitative employer or other abuser. In some detention facilities, the conditions are extremely harsh which could pose health risks. Evidence shows that from a mental health perspective, contact is almost always with public authorities (e.g., arrest, giving evidence, testifying in criminal proceedings) with little understanding of the woman's psychosocial needs. This has a negative effect on a trafficked person's mental health. In the analytical framework of this study this stage will be integrated in the destination stage.



The **return and reintegration stage** is a long-term and multifaceted process. Escaping from the trafficking situation does not automatically guarantee a straight road to recovery. Trafficked persons often experience anxiety, depression, isolation, aggressive feelings or behaviour, self-stigmatisation or perceived stigmatisation through others, difficulty in accessing necessary resources, in communicating with support persons and family as well as negative coping behaviour (e.g., excessive smoking, drinking, drug use). Problems are complicated if the person returns to an abusive family context or where family members were part of the trafficking network.

SEXUAL AND REPRODUCTIVE HEALTH AND HIV

The following table outlines the types of sexual violence that trafficked women are subjected to, and the potential consequences for their sexual and reproductive health.

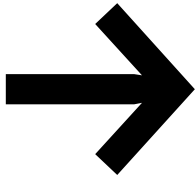
Risks and Abuse from Sexual Violence		Reproductive and Sexual Health Consequences
<ul style="list-style-type: none"> ⊙ Forced vaginal, oral or anal sex; gang rape; degrading sexual acts ⊙ Forced prostitution, inability to control number or acceptance of clients ⊙ Forced unprotected sex and sex without lubricants ⊙ Unwanted pregnancy, forced abortion, unsafe abortion ⊙ Sexual humiliation, forced nakedness ⊙ Coerced misuse of oral contraceptives or other contraceptive methods ⊙ Inability to negotiate sexual encounters 		<ul style="list-style-type: none"> ⊙ Sexually transmitted infections, reproductive tract infections and related complications, including pelvic inflammatory disease, urinary tract infections, cystitis, cervical cancer and infertility ⊙ HIV and AIDS ⊙ Amenorrhoea and dysmenorrhoea ⊙ Acute or chronic pain during sex; tearing and other damage to vaginal tract ⊙ Negative outcomes of unsafe abortion, including cervix incontinence, septic shock, unwanted birth, maternal death ⊙ Difficulties forming intimate sexual relationships

Table 2: Health Risks and Consequences of Trafficking (adapted from Zimmerman et al 2003)

MENTAL HEALTH

Trafficked women are physically, sexually and psychologically abused and are at risk to mental health-related problems. As established by Zimmerman et al (2003), mental health related problems resulting from these abuses include:

- ⊙ Suicidal thoughts, self-harm, suicide
- ⊙ Chronic anxiety, sleep disturbances, frequent nightmares, chronic fatigue, diminished coping capacity
- ⊙ Memory loss, memory defects, dissociation

- ⊙ Somatic complaints (e.g. chronic headache, stomach pain, or trembling) and immune suppression
- ⊙ Depression, frequent crying, withdrawal, difficulty concentrating
- ⊙ Aggressiveness, violent outbursts, violence against others
- ⊙ Substance misuse, addiction
- ⊙ Loss of trust in others or self, problems with or changes in identity and self-esteem, guilt, shame, difficulty developing and maintaining intimate relationships

DECLARATIONS, PRINCIPLES AND POLICIES ON HUMAN TRAFFICKING AND HEALTH

In order to develop effective responses to prevent SRMH-related problems such as HIV infection among victims of trafficking, and for the SRMH care and treatment of victims of trafficking, it is important to have agreement among governments, international organisations and other stakeholders about what should be done and what the priorities are. The inclusion of migrants' health, including the health needs of potential and actual victims of human trafficking, into public health systems is increasingly becoming a concern for governments and health care providers worldwide. Following a rights-based approach to health, all groups of migrants, including victims of human trafficking, should have access to the same health services as the country's citizens irrespective of their legal status.

United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children (2000)

Article 6: Assistance to and protection of victims of trafficking in persons

1. In appropriate cases and to the extent possible under its domestic law, each State Party shall protect the privacy and identity of victims of trafficking in persons, including, inter alia, by making legal proceedings relating to such trafficking confidential.
2. Each State Party shall ensure that its domestic legal or administrative system contains measures that provide to victims of trafficking in persons, in appropriate cases:
 - (a) Information on relevant court and administrative proceedings;
 - (b) Assistance to enable their views and concerns to be presented and considered at appropriate stages of criminal proceedings against offenders, in a manner not prejudicial to the rights of the defence.
3. Each State Party shall consider implementing measures to provide for the *physical, psychological and social recovery of victims of trafficking in persons*, including, in appropriate cases, in cooperation with non-governmental organizations, other relevant organizations and other elements of civil society, and, in particular, the provision of:
 - (a) Appropriate housing;
 - (b) Counselling and information, in particular as regards their legal rights, in a language that the victims of trafficking in persons can understand;
 - (c) Medical, psychological and material assistance; and
 - (d) Employment, educational and training opportunities.
4. Each State Party shall take into account, in applying the provisions of this article, the age, gender and special needs of victims of trafficking in persons, in particular the special needs of children, including appropriate housing, education and care.
5. Each State Party shall endeavour to provide for the physical safety of victims of trafficking in persons while they are within its territory.
6. Each State Party shall ensure that its domestic legal system contains measures that offer victims of trafficking in persons the possibility of obtaining compensation for damage suffered. (United Nations 2000)

To date, a number of countries in East Africa, including the Horn, and Southern Africa have ratified the Palermo Protocol, which obliges States to implement all provision including Article 6 (see figure 3).



Figure 3: Countries in ESA that have ratified the Palermo Protocol (adapted from UNODC)⁸

In addition to Article 6 of the Palermo Protocol, a number of important declarations and principles have been adopted that include references to victims of trafficking and their right to have access to health services, including HIV prevention and care programmes. A number of these are listed below:

UNGASS Declaration of Commitment on HIV/AIDS (2001)⁹

At the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001, 189 countries adopted the Declaration of Commitment on HIV/AIDS. The meeting was an historic landmark, acknowledging the scope of the HIV epidemic and setting out “global actions” to this “global crisis.” The Declaration established a number of goals and time-bound targets on which all countries have to report biannually. In paragraph 61 it makes special mention of trafficking of women and girls:

By 2005, ensure development and accelerated implementation of national strategies for women’s empowerment promotion and protection of women’s full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination as well as all forms of violence against women and girls including harmful traditional and customary practices abuse rape and other forms of sexual violence battering and trafficking in women and girls.

The “Recommended Principles on Human Rights and Human Trafficking” (2002)¹⁰

These Principles, which include 11 Recommended Guidelines on Human Rights and Human Trafficking, have been developed by the United Nations High Commissioner for Human Rights (UNHCHR) in order to provide practical, rights-based policy guidance on the prevention of trafficking and the protection of victims of trafficking. Their purpose is to promote and facilitate the integration of a human rights perspective into national, regional and international anti-trafficking laws, policies and interventions.

⁸ www.unodc.org/unodc/en/crime_cicp_signatures_trafficking.html

⁹ Adopted at the United Nations General Assembly Special Session (UNGASS) on 25-27 June 2001.

¹⁰ Text presented to the Economic and Social Council as an addendum to the report of the United Nations High Commissioner for Human Rights (E/2002/68/Add. 1).

Relevant paragraphs include:

Guideline 6:

Protection and support for trafficked Persons

States and, where applicable, intergovernmental and non-governmental organizations, should consider:

(2) Ensuring, in partnership with non-governmental organizations, that trafficked persons are given access to primary health care and counselling. Trafficked persons should not be required to accept any such support and assistance and they should not be subject to mandatory testing for diseases, including HIV/AIDS.

Guideline 7:

Preventing trafficking

States, in partnership with intergovernmental and non-governmental organizations and where appropriate, using development cooperation policies and programmes, should consider:

(4.) Ensuring that potential migrants, especially women, are properly informed about the risks of migration (e.g. exploitation, debt bondage and health and security issues, including exposure to HIV/AIDS) as well as avenues available for legal, non-exploitative migration.

Guideline 8:

Special measures for the protection and support of child victims of trafficking

States and, where applicable, intergovernmental and non-governmental organizations, should consider, in addition to the measures outlined under Guideline 6:

(7.) Adopting specialized policies and programmes to protect and support children who have been victims of trafficking. Children should be provided with appropriate physical, psychosocial, legal, educational, housing and health-care assistance.

Budapest Declaration on Public Health and Trafficking in Human Beings (2003)

The Budapest Declaration was adopted at the regional Conference on Public Health & Trafficking in Human Beings in Central, Eastern and Southeast Europe, which was held on 19-21 March 2003 in Budapest, Hungary.

According to the Budapest Declaration on Public Health and Trafficking in Human Beings, trafficked persons should receive “comprehensive, sustained, gender, age and culturally appropriate health care (...) by trained professionals in a secure and caring environment.” Furthermore, “minimum standards should be established for the health care that is provided to trafficked victims” with an understanding that “different stages of intervention call for different priorities.”

Although this Declaration deals specifically with human trafficking in Central, Eastern and Southeast Europe, the recommendations are valid for other regions as well.

Guiding principles for a UN system-wide policy on “HIV/AIDS as it relates to human trafficking,” United Nations System Chief Executives Board for Coordination (CEB) (2004)

In April 2004, the United Nations System Chief Executives Board for Coordination (CEB/2004/1) resolved that in their responses to curbing transnational organized crime, UN agencies should immediately implement *inter alia*:

Actions identified in respect of collaborative interventions to counter the trafficking of human beings and the smuggling of migrants including responding to the vulnerability of trafficking victims to HIV/AIDS to be taken up by the Geneva Migration Group¹¹ as appropriate to its mandate.¹²

¹¹ Members of the Geneva Migration Group (now called the Global Migration Group) are the Chief Executives of UNODC, OHCHR, IOM, UNHCR, UNCTAD and ILO.

¹² This directive was subsequently elaborated on in June 2004 (CEB/2004/HCLP/CRP.3), in September 2004 (CEB/2004/7), in February 2005 (CEB/2005/4) and in April 2005 (CEB/2005/1).

The current process of formulating a UN system-wide inter agency policy and strategy on HIV and AIDS and human trafficking is therefore derived from the CEB directive, in accordance with the identified General Assembly instruments, which themselves provide UN entities with a mandate to assist member states in preventing HIV infection in potential and actual victims of human trafficking, and for the care and treatment of HIV infected human trafficking victims.

Guiding principles for a UN system-wide policy on “HIV/AIDS as it relates to human trafficking”:

<i>Principle 1</i>	<i>The AIDS epidemic is exceptional, requiring an exceptional response that remains flexible, creative, energetic and vigilant.”</i>
<i>Principle 2</i>	<i>HIV/AIDS as it relates to human trafficking” is a special case of the epidemic, requiring a specialised focussed response. Within the focussed response, different approaches to sexual exploitation, forced labour and organ removal might be considered.</i>
<i>Principle 3</i>	<i>There are factors which are common to vulnerability to human trafficking and to HIV infection which require long-term solutions.</i>
<i>Principle 4</i>	<i>In the short-term, immediate interventions are required to protect potential and actual victims of human trafficking from HIV infection and to provide care and treatment for HIV-infected victims.</i>
<i>Principle 5</i>	<i>The UN system-wide response to “HIV/AIDS as it relates to human trafficking” should be first and foremost, a human rights response.</i>
<i>Principle 6</i>	<i>Within the overarching human rights response, there is a need to address gender inequality.</i>
<i>Principle 7</i>	<i>The “Three Ones” schema provides a basis for coordinating the work of the UN system in addressing “HIV/AIDS as it relates to human trafficking”: One agreed action framework that provides the basis for coordinating the work of all UN partners; One UN system-wide coordinating authority, with a broad-based multi-UN agency mandate; and One UN system-wide monitoring and evaluation system.</i>
<i>Principle 8</i>	<i>The UN system-wide response to “HIV/AIDS as it relates to human trafficking” requires and encourages the active involvement, contribution and support from relevant international bodies and organizations, all levels of government and civil society organizations.</i>
<i>Principle 9</i>	<i>Victims of human trafficking and HIV-infected victims of human trafficking more particularly, are key resources in the UN system-wide response to “HIV/AIDS as it relates to human trafficking.”</i>
<i>Principle 10</i>	<i>The most efficient and effective responses to HIV/AIDS are evidence-based. Accordingly, research, ongoing monitoring and evaluation should be integral to a UN system-wide response to “HIV/AIDS as it relates to human trafficking.”</i>

Overview of Human Trafficking in East and Southern Africa

There is an immense diversity of people being trafficked from, to and through Africa. Victims are African, Asian and European, coming from urban and rural areas, some with high levels of education and others with low levels. Most often they are women, but children – both girls and boys – and men are also targeted for trafficking (UNODC 2006). Some trafficked women enter destination countries legally and others do so illegally. In the case of trafficking for the purpose of sexual exploitation, some know that they will be engaged in sex work but are unaware of the exploitation that they will encounter. Others are unaware that they will be engaged in sex work, since their traffickers have promised them “legitimate” jobs, for example working in restaurants.

Traffickers themselves are as varied as the people they traffic. They are both women and men. Some are one-time offenders who might exploit a relative or acquaintance; others are part of larger operations including organised crime, seeking to lure irregular migrants to Africa’s more prosperous countries. Some traffickers see the continent as a useful transit point to final destinations in Asia, Europe and North America.

Although there is considerable variation in the profiles of trafficked persons and of their traffickers, the tactics used to recruit, transport and exploit victims are similar. In many cases, women and children are lured with promises of employment or educational opportunities abroad.

At the place of origin the situation of trafficked persons is not necessarily totally desperate, although poverty and lack of livelihood opportunities characterise the environment. Transnational communication and transportation networks resulting from globalisation have provided an awareness of opportunities that purportedly exist elsewhere. Cross-border migration, whether documented or not, is seen as an effective means to achieve these opportunities. The exploitation of victims is further facilitated by their relocation from a familiar place to one that they do not know, where they have neither a safety-net nor a social network to turn to in times of need.

HUMAN TRAFFICKING IN EAST AFRICA AND THE HORN



From the counter-trafficking information campaign, IOM East and Central Africa

All countries in East Africa have been identified as origin, transit or destination points for trafficked women and children. Trafficking occurs both internally and across borders to other countries in East and Southern Africa, and trans-continently to Europe and the Middle East.

→ The 2006 annual Trafficking in Persons (TIP) report by the US State Department states that **Kenya** is a source, transit and destination country for men, women and children trafficked for forced labour and sexual exploitation. Kenyan children are trafficked within the country for domestic servitude, street vending, agricultural labour and sexual exploitation, including for the coastal sex tourism industry. Kenyan men, women and girls are trafficked to the Middle East, other African nations, Western Europe and North America for domestic servitude, enslavement in massage parlours and brothels, and manual labour. Chinese women trafficked for sexual exploitation reportedly transit in Nairobi, and Bangladeshis may transit in Kenya for forced labour in other countries. Burundian and Rwandan nationals known to be engaged in coastal sex tourism also may have been trafficked (US State Department 2006).

Large numbers of Somali asylum seekers in Nairobi may be vulnerable to trafficking. UNHCR Kenya suspects that asylum seekers in both urban and rural settings, especially women and girls, are trafficked to and from Kenya (IOM 2006b).

→ **Tanzania** is a source and possibly transit country for children trafficked for forced labour and sexual exploitation. Girls from rural areas are trafficked to urban centres for domestic servitude and commercial sexual exploitation.

Domestics fleeing abusive employers as well as voluntary migrants unable to find work in urban centres sometimes fall prey to exploitation in prostitution. Boys are trafficked within the country for exploitative work on farms, in mines and in the informal sector. Small numbers of girls are also reportedly trafficked to South Africa, Oman, the United Kingdom and possibly other European or Middle Eastern countries for domestic servitude. Citizens of neighbouring countries may be trafficked through Tanzania for forced domestic labour and sexual exploitation in South Africa and the Middle East (US State Department 2006).

→ **Uganda** is a source country for men, women and children trafficked for forced labour and sexual exploitation. The rebel movement, the Lord's Resistance Army (LRA), reportedly abducts children and adults in northern Uganda and southern Sudan to serve as cooks, porters, agricultural workers and combatants. Abducted girls are subjected to sex slavery and forced marriage. Some abducted children and adults remain in Uganda, while others are taken to southern Sudan or eastern Democratic Republic of Congo. There are reports of a small number of children serving in the Uganda People's Defence Forces (UPDF) and local militias known as Local Defence Units. Ugandan girls are trafficked within the country from rural villages to border towns and urban centres for commercial sexual exploitation (US State Department 2006). Uganda has been identified as a source country of women and children trafficked to Kenya, the Middle East, Europe and North America (IOM 2006b).

→ **Ethiopia** is a source country for men, women and children trafficked for forced labour and sexual exploitation. Children and adults are trafficked within the country for domestic servitude and, to a lesser extent, for commercial sexual exploitation and labour, such as street vending. Small numbers of men are trafficked to Saudi Arabia and the Gulf States for low skilled forced labour. Ethiopian women are trafficked to the Middle East, particularly Lebanon, for domestic servitude, although other destinations include Egypt, South Africa, Sudan and Djibouti. Small percentages of these women are trafficked for sexual exploitation. Transit countries for trafficked Ethiopians reportedly include Djibouti, Egypt, Kenya, Libya, Somalia and Sudan (US State Department 2006).

→ **Djibouti** is a source, transit and destination country for women and children trafficked for the purposes of sexual exploitation and possibly forced labour. Small numbers of girls are trafficked to Djibouti from Ethiopia and Somalia for sexual exploitation; economic migrants from these countries also at times fall victim to trafficking upon reaching Djibouti City or the Ethiopia-Djibouti trucking corridor. Women and children from neighbouring countries reportedly transit in Djibouti for Arab countries, Somalia and Somaliland for ultimate use in forced labour or sexual exploitation (US State Department 2006).

HUMAN TRAFFICKING IN SOUTHERN AFRICA

With its history of southward migration flows, political instability, porous borders, and weak institutions and structures, Southern Africa is fertile ground for irregular migration, and hosts a diverse range of migrant smuggling and human trafficking activities. Facilitated by local smugglers, and an expanding network of transnational criminal syndicates, a significant majority of irregular migrants originate from within the region, although those from as far as China, Pakistan, India and Bangladesh have been arriving in increasing numbers since the mid-1990s. The region's young women and children are especially vulnerable to the recruitment tactics of human traffickers because civil unrest and economic deprivation leave them with few opportunities at home, and make migration to South Africa, the region's most prosperous country, a credible and appealing lure (IOM 2006f).

Figure 4 illustrates the different nationalities of women who are trafficked in Southern Africa for sexual exploitation. Of the total 163 women that IOM has assisted in South Africa, Zambia and Zimbabwe between 2004 and mid-2006, there were 12 different nationalities. This chart should not be taken as representative of the total number of women trafficked into the region, nor of the relative numbers per nationality. There are several reasons why IOM has tended to assist more Thai women than other nationalities, for example accessibility. However, it does give some idea about how globalised the phenomenon of trafficking has become.

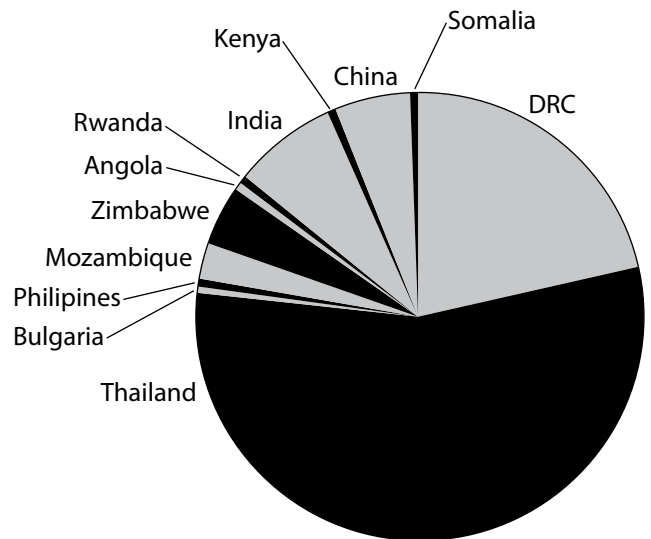


Figure 4: Countries of origin of victims assisted by IOM's Southern African Counter-Trafficking Assistance Programme (SACTAP), January 2004 to August 2006

African women and children are especially vulnerable to the recruitment tactics of traffickers because civil unrest and economic deprivation leave them with few opportunities at home, and make migration a natural and common solution. In other countries in the region, children displaced as a result of HIV and AIDS are expected to undertake more and different work than they are used to, increasing their vulnerability to trafficking (Young and Ansell 2003).

→ **South Africa** is a source, transit and destination country for men, women and children trafficked for forced labour and sexual exploitation. South African women and girls are trafficked internally and occasionally by organised crime syndicates to European and Asian countries for sexual exploitation. Thai, Chinese and Eastern European women are trafficked to South Africa for debt-bonded sexual exploitation. Women from other African countries are trafficked to South Africa and, less frequently, onward to Europe for sexual exploitation (US State Department 2006; IOM 2003a).

In 2003, IOM's report *Seduction, Sale and Slavery: Trafficking in Women and Children for Sexual Exploitation in Southern Africa* identified Lesotho, Mozambique, Malawi and a number of refugee-producing countries as source countries for women and children trafficked to South Africa, with Malawian women also having been trafficked to European destinations. The report revealed that women from Thailand, China and Russia are also being trafficked

to Southern Africa. In 2004, in Issue no.2 of its quarterly publication, *Eye on Human Trafficking*, IOM confirmed that transnational criminal syndicates are also trafficking South African women to East Asia for the purpose of sexual exploitation.

IOM identified the trafficking of women from refugee producing countries such as Angola, Rwanda, Burundi and Democratic Republic of Congo into South Africa (IOM 2003a). Often these women have come from conflict and post-conflict areas, where levels of gender-based violence are high, and access to health care minimal. When they are trafficked they face further dangers: documented cases have indicated that sexual violence, trauma and physically demanding conditions characterise many women's journeys. In addition, IOM reported trafficking in women and girls from Mozambique to Gauteng and KwaZulu Natal provinces of South Africa (IOM 2003a).

→ **Malawi** is a country of origin and transit for men, women and children trafficked for the purposes of forced labour and sexual exploitation. Trafficking victims, both children and adults, are lured into exploitative situations by offers of lucrative jobs in Malawi or South Africa. Children are trafficked within the country for forced agricultural labour. Women in prostitution reportedly draw underage children into prostitution. Anecdotal reports indicate that child sex tourism may be occurring along Malawi's lakeshore (IOM 2003a; US State Department 2006). In addition, IOM reported that women, girl and boy children are trafficked from Malawi to Northern Europe (IOM 2003a).

→ **Mozambique** is a source country for men, women and children trafficked for forced labour and sexual exploitation. The use of forced and bonded child labourers is a common and increasing practice in rural areas, often with the complicity of family members. Women and girls are trafficked internally and to South Africa for forced labour and sexual exploitation; young men and boys are similarly trafficked for farm work or domestic servitude. Trafficked Mozambicans often labour for months in South Africa without pay before the "employer" reports them as illegal immigrants or trespassers. They are then arrested and deported. Traffickers are typically part of small networks of Mozambican and/or South African citizens; however, involvement of larger Chinese and Nigerian syndicates in

the trafficking of Mozambicans has also been reported (US State Department 2006).

→ **Zambia** is a source and transit country for women and children trafficked for forced labour and sexual exploitation. Zambian children are internally trafficked for forced agricultural labour, domestic servitude and sexual exploitation; some reportedly are trafficked to Europe for sexual exploitation. The country's estimated 1.2 million orphans are particularly susceptible to trafficking. Zambian women, lured by fraudulent employment or marriage offers, are trafficked to South Africa for prostitution. Zambia is a transit point for regional trafficking of women and children, particularly from the Democratic Republic of the Congo to South Africa (US State Department 2006).

→ **Zimbabwe** is a source, transit and destination country for women and children trafficked for the purpose of forced labour and sexual exploitation. Zimbabwean children may be trafficked internally for forced agricultural labour, domestic servitude and sexual exploitation. Trafficked women and girls are lured out of the country to South Africa, China, Egypt and Zambia with false job or scholarship promises that result in domestic servitude or commercial sexual exploitation. There are reports of South African employers demanding sex from undocumented Zimbabwean workers under threat of deportation. Women and children from Malawi, Zambia and the Democratic Republic of the Congo transit Zimbabwe en route to South Africa (US State Department 2006).

Examples of trafficking trends in East and Southern Africa

The three trafficking trends looked at in more detail are 1) Ethiopian women trafficked to countries in the Middle East for domestic servitude, 2) Mozambican women trafficked to South Africa for sexual exploitation, and 3) Thai women trafficked to South Africa for sexual exploitation.

1) ETHIOPIAN WOMEN TRAFFICKED TO THE MIDDLE EAST FOR DOMESTIC SERVITUDE

“There is wide scale trafficking of women from Ethiopia to the Gulf – in Lebanon alone, there are an estimated 20,000 to 25,000 Ethiopian domestic workers, a significant number of whom are trafficked” (GTZ 2003). The main countries include Bahrain, Lebanon, Saudi Arabia and United Arab Emirates.

Many Ethiopian women who wish to migrate for work purposes become victims of trafficking, lured by false promises of good jobs, high salaries and an easy life. When a woman reaches her destination, the employer or an agent from the employment agency confiscates her travel

papers and official documents, and costs of passage are increased to force women into domestic labour until the debt is paid off (IOM 2006a; Kebede 2002).

There have been many reports of abuse of Ethiopian migrant women recruited for domestic work in the Middle East and Gulf States. Many women fall prey to physical, mental and sexual abuse by their employers and lead a life of debt bondage in the Middle East (IOM 2006a).

[Ethiopian migrant women] find themselves abroad in very exploitative situations where they are abused and ill-treated in working conditions comparable to modern day slavery. (Kebede 2002)

Ethiopian newspapers reported that between 1996 and 1999, 67 bodies of Ethiopian women were returned from the Middle East and Gulf States. In the majority of these cases, reports accompanying the bodies stated that the cause of death was suicide. However these reports were either unintelligible, or the causes of death were questionable and vague. The resultant uproar, both domestic and international, forced the Government of Ethiopia to acknowledge trafficking as a significant problem (Kebede 2002).

In response, the Ethiopian Government adopted, among other measures, the Private Employment Agency Proclamation (International Labour Organization, 1997) and created a special Inter-Ministerial National Committee on the issue of Ethiopian women being trafficked to the Gulf States. This proclamation was put in place in order to regulate and facilitate processes carried out by registered recruitment agencies and minimise the abuse of workers. The Convention is crucial for the establishment of coherent bilateral agree-



Figure 5: Routes of Ethiopian women trafficked to countries in the Middle East

ments especially as regards protection of migrant workers (Article 8). Furthermore, the Convention seeks to engage mechanisms to investigate abuses and fraudulent practices (Article 10). Some of these fraudulent practices include trafficking. Article 11 lists the type of protection that employment agencies should provide migrant workers, including safety and health. Despite these efforts, there are still significant numbers of Ethiopian women who are fraudulently recruited to work in the Middle East (ILO, 1997).

Ethiopian women are recruited – either through informal recruiters or formal recruitment agencies – to work as domestic workers or employees in restaurants and hotels in countries in the Middle East. Informal recruiters usually know the woman, who may be a family friend (IOM 2005a). It is difficult to identify individual traffickers and even harder to prosecute formal recruitment agencies because they are registered businesses with the Ministry of Labour and Social Affairs.

Migrant domestic workers become trafficked women when they are deceived as to the amount of money they will earn, the working conditions and sometimes even as to the type of job they will do (e.g. promised work as nurses, nannies). In many cases, trafficked women are forced to work 18 hour days, have no rest day, are underpaid or not paid at all, are raped, beaten, threatened and locked in the house. (GTZ 2003)

Eventually, the laws in the country of destination catch up with these women and they will be put in jail and eventually deported to Ethiopia (Kebede 2002). Although countries such as Saudi Arabia, United Arab Emirates and Yemen have put measures in place to combat trafficking (Calundruccio in IOM 2005b), there has not been a significant improvement in the fate of irregular migrants, especially trafficked persons (Kebede 2002).

When the women arrive back in Addis Ababa, government immigration officials or victim assistance organisations are not aware of their deportation. In some cases these women contact organisations such as IOM and Save the Children, after having heard information campaigns for example on the radio. Only then does the full story of their experiences emerge.

2) MOZAMBIKAN WOMEN TRAFFICKED TO SOUTH AFRICA FOR SEXUAL EXPLOITATION

It is estimated that at least one thousand Mozambican women are trafficked to South Africa every year, most of them to work in the sex industry or as sex slaves to workers in mining areas in Gauteng (IOM 2003a; IOM 2006c). Recruiters take advantage of women's vulnerability and their aspirations to work in Johannesburg where many believe "the streets are paved with gold" (SABC 2002). Traffickers entice women with the promise of jobs, and for many the prospect of earning an income in Johannesburg is too enticing to turn down.

The trafficking route often begins in Maputo, although women may be recruited from as far north as Nampula. Minibus taxis transporting women into South Africa cross the border at Ressano Garcia or Ponta de Ouro. From Ressano Garcia women are taken to Gauteng Province. From Ponta de Ouro they are taken either to Gauteng Province or to Durban or Pietermaritzburg in KwaZulu Natal Province (IOM 2003a).



Figure 6: Routes of Mozambican women trafficked to South Africa

Recruitment takes many forms. In some cases, women who are already seeking transportation into South Africa – to visit family for example – approach taxi-owners or drivers themselves to get into the country. Once across the border, they are told that they will not be going to their destination, but instead must work for their trafficker or an associate.

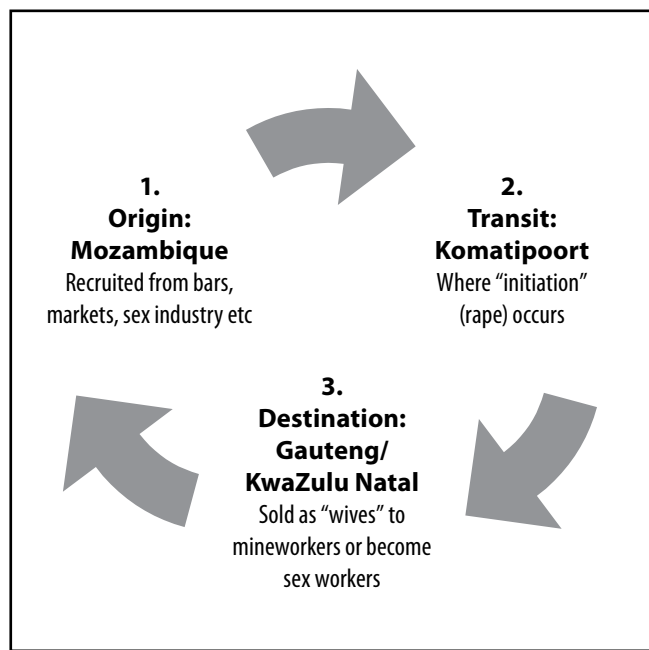


Figure 7: Typical cycle of women trafficked from Mozambique to South Africa

Border crossings also take different forms: in some cases, women are smuggled across on foot, after which they return to their mode of transport and usually spend a night in Komatipoort (on the border of South Africa and Mozambique) or the surrounding area. From there they are taken to different destinations, depending on the demand. Some end up in mining towns near Johannesburg, others in brothels in Johannesburg.

In other cases, traffickers actively target vulnerable women and girls. In this trafficking trend recruiters – often women – find young women in markets, cafes, or bars in Mozambique and promise them well-paid jobs in South Africa working as waitresses in restaurants or in hotels. Once they have crossed the border and are in transit to South Africa they are informed that they will be working in the sex industry.

3) THAI WOMEN TRAFFICKED TO SOUTH AFRICA FOR SEXUAL EXPLOITATION

They worked there [in a hotel in Hillbrow] from Monday to Saturday. They were never allowed to leave the hotel...they come here as slaves; they have to work, they have to earn money. So if they can work on Sunday also, that's fine. He [the agent] used to transport them, about 12 of them, to Pretoria on Sunday and back in the morning. (IOM 2003a)

Thai women are trafficked to South Africa for the purpose of sexual exploitation involving "forced sex work, long working hours, debt bondage, captivity in suburban safe houses, intimidation of the woman and her family members in Thailand, poor and unhygienic living conditions and physical and verbal abuse" (IOM 2003a).

Women are trafficked from Thailand into South Africa in several different ways, including by "cottage industry" traffickers (small-time operators) and those belonging to an "international criminal order" (organised crime) (IOM 2003a).

The common theme in all of these different scenarios is the vulnerability of the targeted women and girls: "most are poor, not very well-educated and speak very little or no English. They come from all parts of Thailand, and sometimes from countries neighbouring Thailand" (IOM 2003a).



Figure 8: Routes of Thai women trafficked to South Africa

Girls from poor or indebted families recruited in rural Thailand by organised crime groups are made to pay off contracts to “honour” debt incurred by their parents. Everything – travel costs, documents and accommodation – is paid for by the recruiters and this accumulates on top of the debt of the parents. The recruiters give them a certain period in which to repay that debt, however this time is usually unrealistic. “They say his girl will have to pay us back within 18 months or you’re dead... they set the time and normally this time is not sufficient for the girl to pay back the money. Every month that she is late with her payments there is a fine or a build up of interest on that money that she must repay” (interview with police officer, Johannesburg, in IOM 2003a).

Thai women travel to South Africa via Johannesburg International Airport. Some come directly from Bangkok, and others from Hong Kong, Kuala Lumpur and Singapore. At the destination, the women are forced into exploitative sex work. Some work in private houses, some in “hotels,” and others in restaurants. They are trapped physically by their “owners,” and also psychologically – they are told that in South Africa they will be attacked on the streets if they leave, and since they cannot speak the language they cannot ask for help. Many are informed of their bondage debt, the fee that they must pay back through sex work in South Africa before they can return home. An estimated figure puts this at around US\$ 7,500, forcing women to work long hours, and often to do “extras” for more money if the client demands – for example to have sex without a condom (IOM 2006c,d).

IOM’s Regional Office for Southern Africa based in Pretoria, South Africa, assists in the return of many Thai women who have been rescued from brothels or have escaped on their own accord. However, many women are never found, and they often remain in South Africa. Perhaps one of the most disturbing phenomena – known as “second wave trafficking” – is that once repayment of their debt is completed, some Thai women become traffickers themselves:

She finishes her contract... That woman then brings in two new women. Now she’s a Mama San¹³ and they work for her... I heard the contracts are between ZAR 50 000 and ZAR 60 000. (IOM 2003a)

¹³ The term *mama san* is a Japanese term that is used commonly to refer to an Asian woman involved in the sex industry, usually as a pimp, bar hostess or “surrogate mother” to sex workers. In the South African sex industry, it refers to Thai victims turned traffickers or Thai brothel madams who assist brothel owners in managing and communicating with sex workers from Thailand or trafficking victims (IOM 2003).

WALSH DESIGN



FOR SALE

**WOMEN AND CHILDREN ARE BEING TRAFFICKED INTO
SOUTH AFRICA AND SOLD INTO THE SEX INDUSTRY.
IF YOU NEED HELP OR INFORMATION PLEASE
CALL: 0800 555 999 VISIT: www.iom.org.za**

INTERNATIONAL ORGANIZATION FOR MIGRATION
REGIONAL OFFICE FOR SOUTHERN AFRICA



PART TWO: Findings & Recommendations

Findings

The findings of this report are discussed within the four stages of the trafficking cycle: origin, transit, destination and return. Because primary data about origin and return were collected for the most part in Ethiopia (Example One), and data about transit and destination were collected in South Africa (Examples Two and Three), the findings reflect this geographical focus (although where there is information about Ethiopian women's experiences at the destination in Middle East countries, this has been included). **The findings therefore concentrate on:**

- 1) **Origin/pre-departure:** SRMH of Ethiopian women before they are trafficked to countries in the Middle East
- 2) **Transit and travel:** SRMH risks and consequences for Mozambican women in transit in South Africa
- 3) **Destination:** SRMH risks and consequences of Mozambican and Thai women trafficked in South Africa and, where data are available, of Ethiopian women in the Middle East
- 4) **Return and reintegration:** SRMH of women who have returned to Ethiopia having been trafficked to countries in the Middle East

Within these four stages several themes emerged relating to the way in which women are vulnerable to SRMH problems. These themes are discussed in more detail in the individual sections, and are illustrated in the following diagram:

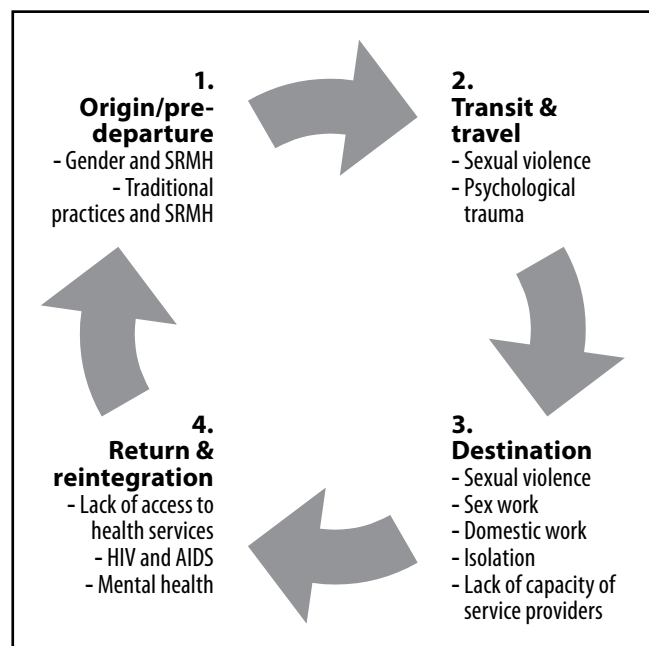


Figure 9: Causes of SRMH vulnerability at the four stages of the trafficking cycle

1) ORIGIN

As stated in the *Budapest Declaration on Public Health and Trafficking in Human Beings* (IOM 2003b), the origin or pre-departure stage defines basic mental and physical health characteristics of the trafficked person at departure, which in turn will affect that person's health-related behaviour throughout the trafficking process. In addition, pre-existing illness or diseases reflect the environment present at the migrant's home, including poverty, lack of knowledge about HIV prevention and its spread, lack of education and poor nutrition. Evidence suggests that there are links between the negative health consequences of the trafficking process and women's SRMH at origin.

Table 3 illustrates some indicators relating to health in the countries of origin of the three examples.

	Ethiopia	Mozambique	Thailand
Per capita expenditure on health (PPP US\$) (2002)	21	50	321
Physicians per 100,000 people (1990-2004)	3	2	30
Contraceptive prevalence rate (%) (1995-2005)	8	6	72
Estimated HIV prevalence (%) ages 15-49) ¹⁴	4.4	16.1	1.4

Table 3: Health indicators in countries of origin (adapted from UNDP 2005 and UNAIDS 2006)

¹⁴Data for Mozambique and Thailand taken from UNAIDS 2006. Data for Ethiopia taken from UNDP 2005, showing 2003 prevalence (Ethiopia statistics from 2005 are unavailable).

As can be seen, in Ethiopia and Mozambique health expenditure and contraception use is low, and HIV prevalence – particularly in Mozambique – is high. In Thailand, HIV prevalence is relatively low and contraception use and health spending are high.

These data are reflected in the findings at later stages of the cycle as will be discussed in more detail later on. For example it was indicated in interviews that Thai women forced into sex work in South Africa are more likely to use a condom and have a higher level of general health than Mozambican women trafficked to the country (IOM 2006c,d). Although other factors contribute to this, there is a correlation with access to health care and health-seeking behaviour at origin.

In Ethiopia, where primary data at origin were collected, health and related issues affect vulnerability to trafficking. Despite limited information about the background of trafficked women, poverty, HIV and AIDS and decreased livelihood options are common themes (IOM 2006a). As a survival strategy, many impoverished families send their daughters away to work in spite of the risks and potentially negative consequences of doing so. Orphaned girl children in the care of relatives are thought to be especially vulnerable to trafficking (GTZ 2003).

This movement of girls is a growing problem, not least due to the devastating effect of HIV and AIDS on households in Ethiopia. To compound this, many women do not complete secondary school education and turn to wage labour to earn a living (IOM 2006a). A small but significant number turn to sex work for survival, increasing the risk of contracting STIs and HIV (IOM 2006a). Other young women remain unemployed without the skills to enter the formal labour market and sustain a decent standard of living. For many, therefore, the opportunity to travel abroad to live and work is one that they welcome (Kebede 2002).

In Ethiopia, women are seen as the “natural” providers of domestic services including cooking, cleaning, care-taking and general household maintenance. This is coupled with the biological role of child-bearing and resultant work. In addition, to supplement household income many Ethiopian women are engaged in paid labour in factories, homes or restaurants and often are exposed to rigorous and labour intensive work environments (Kebede 2002). Subsequently, women who end up in trafficking situations

in the Middle East have already been “conditioned” to endure a harsh labour environment.

Indicators of women’s health in Ethiopia point to a lack of access to health care and inadequate health-seeking behaviour, especially regarding SRMH. In 2000, amongst the poorest 20 per cent of the population, only 0.9 per cent of births were attended by a skilled health professional, and the infant mortality rate for the same group was 92.8 per 1,000 live births (UNDP 2005). These are influenced by gender inequality and traditional practices as outlined below which adversely affect women, and compound SRMH-related vulnerabilities during later stages of the trafficking cycle (IOM 2006a).



Materials from IOM Ethiopia’s counter-trafficking information campaign 2005

1. Gender and SRMH

In the 2005 UNDP *Gender-Related Development Index*, Ethiopia is ranked at 134 out of a total of 140 countries surveyed – just six places from the lowest rating for gender-related development.¹⁵ Women have very limited access to education and training opportunities, especially in rural areas, and as a result women’s access to employment is much more limited than that of men. Various reports on education indicate that the school enrolment of girls is far lower than that of boys (Kebede 2002; UNDP 2005).

Gender norms form the basis of relationship dynamics within households and the wider community, and these influence SRMH and health-seeking behaviour. Some of these factors – such as patriarchal systems – influence health risks indirectly by limiting women’s access to information, education and wealth (WHO 1999). Others, such as traditional practices, discussed below, have a more direct impact on women’s health – particularly sexual and reproductive health.

Many victims of trafficking assisted by IOM Ethiopia reported that they had suffered domestic violence at the place of origin before they were trafficked (IOM 2006a). This has an impact on women’s health in general and specifically when they are exposed to the type of exploitation involved in trafficking.

2. Traditional practices and SRMH

Traditional practices such as early marriage, which is linked to abduction, and female genital cutting (FGC), impact negatively on women’s health (WHO 1999). These contribute to a culture whereby women’s health – particularly sexual and reproductive – is not seen as a priority.

It is estimated that 27 per cent of girls in East Africa are married during early adolescence (UNICEF 2003). In Ethiopia forced early marriage has been reported. In some cases, girls are abducted by older men who engage in forced sexual relations with them. Subsequently, the man

pays a dowry to the girl’s family and marries her. She is forced to accept the marriage as she is seen as “used goods” and can no longer be married to anyone else. If the girl is from a poor family the dowry is of significant economic importance, so the family may be more willing to accept the situation. Girls from poor families are therefore more vulnerable to abduction (Kebede; IOM 2006a).

Obstetric fistula condition¹⁶ – a devastating reproductive health problem – has been linked to early marriage and FGC (UNFPA 2006a). Poverty, poor health services and gender discrimination are interlinked factors contributing to the prevalence of obstetric fistula in Ethiopia. Poverty reduces a woman’s chances of getting timely obstetric care, and women often do not seek medical help until they are either completely isolated by their communities or dying from secondary infections.

Although FGC can increase the risk of haemorrhage and infection during childbirth, it is not clear whether it is typically a causal factor in the formation of fistula condition in all cases. However, two radical forms of FGC, the Gishiri cut, which is practised in northern Nigeria, and infibulation – the stitching up of the vagina, which is practised in Ethiopia – can contribute directly to fistula (UNFPA 2006).

These gender-based traditional practices, coupled with other factors, feed into an acceptance by Ethiopian communities, particularly women, that it is normal to endure poor sexual and reproductive health. This is likely to impact on how victims of trafficking respond in terms of SRMH and health-seeking behaviour at later stages of the trafficking cycle.

¹⁵ Mozambique, the country of origin in the second trafficking example, ranks at 133 out of 140 on the *Gender-Related Development Index* (UNDP 2005).

¹⁶ Obstetric fistula is a hole in the birth canal caused by prolonged labour without prompt medical intervention, such as a Caesarean section. The woman is left with chronic incontinence and, in most cases, a stillborn baby (UNFPA 2006a).

2) TRANSIT

Whether introduced by a violent act or experienced as shock from having learned their fate, this first trauma establishes the context of danger that is now the woman's reality. According to experts on mental health and violence against women, this initial trauma is usually acute, generally engenders symptoms of extreme anxiety, and can inhibit memory and recall. (Zimmerman 2003)

The transit stage refers to the period during which women travel to the place of destination. This stage is the interim period between recruitment at origin and the commencement of work at destination, and includes any time spent in halfway houses or transit areas. During transit women undergo varying degrees of vulnerability to SRMH – depending on their route – though it is especially hazardous for women who are transported over longer period, usually overland.

During this stage women are specifically vulnerable to SRMH-related problems due to:

1. Sexual violence
2. Psychological trauma

Of the three examples, Mozambican women trafficked to South Africa travel overland across the border, usually via a transit town where they spend the night in halfway houses owned by traffickers or their associates. Thai women travel by air, usually from Bangkok (via another city), to Johannesburg International Airport. Ethiopian women tend to travel by air – and sometimes by sea – from Addis Ababa to the Gulf States. This section concentrates on Mozambican women trafficked to South Africa, as in this case the transit stage is particularly dangerous.

1. Sexual Violence

During their time in transit many Mozambican women are sexually abused. In an interview captured on a hidden camera on SABC's Special Assignment programme, a trafficker stated that during transit women must be

“initiated” into sex work through the “washing of hands” (SABC 2003) – the trafficker or one of his associates rapes the women. Women in transit are subjected not only to sexual violence, but they are also traumatised by the realisation that they have been duped into leaving their home country. Often they had believed that they would be going to work in a restaurant or hotel in South Africa. Only during transit do they realise that their fate is to enter into exploitative sex work or become sex slaves.

2. Psychological Trauma

Little information is available about the psychological trauma that Mozambican women trafficked in South Africa experience during transit. However, findings from interviews with trafficked women in Europe discuss anxiety and the “initial trauma” at this stage of the trafficking cycle. This is in part due to the natural anxiety of leaving home and, in this case, crossing the border to a new country with different cultures and norms. However, the main causes of trauma during the transit stage are: 1) it is during this period that most women realise that they have been duped and that the fate awaiting them is not what they had expected; and 2) the sexual violence and physical hardship that women experience during the transit period.

Mozambican women trafficked into South Africa experiencing these violent acts undergo trauma and stress, a tactic used by traffickers to “break” women before they force them to work. This sets the pattern for what is to come at destination, by which time many will be defeated and fatigued, and easily manipulated by traffickers, agents and clients.



3) DESTINATION

"[We]... suffer because someone sells you to a man. You stay with him by force and he does not buy you anything, he does not care about you. When you left home they said you were going to work but when you arrive there, you get no job. You are sold to a man... you find out that you are suffering... you want to get back to Mozambique but you have no money to do so." (Interview with a Mozambican sex worker, IOM 2003a)

At the destination stage trafficked women experience the primary purpose of trafficking – the exploitation. The type of exploitation varies according to trafficking scenario and can include (United Nations 2000):

- ⊙ Exploitation of prostitution or other forms of sexual exploitation
- ⊙ Forced labour or services
- ⊙ Slavery or practices similar to slavery
- ⊙ Servitude
- ⊙ Removal of organs

Of the three examples used for this study, Thai women and Mozambican women tend to be trafficked into South Africa for the primary purpose of sexual exploitation.¹⁷ The main purpose of trafficking Ethiopian women to countries in the Middle East is forced domestic labour.¹⁸

Although most Thai and Mozambican women are trafficked for sexual exploitation, the characteristics of each pattern are different. Thai women tend to work in private homes that are used as brothels where they are forced to perform sex work against their will. This involves long working hours, limited freedom of movement – any movement is accompanied – and, sometimes, forced drug

use. Often a *mama san* cooks food for the women. They are not allowed to leave the brothel or accommodation unaccompanied, or due to intimidation they are too scared to leave. In most cases their documents and papers are removed (IOM 2003a; IOM 2006c).

Mozambican women are taken to mining areas where they are sold as “wives” to mine workers or end up in the sex industry in downtown Johannesburg. On the mines, they become sex slaves to their “husbands,” whose “sense of ownership seems to be legitimised by a perversion of the traditional practice of *lobola*¹⁹ before a marriage” (IOM 2003a).

Mozambican women who are not sold in the mining areas may end up in downtown Johannesburg where they have been identified working in brothels in Hillbrow, together with women from other southern African countries, particularly Lesotho and Zimbabwe. According to an informant, 29.7 per cent of sex workers in Hillbrow, Johannesburg, have a non-South African nationality (IOM 2006c).

Of Thai and Mozambican women trafficked to South Africa to perform exploitative sex work, some were sex workers before or knew that they were coming to South Africa for that purpose. However, they were not aware of the conditions under which they would be working and/or the debt that they would have to pay off (IOM 2006c).

Most Ethiopian women are trafficked to countries in the Middle East for the purpose of domestic servitude. At the destination they experience sexual violence, physical and verbal abuse, racism and xenophobia, isolation, long working hours and denial of salary (IOM 2004a).

¹⁷ Although in one recent case documented by IOM an 18 year old Mozambican woman was trafficked to South Africa to work as a domestic servant (IOM 2006c).

¹⁸ It is believed that trafficking for prostitution also occurs from Ethiopia, however little data about this pattern is available at present (GTZ 2003).

¹⁹ A traditional southern African dowry custom whereby the man pays the family of his fiancée for her hand in marriage.

At the destination stage all trafficked women are vulnerable to SRMH-related problems for several reasons.

These are:

1. High levels of sexual violence can lead to STI and HIV infection and to mental health problems.
2. Sex work increases exposure to especially STIs, HIV and mental-health problems.
3. Domestic servitude exposes women to physical, psychological and sexual abuse.
4. Trafficked women's isolation leaves them physically and psychologically isolated at the destination and unable to access sexual and reproductive health care facilities and psychosocial counselling.
5. Health service providers at the destination do not have the capacity to ensure that services take into account the health needs that are specific to trafficked women. This is particularly the case for the provision of specialised psychosocial counselling.

The first four of these are illustrated in Figure 10, and all five are explained in more detail below.

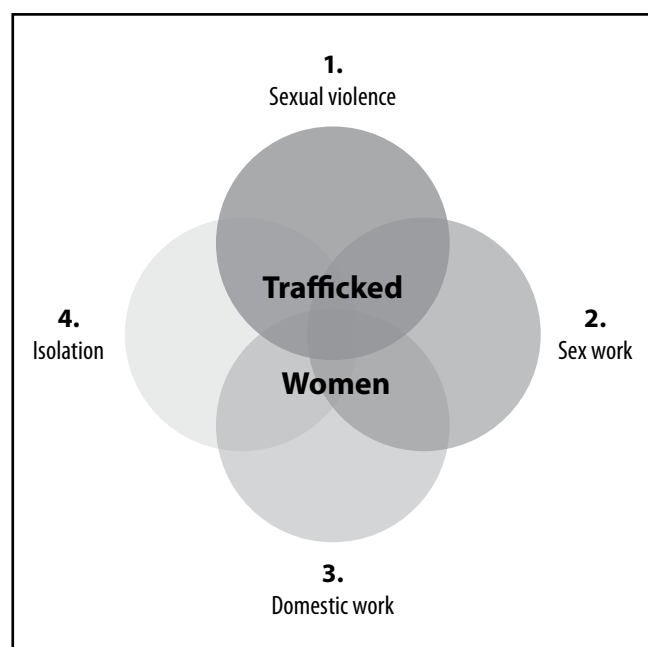


Figure 10: Spheres of vulnerability at destination (adapted from Zimmerman et al 2003)

1. Sexual Violence

As has been discussed – see Table 2 (page 15) – sexual violence is directly linked to SRMH-related problems. One trafficked woman whom IOM assisted became pregnant after having been raped by the owner of the brothel she had been forced to work in (IOM 2006c). The woman experienced an ectopic²⁰ pregnancy. According to the WHO (2005), there is a 6 to 10 times greater risk of ectopic pregnancy in women who have had pelvic inflammatory disease. As outlined in Table 2, pelvic inflammatory disease can be a health consequence of sexual violence.

In an IOM study carried out among 130 returning female migrants who had worked in domestic servitude in countries in the Middle East, 43.1 per cent reported that they had faced sexual abuse in the workplace. Furthermore, of the respondents, 43.7 per cent reported that they were raped in the course of this work (IOM 2004a).

"I was ironing; he came up to me from behind and pushed me to the floor. He raped me. Afterwards he forced me to the kitchen and pulled out a big knife and held it against my chest. He said, 'If you tell anyone, I will kill you or if I don't kill you I will tell the Government about you and you will be deported'. So I didn't say anything, although I felt so bad, I was so scared. Then one day, about a month later he came for me again. But this time, his wife saw, his wife started to fight her husband and then she turned on me. She beat me with a stick and threw a knife at me. I left the house and never went back." (GTZ 2003)

There are recorded cases whereby Ethiopian women have returned from domestic work in the Middle East with sexual and reproductive health problems including HIV (IOM 2006a). Although there is no data about the HIV prevalence of Ethiopian women returning from the Middle East,²¹ in cases where women returned having contracted HIV, it is very likely that this happened during the trafficking process, since HIV testing is mandatory for Ethiopian women migrating to the Middle East to work.

²⁰ An ectopic pregnancy is an abnormal pregnancy that occurs outside the uterus (womb).

²¹ HIV testing is only done for people migrating legally.

2. Sex Work

Violence, including sexual violence, against sex workers by clients, pimps and police has been reported in all regions. Sex workers may find, for example, that trying to negotiate safer sexual practices and/or insistence on condom use may result in violence. Violent sex often causes sensitive mucous membranes to tear, further increasing the possibility of HIV transmission. (UNAIDS 2002)

As has been discussed, many victims of trafficking are trafficked into exploitative or forced sex work. Most women working in the sex industry have not been trafficked, however the industry in general is a useful entry point to collect information about women who have been trafficked. Moreover, through information provided by IOM's SACTAP programme, it is clear that most Thai and Mozambican women trafficked to South Africa are forced to work in brothels or as sex slaves. Because of this, this section looks at the specific SRMH vulnerabilities of women working in the sex industry – particularly in known destination areas in South Africa if information is available.

Sex workers are a population at high risk of contracting STIs and other SRMH-related problems. Primary data collected from brothels in Hillbrow, Johannesburg, shows that sex workers experience high levels of STIs including HIV, in many cases have suffered ongoing abuse since childhood, and exhibit symptoms of mental health disorders. One informant reported that many sex workers – some of whom were believed to have been trafficked – treated for sexual and reproductive health problems had been exposed to some form of physical or sexual abuse as a child (IOM 2006c). In addition, women's general health is poor and their nutrition inadequate, often the result of a diet of cheap fast food, sometimes duelled with alcohol and/or drug abuse. Of these alcohol abuse is the most widespread (IOM 2006c).

2a. Sex Work and Sexual and Reproductive Health

Sex workers (SWs) are particularly vulnerable to sexual and reproductive health-related problems because of:

- ⊙ Sexual violence
- ⊙ Violent sexual practices
- ⊙ Client reluctance to use condoms

Globally, sex workers experience extremely high levels of sexual violence including rape (Farley, Baral, Kiremire, Sezgin 1998). This is also the case in South Africa. One interviewee who runs a shelter in Johannesburg stated that it is very rare to see someone without any evidence of physical abuse (IOM 2006c). In addition, the nature of the sex itself is physically "rough" and thus more risky in terms of health:

"Often one feels pain during sex. Most of the customers have sex with you roughly. Some of them have very large penises. Even if you try and ask the person not to be rough he will ignore you – he will just tell you that he has paid his money – and go on until he is finished." (Interview with sex worker in mining area in Gauteng Province, Campbell 2003)

While condoms are often readily available and women are well informed regarding the benefits of using them, the pressure not to do so can be high (IOM 2006c). This pressure can be financial – clients will pay more for sex without a condom – or physical – clients or pimps force women to have unprotected sex using violence or threats thereof. Furthermore, even in cases where women are able to use condoms with clients, most will not practise safe sex with their "steady" boyfriends²² (IOM 2006c).

SWs' inability to negotiate condom use can be linked to gender norms and abuse that they have experienced throughout their lives. A study among sex workers in a mining area in Gauteng Province – a destination for trafficked women from other countries in southern Africa – found that:

²² "Steady" boyfriends are usually pimps with multiple sexual partners. There are reports that pimps who attend mobile clinic sessions have relatively low levels of STIs, particularly compared to women attending the same sessions (IOM 2006c). More research into this is needed.

The women's life histories suggested that early experiences had often been characterized by economic deprivation, as well as various forms of physical and psychological abuse, often at the hands of men. In many respects such conditions had not been conducive to the development of a sense of confidence in their ability to take control of their lives or their sexual health. This is particularly the case in relation to insisting on condom use in sexual encounters with reluctant male clients – on whose custom they depend for their survival. (Campbell 2003)

Because of these factors, there are high recorded levels of STIs and HIV among sex workers in Gauteng Province. In 2005, data collected from 15 brothels where trafficked women have been identified showed that of women who underwent voluntary counselling and testing (VCT), up to 80 per cent tested HIV positive in a period of one month.²³

Other data collected include (IOM 2006c):

- ⊙ Less than 10 per cent of SWs currently access VCT services
- ⊙ SWs experience extremely high levels of STIs
- ⊙ There is a high rate of abnormal smear results for cervical cancer
- ⊙ There are high levels of stigma about HIV and AIDS among younger sex workers and this influences their willingness to attend mobile clinics

Condom use is reportedly higher amongst Thai women trafficked into sex work in South Africa, which may explain the lower suspected levels of STIs and HIV (IOM 2006c). Most Thai women interviewed by IOM before repatriation state that brothel owners encourage condom use. Despite this, sometimes there is pressure on Thai women not to use condoms. If the client is willing to pay more, Thai women – most of whom are in some form of debt bondage – may be forced to practise unsafe sex (IOM 2006d). There have been cases whereby women deliberately have not used a condom in order to get pregnant and escape the exploitative situation they are in (IOM 2006c).

Although data is not available about the occurrence of STIs including HIV of Thai women in South Africa, some information is available from other regions. For example, as reported by a Human Rights Watch study of Thai women trafficked into debt bondage in Japan, statistics from Japan's National AIDS Surveillance Committee confirm the particular vulnerability of female victims of trafficking and other foreign women to HIV and AIDS in Japan: *from 1985 through 1997, non-Japanese females accounted for 34 per cent of all HIV cases and 8 per cent of all AIDS cases.* Moreover, the same report noted that *trafficked foreign women and girls are denied access to government-subsidized services for HIV/AIDS that are available to citizens of Japan (HRW 2000).*

2b. Sex Work and Mental Health

The following themes emerged about the relationship between mental health and sex work globally:

- ⊙ The link between sex work and childhood abuse
- ⊙ The link between sex work and post traumatic stress disorder (PTSD)

Sex workers are vulnerable to mental health-related problems for several reasons. First, many sex workers have experienced sexual violence as children (Farley, Baral, Kiremire, Sezgin 1998). Second, violence continues into adulthood due to high rates of physical abuse including rape of women working in the sex industry. Sex workers suffer emotional and psychological trauma:

... [Psychological] symptoms [result] from a history of subjection to totalitarian control over a prolonged period... organized sexual exploitation may be one cause of complex PTSD. The violence of pimps is aimed not only at punishment and control of women in prostitution, but at establishing their worthlessness and invisibility. The hatred and contempt aimed at those in prostitution is ultimately internalised. The resulting self-hatred and lack of self-respect are extremely long-lasting. (Farley, Baral, Kiremire and Sezgin 1998)

²³ The monthly figure ranged from about 60 per cent-80 per cent.

According to health and social workers in Johannesburg, almost all SWs in the area suffer from stress and anxiety and levels of depression are extremely high. There is evidence that women engaged in sex work in this area misuse and abuse alcohol and drugs. As stated in one interview, women in sex work “need to take something that will give them strength” and want to feel “numb” (IOM 2006c). Added to the vulnerabilities related to sex work are the risks of being a trafficked woman in the sex industry:

Among female sex workers, those who have been trafficked have the lowest ranking and have less, if any, power in negotiating the conditions of sex. Thus they are the ones that must endure unsafe and violent sex practices, which increase the risk of contracting STIs and HIV. (Wennerholm 2000)

This is extremely difficult to measure, however, it is known that the sex industry in Hillbrow is hierarchical (IOM 2006c), and it is therefore likely that women who have been trafficked would be amongst the most powerless groups. This would compound the already negative health consequences of sex-work.

3. Domestic work

... “domestic workers experience a degree of vulnerability that is unparalleled to that of other workers.” The fact that domestic work takes place in the private sphere is what makes workers especially vulnerable to exploitation. Many remain outside the protection of labour legislation, leaving them little recourse in cases of abuse, non-payment or the arbitrary withholding of wages. One ILO study undertaken in 65 countries revealed that only 19 countries had specific laws or regulations dealing with domestic work. (UNFPA 2006)

Ethiopian women in domestic labour in countries in the Middle East face physical and psychological abuse. An IOM survey of Ethiopian women and girls who had migrated to four countries in the Middle East and North Africa (Lebanon, Egypt, Yemen and Saudi Arabia) to work in domestic servitude found that 45 per cent of respondents had been physically abused in the workplace. Of those that were physically abused, 82 per cent reported that the mode of abuse was “beating with a stick, piece of metal or other objects.” Other modes of abuse were “slashing and cauterisation” (IOM 2004a).

According to Kebede (2002) many returning Ethiopian migrants complain that they had been exposed to strong cleaning chemicals without realizing the risks. Some employers would not allow them to take necessary precautions, such as wearing gloves, and a large number of them suffered skin infections. One returnee said that she was on the same flight as an Ethiopian migrant woman sent home because she had become blind after using a cleaning chemical.

4. Isolation

Trafficked women’s isolation from wider society facilitates the trafficking process. Traffickers use this to control women, and in turn women cannot access health care, nor health promotion messages that reach other at-risk populations. **This isolation can be divided into:**

- a. Physical isolation
- b. Social isolation

4a. Physical isolation

Some trafficked women are held in captivity and therefore physically secluded from the outside world. Most Thai women are held in halfway houses during the day, and taken to brothels for the evening and night. They are not allowed to leave either of these places unaccompanied, and are escorted between the two. As well as having their documents removed so they cannot escape, they are forced to stay through intimidation techniques used by traffickers. For example, some Thai women have said that they were “told that if they try to go anywhere they will be attacked, raped and killed by men in the streets” (IOM 2006c). Since most are completely unfamiliar with the country of destination, this is a powerful tactic to prevent them from running away.

They worked there [in a hotel in Hillbrow] Monday to Saturday. They were never allowed to leave the hotel...they come here as slaves; they have to work, they have to earn money. So if they can work on Sunday also, that's fine. He [the agent] used to transport them, about 12 of them, to Pretoria on Sunday and back in the morning. (Interview with brothel owner and former trafficker, IOM 2003a)

4b. Social isolation

Social isolation is the result of trafficked women's clandestine, foreign and often illegal status, their inability to speak the language, lack of a social "safety net," and lack of understanding of the culture and norms of the country of destination. This is added to the racism and xenophobia often suffered by foreign migrants. Moreover, some women might deliberately try to remain separated from wider society due to fear of what they do not know, or fear of prosecution. All of these factors make it extremely difficult for women to access health care.

Language barriers

In the case of some women trafficked into South Africa, social isolation is exacerbated due to language differences. Thai women brought to South Africa very rarely speak any English – one of the ways in which traffickers and pimps have control over the women. This makes escape difficult: if women try to leave their confinement they cannot talk to anyone, read any signs, or ask for help.

Victims have sometimes mentioned that medical professionals do come to brothels/clubs and that the trafficker explains to them why the medics are there (to test for STIs and HIV) but as they cannot speak English they cannot tell them that they are there against their will and want to leave (IOM 2006c).

When visiting health care facilities, Thai women tend to be accompanied by an interpreter, often the *mama san*, so they cannot discuss their situation or anything that relates to it (including sexual and reproductive health problems), and cannot ask for help.

A private doctor working in Mpumalanga Province in South Africa, where male skilled workers from Thailand

are employed in a refinery, stated that she had examined about six Thai women over the previous five months or so. Although she believed that they were healthy, some of them had been accompanied by a female interpreter. In this case the women said everything through the interpreter, who was in control of the situation. It would have been impossible for the women to ask for help, due to the presence of the older woman, and due to language barriers. Others came to the clinic unaccompanied, but with a note describing their symptoms in English. Further communication was impossible, as they could not communicate in English.

Providing health care through an interpreter is problematic. As one interviewee stated, if the interpreter is male, women are reluctant to discuss matters relating to their sexual and reproductive health (IOM 2006c). In South Africa, IOM's counter-trafficking programme (SACTAP) assists many trafficked Thai women in their return to Thailand. Part of this process involves visiting a doctor who ensures that the woman is physically fit to travel. During this check-up an interpreter is present, and in all but one of the cases this interpreter has been male, since there are no female interpreters available. Although the male interpreter is gender-sensitive and, having been present at the interview stage, is aware of all of the experiences that the women have been through, women rarely mention any problems in regard to their sexual health. The only time that a female interpreter was available, the trafficked woman asked questions relating to sexual health and HIV. This was the only time that such a request was made (IOM 2006c).

5. Service providers' lack of capacity

All of the service providers interviewed as part of this study – most of which work with vulnerable populations – said that they were unsure of how to identify a woman who has been trafficked, and what particular needs trafficked women have. Most agreed that they had worked with women who fit the description of a trafficked person, but at the time it would not have occurred to them that this was the case.

Information about trafficking has reached some service providers which work with vulnerable groups that may include women who have been trafficked. Some

health and outreach workers are aware of who has been trafficked, but they feel there is little that they can do. They do not know what can be done to help the women, and they haven't been trained on how to address the issues, particularly relating to mental health.

Cases in which medical practitioners are certain that the woman they are examining has been trafficked – for example if they are assisting IOM with treating victims of trafficking – stated that they needed clear and standardised guidelines about what should be addressed in the examination. In addition, during interviews with service providers questions were raised about the stage at which HIV testing should be done – for example whether it should take place before women return. Most agreed that VCT should not be done while women are in the country of destination, mainly because counselling would be impossible in many cases due to language difficulties – if women are unfamiliar with the language and have no social safety net then counselling and follow-up is difficult (IOM 2006c).

4) RETURN

On return, trafficked persons often experience anxiety, depression, isolation, aggressive feelings or behaviour, self-stigmatisation or perceived stigmatisation through others, difficulty in accessing necessary resources, in communicating with support persons and family as well as negative coping behaviour (e.g., excessive smoking, drinking, drug use). Problems are complicated if the person returns to an abusive family context or where family members were part of the trafficking network (IOM 2003b).

In Example One – trafficking of Ethiopian Women to countries in the Middle East – women return through different channels. Many end up being held in detention, where health care is minimal, and are deported from the country of destination. In some cases, if women escape from their abusive workplace, they opt to remain in the country. According to Kebede (2002) “migrants, even those in abusive conditions, are reluctant to return until they have made enough money to enable them to be independent, which usually takes quite a long time.” For those that return there are limited opportunities and in some cases “the [regular and irregular] returnees of yesterday have ended up as victims of trafficking today because they have no job opportunities upon their return” (Kebede 2002).

IOM Ethiopia works closely with the Ethiopian Government²⁴ to support efforts in the prevention of trafficking in human beings and the support for safe, orderly migration through pre-departure and post-return arrival information and counselling. There have, however, been difficulties in assisting trafficked Ethiopian women returning from the Middle East. According to IOM Ethiopia, the main challenge is to persuade trafficked persons to identify themselves (IOM 2006a).

Between 2003 and 2005, IOM facilitated counselling services through a telephone hotline to an estimated 7 000 callers and, face-to-face counselling services to approximately 1 000 trafficked persons. The actual number of Ethiopian trafficked persons is most probably much higher but due to the stigma, shame, trauma, ill health,

²⁴ IOM Ethiopia, along with the ILO, has provided support to the Ministry of Labour, Ministry of Foreign Affairs and the Women's Affairs Sub Office in the Office of the Prime Minister to respond to irregular migration, especially trafficking.

dejection and, very importantly, a lack of knowledge on the part of the individual that she is a victim of trafficking, women don't come forward (IOM 2006a). The specific barriers to SRMH care on return to Ethiopia are detailed further below.

For Mozambican women trafficked into South Africa the rate of assisted return is low. No more than 20 trafficked women have been helped by IOM to return to Mozambique, and fewer still from other Southern African countries, see figure 4, page 22 (IOM 2006c). **The primary reasons for this are:**

- ⊙ It is more difficult physically to identify African women trafficked within Africa, unlike Thai women who physically stand out. Thai women are also more likely to seek help from public institutions due to the fact that there is not a large Thai community in South Africa.
- ⊙ Many African women trafficked in the region may be part of a larger community of forced or voluntary migrants, regular and irregular. This makes it harder for them to be identified as trafficked persons and might cause them to opt to remain in the country of destination since they have a support network (IOM 2006c).

Only the third example – trafficking of women from Thailand to South Africa – has a relatively consistent rate of rescue and return (IOM 2006c,d). However, in South Africa there is little information about what happens to Thai women after their return to Thailand. Although IOM is aware of events upon arrival – information that women arrived safely in Bangkok and were assisted to return to their homes – many women do not use reintegration assistance offered to them, thus data about what happens cannot always be recorded.

In the event that a woman is rescued or detained and assisted to return to her home, she faces a significant number of challenges. Stigma is a considerable barrier to effective reintegration, especially for those women who were engaged in exploitative sex work.

Some key findings emerging from the return stage are:

- ⊙ Reintegration has been described as the “most difficult challenge faced by trafficked women” (IOM 2006b).
- ⊙ Some trafficked women – particularly those trafficked within the ESA region – opt to remain at the place of destination.
- ⊙ Re-trafficking of women may occur and has been reported in some cases (Kebede 2002; IOM 2006d).
- ⊙ SRMH and HIV support strategies are fundamental to effective reintegration.
- ⊙ HIV might be a reason for remaining at the place of destination, for example if there are better opportunities for health care at destination, or if the person is afraid of stigma at the place of return.

Ethiopia: return and reintegration

“I was recruited by an individual, well known for this kind of work, to be a domestic servant in Saudi Arabia. I was promised a good income and I saw it as an opportunity to improve my situation and that of my mother. I was very happy that this chance had come my way. I was surprised that when we were being selected to go to our employers, the “pretty” girls were told to stand to one side while the less attractive ones were put in another group. Unfortunately for me, I was chosen as a “pretty” one.

I ended up in Saudi Arabia, working for a bachelor. He repeatedly raped me and I fell pregnant. He made arrangements to marry me.²⁵ However, my recruiter's associate in Saudi Arabia reported my employer to the police and I was arrested and detained for being in the country illegally. I gave birth to my son in jail and they [the police] took him away from me. I went mad and refused to eat and shouted and shouted until they brought him to me twice a week. Finally, the Ethiopian community in the city [Riad] raised funds to facilitate my deportation back to Ethiopia. They also ensured that I was able to get my son back from his father and have him endorsed on my passport. I returned home with my son. I have no job, no money and a son to look after.” (IOM 2006a)

²⁵ “Fornication” and adultery is forbidden under *Sharia* Law and as such, the man had to invoke the option to marry her to avoid punishment. However, this type of marriage offers no protection for the woman.

1. Mental health

Responding to mental health problems is an important but often overlooked element of support for trafficked women who have returned. IOM's psychosocial counsellor in Addis Ababa corroborates this, especially in the area of PTSD, depression and anxiety. Data from counselling outreach facilitated by IOM Ethiopia indicates that trafficked women need a lot of psychosocial counselling to deal with the extreme and unique nature of their experiences and resultant trauma (IOM 2006a).

A health practitioner who works closely with IOM Ethiopia reported that his records show that 60 per cent of the women returning from working in countries in the Middle East had experienced sexual harassment. Additionally 20 per cent suffer from PTSD and 90 per cent from depression. All of the patients show symptoms of stress and anxiety, 50 per cent have suicidal tendencies and 10 per cent show symptoms of psychosis (IOM 2006a). The same doctor stated that the returning women he treats report higher than normal levels of substance abuse, high use of pain medication and sniffing of inhalants such as glue.

2. HIV and AIDS

As has been discussed, trafficked women are vulnerable to HIV infection during the trafficking process. Although there is no quantitative data regarding HIV prevalence of returning women, there is data from other regions linking HIV vulnerability and the situations that trafficked women experience. For example, in Sri Lanka, where migrants often undergo testing, almost half of all reported HIV cases occurred among domestic workers who had returned from the Middle East (UNFPA 2006).

All potential migrants to the Middle East undergo a mandatory HIV test and must test negative in order to receive travel documents from countries of destination (IOM 2006; GTZ 2003). This is non-negotiable and there is little opportunity and incentive for fraud because it will impact negatively on the "business" of recruitment agencies if they are known to recruit HIV positive women.

Of the 289 trafficked women who received counselling support from IOM Ethiopia in 2005, two disclosed that they were HIV positive. The double stigma of being a victim of trafficking and being HIV positive will prevent women

from disclosing their experiences and their HIV status. Disclosing means a more difficult reintegration process, especially if an HIV positive status can prevent effective income earning opportunities to support their families, which is the reason why women left Ethiopia in the first place.

Finally, women who may not have engaged in sex work before the trafficking experience may feel that, upon return to Ethiopia, sex work is the only way to survive. This further increases vulnerability to HIV infection (IOM 2006a).

3. Access to health services

Ensuring effective access to health care to returning Ethiopian women is extremely difficult. When women survive the trafficking experience and return home, they disappear into the larger network of urban centres, possibly back to their families. There is currently little information sharing about the details of deported immigrants between destination countries in the Middle East and Ethiopia. There are no "reception" services available in Ethiopia, which could receive individuals and offer or refer them to health and social services. As such, deported individuals disembark and "disappear without a trace" (IOM 2006a).

When women return to Ethiopia the same barriers to health care discussed in the Origin section (page 30), exist. After the trafficking experience, however, women's health needs change and there is an even greater need for sexual, reproductive and, particularly, mental health care. Lack of mental health care is not only a barrier to women's individual development, but also their reintegration in the country. One study that involved focus group discussions with women coming back from the Middle East found that returnees expressed the need for counselling, particularly those traumatised by abuse suffered in receiving countries (Kebede 2002).

Recommendations

The 12 recommendations below address specifically the health aspects of human trafficking, whilst bearing in mind that prevention of trafficking is the most desirable long-term solution. The first three are overall principles and suggestions which apply to all stages of the cycle and the following nine fall within each stage of the cycle.

1. Recognise the right to health of trafficked persons
2. Work with existing actors
3. Develop regional referral and information networks

1) Origin

4. Mainstream health promotion in counter-trafficking information campaigns
5. Mainstream counter-trafficking information in pre-departure health services

2) Transit

6. Mainstream health into existing counter-trafficking responses

3) Destination

7. Further research on the health consequences of trafficking
8. Use the sex industry as an entry point for research, information dissemination and capacity building
9. Train service providers on trafficking and the health needs of trafficked women
10. Ensure that services and information are available in relevant languages

4) Return

11. Implement regular information and education campaigns in areas of return to raise awareness about human trafficking and health
12. Develop health services that cater to the needs of survivors of trafficking

1. Recognise the right to health of trafficked persons

The findings in earlier sections illustrate the importance of recognising the health impact of trafficking. Although this is beginning to be acknowledged in adopted declarations, principals and conventions, increased advocacy and commitment is needed. Governments from countries in ESA must ensure that these declarations, principals and conventions are implemented and translated into programmes.

According to the World Health Organization, “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity,” and “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” (WHO, 1948). A human rights-based approach to health places trafficked persons at the centre of interventions, ensuring that health is integrated into all counter-trafficking policies and programmes and that these are based around the needs and rights of the trafficked person.

From both a public health and a human rights point of view receiving countries should allow documented and undocumented victims of trafficking access to minimum health services, including reproductive health and STI treatment, psychosocial counselling, voluntary counselling and testing (VCT), post-exposure prophylaxis (PEP) and other emergency health care.

States, NGOs, international organisations and donors should work together and work with ministries of health and other health policy makers to formally recognise trafficking as health problem, include trafficking as a health issue in strategic planning and allocate funds for health interventions (Zimmerman, 2004).

2. Work with existing actors

Interventions to address the health needs of trafficked women should work with existing actors to improve responses.

These actors include:

- ⊙ Government (Department of Home Affairs, Ministry of Health, Social Services/Development)
- ⊙ Law enforcement (Police and Judiciary)
- ⊙ Service Providers:
 - Health services
 - Shelters
 - Counter-trafficking organisations (i.e. IOM)
- ⊙ Non-governmental agencies

As well as capacity-building on issues relating to trafficking and health, a “Helping the Helpers” module should be included in trainings, as outlined in Chapter Five of *The Mental Health Aspects of Trafficking in Human Beings* (IOM 2004b). Psychosocial training should be provided to everyone working with trafficked women. For example, in September 2006 NGO shelter staff from Ankara and Istanbul and IOM counter-trafficking staff participated in an intensive training workshop aimed at sharing best practices on psychosocial assistance to trafficked persons. Part of the training included a debriefing for counter-trafficking workers on how to negotiate conflict, avoid burnout, and develop counselling skills and better routines. Such training should be replicated in East and Southern Africa.

3. Develop regional referral and information networks

At present there is not enough dialogue between the stakeholders working at different stages of the trafficking cycle. Although the recommendations below are laid out within these four stages, strong links should be developed between the stakeholders operating at each different stage.

Zimmerman et al (2004) argue that states, non-governmental organisations, international organisations and donors should work together to establish a government-funded or internationally-funded independent coordinating body in each known country of origin and destination to:

- ⊙ Identify and develop a referral network of services
 - nationally and internationally
- ⊙ Disseminate service information, legal information and news updates between groups
- ⊙ Coordinate the development and dissemination of health information for migrant women in multiple languages

Though these might be difficult to implement in sub-Saharan Africa, where there is little data about human trafficking and limited human and financial resources, the establishment of a referral network between actors at all four trafficking stages is imperative to address health consequences of trafficking effectively. This could involve designated trafficking focal points – trained in mental health, social work and rehabilitation and reintegration issues – systematically sharing case information.

1) ORIGIN

4. Mainstream health promotion in counter-trafficking information campaigns

The place of origin is the logical point for providing information to the general population, to prevent human trafficking and raise awareness of its health impacts. Counter-trafficking organisations, including IOM, should mainstream HIV/STI and SGBV prevention messages into general anti-trafficking information and education campaigns targeting communities and health and social service providers.

Specific recommendations include:

- ④ Reaching at-risk women and girls through projects run in secondary schools. For example, *Our Exercise Book* project in Ethiopia focuses on high school girls, and stresses the importance of staying in school as a way to avoid trafficking and associated risks including HIV infection. Another IOM project in Ethiopia – “Alem’s story” – describes the experiences of a young Ethiopian woman who has been trafficked to a country in the Middle East, and highlights the negative consequences of her experiences. Examples such as these can be replicated in other known countries of origin in ESA.
- ④ Recruitment agencies, where they play a role in human trafficking as is the case in Ethiopia, should be targeted with information and trained on the dangers of irregular migration and trafficking and the links to health, including HIV.
- ④ Communities which are at a high risk of being targeted by traffickers should be engaged to raise awareness on the issue of trafficking as a human rights violation and the links between health, HIV and AIDS, and trafficking.

5. Mainstream counter-trafficking information in pre-departure health services

In countries where mandatory pre-departure HIV testing exists, as is the case in Ethiopia for migrants departing to countries in the Middle East, health service providers and VCT clinics that conduct tests can become entry points for information dissemination. Health service providers should include in their pre- and post-test counselling the potential dangers of irregular migration, including human trafficking and related health consequences. Health workers can refer prospective migrants to service providers such as IOM for information on safe and informed migration. Health service providers could distribute brochures about how to recognise situations where there is a high risk of trafficking, and provide information on prevention, access to treatment and care and referrals to HIV services.

2) TRANSIT

6. Mainstream health into existing counter-trafficking responses

Health interventions during transit are difficult to implement, due to the fact that beneficiaries are mobile at this stage and therefore difficult to reach. However, mainstreaming health into existing counter-trafficking responses would help to ensure that officials and trafficked women are aware of the health consequences of trafficking.

The following are recommended:

- ④ Integrate a health module into counter-trafficking trainings to police, immigration officials and service providers that operate in transit areas. Law enforcement and immigration officials should be trained on the mental health aspects of trafficking, and psycho-social counselling, which will make it easier to communicate with the trafficked person and obtain information. In Kenya and Tanzania IOM has organised training workshops that bring together government, law enforcement, civil society and media to introduce the issue of human trafficking and provide training on the health aspects of this (IOM 2006b).

- ⊙ Implement multilingual information campaigns about the health consequences of trafficking and the health service options available to women in transit areas including airports, border control, transit towns etc.

3) DESTINATION

7. Further research on the health consequences of trafficking

More research about the health aspects of trafficking in ESA is needed. Although research in this area is difficult due to the clandestine nature of human trafficking, it is important to continue to collect information about how best to reduce and prevent the impact of trafficking on health. This research should integrate established guidelines including the WHO *Ethical and Safety Recommendations for Interviewing Trafficked Women* (WHO 2003) and *Researching Violence Against Women: A practical guide for researchers and activists* (Ellsberg and Heise 2005). It is recommended that a participatory approach is adopted, involving formerly trafficked women in the design and implementation of research methods.

8. Use the sex industry as an entry point for research, information dissemination and capacity building

The fact that many trafficked women end up working in the sex industry means that this area can be targeted for interventions, as has been the case in Eastern Europe. (Gronow & McWhinney in GTZ 2005)

Because many women are trafficked into the sex industry in ESA, this industry is a useful entry point for further research and programming. This could include awareness-raising activities among brothel owners, sex workers and their clients, social workers and health care providers, involving

training on the definition of human trafficking and common trafficking trends, building the technical capacity of service providers working with women in the sex industry.

It is recommended that programmes work with the demand-side (clients) of the sex industry for information dissemination. Evidence from Europe suggests that targeting clients of sex workers – in health and trafficking-related education campaigns – could be an effective method of intervention:

So far, the demand side has been neglected in anti-trafficking approaches. Little information is available on clients of prostitutes and possibilities of outreach to clients. Approaches which address clients in a setting where prostitution is regularised (like in Switzerland and most European countries) or accepted (like in Germany and the Netherlands) can be found in the context of health prevention. Until now few measures have been implemented to directly sensitise clients for trafficking issues. (Howe in GTZ 2005)

This client-based approach requires two things: 1) detailed information about sex workers’ client base, and 2) a regularised sex industry. An assessment of sex workers and their clients is therefore needed in order to find out how they would respond to sensitisation campaigns on trafficking and health. In ESA there is little empirical data about the health-seeking behaviour of sex workers and their clients, however, anecdotal evidence suggests that some men who visit sex workers welcome existing information campaigns about health (IOM 2006c). The Esselen Street Clinic in Hillbrow, Johannesburg, has worked informally with clients of sex workers – providing them with information and services relating to sexual and reproductive health. It could therefore be feasible to include information about human trafficking.

Areas where women are trafficked for sexual exploitation could explore this approach. Different examples from Europe and Africa,²⁶ which involved clients of sex workers

²⁶ In Europe, the “Don Juan Project” was developed in Switzerland by Swiss AIDS Control, and a campaign by Terre Des Femmes in Germany targeted clients of sex workers (Howe, in GTZ 2005). In Uganda the Amalgamated Transport and General Workers Union and the Uganda Railway Workers Union (ATGWU-URWU) are examples of groups in Africa that have an HIV Programme targeting clients of sex workers (GTZ 2003).

in campaigns regarding health and forced prostitution, indicate that such an approach can yield good results:

Clients of prostitutes can be reached through campaigns if the campaigns are tailored to their interests and questions. Even the critical topic of trafficking in women for forced prostitution captures the interest of clients and is connected with concrete questions they have. In addition, female sex workers felt supported in their efforts to comply with safer sex rules and were in favour of broader and more frequent client education. (Howe in GTZ 2005)

9. Train service providers on trafficking and the health needs of trafficked women

Service providers that come into direct contact with trafficked women include:

- ⊙ Sexual and reproductive health service providers accessing brothels and areas where trafficked women have been located
- ⊙ Private medics working with trafficked women
- ⊙ Shelters accessed by trafficked women

All service providers interviewed (IOM 2006a-e) indicated that they need further training about human trafficking. Information should include trafficking patterns, the signs to look out for, what to do if it is suspected someone has been trafficked, and the particular health needs of trafficked women.

If health service providers at destination are trained on SRMH needs of trafficked women, the process of treatment and rehabilitation can start at this stage. Through this, patterns of health care and health seeking behaviour which started at the pre-return stage can be built on after return.

The following are recommended:

- ⊙ Train health practitioners on different human trafficking scenarios in ESA. Through this, health practitioners can start to identify clients that are victims of trafficking and refer them for further assistance to IOM and other victim assistance organisations.
- ⊙ Train health practitioners on the health implications of human trafficking including the training manual *The Mental Health Aspects of Trafficking in Human Beings* (IOM 2004b), and IOM's *Recommendations for Reproductive and Sexual Health Care of Trafficked Women in Ukraine* (IOM 2005c) – which should be adapted for use in ESA.
- ⊙ Train other health workers including students, nurses and pharmacists on human trafficking and the links to health.
- ⊙ Advocate for the inclusion of trafficking in existing public health courses at universities and other institutions of further education.
- ⊙ Integrate SRMH in IOM's victim assistance guidelines, and those of other victim assistance providers, to ensure that IOM staff and their implementing partners are aware of the SRMH needs of trafficked persons during the rescue and victim assistance phase. For example, IOM's regional office in Nairobi is facilitating the development of a training manual for health providers (IOM 2006b).

10. Ensure that services and information are available in relevant languages

As is the case for Thai women trafficked in South Africa, language is a significant barrier to effective health care provision, and to women disclosing their status as a trafficked person to health service providers.

For this reason it is recommended that:

- ⊙ Information materials in all relevant languages are provided to health service providers that trafficked women might access.
- ⊙ Psychosocial counselling, on telephone help lines and through face-to-face counselling, should be made available in relevant languages

4) RETURN

At the return stage survivors of trafficking need access to comprehensive sexual, reproductive and mental health services. For the effective reintegration of trafficked persons this process should include medical care, psychosocial support and livelihoods opportunities, especially in the area of income generation. A key element of reintegration is how to minimise stigma and discrimination and break the cycle of vulnerability and possible occurrence of re-trafficking.

11. Implement regular information and education campaigns in areas of return to raise awareness about human trafficking and health

Information and education campaigns at return should be carried out regularly and should include radio programmes targeting returning migrants including trafficked persons to raise awareness about trafficking and health. As well as making health care provision to trafficked persons more effective, if trafficked persons disclose and identify themselves as having been trafficked then information can be collected from them and fed into information campaigns.

Communities that trafficked persons return to should receive education and information to combat stigma and discrimination. More than anything, a returning victim of trafficking requires acceptance and support, more so when she returns home without the assistance of service providers.



12. Develop health services that cater to the needs of survivors of trafficking

Health practitioners at return need to be trained on human trafficking and sensitised on how to conduct medical procedures whilst taking into consideration the mental health needs of trafficked persons.

- ⦿ Victim assistance organisations at return should work with counterparts at destination to ensure that adequate health services are available to and accessed by survivors of trafficking.
- ⦿ It is often advisable that VCT does not take place immediately after a victim of trafficking has been rescued, but instead after they have returned. The victim might be more comfortable and familiar with the culture and language at the place of return, and pre- and post-test counselling must be done in a language with which the victim is comfortable.

Conclusion

I could go into detail about the need for housing and other basic necessities, the importance of counselling, medical care, legal advice, access to job training programs and education. But, realistically, the challenge for states is not identifying the services that victims of trafficking need to survive and grow. The challenge that we face is in getting states to see and respect, at the most basic level, the humanity of all victims and to get states to work with victims/survivors in a way that demonstrates their commitment to protecting the equality and dignity of all human beings. (Human Rights Watch 2002)

Globally, the link between human trafficking and health is a relatively new research area and in East and Southern Africa it is only beginning to be explored. This report is a first step towards gathering information about links in the region, in this case specifically for trafficking of women.

Traffickers target vulnerable women, and when these women are trafficked they are physically, sexually and psychologically abused. Through this experience they become more vulnerable and isolated. At the moment women trafficked in the region do not receive the care that they should. There is a marked lack of trained counsellors working with women who have been trafficked. At present, organisations that aim to counter human trafficking in East and Southern Africa focus to a great extent on the prevention of trafficking, legislative change, and general victim assistance and return, often without adequately addressing the importance of SRMH care.

Through analysing previous research studies from other regions and general information about trafficking in East and Southern Africa, this study has shown that trafficked women face numerous risks to their SRMH. Whether this is due to sexual violence during transit, forced sex work and physical labour at destination, stigma and discrimination on return, or the trauma of all these experiences together, interventions must be developed to address these vulnerabilities.

Organisations that work in the field of counter-trafficking and victim assistance are aware of the health needs of trafficked women, but should acknowledge these needs formally, by incorporating them into existing programmes. Health and social service providers note a knowledge gap about trafficking and the health needs of trafficked women.

The report therefore recommends that training on trafficking be provided for health and social services that work with trafficked women. It also suggests that measures be taken to mainstream the health aspects of trafficking into more traditional counter-trafficking approaches, such as training police and immigration officials, and public information campaigns aimed at trafficked women.

There are successful approaches and lessons to be learnt from other regions that can be adapted in East and Southern Africa. The health of trafficked women must be given its place in the trafficking discourse if we are to address the multiple vulnerabilities of women to trafficking and sexual, reproductive and mental health-related problems. Without such measures the cycle of vulnerability will continue.



Need help?

Did you come to South Africa because you were promised a better life? Did someone lie to you about the type of work you would be doing? Were you tricked into working in the sex industry? Do you feel trapped? Are you abused or threatened with violence? If you have answered 'Yes' to these questions, then you need our help. Call us now. It could save your life.

THE 5 STAGES OF HUMAN TRAFFICKING



0800 555 999

1. TRAFFICKER MAKES OFFER 2. VICTIM IS TRANSPORTED 3. VICTIM IS INTIMIDATED 4. VICTIM IS ENSLAVED OR SOLD BY TRAFFICKER 5. RESCUE

IOM's Southern African Counter-Trafficking Assistance Program (SACTAP) offers help and support to victims of human trafficking. SACTAP is sponsored by the US Department of State's Bureau for Population, Refugees and Migration, the Norwegian Ministry of Foreign Affairs, and South Africa's Department of Foreign Affairs. Visit www.iom.org.za

INTERNATIONAL ORGANIZATION FOR MIGRATION (IOM) REGIONAL OFFICE FOR SOUTHERN AFRICA



PART THREE: Resources

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- * Global Coalition on Women and AIDS womenandaids.unaids.org/themes/theme_2.html
- * UNIFEM Gender and HIV/AIDS www.genderandaids.org
- * Global Alliance against Trafficking in Women www.gaatw.org
- * Human Rights Watch www.hrw.org
- * Human trafficking.org www.humantrafficking.org
- * International Centre for Migration Policy Development www.icmpd.org
- * International Labour Organization www.ilo.org
- * International Organization for Migration www.iom.int
- * Network of Sex Work Projects www.nswp.org
- * Office of the High Commissioner for Human Rights, links to International Human Rights Instruments
www.unhcr.ch/html/intlinst.htm
- * Polaris Project www.polarisproject.org
- * United Nations High Commissioner for Refugees www.unhcr.org
- * Save the Children www.savethechildren.net
- * Sex Worker Education and Advocacy Taskforce www.sweat.org.za
- * United Nations Children's Fund www.unicef.org
- * UNDP: HIV and Trafficking www.youandaids.org/Themes/Trafficking.asp
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www.unodc.org/palermo/convmain.html
- * United Nations Office for Drugs and Crime
www.unodc.org/unodc/en/trafficking_human_beings.html
- * United States Department of State Office to Monitor and Combat Trafficking in Persons
www.state.gov/g/tip/
- * United States Department of Justice www.usdoj.gov/whatwedo/whatwedo_ctip.html
- * Vital Voices www.vitalvoices.org
- * World Health Organization www.who.int

Annexes

ANNEX 1: ANALYTICAL FRAMEWORK

Destination and Origin	Trafficking Trend	Vulnerability Assessment and Research Questions
<p>To Middle East</p> <p>From Ethiopia</p>	<p><i>Trafficking of women out of Africa to the Middle East:</i></p> <p><i>Target Group: Women who have returned</i></p>	<p>Origin:</p> <ul style="list-style-type: none"> ⊙ What perceived and real socio-economic conditions exacerbate women’s vulnerability to trafficking? What role does gender play? ⊙ Are women rural or urban based? ⊙ What livelihood options are available to women (domestic work, sex work, factory work, etc)? ⊙ How do traffickers operate – i.e. are legitimate fronts utilised? What sort of work is offered to women? ⊙ What access to SRMH/HIV services (information, treatment, care, etc) do women have? What is women’s health-seeking behaviour? <p>Transit:</p> <ul style="list-style-type: none"> ⊙ What are the conditions of transit and the consequent vulnerabilities, especially related to SRMH (e.g. rape)? ⊙ What is the legal environment in terms of cross-border movement (e.g. migration – visas)? <p>Destination:</p> <ul style="list-style-type: none"> ⊙ What are the conditions upon arrival and how do these exacerbate existing vulnerabilities? ⊙ Under what circumstances do trafficked women consider return (e.g. danger to life, less money than anticipated, health deterioration)? ⊙ What legal and policy protection is available to women? ⊙ What access to SRMH/HIV services (information, treatment, care, etc) do women have? <p>Return:</p> <ul style="list-style-type: none"> ⊙ What livelihood options are available and to what extent are they influenced by increased vulnerabilities, stigma and discrimination, SRMH/HIV status? Do women remain in urban centres? ⊙ What legal and policy protection is available to women? ⊙ What access to SRMH/HIV services (information, treatment, care, etc) do women have? ⊙ What are the main challenges of reintegration (e.g. stigma, threats from traffickers)?

Destination and Origin	Trafficking Trend	Vulnerability Assessment and Research Questions
<p>To South Africa</p> <p>From Mozambique</p>	<p><i>Trafficking of women within Africa:</i></p> <p><i>Target Group: Women at destination</i></p>	<p>Origin:</p> <ul style="list-style-type: none"> ⊙ What perceived and real socio-economic conditions exacerbate women’s vulnerability to trafficking? What role does gender play? ⊙ Are women rural or urban based? ⊙ What livelihood options are available to women (domestic work, sex work, factory work, etc)? ⊙ How do traffickers operate? What sort of work is offered to women? ⊙ What access to SRMH/HIV services (information, treatment, care, etc) do women have? What is their health-seeking behaviour? <p>Transit:</p> <ul style="list-style-type: none"> ⊙ What are the conditions of transit and the consequent vulnerabilities, especially related to SRMH (e.g. rape)? ⊙ What is the legal environment in terms of cross-border movement (e.g. migration – visas)? <p>Destination:</p> <ul style="list-style-type: none"> ⊙ What are the conditions upon arrival and how do these exacerbate existing vulnerabilities? ⊙ Under what circumstances do trafficked women consider return (e.g. danger to life, less money than anticipated, health deterioration)? ⊙ What legal and policy protection is available to women? ⊙ What access to SRMH/HIV services (information, treatment, care, etc) do women have? ⊙ What happens if women choose to remain at their destination? <p>Return:</p> <ul style="list-style-type: none"> ⊙ What livelihood options are available and to what extent are they influenced by increased vulnerabilities, stigma and discrimination, SRMH/HIV status? Do women remain in urban centres? ⊙ What legal and policy protection is available to women? ⊙ What access to SRMH/HIV services (information, treatment, care, etc) do women have? ⊙ What are the main challenges of reintegration (e.g. stigma, threats from traffickers)?

Destination and Origin	Trafficking Trend	Vulnerability Assessment and Research Questions
<p>To South Africa</p> <p>From Thailand</p>	<p><i>Trafficking of women from Asia into Africa:</i></p> <p><i>Target Group: Women at destination and in the process of return</i></p>	<p>Origin:</p> <ul style="list-style-type: none"> ⊙ What perceived and real socio-economic conditions exacerbate women’s vulnerability to trafficking? To what extent is trafficking linked to cultural factors such as honour and debt repayment? ⊙ Are women rural or urban based? ⊙ How do traffickers operate? Are there legitimate fronts for trafficking /is this organised crime? What sort of work is offered to women? What are women promised in terms of work? ⊙ What access to SRMH/HIV services (information, treatment, care, etc) do women have? <p>Transit:</p> <ul style="list-style-type: none"> ⊙ What are the conditions of transit and what are consequent vulnerabilities, especially related to SRMH (e.g. rape)? ⊙ What is the legal environment in terms of cross-border movement (e.g. migration – visas)? <p>Destination:</p> <ul style="list-style-type: none"> ⊙ What are the conditions upon arrival and how do these exacerbate and exploit existing vulnerabilities? ⊙ Under what circumstances do trafficked women consider return (e.g. danger to life, less money than anticipated, health deterioration)? ⊙ What legal and policy protection is available to women? ⊙ What access to SRMH/HIV services (information, treatment, care, etc) do women have? <p>Return:</p> <ul style="list-style-type: none"> ⊙ What livelihood options are available and to what extent are they influenced by increased vulnerabilities, stigma and discrimination, SRMH/HIV status? Do women remain in urban centres? ⊙ What legal and policy protection is available to women? ⊙ What access to SRMH/HIV services (information, treatment, care, etc) do women have? ⊙ What are the main challenges of reintegration (e.g. stigma, threats from traffickers)?

ANNEX 2: DIRECTORY OF ORGANISATIONS

Ethiopia

ECPAT Ethiopia

Children's rights

PO Box 9562, Addis Ababa, Ethiopia

E-mail: ecpatethiopia@ethionet.et

Ethiopian Women's Lawyers Association (EWLA)

Women's rights

P.O. Box 13760, Addis Ababa, Ethiopia

E-mail: ewla@ethionet.et

www.ewla.org

Forum on Street Children (FSCE)

Children's rights

P.O. Box 9562, Addis Ababa, Ethiopia

E-mail: fsce@telecom.net.et

Kenya

ANPPCAN Kenya

Chemusian Apartments No. B3,

opposite Nairobi Women's Hospital,

Argwings Kodhek Road, Hurlingham,

Nairobi, Kenya

E-mail: admin@anppcankenya.co.ke

The Cradle

Children's foundation

Nairobi, Kenya

E-mail: thecradle@africaonline.co.ke

FIDA Kenya Secretariat

Federation of Women Lawyers - Kenya

Women's rights

Amboseli Road, Off Gitanga Road,

Nairobi, Kenya

E-mail: fida@africaonline.co.ke

E-mail: info@fida.co.ke

www.fidakenya.org

Nairobi Women's Hospital

Sexual and reproductive health services

Argwings Kodhek Rd, Hurlingham

Medicare, Nairobi, Kenya

Ngazi Moja

Community outreach and women's rights

P.O. Box 73019, Nairobi, Kenya

E-mail: salamacommunity@yahoo.com

SOLWODI

Women's rights

P.O. Box 17038, Mombasa, Kenya

80100

E-mail: solwodi@wananchi.com

Mozambique

Rede Came

National Network on Preventing Child Abuse

Children's rights

Maputo, Mozambique

E-mail: antichildabuse@tvcabo.co.mz

E-mail: antichildtrafic@tvcabo.co.mz

South Africa

Esselen Street Clinic

Sexual and reproductive health information and services

17 Esselen St, Hillbrow,

Johannesburg, South Africa

Molo Songololo

Children's rights

Breaside Road, Kenilworth, Cape Town,

South Africa

E-mail: patric@molo.org.za

Mosaic

Sexual and reproductive health services

Ottery Road, Wynberg, Cape Town,

South Africa

E-mail: mdevos@mosaic.org.za

Muslim AIDS Project

Sexual and reproductive health services

Klipfontein Road, Athlone, Cape Town

E-mail: mapwcape@mweb.co.za

New Life Centre

Community outreach and women's rights

Johannesburg, South Africa

Saartjie Baartman Centre

Community outreach and women's rights

Klipfontein Road, Athlone,

Cape Town, South Africa

E-mail: synnov@womenscentre.co.za

Sex Workers' Education and Advocacy Taskforce (SWEAT)

Sex workers rights

Salt River Road, Salt River, Cape Town,

South Africa

E-mail: sweat@iafrica.com

Southern Africa

Southern Africa Regional Network Against Trafficking of Children (SANTAC)

Children's rights network

www.againstchildabuse.org

Tanzania

Kiota Women's Health and Development Organization

Women and children's rights and development

P.O. Box 10127, Dar Es Salaam, Tanzania

E-mail: katri@africaonline.co.tz

Zambia

Tasinth

Drop-in Centre

Stand No. 1638/2716 Malambo Road,

Industrial Area, Off Great North Road,

Lusaka, Zambia

E-mail: tasinthaprog_zm@yahoo.co.uk

E-mail: tasinthaprogramme@zamtel.zm

IOM Counter Trafficking contacts in East and Southern Africa

IOM's Regional Office for Southern Africa

Southern African Counter Trafficking
Assistance Programme (SACTAP)

Tel: +27 12 342 2789

Fax: +27 12 342 0932

E-mail: sactappretoria@iom.int

Website: www.iom.org.za

IOM's Regional Office for East and Central Africa

Tel: +254 20 4 444 174

Fax: +254 20 4 449 577

E-mail: iomnairobi@iom.int

IOM Ethiopia

Tel: +251 1 511 673

Fax: +251 1 514 900

E-mail: iomaddisababact@iom.int



IOM International Organization for Migration

BREAKING the CYCLE of VULNERABILITY

Breaking the Cycle of Vulnerability: Responding to the health needs of trafficked women in East and Southern Africa documents three trafficking trends in the region, and looks at the health risks that trafficked women encounter in each one. **The three trafficking trends are:**

1. Trafficking of Ethiopian women to countries in the Middle East for the purpose of domestic servitude
2. Trafficking of Mozambican women to South Africa for the purpose of sexual exploitation
3. Trafficking of Thai women to South Africa for the purpose of sexual exploitation

In all three trends women are vulnerable to sexual, reproductive and mental health-related problems. At present, organisations that aim to counter human trafficking in East and Southern Africa tend to focus on the prevention of trafficking, legislative change, and general victim assistance and return.

This report investigates these issues and why the health of trafficked women should be integrated in the trafficking discourse in order to address the vulnerability of victims of trafficking to sexual, reproductive and mental health-related problems.

