

A Compendium of  
Monitoring and Evaluation Indicators

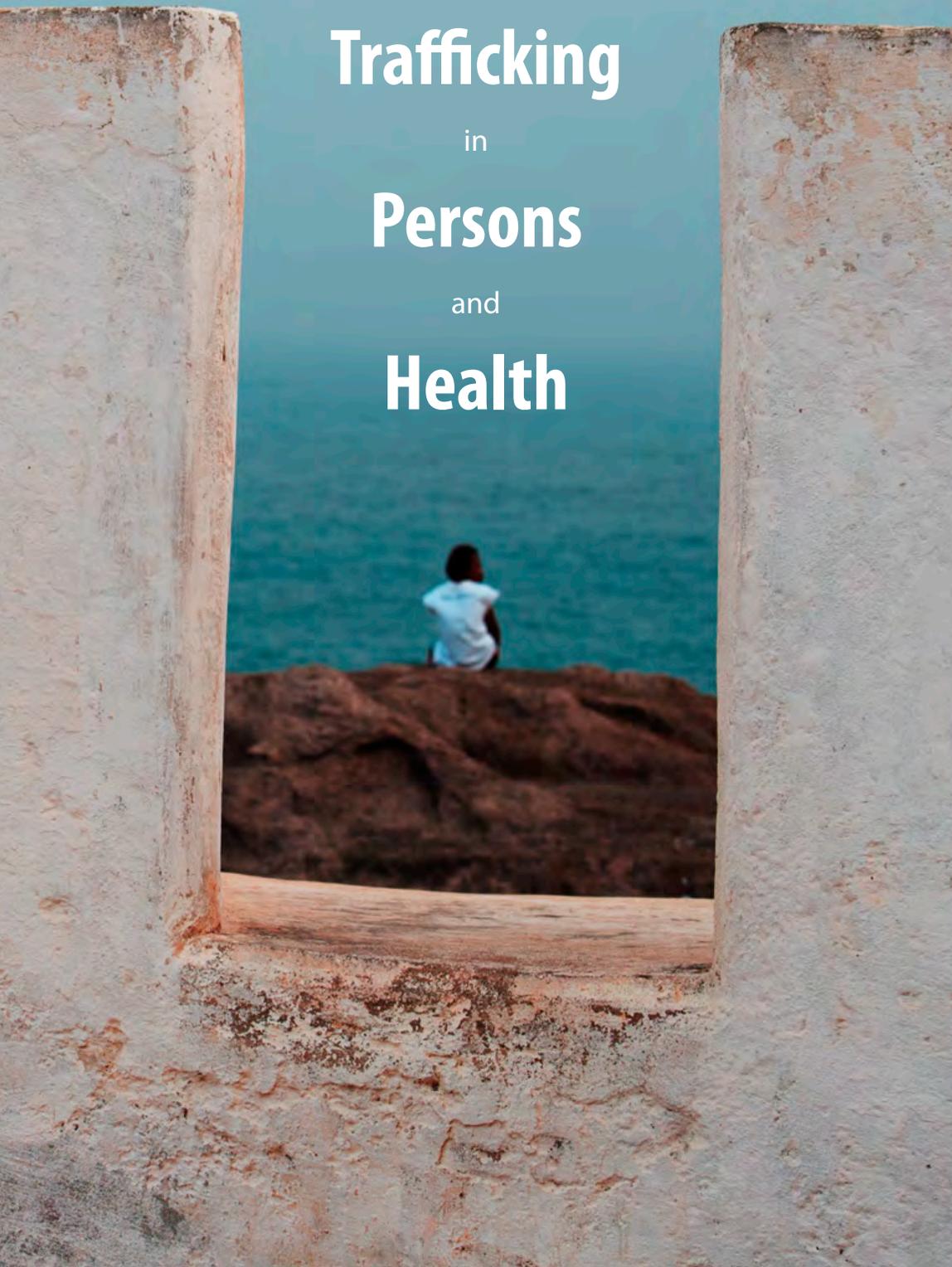
# Trafficking

in

# Persons

and

# Health



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Including Current Methods and Future Directions

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This research has been supported by the President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation cooperative agreement GHA-A-00-08-00003-00 which is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill with Futures Group, ICF International, John Snow, Inc., Management Sciences for Health, and Tulane University. Views expressed are not necessarily those of PEPFAR, USAID, or the United States government. Cover photo by Wayne Hoover.

MEASURE Evaluation would like to thank all who participated in the development of this compendium, and in particular, USAID for the support that made this document possible. We are extremely grateful for the thoughtful contributions by the team of trafficking in persons experts during the consultative meeting and throughout the development process [see Appendix A for participant list]. We extend our appreciation to Carolina Mejia, Jen Curran, and Evis Haake for their assistance in facilitating the consultative meeting, and Jeannine Bratts for her help in ensuring the meeting ran smoothly. Finally, we would like to thank Kristen Wares and Ana Djapovic Scholl for their consistent review, feedback, and support of this effort.

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<b>Acronyms</b>	<a href="#"><u>iv</u></a>
<b>Chapter 1: Background</b>	<a href="#"><u>1</u></a>
Introduction: Trafficking in Persons	<a href="#"><u>1</u></a>
Development of the Compendium	<a href="#"><u>2</u></a>
Organization of the Compendium	<a href="#"><u>3</u></a>
Gender, Health, and Trafficking in Persons	<a href="#"><u>6</u></a>
<b>Chapter 2: Monitoring and Evaluation of TIP Programs</b>	<a href="#"><u>8</u></a>
Program Monitoring and Evaluation	<a href="#"><u>8</u></a>
Where to Go for More Information on M&E	<a href="#"><u>10</u></a>
Ethical Considerations in the M&E of TIP	<a href="#"><u>10</u></a>
<b>Chapter 3: Indicators</b>	<a href="#"><u>13</u></a>
List of Indicators	<a href="#"><u>13</u></a>
Indicator Categories	<a href="#"><u>14</u></a>
Indicator Reference Sheets	<a href="#"><u>15</u></a>
Health Sector Response	<a href="#"><u>16</u></a>
Post-Trafficking Assistance and Outreach Programs	<a href="#"><u>24</u></a>
Health Status and Care Received	<a href="#"><u>32</u></a>
Referrals	<a href="#"><u>41</u></a>
Policy	<a href="#"><u>45</u></a>
<b>Chapter 4: Discussion of Current M&amp;E and Research Methods in TIP</b>	<a href="#"><u>47</u></a>
Methodologies Currently in Use	<a href="#"><u>47</u></a>
Organizational and Systemic Challenges in Research, M&E of TIP	<a href="#"><u>48</u></a>
Moving Forward in Research and M&E of TIP and Health	<a href="#"><u>49</u></a>
<b>Chapter 5: Areas for Further Development</b>	<a href="#"><u>50</u></a>
Recruitment	<a href="#"><u>50</u></a>
Travel and Transit (if applicable)	<a href="#"><u>51</u></a>
Exploitation	<a href="#"><u>52</u></a>
Integration	<a href="#"><u>52</u></a>
Re-integration	<a href="#"><u>53</u></a>
Special Populations or Settings	<a href="#"><u>53</u></a>
<b>Appendix A: List of Participants at Expert Consultation</b>	<a href="#"><u>55</u></a>
<b>References</b>	<a href="#"><u>60</u></a>

<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>AMP</b>	Action, Means, Purpose
<b>DHS</b>	Demographic and Health Survey
<b>FSW</b>	Female sex worker
<b>GBV</b>	Gender-based violence
<b>HIV</b>	Human Immunodeficiency Virus
<b>ILO</b>	International Labour Organization
<b>IOM</b>	International Organization for Migration
<b>LGBT</b>	Lesbian, Gay, Bisexual, or Transgender
<b>M&amp;E</b>	Monitoring and evaluation
<b>NGO</b>	Non-governmental organization
<b>NIH</b>	National Institutes of Health
<b>OHCHR</b>	Office of the United Nations High Commissioner for Human Rights
<b>OVC</b>	Orphans and vulnerable children
<b>SES</b>	socioeconomic status
<b>STI</b>	sexually transmitted infection
<b>TB</b>	tuberculosis
<b>TIP</b>	Trafficking in persons
<b>UN</b>	United Nations
<b>UNAIDS</b>	The Joint United Nations Program on HIV/AIDS
<b>UNDP</b>	United Nations Development Program
<b>UNESCO</b>	United Nations Educational, Scientific and Cultural Organization
<b>UNFPA</b>	United Nations Population Fund
<b>UNGASS</b>	United Nations General Assembly Special Session on AIDS
<b>UNHCR</b>	Office of the United Nations High Commissioner for Refugees
<b>UNICEF</b>	United Nations Children's Fund
<b>UN Women</b>	United Nations Entity for Gender Equality and the Empowerment of Women
<b>USAID</b>	United States Agency for International Development
<b>VAW/G</b>	violence against women/girls
<b>WHO</b>	World Health Organization

## Introduction: Trafficking in Persons

In the field of public health research and prevention, international awareness of trafficking in persons (TIP) has increased significantly. This is also reflected in the growing number of reports, documents and research studies published on the topic. According to the United Nations (UN) *Protocol to Prevent, Suppress and Punish Trafficking in Persons*, TIP is defined as “the recruitment, transportation, transfer, harboring 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.” The crime of trafficking can be determined using the Action, Means, Purpose (AMP) Model. This model requires an action—recruitment, harboring, transportation, provision, or obtaining—of a person using the means of force, fraud, or coercion, for the purpose of exploitation—commercial sex acts or labor services (1–3).<sup>1</sup>

Definitions of TIP vary in conceptualization, implementation, and enforcement of policies and across contexts. While the above United Nations’ definition of TIP is the most widely accepted, the lack of uniformity, along with its clandestine and illegal nature, pose many challenges in data collection and measurement. Accurate statistics on the number of individuals trafficked are very difficult to obtain (4–7). Estimates vary widely from 800,000 persons trafficked across international borders annually to 27 million people living in slavery at any given time around the world; however, there is a lack of consensus on these estimates and the methods used to obtain them (7–9).

TIP is associated with significant individual and public health concerns. Though TIP is gaining attention as a global concern with criminal justice, immigration, and economic and ramifications, the health aspects and consequences of TIP have been neglected (10). Individuals who have been trafficked experience a wide range of negative health impacts, including increased risk of gender-based violence (GBV), mental health problems, poor sexual and reproductive health outcomes, including HIV, physical injuries, and even death (11–35).

Further, researchers have demonstrated that trafficking in persons is fostered by gender inequalities and vulnerabilities on both the demand and supply sides (36). TIP is increasingly recognized as a gross violation of human rights, and certain types are considered a form of gender-based violence. Gender norms make both women and girls and men and boys vulnerable to different types of trafficking, which vary across cultures and settings. Globally, women and girls are more often trafficked for the purpose of sexual exploitation than men and boys who more frequently fall victims of trafficking for forced labor purposes; however, it is important to note that there is a considerable lack of research regarding men and boys who are trafficked into sex or other sectors. Women and girls who have been trafficked face additional gender-spe-

1) It should be noted that the element of means (force, fraud, or coercion) is not required for trafficking if the victim is under the age of 18.

cific health concerns, such as lack of access to reproductive health services, multiple rapes, forced abortion, and increased risk of HIV (37). Research on labor trafficking continues to grow and has also been linked to negative health impacts and gendered vulnerabilities (38, 39). The intersection of trafficking, gender, and health is crucial to understanding and addressing the health needs of women, men and children that have been trafficked. All stakeholders involved in counter-trafficking efforts, from emergency health personnel and program managers to national policymakers must consider the nexus of gender, health, and trafficking to adequately address and combat this complex issue.

## Development of the Compendium

In order to systematically target interventions and track global and country progress in this area, monitoring and evaluation (M&E) indicators are essential. Upon the request of United States Agency for International Development (USAID), MEASURE Evaluation developed this compendium of indicators in consultation with technical experts in the field of trafficking, gender and health.

In October 2013, a consultative meeting of key experts was held, including representatives from USAID, U.S. Department of State, National Institute of Drug Abuse at the National Institutes of Health (NIH), UNICEF, International Organization of Migration (IOM), International Labor Organization (ILO), research institutions, non-governmental organizations (NGOs), and civil society. [See Appendix A for a list of meeting participants.] The goal of the meeting was to reach consensus on the key areas of measurement, and identify or develop indicators for monitoring and evaluating country and program response to trafficking at the intersection of gender and health. Following the consultative meeting, indicators and areas of measurement were synthesized and framed in a conceptual model. Through an interactive process of continued feedback from the expert panel, a final list of indicators was developed for this compendium focusing on the M&E of trafficking within the health sector.

This compendium is designed to assist program managers and decision-makers to plan, monitor, and evaluate their response to trafficking and health. The programmatic areas in this guide cover health sector preparedness, post-trafficking assistance programs' response to health, referrals and policies related to health, and the health status and care received by individuals who have been trafficked. Because trafficking and gender are cross-cutting and pervasive issues that relate to health, there are many other areas not listed in the document that are broadly relevant, but not specific enough for inclusion in this specialized compendium. However, we have included areas for future exploration in Chapter 5, in which a wider range of areas important to trafficking and health, but not directly linked to the health sector response, are discussed. These areas of measurement, such as education and community awareness, were discussed at length during the consultative meeting and throughout the feedback process. Given the need for field-testing and increased evidence in these other areas, specific indicators were not recommended. Rather, the areas for which

measurable and sound indicators could be developed and collected are described. Additional research and indicator development will be vital to addressing trafficking as they relate to the intersection of gender and health in a wider context, including areas that indirectly impact health.

## Organization of the Compendium

The *Conceptual Framework for Human Trafficking, Health, and Gender* (Figure 1) is adapted from Zimmerman et al., for this compendium. It illustrates health and TIP as a multi-staged process of cumulative harm and covers five main stages of trafficking: recruitment, travel and transit (though movement may not always occur as part of trafficking), exploitation, integration, and re-integration (10).

Gender inequalities are added as a cross-cutting concept, as they impact individuals' vulnerability to, experience of, and recovery from trafficking. It should be noted that not every individual will go through all stages of trafficking described in the Zimmerman et al., model or experience all of the potential related health consequences. The framework has been adjusted to highlight that while movement often occurs during trafficking, it is not necessary, as individuals can be trafficked in their own place of origin by their own families (40).

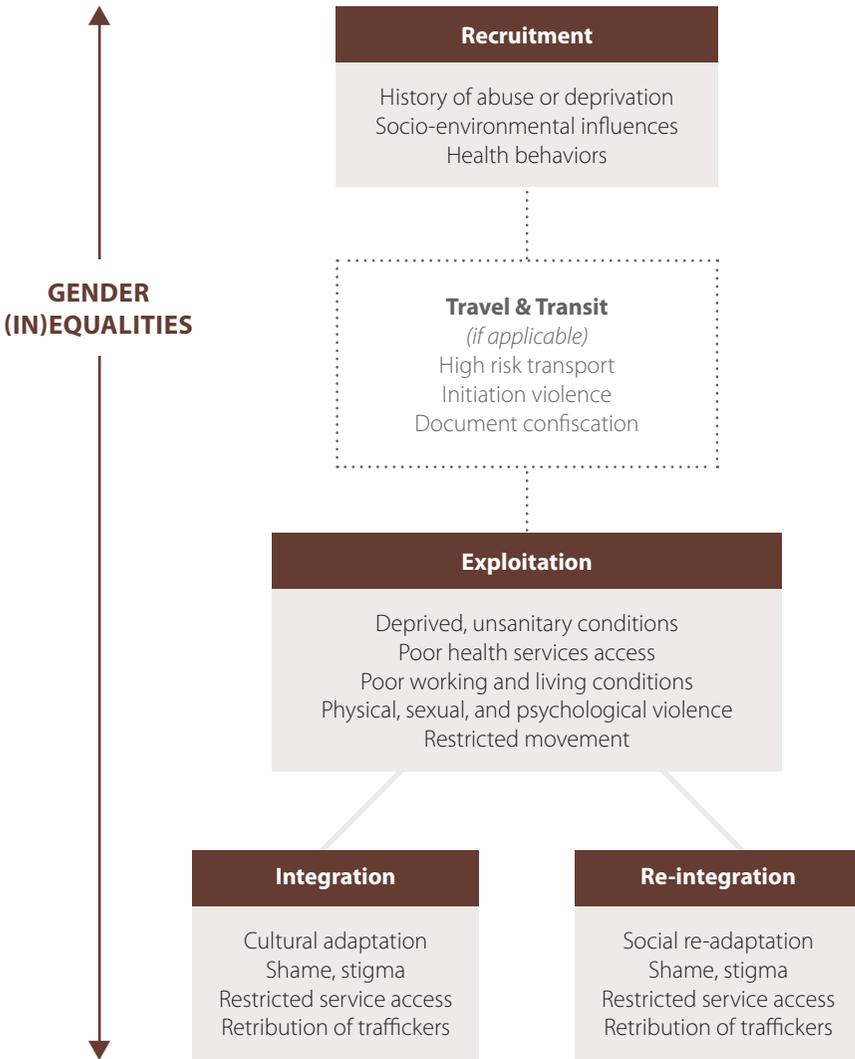
Different health risks and opportunities for intervention may arise in each stage of trafficking. The indicators in this guide fall primarily under the exploitation and integration phases because these stages involve interaction within the health sector. [See Chapter 5 for discussion on areas for future exploration in other stages of trafficking.] We use this conceptual model not as a prescriptive format for evaluating the health effects of trafficking, but as a way to organize and highlight some of the important areas in which indicators have been—or should be—developed for monitoring and evaluating the health sector response to trafficking. This model conceptualizes trafficking, health, and gender; however, it does not replace the foundational Action, Means, and Purpose model detailing the key elements of trafficking (2).

This compendium is designed to be a menu of indicator options to allow users to select indicators that are most applicable to their programs and health facilities. The indicators are meant to be applicable to both labor and sex trafficking.

### **Recruitment**

Recruitment is the stage during which vulnerable individuals are induced, recruited, harbored, transported, provided, or obtained, through force, fraud, or coercion, for exploitative purposes by individuals or agencies (10). It is notable that many individuals who have been trafficked have also have a history of physical and/or sexual abuse prior to their trafficking, and have experienced political instability and economic insecurity (11). In general, it is important to note that there is limited research on people's susceptibility to TIP and there are no clear demographic patterns of who is trafficked (10, 41).

**Figure 1—Conceptual Framework for Human Trafficking, Health, and Gender**



Adapted from: Zimmerman C, Hossain M, Watts C. Human trafficking and health: A conceptual model to inform policy, intervention and research. *Soc Sci Med.* 2011;73(2):327–335.

**Travel and transit (if applicable)**

Travel and transit refers to the stage in which individuals, through force, fraud, or coercion, are transported or controlled by a trafficker for the purpose of exploitation. It is important to note that this stage, or movement of any kind, is not a requirement for trafficking, though it is common. If travel or transit does occur, individuals may be exposed to hazardous transportation, risky border crossings, unauthorized migration, initiation of physical and sexual abuse, and environmental harms (10). Individuals may start to realize they are being trafficked during this stage, at which point they may experience initial psychological trauma. At the end of this stage, the trafficked person may remain with their trafficker for purposes of exploitation, or may be sold as a commodity to someone else, who will then exploit them.

A specific health effect for women and girls, in particular, that may occur during the travel and transit stage is initiation of sexual violence (10). Sexual violence may be directly perpetrated by traffickers themselves, as the beginning of a pattern of coercion and abuse for preparation for the trafficked women and girls to become sex workers, or may be an outcome of risky travel through insecure areas. Sexual and reproductive health care may also be withheld at this stage, and in the future. Similarly, the travel and transit stage may be psychologically damaging to trafficked people as they both begin to understand that they have been deceived and experience coercive and controlling events (10).

**Exploitation**

Exploitation refers to the time period in which individuals are forced or coerced into working or performing services for their trafficker. During this stage, individuals may experience forced labor, debt bondage, sexual, physical and psychological abuse, deprivation, confinement and threats towards them and family members (10). Women who are trafficked for sex often experience high rates of threats and physical and sexual abuse (11). Individuals who are trafficked for labor exploitation are also susceptible to sexual abuse, and also report incidences of threats, physical violence, and hazardous labor conditions. Some individuals experience life-threatening violence, slave-like conditions, or even death, while others are threatened, intimidated and made to feel enslaved.

As the exploitation stage proceeds, trafficked individuals may experience increased health issues. Access to health services during this stage is often rare, unless there is a severe or debilitating injury or illness (10). While accessing health services may be rare, when it happens, this is a key opportunity for health providers to identify potentially trafficked persons, refer them to appropriate help, and provide trauma-informed services (42).

**Integration**

Integration is a long-term and multidimensional stage in which trafficked persons leave their trafficking situation, and possibly relocate, to become active economic, cultural, civil and political members of their community or country and begin to feel as if they are accepted (10). During this period, individuals may experience stigma,

risk of re-trafficking, psychological trauma, difficulty accessing services, and legal insecurity (34). Thus, it is critical that future research regarding integration focus on assessing the experience of stigma and shame, as well as access to essential health and social services geared toward trafficked persons.

### ***Re-integration***

Re-integration is similar to integration, except that this stage applies to trafficked individuals who were removed from their communities of origin and have returned home after trafficking (10). During this stage, they may experience stigma, risk of re-trafficking, psychological trauma, and difficulty accessing services (34). They often encounter difficult conditions, such as financial insecurity, issues with their family, and lack of safety and security (10, 43).

## **Gender, Health, and Trafficking in Persons**

It is well known that TIP is harmful; however, there is a dearth of research on the comprehensive health effects of trafficking, particularly around forms of trafficking other than sexual exploitation (e.g., labor trafficking, child soldiers, begging) and/or trafficking of men and boys. The majority of current research focuses on women and girls that have been trafficked for sex (20) and illuminates the specific negative health outcomes for trafficked individuals. Early research by Zimmerman and colleagues documented a wide range of health consequences including: injuries from physical and sexual violence, poor reproductive health outcomes, mental health symptoms (including depression, anxiety, and suicidal ideation), forced substance use, substance use as a coping mechanism, headaches, fatigue, and weight loss (34). Mental health problems were shown to persist longer than most of the physical health problems. Subsequent research has confirmed and elaborated on these health effects resultant from trafficking (11–33, 35).

Furthermore, most research on the health effects of trafficking has focused on sex work and HIV risk. Among girls and women trafficked for sex work, young age at trafficking has been shown to be associated with longer brothel stays, and in turn with increasing risk for HIV infection (13, 16). Additional research has confirmed that the health and HIV risks for women who are trafficked for sex differ from sex workers who were not trafficked. Studies have shown that female sex workers (FSWs) who were trafficked reported significantly greater numbers of male clients, faced greater difficulties with condom use, and were less knowledgeable regarding HIV transmission than FSWs who were not trafficked (29, 44) while other research has shown no difference in condom use or knowledge, but that women entering sex work via trafficking reporting significantly more clients and more days of sex work (35).

Individuals trafficked for various forms of labor (such as fishing, agriculture, manufacturing, mining, construction, domestic servitude, begging, drug dealing, or food services) or trafficked for the trade of human organs may encounter different health implications than individuals trafficked for sexual exploitation. Research is severely

lacking in these areas of exploitation, but what is known is that health risks of labor trafficking can include poor ventilation and sanitation, exposure to chemical or bacterial hazards, lack of protective equipment, repetitive motion strain, extreme temperatures, and extended work hours (10, 45), as well as sexual abuse. Individuals trafficked for organ removal also face various health consequences such as poor health outcomes following surgery, loss of productive work time, and lack of compensation for damages (46).

Regardless of the type, TIP is set on a backdrop of unequal gender and power dynamics. Gender is the manifestation of socially constructed roles, behaviors, and expectations that are placed on people based on their sex, and vary across place and time (47). Decades of research have demonstrated that gender inequality and violations of human rights have a negative impact on a range of health outcomes for adults and children, through direct and indirect effects (48).

These power imbalances and gender inequalities contribute to the vulnerability of women and minority groups, making them more susceptible to abuse and trafficking (37). Women often lack legal protection, access to health care, economic empowerment, and education, increasing their vulnerability to exploitation, abuse, and TIP (36). Other gendered aspects of trafficking include the feminization of poverty and migration, vulnerability to gender-based violence, and the mislabeling of TIP as only ‘trafficking among women and girls’ (49). Though women are more often trafficked into the sex industry or domestic servitude and men are more frequently trafficked for labor, these gender dynamics call for additional research and attention (36). The intersections of gender, race, and economic marginalization may also influence trafficking risk, particularly for boys (50). Lesbian, gay, bisexual, and transgender (LGBT) individuals are also at increased risk of or vulnerability to trafficking due to discrimination based on their gender identification or sexual orientation (46, 51).

Trafficking is a gross violation of human rights and has serious negative health consequences for any individual that is trafficked. These negative health consequences are also compounded by gender inequalities. Gender inequality can increase vulnerabilities to being trafficked, increase risk of abuses during trafficking, and decrease access to care and treatment during and post-trafficking, as well as increase stigma experienced during integration and reintegration. While gender norms are known to cause differentials in health services access and uptake in general, trafficking can exacerbate these issues due to limited mobility, lack of financial resources, stigma, and health care providers who are not trained to identify and treat victims of trafficking. In addition, health problems are often more advanced by the time trafficked people are able to reach health care (52).

Existing research on TIP and health calls for strengthening the evidence base, methodology, and existing data on health and trafficking to document health consequences, evaluate what works, and improve programs and policies for trafficked persons. This compendium has been developed to assist program managers and decision-makers to monitor and evaluate their response to trafficking, gender, and health.

## Program Monitoring and Evaluation

Monitoring and evaluation (M&E) is the process by which data are collected, analyzed and presented in order to provide information to program managers, policy makers and others related to the progress and results of program implementation and effectiveness. The goal of M&E is to assess and improve the implementation of programs, as well as to demonstrate the effectiveness of those programs. The way a program collects, analyzes and reports data is systematically described in a document called an M&E plan. For example, a good M&E plan will help keep counter-trafficking in persons programs on track, guide the process needed to achieve their stated objectives, and describe how they will demonstrate the effectiveness of their strategies. In this section, we will describe some basic components of M&E that would relate to indicators for and M&E of TIP.

### ***Program monitoring***

Monitoring is the system of routine tracking of a program used to understand how well programs are running on a daily, weekly, monthly or quarterly basis, and where any bottlenecks may exist in overall implementation. Monitoring shows that the program inputs are being used effectively and whether they are leading to expected program outputs. For example, a program designed to train health care providers on identifying and referring potentially trafficked persons will want to keep track of (or monitor) the level of inputs such as funding, staff time, and material development as well as outputs such as number of trainings held in a given period of time. Changes detected in the expected performance levels in these inputs and outputs will alert program managers to possible problems.

### ***Program evaluation***

Evaluation is used to demonstrate how effective programs have been in achieving their targets and results. The data used for program evaluation will be drawn from a number of different sources, such as periodic data collection from surveys (e.g., Demographic and Health Surveys, if applicable), program indicators, or special studies. The information from program evaluations can be used to revise program practices, to achieve better outcomes, as well as to report to donors (Global AIDS Reporting, Millennium Development Goals, etc.).

### ***Criteria for selecting quality indicators***

An indicator is a variable that measures a specific aspect of a program or project. To be effective, indicators should reflect the stated goals and objectives of a program. Indicators are used to show if activities were implemented as planned, or if the program has influenced a change in a desired outcome. The specific program aspect measured by an indicator can be an input, output, or expected outcome. Several criteria describe a good indicator. Indicators must be valid, reliable, comparable (over time or between settings), non-directional, precise, measurable, and programmatically important (53).

Criteria for Selecting Indicators	
<b>Valid</b>	Indicators should measure the aspects of the program that they are intended to measure.
<b>Specific</b>	Indicators should only measure the aspect of the program that they are intended to measure.
<b>Reliable</b>	Indicators should minimize measurement error and should produce the same results consistently over time, regardless of the observer or respondent.
<b>Comparable</b>	Indicators should use comparable units and denominators that will enable an increased understanding of impact or effectiveness across different population groups or program approaches.
<b>Non-directional</b>	Indicators should be developed to allow change in any direction, and not specify a direction in their wording (for example: an indicator should be worded as the level of awareness instead of an increased awareness).
<b>Precise</b>	Indicators should have clear, well-specified definitions.
<b>Feasible</b>	It must be possible to measure an indicator using available tools and methods.
<b>Programmatically relevant</b>	Indicators should be specifically linked to a programmatic input, output or outcome.

Indicators are only as good as the quality of the data used to measure them. Data quality begins with careful protocols guiding data collection, but it can be affected at any point afterwards, including the way it is entered on forms (computerized or not), tallied or aggregated at higher levels, and analyzed to calculate specific indicators. Many factors contribute to poor data quality, including:

- double (or over) counting, when a person, service or other programmatic aspect is counted more than once;
- lack of coverage or appropriate sampling technique that ensures the target population or services are represented in the sample;
- the accuracy with which records are created and reported to a higher system;
- precision used to record the data; whether or not the data reflect current information (timeliness);
- organizational or staff capacity (including finances, time, training, support/supervision, etc.); and
- integrity with which the data are recorded (do people have an interest in not reporting accurately?).

Staff collecting and processing the data need to be trained to understand how important data quality is to the success of the program, as well as empowered with the skills they need in order to retain data quality. Data quality should be addressed in M&E plans by describing the standards used for collection, storage, analysis and reporting. Staff who understand how the data they are collecting will be used, and experience the benefits of data use for program improvement, are more likely to be mindful of data quality (53).

## Where to Go for More Information on M&E

The information in this section provides an introduction to the rationale behind monitoring and evaluation (M&E), and basic definitions of its core concepts. More detailed information on M&E can be found on the MEASURE Evaluation website ([www.measureevaluation.org](http://www.measureevaluation.org)) which includes online courses, links to publications, and other websites pertaining to specific aspects of the field. Also available are two other related and relevant compendiums: *Violence Against Women and Girls: A Compendium of M&E Indicators* (53) and the *Compendium of Gender Equality and HIV Indicators* (48).

## Ethical Considerations in the M&E of TIP

There is a growing demand for high quality information and data to better address and prevent TIP. As a result, trafficked persons are increasingly being interviewed and included as subjects of research (54). It is important that research involving trafficked persons be held to exceptionally high ethical standards to ensure that they do not experience any additional risk or undue harm as a result of their involvement in data collection processes (33).

Trafficked persons often experience injuries and illnesses that bring them into contact with health care providers. For a trafficked person, contact with a health care provider offers a significant opportunity to receive medical care as well as be referred to other critical services (42). Interactions in which information is collected from trafficked persons are highly sensitive due to the particular risks involved. Interviews with trafficked persons may occur at different time points—while the person is still in the trafficked situation, while they are in the care of a service organization, or after they have been reintegrated at home or integrated into a new community. Thus, it is critical for an interviewer or service provider collecting information to consider at which point of the trafficking process the person is, as each stage poses different risks. Interviews with persons who are still under the control of their traffickers can be the most risky; however, interviews that occur after this stage may also pose significant physical and psychological harm (54).

When collecting information from trafficked persons, particular sensitivities must be made to establish trust, obtain cooperation, and understand the subjects' decisions and needs. Interviewers and care providers should approach trafficked persons in a non-judgmental way, with respect and concern for their welfare, in order to elicit honest and in-depth responses (54). Trafficked persons have often experienced traumatic events and it is important for them to feel a sense of safety, dignity and agency. Health care providers have an opportunity to help foster feelings of self-confidence and security by emphasizing confidentiality, valuing informed consent, providing useful referral information and respecting individual choices (42).

It is especially important for interviewers to recognize that each trafficking situation is unique, with different complexities, pressures and solutions. It is critical for service providers to consider what is in the best interests of the individual with whom they are interacting (55). Similarly, there may be special instances where a trafficked person is actually accompanied to a health provider by the trafficker; health providers will need to be aware of this possibility and have training in how to manage this (and other) difficult situations (55).

In 2003, the World Health Organization (WHO) recommended a set of ten guiding principles to the ethical and safe conduct of interviews with women who have been trafficked, the *WHO Ethical and Safety Recommendations for Interviewing Trafficked Women* (54). In addition to these widely recognized principles, the International Organization for Migration (IOM) in 2007 published a set of ethical principles in caring for trafficked persons, *The IOM Handbook on Direct Assistance for Victims of Trafficking* (55). In 2009, the IOM additionally came out with a set of rights-based principles and strategies for health care personnel who come into contact with trafficked persons (42).

While the WHO and IOM guidelines are directed to trafficked females, the guidelines can be applied more broadly to all trafficked persons. However, it is important to note that children and youth who are exposed to trafficking often need special attention. For additional guidance on dealing with younger populations exposed to trafficking, consult UNICEF's *Reference Guide on Protecting the Rights of Child Victims of Trafficking in Europe* (56). Below, we highlight the key principles from the existing WHO and IOM guidelines on ethical research in TIP (54, 55). Guiding principles in conducting research with trafficked people:

- 1. Do no harm.** Treat all trafficked persons as if there is the potential for harm unless evidence points to the contrary. Do not interview any trafficked person whose situation could be worsened from the interaction.
- 2. Identify and assess risk.** Learn and respect the safety concerns of trafficked persons and potential risks to them or their family members. Be particularly mindful of the increased risk involved with interviewing a person who is still in their trafficked situation, as well as the risks to the interviewer or service provider of the trafficked person.
- 3. Ensure confidentiality.** Confidentiality is critical for the safety and welfare of both the trafficked person and the interviewer and also helps to encourage trafficked persons disclose truthful information. Ensuring confidentiality means that all information about and provided by the trafficked person is kept in a secure place, and that the individual is informed of the particular measures taken to protect their anonymity. Data and case files on trafficked persons should be coded and kept in locked or password-protected files.

4. **Obtain voluntary and informed consent.** Make sure that respondents completely understand the purpose and content of the interview, how the information will be used, their right to restrict the information use, and their right to not respond and end the interview or health consultation at any time. Informed consent is essential for medical procedures, health assessments, research activities, and reintegration assistance.
5. **Ensure privacy, safety and security.** All procedures and interviews with trafficked persons should take place in secure and private places away from others, especially their traffickers; if privacy cannot be established and maintained, then the interaction should not take place until a suitable setting is arranged. Before speaking with a trafficked person, it is important to make sure they feel safe and secure; no substantive conversations should take place if the individual does not feel secure and safe.
6. **Provide appropriate medical and referral information and do not make promises that you cannot fulfill.** Be prepared to provide information in the trafficked persons' language about appropriate and trusted support services, including legal aid, medical care, forensic medical exams, counseling, shelter, social support, and security services. Be particularly discrete when providing information to persons who are still in contact with their traffickers.
7. **Be respectful and non-judgmental.** Consider any preconceptions and prejudices you may have and make sure that they do not make you behave in ways that make the trafficked person feel inferior. Provide respectful care that does not discriminate based on gender, sexuality, age, social status, religion, race or ethnicity.
8. **Ask questions in a sensitive way.** The order in which questions are posed, how they are phrased, and the tone in which they are asked are all-important to gaining useful information. This is true for interviews, medical history taking, medical examinations and counseling sessions.

## List of Indicators

Health Sector Response		page
Indicator 1	Proportion of health units that have clinical personnel that have been trained to identify and refer trafficked persons	<a href="#">16</a>
Indicator 2	Proportion of health units that have personnel that have been trained to provide trauma-informed care for trafficked persons.	<a href="#">18</a>
Indicator 3	Proportion of health units that have evidence of trafficking awareness and response materials visibly available.	<a href="#">20</a>
Indicator 4	Proportion of health units that have a documented a protocol for caring for trafficked persons that includes informed consent and stigma-free services.	<a href="#">22</a>
Post-Trafficking Assistance and Outreach Programs		page
Indicator 5	Proportion of labor and occupational health inspectors who are trained to identify and refer trafficked persons within the workplace.	<a href="#">24</a>
Indicator 6	Proportion of post-trafficking assistance programs that facilitate medical and mental health care.	<a href="#">26</a>
Indicator 7	Proportion of post-trafficking assistance programs that use a comprehensive list of health providers.	<a href="#">28</a>
Indicator 8	Proportion of post-trafficking assistance programs that use standardized medical and psychosocial needs assessment tools.	<a href="#">30</a>
Health Status and Care Received		page
Indicator 9	Proportion of identified trafficked persons voluntarily receiving medical and psychosocial care linked to needs identified in a needs assessment.	<a href="#">32</a>
Indicator 10	Proportion of identified trafficked persons who received health care voluntarily through informed consent.	<a href="#">34</a>
Indicator 11	Proportion of identified trafficked persons who received stigma-free and non-discriminatory health services.	<a href="#">36</a>
Indicator 12	Proportion of identified trafficked persons with health issues/conditions.	<a href="#">39</a>
Referrals		page
Indicator 13	Number of identified trafficked persons referred to social welfare services from the health sector.	<a href="#">41</a>
Indicator 14	Number of identified trafficked persons referred to a health unit from social welfare services.	<a href="#">43</a>
Policy		page
Indicator 15	Existence of policies that support and facilitate the health of trafficked persons.	<a href="#">45</a>

## Indicator Categories

### Health Sector Response

The following indicators are designed to measure health sector preparedness and response to TIP. Health units should be prepared to respond to potentially trafficked persons. Health units are often the first line of response to trafficked persons, and thus their ability to identify, refer, and provide appropriate care is essential.

### Post-Trafficking Assistance and Outreach Programs

The indicators in this section relate to the work of projects, programs, and organizations that assist trafficked people during exploitation or after leaving trafficking. What we refer to as “post-trafficking assistance programs” may comprise a number of different types of organizations that provide different services for trafficked people. Organizations most commonly provide legal and immigration assistance, health care and health care referrals, and assistance with other integration/re-integration needs such as housing, employment, and social support. We use the term post-trafficking assistance (as opposed to trafficking assistance) because organizations typically provide support to trafficked people after trafficking due to the difficulties of providing support to currently trafficked people; however, some organizations or outreach programs may serve individuals that are still in their trafficking situation, and these indicators may also be used by those organizations.

### Health Status and Care Received

These indicators measure the health status of and care received by trafficked persons. Documenting the health conditions faced by trafficked persons will provide evidence for programs and decision makers to advocate for improved services and policies. It is also extremely important to understand how and what services were received by trafficked persons in order to increase access to health care, ensure appropriate services, and improve health outcomes.

### Referrals

Health and social services must be able to refer trafficked people to appropriate care and resources to most effectively facilitate treatment and integration/re-integration. This includes referrals from health facilities to other social welfare services and vice versa. A well-functioning social welfare system should have clear linkages between the health sector and other social services.

### Policy

Multi-faceted governmental support is of utmost importance in caring for trafficked people. Strong and supportive policies that are agreed upon, implemented, and regularly monitored provide a directional foundation for improving the health of trafficked people.

## Indicator Reference Sheets

The indicator reference sheets that follow have been developed through consultation with TIP and M&E experts and extensive literature reviews. Many of these indicators are newly developed and defined, and thus untested in the field. MEASURE Evaluation welcomes feedback regarding the indicators and their application in the field.

Common definitions used throughout the reference sheets:

- **Health unit.** Any hospital, clinic or health facility, including governmental, non-governmental or private, that provides health services.<sup>2</sup>
- **Post-trafficking assistance program.** A program or organization that provides support (legal, immigration, health, or social services) to people who have been trafficked.
- **Geographic area.** May be determined by the team collecting these indicators in a specific local context. For example, a geographic area may be defined by local or geopolitical borders (e.g., country or province), or could be the catchment area of a health unit.

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2) Some types of health units may be more likely to receive and provide care for trafficked people, such as primary care, emergency departments or reproductive health clinics. The team collecting data may choose to exclude certain types of health units that would be less likely to see and treat trafficked people (such as podiatrists, dialysis, etc.); however, this may make comparison across contexts more difficult.

## Indicator 1

Proportion of health units that have clinical personnel that have been trained to identify and refer trafficked persons

### Definition

- Proportion of health units in the geographic area of interest that have clinical personnel who have been trained to identify potential victims of trafficking and refer them to appropriate services.
- *Trained to identify and refer* means that the health provider has completed a training that included information on how to recognize trafficked persons and offer referrals to appropriate services (such as health, social welfare, legal, or mental health services) within the last 3 years. By offering referrals to appropriate services, the provider is not mandating the trafficked person receive said services.
- A *health unit* is any hospital, clinic or health facility, including governmental, non-governmental or private, that provides health services.

### Numerator

- Number of health units in geographic area of interest who have personnel that have been trained to identify and refer trafficked persons in the past 3 years.
- Ask manager or health unit representative:
  - » Are there providers at your facility that have completed a training on identifying and referring trafficked persons in the past 3 years?
- If there is at least one provider who has been trained at the facility, the facility would be included in the numerator.

### Denominator

- The total number of health units surveyed within the geographic area of interest.

### Disaggregate by

- Level (health post, health clinic, hospital, etc.) and type (government, NGO, private, etc.) of health unit.
- Region or province (if national study).
- Urban or rural.

### What it measures

- This is an indicator of readiness for health units to identify and refer trafficked persons. If health providers are not knowledgeable in identifying and referring trafficked persons, crucial opportunities to provide services, or even assist a currently trafficked person out of their situation, may be lost.

**Measurement tool**

- A survey of health units in the geographic area of interest. The survey could be part of a specific study on TIP service delivery, or a general study of health units and service provision. The survey should be based on a probability sample of health units in the geographic area of interest.

**How to measure it**

- When health units are visited, a manager is asked if they have any staff who have participated in a training on identifying and referring trafficked persons. Facilities with at least one staff member who has been trained in identifying and referring trafficked persons within the last three years are counted in the numerator. That number is then divided by the denominator, which includes all health units surveyed.
- This indicator suggests using a proportion of health units. If there are not more than 20 units included, it is recommended to use the indicator as a count instead of a proportion.

**Considerations**

- This indicator does not measure the length and quality of the training received, or the providers’ ability to integrate the training into their service provision. It would be useful to query staff about their own readiness to identify and refer based on their training experience; however this would require more resources and effort.
- In addition, the number of total providers in a facility should be considered, when interpreting this indicator. For example, one provider trained in a small facility with only five providers would be a good ratio. However, if the facility was large and only had one provider was trained out of 20, this would be only slightly better than no providers trained since an individual would have little chance of being seen by the trained provider. Lastly, it is important to be aware that indicators relying on self-reports are subject to bias, as the person answering the question may be influenced by what they think the right answer should be.
- It is important to be aware that indicators relying on self-reports are subject to bias, as the person answering the question may be influenced by what they think the right answer should be.
- This indicator measures whether health providers are trained to identify and refer potentially trafficked persons, but does not measure if they are trained to provide appropriate care for trafficked people; for that please see Indicator 2.

## Indicator 2

Proportion of health units that have personnel that have been trained to provide trauma-informed care for trafficked persons.

### Definition

- Proportion of health units in the geographic area of interest that have staff who have been trained to provide trauma-informed care, or a similar approach, to trafficked individuals.
- A *health unit* is any hospital, clinic or health facility, including governmental, non-governmental or private, that provides health services.
- *Trained to provide trauma-informed care* means that the health provider has completed a training focused on providing trauma-informed care for trafficked people, such as the module in the IOM's *Caring for Trafficked Persons: Guidance for Health Providers* training, within the last 3 years. Trauma-informed care is a framework for caring for trafficked persons that involves recognizing the impact of traumatic experiences (including abuse prior to, during, and after the trafficking experience) and treating the person in a way that is individualized, supportive, non-judgmental, integrated and holistic, empowering, and patient-centered. See IOM's *Caring for Trafficked Persons: Guidance for Health Providers* for additional information on trauma-informed care approaches (42).

### Numerator

- Number of health units that have personnel who have been trained to provide trauma-informed care, or a similar approach, for trafficked persons in the past 3 years within the geographic area of interest.
- Ask manager or health unit representative:
  - » Are there providers at your facility that have completed a training on providing trauma-informed care or a similar approach to caring for trafficked persons in the past 3 years?
- If there is at least one provider at the facility that has been trained in the past 3 years, the facility would be included in the numerator.

### Denominator

- The total number of health units surveyed within the geographic area of interest.

### Disaggregate by

- Level (health post, health clinic, hospital, etc.) and type (government, NGO, private, etc.) of health unit.
- Region or province (if national study).
- Urban or rural.

### **What it measures**

- This is an indicator of readiness for health units to receive and treat trafficking survivors using trauma-informed care, or similar approaches. If health providers are not trained to provide trauma-informed care, the services offered could be inadequate, inappropriate, and have negative unintended consequences.

### **Measurement tool**

- A survey of health units in the geographic area of interest. The survey could be part of a specific study on TIP service delivery, or a general study of health units and service provision. The survey should be based on a probability sample of health units in the geographic area of interest.

### **How to measure it**

- When health units are visited, a manager is asked if they have any staff who have participated in a training on providing trauma-informed care, or similar approaches, for trafficked persons. Facilities with at least one staff member who has been trained in provision of trauma-informed care, or a similar approach, within the last three years are counted in the numerator. That number is then divided by the denominator, which includes all health units surveyed.
- This indicator suggests using a proportion of health units. If there are not more than 20 units included, it is recommended to use the indicator as a count instead of a proportion.

### **Considerations**

- This indicator does not measure the length and quality of the training that personnel attended, nor providers' ability to integrate the training into their service provision. It would be useful to query staff about their own readiness to deliver services based on their training experience; however this would require more resources and effort.
- The number of total providers in a facility should be considered, when interpreting this indicator. For example, one provider trained in a small facility with only five providers would be a good ratio. However, if the facility was large and only had one trained provider out of 20, this would be only slightly better than no providers trained since an individual would have little chance of being seen by the trained provider.
- Lastly, it is important to be aware that indicators relying on self-reports are subject to bias, as the person answering the question may be influenced by what they think the right answer should be.

## Indicator 3

Proportion of health units that have evidence of trafficking awareness and response materials visibly available.

### **Definition**

- The proportion of health units that have trafficking awareness and response materials available to patients, community members, and potentially trafficked people. Trafficking awareness and response materials include brochures, pamphlets, information sheets or posters that detail signs of trafficking, how to obtain help, and resources for more information (e.g. hotline number, if one exists). These awareness materials could be posted in areas such as common waiting rooms, bathrooms, or individual exam rooms.
- A *health unit* is any hospital, clinic or health facility, including governmental, non-governmental or private, that provides health services.

### **Numerator**

- The number of health units in the geographic area of interest that have trafficking awareness and response materials posted in at least one place in the facility.
- Ask manager or health unit representative:
  - » Are trafficking awareness and response materials posted in this health unit?
  - » Can you show me at least one place where the materials are posted?

### **Denominator**

- The total number of health units surveyed within the geographic area of interest.

### **Disaggregate by**

- Level (health post, health clinic, hospital, etc.) and type (government, NGO, private, etc.) of health unit
- Rural or urban
- Region or province (if national study)

### **What it measures**

- This indicator measures the availability of trafficking awareness materials for patients and community members who visit the health unit.

### **Measurement tool**

- Survey of health units in the geographic area of interest. The survey could be part of a specific study on TIP service delivery, or a general study of health units and service provision. A probability sample of health units should be selected in order to assess the situation in the geographic area of interest.

**How to measure it**

- To be counted in the numerator, the health unit manager or representative being interviewed must answer yes to the initial question and be able to show at least one place where materials are posted. That number is divided by the This indicator suggests using a proportion of health units. If there are not more than 20 units included, it is recommended to use the indicator as a count instead of a proportion.

**Considerations**

- This indicator measures availability of information regarding trafficking, not its content, quality, or accuracy. It does not measure the effectiveness of the materials, rather it measures whether there is information available for individuals who would like to know more or get help, or raising general awareness about the issue.

## Indicator 4

Proportion of health units that have a documented a protocol for caring for trafficked persons that includes informed consent and stigma-free services.

### **Definition**

- The proportion of health units that have a documented protocol for caring for trafficked people that includes informed consent and stigma-free services in the geographic area of interest. For more information, refer to the OHCHR and the IOM for guidance (55, 57).
- *Informed consent* means that medical personnel explained recommended procedures and treatments to the trafficked person in a language and a way that they can understand (*informed*), and the trafficked person understood and voluntarily agreed to the procedures and treatments given (*consent*).
- *Stigma-free* means that the trafficked person was not treated differently due to their trafficking status.
- *Documented* means that staff are be able to show the protocol during an assessment.
- A *health unit* is any hospital, clinic or health facility, including governmental, non-governmental or private, that provides health services.

### **Numerator**

- The number of health units that demonstrate they have a documented protocol for caring for trafficked people, and that protocol includes informed consent and stigma-free services, within the geographic area of interest.
- Ask manager or health unit representative:
  - » Are there written policies and procedures (a protocol) in this [clinic, hospital, etc.] regarding how to care for trafficked people?
  - » Does that protocol include obtaining informed consent and providing stigma-free services?
  - » May I see a copy of the protocol?

### **Denominator**

- The total number of health units surveyed in the geographic area of interest.

### **Disaggregate by**

- Level (health post, health clinic, hospital, etc.) and type (government, NGO, private, etc.) of health unit
- Region or province (if national study)
- Urban or rural

### **What it measures**

- This indicator measures whether or not a health unit has a standard protocol to guide the identification, treatment, and referral of trafficked persons. The protocol should describe the elements of care that should be provided, and the way in which care should be provided, including obtaining informed consent and providing stigma-free services. The protocol should be displayed or otherwise accessible to health facility staff.

### **Measurement tool**

- A survey of health care units in the geographic area of interest. The survey could be part of a specific study on TIP service delivery, or a general study of health units and service provision. A probability sample of health units should be selected in the geographic area of interest.

### **How to measure it**

- To be counted in the numerator, the health unit must answer yes to all three questions. Health units must be able to show a documented protocol outlining the procedures to be used for identifying, treating, and referring trafficked persons who present to the unit. Health unit staff should be able to state where they can access the protocol when they need to refer to it (e.g., it is posted somewhere, or kept in a place readily accessible to staff). All health units that answer yes to all three questions and show a copy of the protocol are counted in the numerator. This number is then divided by the number of health units surveyed.

### **Considerations**

- It would be ideal to measure how the protocol is implemented, but this would involve a complex assessment. There are currently no standard facility assessments for health unit readiness to deliver services to trafficked persons, but the IOM's *Caring for Trafficked Persons: Guidance for Health Providers* (42) could be used to guide service provision among health providers. This indicator should be paired with other indicators in this section to reflect the preparedness of health units to deliver human trafficking services.
- All health units should include informed consent as part of their standard procedures for any patient, regardless of the type of services or who is receiving health care. Informed consent from trafficked persons is especially important to highlight; however, if the health unit's trafficking protocol does not specifically include instructions on informed consent, but there is an overarching informed consent policy covering all treatment, the health unit may still be counted as part of the numerator of this indicator. The experience of trafficking limits a person's perception of self-control, personal choice, and autonomy. Thus, it is crucial that trafficked individuals are provided information in ways that they can understand (e.g., clear, translated), choice and autonomy during their treatment and recovery.

## Indicator 5

Proportion of labor and occupational health inspectors who are trained to identify and refer trafficked persons within the workplace.

### Definition

- The proportion of labor and occupational health inspectors, in the geographic area of interest, who have been trained to identify and refer potentially trafficked people within the workplace (e.g., agricultural, construction, mining, fishing, factories, domestic workers), to appropriate services.
- *Trained to identify and refer* means that the health inspector has completed a training that included information on how to recognize trafficked persons and offer referrals to appropriate services (such as health, social welfare, legal, or mental health services), within the last three years. (See the ILO's website, [www.ilo.org](http://www.ilo.org), for examples of trainings that have been offered or may be offered in the future.)

### Numerator

- The number of labor and occupational health inspectors in the geographic area of interest who have been trained to identify and refer trafficked people within the workplace in the past 3 years.
- Ask labor and occupational health inspectors:
  - » Have you completed a training on identifying and referring trafficked persons in the last 3 years?
- All inspectors that have attended a training in the past 3 years would be counted in the numerator.

### Denominator

- The total number of labor and occupational health inspectors surveyed in the geographic area of interest.

### Disaggregate by

- Industry of occupation
- Region or province (if national study)
- Urban or rural

### What it measures

- This is an indicator of readiness for labor and occupational health inspectors to identify and refer trafficked persons for appropriate care. If health inspectors are not knowledgeable in identifying and referring trafficked persons, crucial opportunities to assist trafficked persons access services, leave their situation, or seek help, may be lost.

### Measurement tool

- A survey of labor and occupational health inspectors in the geographic area of interest.

### ***How to measure it***

- Labor and occupational health inspectors are asked if they have completed a training on identifying and referring trafficked persons. All inspectors that report they have completed a TIP identification and referral training in the past 3 years would be counted in the numerator. That number is then divided by the denominator, which includes all labor and occupational inspectors surveyed.

### ***Considerations***

- This indicator measures what proportion of health inspectors have completed a TIP identification and referral training; however it does not measure the length and quality of the training, the inspector's ability in identifying, responding to, and referring individuals, or capacity to impose penalties on workplaces which have trafficked persons.
- By offering referrals to appropriate services, the health inspector is not mandating the trafficked person receive said services.

## Indicator 6

Proportion of post-trafficking assistance programs that facilitate medical and mental health care.

### **Definition**

- Proportion of post-trafficking assistance programs that facilitate medical and mental health care, in the geographic area of interest.
- *Facilitate* means offering medical or mental health care on site, providing supported referrals for off-site health services, advocating for health care access, helping clients navigate the health system, and/or assisting clients with transportation to/from health services.
- *Supported referrals* means escorting or arranging an advocate to accompany the trafficked person to the appointment; making advance calls on behalf of clients so they are expected and welcomed when they arrive the referral service location; or a referral letter that they can carry with them, if appropriate and safe.
- A *post-trafficking assistance program* is a program or organization that provides support (legal, immigration, health, or social services) to people who have been trafficked.

### **Numerator**

- Number of post-trafficking assistance programs that facilitate medical and mental health in the geographic area of interest.
- Ask manager or program representative:
  - » Do you provide medical or mental health care to trafficked persons on site?
  - » Do you provide supported referrals for medical or mental health care to clients who have been trafficked?
  - » Do you help trafficked persons obtain medical or mental health care by:
    - Advocating for clients to gain access to health services?
    - Helping them navigate the health system?
    - Assisting or providing transportation to/from health services?

### **Denominator**

- Number of post-trafficking assistance programs surveyed in the geographic area of interest.

### **Disaggregate by**

- Type of post-trafficking assistance program
- Onsite or offsite services
- Medical or mental health care
- Urban or rural

### ***What it measures***

- This indicator measures whether or not post-trafficking assistance programs facilitate medical or mental health care for their beneficiaries. If there is a small proportion of post-trafficking assistance programs that facilitate medical and mental health care, it would indicate that post-trafficking assistance programs are not adequately or systematically responding to the health needs of trafficked persons.

### ***Measurement tool***

- A survey of post-trafficking assistance programs, which could be sample of programs or a census of all programs in the area.

### ***How to measure it***

- In order to be included in the numerator, the post-trafficking assistance program representative must answer “yes” to at least one of the five questions above. All trafficking programs that answer “yes” to at least one of the five questions are counted as part of the numerator, which is divided by the number of post-trafficking assistance programs surveyed in the geographic area of interest.

### ***Considerations***

- This indicator measures whether post-trafficking assistance programs are facilitating medical and mental health care, but it does not measure the type, frequency or quality of services offered.
- It is also important to note that, while not measured by this indicator, safety and security needs should be considered when referring trafficked persons to services.

## Indicator 7

Proportion of post-trafficking assistance programs that use a comprehensive list of health providers.

### **Definition**

- The proportion of post-trafficking assistance programs that use a comprehensive list of health providers for trafficked people in the geographic area of interest. A comprehensive list of health providers includes, but is not limited to: general health services, sexual and reproductive health services, mental health services, and dental or oral health services. In order for the list to be “used,” the post-trafficking assistance program must report that at least one trafficked person was referred to a provider on the list in the last 30 days.
- A *post-trafficking assistance program* is a program or organization that provides support (legal, immigration, health, or social services) to people who have been trafficked.

### **Numerator**

- Number of post-trafficking assistance programs in a geographic area of interest that use a comprehensive list of health providers to refer trafficked people to.
- Ask manager or program representative:
  - » Do you use a comprehensive list of health providers in the area to refer trafficked individuals to?
  - » May I see the list of providers?
  - » When was the last time an individual was referred to a health provider on this list?

### **Denominator**

- Number of post-trafficking assistance programs surveyed in the geographic area of interest.

### **Disaggregate by**

- Type of post-trafficking assistance program
- Rural or urban

### **What it measures**

- This indicator measures commitment to a comprehensive and collaborative approach to health care for trafficked persons. A small proportion of post-trafficking assistance programs that use a comprehensive list of health providers indicates that programs may not be connecting trafficked people to necessary health or mental health services in the area.

### **Measurement tool**

- A survey of post-trafficking assistance programs, which could be sample of programs or a census of all programs in the area.

### **How to measure it**

- In order to be included in the numerator, the post-trafficking assistance program must answer yes to the first question and be able to show the list, which must include at least one provider for each of the following services: general health services, sexual and reproductive health, mental health, and dental or oral health services. The answer to the third question must be within 30 days of the interview for the post-trafficking assistance program to be counted in the numerator. The numerator is divided by the denominator, which includes all post-trafficking assistance programs surveyed in the geographic area of interest.

### **Considerations**

- This indicator is only applicable if there are the listed health services available within the geographic area of interest and if the post-trafficking assistance program does not provide direct care (or direct care in all health areas). If the program does not have a system for tracking referrals, it could be difficult to ascertain the use of the list within the past 30 days. This indicator is not applicable if the post-trafficking assistance program has not encountered any trafficked individuals that needed health or mental health care in the past 30 days.
- This indicator does not measure the quality of service providers on the list, whether they have been trained to provide appropriate services to trafficked persons, or how often the list is updated.
- Ideally, the referral list should only include providers that have been trained in providing care to trafficked persons. The team collecting this indicator could decide to include a caveat about how recently the provider list must be updated and whether the providers on the list must be specifically trained to treat people who have been trafficked.

## Indicator 8

Proportion of post-trafficking assistance programs that use standardized medical and psychosocial needs assessment tools.

### Definition

- The proportion of post-trafficking assistance programs that use standardized medical and psychological needs assessment tools. Standardized medical and psychosocial needs assessment tools refer to established assessment forms and tools that are used by assistance programs to systematically evaluate medical and psychosocial needs of trafficked persons. In order for the tools to be *used*, the post-trafficking assistance program must report that assessment is offered to all willing trafficked persons, and if accepted, the standardized tool is used each time.
- A *post-trafficking assistance program* is a program or organization that provides support (legal, immigration, health, or social services) to people who have been trafficked.
- See the IOM's *Caring for Trafficked Persons: Guidance for Health Providers*, Action Sheet 4: Comprehensive health assessment for an example of a health assessment (42). Specific assessment tools will vary among countries and languages for cultural and situational appropriateness and validity.

### Numerator

- The number of post-trafficking assistance programs in the geographic area of interest that use standardized medical and psychosocial needs assessment tools.
- Ask manager or program representative:
  - » Are there written assessment forms and tools to assess medical and psychosocial needs of trafficked persons?
  - » May I see a copy of the tools?
  - » Are these tools used with all willing trafficked persons at this organization?

### Denominator

- The total number of post-trafficking assistance programs surveyed in the geographic area of interest.

### Disaggregate by

- Type of post-trafficking assistance program
- Region or province (if national study)
- Urban or rural

### What it measures

- This indicator measures whether or not a post-trafficking assistance program has standard assessment tools to guide the identification and treatment of medical and psychosocial needs of trafficked persons. The standard assessment tools should be used consistently with all willing trafficked persons.

### **Measurement tool**

- A survey of post-trafficking assistance programs, which could be sample of programs or a census of all programs in the area.

### **How to measure it**

- To be counted in the numerator, the post-trafficking assistance program must answer “yes” to all three questions and be able to show the documented assessment tools. This number is then divided by the denominator, which includes all trafficking programs surveyed.

### **Considerations**

- This indicator does not measure the quality or validity of the medical and psychosocial assessment tools. It would be ideal to measure how the tools are implemented, but this is beyond the scope of the indicator. The question, “are these tools used with all willing trafficked persons at this organization?” seeks to determine if the tools are used appropriately and systematically, but relies on self-reports by the program, which could be biased.
- Ideally, there would also be variations of the assessments for different populations, such as those that were trafficked for sex work, or trafficked children. Note that the assessment tools referred to in this indicator should always be used in conjunction with informed consent procedures as described and measured in Indicators 4, 9, and 10.
- This indicator was modified from the indicator E.1.2 in *The IOM Handbook on Performance Indicators for Counter-Trafficking Projects*, page 32 (58).

## Indicator 9

Proportion of identified trafficked persons voluntarily receiving medical and psychosocial care linked to needs identified in a needs assessment.

### Definition

- The proportion of identified trafficked persons voluntarily receiving medical and psychosocial care linked to the needs identified in a needs assessment, such as that described in Indicator 8.
- *Voluntarily* means the trafficked individual is consenting to the medical and psychosocial needs being received.

### Numerator

- The number of identified trafficked persons voluntarily receiving medical and psychosocial care linked to the needs identified in a needs assessment, as determined by record review or interviews with trafficked persons. If using interviews, ask:
  - » Are you receiving services based on the needs determined in your assessment?
  - » Was the treatment explained to you?
  - » Did you understand why you received the service/treatment?
  - » Did you give your permission for them to give you the service/treatment?
- If using record review: The number of records that contain evidence that the trafficked person received medical or psychosocial care linked to a needs assessment.

### Denominator

- If using interviews: The total number of identified trafficked persons interviewed at a post-trafficking assistance program that has standardized needs assessments.
- If using record review: the total number of records reviewed which included standardized medical and psychosocial needs assessments.

### Disaggregate by

- Age and sex of trafficked person
- Type of trafficking

### What it measures

- This indicator measures whether or not trafficked persons are receiving medical and psychosocial services linked to the needs identified in the standardized assessments.

**Measurement tool**

- Interviews with trafficked persons receiving services at an organization that uses standardized needs assessment tools; or, record review at a post-trafficking assistance program that uses standardized assessment.

**How to measure it**

- If using interviews, the trafficked person would need to answer “yes” to all four questions to be counted in the numerator, which should be divided by the denominator, which is the total number of identified trafficked persons interviewed at organizations that use standardized medical and psychosocial needs assessments.
- If using record review: To be counted in the numerator, the record must include the individual’s medical and psychosocial needs assessment results, and documentation of services received that are linked to the needs identified in the assessment. The numerator is divided by the denominator, which is the total number of records reviewed that include a standardized medical and psychosocial needs assessment.

**Considerations**

- If this indicator is measured using record reviews, the results will only be as accurate as the data sources. This indicator does not measure the quality of care being received. When conducting a record review, the voluntary aspect can only be measured if it is explicitly documented in the records that the client has voluntarily consented to services or there is a voluntary consent for services form included in the record. If there is no documentation that services were voluntarily accepted on behalf of the trafficked person, this indicator cannot be measured by record review, or would need to be modified to exclude *voluntarily* from its definition. This could be problematic, as discussed in Chapter 2.2, because ensuring services are available voluntarily is a key part of ethical service provision for trafficked persons.
- When a survey of trafficked people is conducted, interviews with trafficked persons need to take place in a private area and in a sensitive manner, and need to adhere to the ethical standards outlined by the *WHO Ethical and Safety Recommendations for Interviewing Trafficked Women* (54). If trafficked persons are being interviewed, referrals for care should be available to any consenting interviewee for any disclosed health issues that are not currently being treated.
- As currently written, this indicator only applies to individuals receiving services at assistance programs that use standardized needs assessments, such as detailed in Indicator 8. This indicator could be modified for application in a wider trafficking survey, but would need to include a question of whether or not the individual received a needs assessment, which would constitute the denominator.
- This indicator was modified from the indicator E.1.2 in *The IOM Handbook on Performance Indicators for Counter-trafficking Projects*, page 32 (58).

## Indicator 10

Proportion of identified trafficked persons who received health care voluntarily through informed consent.

### **Definition**

- The proportion of identified trafficked people who report giving informed consent for all health services they received at their last visit to a health unit in the geographic area of interest.
- A *health unit* is any hospital, clinic or health facility, including governmental, non-governmental or private, that provides health services.
- *Informed consent* means that medical personnel explained recommended procedures and treatments to the trafficked person in a language and a way that they can understand ('informed'), and the trafficked person understood and voluntarily agreed to the procedures and treatments given ('consent').

### **Numerator**

- The number of identified trafficked people who report receiving health services voluntarily at their last visit to a health unit in the geographic area of interest.  
Ask:
  - » Was the treatment explained to you?
  - » Did you understand why you received the service/treatment?
  - » Did you give your permission for them to give you the service/treatment?

### **Denominator**

- Total number of identified trafficked persons surveyed who have received health services in the past 12 months in the geographic area of interest.

### **Disaggregate by**

- Age and sex of trafficked person
- Type of trafficking

### **What it measures**

- This indicator measures whether or not trafficked persons have been forced, coerced, or medically treated without consent. A high proportion of trafficked people that report receiving health care voluntarily indicates that health care providers are respecting trafficked persons autonomy and rights to make decisions about their health care.

### **Measurement tool**

- A survey of trafficked people. For example, this could be a survey of trafficked people receiving services at a post-trafficking assistance program.

### **How to measure it**

- Individuals that answer “yes” to all questions will be included in the numerator. The numerator will be divided by the denominator, which includes the total number of trafficked people included in the survey that received health services in the past 12 months.

### **Considerations**

- Ensuring that individuals understand and voluntarily accept recommended health services is especially important when working with trafficked people. The circumstances of trafficking remove control, personal choice, and autonomy from individuals; thus it is crucial that trafficked individuals are afforded choice and autonomy during their treatment and recovery. See the chapter on ethical considerations for additional discussion of best practices for services offered voluntarily for trafficked people. It is also important to note that this indicator only measures if individuals are consenting to the services they are receiving; it does not measure the quality of services.
- When a survey of trafficked people is conducted, interviews with trafficked persons need to take place in a private area and in a sensitive manner, and need to adhere to the ethical standards outlined by the *WHO Ethical and Safety Recommendations for Interviewing Trafficked Women* (54). If trafficked persons are being interviewed, referrals for care should be available to any consenting interviewee for any disclosed health issues that are not currently being treated.

## Indicator 11

Proportion of identified trafficked persons who received stigma-free and non-discriminatory health services.

### **Definition**

- The proportion of identified trafficked persons who received health services that were not negatively affected by stigma or discrimination due to providers' negative perceptions of factors that may be related to trafficking status (e.g., sex work, language barriers) in a specified period of time (e.g., past 12 months) in the geographic area of interest.
- *Stigma-free* means that the trafficked person was not treated differently due to their trafficking status.
- *Non-discriminatory* means that health care will be provided without consideration to trafficking status or factors related to trafficking status, such as immigration status, participation in sex work, or any other characteristics of the patient.

### **Numerator**

- The number of identified trafficked people who report receiving services that were stigma-free and nondiscriminatory during a specified period of time (e.g. past 12 months) in the geographic area of interest. Ask:
  - » While you were seeking health services, did you experience any of the following because of your trafficking status:
    - unfair or degrading treatment?
    - denied access to health services, including sexual and reproductive health services, contraceptives and condoms?
    - verbally insulted or threatened by providers while seeking health care services?
    - forced to submit to a health or medical procedure that you did not want to have (including HIV testing)?

### **Denominator**

- Total number of identified trafficked people surveyed who sought health services in the past 12 months in the geographic area of interest.

### **Disaggregate by**

- Age
- Sex
- Type of trafficking
- Type of stigma experienced (per above questions).

### **What it measures**

- This indicator measures whether or not trafficked persons experienced discrimination or perceived stigma from any health care providers because they were trafficked.
- This is important because stigma can be particularly detrimental to individual health and the integration or reintegration of trafficked persons (59). Similar to the way HIV/AIDS-related discrimination discourages individuals from seeking services, stigma associated human trafficking contributes to a fear of seeking health services or other treatment related to trafficking (60). Research reveals that formerly trafficked persons avoid using services because they fear needing to provide compensation to the agencies, as well as a perceived sense of stigma toward themselves or their families (61). It is important to note that feelings of perceived stigma or shame may be heightened specifically for survivors of sex trafficking (62).
- A high proportion of trafficked people that report receiving non-discriminatory health care reflects that health care providers are treating trafficked persons with respect, non-judgment, and are not discriminating against them because of their trafficking experience.

### **Measurement tool**

- A survey of trafficked people. This could be a survey of trafficked people receiving services at a trafficking agency.

### **How to measure it**

- Individuals must answer “no” to all four of the questions (i.e., they experienced no stigma) will be included in the numerator. The numerator will be divided by the denominator, which includes the total number of trafficked people included in the survey that sought health services in the last 12 months.

### **Considerations**

- Stigma-free and non-discriminatory services are especially important when working with trafficked people. The experience of trafficking is often associated with high levels of stigma, and individuals can be faced with discrimination from health care providers, community members, law enforcement, family members or any number of people that know the individuals trafficking experience. It is crucial that trafficked persons are afforded health services that are free of stigma and discrimination, as this can be a barrier to accessing health services. See Chapter 2.2, Ethical Considerations, for additional discussion of best practices for ethical and non-discriminatory services for trafficked people.
- It is important to note that this indicator captures individuals who sought health services and measures how they perceived their treatment, but is not an absolute measure of providers’ level of stigma.

- It is also important to note that this indicator does not address the quality of health care provided, but rather only assesses if individuals experienced or perceived stigma and discrimination while obtaining health care. Additionally, this indicator does not measure stigma from other sources, such as a survivor's family, that may impact their ability to seek out or access health care.
- When a survey of trafficked people is conducted, care needs to be used to ensure that individuals are interviewed in a private area and in a sensitive manner, and needs to adhere to ethical standards as outlined by the *WHO Ethical and Safety Recommendations for Interviewing Trafficked Women* (54). If trafficked persons are being interviewed, referrals for care should be available to any consenting interviewee for any disclosed health issues that are not currently being treated.
- This indicator was adapted from the *HIV Stigma Index*. More information can be found here: <http://www.stigmaindex.org/32/analysis/introduction.html>

## Indicator 12

Proportion of identified trafficked persons with health issues/conditions.

### **Definition**

- The proportion of identified trafficked persons with health issues in a specified time period (e.g., last 12 months) in the geographic area of interest.

### **Numerator**

- The number of identified trafficked persons who report having health issues including but not limited to the list below.
- Ask if the trafficked person has experienced any of the following, in the specified time frame (e.g., last 12 months). Check all that apply (34):
  - » Physical health problems including contusions, cuts, burns, broken bones or other injury
  - » Reproductive health problems including sexually transmitted infections, HIV, pelvic inflammatory disease or pain, infertility, vaginal fistula, unwanted pregnancy, unsafe abortion, unusual or abnormal vaginal discharge, or gynecological infection
  - » Mental health problems including suicidal ideation or attempt, PTSD, depression, anxiety, hostility, flashback and re-experiencing symptoms
  - » Headaches, fatigue, dizzy spells, back pain, stomach/abdominal pain, memory problems or body aches
  - » Weight loss
  - » Substance problems including drug or alcohol dependency or overdose
  - » Chronic health problems such as heart disease or high blood pressure
  - » Any other infections or injuries

### **Denominator**

- The total number of identified trafficked people surveyed.

### **Disaggregate by**

- Age
- Sex
- Type of trafficking
- Health issue/condition

### **What it measures**

- This indicator measures what health conditions trafficked individuals are experiencing or have recently experienced. It is important to note that this indicator is not able to differentiate the timing of when health issues began (pre-, during, or post-trafficking); instead, this indicator provides a broad description of the health of trafficked people. Increases or decreases in this indicator do not necessarily reflect the health sector response to trafficking.

**Measurement tool**

- Special study with a survey of trafficked people, or record review of trafficked persons.

**How to measure it**

- If using a survey of trafficked persons (for example, a survey at a post-trafficking assistance program), all individuals responding “yes” to any of the above health conditions within the last 12 months would be entered into the numerator, which is then divided by the total number of people interviewed.
- If using a record review, it could be completed at a health unit or at a post-trafficking assistance program. If using health unit records, the records would need to specify which individuals were identified as trafficked, and those records would be used as the denominator. If using data from a post-trafficking assistance program, records must include which health conditions the trafficked person is experiencing or has experienced. If health conditions are not listed, narratives in the record could also be reviewed for mention of health conditions. However, it would have to be noted in the narrative which health conditions were present and when they were experienced. All records from individuals, who noted that they experienced any of the above health conditions within the past 12 months (or other specified time period), would be counted as part of the numerator. This would be divided by the total number of individual records reviewed. Counts from different post-trafficking assistance programs within the same community can be summed together for an aggregate number of individuals with health conditions for a specified geographic area of interest, based on either a sample of programs, or a census of all programs within a given area.

**Considerations**

- If this indicator is measured using record reviews, the results will only be as accurate as the data sources. Measurement of this indicator relies on records maintained at health units that record information on trafficking status; if using records from post-trafficking assistance programs, this indicator relies on records that include health information and when they were experienced. This information may not be consistently recorded by different providers, which may lead to over- or underestimates in counting individuals with health conditions. A list of checked boxes of health conditions experienced could be added to trafficking records to ensure that these records are properly counted.
- If a survey of trafficked people is conducted, care needs to be used to ensure that individuals are interviewed in a private area and in a sensitive manner, and to adhere to the ethical standards outlined by the *WHO Ethical and Safety Recommendations for Interviewing Trafficked Women* (54). If trafficked persons are being interviewed, referrals for care should be available to any consenting interviewee for any disclosed health issues that are not currently being treated.
- The team collecting this indicator could modify the time period accordingly, to include shorter or longer time periods.

## Indicator 13

Number of identified trafficked persons referred to social welfare services from the health sector.

### **Definition**

- The number of identified trafficked persons referred from a health unit to social welfare services (such as shelter, case management, mental health services, income generation, or legal assistance) for trafficked people in the geographic area of interest.
- A *health unit* is any hospital, clinic or health facility, including governmental, non-governmental or private, that provides health services.

### **Count**

- The number of referrals made from a health unit to social welfare services, (such as case management, shelter, mental health care) in the geographic area of interest.

### **Disaggregate by**

- Type of referral made
- Age of the trafficked individual
- Sex of the trafficked individual

### **What it measures**

- This indicator captures the extent to which health facilities are referring trafficked people to social welfare services. High numbers of referrals to the health sector may indicate that the health facility is aware of and linking to social welfare services in the area; however, the total number of referrals is also dependent the number of trafficked people identified in the area.

### **Measurement tool**

- Record review at health unit, or Initiating and Receiving Service Referral Registers, if they are used at the health unit.

### **How to measure it**

- Count the number of trafficked persons who were provided with a referral to social welfare services during the reporting period at the health unit, or in the geographic area of interest. For example, count the total number of clients referred to shelter. Next, count the total number of clients referred to mental health services. Counts from different health units within the same community can be summed together for an aggregate number of referrals within specified geographic area of interest, based on either a sample of health units, or a census of all health units within a given area.

### **Considerations**

- This indicator is not possible unless the health forms designate that an individual has been trafficked. In addition, this indicator relies on whether health providers documented if and to where a patient was referred. If the provider did not record the referral information, it could lead to over- or underestimates of the number of referrals. Interpretation of this indicator over time may be difficult because it is a count, not a proportion; it will change as need and demand for service, as well as other factors, fluctuate over time. For example, an increase in the count could be caused by more providers referring, or because more people are being trafficked, or identified as trafficked.

## Indicator 14

Number of identified trafficked persons referred to a health unit from social welfare services.

### **Definition**

- The number of TIP referrals received at a health unit from social welfare services (such as shelter, case management, mental health services, income generation, or legal assistance).
- A *health unit* is any hospital, clinic or health facility, including governmental, non-governmental or private, that provides health services.

### **Count**

- The number of TIP referrals received at the health unit from social welfare services.

### **Disaggregate by**

- Type of referral made
- Age of the trafficked individual
- Sex of the trafficked individual
- Level (health post, health clinic, hospital, etc.) and type (government, NGO, private, etc.) of health unit
- Rural or urban
- Type of social welfare service person is being referred from

### **What it measures**

- This indicator measures the extent to which health units are receiving referrals from social welfare services. High numbers of referrals to the health sector may indicate that social welfare services are aware of and linking to health services in the area; however, the total number of referrals is also dependent the number of trafficked people identified in the area.

### **Measurement tool**

- Record review at health unit, or Initiating and Receiving Service Referral Registers, if they are used at the health unit. A Client Referral Form that the patient carries between the referring and receiving services should capture all the relevant information, which is then recorded in the referral registers or client databases.

### **How to measure it**

- Count the number of clients who were referred from social welfare service agencies, such as shelters or organizations providing mental health, case management, or other forms of assistance to trafficked people. This should be obtained from the Receiving Service Referral Register, if one is kept, or record review if referral information is captured on client records.

## Considerations

- Count the number of clients who were referred from social welfare service agencies, such as shelters or organizations providing mental health, case management, or other forms of assistance to trafficked people. This should be obtained from the Receiving Service Referral Register, if one is kept, or record review if referral information is captured on client records.
- This indicator is also not possible unless the health forms designate that an individual has been trafficked.
- This indicator does not capture what proportion of referrals is completed or the quality of service received.
- Interpretation of this indicator over time may be difficult because it is a count, not a proportion; it will change as need and demand for service, as well as other factors, fluctuate over time. For example, an increase in the count could be caused by more providers referring, or because more people are being trafficked, or identified as trafficked.
- For more information on referral monitoring, please see the *Referrals Systems Assessment and Monitoring Toolkit*, available at <http://www.measureevaluation.org/publications/ms-13-60>

## Indicator 15

Existence of policies that support and facilitate the health of trafficked persons.

### Definition

- The existence of national policies that support and facilitate the health of trafficked people. At least one of the following policies or regulations should be included. Check all that apply.
  - » Existence of a policy or legislation requiring that suspected and identified trafficked people are entitled to state supported health care that is non-discriminatory.
  - » Budget line (in government health budget or other appropriate ministry budget) allocating funding for health care services for trafficked people, foreign national or citizen, in the country.
  - » Policy stating that health services for trafficked people are available voluntarily and available regardless of whether or not the trafficked individuals participate in prosecution of their trafficker.
  - » Existence of a mechanism to ensure that the trafficked person retains their health records when being repatriated.
  - » National strategy or equivalent to link suspected and identified trafficked people with health and social services.
- *Non-discriminatory* means that health care will be provided without consideration to age, race, sex, language, religion, ethnic or social origin, gender identity, sexual orientation, trafficking/immigration status, health status, or any other characteristics of the patient. Acceptable forms of above national policies would include national plans of action for trafficking, strategic plans, national policies or laws, or equivalent government documents.
- Yes: The country has at least one policy listed above that supports and facilitates access to and support of health care for trafficked persons.
- No: The country does not have any policies listed above that support and facilitate health care for trafficked people.

### Disaggregate by

- Policy type (as listed above)

### What it measures

- This indicator measures the national and sub-national policy environment for health of trafficked persons. It measures the degree of explicit support for access to health services for trafficked people, on the part of government. If there are one or more of these policies checked, that indicates the national government has made documented efforts to support health access and care for trafficked people.

### Measurement tool

- Document/record review at the national and subnational level.

### ***How to measure it***

- Record review: Existence of actual policies/plans/guidelines that are documented with evidence of approval (or submission for approval). They appear in constitutional provisions; legislation; implementing rules and regulations; executive orders; ministerial level decrees, and other measures of a regulatory nature (including related regulations and enforcement mechanisms); official goals; statements and other formally documented government directives; standards; guidelines; and decrees. If any of the above policies are found in the document/record review, the indicator would be marked as “yes.”

### ***Considerations***

- This indicator does not measure the implementation or enforcement of these policies. The group measuring this indicator could decide that the cutoff to be counted must include more than one of the policies listed, or turn the indicator into a scale with number of policies checked, out of five possible.

Research on TIP is still in its nascent stages. The difficulties associated with researching trafficking are related to its illegality and hard-to-identify population. The population of trafficked people could be considered as the epidemiological iceberg metaphor: only a small portion of the larger population of trafficked people may be “visible”, or the tip of the iceberg that is able to be seen above water. Due to the clandestine nature of trafficking in persons, the visible population of trafficked people may be the sub-population who have been released and are in the process of repatriating through official channels—potentially a very different population than trafficked people as a whole, which may affect both the methodologies able to be used for research and the results of the research itself (4–7).

### Methodologies Currently in Use<sup>3</sup>

Existing research conducted with trafficked people is divided between quantitative (11, 12, 17, 20–23, 26, 27, 29, 32, 35, 63) and qualitative methodologies, including case studies and other anthropological methods (31, 64–75). Very few studies employ mixed methods (33, 38, 76–79). Much of the current research in TIP has not focused on the intersection of trafficking and health, but rather on legal, immigration, or criminal aspects of TIP. Below we have highlighted common trends and methodologies in current trafficking research:

#### *Data sources and structures*

- **Population-based surveys:** Few studies are able to use population-based methods to identify trafficked people for prevalence estimates or create representative samples (4, 7). Population-based surveillance does not lend itself well to studying trafficking given the hidden and highly mobile nature of trafficked individuals. The Ukraine 2007 Demographic and Health Survey (DHS) included a new, short module on trafficking, though it has not become standard DHS practice and there has not been analysis of the data beyond the official report (80).
- **Surveys of specific populations of interest:** A few studies focus on the population of specific groups (e.g., young women or sex workers) or locations (e.g., schools in particular geographic areas) in which trafficked people are presumed to be more prevalent (18, 26, 29, 81, 82).
- **Record review:** Given concerns about confidentiality and safety of trafficked people during research activities, a number of studies use record review (at social services organizations, health centers, etc.) as the primary method of data collection in order to avoid potentially traumatic interviews for trafficked people (14, 22, 24, 27, 28, 30, 31, 83). Data for these studies is restricted to data already included in records or which can be extracted via qualitative coding from recorded narratives in the records.

3) Reference lists in this section not exhaustive; recent or key studies provided as examples.

### **Recruitment of participants**

- Participant recruitment tends to be convenience samples via social services organizations providing assistance to formerly trafficked people, police or the judicial system, brothels, or interactions in other locations where trafficked people may be present (6, 23, 26, 27, 31, 32, 38, 41, 63, 74, 84–89). This is particularly true for qualitative studies, but convenience or participant-driven samples are also quite common for quantitative studies, given the difficulties of conducting a population-based study within this population.
- A common approach has been to interview providers, police, judicial system workers, NGO workers, and other stakeholders involved in trafficking services and/or anti-trafficking advocacy about trafficked people and the organizational responses to trafficking, a methodology suited more to research questions focused on responses to trafficking than to research questions focused on characteristics of trafficked people and their health (90–97).
- Trafficked people who agree to participate in research may be significantly different from those who do not agree to participate, and not all trafficked people may identify themselves as such (41, 89).

### **Sample sizes and analysis**

- **Sample sizes** are generally small given the complexities and costs of conducting primary data collection, especially in hidden populations (89). Record review studies often have larger sample sizes due to the relative ease of extracting data from case records. Qualitative studies that rely on snowball sampling of hard-to-reach sub-populations within trafficking, such as traffickers or women still in a trafficking situation, tend to have the smallest samples (89, 98). While there is acknowledgement that descriptive case study reports can be useful for describing certain trafficking situations in depth, there is concern about representativeness (7, 89).
- **Analytic methods** vary by the type and quality of data available. Many studies are able to describe the characteristics of trafficked people, such as specific health issues, and make basic inferences about prevalence of those health issues among trafficked people. However, some quantitative studies with more comprehensive sampling techniques are able to use more advanced statistical methods to assess more complex research questions (84).

## **Organizational and Systemic Challenges in Research, M&E of TIP**

Systemic and organizational challenges in international research and M&E of TIP may affect the level of information and knowledge on TIP and health.

- **Capacity:** Without the backing of a large international organization, small organizations may not have the resources, staff capabilities, or time to focus on monitoring and evaluation (5, 6).
- **Funding:** Governmental or international organizational funding to work with undocumented workers or non-citizens, or to organizations working with or advocating on behalf of sex workers, may be restricted (4).

- **Competing public health priorities:** Public health systems and other government-run departments may be over-stretched and under-funded, with competing priorities that may make additional M&E of trafficking a lower priority than other more visible health issues.
- **Conflation with sex work:** Measurement of trafficking has been confounded by a frequent conflation with sex work; while many women may be trafficked for sex work, not all sex workers are trafficked and this conflation may limit research and M&E activities (4).
- **International cross-border concerns:** Trafficked people are often moved across international borders and other locations multiple times (4). Capturing the full process of trafficking and trafficked people's health at each stage will require a multitude of data sources and documents from several countries—which do not share data, systems, or possibly even borders (5). While progress is being made to address these challenges (e.g., the IOM Global Human Trafficking Database), health is not the focus of existing work. Assessing the health status of a trafficked person pre-trafficking, during exploitation, and during re-integration is important and would allow for a comprehensive understanding of how trafficking impacts health; however, it would require the active agreement, participation, and coordination of multiple health systems, social service systems, police and judicial systems, and border controls to collect the documentation that would allow for a longitudinal picture to be developed (4, 89).

## Moving Forward in Research and M&E of TIP and Health

Some researchers have developed innovative methods or adapted methods used with other hard-to-reach populations (such as men who have sex with men or sex workers) in order to better reach the trafficked population. Recruitment or population estimation methods for TIP research may include: capture-recapture, where a researcher visits a location where the population of interest congregates, distributes a token or flyer, and returns to redistribute and count those with the first token; or conducting a phone survey using phone numbers from newspaper brothel or sex worker advertisements (6, 79, 99). Similarly, using multiple methods of data collection (such as interviewing both trafficked people and other key informants, or utilizing surveys, qualitative interviews, and official documents like migration or health records) may provide a more thorough picture (4, 6).

Research and M&E will need to expand on current methodologies and approaches in order to more accurately track health among trafficked people, monitor the progress of programs and health facilities providing services, and evaluate which interventions are the most effective. An increased focus on a comprehensive M&E framework and the ability to measure outcomes and impact will improve international, national, and local response to trafficking, gender, and health. The following chapter discusses areas for future development that arose during the literature review, expert consultation, and/or development of indicators that require additional exploration and evidence.

This chapter outlines additional areas that are important to consider in the M&E and research of TIP and health. The chapter again utilizes the framework on the health effects of trafficking from Zimmerman and colleagues [see Chapter 1 for the framework and discussion of each stage of trafficking]; the framework highlights stages that a trafficked person might experience (though not all trafficked people will experience these stages) and the potential health effects at each stage (10). It should be noted that we use the conceptual model on trafficking and health because of the focus on health in this compendium, and that other conceptual models (such as the AMP model) may be more appropriate for discussions of non-health trafficking concerns. Further work is required to develop a comprehensive monitoring and evaluation strategy covering all domains of trafficking, gender, and health. This includes finding appropriate methods, tools, and approaches, including developing and field testing useful indicators, as well as ensuring that these are integrated into sustainable health information systems. The development of process indicators that use existing related indicators to provide an estimate for a new indicator (such as have been used to measure other hard-to-access indicators like child mortality in conflict settings) may also assist in the creation of a broader evidence base (6).

## Recruitment

Future monitoring, evaluation, and research in the area of TIP recruitment needs to address the socio-environmental factors that may make individuals vulnerable to recruitment, such as poverty, educational attainment, gender and limited access to health services, as well the mitigating factors that can help prevent recruitment, such as education, community awareness efforts, and access to health services (37, 41).

## Education

Low educational attainment has also been linked to increased risk of trafficking (35, 37), but other research in this area has found conflicting results (37, 76). Given the lack of consensus on lack of education as a risk factor for trafficking, further work is needed to more fully assess this socio-demographic characteristic's role in risk. Discussion at the consultative meeting also indicated that school dropout specifically (as opposed to lack of any formal education) may be a risk factor for trafficking, and could be measured and evaluated accordingly.

## Awareness

Experts in TIP also hold differing opinions on the effectiveness of raising awareness of trafficking as a prevention effort. While trafficking awareness campaigns abound and a number of studies cite ignorance of trafficking as a risk factor, there is little evidence to support the effectiveness of awareness campaigns (37). One perspective suggests that education around TIP can help to make people more aware of its existence and potentially avoid traffickers' deceptive efforts. However, other researchers note that traffickers may be family members or close friends, complicating the dynamics of trafficking and weakening the argument that awareness alone will mitigate trafficking.

### ***Access to health care***

Access to affordable health care in communities was discussed as a prevention measure because it can be a significant cause of debt in source communities, putting families at risk of trafficking. Due to the lack of empirical evidence, additional research is needed to confirm the link and recommend related indicators.

While indicators for prevention in the areas of education, school dropout, and community awareness were suggested for inclusion in this compendium, it was determined that before suggesting individual M&E indicators in these areas, more research is needed to elucidate the relationship between education, awareness, and risk of trafficking.

### **Travel and Transit (if applicable)**

If trafficked people are physically transported as part of trafficking (which may not always happen), the often clandestine nature of travel and border crossings during trafficking, and the fact that people may not yet be aware they are being trafficked, may limit the ability to identify and monitor health effects of trafficking at this stage. However, post-arrival and post-trafficking, when most trafficked people are able to seek and receive assistance, it will be important to assess the full health risks faced by individuals and the related consequences of trafficking, including health problems that may have been experienced during the high-risk travel period.

Common themes in the travel and transit stage include migration checkpoints and transnational border interactions; high-risk travel and health; sexual violence; and initial psychological trauma. Future research that addresses these areas and an individual's progress through the possible stages of trafficking will be important in developing a full understanding of the health consequences of this stage of trafficking. Until more effective methodologies can be developed, it will remain difficult to collect real-time M&E information about this stage of trafficking.

### ***Migration checkpoints and other interactions with transnational borders***

While much TIP travel occurs through clandestine, high-risk travel that avoids official border crossing and immigration, some trafficked people do transit through official means (10). This offers one of the few opportunities for identification, protection, and monitoring during the travel and transit stage. While legal border crossings may present an opportunity, at the same time, this involves multiple countries or governmental entities that may or may not be in communication, using similar systems, or even on good terms where there is incentive to share data. Where legal labor brokers are used to provide a cover of legality for TIP, governmental oversight throughout both the pre-transit and the travel and transit stage may be possible. Additionally, some countries have initiated policies to brief individuals traveling on certain types of visas (e.g., domestic worker) about their rights and how to identify and report trafficking if they encounter it. Further research and monitoring of these types of policies would help determine their efficacy in the future. Other possibilities

discussed at the consultative meeting include increased monitoring of labor brokers and inclusion of policies requiring that ‘know your rights to health care’ material is provided by labor brokers and at migration checkpoints.

## Exploitation

It is particularly difficult to ethically collect data, provide services, or gain insight about trafficked individuals and their health during this stage because they are still being exploited in their trafficking situation and may be punished or penalized for having contact with outsiders. Key areas to consider for future research include health outreach programs or clinics, harm reduction interventions (such as increasing access to and acceptability of male and female condom use), and labor and occupational health inspectors that are trained to identify and refer trafficked people within the workplace.

## Integration

The majority of this compendium includes indicators that fall under this phase of trafficking by examining how prepared the health sector is to identify and provide services to trafficked persons following a trafficking experience, how post-trafficking assistance programs are providing or linking to health services, and the government’s commitment and support of health care via national policies. The majority of these indicators, as well as the majority of current research, focuses on the negative health and mental health consequences associated with trafficking during or with recently escaped trafficked persons. As such, many health interventions aimed at serving trafficked people attempt to address the injuries and negative outcomes sustained during the process. However, it must be acknowledged that while addressing immediate and urgent health needs is critical to restoring trafficked individuals to health and safety, the long-term and chronic health needs of trafficked persons must not be overlooked. Research indicates that mental health issues, including post-traumatic stress, take a significant amount of time to abate (11, 19).

### ***Shame and stigma***

In addition to health conditions and access to health services, it is important to consider the trafficked person’s experience of shame, stigma, and perception of services received. There are substantial gaps in knowledge, from the trafficked person’s point of view, regarding health services received, integration into the community, stigma from friends, family or community members. The trafficking community would benefit from additional measures of stigma, similar to the *HIV Stigma Index*, which was developed in close collaboration with stakeholders at all levels, including HIV-positive individuals (100).

### ***Trafficked persons' experiences with services***

It is important to understand how trafficked people perceive their interactions and experiences with health and social services in order to provide quality care and improvement in those services. This could include: measures of the health systems' cultural and linguistic capacity to provide care; the quality of care provided; assessment of safety and security processes in place while caring for trafficked people; and assessment of facilities' and health systems' ability to keep trafficked persons' health records and data secure and confidential. Self-reported measures of satisfaction with health services were discussed for possible inclusion in this compendium, but were excluded because they are not robust quantitative indicators at this time. This is an area for future attention that is suited to both qualitative and quantitative research methods.

### ***Access to health services after trafficking***

Additionally, it is important for researchers to investigate the level of access trafficked persons have to health and social services after they have left their trafficked situation, particularly in the long term.

## **Re-integration**

Identifying appropriate and measurable indicators during the re-integration stage are challenging, as many elements contributing to the successful re-integration of a trafficked individual are at the community and societal level and are more complex to measure. Areas to consider for further research would include existence and effectiveness of re-integration supports, access to health care, education, and income generation, safety and security, re-victimization or re-trafficking, and community norms and attitudes surrounding people that have been trafficked. In addition, many of the same concepts in integration apply to re-integration: shame and stigma, access to health services, and measures of experience from the trafficked person's perspective.

## **Special Populations or Settings**

Much of the literature on TIP focuses on women and girls and there has been limited attention given to other populations or special settings. Examples of such populations include men and boys, refugees, sexual and gender minorities, minors and orphans. As the breadth and depth of research and M&E on TIP increases, it will be important to develop new methods and approaches to target these sub-populations within trafficking research.

### ***Minors***

To reach adolescents (including adolescent boys), researchers may use schools or treatment/rehabilitation programs as recruitment bases, a method that has been used in other research with minors (50). There are examples of initial studies addressing minors, including boys, with methods that can be built upon for the future (76, 81, 82, 86, 101).

***Men and boys***

Few existing TIP research studies target men or boys, due to the commonly held view that trafficking is an issue for women and girls. Men may be less able or willing to identify themselves as trafficked (102). More research including men and boys that have been trafficked is urgently needed in order to more fully understand their experiences with trafficking.

***Labor trafficking***

The lack of research on labor trafficking conceals a population that is estimated to be as large as 21 million people (38, 39). Certain types of labor trafficking (such as bonded, indentured, or guest-worker construction work) may be more prevalent among men (39). To more fully understand the global reach of all forms of TIP, future research and M&E will need to more comprehensively include both labor trafficking/forced labor and men as populations of interest.

***Sexual and gender minorities***

While it has been noted that a gendered view of trafficking may perpetuate a stereotype of women and girls as trafficking “victims” to the exclusion of men and boys, the same may be said for sexual and gender minorities (51). Examining the structure of recruitment and data collection methods in trafficking research could yield more inclusive and descriptive studies that include the full range of sexual and gender identities and would illuminate the population of trafficked people and the effects of trafficking on specific sub-populations or identities (51).

***Refugees and humanitarian crises***

Refugees and trafficking may intersect in a number of ways: refugees or displaced people are in uncertain physical, legal, and economic situations and often without enough food or means to support themselves; they may be particularly vulnerable to duplicitous labor brokers or others who promise escape from a refugee or other humanitarian crisis; trafficked people may be able to claim refugee status after being trafficked to a country; and the presence of humanitarian operations and/or peacekeepers in a conflict setting may increase the potential for trafficking for sexual exploitation, either of the refugees themselves or other persons (103, 104). However, the existing difficulties in conducting research in refugee settings compounded with the difficulties in conducting research with trafficked persons make this an area without significant current attention. Intersectional research that addresses the relationship(s) between trafficking and humanitarian crises will be important to disentangle in the future.

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2. Polaris Project. *The A-M-P Model*. <http://www.polarisproject.org/resources/resources-by-topic/human-trafficking>. Accessed July 31, 2014.
3. UNGIFT. *What is human trafficking?* <http://www.ungift.org/knowledgehub/en/about/human-trafficking.html>. Updated 2014. Accessed July 31, 2014.
4. Cwikel J, Hoban E. Contentious issues in research on trafficked women working in the sex industry: Study design, ethics, and methodology. *J Sex Res*. 2005;42(4):306–316.
5. Laczko F, Gramegna MA. Developing better indicators of human trafficking. *Brown J. World Aff*. 2003;10:179.
6. Tyldum G, Brunovskis A. Describing the unobserved: Methodological challenges in empirical studies on human trafficking. *Int Migr*. 2005;43(1-2):17–34.
7. Fedina L. Use and Misuse of Research in Books on Sex Trafficking: Implications for Interdisciplinary Researchers, Practitioners, and Advocates. *Trauma Violence Abuse*. 2014. doi: 1524838014523337 [pii].
8. Bales K. *Disposable people: new slavery in the global economy*. Berkeley, CA: University of California Press; 1999.
9. U.S. Department of State. *Trafficking in Persons Report 2007*. Washington, DC: U.S. Department of State; 2007.
10. Zimmerman C, Hossain M, Watts C. Human trafficking and health: A conceptual model to inform policy, intervention and research. *Soc Sci Med*. 2011;73(2):327–335.
11. Zimmerman C, Hossain M, Yun K, et al. The health of trafficked women: a survey of women entering posttrafficking services in Europe. *Am J Public Health*. 2008;98(1):55–59. doi: AJP.H.2006.108357 [pii].
12. Silverman JG, Raj A, Cheng DM, et al. Sex trafficking and initiation-related violence, alcohol use, and HIV risk among HIV-infected female sex workers in Mumbai, India. *J Infect Dis*. 2011;204 Suppl 5:S1229–34. doi: 10.1093/infdis/jir540 [doi].
13. Silverman JG, Decker MR, Gupta J, Maheshwari A, Patel V, Raj A. HIV prevalence and predictors among rescued sex-trafficked women and girls in

Mumbai, India. *J Acquir Immune Defic Syndr*. 2006;43(5):588–593. doi: 10.1097/01.qai.0000243101.57523.7d [doi].

14. Silverman JG, Decke MR, Gupta J, Dharmadhikari A, Seage GR, 3rd, Raj A. Syphilis and hepatitis B Co-infection among HIV-infected, sex-trafficked women and girls, Nepal. *Emerg Infect Dis*. 2008;14(6):932–934. doi: 10.3201/eid1406.080090 [doi].
15. Silverman JG, Saggurti N, Cheng DM, et al. Associations of Sex Trafficking History with Recent Sexual Risk among HIV-Infected FSWs in India. *AIDS and behavior*. 2014;18(3):555–561.
16. Silverman JG, Decker MR, Gupta J, Maheshwari A, Willis BM, Raj A. HIV prevalence and predictors of infection in sex-trafficked Nepalese girls and women. *JAMA*. 2007;298(5):536–542.
17. Sarkar K, Bal B, Mukherjee R, et al. Sex-trafficking, violence, negotiating skill, and HIV infection in brothel-based sex workers of eastern India, adjoining Nepal, Bhutan, and Bangladesh. *J Health Popul Nutr*. 2008;26(2):223–231.
18. Page K, Stein E, Sansothy N, et al. Sex work and HIV in Cambodia: trajectories of risk and disease in two cohorts of high-risk young women in Phnom Penh, Cambodia. *BMJ open*. 2013;3(9):e003095.
19. Ostrovski NV, Prince MJ, Zimmerman C, et al. Women in post-trafficking services in Moldova: diagnostic interviews over two time periods to assess returning women's mental health. *BMC Public Health*. 2011;11:232-2458-11-232. doi: 10.1186/1471-2458-11-232 [doi].
20. Oram S, Ostrovski NV, Gorceag VI, et al. Physical health symptoms reported by trafficked women receiving post-trafficking support in Moldova: prevalence, severity and associated factors. *BMC Womens Health*. 2012;12:20. doi: 1472-6874-12-20 [pii].
21. Muftic LR, Finn MA. Health outcomes among women trafficked for sex in the United States: a closer look. *J Interpers Violence*. 2013;28(9):1859–1885. doi: 10.1177/0886260512469102 [doi].
22. McCauley HL, Decker MR, Silverman JG. Trafficking experiences and violence victimization of sex-trafficked young women in Cambodia. *International Journal of Gynecology & Obstetrics*. 2010;110(3):266–267.
23. Hossain M, Zimmerman C, Abas M, Light M, Watts C. The relationship of trauma to mental disorders among trafficked and sexually exploited girls and women. *Am J Public Health*. 2010;100(12):2442–2449.

24. Gupta J, Raj A, Decker MR, Reed E, Silverman JG. HIV vulnerabilities of sex-trafficked Indian women and girls. *International Journal of Gynecology & Obstetrics*. 2009;107(1):30–34.
25. George A, Sabarwal S, Martin P. Violence in contract work among female sex workers in Andhra Pradesh, India. *J Infect Dis*. 2011;204 Suppl 5:S1235–40. doi: 10.1093/infdis/jir542 [doi].
26. George A, Sabarwal S. Sex trafficking, physical and sexual violence, and HIV risk among young female sex workers in Andhra Pradesh, India. *International Journal of Gynecology & Obstetrics*. 2013;120(2):119–123.
27. Falb KL, McCauley HL, Decker MR, Sabarwal S, Gupta J, Silverman JG. Trafficking mechanisms and HIV status among sex-trafficking survivors in Calcutta, India. *International Journal of Gynecology & Obstetrics*. 2011;113(1):86–87.
28. Dharmadhikari AS, Gupta J, Decker MR, Raj A, Silverman JG. Tuberculosis and HIV: a global menace exacerbated via sex trafficking. *International Journal of Infectious Diseases*. 2009;13(5):543–546.
29. Decker MR, McCauley HL, Phuengsamran D, Janyam S, Silverman JG. Sex trafficking, sexual risk, sexually transmitted infection and reproductive health among female sex workers in Thailand. *J Epidemiol Community Health*. 2011;65(4):334–339. doi: 10.1136/jech.2009.096834 [doi].
30. Decker MR, Mack KP, Barrows JJ, Silverman JG. Sex trafficking, violence victimization, and condom use among prostituted women in Nicaragua. *Int J Gynaecol Obstet*. 2009;107(2):151–152. doi: 10.1016/j.ijgo.2009.06.002 [doi].
31. Crawford M, Kaufman MR. Sex trafficking in Nepal: survivor characteristics and long-term outcomes. *Violence Against Women*. 2008;14(8):905–916. doi: 10.1177/1077801208320906 [doi].
32. Abas M, Ostrovski NV, Prince M, Gorceag VI, Trigub C, Oram S. Risk factors for mental disorders in women survivors of human trafficking: a historical cohort study. *BMC Psychiatry*. 2013;13(1):1–11.
33. Zimmerman C, Hossain M, Yun K, Roche B, Morison L, Watts C. *Stolen Smiles: The physical and psychological health consequences of women and adolescents trafficked in Europe*. London, United Kingdom: The London School of Hygiene & Tropical Medicine; 2006.
34. Zimmerman C, Yun K, Shvab I, et al. *The health risks and consequences of trafficking in women and adolescents: findings from a European study*. London,

United Kingdom: London England London School of Hygiene and Tropical Medicine; 2003.

35. Gupta J, Reed E, Kershaw T, Blankenship KM. History of sex trafficking, recent experiences of violence, and HIV vulnerability among female sex workers in coastal Andhra Pradesh, India. *International Journal of Gynecology & Obstetrics*. 2011;114(2):101–105.
36. U.S. Department of State. *Trafficking in Persons Report 2009*. Washington, DC: U.S. Department of State; 2009.
37. Perry KM, McEwing L. How do social determinants affect human trafficking in Southeast Asia, and what can we do about it? A systematic review. *Health Hum Rights*. 2013;15(2).
38. Bélanger D. Labor Migration and Trafficking among Vietnamese Migrants in Asia. *Ann Am Acad Pol Soc Sci*. 2014;653(1):87–106.
39. International Labour Organization (ILO), Special Action Programme to Combat Forced Labour (SAP-FL). *ILO Global Estimate of Forced Labour: Results and methodology*. Geneva, Switzerland: ILO; 2012.
40. United Nations General Assembly. *Protocol to prevent, suppress and punish trafficking in persons, especially women and children, supplementing the United Nations convention against transnational organized crime*. 2000.
41. Tyldum G. Limitations in Research on Human Trafficking. *Int Migr*. 2010;48(5):1–13.
42. Zimmerman C, Borland R. *Caring for Trafficked Persons: Guidance for Health Providers*. Geneva, Switzerland: International Organization for Migration (IOM), London School for Hygiene and Tropical Medicine (LSHTM) & United Nations Global Initiative to Fight Trafficking in Persons (UN.GIFT); 2009.
43. Brunovskis A, Surtees R. Coming home: Challenges in family reintegration for trafficked women. *Qualitative Social Work*. 2012;12(4):454–472.
44. Silverman JG, Decker MR, McCauley HL, Mack KP. *Sex Trafficking and STI/HIV in Southeast Asia: Connections Between Sexual Exploitation, Violence and Sexual Risk*. Colombo, Sri Lanka: UNDP Regional Centre in Colombo; 2009.
45. WHO. *Understanding Violence Against Women: Human Trafficking*. Geneva, Switzerland: World Health Organization; 2012.

46. U.S. Department of State. *Trafficking in Persons Report 2014*. Washington, DC: U.S. Department of State; 2014.
47. World Health Organization. *Gender, women and health*. <http://www.who.int/gender/whatisgender/en/>. Updated 2014. Accessed July 14, 2014.
48. Bloom S, Negroustoueva S. *Compendium of Gender Equality and HIV Indicators*. MEASURE Evaluation; November 2013.
49. Duong KA. Human Trafficking in a Globalized World: Gender Aspects of the Issue and Anti-trafficking Politics. *Journal of Research in Gender Studies*. 2012(1):48–65.
50. Reid JA, Piquero AR. Age-graded risks for commercial sexual exploitation of male and female youth. *J Interpers Violence*. 2014;29(9):1747–1777. doi: 10.1177/0886260513511535 [doi].
51. Robertson MA, Sgoutas A. Thinking beyond the category of sexual identity: At the intersection of sexuality and human-trafficking policy. *Politics & Gender*. 2012;8(03):421–429.
52. Barrows J, Finger R. Human trafficking and the health care professional. *South Med J*. 2008;101(5):521–524. doi: 10.1097/SMJ.0b013e31816c017d [doi].
53. Bloom SS. *Violence Against Women and Girls: A Compendium of Monitoring and Evaluation Indicators*. MEASURE Evaluation; October 2008.
54. Zimmerman C, Watts C. *WHO Ethical and Safety Recommendations for Interviewing Trafficked Women*. Geneva, Switzerland: World Health Organization; 2003.
55. IOM. *The IOM Handbook on Direct Assistance for Victims of Trafficking*. Geneva, Switzerland: International Organization for Migration; 2007.
56. Dottridge M. *Reference Guide on Protecting the Rights of Child Victims of Trafficking in Europe*. UNICEF Regional Office for CEE/CIS; 2006.
57. Office of the High Commissioner for Human Rights. *Recommended Principles and Guidelines on Human Rights and Human Trafficking*. New York: UN Economic and Social Council; 2002.
58. IOM. *Handbook on Performance Indicators for Counter-trafficking Projects*. Geneva, Switzerland: International Organization for Migration; 2008.

59. Vijayarasa R. The State, the family and language of 'social evils': re-stigmatising victims of trafficking in Vietnam. *Culture, health & sexuality*. 2010;12(S1):S89–S102.
60. Vijayarasa R, Stein RA. HIV and Human Trafficking–Related Stigma: Health Interventions for Trafficked Populations. *JAMA*. 2010;304(3):344–345.
61. Logan TK, Walker R, Hunt G. Understanding human trafficking in the United States. *Trauma Violence Abuse*. 2009;10(1):3–30. doi: 10.1177/1524838008327262 [doi].
62. Macy RJ, Johns N. Aftercare services for international sex trafficking survivors: informing U.S. service and program development in an emerging practice area. *Trauma Violence Abuse*. 2011;12(2):87–98. doi: 10.1177/1524838010390709 [doi].
63. Wirth KE, Tchetgen Tchetgen EJ, Silverman JG, Murray MB. How does sex trafficking increase the risk of HIV Infection? An observational study from Southern India. *Am J Epidemiol*. 2013;177(3):232–241. doi: 10.1093/aje/kws338 [doi].
64. Aborisade R, Aderinto A. Pathways to sex workers' social rehabilitation and assessment of rehabilitation approaches in Nigeria: Evidence from a qualitative study. *Gender and Behaviour*. 2008;6(2):1925–1959.
65. Baldwin SB, Eisenman DP, Sayles JN, Ryan G, Chuang KS. Identification of human trafficking victims in health care settings. *Health and Human Rights: An International Journal*. 2011;13(1).
66. Budiani-Saberi DA, Raja KR, Findley KC, Kerketta P, Anand V. Human trafficking for organ removal in India: a victim-centered, evidence-based report. *Transplantation*. 2014;97(4):380–384. doi: 10.1097/01.TP.0000438624.83472.55 [doi].
67. Choi SY. Heterogeneous and vulnerable: the health risks facing transnational female sex workers. *Sociol Health Illn*. 2011;33(1):33–49.
68. Collins SP, Goldenberg SM, Burke NJ, Bojorquez-Chapela I, Silverman JG, Strathdee SA. Situating HIV risk in the lives of formerly trafficked female sex workers on the Mexico–US border. *AIDS Care*. 2013;25(4):459–465.
69. Gezinski L, Karandikar S. Exploring Needs of Sex Workers From the Kamathipura Red-Light Area of Mumbai, India. *Journal of Social Service Research*. 2013;39(4):552–561.

70. Goldenberg SM, Engstrom D, Rolon ML, Silverman JG, Strathdee SA. Sex Workers Perspectives on Strategies to Reduce Sexual Exploitation and HIV Risk: A Qualitative Study in Tijuana, Mexico. *PloS one*. 2013;8(8):e72982.
71. Karandikar S, Gezinski LB, Meshelemiah JC. A qualitative examination of women involved in prostitution in Mumbai, India: The role of family and acquaintances. *International Social Work*. 2013;56(4):496–515.
72. Sandy L. Just choices: Representations of choice and coercion in sex work in Cambodia. *The Australian Journal of Anthropology*. 2007;18(2):194–206.
73. Spanger M. Doing love in the borderland of transnational sex work: Female Thai migrants in Denmark. *NORA-Nordic Journal of Feminist and Gender Research*. 2013;21(2):92–107.
74. Vijayarasa R. The Cinderella syndrome: Economic expectations, false hopes and the exploitation of trafficked Ukrainian women. *Women's Studies International Forum*. 2012;35(1):53–62.
75. Vindhya U, Dev VS. Survivors of Sex Trafficking in Andhra Pradesh Evidence and Testimony. *Indian Journal of Gender Studies*. 2011;18(2):129–165.
76. Taylor L, Mulder M, Formoso B, et al. Dangerous Trade-offs: The Behavioral Ecology of Child Labor and Prostitution in Rural Northern Thailand 1. *Curr Anthropol*. 2005;46(3):411–431.
77. Raphael J, Reichert JA, Powers M. Pimp control and violence: Domestic sex trafficking of Chicago women and girls. *Women & Criminal Justice*. 2010;20(1–2):89–104.
78. Demir OO, Finckenauer JO. Victims of sex trafficking in Turkey: Characteristics, motivations, and dynamics. *Women & Criminal Justice*. 2010;20(1–2):57–88.
79. Gould C. Sex Trafficking and Prostitution in South Africa. *Ann Am Acad Pol Soc Sci*. 2014;653(1):183–201.
80. Ukrainian Center for Social Reforms (UCSR), State Statistical Committee (SSC) [Ukraine], Ministry of Health (MOH) [Ukraine], and Macro International Inc. *Ukraine Demographic and Health Survey 2007*. Calverton, MD: UCSR and Macro International; 2008.
81. Okonofua F, Ogbomwan S, Alutu A, Kufre O, Eghosa A. Knowledge, attitudes and experiences of sex trafficking by young women in Benin City, South-South Nigeria. *Soc Sci Med*. 2004;59(6):1315–1327.

82. Omorodion FI. Vulnerability of Nigerian Secondary School to Human Sex Trafficking in Nigeria. *Afr J Reprod Health*. 2009;13(2):33–48.
83. Dewan SE. Patterns of service utilization among pre-certified victims of human trafficking. *International Social Work*. 2014;57(1):64–74.
84. Deb S, Mukherjee A, Mathews B. Aggression in sexually abused trafficked girls and efficacy of intervention. *J Interpers Violence*. 2011;26(4):745–768. doi: 10.1177/0886260510365875 [doi].
85. Jana S, Dey B, Reza-Paul S, Steen R. Combating human trafficking in the sex trade: can sex workers do it better? *J Public Health (Oxf)*. 2013. doi: fdt095 [pii].
86. Blackburn AG, Taylor RW, Davis JE. Understanding the complexities of human trafficking and child sexual exploitation: The case of Southeast Asia. *Women & Criminal Justice*. 2010;20(1–2):105–126.
87. Gray GG, Luna L, Seegobin W. Exploring resilience: strengths of trafficking survivors in Cambodia. *International Journal of Adolescent Medical Health*. 2012;24(4):363–371.
88. Maher L, Mooney-Somers J, Phlong P, et al. Selling sex in unsafe spaces: sex work risk environments in Phnom Penh, Cambodia. *Harm Reduct J*. 2011;8(1):30–7517–8–30. doi: 10.1186/1477-7517-8-30 [doi].
89. Brunovskis A, Surtees R. Untold stories: biases and selection effects in research with victims of trafficking for sexual exploitation. *Int Migr*. 2010;48(4):1–37.
90. Reid JA. Doors wide shut: Barriers to the successful delivery of victim services for domestically trafficked minors in a southern US metropolitan area. *Women & Criminal Justice*. 2010;20(1–2):147–166.
91. Chisolm-Straker M, Richardson LD, Cossio T. Combating slavery in the 21st century: The role of emergency medicine. *J Health Care Poor Underserved*. 2012;23(3):980–987.
92. Grubb D, Bennett K. The readiness of local law enforcement to engage in US anti-trafficking efforts: an assessment of human trafficking training and awareness of local, county, and state law enforcement agencies in the State of Georgia. *Police Practice and Research*. 2012;13(6):487–500.
93. Hom KA, Woods SJ. Trauma and its aftermath for commercially sexually exploited women as told by front-line service providers. *Issues Ment Health Nurs*. 2013;34(2):75–81.

94. Kliner M, Stroud L. Psychological and health impact of working with victims of sex trafficking. *Journal of occupational health*. 2012;54(1):9–15.
95. Lux K, Mosley JE. Cross-sectoral collaboration in the pursuit of social change: Addressing sex trafficking in West Bengal. *International Social Work*. 2014;57(1):19–26.
96. Kamazima SR, Kazaura MR, Ezekiel MJ, Fimbo B. Reported human traffickers' profiles: a key step in the prevention of trafficking in persons through HIV and AIDS interventions in Tanzania. *East Afr J Public Health*. 2011;8(2):77–81.
97. Konstantopoulos WM, Ahn R, Alpert EJ, et al. An international comparative public health analysis of sex trafficking of women and girls in eight cities: Achieving a more effective health sector response. *Journal of Urban Health*. 2013;90(6):1194–1204.
98. Troshynski EI, Blank JK. Sex trafficking: an exploratory study interviewing traffickers. *Trends in Organized Crime*. 2008;11(1):30–41.
99. Cwikel J, Ilan K, Chudakov B. Women brothel workers and occupational health risks. *J Epidemiol Community Health*. 2003;57(10):809–815.
100. Berger BE, Ferrans CE, Lashley FR. Measuring stigma in people with HIV: Psychometric assessment of the HIV stigma scale. *Res Nurs Health*. 2001;24(6):518–529.
101. Gjermeni E, Van Hook MP, Gjipali S, Xhillari L, Lungu F, Hazizi A. Trafficking of children in Albania: Patterns of recruitment and reintegration. *Child Abuse Negl*. 2008;32(10):941–948.
102. Surtees R. *IOM Global Database Thematic Research Series: Trafficking of Men—A Trend Less Considered: the Case of Belarus and Ukraine*. Vol 36. Geneva, Switzerland: IOM International Organization for Migration; 2008.
103. Riiskjær M, Gallagher AM. *Review of UNHCR's efforts to prevent and respond to human trafficking*. Vol PDES/2008/07. Geneva, Switzerland: United Nations High Commissioner for Refugees Policy Development and Evaluation Service; September 2008.
104. Women's Commission for Refugee Women and Children. *Abuse Without End: Burmese Refugee Women and Children at Risk of Trafficking*. New York: Women's Commission for Refugee Women and Children; 2006.



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