

A close-up, high-contrast photograph of a person's eyes, looking directly at the camera. The image is dark and moody, with the eyes being the primary light source. The skin around the eyes is visible, showing some texture and shadows.

*Joint efforts of police and health authorities
to combat trafficking in human beings*

HANDBOOK

for professionals at the interface of police & health authorities

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Introduction

Trafficking in Human Beings (THB) is modern-day slavery. It is a serious crime and a violation of human rights. Almost every country in the world is witness to this crime, either as a source, transition or destination country of victims of THB - or a combination thereof. In view of the severity of the crime the European Union (EU) has established a number of initiatives, measures and funding programmes to combat THB since the early 1990s.

The current handbook is an outcome of these efforts. It is one of the results of the project „Joint efforts of Police and Health Authorities in the EU-Member States and Third Countries to Combat and Prevent Trafficking in Human Beings and Protect and Assist Victims of Trafficking”(HOME/2010/ISEC/AG/062), which has been realised with the financial support from the Prevention of and Fight Against Crime (ISEC) Programme of the European Commission – Directorate-General Home Affairs, within the targeted call for proposals “Trafficking in Human Beings” for action grants under the 2010 Annual Work Programme.

Because of the complexity of the issues involved in combating THB, the EU has chosen a holistic approach, integrating actions in the field of prevention of the crime with activities geared to protecting the victims, prosecuting the criminals and developing partnerships between the various institutions and actors involved in the process.

The current handbook follows this approach by focusing on the victims, the provision of assistance, empowering them to realise their rights and paying attention to their mental, physical and social needs. In this sense the handbook follows a human rights based approach.

In order to effectively support the victims, the focus is on informing and training the professionals and institutions involved in providing assistance, in particular in the medical field, as the identification of victims and cooperation with law enforcement tend to be challenging.

The handbook consists of two parts, a manual for trainers providing content material such as information on THB, the legal ramifications, the various facets in the different phases and stages of the process of THB, the institutional actors and professions involved, with a special focus on the medical professions and their interaction with the victims and law enforcement. The second part is a training curriculum consisting of four modules, which are providing information on the learning environment, the didactics and learning methods and the linkage to the respective content material provided in the first section of the handbook. The curriculum is conceived as a four-day training, which may be either reduced or extended, depending on the objective of the training, e.g. for awareness raising only or for a deepened understanding of the issues involved and for competence building.

Aims of this handbook

The aim of this handbook is to contribute to the development of skills and the implementation of good practices for better medical protection of trafficked victims. In addition, the objective is to improve cooperation between the medical field, law enforcement, the justice system and NGOs to enhance the protection of victims, to provide general health and mental health assistance during the rehabilitation and reinsertion phase while at the same time supporting the victims to act as witnesses in prosecuting the criminals.

Using this handbook

The handbook applies a human rights approach in focussing on the victims, ensuring confidentiality, respecting patient rights and providing support in the reflection period.

The basic consideration is to care for the security and the (medical) well-being of patients as this is a prerequisite for an effective referral, disclosure and cooperation with authorities.

The handbook employs a bottom-up approach in order to raise the awareness of health care professionals to THB, thereby enticing them to participate in local networks with social workers to complement centralised top-down action by national governments.

The handbook chooses a broad definition of types of trafficking, victims and situations, in order to avoid a bias towards specific target groups and to ensure an understanding of the whole scope and spectrum of THB.

Those who have little time should read the following brief guide on issues of THB. Those who want to learn more can deepen their knowledge by reading through the various content chapters of the manual. Those who want to prepare a training session should turn to the second part of the handbook, the curriculum.

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Executive summary:

Brief guide for professionals at the interface of police and health authorities

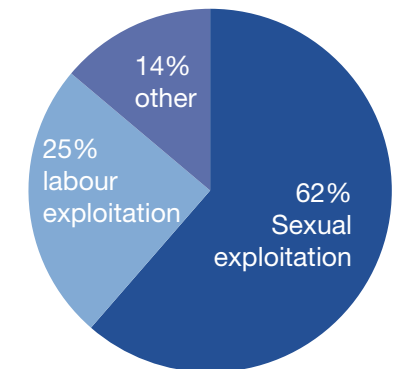
The following is a brief guide for professionals at the interface of police and health authorities to gain some insight into the topic of trafficking in human beings. The main purpose is to raise awareness of THB by providing basic information and some cornerstones of processes involved. Therefore the information given is condensed and not comprehensive.

What is trafficking in human beings?

The crime of human trafficking is a modern form of slavery and a serious violation of human rights. The crime of trafficking in human beings is evident, when the act of recruitment and transfer of a person is taking place by means of force, deception or abuse of vulnerability for the purpose of sexual exploitation, forced labour or other types of exploitation.

ACT	MEANS	PURPOSE	= TRAFFICKING
Recruitment	Force	Sexual exploitation	
Transfer	Deception	Forced labour	
Receipt of persons	Abuse of power or vulnerability	Other types of exploitation	

Data on the prevalence of human trafficking has been assembled in the European Union. In 2010, in the 27 Member States police and specialized social services formally registered 9.528 identified and presumed victims of trafficking (Eurostat 2013). According to conservative estimates by the International Labour Organisation (ILO), the actual number of trafficked persons is much higher, namely 880.000 trafficked persons in the EU and 20.9 million globally (ILO 2012). Distinguishing between different types of trafficking, Eurostat identified 62% of all cases as sexual exploitation, 25% as forced labour, and 14% as other forms of exploitation, including forced begging, selling of children and organ removal. It is expected that the extent of forced labour is strongly underrepresented in these statistics.

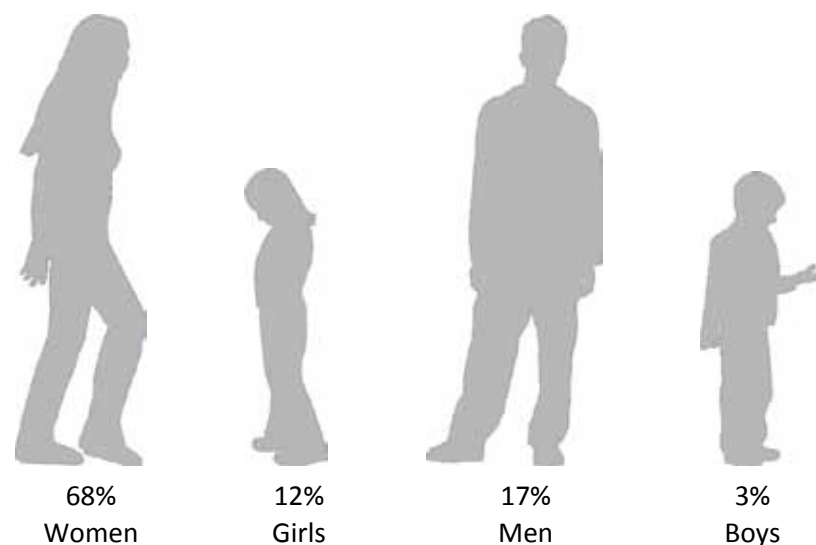


Who are the victims?

According to Eurostat, the great majority, namely 80% of trafficked persons, are females (68% women and 12% girls), and only 20% males (17% men and 3% boys).

61% of all identified and presumed victims in the EU originate from EU countries, while 39% come from non-EU countries. In theory, every Member State can simultaneously be a country of origin and a country of destination of trafficked persons, but in practice many countries tend to be either importers or exporters of trafficked persons. Accordingly, national policies for assisting victims of trafficking tend to focus either on foreigners or on their own citizens. This means that health care providers need to analyse their local situation, as it may differ between countries and larger regions. Some encounter victims, who are still in the phase of exploitation; some are dominated by victims, who have escaped exploitation; whilst elsewhere health professionals may be confronted with patients, who could be regarded as potential victims because of their socio-economic vulnerability.

Source: European Commission 2013



Reasons for police and NGOs to involve health care providers

While the identification and registration of presumed victims of trafficking is up to police authorities and NGOs, health care professionals can play an important role in helping the victim and combatting trafficking:

- Referral of possible cases of trafficking
- Exchange of generalised observations
- Collection of forensic evidence
- Assessment of the ability of victims to testify
- Attention to the health needs of victims and witnesses
- Determination of the degree of vulnerability of the victim and the gravity of the crime

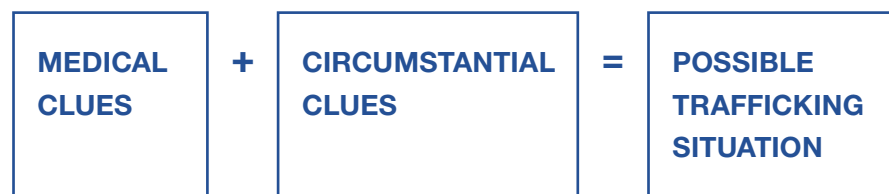
Why should health care providers look out for clues of trafficking?

The main obligation of health care providers is not to investigate crimes but to care for their patients and to ensure their well-being. Given this obligation to care implies that health care providers should be aware of the specific needs of victims of trafficking and to look out for certain clues which may be indicative of a case of trafficking such as:

- specific medical conditions of a patient may be explained by trafficking;
- the trafficking situation may influence the options for medical treatment;
- the option to be referred to further assistance may be the only one the victim has;
- there may be a legal obligation to denounce or report the case (e.g. in the case of minors)
- the collection of data/evidence for a formal investigation may be enhanced.

Spotting clues of trafficking

Health care providers are often under time pressure when attending to their patients as the demand for health services tends to be high and often under time pressure. Linking specific medical clues to circumstantial clues can be a quick and efficient way to inform the medical profession about a potential trafficking victim.



Medical clues of trafficking

There are no unique and clearly defined medical symptoms of trafficking. However, several physical and psychological symptoms are typical and may be caused by physical violence, sexual abuse or poor working and living conditions attributable to trafficking and exploitation.

Some major physical clues are:

- Fatigue, weight loss
- Musculoskeletal symptoms
- Sexual and reproductive health symptoms
- Neurological symptoms
- Gastrointestinal symptoms
- Cardiovascular symptoms
- Eye problems
- Dermatological symptoms
- Substance abuse

Some psychological clues are:

- Trauma symptoms
- Depression symptoms
- Anxiety symptoms
- Hostility symptoms

Circumstantial clues of trafficking

There are also a range of circumstantial clues, which in combination with the above medical symptoms may be indicative of a trafficking situation.

- Migration history
- Coercion and control
- Identity documents, insurance status
- Working conditions
- Living conditions

How to assess a possible trafficking situation

Having spotted first clues of trafficking, one has to be careful in pursuing the case further and assessing a possible trafficking situation. In case of a suspicion:

- Ensure your safety and the safety of the patient
- Ensure privacy of the consultation, try to separate the patient from escort person and mobile phone
- Always link questioning on circumstances with medical indications and the health situation of your patient
- Be supportive and open to anything your patient reports
- Do no harm
- Do not inquire about trafficking-related issues in front of others
- Do not involve the patients' escort in medical consultation

How to deal with a possible trafficking situation

Having found additional clues, which further support your suspicion of a possible trafficking situation, you have several options to take into consideration:

- If medical emergency assistance is required, provide emergency care first
- If possible and upon obtaining the consent of the patient, perform a comprehensive health examination beyond the immediate indication
- If referral is not possible or desired, and compliance with follow-up treatment unlikely, maximize the effect of the single encounter with medical treatment and referral information
- If referral is not possible or desired, but compliance with follow-up exams or treatment likely, provide medical care and prepare for follow-up
- If you are obliged by law to report the incident (e.g. in case of child abuse), refer to the responsible institution
- If referral is possible and desired, select a service provider you can trust and confide in and obtain informed consent of the patient
- If available, seek support from an internal focal point at your institution, or from a local anti-trafficking organisation or use the national referral mechanisms.
- Do not try to rescue your patient without ensuring a safe referral
- Do not refer your patient without informed consent
- Do not make promises you cannot keep

Be prepared for a possible encounter with a potential victim of trafficking

There are many things health care providers should do when preparing for an encounter with a possible trafficking situation:

- Assign persons who are responsible for building up an expertise on trafficking at your health care facility, e.g. link up with violence protection units or develop specialised focal points

- Identify and assess relevant social services who can become potential partners and addressees for referral
- Develop inter-organisational referral arrangements and protocols
- Create and distribute pocket cards with basic information on trafficking to a well-defined group of colleagues and partners

I. Trafficking in human beings:

Understanding
the phenomenon

1.1 Prevalence of trafficking in human beings

Several studies aim at describing the prevalence of trafficking in human beings for international comparisons. For Europe, a recent Eurostat report provides the most reliable data. Reports produced by the United Nations Office on Drugs and Crime (UNODC) and by the International Labour Organisation (ILO) describe the phenomenon on a global scale.

Eurostat data

In its first report at the EU level on statistics on trafficking in human beings, which includes data for 2008, 2009 and 2010, Eurostat reported a total number of 9.528 identified and presumed victims in the 27 EU Member States in 2010 (Eurostat 2013: 10).

These data contain victims who have been registered either through formal identification by the relevant authority in Member States, or by a registering organization without following formal procedures for identification but on the informed presumption that it is a trafficked person (Eurostat 2013: 22). Registering organizations which delivered data to Eurostat were above all the police (19 countries), NGOs (9 countries) and other sources (10 countries), e.g. social services, international organisations, prosecutors or local authorities. Not one of the registering organizations was from the health sector. Even though Eurostat's questionnaires provided a consistent terminology and well defined sets of indicators, the availability of data depended much on

legal definitions of trafficking in the respective countries, on selected indicators used in the respective countries and on specific practices of documentation typical for the Member States and the respective registering organizations. Therefore, the Eurostat-data can only show the way and provide a rough orientation on levels and composition of THB; they should therefore be interpreted with caution.

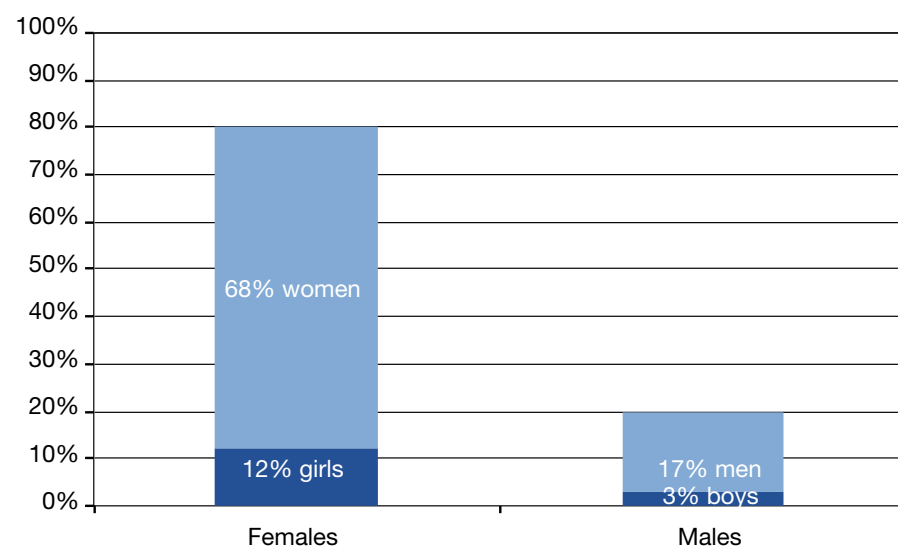
Example: Confined construction workers

Four construction workers, who originated from Balkan countries, were rescued by the police from an apartment in Vienna. The 'landlord', who kept them confined, also acted as their job adviser and brought them to different construction sites in the area. Since the workers did not testify, police could not prosecute the crime of trafficking. Instead, the 'landlord' was charged with unlawful detention, exploitation of foreigners and welfare fraud.

Source: Zingerle & Alionis 2013: 24t

Figure 1: Identified and presumed victims by gender and age group (2008-2010)

Source: Eurostat 2013: 10, own calculations and graph.

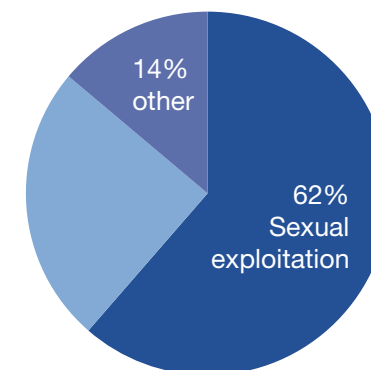


Of all registered victims in 2008-2010 (Figure 1), 80% were females and 20% males. Disaggregating these data by age show that minors (younger than 18) account for 15%, while adults account for 85% of the total number of victims of trafficking in human beings.

Distinguishing different forms of exploitation (Figure 2), the vast majority (62%) of the registered victims have been trafficked for the purpose of sexual exploitation, 25% for labour exploitation (including domestic servitude) and 14% for other purposes (forced begging, criminal activities, removal of organs, and selling of children).

Figure 2: Different forms of exploitation (2008-2010)

Source: Eurostat 2013: 10, own calculations and graph.



Further analysis clearly indicates that gender specific vulnerability prevails for different forms of exploitation (Figure 3). 96% of the victims of sexual exploitation are females (4% males), while the majority (77%) of the victims of labour exploitation are males (23% females). The gender difference for other forms of exploitation is less extreme. 62% of this group are females and 38% males.

Focusing on the origin of identified and presumed victims (Figure 4), in 2010, a clear majority (61%) of the registered victims originated from an EU-MS and were trafficked between EU Member States, while 39% came from non-EU countries.

Figure 3: Gender shares by form of exploitation (2010)

Source: Eurostat 2013: 10, own calculations and graph.

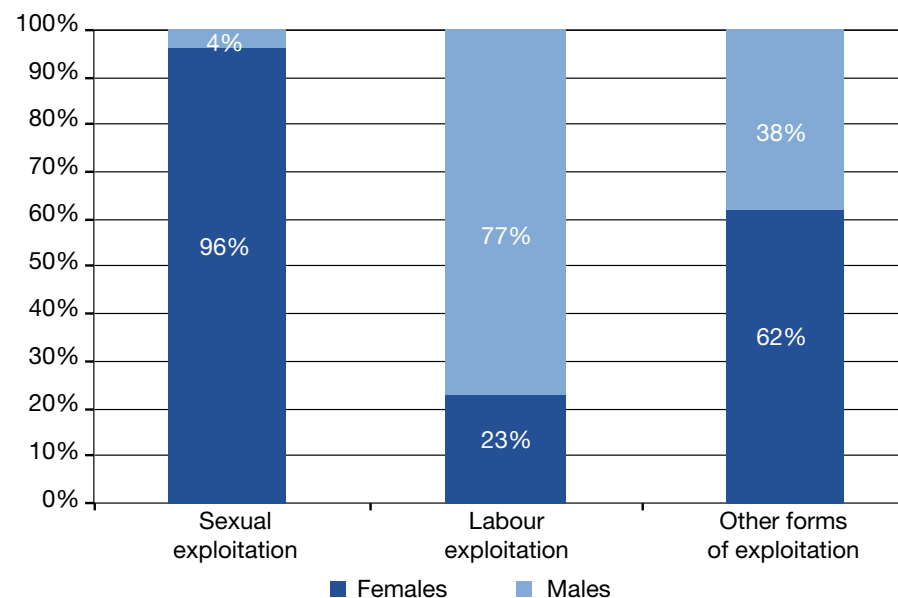
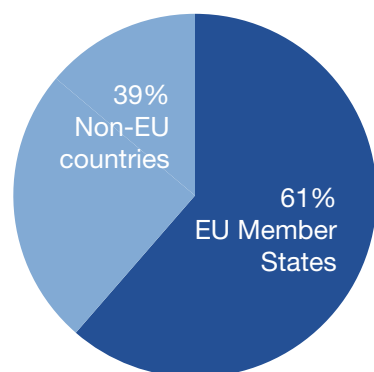


Figure 4: Origin of identified and presumed victims (2010)

Source: Eurostat 2013: 10, own calculations and graph



There can be two different reasons why victims hold the citizenship of the registering country. Either they are victims of domestic trafficking in their home country or they are migrants who were registered as trafficked persons only after having returned to their home country. Remarkably, 5 EU Member States (Bulgaria, Hungary, Lithuania,

Romania, Slovakia) documented and reported only identified and presumed victims with the same citizenship as the registering country, while 5 EU Member States (Belgium, Cyprus, Denmark, Greece, Malta) only documented victims with a citizenship other than the registering country, while 12 countries documented victims with either citizenship, the one of the reporting country and of a third country, with widely differing proportions (Figure 5). For EU Member States missing in this list data are not available (Eurostat 2013: 53). These data make clear that trafficking in human beings has very distinct manifestations in different countries, and that some organizations and countries only register selected aspects of the phenomenon. Such a practice of documentation also carries the danger of a biased perspective, perceiving trafficking in human beings as a problem either exclusively of foreigners, or of one's own citizens.

UNODC data

In its Global Report on Trafficking in Persons 2012, the United Nations Office on Drugs and Crime (UNODC) followed the definitions for trafficking in human beings made by the Palermo protocol. Unfortunately, the report does not give absolute numbers for the global level, but mainly presents ratios to describe trafficking patterns. For 2009, it found that 76% of all detected victims have been females (59% women and 17% girls) and 24% males (14% men and 10% boys). Distinguishing between different forms of exploitation in 2010, 58% of all detected victims have been trafficked for the purpose of sexual exploitation, 36% for the labour exploitation and 6% for other forms of exploitation (UNODC 2012: 10, 36).

ILO data

Other attempts to fathom the extent and prevalence of trafficking on a global scale were made by the International Labour Organisation (ILO) in its Global Estimate of Forced Labour (2012a). Based on its own

Initiatives for international data collection:

- Guidelines for the collection of data on trafficking in human beings, including comparable indicators (IOM & BM.I 2009)
- Anti-Trafficking Data Collection and Information Management in the European Union – a Handbook (ICMPD 2009)
- Operational indicators for trafficking in human beings (ILO & EC 2009)

National data in international reports:

- Trafficking in human beings 2013 edition (Eurostat 2013)
- Global report on trafficking in persons (UNODC 2012)

definitions and categories, which are similar but not fully equivalent with those of the Palermo protocol, ILO estimates that on average 20.9 Mio people have been in forced labour at any given point of time in the period of 2002-2011.

Examining the distribution of forced labour by world region (Figure 6), Asia & the Pacific account for 56% of the global total, Africa for 18%, Latin America and the Caribbean for 9%, Central & South-Eastern Europe (non-EU) together with CIS countries for 7% and the Middle East for 3% (ILO 2012a: 13, 16). The ILO regards these estimates as conservative, since they are based on open source information on reported cases of forced labour.

Based on the same data, the ILO also estimated the absolute number of 880.000 forced labourers in European Union Member States, which accounts for 4% of the global total. Statistically, this equals about 1.8 trafficked persons per 1.000 inhabitants. Out of the total number for the EU, 30% are estimated to be victims of forced sexual exploitation, and 70% are victims of forced labour exploitation (ILO 2012b).

Figure 5: Share of total identified and presumed victims holding the same citizenship as the registering country (2010)

Source: Eurostat 2013: 31 + 53, own calculation and graph

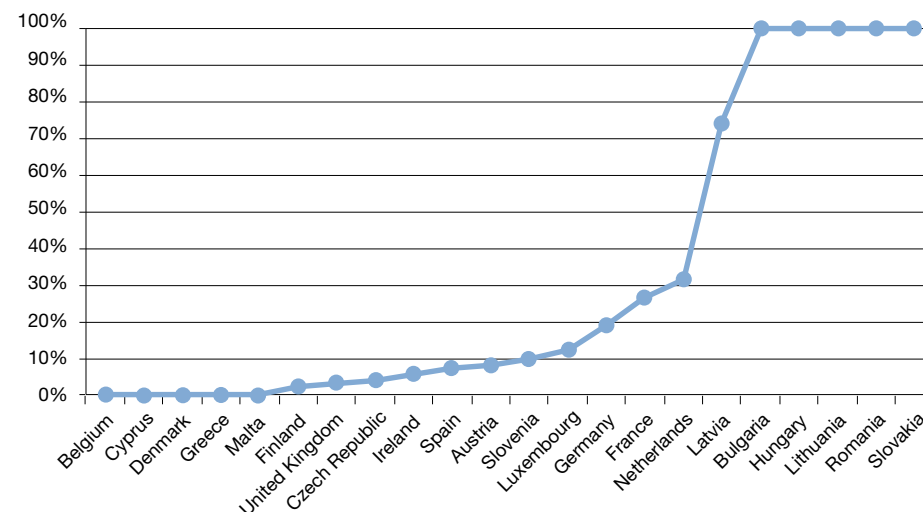
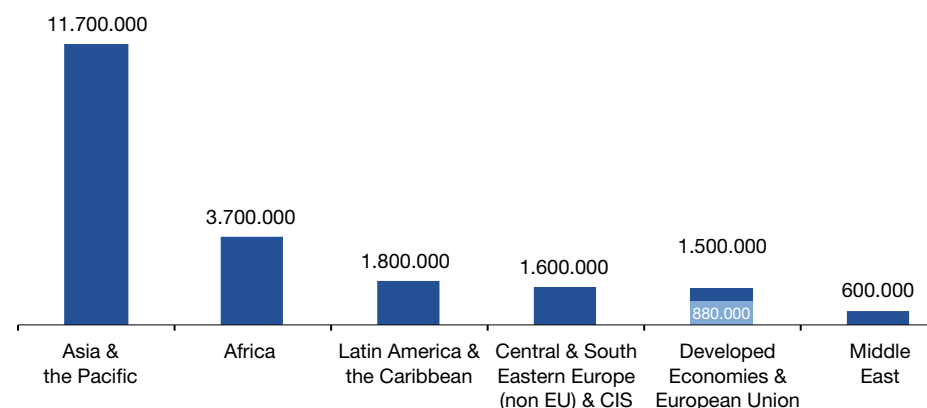


Figure 6: Estimate of forced labour by world region

Source: ILO 2012, own calculation and graph

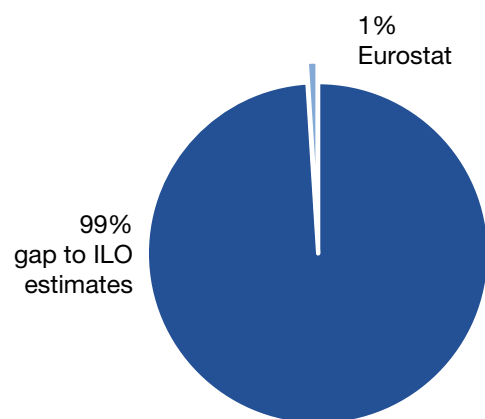


Discussion

The gap between Eurostat data and ILO estimates of the prevalence of trafficking in human beings must not come as a surprise (Figure 7). Eurostat only counts officially registered cases of THB in the EU while the ILO estimates – on the basis of reported cases – a global figure of reported plus unreported cases (see Belser, De Cock, & Mehran 2005). Accordingly, Eurostat data only provides information about the tip of the iceberg, about 1% (9.528) of the entire 880.000 cases estimated by ILO. In spite of critique the European Commission is not endeavouring to estimate the extent of underreporting but is instead referring to the ILO for estimates of the larger picture (e.g. European Commission 2012, 2013).

Figure 7: Gap between Eurostat data and ILO estimates on the prevalence of trafficking in human beings

Source: ILO 2012b and Eurostat 2013, own calculations and graph

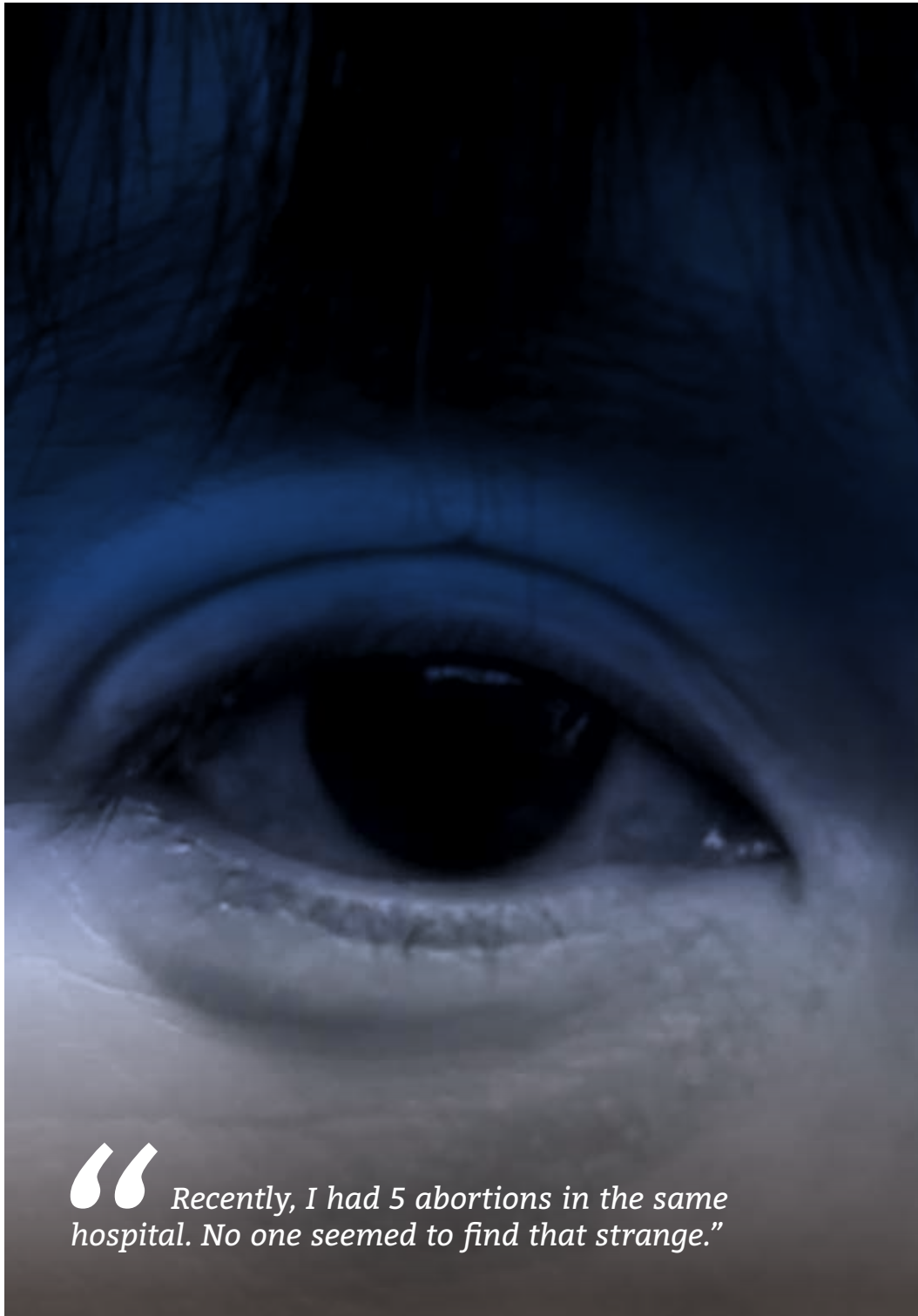


It is only in the last decade that trafficking in human beings has become a major topic in the international political arena (United Nations, European Council, OSCE, European Union), which resulted in various international agreements, directives and policy documents. It took some time to transfer the content of these documents into national legislation, to build up the necessary institutional infrastructure to combat

trafficking in human beings and to assist victims, and – subsequently – to develop reporting mechanisms for registering identified and presumed victims. In many countries, these structures are very young or still in the making, and not yet fully developed.

As a result there do not only exist different degrees of awareness of the phenomenon of trafficking in human beings, but also different (national and organizational) interpretations of the international regulations. Some focus only on certain categories of victims (e.g. females, foreigners) or certain forms of exploitation (e.g. sexual exploitation). Additionally, the ways of reporting may differ between countries, which complicate international comparisons and cooperation.

Difficulties in measuring the phenomenon on an international or global scale arise from different legal definitions and different priorities in law enforcement (e.g. giving a lower priority to labour exploitation as compared to sexual exploitation). These differences may result in under-reporting of certain forms of exploitation and in a large unknown number of the crime of trafficking in human beings, comparable to identifying only the tip of an iceberg. Accordingly, the identification of victims and the collection of sound statistical data for international comparisons are among the most pressing issues in the fight against THB.



“Recently, I had 5 abortions in the same hospital. No one seemed to find that strange.”

1.2 Definitions on trafficking in human beings

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)

This definition was first introduced by the United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons (also called the Palermo Protocol) (2000), and subsequently used in adapted form for similar documents of other international bodies, e.g. for the Framework Decision on Combating Trafficking in Human Beings by the European Union (2002), for the OSCE Action Plan to Combat Trafficking in Human Beings (2003) or for the Convention on Action against Trafficking in Human Beings by the Council of Europe (2005).

Figure 8: Three elements of trafficking: act, means, purpose

Source: own graph, inspired by www.unodc.org/unodc/en/human-trafficking/what-is-human-trafficking.html

ACT	MEANS	PURPOSE	= TRAFFICKING
Recruitment	Threat or use of force	Sexual exploitation (incl. prostitution)	
Transfer	Coercion	Forced labour (incl. servitude, slavery, etc.)	
Harbouring	Abduction	Other types of exploitation (incl. removal of organs)	
	Fraud		
	Deception		
	Abuse of power or vulnerability		
Receipt of persons	Giving/ receiving payments/ benenfits		

Apart of their origin, the common feature of these documents lies in the fact that they integrate the act, the means and the purpose in the definition of the crime of trafficking. Only if all three come together, the crime of trafficking in human beings is realised (Figure 8). The exception of this rule is the case of trafficked children. Here it is enough to combine the act and the purpose to realize the crime of trafficking.

The act (What is done)

Following the definitions of the UN Protocol mentioned above, recruitment, transportation, transfer, harbouring or receipt of persons, all these are acts of trafficking. These acts can also be used to distinguish different roles of perpetrators in the trafficking networks, e.g. recruiters, transporters, harbourers and receivers (e.g. IOM 2009: 53f).

Remarkably, these definitions do not just comprise direct acts of transport, but they also comprise the reception (which also implies the exploitation) of persons who have been trafficked. International documents, frameworks and treaties therefore ask national legislators to criminalise and sanction not only acts of traffickers, but also those who make use of services of victims of THB.

The means (How it is done)

The UN Protocol provides a long list of means which are used by perpetrators to control trafficked persons: the threat or use of force, coercion, abduction, fraud, deception, the abuse of power or of vulnerability, and the giving or receiving of payments or benefits to achieve the consent of somebody having control over another person.

Because of the nature of the text, the terms used are rather abstract and focused on legally relevant elements of the offence. There exist several attempts to further specify these means and to generate comprehensive lists of indicators of trafficking (e.g. IOM & BM.I 2009; ICMPD 2009, ILO & EC 2009), but as of yet none of these lists of indicators has been turned into a generally accepted standard.

Table 1: Types of exploitation

Source: Eurostat 2013: 24

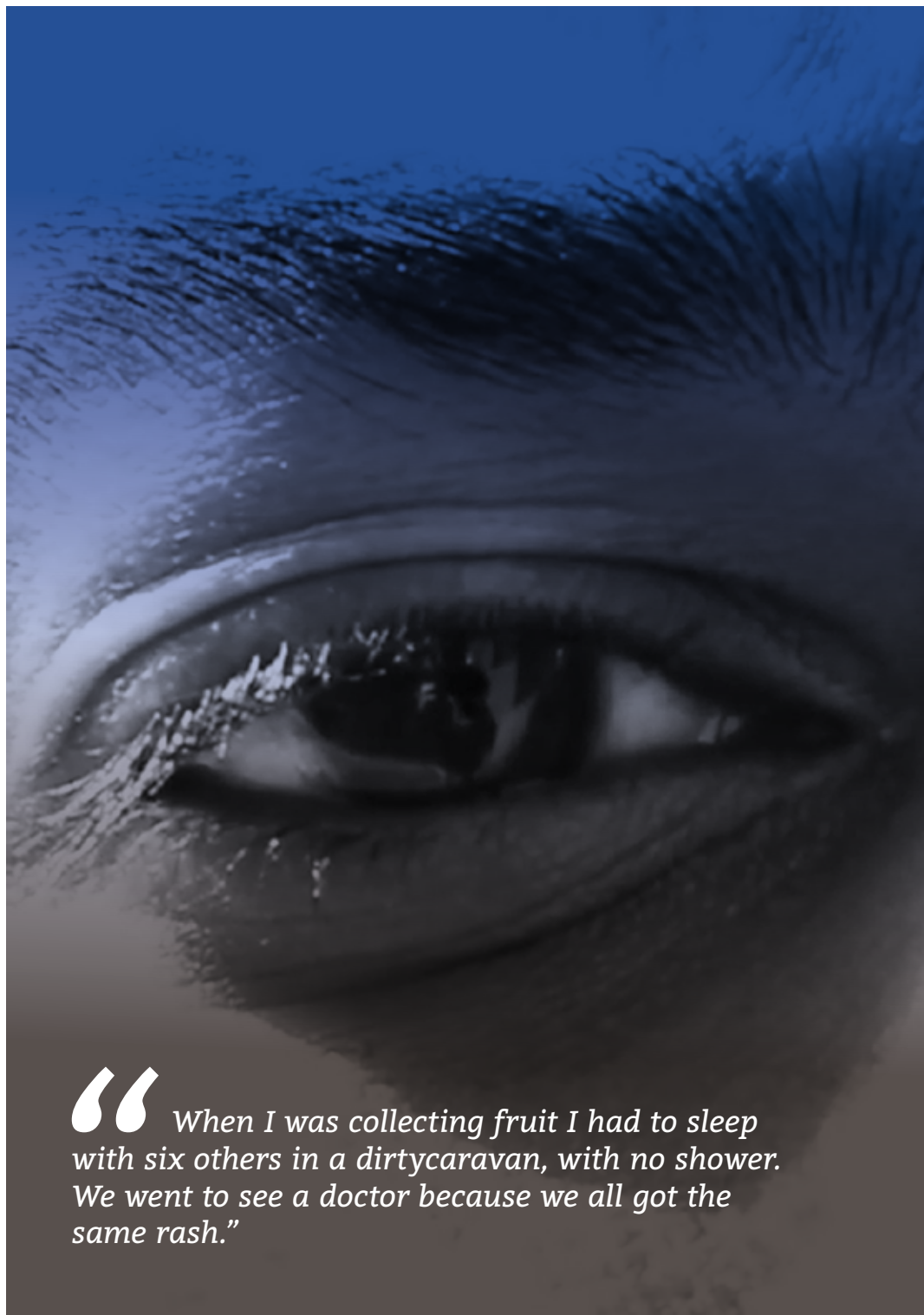
Types of exploitation	Environments where exploitation can take place
Sexual exploitation	Street prostitution Window prostitution Private flats Brothels Strip clubs/bars Pornography production companies Escort services Massage parlours Modelling agencies Hotels Private clubs
Labour exploitation Forced labour Domestic servitude	Factories Agriculture Plants Construction Tourism In-house factories Nursing Mines Fishing vessels Logging industry Service sector (hotels, restaurants, cafés)
Other exploitation Forced begging or use for begging Criminal activities Removal of organs Forced marriage or forced adoption	

The variations between different sets of indicators may be due to different purposes they serve, e.g. law enforcement vs. legal prosecution vs. generating sound statistical data. They may for example focus on describing the process of trafficking in all sequential steps in all (prosecutable) detail to understand the crime as such, but with lesser interest on the effects of the crime on the trafficked person. This handbook aims at filling the gap by dealing in more detail with different means of trafficking and their respective consequences for the victim later in this text, in chapter 3.2.

The purpose (Why it is done)

The purpose of trafficking, defined by the type of exploitation, is used as the main indicator to distinguish different types of trafficking. The wide range of types mentioned in policy documents can be a little confusing, especially since these different types do not all have the same quantitative relevance. Therefore we follow the hands-on approach of Eurostat, which distinguishes between three main categories of exploitation (Table 1) and assigns more detailed types to these three categories.

For some of these types one may also add the environment, where the specific forms of exploitation tend to take place. This is especially interesting for labour exploitation, since there are some industries, which are especially attractive for traffickers.



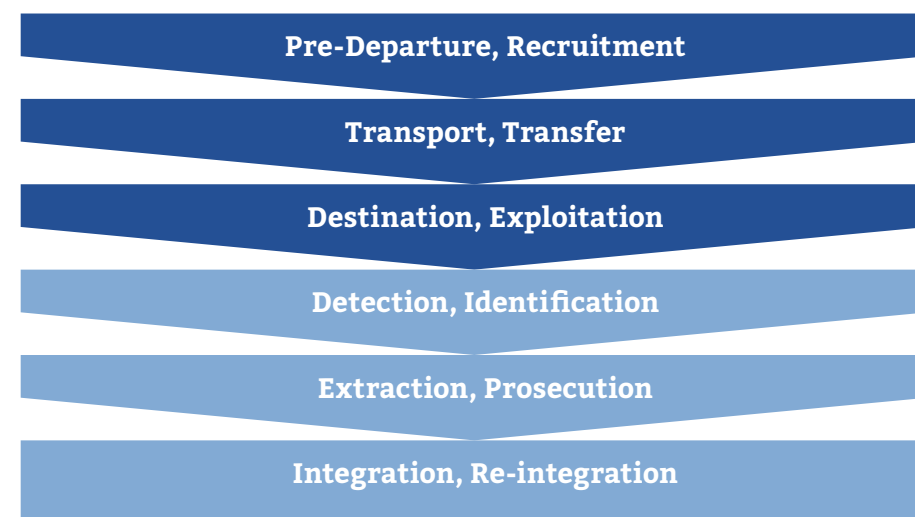
“ When I was collecting fruit I had to sleep with six others in a dirty caravan, with no shower. We went to see a doctor because we all got the same rash.”

1.3 Different phases in the process of trafficking and counter-trafficking

While the definitions on acts, means and purposes of trafficking mentioned above are of eminent legal importance, for practical reasons it can be helpful to distinguish different stages in the process of trafficking: recruitment, transit, and exploitation at the place of destination. Payoke expanded this concept by adding three steps which are crucial for the fight against THB and for protecting the victims: Identification, extraction/prosecution and re-integration (Payoke 2010: 33ff.).

Figure 9: Phases of trafficking and counter-trafficking

Source: Payoke 2010: 33



Pre-departure, recruitment

In the pre-departure phase, the recruiter contacts the victim and tries to build up trust (through lies and false promises about opportunities for jobs, education or marriage) or to build up pressure (through coercive tactics, threats or abduction). Recruiters can be community members, friends or neighbours, sometimes even the boyfriends or parents of the victim. Recruitment can also take place via agencies for employment, travel, educational exchange, or modelling. Often recruiters are only intermediaries in a trafficking ring.

Transport, transfer

At the next stage, victims are transported to their destination and transferred to other intermediaries or to their final exploiters. This stage is often accompanied by a withdrawal of documents from the victim. Accomplices in this transport and transfer process can be the owners of accommodations or of transport facilities.

Destination, exploitation

Arriving at the final destination, the planned form of exploitation is fully unfolded. Victims are forced to work to pay off their 'debts', charged by the perpetrator for transportation, accommodation, food, and documents. Often, they find themselves in deplorable living conditions and are cut off from their family or other social contacts outside the network of trafficking. They are kept short of money and other resources, and kept in a vulnerable situation, so that they are convinced to have no other choice than to follow the instructions of the traffickers.

Detection, identification

In the fortunate event that the victim is detected, it may be the border

Example: Trafficking as a multinational crime

Citizens from Azerbaijan have been exploited at tobacco fields in Poland for a very long time. Using tourist visa they had been flown to Italy and were subsequently transferred via Austria to Poland. They never received any payment for their work. The case was detected by border control officers, who treated the victims as perpetrators. Only after the OSCE intervened was their status as victims of trafficking recognized.

Source: Cyrus 2011

control en route, when crossing borders or the police, who may detect them in locations where they are forced to work. In other cases, potential victims are detected by social or medical services, often incidentally when doing their normal work. It is crucial to distinguish between the (sometimes random) detection of potential victims, and the formal identification of victims in administrative acts. The formal identification of a victim assigns a specific status to the individual, which also has specific consequences, e.g. the withdrawal of the victim from its exploitative current situation. In contrast, the detection of potential victims does not necessarily carry these consequences as the pulling out of the potential victim from its situation affords the consent of the victim, at least in the case of adults. This means that the move from detection to actual formal identification has to be the victim's free will. Often, for various reasons, victims will refuse to take this step, however.

Extraction, prosecution

The next, necessary step is the actual extraction of victims from the environment of their exploitation. In the best case scenario, the victims are referred to competent programs or facilities for shelter and assistance. In less fortunate cases, victims may also face arrest and deportation, depending on the availability of facilities and on the competence of the referring party. Extraction from the environment

of exploitation as well as the quality of victims support structures will determine the willingness of victims to cooperate in the judicial process to prosecute the traffickers.

Integration, re-integration

The withdrawal from the environment of exploitation makes it necessary for a victim to find a new, different place in society, which is distinct from the former environment. Since trafficking is often linked to migration, a victim may seek integration in the country/place of destination – or rather exploitation – or wish to return to the country/place of origin and seek re-integration there. The chosen option carries in the one or other case different implications. In either case, the process of integration or re-integration is difficult and requires strong and diverse support mechanisms in the country of integration.

Encountering victims during the process of trafficking and counter-trafficking

In principle, every country can be a country of origin, of transit and of destination in the process of trafficking and counter trafficking. Therefore, in every country one could encounter trafficked persons in every stage of the process, both foreigners and own nationals in different stages of trafficking. In practice the proportions of foreigners and of own nationals among all trafficked persons tend to be unevenly distributed in most countries. Due to different socio-economic situations, wealthier countries tend to be countries of destination of trafficked persons from poorer foreign countries, while poorer countries tend to show higher proportions of own nationals among all trafficked persons. This may lead public authorities to focus only on selected target groups, while turning a blind eye on other groups. At least Eurostat data suggest this conclusion (see Figure 4).

From the perspective of law enforcement, it is possible to identify victims before, during and after exploitation takes place (OSCE 2011). Most commonly the identification during exploitation will take place in countries of destination, while the identification before and after exploitation will take place in countries of origin. Especially in the recruitment phase, it may be possible for front-line police officers to identify potential victims (who are at risk of being trafficked) among members of vulnerable groups (e.g. people with very low income, low education, with debts or with disabilities), if clues of attempted recruitment can be spotted. Police may also detect individuals, who have escaped or been released from an exploitative situation, especially among migrants who return home and who are in a difficult economic, emotional and health situation. These presumed victims can be referred to the appropriate services, which can assist them in their recovery and prevent them from being re-trafficked.

The exploitation phase and the post-exploitation phase are the stages in the trafficking process, which are probably the most relevant for health care providers.

II.

The role of health care providers in caring for trafficked persons

2.1

The relevance of health care in international legislation and policy documents

International legislation

We see a plethora of international conventions, regulations and treaties, which ban forced labour, slavery and the sexual or economic exploitation of human beings, all of which are crimes closely related to trafficking in human beings. Many of these documents also deal with health aspects of these crimes.

To provide some insight, one may begin with the Convention Concerning Forced or Compulsory Labour issued by the International Labour Organization (ILO, then a subunit of the League of Nations, today of the United Nations) in 1930, followed by the Universal Declaration of Human Rights in 1948, and again by the Convention on the Rights of the Child which has been adopted by the General Assembly of the United Nations in 1989.

In recent decades, flowing from increased globalisation and transnational mobility, the topic received new attention culminating in the adoption of the Protocol to Prevent, Suppress and Punish Trafficking in Persons (also referred to as the Palermo Protocol) by the United Nations in 2000. Even though this protocol was only a supplement to the UN convention against transnational organised crime, and therefore mainly dealing with measurements of criminal investigation and prosecution, it established the protection of victims

Health care in international legislation

- Protocol to Prevent, Suppress and Punish Trafficking in Persons (UN 2000)
- OSCE Action Plan to Combat Trafficking in Human Beings (2003)
- Council of Europe Convention on Action against Trafficking in Human Beings (2005)
- Directive 2011/36/EU on preventing and combating trafficking in human beings and protecting its victims

Health care in policy documents

- Recommended Principles and Guidelines on Human Rights and Human Trafficking (OHCHR 2002)
- EU Strategy towards the Eradication of Trafficking in Human Beings (EC 2012)
- Budapest Declaration on Public Health & Trafficking in Human Beings (IOM 2003)

Source: inspired by Márquez Sánchez 2013

as one of its cornerstones, paying particular attention to women and children, and explicitly requesting the signatory states to provide medical and psychological assistance to victims of trafficking.

In 2005, the Council of Europe Convention on Action against Trafficking in Human Beings also stipulated that each signatory state assist victims of trafficking in their physical, psychological and social recovery; the minimum requirements are access to emergency medical treatment (for irregular migrants) and other necessary medical treatment of all victims lawfully residing in the territory.

Similarly, the Directive 2011/36/EU on preventing and combating trafficking in human beings and protecting its victims adopts a holistic and human rights based approach in the fight against trafficking in human beings. This document addresses various health aspects connected to trafficking. It puts a focus on the health status of the victim, e.g. by introducing it as a criterion to establish the vulnerability of

the victim and to assess the gravity of the crime. Further, the document requests the individual needs of victims to be taken into account during criminal investigations and proceedings, as well as the provision of assistance (e.g. medical treatment), if needed, after the completion of criminal proceedings. Assistance and support measures (including medical treatment) have to apply a gender perspective and follow a child rights approach; before providing assistance the consent of the victim should be obtained on an informed basis. By explicitly naming health care personnel, the directive expects public authorities to provide adequate education and training for personnel likely to come in contact with victims of trafficking.

Other policy instruments

In addition to formal legislation a wide range of policy documents addresses the issue of health service provision for victims of trafficking. In what follows we present some prominent examples:

The Office of the High Commissioner for Human Rights presented Recommended Principles and Guidelines on Human Rights and Human

GRETA country reports

As part of the monitoring of the implementation of the European Convention on Action against Trafficking in Human Beings, a Group of Experts on Action against Trafficking in Human Beings (GRETA) has been established. They produce country reports on every signatory state of the convention. These reports assess the legal framework and the institutional arrangements for combating trafficking. They are a valuable source of information about the various ways chosen by the signatory states to achieve the objectives of the convention.

Source: www.coe.int/t/dghl/monitoring/trafficking/Docs/Monitoring/Country_Reports_en.asp

Trafficking (OHCHR 2002) to the United Nations Economic and Social Council. The paper called for the provision of adequate physical and psychological care to trafficked persons without making it conditional upon their consent to cooperate and help with legal proceedings against the perpetrators. In addition, access to primary health care and counselling should be provided in partnership with non-governmental organisations without mandatory testing for diseases.

The EU Strategy towards the Eradication of Trafficking in Human Beings, which was issued by the European Commission in 2012, also attributes an important role to the health care sector in a multi-disciplinary policy against trafficking; it emphasizes the need for cooperation between different institutions and for improving the information of victims about their rights to assistance and health care.

The participants of the Regional Conference on Public Health & Trafficking in Human Beings in Central, Eastern and Southeast Europe agreed upon the Budapest Declaration on Public Health & Trafficking in Human Beings (IOM 2003). The declaration asked for comprehensive and sustainable gender, age and culturally appropriate health care for victims of trafficking. It raised awareness for the need to distinguish between the different health priorities in the various stages of the trafficking and counter-trafficking process. In the initial rescue phase, the focus is on basic health care, crisis intervention and treatment for injury and trauma, quite in contrast to the rehabilitation phase where the focus of health care is on the long term needs and the reintegration of the victim.

2.2 Health care institutions in the context of national referral mechanisms

Following OSCE & ODIHR (2004: 15) a “National Referral Mechanism (NRM) is a cooperative framework through which state actors fulfil their obligations to protect and promote the human rights of trafficked persons, coordinating their efforts in a strategic partnership with civil society.” The main aim of a national referral mechanism is to establish an effective network of services where presumed and identified victims can be referred to for specific and targeted support. Another and equally important aim of a national referral mechanism is the improvement of national policies and regulations on victim related issues and the coordination of actions and policies between different institutions, agencies and civil society organisations.

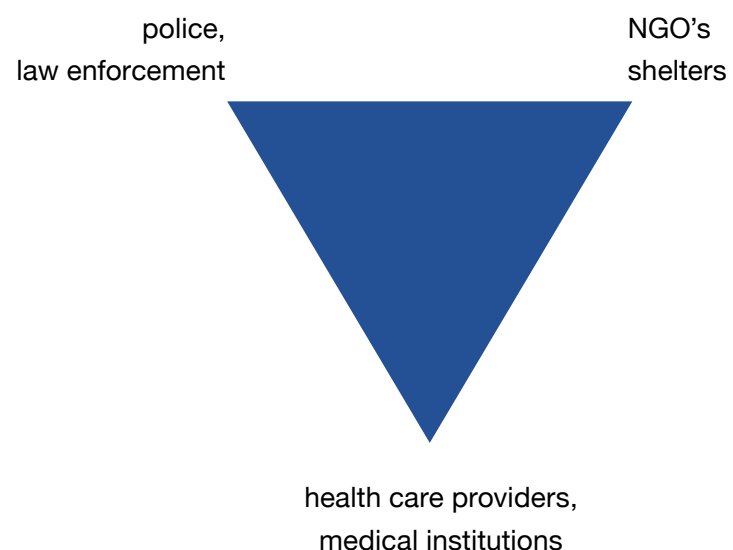
The (further) development of national and international referral mechanisms is also among the top priorities of the EU Strategy towards the Eradication of Trafficking in Human Beings (EC 2012). One can build on the foundations of national referral mechanisms laid down in the OSCE Action Plan to Combat Trafficking in Human Beings, which was adopted by the Permanent Council of the Organization for Security and Cooperation in Europe (OSCE) in 2003. In the same vein the European Convention on Actions against Trafficking in Human Beings (Council of Europe 2005) aims at establishing specialised authorities or entities within authorities and coordinating bodies.

The objectives of the various institutions involved in national referral mechanisms may differ; while the OSCE Action Plan put specific emphasis on the co-operation between the police and non-governmental organisations (NGOs), others focus on the integration and cooperation between social protection units and medical institutions. The OSCE Action Plan suggested that first-hand medical and psychological assistance for trafficked persons should be provided in shelters which are often run by NGOs, rather than by medical institutions which are separate but part of a referral system between various independent institutions.

Maybe the preference given to a specific organisational model in an important policy document is one reason why many countries tend to exclude medical institutions from their national referral mechanisms.

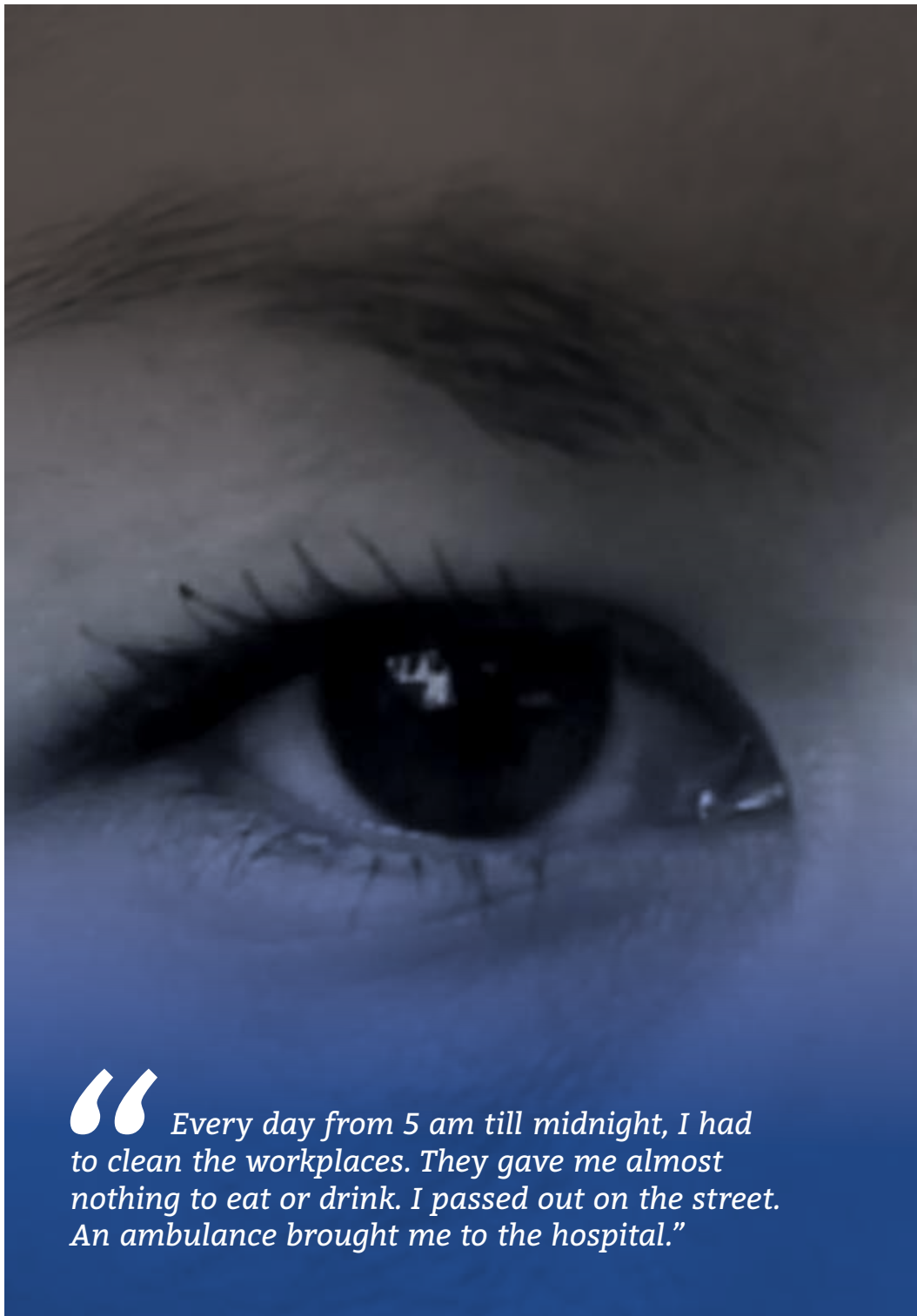
Figure 10: Distinguishing between professional orientations and duties

Source: own graph



Before endeavouring to promote a stronger involvement of the health care sector in counter-trafficking activities and in national referral mechanisms, it is advisable to examine the priorities of the major institutions involved in the process, i.e., police authorities, specialised NGO's and the medical field. Only on the basis of a mutual understanding of the specific role of the professions involved and their legal and ethical bindings, will one be able to integrate and coordinate their actions fruitfully. Understanding and respecting distinct professional rationales, prerogatives and institutional requirements will form the basis for mutual trust and allow finding ways for effective trans-disciplinary and cross-institutional collaboration.

In contrast to members of specialised law enforcement units, who actively search for victims of trafficking, and in contrast to employees of victim support services, who are dealing with victims of trafficking on a daily basis, health care professionals may only occasionally come across victims of trafficking. In most cases where health care providers are contacted by victims of trafficking the main purpose is the need for treatment of a health problem. Often the victim is not alone but accompanied by the trafficker whose objective is to camouflage any exploitation rather than help with identification. Even though, health care providers may often be the first, sometimes even the only opportunity for trafficked persons to contact somebody outside the network of trafficking and the exploiter. Therefore, health care providers may play a crucial role in providing assistance, guidance and protection for a presumed victim of trafficking.



“ Every day from 5 am till midnight, I had to clean the workplaces. They gave me almost nothing to eat or drink. I passed out on the street. An ambulance brought me to the hospital.”

2.3 Police and NGOs: formal registration of identified and presumed victims

As mentioned before, Eurostat statistics only document trafficked persons, who have been formally registered by the relevant state authorities and/or by specialised institutions: the police, specialised social services and NGO's. So far, health care institutions do not formally register trafficked persons. This is important to know, as the identification of victims of trafficking in human beings is often regarded as one of the most important challenges in combating the crime while at the same time caring for the victims.

A prerequisite for the analysis of this challenge is an understanding of the definitions and current practices of formal victim registration.

“The police seem to be the dedicated authority for formally identifying persons as a victim of trafficking in human beings in most Member States.” (Eurostat 2013: 30)

“Data on ‘identified’ victims will most likely come from the police. Data on ‘presumed’ victims of trafficking in human beings may be available from national rapporteurs (or equivalent mechanisms which tend to act as national coordination bodies), victim assistance services, immigration services, labour inspections and border guards.” (Eurostat 2013: 23)

Example: Using differing documents for health care

In recent years, the out-patient clinic for people without insurance, Amber-Med in Vienna, has been visited by Chinese patients using differing identification documents. This came to the fore as a patient attracted attention who had a rare disease and handed in a different identification card when returning for treatment. Staff members of the clinic assume that exploiters of Chinese workers retain identity documents on a regular basis and hand over false documents, if visits to the doctor are inevitable.

Source: Zingerle & Alionis 2013: 25

The formal identification of victims is not only complicated because of the complexity of the crime, but also because of the complexity of the required administrative procedures. Formal identification in the sense of Eurostat can only be done by the dedicated state authority, in most cases of EU Member States by the police. In practice, the formal identification is done by experts of specialised counter-trafficking units, which may base their decision on the preliminary identification of non-specialised field officers. Formal identification requires the collection of data, which have to be documented in a formalised way (e.g. in a template) and interpreted according to the legal definition of trafficking in the respective national legislation. Sometimes only trained professionals are entitled to perform interviews with trafficked persons, to ensure that the expert has the sensitivity to deal with (sometimes traumatised) victims and the scrutiny to document the necessary details. As a result of the formal identification, the status of a victim of trafficking is formally assigned and documented. This is a prerequisite for other formal decisions, e.g. for a procedural identification of a victim during a justice process as a witness or injured party, or for a juridical identification by court decision in the context of possible compensation claims of the victim (OSCE 2011: 47).

Law enforcement entities tend to act closer to legal definitions, bearing in mind their obligation to prosecute perpetrators. This implies a narrower scope for identifying trafficked persons. On the other hand the

practice of NGOs or other victim support services tends to be based on the trafficking situation and on the wish to assist presumed victims (OSCE 2011: 16). NGOs tend to apply looser criteria for 'presumed victims' with a broader scope for the registration of trafficked persons, and a less formalised entitlement for taking action. The registration of a presumed victim can, for example, be a prerequisite for the person to enter a shelter of an NGO or to access a recovery and reflection period. To access the services does not oblige the presumed victim to be formally or legally identified as a trafficked person.

Both the formal registration of 'identified victims' by the police and the registration of 'presumed victims' by NGOs or social services have in common the need for formal registration in order to establish a case for criminal prosecution or for victim support.

Reasons for police and NGOs to involve health care providers

As police and NGOs are entitled as well as obliged to identify and formally register identified and presumed victims, the support of health care providers may be crucial for addressing all issues relevant for identification. The low number of formally identified and registered victims maybe an indication of the need for inclusion of the medical and health services in the identification process, as the health situation is a major indicator of the crime. Given that health care professionals are often the first, sometimes even the only, contact of trafficked persons

Reasons for police and NGOs to involve health care providers

- Referral of possible cases of trafficking
- Exchange of generalised observations
- Collecting forensic evidence
- Assessing ability to testify and caring for health needs of witnesses
- Determining vulnerability of the victim and gravity of the crime

to public services, the health care sector could play an important role in detecting the crime. Properly administered, the referral of presumed cases of trafficking to shelters and special police units could be an important service to the presumed victims.

Health professionals can also provide invaluable support in criminal proceedings by sharing circumstantial, anonymised information with the police. Properly trained health care professionals can spot clues of trafficking and inform specialised police. In addition, they can address their own feelings and threats they receive, aimed at keeping them from reporting presumed cases of trafficking; this information may be an important input in threat analyses of special police units.

In addition, the services of the medical profession may be needed to investigate the crime, e.g. by providing forensic evidence, thereby helping with judicial proceedings. If involved in the identification of presumed victims from the very beginning, the collection of forensic evidence may be part of standard proceedings. For this to happen it should be clear to the medical profession that it is crucial for successful prosecution to establish a clear link between the health condition and the crime of trafficking. Therefore an early involvement of health professionals in the proceedings may be the key to success of judicial proceedings.

In the course of criminal investigations and court proceedings the active participation of victims as witnesses is often necessary. To this end, medical advice to police, e.g. as to the ability of the presumed victim to testify as witness, may be just as important as the medical support of the presumed victim during this often traumatic phase of proceedings. The help of health professionals is also needed to establish the health condition of a victim prior to trafficking and as a result of trafficking. It informs about the gravity of the health damage as a result of trafficking which in turn is decisive for the penalty imposed on the perpetrators.

2.4 Health care providers: dealing with clues of trafficking

In contrast to other actors (e.g. police and NGOs), health care providers have no immediate obligation to register presumed trafficked persons. Their medical treatment and their obligation to help is given without a need of documentation. They can help their patients without having to label them as ‘identified victim’ or ‘presumed victim’. Up to now, the formal registration of victims is not the responsibility of health care institutions, and health care providers are reluctant to take on the task of documentation; they prefer to leave it with the police or with NGOs, since it might endanger their medical objectivity. But some sort of notification or referral to the respective institutions appears warranted.

As health care providers may encounter trafficked persons during their course of work, there is a need for awareness of the phenomenon of THB and the signs and circumstantial clues linked to THB victims so that they can be identified/detected, analysed and well taken care of. In addition, it is necessary to know what proper actions are called for to help the victim.

Reasons for health care providers to look out for clues of trafficking

The medical conditions of a patient may be explained by the ‘means’ of trafficking, e.g. physical or sexual violence, abusive working and living conditions. Reading the clues of a potential trafficking case

carefully may improve the hypothesis for the anamnesis/diagnosis; the information gained may improve therapy and treatment of the patient, and ensure her/his sustainable recovery.

Detecting clues of a potential trafficking case can result in a closer look at a patient and, if the suspicion can be substantiated, the provision of information to the patient about the crime, her/his rights and different options to obtain further assistance or to receive protection in a shelter.

In certain cases health care professionals may be obliged to denounce or report a suspected victim of THB. For instance, in most countries violence against children and their maltreatment have to be reported, overriding the rule of confidentiality of the medical professions. In some countries these obligations also exist in case of the detection of sexual abuse or presumed cases of trafficking.

By establishing that a crime is the cause of the medical condition of a patient can lead to a faster and more accurate collection of data and of forensic evidence. If the victim consents (a requirement for adults only) the doctor should employ standard operation procedures, namely to document the case history and physical examination, to record and classify the injuries, and to take forensic specimen of the patient.

Last but not least, a medical doctor may also perform a medical examination as part of a formal investigation, initiated by law enforcement professionals.

Reasons for health care providers to look out for clues of trafficking

- Medical condition of a patient may be explained by trafficking
- The trafficking situation may influence the choice of treatment
- Chance to refer the patient to further assistance
- Potential obligations to denounce
- Collecting data/evidence needed for a formal investigation

2.5 Different actors in the health care system

The probability of encountering trafficked persons in the health care system of a country and the opportunity for and options of health care professionals to act depend on a range of factors, e.g. the accessibility of the health care system for migrants, the structure of the health care system and the specialisations and status of the various health care professionals.

Accessibility of the health care system for migrants

The accessibility of a national health care system is largely determined by the entitlements provided by the respective welfare regimes. These, vary significantly between the EU-27 Member States (Biffl 2012). Access can be even more complicated in the case of migrants, particularly irregular ones, since residence and labour market regulations may introduce restrictions on entitlements. One approach to assess the accessibility of national health care systems is to focus on undocumented migrants (in the EU the so-called third-country nationals without valid residence or work permits); and to establish to what extent the specific Member State grants health and health care services. They may be minimum rights (defined as affordable or free access to emergency care) or the whole gamut of services of natives. In 2010, only 5 Member States granted more than minimum rights, 12 member States granted just the minimum rights, and 10 Member States granted less than minimum rights (e.g. by charging for emergency care) (Björngren-Cuadra 2012). Similar problems may be experienced by citizens of an EU country, who live under precarious working and living conditions

because of a lack of social security coverage and a valid work contract.

In any case, it is necessary to know the peculiarities of national health care systems, the opportunities they offer and limitations they impose in relation to health services provision. As many victims of THB tend to have migrant status, often of an irregular kind, special regulations may have to be taken into account.

Table 2: Rights of undocumented migrants to access health care in EU Member States (2010)

Source: Björngren-Cuadra 2012

Less than minimum rights	Austria, Bulgaria, Czech Republic, Finland, Ireland, Latvia, Luxembourg, Malta, Romania, Sweden
Minimum rights	Belgium, Cyprus, Denmark, Estonia, Germany, Greece, Hungary, Lithuania, Poland, Slovakia, Slovenia, UK
More than minimum rights	France, Italy, Netherlands, Portugal, Spain

Fields of specialisation

In theory, every field of specialisation in the health care system can encounter trafficked persons. In practice, there are a few fields which are more likely to come across such persons, namely:

- Emergency care and trauma surgery
- Ambulance services
- Gynaecology and reproductive health services
- Dermatology and sexual health care
- Paediatric health care
- General medicine

- Odontology
- Radiology
- Forensic medicine
- Psychiatry and psychotherapy

Emergency care, trauma surgery and ambulance services will often be the first to encounter trafficked persons, e.g. if victims of THB are injured due to violence or in case of accidents. Victims of sexual exploitation may see gynaecologists, dermatologists or sexual health care centres to have their case treated. These may be caused by sexual violence, sexually transmitted diseases, or who are in need of reproductive health services for abortions. Specialists in paediatric health care, odontology, radiology as well as general medicine may meet victims of trafficking, while specialisations like forensic medicine and psychiatry tend to encounter victims of trafficking through referral.

Health care professions

Apart from medical doctors in the different medical fields of specialisations, there also exists a range of different health care professions, who may be involved in providing help to victims of trafficking, e.g.:

- Paramedics
- Nurses
- Medical-technical assistance
- Administrators (e.g. receptionists)
- Management
- Inter-professional teams

Each of these professions has its specific role in the treatment chain of patients because the provision of health services is characterised by a complex division of labour. As the overall objective is to care of the patient, each element in the chain is important and should therefore be involved in looking out for clues of trafficking, e.g. before

and during anamnesis, the receptionist can take note of the lack of identity documents, the nurse can identify and distract a potential 'minder', while the medical doctor can focus on the medical indications and make use of the information collected by others in his/her inter-professional team.

Organisational settings

The particular organisational setting may also be a determining factor in the probability of coming across cases of trafficking, the chances of reacting to them and taking proper action to assist the potential victim.

- Large hospitals vs. small medical practices,
- Public vs. private facilities,
- National vs. local authority/ownership,
- Mobile clinics and outreach services, health services free of charge.

These different organisational settings will also have an influence on trafficked persons or their 'minders' on expected treatment and discretion, and also on referring institutions, e.g. law enforcement and NGO's. In larger cities, big hospitals may be seen as more 'anonymous' than small medical practices (which may be the only form of health care in more rural areas). In many cases, public institutions will be regarded as more affordable, but sometimes also as less trustworthy either because of their links to public administration and law enforcement or because of a their predisposition to corruption, clientelism and political interference.

Depending on the political system and administrative structure of a country, it may be necessary to distinguish between different levels of political control or public administration, e.g. between national, regional and local; and between different forms of ownership, e.g. public body or public health insurance company versus private clinic. These differences are important, since they can have an impact on pertinent regulations, funding streams, levels of decision making, policy development and provision of care for victims of trafficking. Some countries have mobile clinics and outreach services, or health

services free of charge for marginalised persons or groups of persons without health care coverage. These services are potentially preferred contact points for trafficked persons.

Specialised focal points, multidisciplinary groups and related units

Sometimes organisations implement special procedures to cater for the needs of trafficked persons by developing a chain of actions to be pursued in case of suspected trafficking. In smaller organisations these may be individuals, who in addition to their main task have the responsibility to serve as focal points for all issues related to trafficking. In larger organisations, these focal points tend to be organised as multidisciplinary teams, composed of experts from different medical fields and professions. The responsibilities of focal points can, for example, be the accumulation of expert knowledge in the topic of trafficking; they may act as a bridge to other institutions (e.g. the police or NGO's) or offer care for the presumed victims and inform them about their rights and possible assistance beyond medical treatment.

In some countries, multidisciplinary teams are organised at a regional level as inter-organisational groups, which also function as coordinators between different organisations. These inter-organisational teams do not only consist of members of health care professions, but include members of various professions, in particular law enforcement, social services, NGO's, but also judges, teachers, labour market services and community workers. The latter are of particular importance for re-integration into 'normal' life in the community and work.

In countries and/or organisations where the targeted organisational structures for combating trafficking are less developed, it may be advisable to assign certain specific tasks to units which already exist and which deal with related issues, e.g. special task forces or multidisciplinary groups for the prevention of domestic violence or violence against children. For more on this issue, see chapter 5.

III.

The victim's perspective

3.1

Voices of victims

“Every day from 5 am until midnight I had to clean the workplaces. They gave me almost nothing to eat or drink. I passed out on the street. An ambulance brought me to the hospital.”

(Woman from Eastern Europe, about 25)

“I fell off a scaffolding. At the hospital my boss told me to keep my mouth shut, because I have no insurance.”

(Man from Eastern Europe, about 35)

“When I was collecting fruit, I had to sleep with six others in a dirty caravan, without shower. We went to see a doctor, because we all had the same rash.”

(Man from Southern Asia, about 30)

“I work from 6 pm until 6 in the morning. I don't know what city I am in. I don't have a passport.”

(Woman from Northern Africa, about 20)

“Recently I had my 5th abortion in the same hospital. No one seemed to find that strange.”

(Woman from Eastern Asia, about 30)

“I had to clean chemical containers without mask. After a couple of months I had to see a doctor for pneumonia. No one thought that was suspicious.”

(Man from Southern Europe, about 30)

“The press machine had crushed all the fingers of my right hand. My boss told me to say I had crushed my fingers myself whilst on vacation in Antwerp. The doctor believed me.”

(Man from Southern Europe, about 40)

“I had to work the land in sub-zero temperatures. Take care of the cattle. Sleep in freezing stables. My fingers turned black because I could not keep them warm.”

(Woman from Southeast Asia, about 30)

“The evil spirit has made me sick. But I won’t go back to the doctor, because I fear the evil spirit will also make my family sick.”

(Woman from Western Africa, about 35)

Source: Payoke’s awareness raising video (www.youtube.com/watch?v=iRz3YjTJ7TE)

Example: Sense of shame of a raped victim

“A woman from Eastern Europe employed as a domestic worker suffered a daily regime of vaginal and anal rape and other acts of humiliation. Upon returning home, she continued to suffer both physical and psychological effects, but never told her husband (the truth about) what had happened to her, believing that were he to find out, he would leave her and her son.”

Source: WHO 2003b: 2

3.2 Means of trafficking and potential consequences for the victim

Of the three components of the crime of trafficking in human beings (act, means purpose), the means used by the perpetrators to convince the victim to obey and follow the orders of the trafficker carry the key to understanding the motives of the trafficked persons. In order to be able to take the victim’s perspective it is crucial to know what means are used and why the victim follows suit.

The terms used in legal documents (e.g. the UN Protocol or the Directive 2011/36/EU) for defining the means of trafficking tend to be rather abstract, focusing on the aspects relevant for the legal requirements for the crime. Practitioners and health professionals need a more practical description, however, terms which are close to the experience of the victim and helpful for identifying the health needs of the victim. Accordingly, practitioners and researchers, e.g. Zimmerman et al. (2003: 23ff), have translated the legal definitions and terms into practical experiences which allow the development of a narrative close to the actual circumstances of the victims. For the purpose of this handbook, we focus on health risks and abuses resulting from means of trafficking, thereby giving meaning to legal terms and definitions to health professionals.

Table 3: Means of trafficking in legal and in medical terms

Source: contrasting United Nations 2000 and Zimmerman et al. 2003

Means of trafficking: LEGAL DEFINITIONS	Means of trafficking: MEDICAL DEFINITIONS
Threat or use of force Coercion Abduction Fraud Deception Abuse of power or vulnerability	Sexual abuse Abusive working and living conditions Physical abuse Psychological abuse Economic pressure and debt bondage Legal insecurity Social restriction and manipulation Marginalisation Forced and coerced use of drugs and alcohol
Giving or receiving payments or benefits to achieve consent of a person controlling another person	

Comparing both sets of definitions and three components of the crime of trafficking in human beings (act, means purpose), the means used by the perpetrators to convince the victim to obey and follow the orders of the trafficker carry the key to understanding the motives of the trafficked persons. In order to be able to take the victim's perspective it is crucial to know what means are used and why the victim follows suit.

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From table 3 it becomes obvious that both focus on a wide variety of pressures trafficked persons may be exposed to. In both cases the categories and examples used are overlapping rather than mutually exclusive. For example, it is not possible to clearly distinguish between threat and coercion, or fraud and deception, or between psychological abuse and social manipulation, or social restriction and marginalisation, respectively. At the same time it is not possible to find terms which satisfy legal requirements as well as medical definitions simultaneously. Accordingly, both sets of indicators tend to be used by the various professions involved as they may complement each other and provide a deeper understanding of the means employed by traffickers.

A special case among the different legal definitions is the exchange of money or of benefits among perpetrators who negotiate the control over a third person. In legal terms, it is a clear sign of trafficking and of collaboration in committing a crime, but it does not have any direct medical implications for the victim.

In addition to specifying the medical definitions and implications of means of trafficking for the health situation of the victim via examples Zimmerman et al. (2003: 23ff) focused on the specific case of women. We adapt their list of health consequences such that it becomes applicable for other cases as well. Table 4 provides a concise overview of the different means used to influence and enslave trafficked persons; it also gives a vivid account of the vast variety of health consequences for the victims.

Table 4:
Means of trafficking and potential consequences for the victim

Source: adapted from Zimmerman et al. (2003: 23ff)

Means of trafficking	Potential consequence for the victim
Sexual abuse <ul style="list-style-type: none"> • Forced sex and sexual humiliation • Forced prostitution and forced acceptance of clients • Forced (e.g. unprotected) sexual practices • Forced or unsafe abortion • Coerced misuse of contraceptives 	Sexual and reproductive health <ul style="list-style-type: none"> • Inability to negotiate sexual encounters • HIV/AIDS • Sexually transmitted infections (STI) and related complications • Injuries and illnesses of the reproductive system and the urinary tract • Unwanted pregnancy • Negative outcomes of unsafe abortions
Abusive working and living conditions <ul style="list-style-type: none"> • Excessive working hours, lack of breaks or days off • Dangerous working conditions (high risk workplace, insufficient labour protection, lack of adequate protective gear) • Dangerous living conditions (unsafe, unhygienic, over-crowded) 	Occupational and environmental health <ul style="list-style-type: none"> • Exhaustion and poor nutrition • Work-related injuries, disabilities and illnesses • Infections, parasites and communicable diseases
Physical abuse <ul style="list-style-type: none"> • Physical attacks (beating, kicking, knifing, cigarette burns, captivation, etc.) • Physical deprivation (sleep, food, light, basic necessities) 	Physical abuse <ul style="list-style-type: none"> • Injuries and disabilities (fractures, sprains, bruises, contusions, lacerations, head trauma, nerve or sensory damage, dental problems) • Fatigue, exhaustion

Means of trafficking	Potential consequence for the victim
Physical abuse (sequel) <ul style="list-style-type: none"> • Withholding medical or other essential care • Organ harvesting • Murder 	Physical abuse (sequel) <ul style="list-style-type: none"> • Poor nutrition, malnutrition • Deterioration of pre-existing conditions • Death
Psychological abuse <ul style="list-style-type: none"> • Intimidation of and threats to trafficked persons and their loved ones • Lies, deception and blackmail to coerce trafficked persons into exploitation • Lies about authorities, local situation, legal status • Emotional manipulation by friends of family members, who act as perpetrators • Creation of uncontrollable events and environment 	Mental health <ul style="list-style-type: none"> • Trauma syndrome (re-experiencing of events, jumpiness, irritability, avoidance, numbness) • Chronic anxiety (nervousness, emotional shakiness, panic spells, restlessness) • Depression (feelings of sadness, loneliness, hopelessness, suicidal thoughts, loss of interest) • Hostility (aggression, annoyance, frequent arguments, urge to smash things) • Guilt, shame, loss of self-esteem • Loss of trust in others
Economic pressure and debt bondage <ul style="list-style-type: none"> • Usurious charges for documents, travel, housing, food, other basic necessities • Deceptive accounting practices, control over earnings • Economic penalties for misconduct towards exploiter • Indentured servitude resulting from inflated debts 	Economic related well-being <ul style="list-style-type: none"> • Inability to generate and control resources for economic well-being • Inability to afford nutrition, hygiene, safe housing • Inability to afford health care • Pressure to accept health-related risks • Rejection by family for not sending money

Means of trafficking	Potential consequence for the victim
Legal insecurity <ul style="list-style-type: none"> • Bringing trafficked person in problematic legal situation (e.g. work without permit, involvement in crimes) • Confiscation of documents by perpetrators • Misinforming a trafficked person about his/her legal status • Threats by perpetrators to expose a trafficked person to authorities 	Legal insecurity <ul style="list-style-type: none"> • Danger of arrest, prosecution and detention • Deportation to insecure locations, risk of re-trafficking • Inability or difficulty seeking protection from authorities • Lack of knowledge about legal opportunities • Inability or difficulty obtaining treatment from health care providers • Deterioration of health status as a result of reluctance to use health services
Social restrictions and manipulation <ul style="list-style-type: none"> • Restriction on movement, time, and activities • Frequent reallocation • Denial of contacts to family, friends, and local community • Discouragement of friendships between co-workers • Denial of privacy • Manipulation of perception and reputation of the trafficked person 	Social well-being <ul style="list-style-type: none"> • Physical and psychological dependence on perpetrator • Feelings of isolation, loneliness and exclusion • Inability to establish and maintain supportive relationships • Lack of instruments to gather information about social and institutional environment • Vulnerability to injuries, illnesses and social misconduct due to lack of feedback • Rejection by family, friends, community, society • Difficulty with (re)integration and developing healthy relationships

Means of trafficking	Potential consequence for the victim
Marginalisation <ul style="list-style-type: none"> • Inhibiting adaptation to language, and to social and cultural norms • Creating fear of law enforcement and other public services • Creating fear of public discrimination and stigmatisation related to gender, ethnicity, social position, form of labour 	Health service uptake and delivery <ul style="list-style-type: none"> • Lack of knowledge about and integration into social environment, loneliness • Alienation from available public services and resources, including health care • Lack of continuity of health care and social support • Reluctance to leave exploitative situation, helplessness • Unhealthy coping strategies, e.g. use of addictive substances
Forced and coerced use of drugs <ul style="list-style-type: none"> • Coercive use of alcohol or drugs in order to decrease self-protective defence against high risk activities or unwanted sexual acts • Force drug addiction on victim in order to increase dependence upon perpetrator 	Substance abuse and misuse <ul style="list-style-type: none"> • Participation in high risk activities and unwanted sexual acts • Addiction, overdose • Brain or liver damages, needle-introduced infections



“ I had to clean chemical containers without a mask. After a couple of months I had to see a doctor for pneumonia. No one thought that was suspicious.”

3.3

The rights of victims of trafficking

The following paragraphs focus on the rights of victims as defined in international legislation, above all the Directive 2011/36/EU and the Council of Europe Convention. It has to be borne in mind that international definitions and directives of that kind have to be translated into laws and policies of every EU Member State (MS). However, given the complexity of the issues involved, EU -MS are free to choose on how to go about implementing the gist of the directive into their national legislation, local regulations, services provided and infrastructures established. Thus, the concrete rights and entitlements of victims of trafficking and local procedures may differ widely between EU-MS. The following paragraphs can therefore only provide some general insights and guidelines for ensuring the rights of victims at national and local level.

Identification and non-prosecution of victims

It is the responsibility of the qualified authorities (mostly specialised police units and accredited NGOs) to assess and identify a potential victim on reasonable grounds (Directive 2011/36/EU: 8). Only if the status of a presumed or identified victim of THB has been assigned by the relevant authorities can the persons claim their legal entitlements to assistance and support.

In practice the identification of victims is a difficult task, particularly in case of consent to parts of the eventual trafficking narrative or the involvement in unlawful activities. However, Directive 2011/36/EU: 6-7 clearly states that the consent of a victim is irrelevant when the criteria

Table 5: Difference between smuggling and trafficking

Source: International Center for Migration Policy Development (ICMPD),
www.anti-trafficking.net/differencebetweensmugglingand.html

	SMUGGLING	TRAFFICKING
Type of crime	Crime against the State (violation of immigration laws/ public order); the crime of smuggling does not entail the violation of the rights of the smuggled person.	Crime against a person, the victim; violation of the rights of the victim (violation of a person's human rights; victim of coercion and exploitation) this case obliges the State to act and treat the person as a victim of a crime.
Why do we fight it?	To protect the sovereignty of the state	To protect a person against human rights violations; obligation of the State to provide adequate protection to its citizens
Nature of crime and duration of customer relationship	Commercial; the relationship between the smuggler and the migrant ends with the illegal border crossing and the paid fee	Exploitative; the relationship between the trafficker and the victim continues in order to maximise economic and/or other gains from exploitation
Rationale	Organised movement of persons for profit	Organised recruitment/ movement and exploitation of the victim for profit
Rationale	Illegal border crossing is a defining element	Purpose of exploitation is the defining element, border crossing is not an essential element of the crime
Rationale	Migrant's consent to illegal border crossing	Either no consent, or initial consent made irrelevant because of use of force, coercion, at any stage of the process

for a case of trafficking are fulfilled. In such a case the authorities are not to impose penalties on the identified and presumed victim for their involvement in criminal activities which were directly linked to the case of trafficking.

The ambiguity in the process of identification, i.e. the identification of a person as a potential victim or an offender of the law, is particularly visible in the case of irregular migration, when the police is to distinguish between the crime of smuggling and the crime of trafficking in human beings (Table 5). Because of the complexity of issues involved the Council of Europe Convention (p 10) postulates not to expel a potential victim from a country but to offer assistance and support as long as the formal identification process lasts.

Rights of victims

- Identification and non-prosecution
- Assistance and support
- Reflection and recovery period
- Protection during criminal investigation and court proceedings
- Special assistance, support and protection for child victims
- Compensation to the victim

Assistance and support of victims

„A person should be provided with assistance and support as soon as there is reasonable-grounds indication for believing that he or she might have been trafficked and irrespective of his or her willingness to act as a witness. In cases where the victim does not reside lawfully in the Member State concerned, assistance and support should be provided unconditionally at least during the reflection period.” (Directive 2011/36/EU: 4) Another passage in this document requests Member States to provide assistance and support to victims „before, during and for an appropriate period after the conclusion of criminal proceedings” (Directive 2011/36/EU: 8).

The directive specifies that the assistance and support measures are to ensure the subsistence of victims, in particular:

- appropriate and safe accommodation (often provided by specialised shelters)
- material assistance
- medical treatment, including psychological assistance, counselling and information
- translation and interpretation services where appropriate
- information about a reflection and recovery period
- information on possible international protection and/or refugee status
- care for victims with special needs, in particular related to pregnancy, disability, health problems, mental disorders, or the experience of psychological, physical or sexual violence

The directive requests that assistance and support be provided unconditionally, without the obligation of the victim to cooperate in the criminal investigations and court proceedings. Additionally, a consensus should be obtained for cooperation in the above proceedings, based on information about the options of the victim and the potential consequences for the victim.

One may take this regulation as the right of trafficked persons to take responsibility for their future life. In contrast, the interests of child victims are defended by individuals acting on their behalf, i.e. parents or appointed guardians.

Recovery and reflection period

According to the Council Directive 2004/81/EC, the victim of trafficking has the right to a reflection period to recover from the trauma and to escape the reach of perpetrators. The reflection period is also to allow the time for deliberation to the effect of making an informed decision about a possible cooperation with the relevant authorities in criminal investigations and court proceedings.

While this directive leaves it up to the individual Member States to determine the duration of such a reflection period, the Council of Europe Convention recommends a minimum duration of 30 days.

Protection of victims during criminal investigations and proceedings

Should trafficked persons decide to cooperate with the relevant authorities during criminal investigations and court proceedings, they are entitled to access the following protection measures (Directive 2011/36/EU: 10-11):

- legal counselling of the victim
- legal representation of the victim, including for the purpose of claiming compensation
- appropriate protection of the victim on the basis of an individual risk assessment, e.g. access to witness protection programmes
- special attention to prevent secondary victimisation, e.g. avoiding unnecessary repetition of interviews and visual contact between victims and perpetrators, avoidance of giving evidence in open court, prevention of unnecessary questioning concerning victim's private lives

Special assistance, support and protection of child victims

According to the Directive 2011/36/EU: 9 the child's best interest has to be the primary consideration for assistance, support and protection measures for child victims. Should the age of a person be unclear, the youth is to be presumed to be a child to obtain access to the relevant measure, in particular:

- specific measures to find sustainable solutions for the child
- access to education within reasonable time
- appointment of a guardian, where the holders of parental responsibility

are excluded from representing the child because of a conflict of interest

- support to the family of the child victim, in case the family resides in the territory of the Member State

Additionally, the directive requests a range of very detailed regulations to be taken into account to ensure the protection of child victims in criminal investigations and court proceedings; also special assistance, support and protection of unaccompanied child victims has to be ensured.

Compensation to victims

Directive 2011/36/EU: 10 also requests Member States to grant access to existing schemes of compensation to victims of violent crimes. The Council of Europe Convention (p 11) indicates that the establishment of a fund for victim compensation, sourced by the revenues from monetary sanctions against convicted offenders, could be one way to go to ensure compensation.

Discussion

While the rights of victims of trafficking are laid down in international laws, EU member states may differ in their country-specific interpretation of these rights, accounting for large differences in the national implementation and regulations. Additionally, the institutional infrastructure, the design of measurements for assistance and support of victims of trafficking, as well as the resources allocated to the pertinent service provision may differ significantly between EU-MS. Last but not least, it is necessary to assess locally (and by the individual victim) to what extent the respective legislative framework and support measures respond to the actual needs of trafficked persons and to what extent they are sufficient to address the major concerns of victims.

3.4 Basic concerns of victims

Frequently, it is not the first impulse of trafficked persons to seek protection or assistance with the police and NGOs. These institutions may not be seen as holding a solution to their often intractable situation. The situation of a victim may be very complicated. He or she may feel bound by concerns for the family, by vows or other concerns which are cleverly nurtured by the perpetrators. Largely following Payoke (2010: 38f), one may distinguish between the following basic concerns of victims:

Concerns about the personal safety of a victim mainly relate to how far the sphere of influence of the trafficker or the trafficking organisation reaches, and what measures the traffickers may take to revenge disclosure. If the victim has experienced physical or sexual violence, these concerns will be particularly strong. The challenge of the victim is to identify a person or institution strong and reliable enough to protect her/him against the traffickers.

Similar concerns may be raised on the safety of the family of the victim. Often, the traffickers have contacts in the place of origin of the victim and might get there to endanger the victim's family faster than any foreign law enforcement agency could act to arrange security measures.

Concerns of victims

- Personal safety
- Safety of family
- Financial situation
- Living conditions
- Legal situation
- Social integration

“The factors affecting the security and well-being of a woman [a person] who has been trafficked are the same factors that affect disclosure.”

Source: WHO 2003: 3

The financial situation of a victim is another crucial concern, as they may not hope to pay back ‘debts’ to the trafficker or exploiter and as they may fear to lose their ‘job’. Even if the job is badly paid and the working conditions are abusive, it is often the only job available to the victims, or so they believe. In many cases, entire families rely on this one exploitative job and expect remittances.

Frequently other basic requirements like accommodation, clothing and food are also under the control of traffickers or their agents. The idea of exposing the traffickers may therefore raise concerns about their own survival.

Since trafficked persons often have an irregular migrant status, possibly without a residence or work permit, they may have concerns about their right to stay and may be afraid of deportation. If they have been involved in forced criminal acts, like pick-pocketing or shoplifting, they may be afraid of prosecution.

Additionally, victims may have concerns about their integration in the resident and/or source country, not knowing where to turn to after having escaped their traffickers. They may be afraid of returning to their place of origin for fear of a contemptuous reception, given their experiences abroad which many may regard as shameful. Thus, they may feel rejected in the country where they have been exploited as well as in their home country.

3.5 Other barriers to disclosure

Beyond these basic concerns of a trafficked person there may be additional barriers to disclosing his/her unfortunate situation of exploitation to health care professionals, police or other public services.

One barrier may be the lack of autonomy of the victim, which can be the result of various factors. One frequent factor, especially of migrants, lies in language difficulties or problems in understanding the specific social and institutional environment of the place of exploitation. In addition, traffickers tend to undermine every attempt of a victim to act independently, through coercion or control.

Traffickers or their agents can accompany victims of trafficking when they are required to visit a health care provider and intervene in subtle ways during the consultation process, e.g. by translating for them, answering questions on their behalf, or filling out forms for them. The physical presence of the trafficker or of one of his agents during a medical consultation may be expected to put a victim under pressure.

Barriers to disclosure

- Lack of autonomy
- Lack of privacy for consultation
- Indifference or prejudiced attitude of health care personnel
- Lack of trust in health care personnel
- Hopelessness and helplessness
- Do not see themselves as victims

Even without the perpetrator being present, victims can have strong fears (for themselves or their family) or sense of shame (about the activity she/he is involved in, about her/his dependence). It is, therefore, difficult for a victim to overcome these feelings and to disclose confidential information to a healthcare professional, especially if there is a lack of privacy in the consultation situation, i.e. if too many people are around.

Given the precarious state many victims of THB have to live in, any sign of prejudice (e.g. towards foreigners, ethnic groups, disadvantaged people or sex workers) on the part of healthcare professionals can be very discouraging. The same can be said about a demonstrable lack of interest of health care professionals in the living and working conditions of their patients, in the reasons for their injuries, illnesses or a weak state of health generally. Lack of time during consultation can easily be interpreted as lack of interest.

Another barrier can be a lack of trust of the victim in the health care provider. What does it mean that the trafficker took the victim to this place? Who will the health care professional believe in case of disclosure: the victim or the self-confident trafficker? Will the health care professional ensure confidentiality of disclosed information, or will he/she inform others, e.g. the police?

Having been under coercion and control by an exploiter or a network of traffickers can lead to strong feelings of hopelessness and helplessness. Usually, the perpetrators will have inflicted strong pressure and violence on the victim, which may convince him/her that it might be safer to stay within these walls of exploitation rather than exiting and risking punishment or revenge. If they see no realistic chance to escape this situation, why should victims take the risk of disclosure? What good could come of it for them?

Last but not least, victims may be unable to identify themselves as victims. For example, they may feel truly obliged to repay even unjustified debts to their employer, or to accept the rules set by their

traffickers, as they do not know their legal rights in the country of exploitation. If they have experienced long periods of servitude and if they do not know their rights, they may regard their situation as a case of bad fate, but not necessarily unjust in a legal sense.

It is imperative to recognize that identified or presumed victims of trafficking may have justified concerns about disclosing their unfortunate situation to the relevant authorities. Rather than pushing them towards disclosure, respect for their dignity requires sincere efforts to understand their concerns and acceptance of their decisions.

IV.

Dealing with possible victims of trafficking

The same ethical principles which have been developed for the medical-legal care of victims of sexual violence (WHO 2003b: 19), also apply to the provision of services to victims of trafficking, especially if these services are provided by health care professionals:

- **Autonomy.** The right of patients to make decisions on their own behalf, based on informed consent.
- **Beneficence.** The obligation to act in the best interest of the patient.
- **Non-maleficence.** The obligation to avoid harm to the patient.
- **Justice or fairness.** The obligation to do what is rightfully appropriate.

These ethical principles have to be translated into practical actions.

4.1 General recommendations

There already exist several very instructive recommendations and guidelines for dealing with presumed victims of THB, e.g. the WHO Ethical and Safety Recommendations for interviewing trafficked women (WHO 2003b), the Guidelines on the protection of child victims of trafficking (UNICEF 2006), or the Guide to ethics and human rights in counter trafficking (UNIAP 2008).

These guidelines were developed mainly for counter-trafficking research and programs, for media and for state agencies which focus on counter trafficking. All these actors tend to act pro-actively in their approach to presumed victims of THB in their environment, with the main goal of finding and identifying victims of THB.

General recommendations

- Do no harm
- Know your subject and assess the risks
- Prepare referral information, be careful with advice
- Adequately select and prepare co-workers
- Ensure anonymity and confidentiality
- Get informed consent
- Respect each victim's assessment of his/her situation and safety
- Do not re-traumatize a victim
- Be prepared for emergency intervention
- Put information collected to good use

Source: adapted from WHO 2003b

The situation of health care professionals (medical doctors, nurses, paramedics, receptionists at health care facilities) is different, since their main task is not to look out for victims of THB but to care for patients in their particular domain of work and expertise. With respect to victims of THB, health care professionals need to employ a reactive approach, since the contacts are normally initiated by the patients themselves; victims would only be detected incidental to their regular medical operations.

As a result, the situation and the forms of conversation in these circumstances are different. Normally, patients seeking medical assistance go to health care facilities, i.e. the health care professionals are at their home base. They are not 'interviewed', rather they have come for expert advice and help from the medical profession in a normal consultation process. This is why it is justified to provide guidance to health professionals in their task to identify and help victims of THB. For this purpose, we will mainly adapt the recommendations of WHO (2003), but also draw on other sources.

Do no harm

This is the first principle in most ethical guidelines. Before trying to confirm your suspicion as a result of a medical consultation, consider the risks which might come with raising the issue directly or indirectly with the potential victim. The trafficker or his agent might observe your attempt, or the victim might get frightened and avoid any further medical treatment. Therefore, be careful with any step you take, and avoid any further harm for the presumed victim. The interest of your patient has priority over your curiosity.

Know your subject and assess the risks

Depending on the type of exploitation you assume to be the case, different implications and risks may be relevant. The more you know about the phenomenon in general, the better you can assess the kind of risks involved. Additionally, take all the information you get from your patient (and from the circumstances) to create a hypothesis about the presumed form of trafficking and its potential effect on the medical condition of your patient. Also assess the physical and mental condition of your patient and his/her possible reaction to more questions or the attempt to directly address the topic of presumed trafficking.

Prepare referral information; be careful with advice and promises

In case you find more signs to confirm your suspicion, or in case the presumed victim discloses her/his secret to you, be prepared to offer referral information to competent contact points of the national referral system and/or to local authorities, NGO's, hotlines or focal points, which can provide assistance and protection for the victim. Information about the rights of the victim can be helpful as well. Only refer to institutions and information you trust. However, be careful with any advice you give. Do not raise hopes, you (or others) cannot fulfil.

Properly select and prepare co-workers

Properly select and prepare co-workers you wish to involve in the consultation with a presumed victim, or in the management of a presumed case of trafficking. Try to jointly discuss what each of you found out about the case. Make sure that you have a common understanding of THB in general and about the strategy to deal with your specific case. If you need an interpreter, make sure she/he is trustworthy and not in any way connected to the trafficker. Preferably, the interpreter is not connected to the victim either.

Try to find colleagues, with whom you may discuss (anonymous) cases. Consider whether you may wish to develop basic referral information jointly for your team or your institution.

Ensure anonymity and confidentiality

In a health care environment, anonymity and confidentiality should be common practice. However, there may be exceptions from the general rule of confidentiality, e.g. due to the obligation to denounce in certain cases, like child maltreatment. Establish a common understanding in your institution about the legal limitations to confidentiality in your country.

Example: Grey area of exploitation

A German temporary placement agency that employed workers in an Austrian slaughterhouse went bankrupt. Many of the workers came from Hungary and had to work for up to 19 hours. They were not paid for overtime, but per processed piece of livestock only. Labor unions accuse this company and other similar cases of breaching labor law and engaging in wage and social dumping. This is a grey area of exploitation, which is close to trafficking.

Source: adapted from WHO 2003b

Get informed consent

For many forms of medical consultation and treatment, it is necessary for you to obtain the informed consent of your patient. This is especially so in cases where it is necessary to go beyond normal procedures, e.g. to confirm and document indicators for THB or to take forensic evidence, you will need the consent of your patient. Make sure the patient knows all the consequences of disclosing information to you.

Respect each victim's assessment of his/her situation and risks to his/her safety

The victim is the expert of his/her situation. Quite probably, he/she is better equipped than you to assess the risks for his/her personal safety. Listen and try to understand the victim's assessment.

Do not re-traumatize a victim

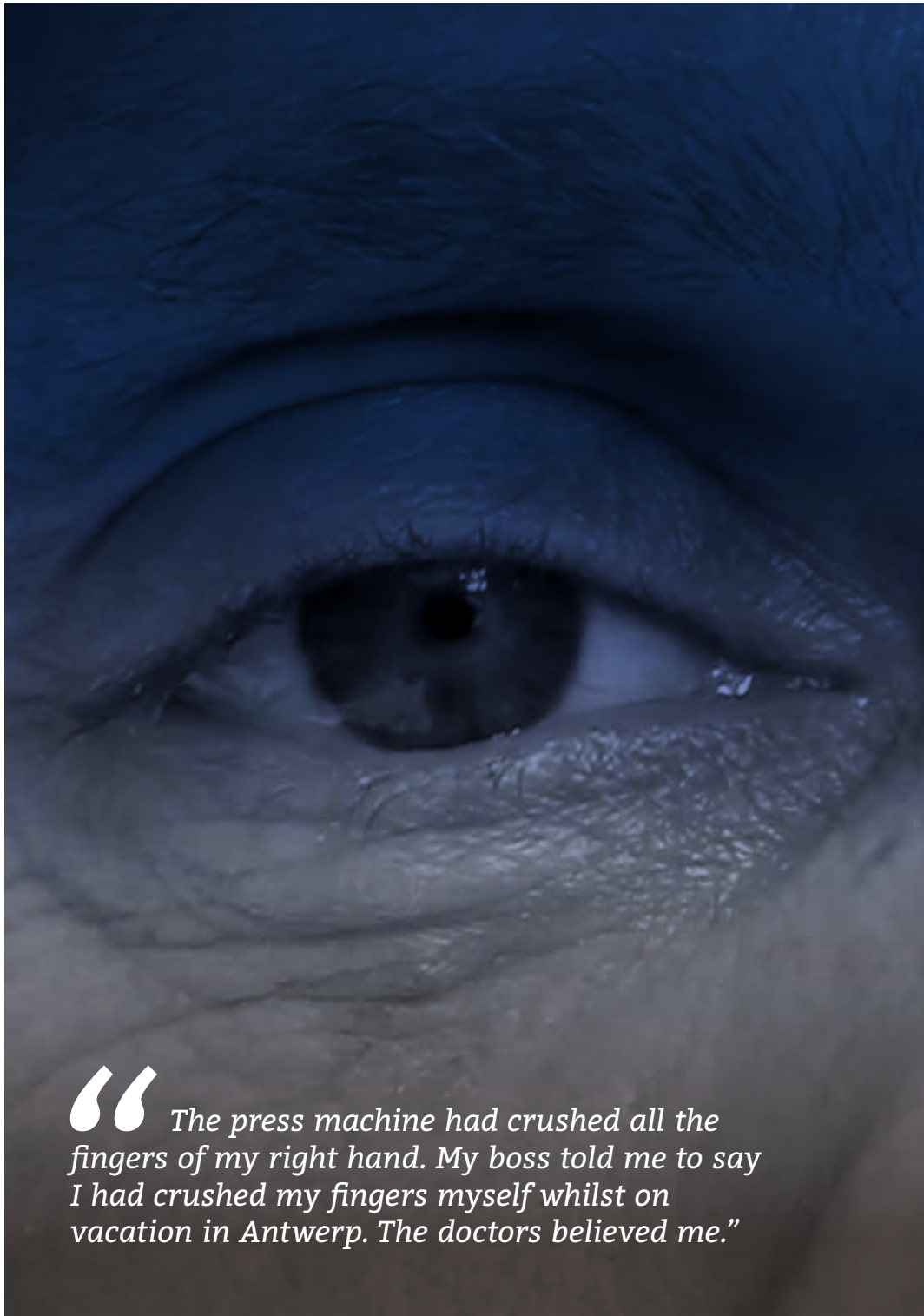
Ask as much as necessary for further action and as little as possible to avoid harm for your patient. If you know that for identification a full interview will be performed by the experts involved you have to involve, you do not have to ask everything yourself.

Be prepared for emergency intervention

The need for emergency interventions may arise, e.g. to quickly separate the victim from the trafficker and/or his agents, to call the security or the police. Be prepared for scenarios like this.

Put information collected to good use

Develop a strategy about how to deal with different kinds of information, e.g. unconfirmed clues of trafficking vs. confidential disclosure of information vs. denounced information vs. anonymous statistical data. Set up groups of doctors for the confidential debate on cases under conditions of medical confidentiality. Develop contacts with trustworthy individuals in other institutions, e.g. law enforcement agencies and specialised NGO's.



“The press machine had crushed all the fingers of my right hand. My boss told me to say I had crushed my fingers myself whilst on vacation in Antwerp. The doctors believed me.”

4.2 Spotting clues of trafficking

As mentioned above, it is not the task of health care providers to formally identify and register victims of trafficking. They are, however, required to look out for clues of trafficking, to assess whether the injuries or diseases of the patient may be the result of THB, given circumstantial indicators, and whether these considerations may have implications for the type of treatment and for further actions to help the potential victim. Linking specific medical clues and circumstantial clues may suggest that a person has been trafficked. As health care professionals tend to work under enormous time pressure to attend to their patients and to make quick decisions, they need to have some simple indicators to detect potential clues of trafficking. The following sub-chapter addresses some of these indicators.

Figure 11: Linking medical clues and circumstantial clues that a patient may have been trafficked

Source: own graph, inspired by Zimmermann & Borland 2009: 89

MEDICAL CLUES

- Physical clues: injuries or illnesses associated with abuse, violence or poor working and living conditions
- Psychological clues: signs of trauma, depression, anxiety, hostility

+

CIRCUMSTANTIAL CLUES

- Migration history
- Coercion and control
- Identity documents, insurance status
- Working conditions
- Living conditions

= POSSIBLE TRAFFICKING SITUATION

4.3 Medical clues

Even if there are no clearly defined medical symptoms of trafficking, there is a range of work-related symptoms and post-trauma reactions, which may induce a health care provider to suspect that a patient has been trafficked or suffered exploitation. Some of these symptoms may be caused by physical violence, sexual abuse, or poor working or living conditions flowing from trafficking. Following Zimmermann & Borland (2009) and Zimmermann et al. (2006), the following medical symptoms can be interpreted as potential clues for trafficking.

Physical health symptoms

- **Fatigue, weight loss**

Exhaustion and the loss of appetite may be signs of excessive working hours, but also of a generally stressful situation. Weight loss can also be a sign of malnutrition or dehydration caused by deplorable working or living conditions.

- **Musculoskeletal symptoms**

Fractures, sprains, bruises or cuts may be caused by physical violence of perpetrators, but may also result from labour exploitation in high-risk environment or without adequate personal protective equipment. Amputated limbs may result from work accidents, older amputations or crippled limbs may be indicators of forced begging. Back pain may result from repetitive motion activities like back-bending or lifting, but also from mental stress. Dental problems may be associated with unattended health care, or may result from physical violence.

- **Sexual & reproductive health symptoms**

Most of the symptoms in the sexual and reproductive system, such as urination pain, pelvic pain, vaginal problems, unwanted pregnancy or

Physical clues

- Fatigue, weight loss
- Musculoskeletal symptoms
- Sexual & reproductive health symptoms
- Neurological symptoms
- Gastrointestinal symptoms
- Cardiovascular symptoms
- Eye problems
- Dermatological symptoms
- Substance misuse

gynaecological infections can be associated with sexual violence or forced prostitution.

- **Neurological symptoms**

Neurological symptoms, like headaches, memory difficulty or dizzy spells, can be stress related, but also result from head or neck trauma, caused by physical violence or work-related injuries.

- **Gastrointestinal symptoms**

Some gastrointestinal problems, such as stomach or abdominal pain, nausea, vomiting, diarrhoea and constipation can be part of a post-trauma symptomology. They may also result from infections, caused by bad food quality or by poor hygienic conditions.

- **Cardiovascular symptoms**

Chest or heart pain and shortness of breath are cardiovascular symptoms, which are often associated with anxiety. Heart palpitation and respiratory problems can also be caused by overexposure to heat or cold, by chemical and biological hazards, or by airborne contaminants (e.g. fumes, dust, particles).

- **Eye problems**

Vision problems or eye pain may result from violence, but also from work-related injuries.

- **Dermatological symptoms**

Skin problems, such as rashes, itching or sores may be caused by unhygienic conditions, but also by chemical and biological hazards. Sexually transmitted diseases and HIV may be caused by forced prostitution.

- **Substance misuse**

Perpetrators sometimes force or seduce their victims into alcohol abuse or drug addiction as means of coercion and control.

Psychological symptoms

- **Trauma symptoms**

Trauma symptoms can comprise the re-experiencing of traumatic events in memories and nightmares, psychological arousal like jumpiness or irritability, and avoidance and numbing, which can be found in expressions of indifference or emotionlessness, but also in the inability to remember or talk about traumatic events.

- **Depression symptoms**

Depression symptoms comprise expressions of sadness or loneliness, feelings of worthlessness or of hopelessness, suicidal thoughts, but also a lack of interest in things.

- **Anxiety symptoms**

Since trafficked persons often experience threats and coercion, they can show different signs of anxiety, such as nervousness or emotional shakiness, fear that even can lead to panic spells, tenseness or restlessness. They also can be suddenly scared without obvious reason.

- **Hostility symptoms**

Trafficked persons can also show hostility symptoms, such as being easily irritated or annoyed. They can have temper outbursts, run into frequent arguments or feel the urge to smash things or to hurt someone.

Psychological clues

- Trauma symptoms
- Depression symptoms
- Anxiety symptoms
- Hostility symptoms

4.4 Circumstantial clues

Migration history

Indications of migration (e.g. if a patient looks like a foreigner or does not speak the local language) may contribute to the larger picture of a possible trafficking situation. The migration history, e.g. the reason for migration given by the patient may provide important insights and clues; one has to listen carefully. Often trafficked persons have been taken to the place/country of destination by lies and false promises, or by having trusted acquaintances, family members or members of the same ethnic group. Sometimes they have been subject to force or abduction.

Coercion and control

Traffickers often accompany their victims as 'minders', trying to control every step of the victim, e.g. his/her communication with health care professionals. Patients may seem to be frightened or to be highly dependent on the person accompanying them. Trafficked persons are often subject to intimidation, coercion and control by their traffickers and exploiters. This can range from concrete threats (e.g. to inform the police, to withhold wages) to physical or sexual violence.

Circumstantial clues

- Migration history
- Coercion and control
- Identity documents, insurance status
- Working conditions
- Living conditions

Identity documents, insurance status

Lack of identity documents or of health insurance may be clues of a trafficking situation. Often traffickers retain identity documents or other valuable possessions of their victims; this is an efficient means of coercion and undermines the autonomy of a person. Unclear insurance status can be a side effect of undocumented (or exploitative) work.

Working conditions

Many victims of forced labour or sexual exploitation have to endure deplorable working conditions. Industries often associated with trafficking are for example construction, agriculture and livestock farming, domestic service, manufacturing and food processing, prostitution and pornography. Often these industries come with dangerous working conditions and the exposure to chemical, bacterial or physical dangers. Trafficked persons may feel forced to work with poor training and equipment, to take extreme risks in dangerous situations or to work extensive overtime. They may look overworked, tired, have a bad medical constitution, or may wear inappropriate work wear. Often, they are in debt bondage or do not receive any wages.

Living conditions

Trafficked persons tend to be exposed to abominable living conditions, in places with poor hygiene, lack of heating or cooling in overcrowded rooms. They may also receive food and beverages in insufficient quantity or of bad quality, which may lead to malnutrition or dehydration. Often they live in the home of their employer, in the same place they work, together with many others, or in remote places. Sometimes they are not allowed to leave the premises, or are even locked up.

4.5 Talking to your patient

For the initial assessment of a patient whom you suspect to be a trafficked person, it is crucial to ensure your own safety as well as the safety of the patient. Before enquiring about trafficking-related circumstances, find ways to ensure privacy of the consultation, protecting it especially from the patient's accompanying persons. When exchanging information within your team, be careful not to be observed by others.

When talking to your patient for the first time, especially when enquiring about trafficking clues, always ask questions related to the medical situation of your patient and/or the relevant procedures of the health care facility. Only ask for information that might be relevant to your scope of action, and avoid going beyond that, particularly out of mere curiosity. Be supportive and open to whatever information your patient gives you, without becoming judgemental or pushy. Partly following Zimmermann & Borland (2009: 81f), it may be helpful to prepare questions and scenarios in advance, before encountering a patient who might have been trafficked.

Example: From sexual exploitation to second chance education

During his adolescence, a young migrant was handed over to a 'job adviser', an acquaintance of his parents. Against his will and against previous claims, he was forced to work as a sex worker in Austria. Only gradually, he could liberate himself from this situation of exploitation and develop other perspectives for his future, e.g. by attaining his school leaving exam via second-chance education. Only his confidants know about his trafficking experience, but he does not intend to denounce the perpetrators or to sue for compensation.

Source: Zingerle & Alionis 2013: 30

Table 6: Medical conditions and questions for circumstantial clues

Source: inspired by Zimmermann & Borland (2009: 81f)

Circumstantial clues	Some ways to ask or to respond
Migration history	<p><i>Only if the patient raises the topic of his or her migration history, it is advisable to ask for more details, e.g.:</i></p> <p><i>“How do you like staying in this country/city/region? Does it meet your expectations? Why did you come in the first place?”</i></p> <p><i>“Do you have friends or family in this country/city/region? Who helped you to get here? How did you get here?”</i></p>
Coercion and control	<p><i>“For the next examination (e.g. X-ray), we have to change the room. Due to safety/hygiene regulations, only health care staff and patients (no ‘minders’) may enter this room. Is this ok for you?”</i></p> <p><i>“Do you feel safe to talk about things that are bothering you? Are you afraid of anybody?”</i></p> <p><i>“I would like to see you for follow-up treatment next week. Are there any challenges or difficulties for you to come back?”</i></p> <p><i>“You look nervous. Do you have any concerns? Is anybody waiting for you? Do you feel comfortable leaving the persons accompanying you in the next room? Are you under pressure to return to your job? Has anybody threatened you or your family?”</i></p> <p><i>“Your health condition makes it advisable that you stay overnight at the hospital. Would you like to stay?”</i></p>

Circumstantial clues	Some ways to ask or to respond
Identity documents, health insurance	<p><i>“Just for the medical record, your identity papers would be helpful. Where are your documents and how can you get them?”</i></p> <p><i>“Do you have health insurance, or do you have other sources of funding to pay for health care?”</i></p>
Working conditions	<p><i>“You look exhausted. How long do you work daily, per weekly? Do you have breaks during the day and do you have days off? Since when have you had this routine?”</i></p> <p><i>“Where you injured while working? Can you tell me about your work and how this happened? Do you have injuries elsewhere?”</i></p> <p><i>Children: “Where do you go to school?”</i></p>
Living conditions	<p><i>“You look very tired. Do you get enough sleep? Tell me about the place you live and sleep at. Is it quiet enough to get some rest? Can you open your windows for fresh air?”</i></p> <p><i>“To understand the reasons for your infection, I need to know more about your situation at home / at work. Are you sharing your bedroom with others? Are you exposed to dangerous chemical or biological substances? Do you know others, who may have similar symptoms?”</i></p> <p><i>“You look very slim/pale. Can you tell me about your normal diet? What do you normally eat and drink? How much and how often? Where do you get your food?”</i></p>



*“The evil spirit has made me sick.
But I won't go to the doctor, because I fear the
spirit will also make my family sick.”*

4.6

Draft of a standard operation procedure for dealing with possible victims

Basically, there are two ways by which health care providers can encounter victims of trafficking. On the one hand, victims can come to the health care provider after having been identified or registered as a presumed victim by the police or victims' support service. This situation tends to be easier for the health care provider, since formally identified victims would normally have exited the trafficking situation and are being taken care of by the police or the support service. The other situation, when a health care provider encounters a patient who might be a victim of trafficking directly, is more challenging. Here the health care provider has to suspect that the presumed victim is still in a trafficking situation.

Based on Zimmermann & Borland (2009: 79ff.) concrete recommendations can be given on what health care providers could do if they encounter a patient who might be a victim. These recommendations may serve as a basis for the development of a Standard Operation Procedure (SOP), even if they have to be adapted to local requirements and regulations (see Figure 12).

Ensure your own safety first (1)

After having spotted the first clues of a trafficking situation, a health care provider should be alerted and take immediate steps to intervene.

Don'ts:

- Do not try to rescue your patient without knowing a safe referral
- Do not enquire about trafficking-related issues in front of others
- Do not involve the patient's company in medical consultation
- Do not disclose your personal address to the patient
- Do not inform authorities or refer your patient without informed consent
- Do not make promises you cannot keep

Source: Zimmermann & Borland 2009: 81f.

Top priority should be to ensure one's own safety first, e.g. by assessing the potential safety risks of the situation and the opportunities to act.

Ensure the privacy of the consultation (2)

In parallel, the health care provider should ensure the privacy of the consultation with the patient. It can be helpful to apply pre-developed tactics and explanations, e.g. on how to separate the patient from people accompanying him/her, or why a professional interpreter (rather than the suspicious companion) will be used for translating the consultation.

Provide medical emergency assistance (3)

In cases of emergency do not elaborate too much on the causes of the patient's injuries or illnesses, but focus on stabilising the health condition, either by performing the emergency medical assistance yourself, or by referring to other health services. In case you are alone with your patient, try to clarify whether contact with the police is desired.

Comprehensive medical exam (4)

If you suspect a case of trafficking, go beyond the treatment of the immediate health problem. Since this might be the only encounter

of your patient with a health care provider for a very long time, a comprehensive health examination may be advisable, since it provides a comprehensive assessment of the health status of a patient.

Forensic evidence (5)

A very specific issue is the option of a forensic examination, which may be especially appropriate in cases of sexual or other forms of violence. Preferably, a forensic exam is done by a forensic specialist or somebody who received special training in this area. It should be performed only when clear intentions to use the results in a criminal prosecution exist, and when the legal and procedural requirements for gathering evidence via a forensic examination can be guaranteed. One crucial prerequisite is the informed consent of the patient, based on a full understanding of the consequences of such a procedure.

Maximise the effect of a single encounter (6)

If the patient's compliance with further follow-up treatment is not likely and if the referral to other services is not possible or desirable, try to maximise the effect of the single encounter. Provide the patient with as much information as possible about his or her medical status with a complete regime of prescribed medication, if applicable. Provide also general information about the crime of trafficking, available support services and concrete contact points. In communicating the latter information, be careful not to endanger the patient or yourself with documents that may be traced back to you.

Prepare for follow-up consultation (7)

If referral to other services is not possible or desired, but the prospects for follow-up consultations with the patient are good, focus on providing immediate medical care. You can prepare a strategy for the

next meeting, perhaps with more specific information about potential referrals or better arguments for your patient.

Comply with reporting obligations (8)

There may be the legal obligation to report a case of THB to specific institutions or authorities, depending on the circumstances or local regulations. One of these circumstances could be child abuse. If you are obliged to report, try to find a person you can trust in the prescribed institution.

Select trusted service (9)

If you are not obliged to report to a specific institution and if a referral is an option your patient is willing to consider, select a service you trust and one which fits the needs of your patient best. This may be, for example, another medical facility, a specialised victims' shelter or a counter-trafficking institution, or a special law enforcement unit. Wherever possible, counter-trafficking specialists are the preferred referral option.

Gain the consent of patients before referring them to the social service or police (10)

To gain the informed consent of the patient is a prerequisite in other stages of standard operation procedures, e.g. before starting a comprehensive examination or before collecting forensic evidence. In order to be able to obtain the consent the patient has to be properly informed about all aspects and potential consequences of every step, e.g. of the medical examination, the collection of forensic evidence and the referral to a specific service, a victims support facility or the police.

4.7 Medical documentation and forensic evidence

Medical documentation is crucial for medical procedures, e.g. to link diagnosis and treatment and to follow up care in individual cases, but also for research and analyses of larger samples of similar cases.

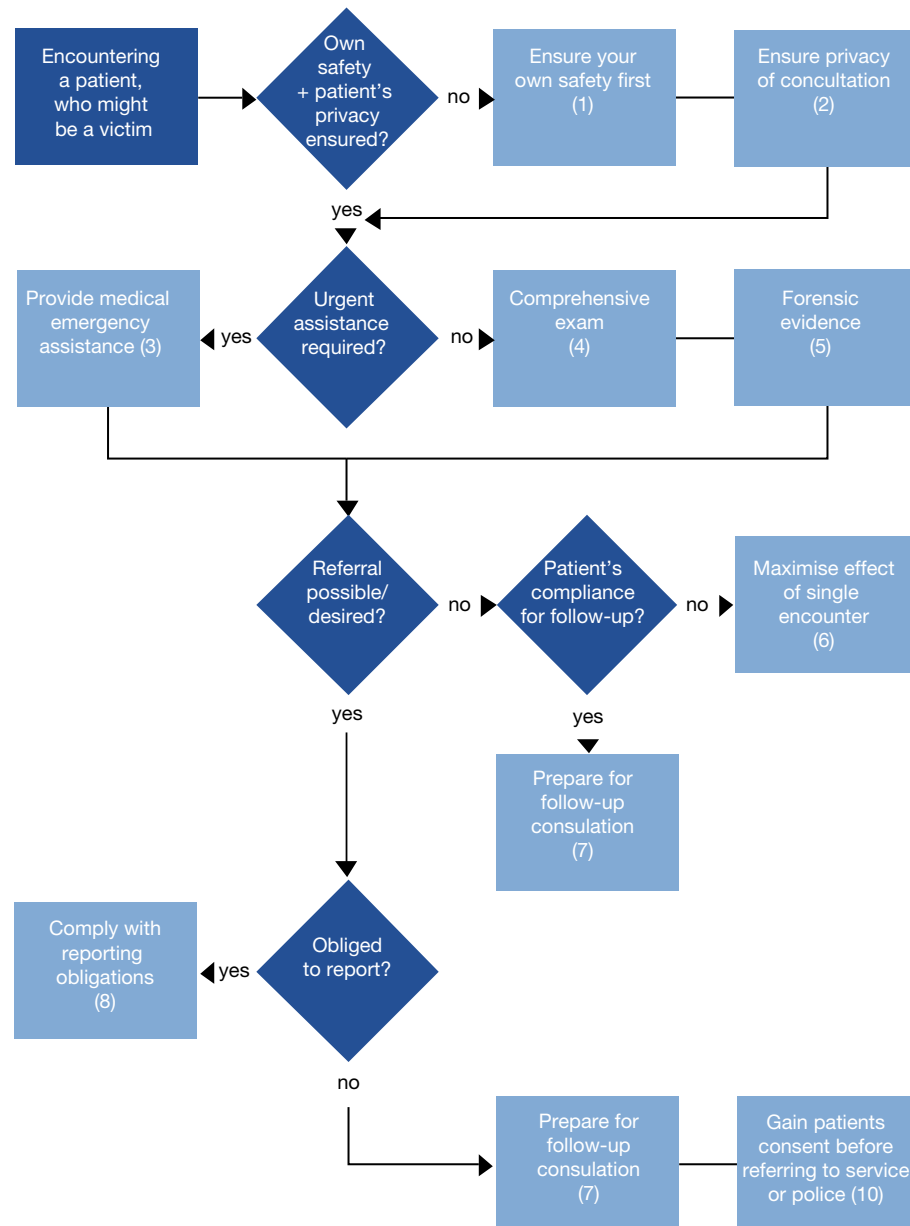
Additionally, medical records may be very useful in legal proceedings, in particular for police to establish a case against a perpetrator. Equally important, medical documentation may help a patient to receive the formal identification as a victim of crime (a status that tends to be a prerequisite for obtaining various forms of assistance and support, especially in the context of trafficking in human beings), to win the case against the perpetrator and possibly receive compensation for the harms inflicted.

How to write of medical protocols to help with criminal proceedings

In a study on the usefulness of medical records in legal proceedings, Isaac & Enos (2001) identified deficiencies of medical records which meant that they could not be used as adequate medical evidence in legal proceedings in cases of domestic violence. Major shortcomings in most reports were the lack of photographs of injuries or body maps for locating injuries, illegible handwriting of health care professionals, unclear source of information and the lack of circumstantial information, e.g. a description of the patient's demeanour. One may assume similar deficits in medical records dealing with identified or presumed victims of THB.

Figure 12: Draft of a standard operation procedure for dealing with possible victims

Source: own graph, following Zimmermann & Borland 2009: 79ff.



Based on these observations, the authors provided a range of recommendations to health care providers on how to improve their medical records such that they could be used in legal proceedings against the perpetrator. These recommendations may be adapted as follows such that medical documentation of possible cases of trafficking could be used to help the victims in court:

- Take photographs of injuries which may have been the result of physical violence, or of medical conditions suspected to have resulted from exploitative working and living conditions
- Use a 'body map', a schematic drawing of the human figure to indicate the location and size of injuries
- Write legibly
- Clarify the identity of the different speakers and sources of information, e.g. by making your observations distinguishable from the patient's own words, which could be put in quotation marks.
- In case your observations are inconsistent with the patient's statements, record the reasons for your suspicion.
- Use medical terms and avoid legal terms such as 'trafficker', 'perpetrator', 'crime'
- Stick to observations and factual information, avoid interpretation and summaries
- Describe the patient's demeanour, e.g. by indicating whether the patient seems to be nervous, angry, anxious, etc. If a person, who accompanies the patient, interferes in the consultation, influences the patient or provides additional information without being asked, it should be documented as well.
- Record the time of the examination and the time of the incident, which led to the injuries.

Many of these aspects may be included in regular medical records without to formally change the protocol. They will improve the general quality of medical records, and may prove helpful at a later stage, in case they have to be used in court proceedings.

Forensic examination and documentation

In cases, where the criminal background of an injury or medical condition seems to be evident or highly probable, or when the patient disclosed a criminal background to the health care provider, the health care provider should suggest a forensic examination of the patient. Frequently, a forensic examination is a specific medical procedure, regulated by particular community protocols. Sometimes, forensic examinations can only be performed at specialised institutions. In cases of child abuse, the forensic examination has to be closely coordinated with the forensic interview, which has to be performed by accredited forensic interviewers (WHO 2003a: 82f).

There are, however, also situations when any medical practitioner may perform a forensic examination and documentation. Recently, the Federal Ministry of Interior in Austria (BM.I) together with the Austrian Medical Chamber (ÖAK) and the Austrian Association for Forensic Medicine (ÖGGM) developed a “Documentation form for victims of violence” for health care providers. Interestingly, this form offers two alternative options of consent. One is directly connected to an ongoing process of police investigation. The other one only agrees to the storage of forensic evidence for a year just in case the victim wants to trigger a police investigation at a later stage. This mechanism allows for the immediate collection of forensic evidence, while postponing the decision about its use.

Following WHO (2003a), a forensic examination should contain:

- the initial assessment including an assessment of the priorities and obtaining informed consent
- the medical history including the general medical history, the assault itself, possibly also some of the circumstances of the trafficking situation, when it is of medical relevance
- the physical examination
- recording and classification of injuries
- diagnostic tests, specimen collection and forensic evidence

Very practical hands on routines for collecting and documenting medical histories and forensic evidence for victims of sexual or domestic violence have been developed by WHO (2003a) and BM.I et al. (2013), respectively. They can easily be adapted to documenting medical histories of victims of THB. However, to introduce or adapt these more extensive formal procedures of forensic examination, one has to respect local laws, regulations and protocols. This is of particular importance for the storage of and the access to records. Patient records and information have to be kept strictly confidential, and in accordance with local, state and national statutes. Forensic evidence and specialised forensic documentation should only be produced, when it is clear what use they are intended for if issues of confidentiality arise.

V.

Creating local referral mechanisms

In caring for presumed and identified victims of trafficking, health care professionals and health care providers are not alone. Given the diversity of victims and the variety of circumstances and different implications of trafficking, there exists a wide range of institutions with different roles and specialised tasks, which might be able to assist victims of trafficking. In order to be able to refer patients to the 'best' institution in terms of fitting in with the needs of the victim, it is crucial to know about these other institutions in advance, i.e. before encountering a patient that might be a victim of THB. The better the knowledge about the diversity of services available to potential victims of trafficking the safer and more effective a referral will be.

However, referral is more than the mere transfer of a patient to another service provider. Even if health care providers are not responsible for caring about all needs of a patient, health care professionals should understand not only the potential benefits of referral, but also the difficulties and potential risks. A health care provider should identify services as potential partners, and develop inter-organizational referral arrangements (Zimmermann & Borland 2009: 117f.).

5.1 Identifying services as potential partners

The variety of potential partners correlates with the diversity of needs of victims in your catchment area, but it also depends on the availability of the various services. Every health care provider will have to compose his/her specific, localised list of service providers. Here are some aspects to consider when looking for adequate service providers, without the claim of full coverage of the issues to be taken into account.

Experts and/or focal points at your institution

For a start, it is advisable for a health care facility to designate a person, a (prospective) expert, who might serve as a contact point and/or coordinator of questions relating to the assistance of victims of trafficking in human beings. Larger institutions might set up focal points or task forces, comprising more individuals from different disciplines. Some of the main tasks of these organisational units are: to accumulate expertise, to develop strategies/policies of assistance and to coordinate the internal as well as external activities, the reach-out, of the institution. They may even serve as points of internal referral, i.e. a hub for standard operating procedures within the institution, to help health care professionals who identified a potential victim of THB in their unit and who are in need of support from other or more specialised units in the health facility.

Counter-trafficking organisations and/or specialised shelters

Many countries have counter-trafficking organisations and specialised shelters for victims of trafficking. Often these facilities are organised by (national or international) NGO's, but sometimes they are state owned facilities. Their focus on counter-trafficking and on assisting victims of trafficking ensures professional experience and expertise, which explains why they are often the preferred address for referrals. Sometimes, these facilities specialise on specific groups of victims (e.g. women, men children) or on specific types of exploitation (e.g. sexual exploitation), but they tend to be the ones who know best about other relevant to which the potential victims may be referred.

National referral mechanism

Many countries have already embarked on developing their own national referral mechanism; they may serve as valuable point of reference for newcomers. As of now, centralised top-down initiatives are still in the making by many national governments. Where they exist they are in general far from comprehensive and too distant for

Example: Father and sons from Poland

A cleaning firm from Poland brought a father and his two sons to Vienna. They did not get their salaries for months, but received threats against their families at home. A street worker, who listened to their story, called the company. As a result, the three workers were paid off with an unknown amount of money, but were also transferred to another office in a different Austrian region and thereby lost contact to the social worker.

Source: Zingerle & Alionis 2013: 32, own translation

local actors to be reached, let alone of immediate use and support of local needs. Therefore, it is essential for health care providers to take complementary, bottom-up action and to develop their own, decentralised referral network, which can link up with their NRM.

Telephone hotlines

A range of different hotlines is available on national and international level, which tend to be maintained by specific service providers, e.g. domestic violence, child service or missing persons hotlines a. In some countries specific counter-trafficking hotlines have been put in place (see for example Hoff, Wijers, Dottridge, Kaverman, & Rabe 2009). Hotlines can serve different purposes. They can aim at the individual victim (which may be a challenging undertaking, given the diversity of languages and needs). But they can also be directed at supporting service providers, who need advice in dealing with presumed victims of THB. The latter is easier to organise and to maintain as a hotline.

Other shelters and housing services

Apart from specialised counter-trafficking shelters (which may be far away from your health care facility) there may be shelters which are closer to you but which are not specialised in helping (presumed) victims of THB. Examples are shelters for victims of domestic violence, children and adolescent shelters, homeless shelters or shelters for

migrants and refugees. These may be helpful service providers, particularly if you refer the prospective victims to the respective service provider closest to the demographic composition or other of your presumed victims of THB, i.e. differentiate between shelters for females, males, children and adolescents.

Health services

Depending on the profile of your own health care facility, it may prove useful to compile a list of partner institutions for medical referral to other health services. Potential candidates are emergency hospitals, reproductive health services and sexual health clinics, mental health and counselling services, dentists, mobile clinics and health services free of charge, or alcohol and drug clinics, to name a few. Special consideration should be given to the services of forensic experts, particularly to help with identification and a medical report which can be used for prosecution of the perpetrator.

Police, law enforcement services

Police units and other law enforcement services have specific institutional profiles and roles in the process of combatting THB, which have to be taken into account. Local police units often do not have the necessary knowledge and training on actions to be taken in case of suspected cases of THB. While all local police units in the area of health facilities should at least have a minimum of training and awareness of the special circumstances and challenges of trafficking cases, this cannot as yet be expected, implying that local police units should only be contacted in cases of emergency. The preferred contact should be specialised counter-trafficking units, or else focal points on sexual violence or abused children.

Contacting law enforcement services can carry certain risks for the presumed victim, since official contacts may have serious legal consequences and may trigger police interventions. In addition, in some countries police officers may be corrupt or may have an agenda that is

not necessarily in the best interest of the trafficked person. Therefore health care providers should link-up with trustworthy law enforcement officers and police officers in specialised police units.

Refugee or immigrant services

Since trafficking in human beings often has to do with cross-border migration, refugee or immigrant services may be valuable sources of assistance for trafficked persons, especially with respect to regulations on asylum, residence rights and other related regulations (e.g. work permits).

Legal aid services

Given the complex legal ramifications of formal identification of victims, the cooperation of law enforcement services, e.g. to serve as possible witnesses and access to legal aid services can be of great help for victims of THB, not least in order to learn about the interlinkages between criminal, immigration and civil law. But health care providers may also find legal assistance and advice when dealing with presumed cases of trafficking very helpful. This information can be provided by independent lawyers or by community legal aid services.

Interpreters

To ensure accurate and successful communication with the presumed victim, it may be necessary to work with interpreters. In cases, where the crime of trafficking may be suspected, it is crucial not to have family, employers or other associates to translate for the patient or to allow them to speak on behalf of the patient. It is therefore often crucial for identification purposes to have professional interpreters at hand, professionals who comply with rules of confidentiality and who can deal with sometime stressful medico-legal cases of presumed trafficking.

5.2

Develop interorganisational referral chains

The following factors may serve as examples of indicators to be taken into account when wanting to develop a referral chain of institutions and potential partners:

- Specialised expertise and non-discriminatory treatment
- Reputation and trustworthiness
- Experience and/or openness towards dealing with victims of trafficking
- Security and accessibility
- Confidentiality and procedures to obtain informed consent
- Language competence, sensitivity towards different cultures, Traditions and religious beliefs
- Financial regulations of services

For developing inter-organisational referral chains, a common view on the following issues should be found between the various organisations/ partner institutions:

Details of services

Identify and clarify the type and extent of services expected from your counterpart and the limits of their expertise and resources. Take potential costs to the patient into account.

Case information and confidentiality

Identify and clarify the extent of information needed on the individual referral, the care and security needs and on ways of keeping the received information confidential. Communicate only necessary and pertinent information.

Patient's information and consent

Discuss and clarify with your partner organisation:

- how the patient will be counselled on all the care to be offered,
- how the information about all options the potential victim has is transmitted and how a full understanding of the options and their implications is guaranteed, and
- how consent for action is obtained from the potential victim.

Explain the respective procedures of your own institution to your partner organisation.

Establish responsible contact persons/units in both institutions

Clarify, who has the authority and responsibility to release or accept cases of referrals, who will arrange the transfer between both institutions, and who will escort a referral case, if necessary.

Follow-up arrangements and feed back

Clarify how post-appointment information-sharing can take place, e.g. about prescription and medical treatment, potential health and security risks. This exchange of information can also include feedback on procedural issues which could improve the inter-organisational relationships. Again, only exchange pertinent information.

Table 7: Institutional partners for referral

Source: adapted from Zimmermann & Borland 2009: 117f.

Service provider, contact details	Description of services	Assessment, general remarks
Experts and/or focal points at your own institution		
Counter trafficking organizations and/or specialized shelters		
National referral mechanism		
Telephone hotlines		
Other shelters and housing services		
Health services		
Police, law enforcement services		
Refuge and/or immigrant services		
Legal aid services		
Interpreters		
Other services		

Table 7 may help you identify the possible referral chain of institutions and services in your area. Note down telephone numbers and contact names, give a brief description of the respective services, include some general remarks on the resources and competencies of the service providers and/or how best to make use of them. Rather than aiming for a comprehensive institutional chain identify trustworthy and reliable candidates for partnership in the fight against THB and the provision of assistance to the potential victims.

5.3

Creating and using pocket cards

Pocket cards can be used as tools for health care providers in the front line, i.e. of health service providers who are likely to encounter trafficked persons at least occasionally. They can serve as reminders of basic information about trafficking, provide succinct instructions on how to deal with trafficking situations and serve as guides to referrals. In that sense pocket cards can connect health care providers with specialised support structures of counter-trafficking.

Pocket cards can be many and varied. Each pocket card should, however, have a clearly defined institutional ownership or editorship, e.g. a focal point for trafficking at a hospital, a local counter-trafficking organisation, or the provider of a national counter-trafficking hotline.

Before developing a pocket card yourself, it may be useful to determine the target audience, e.g. emergency care, outreach services for patients without health insurance, and the catchment area, e.g. a single institution, a region, a country.

Example: No money after debt repayment

A construction worker from Albania was picked up by immigration authorities in Austria. He has been smuggled under the promise of good income opportunities. But after having repaid his debts with the smugglers, his pay was withheld several times. Subsequently, immigration authorities deported the man.

Source: Zingerle & Alionis 2013: 26

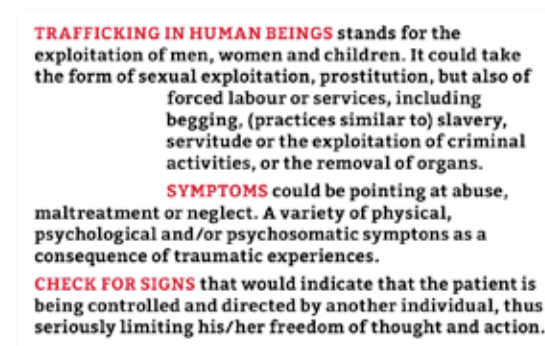
Figure 13: Draft of a pocket card, front side

Source: own graph



Figure 14: Draft of a pocket card, back side

Source: own graph



Much of the information on a pocket card has to be localised and authorised by the editing institution, e.g. referral information or details about the recommended standard operation procedure ('dealing with a trafficking situation').

Pocket cards should only be distributed in the context of training sessions, otherwise they can easily be misunderstood or have unintended effects.

The size of a pocket card could be 8.5 cm x 5.5 cm, which is the standard format of bank cards and business cards. This format makes the pocket card fit easily into wallets and 'pockets'. Depending on the resources available, pocket cards can be produced either as elastic or cardboard cards, or simply as paper card print-outs.

VI.

Prosecution and re- integration, the difficult way forward

Identifying a victim of trafficking in human beings is the most difficult one for health professions, law enforcement and social workers, but it is not the end of the story. The next steps to be taken in order to help prevent THB relate to the prosecution of the perpetrators and re-integration of victims of trafficking. The objective of prosecution is, apart from punishing the perpetrators and confiscating the assets which are the gains from trafficking, to dismantle the criminal network, which is often behind that crime (CPS 2011). To achieve this objective all parties need to cooperate, assisting the public prosecutor to establish a strong case.

It is of crucial importance to gather good evidence, because a victim of trafficking can only hope for compensation and for justice, if the case is brought to court. As far as the role of the medical profession is concerned it is central to establishing a strong case of trafficking. This puts the medical reports together with police evidence and the statement of the victim into the centre of the case. It is one of the three pillars upon which a judge can establish a case. Because of the complexity of THB cases, specialist prosecutors with experience and special training tend to be trusted with the legal case, often going beyond criminal law and applying civil law and labour law.

As most of the perpetrators act within organized crime it is a concern of every government and the European Union to bring as many cases of trafficking into the courts as possible, thereby hoping to break-up the networks. The police and the courts have to provide appropriate protection and safety for the persons giving evidence. Victims may fear to give evidence as well as health professionals and others involved in the identification of the crime. The phase of prosecution represents an interface between health professionals, law enforcement, justice, specialised NGOs and community groups. It is also a phase where the medical profession has to perform various actions, on the one hand to assist the presumed victim of THB, e.g. by providing mental health support and, on the other hand, to help with the identification of the case, e.g. via providing forensic evidence.

Due to the global nature of THB, frequently involving border crossings of the presumed victim, courts tend not only to cooperate with national institutions and agencies but also with international organisations.¹ The role of the prosecutor is to ensure that all possible evidence is brought to the fore. He may also go beyond the focus of the human rights aspect of the crime, e.g. if the victim is not willing to act as a witness, and turn to the economic aspect of the crime. This allows a shift of action from the victim to other witnesses who may provide evidence, thereby taking the load off the victim to serve as witness in the prosecution phase. The onus for providing evidence moves then to the police and to financial investigators. The latter will pursue the financial assets of the traffickers. In this way the prosecutor acts not only in the interest of the victim but also in the public interest.

It has to be borne in mind that victims may not always want to proceed with criminal proceedings, particularly if their residence status is uncertain. However, if victims have been identified as victims of THB and gone through the National Referral Mechanism, they are entitled to a residence permit if they assist with criminal proceedings and act as witnesses.

Re-integration: a complex set of actions

The question of integration or re-integration of victims of trafficking is a complex one. Re-Integration may be seen as a process that accompanies a victim from the point of identification until the final settlement in the host-country (integration) or the source country (re-integration). It involves a variety of organisations, services and professional help and support. The services comprise physical and mental rehabilitation, implying medical and health care as well as social services (including housing, e.g. in a shelter), but also education and training – including language training of the host country – to raise the employability of the victim and to ensure a way back into a ‘normal and

safe’ life. In order to ensure such a life, also community services and the police have a mandate. They have to make sure that the victim is protected from any harm which could flow from standing up against the trafficker, e.g. in the case of prosecution, or from being stigmatised and vulnerable as a result of being identified as a former victim of THB (legal protection). This means that the services comprise medical and psychosocial assistance, shelter, legal protection, counselling, education and training, work, micro-credits, scholarships...

Accordingly, a complex set of institutional cooperation and work across various disciplines has to be put in place by every country – multilevel public sector coordination (from ministerial level to State level and the communities) and multidisciplinary teams (from law enforcement and medical professions to social services, education and training and labour market services).

Standard operating procedures between public sector institutions, NGOs and private industries are a challenge to be addressed. In order to be able to make such institutional coordination work and sustainable a Monitoring System has to be put in place which identifies the kind of support to be provided (victim needs analysis) and which allows an evaluation of the support measures, to help identify what works and where challenges remain.

A major challenge of victims of trafficking concerns the residence status. One could actually promote the coming out/self-identification of victims of THB by ensuring/promising a permanent residence status. As the situation stands today, victims of THB who are citizens of the EU have the right to free mobility and settlement anywhere in the EU. This is not the case of third country citizens, for whom the asylum legislation applies, i.e. temporary residence status in the country of first entry and exploitation (Dublin convention). This may send victims of THB in orbit. Nonetheless, for the medical profession, law enforcement and social services the agenda is clear: they are to provide adequate services in the country of (temporary and/or permanent) residence of the victim. This may mean in case of bilateral agreements between the country of

1. Eurojust is one of those institutions. It was established in 2002 as a permanent network of 27 experienced prosecutors, one from each EU State, whose task is to improve the effectiveness of cross-border investigations and prosecutions in the EU.

exploitation/country of residence of the victim and the source country of the victim that he/she may return voluntarily (assisted voluntary return). In such a case the victim may or may not want to return to the former home community; those who want to be assisted and resettled elsewhere may be afraid of being stigmatised as victims of THB or to escape the environment which may have contributed to their plight.

The above goes to show that Re-Integration may involve various phases:

- In the country of identification of third country citizens: pre-departure assistance (shelter, medical care, legal services...)
- In case of referral to source country: travel assistance
- After arrival in source country: reception, reintegration and resettlement assistance

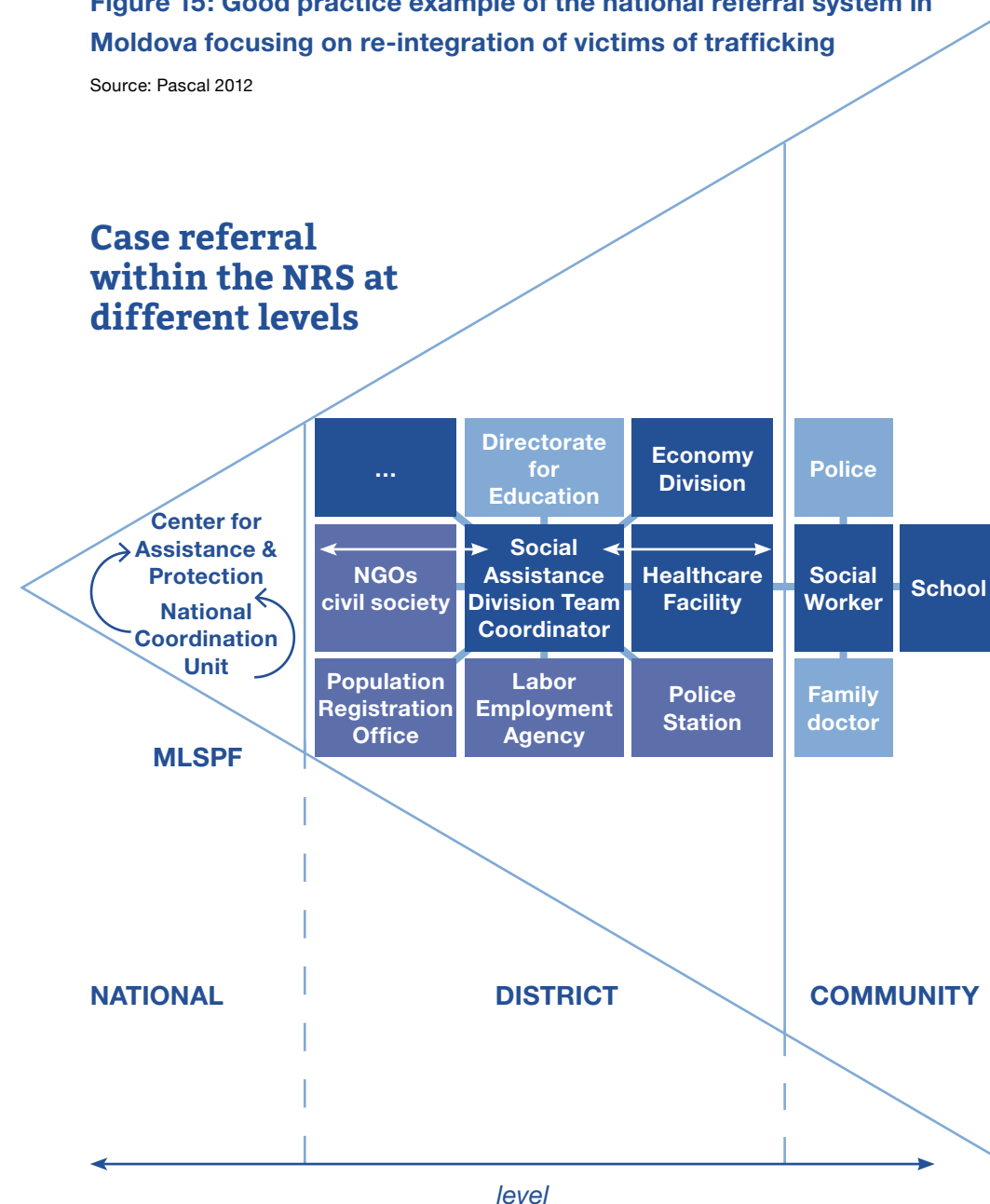
In all these phases cooperation between the various institutions and professions as documented above are key to successful re-integration and rehabilitation. This can be demonstrated by a good practice example of re-integration of victims of THB, as has been developed by Moldova between 2006 and today (Figure 15).

It can be taken from Figure 15 that re-integration measures have to follow a top-down and bottom-up approach. This means that the national referral system is not only a prerequisite for successful identification of potential victims and prosecution of the perpetrators but also a crucial organisational tool to help victims of THB to find their way back into society. As the majority of victims are young and have often not even finished their schooling before being trafficked, it is a moral obligation and an economically rational decision of the society to provide a second chance, i.e. to help take up schooling, choose an occupation and/ or be supported to find an adequate job. At the same time it will be important to provide medical treatment to overcome the trauma of trafficking and social assistance, implying the integration of medical health services and social workers in the re-integration process. But ensuring the security of the victim will be on the agenda for some time to come as well, should re-trafficking be prevented. This means that law enforcement will have to be part of the re-integration strategy as well.

Integration has to be achieved at local level, implying the inclusion of the communities in a national strategy of re-integration, cutting across various ministries and national agencies, as can be expected in a complex horizontal issue as THB.

Figure 15: Good practice example of the national referral system in Moldova focusing on re-integration of victims of trafficking

Source: Pascal 2012



VII.

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Curriculum

The first day of training

is an introduction into THB, an exercise to raise awareness, largely carrying the messages of the 'Brief guide for health care professionals' in the beginning of the manual.

Objectives of the first training day

- To raise awareness of and develop understanding for the crime of human trafficking
- to learn about the motives and actors involved in this serious crime and about the consequences for the individuals/victims
- to learn about the chain of institutions involved in combatting THB, their role in helping the victim and prosecuting the trafficker

Learning outcomes of the first day of training

- The participants will know about the difficulties to identify a possible victim of THB
- The participants will know the main indicators to identify a victim of THB
- The participants will know about the importance of a good medical report and they will know what it must contain.
- The participants will know more about the way to carry out interviews of potential victims of THB
- The participants will know the standard operation procedures to follow if identifying a (potential) victim of THB
- The participants will know about the national or local referral system and the next steps to take.

The target group of the manual are peer group trainers who will need to be familiar with the content material presented above. The training needs differ by type of profession, e.g. between the various health professions and law enforcement (police and border guards). In what follows we focus on a 4-day curriculum directed towards health professionals and law enforcement officers. The first day is conceptualised as in house training in hospitals for health professions and the police of the hospital neighbourhood (first line police officers) as they will have to cooperate in identifying suspected cases of victims of THB.

Day 1: Overview on Victim identification and protection

Unit	Content	Didactic Concept Working Mode
09:00 - 9:30 Session 1	Introduction <ul style="list-style-type: none"> • Trainer Team • Participants • Objectives 	Interaction and Presentation
09:00 - 9:30	Legal Framework	
09:30 - 10:30 Session 1	<ul style="list-style-type: none"> • UN Framework • EU Framework • CoE Framework • National Framework 	Short film Presentation
10:30 - 11:30	Break	
11:00 - 12:30 Session 3	Awareness Raising <ul style="list-style-type: none"> • Definitions of THB • Causes of THB • Consequences of THB • Geography of THB • Myths about Human Trafficking • New Patterns and Trends 	Presentation
12:30 - 14:00	Lunch Break	
14:00 - 15:00 Session 4	European Coordination & Cooperation <ul style="list-style-type: none"> • Specific challenges for the EU (irregular migration, gender discrimination, labour market/employment, child abuse...) • Cooperation against THB (partners, tools to facilitate cooperation) 	Group work Presentation
15:00 - 16:30 Session 5	Case study Importance of victim identification and challenges Indicators for victims Signs of abuse/mistreatment How to file a good medical report Behaviour of potential VOTs	
16:30 - 17:00	Break	
17:00 - 18:30 Session 6	The importance of good questioning Safe referrals Introduction into the use of pocket cards	

Reference list for the first day of training

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The second day of training

is offering a deepening of knowledge on the identification of victims of THB by the health services and the acquisition of skills and competences to better contribute to combatting THB.

The learning outcomes of day 2 will be:

- The participants will be able to identify the gaps between health protection and law enforcement in the three dimensions of THB (identification, prosecution and integration/re-integration)
- The participants will know how to identify victims and what actions to take/procedures to follow (victim protection as well as public health protection)
- The participants will develop skills and learn about best practices for the better medical identification
- A strengthening of interagency relationships and the establishment of contact points/persons in each organisation (specialised and well informed/trained representatives of the respective institutions)

Reference list for the second day of training

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- Susie B. Baldwin, David P. Eisenman: Identification of human trafficking victims in health care settings (2011); In: Health and Human Right, Vol

Day 2: Knowledge deepening and acquisition of skills

Day & Unit	Content	Working Mode
09:00 - 10:30 Session 1	Case study Importance of victim identification and challenges <ul style="list-style-type: none"> • creating a “safe space” in the clinic • medico-legal considerations Indicators of victims of THB <ul style="list-style-type: none"> • General basis • Sexual exploitation • Forced labour • Domestic servitude • Child victim 	Short film/ awareness raising Interaction and Presentation Presentation UNODC indicators, handout
10:30 - 11:00	Break	
11:00 - 12:30 Session 2	Clues of abuse/mistreatment <ul style="list-style-type: none"> • Comprehensive health assessment How to file a good medical report <ul style="list-style-type: none"> • Data collection and security Behaviour of potential VOTs <ul style="list-style-type: none"> • Trauma and P.T.S.D 	PowerPoint/slides of medical examinations Presentation
12:30 - 14:00	Lunch Break	
14:00 - 15:30 Session 3	The importance of good questioning <ul style="list-style-type: none"> • How to perform an interview with a possible VOT; Dos and don'ts • Screening tools • Interviewing children • Cultural barriers • The use of interpreters • Introduction to VITA (Victim Translation Assistance Tool) 	Presentation, group work Pegasus 7 steps model IOM Victim of Trafficking Screening form VITA (www.ungift.org)
15:30 - 16:00	Break	
16:00 - 17:30 Session 4	Safe referrals <ul style="list-style-type: none"> • Assistance, support and protection Introduction into the development of pocket cards	Presentation Counter-trafficking protection and assistance Referral mapping form (example: UN.GIFT) Pocket cards
17:30	End of day 2	

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Day 3: Knowledge deepening and acquisition of skills

Session	Content	Working Mode
09:00 - 10:30 Session 1	Indicators for traffickers <ul style="list-style-type: none"> Traffickers profile Case study	Presentation Short film
10:30 - 11:00	Break	
11:00 - 12:30 Session 2	Protection and Security of victim <ul style="list-style-type: none"> risk assessment victims' rights witness protection measures testimonial options victim's testimony 	Presentation
12:30 - 14:00	Lunch Break	
14:00 - 15:30 Session 3	Evidence <ul style="list-style-type: none"> victim's testimony material evidence medical reports gathered information challenges 	Presentation Interactive discussion
15:30 - 16:00	Break	
16:00 - 17:30 Session 4	Case study of trafficking case <ul style="list-style-type: none"> principles best practice Introduction to the UNODC Trafficking Case Law database	Group work, interactive discussion UNODC Human Trafficking Case Law Database
17:30	End of Day 3 on Prosecution	

The third day of training

is focusing on the prosecution of the perpetrators, focussing on the provision of in depth information and training to law enforcement officers who have to apply active police work to come forward with evidence beyond the one given by the victims, in order to raise the probability of success.

The objectives and learning outcomes of training day three are

- The participants will know about the profile of a trafficker.
- The participants will know about the main aspects of prosecution, such as the rights of a victim and/or witness to trafficking and the testimonial options.
- The participants will understand the importance of good evidence, and they will know what good evidence consists of.
- The participants will have applied their knowledge to a real trafficking case to better understand the principles.

Reference list training third day 3

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The fourth day of training

is bringing all professions and disciplines involved in combatting THB around the table to discuss bottom-up co-operations with a special focus on re-integration of victims into a normal life. As the process of promoting re-integration involves many players, a deeper understanding of the needs of the individual victims is needed and the establishment of efficient support structures which include social, medical, educational and employment issues. In order to provide adequate support, the measures have to be coordinated and monitored. Although every case may be different, for the referral system to be effective differentiated feedback is needed.

Another aspect to be taken into account are the residence rights, as re-integration may imply two different country options of residence. The victim needs new perspectives which means that they may not want to look back or return to the country of origin, for fear of being re-trafficked. Some victims may face threats of their perpetrators, e.g. to harm the victim's family. A shelter can provide transitory help, but one day the victim needs to step out and take full responsibility for her/his life. This process needs support from various players, the medical profession, NGOs, law enforcement, judiciary and public administration.

Objectives and learning outcomes the fourth training day

- The participants will know about the medical, social and education and training needs of a victim of THB for successful re-integration.
- The participants will understand the need for counselling of victims and know about the main tools to support them.

Day 4: Re-integration

Session	Content	Working Mode
09:00 - 10:30 Session 1	Victims need assessment	Lecture
10:30 - 11:00	Break	
11:00 - 12:30 Session 2	Counselling and information to be given to victims <ul style="list-style-type: none"> • legal rights, identity documents, housing, employment, education, training opportunities, assistance with voluntary returns, medical assistance, treatment of traumatized victims, etc. 	Lecture Group work
12:30 - 14:00	Lunch Break	
14:00 - 15:30 Session 3	Safe accommodation <ul style="list-style-type: none"> • Shelters 	Lecture Payoke Handbook
15:30 - 16:00	Break	
16:00 - 17:30 Session 4	Monitoring and evaluation <ul style="list-style-type: none"> • standardized data collection 	Lecture Interactive discussion
17:30	End of Day 4 on (Re)Integration	

- The participants will have knowledge about the shelters and the support provided.
- The participants will understand the monitoring and evaluation of re-integration measures.

Reference list day four

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Colophon

Joint Efforts of Police and Health Authorities to Combat Trafficking in Human Beings. Handbook for professionals at the interface of police and health authorities.

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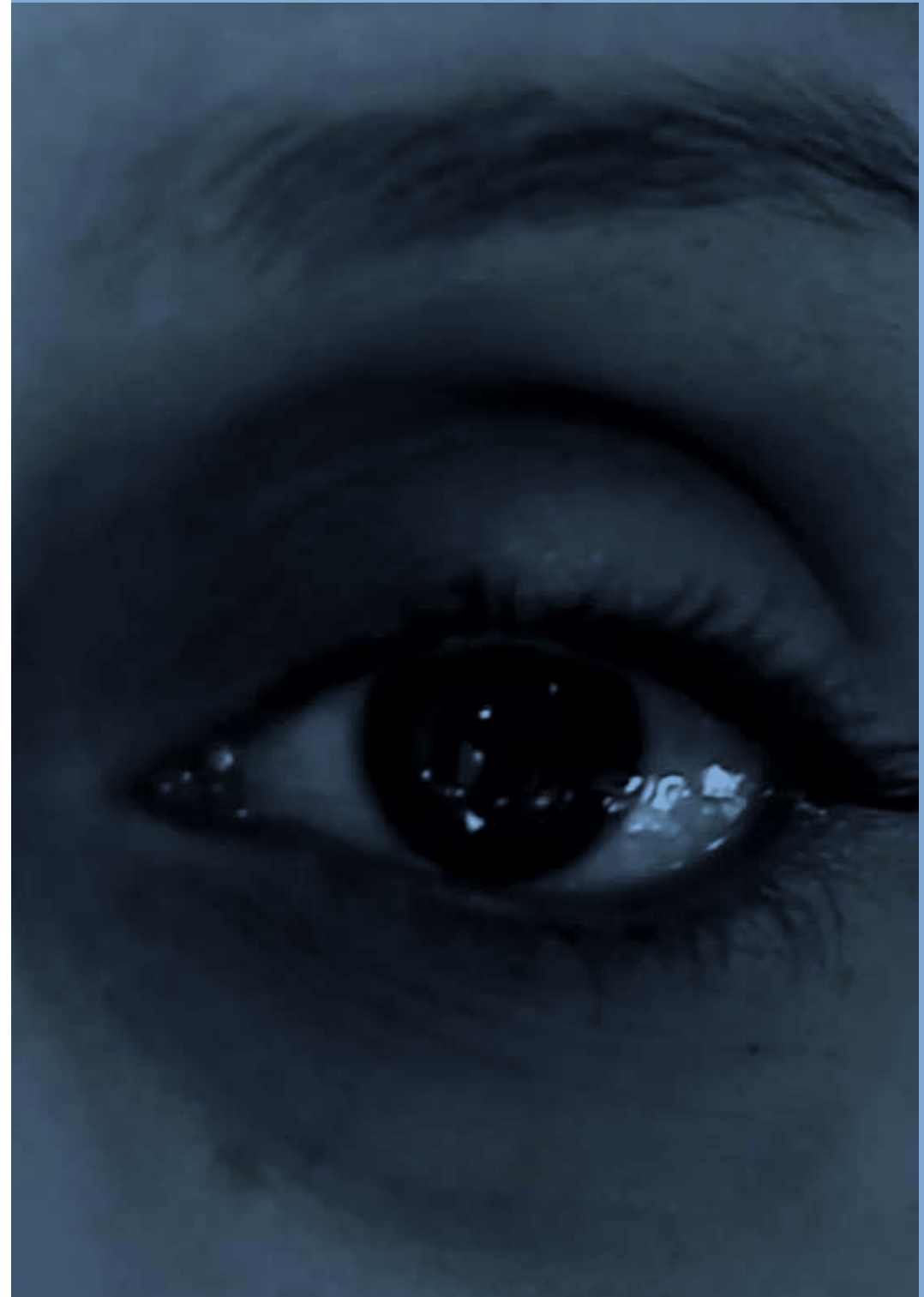
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