Sex trafficking in Ireland from a health care perspective.

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Citation  
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Abstract

Sex trafficking within Ireland is a hidden phenomenon. In 2010, 78 alleged victims were reported to An Garda Síochána and the recorded levels of human trafficking into Ireland have remained at this level for the last four years. Despite this, no Irish guidelines or referral pathways exist to assist health care professionals. This paper highlights that health care professionals are not aware of this occurrence nor have they been trained to identify victims. Due to a lack of awareness many potential opportunities to detect these victims may be missed. While there is no single set of symptoms or signs that differentiates sex-trafficked victims from other sex workers, an awareness of common physical and psychological health problems associated with sex trafficking by health care professionals may increase victim detection rates. This paper summarises indicators, approach mechanisms, screening questions and a referral guideline relevant to the Irish health care system. This step-by-step guide can be used by health care professionals who encounter such a situation.

Introduction

Sex trafficking is a hidden phenomenon. Victims usually have poor access to healthcare and thus may only present when their medical situation becomes severe or life threatening. Although sex trafficked victims are less likely to use health and social services than non-trafficked sex workers, the data from other countries indicate that victims may present to various healthcare settings: within the asylum process, outreach services for prostitution or migrant groups and sexual assault units. One study found that 28% of victims had access to a healthcare provider while still in captivity, however the fact that they had been trafficked went undetected. This illustrates the potential opportunity for intervention by health care professionals if they are equipped with the knowledge of the indicators, appropriate approach mechanisms and screening questions associated with sex trafficking. This demonstrates the need for an awareness raising and training programme amongst health care professionals. Many obstacles are responsible for the silence of these women. If health care professionals are aware of these barriers, they can ensure that these victims are informed of all the relevant referral pathways and support services in place in Ireland which enable them to make an informed decision.

Methods

A review was conducted to address the following topics (1) the migrant sex trafficking epidemiology in Ireland and the Irish response; (2) to determine if under-detection of victims is occurring within the Irish health care system; (3) availability of Irish educational and training resources for health care professionals; (4) indicators, screening questions and approach mechanisms to be used in a health care setting for sex-trafficked victims identification; and (5) sex-trafficking referral resources available in Ireland for health care providers and the possibility of implementing a guideline. A literature review on sex-trafficking in migrants was conducted. The PubMed database was searched using the following keywords: sex trafficking AND female AND humans. We categorised material into three themes; indicators, approach and screening questions. The systemic search was expanded to include grey literature (keywords: sex trafficking and health care professional.) and a backward literature review. Semi-structured interviews were conducted with five key health professionals, from acute care, NGOs, and from state agencies in order to (1) relate our quantitative literature to the Irish context; and (2) to construct referral pathways to be used by health care professionals. Some informants declined interviews stating lack of knowledge which is a result in itself.
Table 1: Flow Chart Summary of Resources

Results

The Irish Situation

Before the introduction of The Criminal Law (Human Trafficking) Act 2008, Ireland was ill-equipped legally, politically and in terms of service provision to deal with this emerging phenomenon. Since then, a National Referral Mechanism (NRM) and four dedicated state units have been setup. A sixty day recovery and reflection period for suspected victims of trafficking and six months Temporary Residence Permission (renewable) exist conditional on participation with authorities. Estimation of the prevalence is problematic due to the criminal nature of sex-trafficking and its overlap with the related activities of prostitution and illegal immigration, and due to the extreme fear which makes disclosure by a victim unlikely. In 2010, 78 alleged victims were reported to An Garda Síochána and the recorded levels of human trafficking into Ireland have remained at this level for the last four years. Sexual exploitation is the most common form of human trafficking with 70% of cases reported to authorities. Women constitute the majority of victims. The most prevalent countries of origin were Eastern Europe, Nigeria, other parts of Africa, South America and Asia. The "2009-2012 National Action Plan" by the former Department of Justice, Equality and Law Reform recognised the need to provide awareness raising training to frontline healthcare providers. It identified the Irish College of General Practitioners (ICGP) to develop a training programme. Development of training resources have been implemented for law enforcement and airline staff and for secondary school teachers; however to date this effort has not extended to health care professionals. In September 2010 a healthcare publication for General Practitioners (GP) and a series of leaflets and information cards were sent to 2400 GPs around the country.
Health care professionals are not aware of this occurrence nor have they been trained to identify victims. Many declined interviews citing lack of knowledge and awareness. Currently existing awareness and training strategies are not tailored to the health care system. Therefore we have created a list of indicators and victim approach advice that is tailored to Irish health service providers. Based on an IOM publication, two tables were adapted taking into consideration the Irish support services available. All indicators should be considered cumulatively. No single set of symptoms or signs differentiates sex-trafficked victims from other sex workers. However, by being aware of the common physical and psychological health problems associated with sex trafficking health care professionals can increase victim detection rates. Screening questions are used to establish whether the definition of trafficking is satisfied, and all questions should be tailored to the victim’s health.

Identification

An in-depth understanding of the sex-trafficking referral pathways available in Ireland was gained. No Irish guidelines or referral pathways existed to assist health care professionals. The safety of each party must be prioritized. Due to security risks rescuing the patient at a particular time may be impossible, but other options are available to assist a patient even if you never encounter them again. All decisions should be made with a patient’s informed consent, engaging the patient in the decision making and educating them on all the available options. One should not coerce a patient into a referral but recommendations can be made to victims to seek an anonymous and comprehensive analysis of their situation in order to make an informed decision. However when children are potential victims of sexual abuse disclosure is mandatory. Within Ireland two referral pathways exist, the National Referral Mechanism (NRM) and non-governmental organizations (NGOs) but they often overlap and are interlinked. State support is available through the NRM, which is conditional on collaboration with investigations. There are a number of NGOs which provide services to victims of trafficking that are non-conditional and confidential and can be used when victims do not want to report the crime for particular circumstances. In Ireland at present people seeking asylum that are also sex-trafficked are not eligible for the same services that non-asylum seeking victims receive.
<table>
<thead>
<tr>
<th>INDICATORS</th>
<th></th>
<th>APPROACH MECHANISMS</th>
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<tbody>
<tr>
<td>• International migrant</td>
<td>• Safety (patient, yourself, health facility)</td>
<td></td>
</tr>
<tr>
<td>• Job sector associated with trafficking</td>
<td>• Alone, suggest private exam required.</td>
<td></td>
</tr>
<tr>
<td>• Physical signs/symptoms: trauma, reactions, injuries, illnesses/infections</td>
<td>• Do not make promises you cannot keep.</td>
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<tr>
<td>• Poor nutrition, hygiene and lack of health care</td>
<td>• Try to get an interpreter. Try to avoid asking anyone accompanying the patient to assist with interpretation/examination, even if they speak the same language. Use a telephone translation service. Ensure a private consultation.</td>
<td></td>
</tr>
<tr>
<td>• Fearful, mistrust, anxious</td>
<td>• Ask the patient whether he/she feels safe to talk about things that may be bothering him/her at this time.</td>
<td></td>
</tr>
<tr>
<td>• Do not speak local language</td>
<td>• Always ask your questions in relation to the patient’s health and in the simplest way possible.</td>
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<tr>
<td>• Legal issues/immigration issues</td>
<td>• Note: Some victims are unaware that they are a victim of a crime. Their rights and support services need to be explained to them.</td>
<td></td>
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<tr>
<td>• Minder/captor (may accompany to serve as translator)</td>
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</tbody>
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Discussion

The lack of awareness and training for victim identification and referrals may exacerbate the under-detection of sex-trafficked victims within the Irish health care system. There are many barriers that prevent these women from reporting the crime to health care professionals: threats to the victims’ family, fear or coercion from traffickers, distrust of authority due to past experiences with corrupt systems within their country of origin and also lack of information on their rights and support services available. The time constraints in clinical consultations may not allow sufficient time to develop trust, an essential component of disclosure. Health care professionals tend to focus on the presenting complaint, possibly missing other indicators and deliver healthcare without tailoring their service to the needs of this vulnerable group.

Educating healthcare providers to identify, assess, and intervene appropriately on behalf of sex-trafficked victims is critical to provision of a comprehensive anti-human trafficking response, and has not been done in this country to date. Victims’ needs vary and the complexity of each situation is acknowledged in this Guideline (Table 4). Health
care professionals should be aware that safety is the primary consideration when dealing with victims of human trafficking. Recognising a victim is only the first step and training is necessary on the different referral avenues available, without compromising both safety and ethical principles. While intervention can be beneficial, making the wrong referral decisions can result in unintended consequences, often causing further damage to victims. Entrance to the NRM is conditional on the patient severing all ties with the trafficker and assisting with investigation. An Garda Síochána have been appointed the first point of contact in the NRM as they are specialized to investigate the validity and in risk assessment. The complexity of situations varies and some victims make the informed decisions not to disclose. Assigning An Garda Síochána as the first point of contact to the NRM may, however, prevent victims from coming forward. The Care Plan constructed by HSE Anti-Human Trafficking Unit (AHTU) consists of 8 categories to fully support the victims towards recovery. If in doubt, health care professionals can refer directly to HSE AHTU who will then activate the referral cascade and contact An Garda Síochána. Having leaflets and information readily available in different languages with contact information can enable health care professionals to deliver contact information discretely to patients.

This research was limited to migrant sex trafficked female adult victims and did not include domestic sex-trafficked victims, nor males and minors. It did not include already identified victims. Thus future research is needed for these population groups. The under-detection of victims of sex-trafficking is a real issue in Ireland and an awareness raising and comprehensive training exercise should be implemented for health care professionals. The referral guideline presented here could be distributed widely to health care professionals within Ireland to enable them to respond and refer appropriately.

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Acknowledgements

We are especially grateful to our key informants who took the time to share with us their insights, perspective and feedback on the referral pathway. We recognise the help of an anonymous reviewers.

References


