Human Trafficking and Health in UK Public Policy

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Declaration

I, Siân Louise Oram, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signed: [redacted]..... Date: 28/04/2011.....

Abstract

Background: The issue of human trafficking has risen up international and national political agendas in the last decade. Existing evidence suggests that many trafficked people suffer from a range of health problems as a result of their experiences. This research sought to analyse how health was incorporated into the UK response to trafficking between 2000 and 2010.

Methods: Qualitative data was collected through semi-structured interviews, participant observation at policy-relevant events and document collection. Data analysis was organised according to the principles of framework analysis.

Results: Trafficking has been defined in the UK as a problem of organised immigration crime and the dominance of this definition has limited the extent to which health was incorporated into the national policy response. Non-governmental organisations (NGOs) strategically used information about the health consequences of trafficking to support their arguments for the provision of support and protection to trafficked people. They did not use the information, however, to argue for health-related policy change. The Department of Health (DH) and healthcare providers were not engaged in trafficking policymaking and there was no discernable domestic pressure to develop a health-based response. A limited amount of health-related policy change did occur following the UK's ratification of the Council of Europe Convention on Action against Trafficking in Human Beings, but the scope of these changes was restricted by the lack of awareness in the health sector about trafficking and by the shortage of information relating to how trafficked people use health services.

Conclusions: Future health-related policy change is likely to be limited so long as healthcare providers fail to act as advocates within the policymaking process and the DH remains on the margins of the policy subsystem.

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Abbreviations

ACF	Advocacy Coalition Framework
ACPO	Association of Chief Police Officers
AIUK	Amnesty International UK
ASI	Anti Slavery International
AtLEP	Anti Trafficking Legal Project
BIA	Borders and Immigration Agency
CA	Competent Authority
CEOP	Child Exploitation and Online Protection centre
DCSF	Department for Children, Schools & Families
DH	Department of Health
ECAT	Council of Europe Convention on Action against Trafficking in Human Beings
EHRC	Equalities & Human Rights Commission
FR	First Responder
HAC	Home Affairs Committee
JCHR	Joint Committee on Human Rights
ILO	International Labour Organisation
ILPA	Immigration Law Practitioners' Association
IND	Immigration and Nationality Directorate
IOM	International Organisation for Migration
LSCB	Local Safeguarding Children Board

LSHTM	London School of Hygiene & Tropical Medicine
MoJ	Ministry of Justice
MPS	Metropolitan Police Service
MS	Multiple Streams
NGO	Non Governmental Organisation
NRM	National Referral Mechanism
OCJR	Office for Criminal Justice Reform
OSCE	Office for Security and Cooperation in Europe
PTSD	Post Traumatic Stress Disorder
SOCA	Serious Organised Crime Agency
UKBA	UK Border Agency
UKHTC	UK Human Trafficking Centre
UN	United Nations
WHO	World Health Organisation

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Chapter 1

Background to the research

1.1 Defining human trafficking

The trafficking of adults and children into situations of exploitation is an emotive and often controversial issue that encompasses diverse experiences. Since re-emerging on the international political agenda in the 1980s, and particularly since the mid-1990s, the issue has captured the attention of politicians, non-governmental organisations (NGOs) and journalists around the world. Consequently, over the past twenty years, there have been intense international efforts to define and quantify trafficking (e.g., O'Neill Richard 1999; ILO 2005), to develop effective anti-trafficking strategies (e.g., ICMPD 2006b; UNODC 2008), and to monitor countries' commitment to tackling the issue (e.g., GRETA 2010; US Department of State 2010). Despite a lack of supporting evidence, claims have abounded that hundreds of thousands of people are trafficked into exploitation each year and that the "trade in human beings" is vastly profitable; as recently as 2010, the UN Office for Drugs and Crime (UNODC) estimated that seventy thousand people were trafficked to Europe for sexual exploitation each year, in a market worth an annual €2.5 billion (UNODC 2010a).

During the 1980s and for most of the 1990s discussions focussed on the trafficking of women and girls for the purposes of sexual exploitation (Wijers and Lap-Chew 1997; Outshoorn 2005). Towards the end of the 1990s, however, the mounting interest in human trafficking was accompanied by arguments that the scope of what was understood to constitute trafficking needed to be broadened. The list of purposes for which people may be trafficked is thus ever-expanding, but most commonly includes forced prostitution; domestic servitude; forced marriage; forced labour in industries including agriculture, construction, factories, cleaning, catering, hospitality; criminal activities such as selling counterfeit DVDs, petty theft, and tending cannabis farms; street begging and benefit fraud (Wijers and Lap-Chew 1997; ASI 2001; Anderson and Rogaly 2005; ILO 2005; ASI 2006b; ECPAT UK 2010; SOCA 2010). Defining human trafficking in a way which both adequately encompasses its complexity and is acceptable to the plethora of interested parties is highly challenging.

The difficulties that this diversity presents to those hoping to define trafficking are further compounded by the complexity of the concepts which underpin the issue, including consent, coercion, and exploitation. Furthermore, the treatment of these concepts, and of trafficking, may differ according to a person's political or ideological agenda. Commentators have argued that these agendas have included, for example, female sexuality and autonomy (Berman 2003; Andrijasevic 2007), beliefs about prostitution, immigration policy and border security (Doezema 2000; Berman 2003), and the role of national sovereignty in a united Europe (Berman 2003). This section introduces the definition of trafficking that is, currently, the most commonly used in trafficking dialogues and which was developed during the negotiations of the United Nations Optional Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children (hereafter referred to as the Palermo Protocol). It then discusses how notions of exploitation, consent and harm have been conceptualised within this definition and in the context of the UK response to trafficking.

1.1.1 The Palermo Protocol

The Palermo Protocol, which was negotiated as an Optional Protocol to the UN Convention on Transnational Organised Crime, states that:

> [Trafficking is] the recruitment, transportation, transfer, harbouring or receipt of persons by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power, or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at minimum, the exploitation of prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.
>
> (United Nations 2000)

The Palermo Protocol failed to define however, several of the constituent elements of trafficking, including exploitation, consent, and coercion (Anderson and Andrijasevic 2008; Munro 2008b). Some attempts have been made to operationalise the definition. The International Labour Organisation (ILO), for example, has developed 66 strong, medium and weak indicators of trafficking, grouped into six dimensions: recruitment by abuse of vulnerability, recruitment by deception, recruitment by coercion, abuse of vulnerability at destination, coercion at destination and

exploitative conditions at work (ILO 2009). Despite these efforts, and as discussed in detail in the remainder of this section, the interpretation and application of the Palermo Protocol definition remains contentious, particularly in relation to the distinctions to be drawn between, firstly, the trafficking and smuggling of migrants and, secondly, human trafficking and prostitution.

1.1.2 Exploitation

Scholars have noted that despite long-running debates about what constitutes exploitation and why it is considered to be objectionable, the concept of exploitation remains "ill-defined" and "slippery" (Hill 1994; Bufacchi 2002). The Palermo Protocol does not attempt to define exploitation and, more generally, the complexity of exploitation has not been adequately addressed within human trafficking policymaking. Consequently, questions such as whether harm is an essential component of exploitation and whether a person's consent (or the conditions under which that consent is given) is relevant to whether a person is believed to have been exploited, have gone unanswered (Munro 2008b; Munro 2008a)

The failure to define exploitation within the context of trafficking also means that the distinction between trafficking and other forms of migrant exploitation is also highly problematic. Anderson & O'Connell Davidson have drawn attention to how the experiences of migrants, both regular and irregular, may fall anywhere along a continuum of exploitation, and to how an objective and universal standard to mark the point at which one crosses a "threshold of exploitation" and can be considered trafficked is yet to be established (Anderson and O'Connell Davidson 2003). They have therefore criticized the dichotomization of trafficking and smuggling as overly simplistic[1] and have argued that there is no "moral or analytical reason" in distinguishing between trafficked, smuggled, or illegal immigrants in situations of forced labour if the primary concern is to combat exploitation (Anderson and O'Connell Davidson 2003). Furthermore, it has been suggested that drawing a distinction between the two may act to undermine safeguards for the protection of migrants against exploitation and human rights violations, in that it allows trafficking to become an issue of human

[1] The UN has suggested that three distinctions can be drawn between the them: firstly, whereas smuggling is characterised by illegal entry and international movement, trafficking may involved either legal or illegal entry into a country and can occur internally; secondly, whilst in smuggling, the relationship between the "agent" and "customer" ends upon reaching the destination, in trafficking the relationship is ongoing and exploitative; and thirdly, there is normally little coercion or violence employed during the smuggling process, but trafficked people often experience coercion, violence, and threats from their traffickers (UNODC 2010b).

rights and individual harm whilst positioning smuggling as an issue of illegal migration and harm to the state (Gallagher 2002).

Munro has argued that the failure to address these issues at the international and domestic policy level has enabled destination states to selectively interpret their commitments under anti-trafficking instruments and to follow different responses to trafficking for labour exploitation and sexual exploitation (Munro 2008a). In the UK, for example, although the National Action Plan on Tackling Human Trafficking uses the Palermo Protocol definition of trafficking (Home Office 2007b), the legislative definitions of trafficking for sexual exploitation and for other forms of labour exploitation differ both from each other and from the Palermo Protocol.

Trafficking for sexual exploitation is criminalised within the Sexual Offences Act 2003, which does not define exploitation and, in contrast to the Palermo Protocol definition, does not require either coercion or deception to have taken place for an offence to have been committed (Brooks-Gordon 2006; Munro 2006). Munro has suggested that this implies that working, or being intended to work, as a prostitute suffices for exploitation to have occurred (Munro 2005; Munro 2008a); the increasingly abolitionist sentiment of UK prostitution policy has been noted by number of academics (Kantola and Squires 2004; Brooks-Gordon 2005; Munro 2008a; Phoenix 2008). Guidance from the Sentencing Guidelines Council states that the offences are "designed to cover anyone involved in any stage of the trafficking operation, whether or not there is evidence of gain" and that the recommended sentencing range for a person involved at any level in any stage of trafficking where there was no coercion of the trafficked person is one to four years. Financial or other gain, and the coercion and vulnerability of trafficked people are listed as aggravating factors which should move sentences towards the maximum of fourteen years (SGC 2007).

Trafficking for all other forms of exploitation is separately covered under the Asylum and Immigration (Treatment of Claimants, etc) Act of 2004 (Great Britain 2004a), which created an offence of arranging and facilitating the travel of a person with the intention to exploit them, or with the belief that the person will be exploited by other persons in the UK or elsewhere. Again, exploitation is not defined, but this Act does list the circumstances under which exploitation is to be considered to have been established, including where force, coercion, or deception has taken place (Munro 2008a).

1.1.3 Consent

Exploitation theorists have argued that a person can consent to their exploitation and, indeed, derive benefit from being exploited (Wood 1995). The validity of a person's consent to their exploitation and the conditions under which this consent is nullified were contentious issues within the Palermo Protocol negotiation process and are yet to be resolved (Gallagher 2001).

In her account of the Palermo Protocol negotiations, Gallagher reports on the divisions that emerged with regard to whether trafficking could occur irrespective of a person's consent (Gallagher 2001). One group of States (e.g., Argentina, the Philippines) and NGOs argued that any distinction between forced and voluntary prostitution would give legitimacy to prostitution and was therefore unacceptable. Their arguments were based upon beliefs that prostitution is a form of violence against women and an abuse of human rights (Jeffries 1977; Barry 1979). These academics and activists deny the existence of voluntary prostitution. Barry has argued, for example, that all migration for prostitution should be considered to be trafficking and that structural factors (such as gendered violence and poverty) invalidate migrant women's consent to work in prostitution (Barry 1995). Furthermore, Hughes has suggested that all prostitutes should be considered to be "victims of trafficking" because they are all forced in some way (for example by poverty, abuse, or drug addictions) into selling sex and should not be considered to have consented to do so (Hughes 2002).

Opposing this view, other States (e.g., the USA) argued that a failure to distinguish between the two would blur the boundary between trafficking and smuggling (Gallagher 2001). Activists also lobbied for the definition to include a focus on coercion and consent, believing that drawing a distinction between forced and voluntary prostitution was necessary, firstly in order to prevent the normalisation of exploitation suffered by trafficked persons, and secondly to protect consenting sex workers from anti-trafficking laws (Chapkis 2003; Munro 2005). These activists drew upon arguments that that prostitution is a legitimate form of labour ("sex work") and that women can and do choose to work in the sex industry. Bindman argued, for example, that many women judge sex work to be their best option even given the dangers of social exclusion and economic exploitation and go to "courageous lengths to enter the sex industry" (Bindman 1998). Agustín, whilst acknowledging the role of structural factors and misfortune in women's migration experiences, has argued for a greater emphasis on how trafficked women may exert agency within the migration process (Agustín 2005; Agustín 2006).

The compromise position was an "unwieldy" sub-article stating that consent was irrelevant where "stated elements of the definition" (such as coercion, deception, and abuse of vulnerability) had been used. Although Doezema has argued that the use of coercion or force as an essential component of trafficking reflects a welcome shift in international prostitution and trafficking discourses away from abolitionism (Doezema 1998; Doezema 2002), she and others have criticised the distinction on a number of counts. Doezema has claimed, for example, that the distinction enables a division to be made between 'innocent' and 'guilty' sex workers and that this is problematic in a context in which un-coerced sex workers experience abuses but are not protected (Doezema 1998). Others have argued that women's experiences do not necessarily fall neatly along a "continuum" from coercion to consent. Busza, drawing on fieldwork with Vietnamese brothel workers in Cambodia, suggested that women's experiences may change over time (for example being originally tricked into sex work but later choosing to sell sex independently) and that the circumstances of their entry into sex work may not necessarily be relevant to their current motivations and priorities (Busza 2004). In the UK, Harding and Hamilton found that coercion and consent coexisted in the narratives of on-street sex workers (Harding and Hamilton 2009).

Statements that describe the recruitment of trafficked women as a process of either abduction or deceit, such as Kelly and Regan's assertion that trafficked women "are never fully aware" of the circumstances they are entering into (Kelly and Regan 2000), have also caused division amongst academics and activists. Agustín claims, for example, that her research challenges these claims directly and that many women knowingly enter into situations of exploitative sex work (Agustín 2005; Agustín 2006). Doezema has also criticised such statements, claiming that they reflect the need to establish public and political compassion for migrant women working in a morally condemned profession and undermine the sex-as-work discourse by establishing that one would not choose to work in the sex industry unless forced by circumstance (Doezema 2000).

Within the UK, the irrelevance of consent to the offence of trafficking for sexual exploitation has been criticised for denying the agency of female migrant sex workers (FitzGerald 2008). Academics have argued that in practice, however, frontline professionals working with trafficked people reinsert ideas about consent, coercion, and deception in determining who should and should not be considered to be trafficked (Munro 2005; Munro 2006; O'Connell Davidson 2006).

1.1.4 Harm

Although harm is not a component of the definition of human trafficking provided by the Palermo Protocol, a number of academics have argued that actual or threatened violence is central to how trafficking is understood (Doezema 2000; Aradau 2004; O'Connell Davidson 2006; Andrijasevic 2007). O'Connell Davidson concluded from her interviews with police officers working on trafficking in the UK, for example, that "physical suffering is the litmus test for police officers and immigration officials involved in sorting [victims of trafficking] from undocumented migrants working illegally in the sex sector" (O'Connell Davidson 2006). Aradau similarly argued that trafficked women's experiences of violence and suffering work to dis-identify them from other migrant workers and, given their "redeeming qualities", allow a case to be made for granting them protections and rights (Aradau 2004).

Themes of violence and harm, which have been developed in the anti-trafficking campaigns of international organisations such as the International Organisation for Migration (IOM) and the Organisation for Security and Cooperation in Europe (OSCE), seem to have attracted public and political attention to the issue of human trafficking and to have enabled a move away from policies that criminalised and stigmatised trafficked women as illegal immigrants and prostitutes (Aradau 2004; O'Connell Davidson 2006). Their prominence in trafficking dialogues has, however, been criticised by several academics. Researchers have questioned, firstly, the representativeness of the violent imagery and narratives that have been heavily used in anti-trafficking advocacy and campaign works (Aradau 2004; Saunders 2005; O'Connell Davidson 2006; Andrijasevic 2007; Brunovskis and Surtees 2010). Secondly, academics have argued that the tendency to emphasise violence and harm has enabled policymakers to blame "a subset of bad men" for the existence of human trafficking whilst overlooking the "structural preconditions of exploitative labour" (Bernstein 2010). Furthermore, academics have suggested that by creating a "humane consensus" on the need to stamp out human trafficking, narratives of violence and harm have neutralised debates on sexual freedom, labour and migration (Anderson and Andrijasevic 2008; Bernstein 2010).

1.2 State of knowledge on human trafficking

Kelly, in her 2005 review of trafficking research in Europe, remarked upon the huge expansion in publications and research on trafficking since the 1990s but also noted, as have others, that a

number of gaps remain in what is known about the phenomenon of trafficking and the effectiveness of the response to it (Salt 2000; Kelly 2002; Kelly 2005; Laczko 2005; Goodey 2008). In particular, these reviewers have noted that research has focused predominantly on trafficking for sexual exploitation; has generally been based upon the experiences of trafficked people and that very few studies has been conducted to date with traffickers; and that there have been few independent evaluations of the impact of counter-trafficking programmes. This section begins with a discussion of some of the conceptual and methodological difficulties that trafficking poses for research. It then reviews selected aspects of what is known about trafficking in the UK.

1.2.1 Conceptual and methodological challenges

Difficulties in defining trafficking have continued despite the negotiation of a definition in the Palermo Protocol. For researchers, this has translated into problems in deciding who should be included within studies on human trafficking (Kelly 2005; Laczko 2005) and has contributed to the poor comparability of studies. Some researchers may believe that women cannot meaningfully consent to work in the sex industry and therefore categorise all female sex workers as trafficked for the purpose their study, others may categorise migrant sex workers but not domestic sex workers as trafficked, and others will define women working in the sex industry as trafficked only if they report having been coerced or deceived into doing so. Researchers are also likely to differ in the distinction they make between trafficking and smuggling and in the criteria and threshold used for determining when a person's working and living conditions become so exploitative that the person should be included within studies on human trafficking.

Researchers also suggest that studying human trafficking is made more difficult because the problem is under-reported and under-detected. The difficulties researchers face in identifying hidden populations of trafficked people have meant that most studies are conducted with small numbers of people following their contact with the police or support organisations. The representativeness of such research is, however, unclear (Laczko 2005; Tyldum and Brunovskis 2005). Neither the ratio of detected to undetected cases, nor whether there are systematic differences between the experiences of people who do and do not choose to come forward, are known. A number of factors have been suggested to militate against trafficked persons coming forward to engage with police authorities or support providers. Goodey has suggested, for example, that trafficked persons may be unaware of how to report their abuse and that restrictions on their freedom of movement may mean they are unable to report their abuse when they would otherwise

want to do so (Goodey 2008). She and other researchers have also argued that trafficked people may not come forward because they fear further harm towards themselves or their families, and may not trust the ability or willingness of the police to assist them (Goodey 2008, Brennan 2005, Laczo 2003). The failure of service providers, police officers and other officials to recognise and provide post-trafficking support to people who do not match their understanding of what a trafficked person looks like introduces further bias into research, as may trafficked people's refusal to participate in research or to give accurate answers because they fear further harm and stigmatisation (Tyldum and Brunovskis 2005)

1.2.2 The scale of human trafficking in the UK

Efforts to estimate the scale of trafficking both nationally and internationally continue to be impeded by the conceptual and methodological problems discussed in section 1.2.1, and Salt's comment in 2000 that "most statistical data on numbers trafficked are at best crude estimates" would seem to still hold true (Salt 2000; Kelly 2005; Tyldum 2010). Although NGOs and politicians have claimed that thousands of people have been trafficked into the UK (HC 2007; BBC 2008; HAC 2009b; HAC 2009a), records show that, to date, only a small number of people have been identified by the police or assisted by post-trafficking support services (Avenall 2007; Home Office 2009b; Home Office 2009a).

As shown overleaf in Table 1, estimates of the scale of human trafficking in the UK have typically been based on police and NGO data. Reports that have extrapolated from the number of identified trafficked people to an estimate of the number of trafficked people present in the UK have generally based their calculations on the number of women working as sex workers in the UK. The size of this population, however, is itself unknown. Hilary Kinnell's much-cited 1999 report speculated, based upon a survey of sixteen services, that there were 80,000 sex workers in the UK (Kinnell 1999). In 2009, an updated estimate based on 38 specialist sex worker services suggested that there were just under 36,000 sex workers working in England and Scotland (Cusick, Kinnell et al 2009).

Table 1: Summary of reports providing estimates of the scale of human trafficking in the UK

Report	Authors	Data Sources	Type of trafficking	No. identified trafficked people	No. estimated trafficked people
Stopping Traffic (2000)	Academics	Police data	Female sexual exploitation	71	142-1420 per year
Home Office Report (2003)	Home Office	NGO report, newspaper article, guide to UK sex work venues	Female sexual exploitation	-	4.000 currently present
A Scoping Project of Child Trafficking in the UK (2007)	Child Exploitation and Online Protection Centre (CEOP)	Survey of local authorities	Child trafficking	330	-
Strategic Threat Assessment Child Trafficking in the UK (2009)	CEOP	Survey of local authorities	Child trafficking	325	-
Setting the Record (2010)	Association of Chief Police Officers (ACPO)	Police data, print adverts, online resources, police interviews with migrant sex workers	Female sexual exploitation	124	2,600 currently present

The first estimate of the scale of human trafficking in the UK, the Home Office-commissioned "Stopping Traffic" report, suggested that somewhere between 142 and 1,420 women were trafficked to the UK each year for sexual exploitation (Kelly and Regan 2000). This figure was extrapolated from police data which showed that 71 trafficked women were "known" in 1998 using a series of assumptions, for example about the proportion of migrant sex workers who were likely to have been trafficked.

A later Home Office report estimated that there may have been up to 4,000 women who had been trafficked for sexual exploitation present the UK in 2003 (Dubourg and Prichard 2003). The authors noted that 4,000 women was an "upper bound" estimate, and that the estimate had "large margins of error" due to the "very poor data" available for analysis. Despite these caveats, NGO advocates, politicians, and journalists repeatedly claimed that *at least* 4,000 women were trafficked

into sexual exploitation in the UK *each year* (Blackburn 2007; Dugan 2008; HAC 2009b; Bone 2010; MedailleTrust 2010; Salvation Army 2010). The report's estimate was based on extrapolations from "Sex in the City" (an NGO study which attempted to map commercial sex across London), an article from The Times and McCoy's Guide to British Massage Parlours. The rationale for key assumptions, for example that all foreign sex workers in walk-up premises are trafficked, is not clear.

The "Sex in the City" report, upon which the Home Office's estimate heavily relied, was produced by the Poppy Project, an NGO which is funded by the government to provide accommodation and support to women who have been trafficked for sexual exploitation. The study was conducted covertly: male researchers contacted venues that had been located online or through print media to enquire about the women working on the premises and the available services (Dickson 2004a). A second report, "Big Brothel", was produced by the same organisation in 2008 and used a similar methodology (Bindel and Atkins 2008). Although neither report attempted to quantify the scale of trafficking, the authors concluded that trafficking was both present in every borough of London and on the increase. "Sex in the City" drew these conclusions from interviews with trafficked women receiving support from the Poppy Project and from reports from sexual health outreach workers that brothels were becoming more difficult to access (Dickson 2004a). In "Big Brothel", these conclusions were based upon the apparent availability of high-risk sexual services and upon the low prices for these "specialist" services, which the researchers suggested indicated women had little control or choice over their activities and were working within a saturated market (Bindel and Atkins 2008). The methodology, and conclusions, of the "Big Brothel" report were heavily criticised in a joint statement made by 27 academics, however, who argued that the research's use of covert research methods was unjustified, questioned the reliability of information provided to male callers in receptionists' "sale pitches", and suggested that the "anecdotal indicators" of trafficking in the report were inappropriate (Sanders, Pitcher et al. 2008).

An update to the Home Office's 2003 estimate did not come until 2010, and both the 2007 and 2008 National Action Plans claimed that there were up to 4,000 trafficked women present in the UK (Home Office 2007b; Home Office 2008). In 2010, the Association of Chief Police Officers (ACPO) published their report into the scale of migrant sex work and trafficking in England and Wales (Jackson, Jeffery et al. 2010). The first part of the research used advertisements in the printed media, internet web sites, and police intelligence to estimate the numbers of businesses, beds per business, and area of origin of the women working in each region of England. The report

estimated that there 30,000 female off-street sex workers in England and Scotland, 57% of whom of whom were migrants. The proportion of migrants amongst sex worker populations was believed to vary from 31.5% in Yorkshire and the Humber to 96.4% in London. In the second part of the research, police officers conducted interviews with 210 female migrant sex workers and rated the information provided by women against the previously mentioned ILO indicators of trafficking. Women were categorised as trafficked if they met four or more of the ILO dimensions of trafficking and as vulnerable if they met one to three dimensions. 24 of the interviewed migrants were believed to have been trafficked, which was extrapolated to provide a total estimate of 2,600 trafficked migrant sex workers in England and Wales (Jackson, Jeffery et al. 2010).

The ACPO report was welcomed by the UK Network of Sex Work Projects as providing a more "nuanced" picture of the UK sex industry (UKNSWP 2010). The reliability of the report was, however, immediately questioned: data was not collected in the same way in each region, no information was available for the North West, North East, or East Midlands regions, and the methods used risked double counting sex workers who worked from different premises on different days. Furthermore, it was not clear how the interviewed migrant sex workers were selected or how demographically representative they were, and allowing the police to use their judgement in the scoring of women against the indicators risked introducing bias (Brooks-Gordon 2010).

Finally, two assessments of child trafficking in 2007 and 2009 by the police-led Child Exploitation and Online Protection Centre (CEOP) identified 330 and 325 potential victims of child trafficking, respectively (Kapoor 2007; CEOP 2009). Data was gathered from local authorities using a risk assessment matrix, and the estimates included children thought to be at low or medium risk of having been trafficked.

1.2.3 Profiling the people who are trafficked to the UK

Attempts have been made over the past five years to develop profiles of people trafficked to the UK in order to, for example, assist police officers and immigration officials in identifying trafficked people during operations and routine enforcement work (Home Office 2007b). Academics have suggested, however, that the development of such profiles is fraught with difficulties. Firstly, trafficked people are a highly diverse group: they come from a variety of source countries; have different socioeconomic, education, and work backgrounds; and differ in age, sex and ethnicity. They are forced into a multitude of different forms exploitation; the time that they are exploited

may range from days to years; and they have varying experiences of psychological coercion and physical abuse (Salt 2000; Brennan 2005). Secondly, the "profile" of trafficked people has been suggested to be highly dynamic, as a result of both changing trafficking trends and revisions to what is understood and accepted to constitute tra"fficking (Tyldum 2010). Consistent with this, a 2007 Europol intelligence bulletin stated that "the UK has found it difficult to find a 'typical' history of a trafficked victim" (EUROPOL 2007).

This research's review of publicly available statistics relating to trafficked people in the UK from the National Referral Mechanism (NRM), policing operations and the Poppy Project found that data has been presented primarily in relation to characteristics such as nationality, age, gender and industry of exploitation (UKHTC 2008b; UKHTC 2008a; HAC 2009a; UKHTC 2009a; UKHTC 2010a). This data is not presented because it is not comparable between sources. For example, the Poppy Project only accepts adult women who have been trafficked for sexual exploitation in the UK, whereas the UKHTC and NRM data includes trafficked children and adults who have been trafficked for labour exploitation. Furthermore, each of these sources of information is likely to suffer significant biases: there are likely to be systematic differences between trafficked people who do and do not accept assistance from post-trafficking support services; and some groups are more likely than others to enter into the NRM, or may be less likely to be accepted as having been trafficked (Brunovskis and Surtees 2007; ATMG 2010; Brunovskis and Surtees 2010). Moreover, insufficient information was available for an analysis of how the ages and nationalities of people trafficked to the UK may have changed over time.

Academics have suggested that, despite the difficulties inherent in attempts to profile trafficked people, politicians, journalists and anti-trafficking campaigners use a consistent set of symbols when talking about trafficked women: women are suggested to be naïve and helpless foreigners, and are described as being young, virginal and beautiful (Doezema 2000; Berman 2003; Andrijasevic 2007). It is suggested that these tropes work to construct the innocence of "victims of trafficking" and act as a counterpoint to "wicked" traffickers. Similar analyses in relation to trafficking for labour exploitation suggest a less homogeneous treatment. Anderson & Rogaly, for example, found that media attention to people trafficked into forced labour sometimes depicted them as victims exploited by cruel (and often foreign) gang-masters and sometimes as people "benefiting from undeserved opportunities" (Anderson and Rogaly 2005). Anti Slavery International drew similar conclusions from an analysis of media reports and noted that workers

who had been trafficked into forced labour were only deemed deserving of public sympathy if "involved in an accident or disaster" (Skrivankova 2006).

1.3 Evidence relating to human trafficking and health

A number of reports and guidance documents authored by NGOs that work to support trafficked people refer to the negative physical and mental health consequences of trafficking (GAATW 1997; AAF 2001; IOM 2007). The handbook produced in 1997 by the Global Alliance Against Trafficking in Women (GAATW) states, for example, that physical and psychological health issues may arise as a result of "rape, assault, sexual and physical abuse, deprivation of food, intimidation and threats, physical and social isolation, and bondage" in the trafficking situation (GAATW 1997). A 2001 report by the Animus Association Foundation discusses the psychological and emotional problems of trafficked women and states that many women experience post-trauma symptoms as a result of their experiences in the trafficking situation (AAF 2001). This section briefly discusses the concepts of "health", "violence" and "trauma" and defines them for the purposes of this research. It then presents the results of a systematic review of the literature on health and trafficking, which focused upon trafficked people's experiences of violence; their physical, sexual and reproductive health, and mental health; and levels of substance abuse. The section closes with a discussion of the gaps in the evidence base on trafficking and health.

1.3.1 Defining health

Although biomedical models of health and medicine dominate health research and the provision of healthcare services, there has been a recent paradigm shift towards models that emphasise "health, functioning, and wellbeing" (Larson 1999). Biomedical models of health emphasise the absence of disease or disability and liken the human body to a machine that can be "restored to working order" through scientifically-based medical treatment (Giddens 2006). These models distinguish between disease (conditions in which the structure or function of parts of the body are disturbed) and illness (individual perceptions that one is suffering from disease) and suggest that health is a relative, and virtually indefinable, concept (Wood 1986). Detractors have argued, however, that biomedical models are not easily reconciled with psychological and psychiatric disorders and that they do not give adequate attention either to the role of preventative medicine in safeguarding health or the role of social factors in causing ill-health (Larson 1999).

The World Health Organisation's (WHO) definition of health is the most well-known and heavily used of the wellbeing-based models (Larson 1999). It suggests that health should be understood as "a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity" (WHO 1946). Although widely used, the definition has also been criticised on several counts. Authors have noted in particular that there is no consensus on what is meant by wellbeing (Bice 1976; Patrick and Erickson 1993) and that the definition is so comprehensive that it makes "invalids of us all" (Wood 1986). Although operational definitions were developed for physical, mental and social wellbeing during the 1970s, a paper that reported on their usefulness concluded that "social wellbeing" should be dropped from the definition of health (Ware, Brook et al. 1981). More recently, Saracci has also proposed that the definition be restricted to "a condition of wellbeing free of disease or infirmity and a basic and universal human right" (Saracci 1997). Nonetheless, this study defines health according to the full WHO definition. The breadth of the definition makes it the most appropriate to use in a qualitative study that includes amongst its objectives how health has been conceptualised by stakeholders working within the trafficking policy process (see section 1.6). Furthermore, the definition's recognition of the social and political determinants of health would seem to make it suitable for research that is concerned with the policy process.

1.3.2 Defining violence

For similar reasons, this research uses a broad definition of violence, again taken from the WHO. The definition states that violence is the "intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation" (WHO 1996). The inclusion of "power" within the definition allows for the inclusion of threats, intimidation, and neglect as acts of violence. The definition also associates violence with intent and also with health and wellbeing. It therefore categorises intentional acts that are culturally acceptable as forms of violence if they are injurious to health or wellbeing, and recognises violence that does not result in injury or death but may still impose psychological, social, and economic burdens to those who experience it (Krug, Dahlberg et al. 2002). There is a substantial body of research that has established a relationship between violence and physical, sexual and reproductive, and mental health (Koss and Heslet 1993; Campbell 2002; McNutt, Carlson et al. 2002). A review of this literature is, however, beyond the scope of this chapter.

The WHO has also suggested a typology of violence that distinguishes between the nature of the act (physical, psychological, sexual or related to deprivation and neglect), the setting (e.g., the home, the street or institutional settings), and the relationship between the perpetrator and the victim (e.g., intimate partner, familial, community member or state actor) (Krug, Dahlberg et al. 2002). Other models are concerned more with the causes of violence than with categorising the form that violence takes. White and Humphrey, for example, identified four types of victimisation models: psychological/psychiatric models, which emphasise individual risk factors; cultural models, which are concerned with cultural norms and attitudes; social models, which emphasise the role of environmental and situational factors in increasing the risk of violence; and developmental models, which are concerned with, for example, learned behaviour (White and Humphrey 1997). Heise's ecological model of the causes of violence integrates factors from across these models and suggests that risk factors coexist at the individual, interpersonal, community, and societal levels (Heise 1998).

1.3.3 Defining trauma

Trauma is conventionally understood to relate to the experiencing of sudden, unexpected or extraordinary events that threaten a person's safety and disrupt their psychological functioning in such a way that their daily activities are disrupted (McCann and Pearlman 1990; Herman 1997). Experiences of trauma may be associated with mental health conditions including post traumatic stress disorder (PTSD), depression, and anxiety (Mayou and Farmer 2002).

Post traumatic stress disorder (PTSD) first appeared as a psychiatric condition in the Diagnostic and Statistical Manual of Mental Disorders in 1980 (APA 1980). Since then, there has been substantial debate regarding how broadly the traumatic stress criteria should be defined; whether trauma can be measured reliably; and the nature of the relationship between trauma and PTSD (Weathers and Keane 2007). The traumatic stress criteria for PTSD have evolved over time, and have most recently been defined as events which "involve actual or threatened death or serious injury, or other threat to one's personal integrity" and "learning about the unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate" (APA 2000). Although some researchers have called for this definition to be expanded further (Avina and O'Donohue 2002; Mascher 2003), others have argued that the definition is already too broad and results in problems in distinguishing between normal and psychopathological distress (McNally 2003). The increasing profile of post-traumatic stress within programmes and services working

with, for example, refugees has also been criticised by some researchers, who argue that it reflects Western trends of "medicalising distress" and assumes both that there is a universal response to stressful events and that Western models of psychological support have cross-cultural relevance (Summerfield 1999; Summerfield 2001).

1.3.4 A systematic review of health and human trafficking

In contrast to the sizable bodies of literature concerned with estimating the scale of human trafficking, describing the dynamics of the trafficking process (e.g., Salt 2000; Içduygu and Toktas 2002; Shelley 2003; Bilger, Hofmann et al. 2006; Jandl 2007; Kara 2009; Leman and Janssens 2011), and reviewing legal frameworks for addressing trafficking (e.g., Chuang 1998; Kelly and Regan 2000; Corrigan 2001; Gallagher 2001; Fitzpatrick 2002; Gallager 2006), only a small number of peer-reviewed articles presenting primary research on health and trafficking were identified. Indeed, some of the literature purportedly relating to trafficking and health was concerned with a discussion of the scale and dynamics of trafficking and provided only a limited review of health outcomes (e.g.,Gajic-Veljanoski and Stewart 2007).

The review was based on searches of the PubMed, Web of Science, PsychInfo, and EMBASE databases. The search terms[2] returned 367 unique records. Screening of the titles and abstracts against the inclusion criteria, shown in Table 2 (overleaf), excluded 342 records to leave 25 journal articles for retrieval. A further eleven articles were excluded upon reading, leaving fourteen articles for analysis in the literature review. The reference lists of all retrieved papers were scanned for additional articles: this identified four potential papers of interest, which were also excluded after reading.

[2] The following search terms were used for Ovid Medline, Embase and PsychInfo: (human trafficking.mp OR people trafficking.mp OR trafficking in people.mp OR sex trafficking.mp OR woman trafficking.mp OR child trafficking.mp OR trafficked people.mp OR trafficked women.mp OR trafficked men.mp OR trafficked children.mp OR forced labour.mp OR forced labor.mp OR forced prostitution.mp OR sexual slavery.mp) AND (health/ OR well-being.mp OR wellbeing.mp OR ill-health.mp OR illness.mp OR "Wounds and injuries/" OR wound.mp OR injur$.mp OR disease/ OR disability.mp OR infection/ OR symptom.mp OR trauma.mp OR "mental illness"/ OR "mental disorder"/ OR anxiety/ OR depression/ OR fear/ OR guilt/ OR hostility/ OR suicide/ OR "Behavioral symptom"/ OR "Self-injurious behaviour"/ OR "Reproductive behavior" OR "Risk taking"/ OR "Sexual behavior"/ OR "Social behavior"/ OR violence/ OR rape/ OR "sexually transmitted diseases"/ OR HIV/ OR pregnancy/ OR "abortion, induced"/) NOT (protein OR membrane OR cell)

Table 2: Inclusion criteria for systematic literature review on health and human trafficking

Setting	• Any setting
Participants	• Males/females • Adults/children • People self-identifying as, or believed by researchers as, having been trafficked
Language of paper	• English
Objective	• Investigation of health exposures during trafficking situation or, investigation of health needs of trafficked people
Study design	• Cross sectional survey • Cohort study • Case control study • Experimental study (e.g., randomised controlled trials) with baseline measures of the outcomes of interest • Secondary quantitative analysis of organisational records • Quantitative analysis of interview data
Outcome measures	• Prevalence of experiences of physical, psychological, or sexual violence whilst trafficked • Prevalence of physical health symptoms amongst trafficked people • Prevalence of psychological health symptoms amongst trafficked people • Prevalence of sexual and reproductive health symptoms amongst trafficked people • Prevalence of substance abuse amongst trafficked people

Table 3 (overleaf) summarises the key features of the papers included in the literature review. All of the studies were conducted with trafficked women or female children. One study conducted research specifically with trafficked children (Chatterjee, Chakraborty et al. 2006), and although the other studies included minors within their samples they did not disaggregate their results by age group. The majority of studies (twelve of fourteen) were conducted once trafficked people had exited the situation of exploitation: these studies were facilitated by support organisations, which provided access either to trafficked women for interview or to the data they held on them. Seven of the fourteen papers referred to studies conducted in South East Asia (Nepal, Thailand and Cambodia), four to studies conducted in India, and three papers presented the results of two studies relating to trafficking in Europe (Zimmerman, Hossain et al. 2008b; Di Tommaso, Shima et al. 2009; Hossain, Zimmerman et al. 2010a). Other studies have been conducted in Israel (Chudakov, Ilan et al. 2002; Cwikel, Ilan et al. 2003b; Cwikel, Chudakov et al. 2004) and in Greece (Antonopoulou 2006) but were excluded from the review because they did not disaggregate health outcomes information for trafficked and non-trafficked migrant sex workers and did not present quantitative information on health outcomes, respectively.

The majority of articles presented information on only a limited array of health indicators; the studies in South East Asia in particular focused predominantly on the prevalence of HIV/AIDS and co-

infection (Silverman, Decker et al. 2006; Silverman, Decker et al. 2007b; Sarkar, Bal et al. 2008; Silverman, Decker et al. 2008; Dharmadhikari, Gupta et al. 2009; Gupta, Raj et al. 2009).

Table 3: Characteristics of papers included in review on health and human trafficking

	Sample					Study Design		Outcomes
Author	**Size**	**Age**	**Type of expl.**	**Stage of traffickin g**	**Country/ region**	**Data Source**	**Setting**	**Health outcomes of interest**
Zimmerman et al 2008b Zimmerman et al 2008a	192 213	15-45	Sexual	Post-exit	Europe	Survey	NGO support org.	Violence; physical, mental, sexual & reproductive health.
Di Tommaso et al 2009	4,559	9->40	Sexual	Post-exit	Europe/C entral Asia	Data-base	IGO support org.	Violence
Tsutsumi et al 2008	164	11-44	Sexual; other labour	Post-exit	Nepal	Survey	NGO support org.	Mental; HIV/AIDS
Silverman et al 2007b Silverman et al 2008 Dharmadhi kari et al 2009	287 246 287	7-32*	Sexual	Post-exit	Nepal	Case files	NGO support org.	HIV/AIDS; HIV/AIDS, syphilis; hepatitis B. HIV/AIDS, TB
Crawford et al 2008	20	12-19*	Sexual	Post-exit	Nepal	Case files	NGO support org.	Physical, mental, sexual health.
Chatterjee et al 2006	41	10-18	Sexual	Post-exit	India	Intervie ws	NGO support org.	Physical, mental health; HIV/AIDS
Gupta et al 2009	61	14-30	Sexual	Post-exit	India	Case files	NGO support org.	HIV/AIDS
Sarkar et al 2008	580	<20 - >40	Sexual	Currently trafficked	India	Survey	Brothels	Violence; HIV/AIDS
Silverman et al 2006	175	8-29*	Sexual	Post-exit	India	Case files	NGO support org.	HIV/AIDS
McCauley et al 2010	136	-	Sexual	Post-exit	Cambodia	Data-base	NGO support org.	Violence; sexual health
Decker et al 2010	815	-	Sexual	Currently trafficked	Thailand	Survey	Sex work venues	Violence, sexual & reproductive health.

1.3.4.1 Experiences of violence

Women and girls trafficked into sexual exploitation were found to report high levels of violence. 95% of women in Zimmerman et al's European study, for example, reported having experienced either physical or sexual violence whilst trafficked (Zimmerman, Hossain et al. 2006). Analysing a much larger European dataset, Di Tommaso et al found that 82.1% of 3,059 women reported having experienced violence whilst trafficked (Di Tommaso, Shima et al. 2009). These rates of violence compare with some of the highest recorded national rates of gender-based violence in the world (Watts and Zimmerman 2002).

High levels of violence were also reported by the studies conducted in India and South East Asia. Gupta's qualitative analysis of case files of women and girls receiving support from an Indian NGO after having been trafficked into sexual exploitation found, for example, that all of her sample reported having been raped when initiated into forced sex work and that many women and girls reported ongoing sexual and physical violence as methods of punishment and control (Gupta, Raj et al. 2009). McCauley et al's analysis of 136 case records, drawn from 26 Cambodian NGOs, found lower levels of reported violence: 9.6% of women and girls reported having experienced physical abuse and 33.1% reported forced sex acts (McCauley, Decker et al. 2010). It is possible that the researchers' decision to categorise all women who entered into sex work below the age of eighteen as trafficked contributed to this: Sarkar's survey of brothel-based female sex workers found that whereas 57% of 139 trafficked sex workers reported violence, only 15% of 441 non-trafficked sex workers did so (Sarkar, Bal et al. 2008).

1.3.4.2 Physical health

Only a minority of studies reported on the physical health consequences of human trafficking: one European study based on interviews with trafficked women (Zimmerman, Hossain et al. 2008b), an Indian study that used interviews with 41 trafficked children (Chatterjee, Chakraborty et al. 2006) and a Nepalese study which analysed a random sample of twenty NGO case records (Crawford and Kaufman 2008). The full report to Zimmerman et al's European study provides more detailed information regarding the physical health of the trafficked women they interviewed, and is drawn upon to supplement this section of the review (Zimmerman, Hossain et al. 2006).

Zimmerman et al interviewed trafficked women using structured questionnaires over three time periods: between 0 and 14 days post-entry into NGO support services, 28 to 56 days post-entry, and 90 or more days post-entry. The study reported on a range of physical health consequences of trafficking, including pains and injuries; neurological, gastrointestinal and cardiovascular symptoms; and infections and found that 57% of women reported suffering from between 12 and 23 concurrent symptoms at first interview (Zimmerman, Hossain et al. 2006).

Women stated at first interview, for example, that they currently suffered from pains to their backs (69%), stomachs (61%), mouths and jaws (58%), chests (50%), eyes (33%), and ears (15%). 12.5% women also reported having sustained fractures or sprains whilst in the trafficking situation. Pain and numbness may result from violence and injury, but also from chronic levels of fear and stress (Campbell 2002). Neurological health consequences, most commonly headaches (83%), dizziness (70%) and memory loss (62%), were reported by many women, and again may have resulted from violence, injury, fear and stress. Fatigue (81%), weight loss (47%) and skin problems (28%) were also reported, likely due to chronic levels of stress and fear, poor living and working conditions, and inadequate nutrition. The proportion of women reporting between 12 and 23 concurrent symptoms dropped to 7% at second interview, and to 6% once they had been receiving care for 90 or more days.

It is difficult to assess whether the physical health problems reported in Chatterjee's study of trafficked children can be attributed to girls' experiences whilst trafficked, as some of the interviewees had been resident at the NGO shelter for several years (Chatterjee, Chakraborty et al. 2006). The array of health outcomes reported in Crawford's analysis of trafficked children's case files, including headaches (35%), stomach pains (25%), pelvic pain (15%), skin conditions (10%) and fatigue (10%) (Crawford and Kaufman 2008), is similar to those found by Chatterjee and by Zimmerman. The authors note, however, that case records contained minimal detail and that "diagnoses" were made by counsellors with only basic training (Crawford and Kaufman 2008).

Sexual and reproductive health

Studies on sexual violence have found that forced sex can cause gynaecological problems through trauma to the reproductive tract; increased transmission of micro-organisms into the bloodstream following trauma; immune system depression due to high levels of stress and depression; and inability to negotiate condom use and so protect oneself from disease transmission (Campbell

2002). The elevated risk of sexually transmitted infection (STI), urinary tract infection (UTI), pelvic infection, and HIV were discussed by several reports on the health and welfare of trafficked persons (GAATW 1997; IOM 2007; IOM, LSHTM et al. 2009) Also reported were an increased likelihood of pregnancy, unsafe abortion and fears of infertility.

In most studies, discussions of the sexual and reproductive health consequences of trafficking centred upon infection with HIV. Although women trafficked into sexual exploitation may be at elevated risk of infection, prevalence is partly dependent upon local prevalence and patterns of infection. The prevalence reported by the Indian and South East Asian studies ranged from 13% to 63% (Silverman, Decker et al. 2006; Silverman, Decker et al. 2007b; Crawford and Kaufman 2008; Sarkar, Bal et al. 2008; Silverman, Decker et al. 2008; Tsutsumi, Izutsu et al. 2008; Gupta, Raj et al. 2009). The highest prevalence of infection was found by the study which looked specifically at trafficked children (Chatterjee, Chakraborty et al. 2006); an analysis of 287 case records of Nepalese women and girls trafficked to India for sexual exploitation also found that the odds of infection were significantly higher amongst those who were fourteen or younger when trafficked than amongst those who were eighteen or older (Silverman, Decker et al. 2007b). Silverman et al suggested that the increased risk of infection at younger age may be attributable to girls' greater biological vulnerability, poorer knowledge of HIV/AIDS risk and appropriate protection methods, and inability to negotiate condom use (Silverman, Decker et al. 2007b). Zimmerman et al found that only 2% of women participating in their study reported having been diagnosed as HIV positive; their report suggests, however, that this may underestimate the prevalence of HIV infection amongst women trafficked in Europe as many women had not received an HIV test at the time of interview (Zimmerman, Hossain et al. 2006).

Infection with HIV may increase the odds of infection with STIs, and vice versa. Silverman et al found, for example, that the odds of infection with syphilis and hepatitis B were significantly increased amongst trafficked Nepalese women who were HIV positive (Silverman, Decker et al. 2008). Five studies reported upon the prevalence of STIs amongst women and girls trafficked for sexual exploitation (Zimmerman, Hossain et al. 2006; Crawford and Kaufman 2008; Silverman, Decker et al. 2008; Decker, McCauley et al. 2010; McCauley, Decker et al. 2010). The reported prevalence of individual STIs was likely to reflect local epidemiology, but the overall prevalence of infection ranged from 35% to 65%. All but one study relied upon women's self-reports of STI infection and, due to problems of undiagnosed asymptomatic infection or failure to disclose, recall or understand a previous diagnosis, may underestimate the actual prevalence in these samples. The

proportion of women reporting having had access to sexual health checks whilst trafficked varied according to the study setting: only 32% of women in Zimmerman et al's NGO-based study reported having received a sexual health check whilst trafficked, whereas 66% of those participating in Decker et al's survey of brothels in Thailand did so (Zimmerman, Hossain et al. 2006; Decker, McCauley et al. 2010). Decker's study may overestimate the proportion of trafficked women who have access to sexual healthcare in this setting, as it could survey only those women to whom brothel managers permitted access.

A range of further gynaecological problems were also reported by Zimmerman's study, including vaginal discharge (71%), vaginal bleeding (10%), vaginal pain (24%), pelvic pain (59%), and pain during urination (17%) (Zimmerman, Hossain et al. 2006), but were not included as health outcomes in the other selected studies.

1.3.4.4 Mental health

Four studies reported on the mental health of people trafficked for sexual exploitation. Two focused on adult women and older adolescents (Tsutsumi, Izutsu et al. 2008; Zimmerman, Hossain et al. 2008b) and two on female trafficked children (Chatterjee, Chakraborty et al. 2006; Crawford and Kaufman 2008).

Zimmerman's study used the Brief Symptom Inventory, which measures anxiety, depression, and hostility, and the Harvard Trauma Questionnaire, which measures symptoms indicative of Post Traumatic Stress Disorder. Tsutsumi measured similar outcomes of interest using the Hopkins Symptoms Checklist 25 (HSCL-25) and the PTSD Checklist Civilian Version (PCL-C). Although the studies used different instruments, both found that the women in their samples report very high levels of poor mental health. Tsutsumi compared the mental health of women trafficked into sexual exploitation and labour exploitation and found that although both groups reported very high symptom levels, women trafficked into sexual exploitation had significantly higher levels of symptoms indicative of depression (100% versus 81%) and post traumatic stress disorder (29.5% versus 7.5%) (Tsutsumi, Izutsu et al. 2008). Zimmerman found that the symptom levels reported by trafficked women placed them in the 95th, 97th, and 98th percentiles for hostility, anxiety, and depression, respectively, based on a reference population of American adult females, and that 57% of women reported symptoms that were indicative of PTSD (Zimmerman, Hossain et al. 2008b). A second paper based on this study, which used lower thresholds for poor mental health, found that

anxiety and depression were significantly higher amongst women who had been trafficked for more than six months and significantly lower for women who had exited exploitation three or more months previously (Hossain, Zimmerman et al. 2010a). Other reported mental health issues reported by Zimmerman et al include suicidal ideation, disordered eating, sleep disturbance and insomnia, aggression and violence towards others, loss of trust in others, and guilt, shame and low self-esteem (Zimmerman, Hossain et al. 2006).

Neither of the two studies with trafficked children reported using diagnostic or screening instruments to measure or report on the mental health of their samples. Chatterjee reports that high levels of depression (73%), anxiety (34%) and insomnia (29%) were found amongst the children they interviewed (Chatterjee, Chakraborty et al. 2006). How these health outcomes were assessed, however, is unclear, and the results are not disaggregated according to how long the children had been receiving care with the NGO. As noted previously, the limited information contained in children's case files limits the analysis Crawford et al may make of mental health outcomes (Crawford and Kaufman 2008).

Materials produced by NGOs and inter-governmental organisations (IGOs) suggest that the mental health of trafficked persons could be adversely affected by legal, administrative and social responses to human trafficking (e.g., IOM 2007). Interactions with police, criminal justice, and immigration authorities, for instance, risked re-traumatising women through unsympathetic, invasive, and hostile questioning. Conflict and boredom in shelter settings could cause stress, whilst the prospect of reunion with families and children and of returning to home communities could induce anxiety and fear. The process of undergoing medical testing and treatment could itself result in re-traumatisation, fear and anxiety if not sensitively managed. None of the studies included in this review presented information relating to the health impact of responses to trafficking.

1.3.4.5 Substance abuse

The GAATW and IOM handbooks suggested that trafficked persons may have addictions and substance misuse problems as a result of being encouraged or forced to use alcohol and drugs in the trafficking situation (GAATW 1997; IOM 2007; IOM, LSHTM et al. 2009). These reports suggest that alcohol and drugs may be used to create dependence on the traffickers; to enable trafficked persons to work for longer hours, take on harder work, and endure abuse; and to force trafficked

persons to accept activities they find degrading. The full report of Zimmerman et al's European study found that around three quarters of women did not drink alcohol, or drank only occasionally, whilst trafficked. Of the 27% that drank most or every day, women reported that they drank to cope with their situations, to stay warm, or because they worked from bars and were required to consume alcohol with clients (Zimmerman, Hossain et al. 2006). The majority of these women reported that they had been able to cut down on their use of alcohol since leaving the trafficking situation. Only 14% of women reported having taken illegal drugs whilst trafficked, and ongoing problematic drug use was not apparent. A London-based study that aimed specifically to explore drug use amongst migrant and trafficked off-street sex workers also failed to find evidence of problematic drug use (Dibb, Mitchell et al. 2006). Only one of the South East Asian studies reported on alcohol and drug use: a qualitative analysis of 61 case files from an Indian NGO found that women reported both being coerced to consume alcohol and to using alcohol and local drugs to cope with the violence they were subjected to whilst trafficked (Gupta, Raj et al. 2009).

1.3.4.6 Knowledge gaps

The literature review identified a number of gaps in the research on health and human trafficking. Firstly, the review did not identify any peer-reviewed research that focused on the health consequences of trafficking for forced labour. Secondly, no studies were found which either examined the health needs of men who had been trafficked or included men within the study sample. Research that specifically examined the health needs of trafficked children was also limited. In relation to trafficking for sexual exploitation, the research identified a number of gaps which arose because of studies' narrow focus on reporting of short-term health consequences of people's experiences in the trafficking situation and authors' failure to disaggregate data on the basis of whether or not women had been trafficked into sex work.

Information published on the health consequences of forced labour is currently restricted to anecdotal information in NGO reports. The health consequences documented in these reports reflect the occupational health risks for the relevant industries. For instance, reports described the health consequences of trafficking into factory work (including processing and manufacturing) as including chronic coughs and respiratory problems; severe headaches; allergies; skin infection and irritation from poor working conditions; eye-strain and visual problems due to long periods of close concentration and bright light; back and general body pain from repetitive work, restricted posture and heavy lifting; and injury due to poor health and safety provisions (GAATW 2003; HRC 2004).

Similar health risks were identified in literature on occupational health and safety, particularly where labour conditions were exploitative (Punnett L 1985; Sokas RK 1989; Moure-Eraso R 1997; Stellman 1998; Jeebhay MF 2000; Burgel BJ 2004; Chand 2006). The conditions in which people trafficked for labour exploitation live and work may also pose a risk to their physical and mental health. Conditions that are overcrowded, poorly ventilated, and lack adequate sanitation, for instance, may increase the risk of infectious and communicable diseases. Long working hours and poor nutrition may contribute to fatigue, weight loss and malnutrition. Abuse, threats, and the stress of repaying debt arrangements may result in poor mental health.

Research is also needed to explore how men experience violence and other forms of harm whilst trafficked and the physical and mental health needs they may have as a result of having been trafficked. Studies have suggested, for example, that experiencing domestic violence may impact men and women's physical and mental health differently (Coker, Davis et al. 2002). Moreover, only two studies specifically researched the health of trafficked children and both had methodological weaknesses that limited the conclusions that could be drawn from them. Both pointed, however, to an array of negative physical and mental health outcomes, which future research should explore further.

Studies tended to report upon the immediate health consequences of trafficking for sexual exploitation. The review did not identify, for example, longitudinal research that could enable analysis of the long term impacts of trafficking on people's physical, psychological, and social well-being and the factors that predict recovery. Furthermore, no studies were identified which tested health interventions, and no research on how health could be positively or negatively affected by institutional responses to trafficking was found. Such research is needed to inform the development of policies on human trafficking that are both sensitive and responsive to the health needs of trafficked people. Only two studies were identified that compared the experiences of violence or the health needs of women who had been trafficked into the sex industry with those of non-trafficked sex workers. Four further studies which could have contributed to the knowledge base on this point were excluded from the review because they did not disaggregate their results according to whether or not women were believed to have been trafficked (Chudakov, Ilan et al. 2002; Cwikel, Ilan et al. 2003a; Cwikel, Chudakov et al. 2004; Decker, Mack et al. 2009). Future research outputs should present disaggregated analyses, which would firstly allow the identification of similarities between these groups and suggest how existing knowledge and experience can be applied to meeting the health needs of trafficked persons, and secondly facilitate the identification

of trafficking-specific health needs and inform the development of appropriate and targeted health services.

Study Limitations

The reviewed papers consistently suggested that trafficked people were at risk of multiple health problems. The studies had several important limitations, however, and the synthesis of their findings is hampered by the conceptual and methodological difficulties highlighted in section 1.2.1.

Constructing a representative sample of trafficked persons with whom to conduct research is highly challenging. Studies in this review predominantly used support organisations to access either trafficked people for interview (Chatterjee, Chakraborty et al. 2006; Tsutsumi, Izutsu et al. 2008; Zimmerman, Hossain et al. 2008b; Hossain, Zimmerman et al. 2010a) or their medical records (Silverman, Decker et al. 2006; Silverman, Decker et al. 2007b; Crawford and Kaufman 2008; Silverman, Decker et al. 2008; Dharmadhikari, Gupta et al. 2009; Di Tommaso, Shima et al. 2009; Gupta, Raj et al. 2009; McCauley, Decker et al. 2010). Such methods may overestimate the health consequences of trafficking, as persons accessing care may be more likely to represent extreme cases of abuse.

The review also found that definitions of human trafficking were not used consistently by researchers and that the comparability of study findings was therefore limited. Two papers, for example, reported that they included as trafficked any woman who was coerced, forced, or had involuntarily entered sex work or who reported having been younger than eighteen years when first paid for sex (Decker, McCauley et al. 2010; McCauley, Decker et al. 2010). Other studies appeared to adhere more closely to the Palermo Protocol definition of human trafficking, but researchers' reliance on NGO support services for access to trafficked women and/or their medical files means that samples are likely to have varied according to NGO eligibility criteria.

An issue that was not discussed in section 1.2.1 but which became apparent during the review is the differences between researchers' choice of instruments for surveying physical and mental health. Three studies presented information on the prevalence of physical health symptoms (Chatterjee, Chakraborty et al. 2006; Crawford and Kaufman 2008; Zimmerman, Hossain et al. 2008a). Of these, Zimmerman et al used an "adapted" version of the Miller Abuse Physical Symptoms and Injury Survey, Crawford et al used information in children's case files but do not state how the

range of physical health symptoms were originally determined (e.g., clinical examination, self report), and it is not clear whether the children in Chatterjee et al's study reported symptoms spontaneously or in response to specific questions. Four studies collected information on the mental health of people trafficked for sexual exploitation (Chatterjee, Chakraborty et al. 2006; Crawford and Kaufman 2008; Tsutsumi, Izutsu et al. 2008; Zimmerman, Hossain et al. 2008a). Neither of the two studies on the mental health of children reported the use of specific survey instruments to gather data on the children's mental health, and so the extent to which these studies accurately report on the prevalence of "depression", "anxiety", or "withdrawal" is therefore questionable (Chatterjee, Chakraborty et al. 2006; Crawford and Kaufman 2008). Both of the studies that collected data on the mental health of adults and older adolescents reported the use of standard survey tools: Zimmerman et al used the Brief Symptom Inventory (BSI) to measure depression, anxiety and hostility and the Harvard Trauma Questionnaire (HTQ) to measure PTSD, whilst Tsutsumi et al used the Hopkins Symptoms Checklist (HSCL-25) to measure anxiety and depression and the PTSD Checklist Civilian Version (PCL-C) to measure PTSD (Tsutsumi, Izutsu et al. 2008; Zimmerman, Hossain et al. 2008a; Hossain, Zimmerman et al. 2010b). Tsutsumi et al report that HSCL-25 and PCL-C have been validated for use in Nepalese populations. Zimmerman et al reported that the BSI and HTQ have previously been used cross-culturally and with traumatised populations but that they have not been validated for their specific study population. The use of Zimmerman et al's study as a rationale for providing treatment to women trafficked for sexual exploitation has been criticised by the British Psychological Society, who highlighted the lack of validation of the instruments used for measuring physical and mental health and also questioned the researchers' qualifications to use or interpret the instruments (BPS 2007).

1.4 Responding to human trafficking

This section discusses the key anti-trafficking instruments and recommendations for responding to trafficking which have developed at the international level and highlights their relevance for responding to the health needs of trafficked people. It then outlines the major developments in the UK's response to trafficking, including the publication of a specific anti-trafficking strategy, the establishment of dedicated anti-trafficking organisations and the implementation of procedures for the identification and referral of trafficked people.

1.4.1 International Developments

Since the 1990s, human trafficking has been the subject of a number of international conferences, programmes of action and resolutions; Appendix A provides an overview of the major events at this level. The negotiation of the Palermo Protocol was one of the key international developments of recent years and led to the development, after protracted negotiations, of an internationally accepted definition of human trafficking. Furthermore, the Palermo Protocol obliged signatory governments to criminalise human trafficking in their domestic legislation and to develop comprehensive programmes and policies to prevent and combat human trafficking (United Nations 2000). The Palermo Protocol also encouraged governments to consider providing protection and support to trafficked people, but stopped short of obliging them to do so:

> "Each State Party shall *consider implementing* measures to provide for the physical, psychological and social recovery of victims of trafficking in persons, including, in appropriate cases, in cooperation with non-governmental organizations, other relevant organizations and other elements of civil society, and, in particular, the provision of:
>
> (a) Appropriate housing;
> (b) Counselling and information, in particular as regards their legal rights, in a language that the victims of trafficking in persons can understand;
> (c) *Medical, psychological and material assistance*; and
> (d) Employment, educational and training opportunities."
>
> (United Nations 2000, emphasis added)

The European Union (EU) and the Council of Europe also turned their attention to human trafficking during the 1990s; Appendix A also lists the key trafficking-related activities of these two institutions over the past twenty years[3]. In 2002, for example, the EU issued a Framework Decision that required Member States to take action to criminalise trafficking in human beings (EC 2002). The EU also developed two directives requiring that Member States introduce temporary residence permits for trafficked people under certain conditions and provide trafficked people with support

[3] The European Union (EU) is a political and economic community of, at present, twenty-seven member states that has legal powers to introduce legislation that directly affects all member states. The Council of Europe is a separate institution with forty-seven member states and has at its heart the European Convention on Human Rights and the European Court of Human Rights, which enforces the convention.

and assistance (EC 2004; EC 2010); the UK has, however, exercised its right to opt out of both of these directives.

The negotiation of the 2005 Council of Europe Convention on Action Against Trafficking in Human Beings (ECAT) has been one of the key developments in European policymaking on human trafficking. In contrast to the Palermo Protocol, ECAT requires signatory States to provide assistance and protection to trafficked people and also requires the introduction of a formalised process for victim identification (Council of Europe 2005). Specifically, Articles 10, 13 and 14 of ECAT state that signatory States' "competent authorities" (defined as the "public authorities which may have contact with trafficking victims") must have persons trained in identifying and referring trafficked persons, and that as soon as there are reasonable grounds to suspect that a person is trafficked any processes to remove them from the country must stop for a period of at least 30 days to allow the person to begin to recover and reflect upon whether they wish to cooperate with law enforcement authorities (Council of Europe 2005).

During this period, persons suspected of being trafficked or formally identified as such are entitled to a number of basic protection and assistance measures detailed under Article 12, including appropriate accommodation, healthcare, translation and interpretation services, counselling and information on their legal rights, and education if a minor. Following the 30 day period, a renewable residence permit can be issued to persons formally identified as trafficked where the competent authority deems it necessary on the grounds of the person's individual situation or to enable participation in criminal proceedings against the trafficker.

ECAT goes further than the Palermo Protocol with regards to the provision of healthcare but does not create a legal obligation for States to provide all trafficked persons with appropriate medical care. Instead, Article 12 requires that "each Party shall adopt such legislative or other measures as may be necessary to assist victims in their physical, psychological and social recovery. Such assistance shall include at least...*access to emergency medical treatment*" (Council of Europe 2005, emphasis added). The Convention also specifies that each State will "provide necessary medical or other assistance to victims *lawfully resident* within its territory who *do not have adequate resources and need such help*". Under the terms of ECAT, signatory States are thus only obliged to provide full assistance to EU nationals who would be lawfully resident in the state if trafficked there and to non-EU nationals who have been granted a residence permit. The UK is therefore not currently

bound by international requirements to provide comprehensive healthcare services to trafficked people.

The increasing international focus on trafficking has been accompanied by the publication of a plethora of guidelines and best practice reports by IGOs and NGOs. Guidance has been developed in respect of the development of national anti-trafficking strategies (e.g., ICMPD 2006b; UNODC 2008) and the various components of an operational response to trafficking, including: identifying and referring trafficked people (e.g., OSCE 2004; IOM 2005; UNHCR 2009); investigating and prosecuting traffickers (e.g., ICMPD 2004; ICMPD 2006a; UNODC 2009); and protecting and supporting trafficked people (e.g., Oxfam 2003; LSI 2006; IOM 2007; Surtees 2008b; Surtees 2008a). The "guiding principles" recommended by these reports most commonly include that the response to trafficking should be multi-agency (and, in particular, should enable NGO participation in the development and implementation of anti-trafficking strategies), be based upon human rights principles and facilitate the provision of holistic and flexible support that meets the individual needs and vulnerabilities of trafficked people.

Over the past five years, the development of National Referral Mechanisms (NRMs) has become an important best-practice component of European and Eurasian responses to trafficking (USAID 2008). NRMs are "cooperative frameworks through which state actors...ensure that the human rights of trafficked persons are respected and provide an effective way to refer victims of trafficking to services...[and] improve national policy and procedures on a broad range of victim-related issues such as residence and repatriation regulations, victim compensation and witness protection" (OSCE 2004). The OSCE recommend that an NRM should incorporate guidance on identifying and treating trafficked persons, making referrals to specialised support agencies, harmonising assistance programmes with criminal justice proceedings against traffickers, enabling multi-agency participation, and what constitutes appropriate monitoring and evaluation. Despite the development of an exhaustive set of performance indicators for assessing the success of efforts to prevent trafficking, prosecute traffickers and protect and support trafficked people (IOM 2008), there are nonetheless very few evaluations of counter-trafficking policies in general or of programmes that provide support and assistance to trafficked people (Kelly 2002; Kelly 2005; Laczko 2005; GAO 2008).

Very little guidance is available on the development of an appropriate health sector response to trafficking; to date the most comprehensive guidance is provided by the IOM (IOM, LSHTM et al.

2009). Here, the key principles of the response to trafficking include prioritising the safety of trafficked people, self and staff; providing respectful and equitable care; collaborating with other support services; ensuring the privacy and confidentiality of trafficked people; and obtaining voluntary and informed consent before sharing information, providing care, or making referrals, The (non-binding) Budapest Declaration on Public Health And Trafficking in Human Beings, the most comprehensive international statement on trafficking and health, also called for trafficked persons to be given access to comprehensive and long-term care that was gender-, age-, and culturally-appropriate; for healthcare to be provided by trained professionals on the basis of confidentiality and informed consent; and for the establishing of minimum standards of care, based on comprehensive research and best practice (IOM; and USAID 2003).

1.4.2 UK Developments

The UK's strategy for addressing human trafficking was first set out in "Secure Borders, Safe Havens" the 2002 White Paper on immigration, asylum and citizenship (Home Office 2002). Trafficking was included within a chapter entitled "Tackling Fraud – People Trafficking, Illegal Entry and Illegal Working" and, whilst distinguished from people smuggling, it was suggested to usually involve a "breach of immigration law" (Home Office 2002). This early strategy focused upon a small number of aims: the introduction of legislation to criminalise human trafficking and combating both illegal working and organised crime through increased enforcement activity; cooperating with the EU, transit, and source countries in preventative and enforcement activities; and arranging protection, where necessary, to trafficked people who were "willing to come forward to UK authorities". The paper also stated that although the government would consider the individual circumstances of those trafficked people who, by cooperating with the authorities, risked reprisals against themselves and their families, where people were "not entitled to remain here, and it is not appropriate to let them stay, they must be returned to their own country wherever possible. To do otherwise would undermine the UK's immigration law and open the door for traffickers to exploit more victims". Support would be provided to trafficked people to "assist them to return" to their own country.

Shortly afterwards, the provision of government-funded accommodation and support for women trafficked into sexual exploitation was initiated with the establishment of the London-based Poppy Project. Funding was initially provided in March 2003 for a six month pilot project, but was extended for a further eighteen months once it became apparent that plans to evaluate the success of

the project in securing evidence against traffickers and consequent convictions were over-ambitious within the original timescale (Taylor 2004). Concerns that the project would be overwhelmed by requests for assistance led to the development of stringent eligibility criteria. Women were only eligible for support if they had been forcibly exploited in the UK and were working in prostitution at the time of referral, intended to return to their country of origin, and were willing to cooperate with the authorities (as discussed below, these criteria have since been relaxed). In Scotland, Glasgow City Council established the Trafficking Awareness Raising Alliance (TARA) to provide support and crisis accommodation to women who had been trafficked for sexual exploitation in the UK (Scottish Government 2010). A number of voluntary organisations, predominantly faith-based (e.g., the Medaille Trust and the Salvation Army), also developed projects to accommodate and/or support women who had been trafficked for sexual exploitation.

In January 2006, the Home Office launched a consultation on the response to trafficking, proposing to focus on the prevention of trafficking, prosecution of traffickers, and protection of trafficked persons (Home Office 2006b). The consultation asked respondents to comment on eighteen aspects of a draft plan, including: whether the scope of the plan was adequate; whether specific actions were missing from the proposals; how efforts to measure the scale and nature of trafficking in the UK could be improved; what more needed to be done to move the response to trafficking into core police business; how support services for trafficked people could be replicated or expanded; and the benefits and drawbacks of introducing reflection periods and residence permits for trafficked people (Home Office 2006b). 206 individuals and organisations responded to the consultation, including 89 religious organisations, 55 NGOs, fourteen police forces, and nine government departments (Home Office 2006c). The summary of responses to the consultation, published in June 2006, noted that a number respondents had suggested that trafficking should be seen not only as an issue of organised immigration crime but also as a violation of human rights, and that attention must be paid to labour trafficking and child trafficking in addition to trafficking for sexual exploitation. Furthermore, many respondents had argued that victim support and protection should be central to the response to trafficking, and that physical and psychological health needs arising as a result of trafficking should be recognised and met (Home Office 2006c).

The Association of Chief Police Officers (ACPO), in their response to the trafficking consultation document, recommended that the Home Office create a centre of excellence to coordinate the policing response to trafficking (Home Office 2006c). The UK Human Trafficking Centre (UKHTC) was subsequently established in October 2006 and was tasked with "the development of

expertise and operation co-ordination in relation to trafficking" and "the development of a "victim-centred human-rights based approach to tackling human trafficking" (Home Office 2007b). Over the next three years the UKHTC grew from two full-time staff to 34 (a number of whom were seconded from outside agencies, including the Serious Organised Crime Agency (SOCA), the UK Border Agency (UKBA), and the Poppy Project) (HAC 2009a) and took on responsibility for delivering much of the UK response to trafficking (Home Office 2007b; Home Office 2008; Home Office 2009b).

The government published its National Action Plan on Tackling Human Trafficking in March 2007, coinciding with the bicentenary of the abolition of the transatlantic slave trade and the announcement that the UK would sign ECAT (Home Office 2007b). It detailed the government's strategy for addressing trafficking, and was updated in July 2008 and October 2009 (Home Office 2008; Home Office 2009b). The 2007 plan stated that "victims trafficked into sexual exploitation, or who have experienced sexual violence or abuse as part of their exploitation, may have experienced a high level of physical, emotional and psychological trauma", and amongst the proposals to protect and assist trafficked persons were a small number of actions relevant to health (Home Office 2007b). The improved identification of trafficked persons was a key element of protection and assistance, and was to be achieved through awareness raising and the training and supporting of frontline professionals. The document stated that such efforts should extend beyond professionals working in enforcement activities and include health and sexual health professionals. This would be achieved through updates to the online "Trafficking Toolkit" that was already publicly available and by the inclusion of human trafficking within the Department of Health's (DH) Victims of Violence and Abuse Prevention Programme (VVAPP), which aimed to "equip professionals and services to identify and respond to the mental and physical health effects of...sexual exploitation" (Home Office 2007b). The National Action Plan also stated that tackling human trafficking was to be included within the scope of other existing programmes of work, such as the DH-funded handbook on the sexual health needs of asylum seekers and refugees, and that trafficked people would benefit from the outputs of other government programmes (such as joint work between the Home Office and the DH to improve the access of victims of sexual violence and abuse to health and support services, and the programmes developed under the 2007 Cross Government Sexual Violence and Abuse Action Plan).

In the 2008 and 2009 updates to the National Action Plan, health-related action points continued to focus on the identification as well as the support of trafficked persons, and were linked to wider

government policies and programmes. The 2008 update noted that the plans to raise awareness of trafficking amongst healthcare providers through the VVAPP had been delayed. It also reported that anecdotal information had suggested that women trafficked into sexual exploitation were often allowed to access sexual health services, and that the DH and the Office for Criminal Justice Reform (OCJR) would therefore carry out targeted awareness raising and training activities with sexual health staff (Home Office 2008). The need to include healthcare providers within awareness raising and training activities was restated in the 2009 update, which again included plans to publish specific guidance for healthcare practitioners as part of the online "Trafficking Toolkit" (Home Office 2009b). Finally, the Department of Health would consider how to improve the NHS response to trafficking within a new taskforce. The Violence Against Women and Girls Taskforce would "identify the role and response of the NHS in relation to violence against women and girls" as part of a cross government anti-violence strategy.

ECAT entered into force in the UK in April 2009, placing obligations on the government to introduce formal procedures for the identification of trafficked people and prompting the introduction of the UK NRM. Under the NRM, specified "First Responder" agencies (currently the police, SOCA, the Gangmasters' Licensing Authority, UKBA, Local Authorities, the Poppy Project, TARA, the Migrant Helpline, the Medaille Trust, the Salvation Army and Kalayaan (UKBA 2009c)) may refer people they suspect of having been trafficked to one of two "Competent Authorities" for identification. The UKBA Competent Authority (CA) handles cases are already in the asylum and immigration system, whilst the UK Human Trafficking Centre (UKHTC) CA handles all other cases. Following a referral, the CA makes an initial "reasonable grounds" decision (targeted to be within five working days) using a low threshold test as to whether they believe that a person is likely to have been trafficked. A positive decision automatically grants the person a 45 recovery and reflection period during which time no action may be taken to remove them from the UK (Home Office and BIA 2008). A more rigorous assessment of whether a person is, on the balance of probabilities, thought to be trafficked is also conducted by the CA during this 45 day period, following which a "conclusive grounds" decision is made. A person who receives a positive "conclusive grounds" decision can then apply for a one year residency permit either on humanitarian grounds or to assist with a criminal investigation against their traffickers (Home Office and BIA 2008).

Table 4 shows the proportion of applications refused at the reasonable and conclusive grounds stages. Of the 706 applications made to the NRM between April 2009 and March 2010, half had

been granted a positive decision at the reasonable grounds stage, 17% were awaiting a decision, and nearly 30% had been refused. Of the 361 who had received a conclusive grounds decision, just over a third had received a positive decision whilst around a fifth had been refused. Although claimants may seek judicial review of decisions made within the NRM, the NRM does not include a procedure for appealing negative decisions at either the reasonable grounds or conclusive grounds stage.

Table 4: Outcomes of applications to the National Referral Mechanism for the period April 2009 - March 2010

Outcome of Application	Reasonable Grounds Stage (%)	Conclusive Grounds Stage (%)
Accepted	51.1	34.1
Refused	27.2	19.4
Pending	17.3	39.3
Other*	4.4	7.2
Total	100 (n=706)	100 (n=361)

(UKHTC 2010b)

* The "Other" category includes applications that have been suspended or withdrawn, including because the applicant has gone missing.

ECAT also obliged the UK to extend its provision of support and protection to *all* people who were identified as trafficked through the NRM. The support capacity of the Poppy Project was therefore expanded from 36 to 54 bed-spaces (including five spaces for women who had been trafficked for domestic servitude) and its geographical coverage increased to include the provision of support in Sheffield and Cardiff through two affiliated NGOs (Home Office 2009b). Women can receive support from the project if they have been trafficked to the UK and subsequently sexually exploited or exploited in domestic servitude. Women who receive a negative reasonable grounds decision from the NRM, however, must move on from the project within four weeks. TARA was also funded to provide support to women trafficked for sexual exploitation in Scotland. Finally, the Migrant Helpline was funded to provide care and accommodation for men and women who had been trafficked into the UK for labour exploitation. Trafficked children are supported by local authorities under the terms of section 20 of the Children's Act 2004 (Great Britain 2004b).

1.5 Access and Availability of Healthcare Services

This section provides an overview of policies relating to the entitlement of migrants, in general, and to trafficked migrants, in particular, to mainstream healthcare services in the UK. Prior to the implementation of ECAT, existing healthcare regulations meant that emergency medical care was already accessible to trafficked people. ECAT-related legislative changes in 2008, however, gave trafficked persons enhanced access to free medical care under certain conditions.

1.5.1 Healthcare Entitlements

A person's access to free NHS care is dependent upon whether they are considered to be "ordinarily resident"[4] in the UK. Under the National Health Service Act 1977, the Secretary of State has the authority to make regulations to charge those not "ordinarily resident" for the NHS care they receive (Great Britain 1977). Prior to 2004, migrants were exempt from charges for secondary care if they had been in the UK for 12 months or more or if they had arrived with the purpose of taking up permanent residence in the UK. The NHS (Charges to Overseas Visitors) Regulations 2004 (Amended) added requirements that the period of residence had to be lawful and that proof of legal residence had to be provided (S.I.2004/614). Exemptions from charges were only possible for specified categories of visitor[5] and particular categories of illness or treatment, including services provided in Accident and Emergency departments, sexual healthcare, family planning services, compulsory treatment under the Mental Health Act 1983 and treatment for specified infectious diseases. General Practitioners (GPs) continued to have discretion "to offer NHS treatment to all people", but could refuse to register people as patients on the basis of their immigration status, and overseas visitors referred for secondary care by their GP were not automatically entitled to free hospital treatment (DH 2004b).

[4] The term "ordinarily resident" is not defined in the National Health Service Act 1977. It is a common law concept, the established meaning of which is that a person is ordinarily residing in the UK, apart from temporary or occasional absences, and that their residence has been adopted voluntarily for settled purposes as part of the regular order of their life for the time being. Its definition with regards to access to free healthcare has been challenged in recent years.

[5] Those exempt include people who have been lawfully living in the UK for the preceding 12 months, asylum seekers who have made a formal application to the Home Office which has not yet been determined; refugees; nationals of non-EEA countries with which the UK holds bilateral or reciprocal health arrangements and which allow referrals to the UK to receive specific treatment with the agreement of their home country; and nationals of countries that are signatories of the European Social Charter who are genuinely without money to pay for necessary treatment (S.I.2004/614).

Trafficked migrants were subject to these general regulations until the entry into force of ECAT in April 2009. As illustrated by Table 5, some categories of trafficked persons were automatically entitled to free healthcare on the basis of their immigration status whilst others were not.

Table 5: Potential immigration statuses of trafficked people and their eligibility for free primary and secondary healthcare (pre 2009)

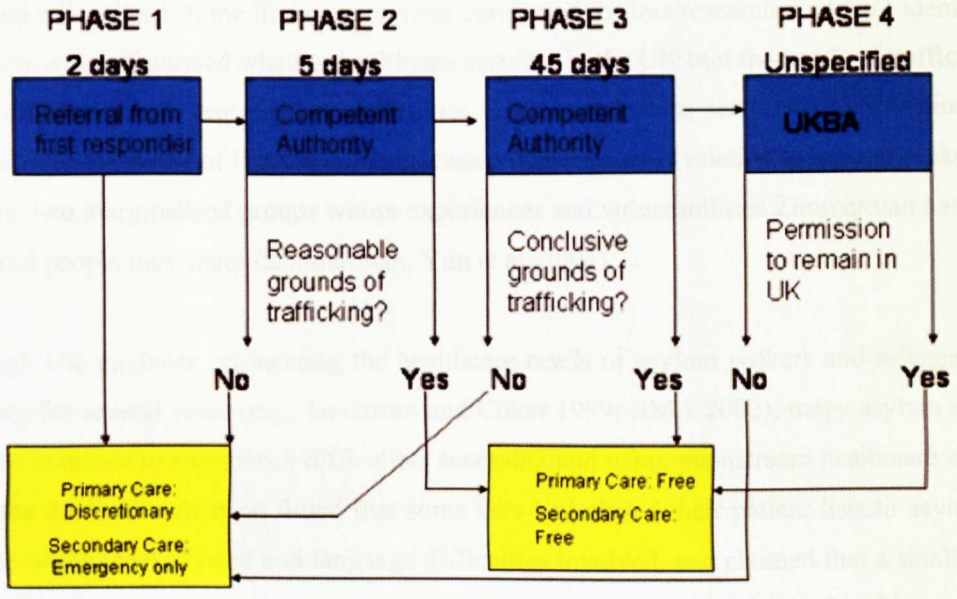
Immigration Status	Eligible for care
Unlawfully in the UK, no asylum or human rights claim made, not a European national	No
Asylum seeker awaiting a decision	Yes
Asylum claim/human rights claim refused	No
EU citizen with the right to reside in the UK	Yes
EU citizen with no right to reside in the UK	No
Granted asylum or leave to remain	Yes

(Willman 2008).

Legislative changes to the NHS (Charges to Overseas Visitors) Regulations in 2008 in preparation for the implementation of ECAT meant that trafficked people were exempt from charges for primary and secondary medical care if they had entered into the NRM and were either in receipt of a current recovery and reflection period or had been granted a temporary residence permit (S.I.2008/2251). The flowchart in Figure 1 (overleaf) was developed from the charging regulations and associated guidance and illustrates trafficked people's entitlement to free medical care at the different points in the NRM referral process[6].

[6] The diagram assumes that the trafficked person was not eligible for free healthcare on other grounds, for example because they had claimed asylum. The NRM operates separately to the asylum system. A person could simultaneously enter the NRM to be recognised as trafficked and submit an application for asylum. If the person was, through the NRM, found not to be trafficked they could continue to access free primary and secondary healthcare due to their asylum-seeking status. If the asylum claim then failed, however, and appeals were exhausted, the entitlement to free healthcare would be withdrawn. The entitlement to healthcare accessed through the NRM is also separate to the system of entitlements for EU citizens under EU law.

Figure 1: Healthcare entitlements in the National Referral Mechanism



(DH 2004a; DH 2009; S.I.2008/2251)

In phase one, prior to their referral into the system, a person who is suspected of having been trafficked has no entitlement to access services for free on the basis that s/he may have been trafficked and is subject to the general framework governing the access of foreign nationals to the health service. Once a person has been referred into the system but before the CA has made a reasonable grounds decision (phase two), persons thought to be trafficked continue to be subject to the general framework governing the access of foreign nationals to the health service. In phase three, a positive reasonable grounds decision entitles the trafficked person to receive free and full primary and secondary medical care through the NHS. To prove that one has been accepted as trafficked by a CA, trafficked persons may be required to present their letter of confirmation from the CA to medical staff (DH 2009). Following the 45 day recovery and reflection period, if the CA makes a positive conclusive grounds decision (phase four), the person is eligible to apply for a temporary residency permit either on humanitarian grounds or to assist in a criminal investigation. Whilst in receipt of one of these residency permits a person will have free and full access to primary and secondary healthcare through the NHS. Persons who choose not to enter into the NRM, or whom the CA does not believe to be trafficked, remain subject to the general regulations around the access of overseas nationals to NHS care.

1.5.2 Availability and accessibility of healthcare services

As stated in section 1.3, the literature reviews conducted for this research could not identify articles or reports which discussed whether healthcare services in the UK met the needs of trafficked people or if trafficked people experienced difficulties in accessing these services. This section therefore provides a brief review of literature that discusses these issues in relation to asylum seekers and sex workers, two marginalised groups whose experiences and vulnerabilities Zimmerman has suggested trafficked people may share (Zimmerman, Yun et al. 2003).

Although UK guidance on meeting the healthcare needs of asylum seekers and refugees has been available for several years (e.g., Levenson and Coker 1999; BMA 2002), many asylum seekers and refugees continue to experience difficulties accessing and using mainstream healthcare services. In 2000, the Audit Commission found that some GPs had closed their patient lists to asylum seekers because of the level of need and language difficulties involved, and claimed that a small number of GP services were shouldering a disproportionate amount of provision for this group (Audit Commission 2000). More recently, the 2007 inquiry by the Joint Committee on Human Rights (JCHR) into the treatment of asylum seekers and a 2010 review for the Equality and Human Rights Commission both reported that asylum seekers experience difficulties in registering with GPs and arranging appropriate interpretation services, and suffer from poor continuity of care (JCHR 2007; Aspinall and Watters 2010). Other studies have additionally found that asylum seekers' access to healthcare services is hindered by a lack of familiarity with how the NHS works, the lack of language appropriate information about services and the costs of travelling to appointments (North of England Refugee Service 2000; Burnett and Peel 2001). Asylum seekers and refugees are reported to face particular difficulties accessing appropriate mental healthcare services. Research conducted for the Commission on Public Patient Involvement in Health, for example, found that mental healthcare provision for refugees and asylum seekers in London was lacking and that there was a "general lack of awareness" of asylum seekers and refugees being a group with distinct, multiple and complex needs and of the need for providers to have specialist knowledge when working with them (Ward and Palmer 2005).

Migrant sex workers may also face barriers in accessing care due to their immigration status, unfamiliarity with how health services are provided, and language difficulties. More generally, researchers and services providers have noted that providing accessible and high quality care to sex

workers is made challenging by issues of mobility, discrimination and criminalisation (Rekart 2005; UKNSWP 2009). Evidence-based guidance on providing services to, and conducting awareness-raising and education activities with, sex workers is available, however, and emphasises the need for non-judgemental and confidential service provision which respects the human rights, views, and experiences of sex workers, the need to involve sex workers in the development and implementation of interventions and the need to engage with the socio-legal context in which sex work takes place (EUROPAP/TAMPEP 1998; WHO 2003; UKNSWP 2008).

Health services for sex workers in the UK have tended to focus on sexual health care, and the specific provision of other services (such as counselling and therapeutic services) remains extremely limited (UKNSWP 2009). Furthermore, providers report that increasing financial pressures are restricting the services that they are able to provide; targeted services have begun to be withdrawn from HIV prevention budgets and, more generally, funding for sexual health services has been de-prioritised (IAG 2004; Cusick and Berney 2005). Sex worker services have also been affected by a policy "drift" from harm minimisation to abolitionism over the past decade, and are increasingly dependent on Home Office, rather than health authority, funding (Phoenix 2008).

1.6 Research Aim and Rationale.

The literature on the health impact of human trafficking suggests that meeting the health needs of trafficked persons may be an important part of a response which supports and assists the recovery of trafficked people. International instruments have placed only limited obligations on governments to meet these needs, however, and at the domestic level, although legislative changes have extended the healthcare entitlements of trafficked people, the UK National Action Plan on Tackling Human Trafficking does not articulate a coherent strategy for specifically meeting the health needs of this group.

The research presented in this thesis aimed to analyse the ways in which health had been incorporated into the development of the UK response to trafficking between 2000 and 2010 and had the following objectives:

1) To analyse how was health conceptualised within the trafficking context;
2) To identify the barriers to incorporating health into human trafficking policy, how they were used, and why;
3) To identify the opportunities for the incorporation of health in human trafficking policy, how they were used, and why;
4) To contribute to the understanding of the modern UK policy process;
5) To identify the strategic implications for the future inclusion of health in policies that are not initiated or led by the Department of Health.

Chapter 2

Theoretical and Conceptual Aspects of the Research

This chapter provides a review of the literature on selected stages of the policy process and presents the conceptual framework that was developed for the research. Writing in 2003, Fischer claimed that, historically, the field of policy analysis had been dominated by "neo-positivistic and empiricist" studies which used "technocratic" techniques such as cost-benefit analysis and risk analysis to inform a rational model of the policy process (Fischer 2003). He and others have criticised the separation of facts and values in these studies and their attempts to generate context-independent maxims with which to explain the policy process (Hajer 1993; Fischer 1998; Yanow 2000; Fischer 2003). Instead, Fischer encouraged the use of qualitative (or "interpretative") approaches to policy analysis and placed emphasis on the importance of values, beliefs and meanings within public policymaking.

The aims of this study were compatible with the principles of qualitative policy analysis and, as will be discussed in Chapter 3, the research followed a qualitative study design. The policy literature review presented in this chapter is therefore particularly concerned with the theories and concepts that lend themselves to a qualitative analysis of the policy process. An overview of the literature on problem definition, agenda setting and policy formulation is followed by a discussion of three policy theories that attempt to integrate multiple theoretical perspectives on public policymaking into a single model. The chapter then presents the conceptual framework that has guided the collection and analysis of data in this research and which is based upon the concepts discussed in this chapter

2.1 The Stages Heuristic

The stages heuristic model describes the policymaking process as a series of discrete stages: problem identification, policy formulation, policy implementation and policy evaluation. It has been widely discredited as a description of policymaking (Sabatier and Jenkins-Smith 1993; John 1998; Sabatier and Jenkins-Smith 1999), and although it is often used to apply order to the policy process or to enable the analyst to focus on a particular aspect of policymaking, critics have argued

that it is apt to "confuse rather than to illuminate" the process of policy analysis (John 1998). Nonetheless, this literature represents a considerable body of policy scholarship and was used to enrich the conceptual framework which guided the research. This section therefore provides a review of the key literature on selected stages of the policy process:

Chapter 1 showed that there were limited health-related developments in human trafficking policy in the period under study. The literature on policy implementation and evaluation is therefore not included in this review. For ease of presentation, problem definition and agenda setting, two parts of the problem identification process, are reviewed as separate stages.

2.1.1 Problem Definition

Policy scholars have suggested that the way in which a problem is defined determines whether the problem reaches the government's agenda, which actors become involved in the policy process and what type of policies are formulated in response to it (Edelman 1988; Baumgartner and Jones 1993; Schneider and Ingram 1993; Rochefort and Cobb 1994; Kingdon 2003). Kingdon, for example, has written about how re-categorising the problems faced by disabled people when using public transport from a transportation issue to a civil rights issue, strengthened activists' arguments for retrofitting subway stations to ensure *equal* access for disabled passengers and delegitimized dial-a-ride services as a potential policy solution (Kingdon 2003).

Although policy actors may define a particular problem in different ways, scholars have suggested that successful policymaking requires the dominance of a single definition (Goffman 1971; Coughlin 1994). Groups involved in the policy process therefore have an interest in establishing a problem definition that serves their values and interests (Kingdon 1984; Nelson 1984; Baumgartner and Jones 1993). Nelson, in her analysis of the political response to child abuse in the USA, distinguished between the dynamics of definition for "valence issues" and "position issues". She argues that valence issues (such as child abuse) are strongly symbolic and, because they elicit a fairly uniform response from stakeholders, do not lead to ongoing argumentation over the most appropriate problem definition and policy response. In contrast, position issues have a more adversarial quality and the processes of problem definition and policy formulation are characterised by comparatively higher levels of conflict (Nelson 1984).

Scholars of the policy process have identified several elements which contribute to how a problem is defined, including causality, severity, incidence, proximity and the social image of the target population. These components are discussed in the remainder of this subsection.

If it is true that conditions only become problems when we believe that something can and should be done about them, then policy actors' perception of how an issue is caused is key to its being identified as a problem (Kingdon 1984; Stone 1989). Indeed, Rochefort & Cobb have stated that "culpability is the most prominent of all aspects of problem definition" (Rochefort and Cobb 1994). Stone has suggested that policy actors develop "causal stories" about issues in which they attribute the existence of issues to the actions of individuals and organisations (Stone 1989). She identifies four categories of causal stories: accidental, inadvertent, mechanical, and intentional. Accidental causal stories refer to problems that arise as the unintended consequences of unguided actions (e.g., natural disasters), inadvertent causal stories refer to the unintended consequences of purposeful actions (e.g., unforeseen side effects and carelessness), mechanical stories refer to the intended consequences of unguided actions (e.g., planned obsolescence) and intentional causal stories refer to the intended consequences of purposeful actions (e.g., assaults and conspiracies) (Stone 1989). Stone argues that people who believe that they are the victims of harm will attempt, firstly, to claim that another party has intentionally caused the problem, and, if unsuccessful, will then seek to establish either mechanical or inadvertent causation. In response, parties who are accused of having caused a problem will argue that the problem was caused accidentally or by someone else. Stone also suggests that causal stories are important to the process of policy formulation, because they establish a locus, or a chain, of responsibility against which policy initiatives can be directed.

Policy scholars have suggested that the severity, incidence and proximity of a problem affect how an issue is able to capture people's attention, the priority afforded to it, and the nature of the policy developed to address it (Rochefort and Cobb 1994). Defining a problem as a crisis or an emergency, for instance, can elevate it up through a crowded agenda. Lipsky defines emergencies as "life-threatening or system-threatening condition[s] of recent onset or severity about which there is a general belief that something can and should be done" and describes how designating a problem an emergency legitimises the rapid mobilisation of extraordinary resources and allows policymakers to postpone more complex and costly long-term interventions (Lipsky and Rathgeb Smith 1989). This is only the case, however, if the problem is accepted to be an emergency or crisis, and thus measures of incidence and severity, and their interpretation, may be the subject of disagreement.

An issue's proximity relates to the extent to which people feel it has personal relevance for them. Narrowly defined issues are suggested to be more successful in eliciting sympathy and targeting resources (Rochefort and Cobb 1994), but agenda-setting scholars have also noted that issues are more likely to reach the political agenda if they have wide social significance (Cobb and Elder 1972). Advocates may therefore seek to widen the social relevance of narrowly defined issues by using proximity-increasing tactics. Employing phrases such as "national tragedy" or "national outrage" may, for example, construct an issue as being close to home (Rochefort and Cobb 1994).

Policy scholars have also argued that an issue is more likely to be reach the institutional agenda if it is relatively novel (Cobb and Elder 1972). The transition of a new problem to the political agenda may be undermined, however, by the difficulties of finding a solution with which to address it and by the challenge of establishing a single accepted policy image. Bosso claims that the behaviour of policy elites and competing advocacy groups during these nascent conflicts are crucial to a problem's definition and to future policy formulation (Bosso 2000). He argues that during early debates elites are likely to have "disproportionate impacts over the intellectual and symbolic boundaries of problems", and that it is during early conflicts that governments and institutions become either bulwarks against, or avenues for, change.

The social construction of a target (or "problem") population refers to the recognition of shared characteristics that make a group socially meaningful and the attribution of specific values to these characteristics. Schneider and Ingram have identified four categories of social groups using a two-way matrix of deserving/undeserving and powerful/weak and argue that a group's position within this matrix affects not only the willingness of governments to help them, but also the type of policy formulated, the level of control the group has over the design of the policy, how the policy is justified to the public and how the policy is implemented (Schneider and Ingram 1993). For example, "dependent groups", such as mothers and children, are positively constructed but have little political power. Policymakers are likely to appear sympathetic towards them but are unlikely to allocate sufficient resources to policies which address their needs. Schneider and Ingram also suggest that although social constructions can be relatively enduring, political actors invest significant resources in attempts to reposition a group within the two-way matrix.

2.1.2 Agenda Setting

In discussing the process of agenda setting, Cobb & Elder draw a distinction between systemic and institutional agendas (Cobb and Elder 1972). They suggest that the institutional agenda comprises the issues that are being seriously considered by decision-making bodies, whereas the systemic agenda also includes the wider range of issues that are being considered only by the public and by experts. Cobb & Elder state that the public appeal of an issue is key to its transition from the systemic agenda to the institutional agenda and that an issue's public appeal is linked to its specificity, social significance, temporal relevance, complexity and categorical precedence. Under their model, an issue will fare better if it is well-defined, widely relevant, timely, easy to understand and new.

Cobb built on this analysis in a later paper, describing three ways by which an issue could reach the institutional agenda (Cobb, Ross et al. 1976). Firstly, the outside initiative model accounted for the way in which issues arose in non-governmental groups and were expanded to reach the public agenda and then the institutional agenda. Secondly, the mobilization model described issues that were initiated inside government and quickly achieved institutional agenda status, but which had to be harnessed to the public agenda for successful implementation. Finally, the inside initiative model described issues initiated inside government but which were not expanded to the public agenda.

Nelson suggested that the process of agenda setting could be broken down into four stages: issue recognition, issue adoption, issue prioritisation and issue maintenance (Nelson 1984). Indicators, for instance from routine monitoring or timely studies, may prompt issue recognition but are primarily used to assess the magnitude of already recognised issues (Kingdon 1984). Where indicators are insufficient to prompt issue recognition, an issue may need a push from a "focusing event" or powerful symbol to move it onto the agenda (Kingdon 1984). Focusing events, however, are suggested to only create pressure on the government to act when they are combined with the belief that society can "do something about" a problem (Downs 1972; Kingdon 1984). The move from issue recognition to issue adoption therefore requires, firstly, the sense that the government should take action on an issue and, secondly, the existence of a feasible and acceptable solution (Hall 1975; Kingdon 1984; Nelson 1984).

In contrast to the structured models of agenda setting suggested by Cobb, Elder and Nelson, the "garbage can" model stresses the random nature of the process (Cohen, March et al. 1972). The garbage can model suggests that organisational policymaking is the result of unique couplings of problems and solutions in the garbage "mix" and depends on a complicated mesh of the choices available, the problems that are known to the organisation, the mix of solutions requiring a problem and the demands being made upon the decision-makers. Kingdon's "Multiple Streams" model of the policy process, described in detail in section 2.2.2, builds upon this model.

2.1.3 Policy Formulation

Three major theories underpin studies of policy formulation: rational decision-making (Simon 1976) incremental decision-making (Lindblom 1959), and mixed scanning (Etzioni 1967; Etzioni 1986).

Rational decision-making theories offer prescriptive models based on the assumption that individuals have the capacity to act in a rational manner (John 1998), and list a number of ordered steps that lead to the optimal solution. Firstly, a problem is identified, and policymakers' goals, values and objectives in respect of the problem are ranked and clarified. Secondly, all alternative strategies for achieving policymakers' goals are listed and a comprehensive analysis of the consequences of each is undertaken. Finally, the options are compared and the one which maximises preferences is chosen.

The rational choice model has been criticised, however, both as a descriptive and prescriptive tool. It is argued, for example, that problem definition is more complex than this approach suggests, that power relationships and competing organisational priorities make the objective ranking of goals and values problematic and that not all possible options can be considered to be viable policy solutions (Lindblom 1959; Parsons 1995). Furthermore, resources may not be available to complete a detailed analysis of all options. Simon's model of "bounded rationality" therefore updated the theory to suggest that decision-making processes were constrained by psychological and organisational factors, the cost and incompleteness of information and the complexities of choice, but that decision-making within the boundaries of these constraints could still be rational (Simon 1976). According to this model, decision makers "satisfice" instead of aiming to find optimal solutions.

Lindblom, a major critic of rational theories, proposed "incrementalism" as an better alternative (Lindblom 1959). According to this model, policy-makers make changes through incremental steps and do so by comparing a limited number of alternatives that are not far removed from the status quo. As a descriptive tool, however, it cannot explain radical policy decisions or the conditions under which a problem is redefined, and it fails to address the dimensions of power that can keep particular policy alternatives off the agenda (Parsons 1995; John 1998). As a prescriptive tool it advocates a conservative approach above innovation and risks that incremental change occurs "in many directions at once but [leads to] nowhere" (Etzioni 1967).

Based on the criticisms of both the rational decision-making and incremental models, Etzioni described a "third way" of approaching policy formulation (Etzioni 1967). He suggested that due to limited resources, decisions are made in a hierarchical fashion: firstly, policymakers conduct a "broad sweep" of a policy area to facilitate fundamental decision-making, and then, a more detailed analysis is undertaken to determine the steps that will follow from these fundamental decisions. The model overcomes the "unrealistic demands of rationalist theories" by limiting the level of information required to make major decisions regarding policy goals and, by enabling policy-makers to take a long-term view of alternative policies, also overcomes the conservatism inherent to incremental models (Etzioni 1967).

2.2 Integrated Theories

Five major theories of the policy process dominate the literature on public policymaking: rationalism, institutionalism, socioeconomics, network theory, and ideas-based theory. Although policy scholars tend to work predominantly within one tradition, John has suggested that models which integrate all five perspectives are needed if the complexity of the policy process is to be understood and explained (John 1998). This section therefore reviews the literature on three major integrated theories of the policy process: the Advocacy Coalition Framework, the Multiple Streams model and Punctuated Equilibrium.

2.2.1 The Advocacy Coalition Framework

Sabatier's Advocacy Coalition Framework (ACF) has been described as one of the most influential policy models of recent years (Fischer 2003). The framework was developed within an American context and was initially criticised as being more applicable to the open politics of the USA than to Western European systems (Eberg 1997; Kubler 1999). Later revisions amended the model to

increase its relevance to European politics (Sabatier and Weible 2007) and a 2009 review found that it had received considerable testing and application in this context (Weible, Sabatier et al. 2009).

Although Sabatier has added and refined the hypotheses of the ACF in a series of reviews (Sabatier 1998; Sabatier and Jenkins-Smith 1999; Sabatier and Weible 2007; Weible, Sabatier et al. 2009), the model continues to be based upon four key assumptions. Firstly, policy analysis should be conducted at the level of the policy subsystem, secondly, policies are best thought of as translations of belief systems, thirdly, understanding policy change requires a time perspective of a decade or more, and finally, technical and scientific information should be expected to play a key role within the policy process (Sabatier and Jenkins-Smith 1993).

Policy subsystems are defined as the constellation of actors from a range of organizations who are "actively concerned with a policy problem" (Sabatier and Jenkins-Smith 1993). The ACF aggregates these actors according to their membership of particular "advocacy coalitions" (rather than on the basis of their institutional affiliation), which engage in coordinated activity over time in an effort to further their policy preferences. Actors within an advocacy coalition share a set of normative and causal beliefs, the structure of which Sabatier suggests are hierarchical and tripartite (Sabatier and Jenkins-Smith 1993). According to the ACF, belief systems consist of a "deep core" of normative and ontological beliefs, "policy core" beliefs that relate to the specific policy problem of interest, and a shallower "secondary" layer of beliefs concerning, for instance, policy preferences. Sabatier argues that coalitions' preferred policy solutions reflect their deeper norms and beliefs.

Also working within the policy subsystem are "policy brokers", actors (e.g., senior civil servants) who mediate conflict between competing coalitions and seek to negotiate policy solutions whilst maintaining the integrity of the subsystem. The distinction between a broker and an advocate is suggested to exist along a continuum, however, and Sabatier notes that the extent to which civil servants function as policy advocates depends on the clarity of their department's policy goals.

Numerous other policy theorists also use the concept of policy networks to refer to clusters of actors and organisations which interact during policy-making and share resources in order to achieve their policy goals. Hajer, for example, groups organisations into coalitions on the basis of their policy beliefs but suggests that coalition members may not necessarily work together in a coordinated manner to influence policy (Hajer 1993; Hajer 1995). Rhodes & Marsh discuss "policy networks"

as an expansive concept which encompasses a continuum of relationships between state and civil society, varying according to a number of factors including the number of members, the frequency and stability of interactions, the degree of consensus regarding policy goals and the groups' resources (Rhodes and Marsh 1992). At one end of the continuum are "issue networks" (wide groups that encompass a range of interests and have a fluctuating membership) and at the other are "policy communities" (highly integrated networks with stable and restricted membership), although no group is likely to fit either definition entirely. Reflecting the unequal distribution of power and resources within a subsystem, both a policy community and an issue network can exist for a given policy area, with the former working at the core of policymaking and the latter at the periphery.

Over time, and often in response to external forces, Rhodes & Marsh suggest that policy networks may become more or less integrated or that different interests may come to dominate them. Case studies of the UK policy process have suggested, however, that rapid change in policy networks is the exception (Rhodes and Marsh 1992; Dowding 1995; Dowding 2001; Marsh and Smith 2001). Sabatier has hypothesised that once coalitions have formed, their stability (and inter-coalition conflict) is increased by the tendency for actors in different coalitions to interpret evidence through different "lenses". In high-conflict situations, this tendency, combined with the propensity of actors to weigh defeats more heavily than victories, can result in a mutual "devil-shift" in which each coalition believes the other to be more powerful and malevolent than they probably are (Sabatier, Hunter et al. 1987). Fenger & Klok, whilst agreeing that inter-coalition conflict is more likely when disagreement is at the level of deep or policy core beliefs, have also suggested that patterns of inter-coalition conflict and coordination are patterned by the nature of coalition interdependencies (Fenger and Klok 2001).

The ACF predicts that, on the basis of decisions made by policymakers, the actions of other coalitions or new information about the policy problem, coalitions may undergo policy oriented learning (POL) and revise their beliefs or strategies. Sabatier claims, however, that changes to fundamental beliefs, and therefore major policy changes, are unlikely to occur as a result of POL alone. Abrar et al's analysis of changes in UK domestic violence policy supported this hypothesis: the study found that although a coalition of police and government officials altered its policy core beliefs over two decades in response to cumulative interactions with a coalition of feminist NGOs and activists, the deep core beliefs of each coalition remained stable (Abrar, Lovenduski et al. 2000).

Instead, the ACF predicts that policy stability and change is a function of the interaction of competing advocacy coalitions within a policy subsystem; external changes in socioeconomic conditions, governing coalitions and other policy subsystems; and constraints and resources such as the basic attributes of the problem and fundamental socio-cultural values and structures (Sabatier and Jenkins-Smith 1993). Case studies of British policymaking have suggested, however, that policy networks tend to promote policy stability rather than policy change (Rhodes and Marsh 1992) and that socioeconomic conditions are more likely to act constraints on policy choices than stimulate change (John 1998).

Sabatier has suggested that the ACF should work well in policy domains in which issues are dominated by normative concerns (such as abortion and gay rights) as these subsystems are characterised by well-defined coalitions with conflicting belief systems. Although the majority of case studies using the ACF have analysed change in environmental and energy policy (Weible, Sabatier et al. 2009), the model has also been used to analyse the development of the Trafficking Victims Protection Act (TVPA) in the USA (Footen 2007). This study found, however, that the system proposed by Sabatier for mapping the beliefs of coalitions was of limited value and that, because trafficking was uniformly condemned by policy stakeholders, competing advocacy coalitions had been able to temporarily overcome the differences in their deep core beliefs (Footen 2007).

2.2.2 Multiple Streams Model

Kingdon's Multiple Streams model (MS) is concerned mainly with agenda setting, but is also relevant to the policy formulation "stage" of the policy process (Kingdon 1984; Travis and Zahariadis 2002). It suggests the existence of three independent "streams" in the policymaking process: the problem stream, the policy stream, and the political stream[7]. The model suggests that the three streams interact over time and predicts that when conditions in the streams are complementary, "windows of opportunity" may emerge and policy change becomes possible (Kingdon 2003).

The problem stream comprises the various issues and conditions that policymakers may want to address. Not all issues, however, are perceived as problems and a single issue may be thought of as

[7] Some policy scholars have argued that the streams are better thought of as inter-dependent, as changes in one can cause or reinforce changes in the others. Others maintain that the treatment of streams as independent is the major conceptual contribution of the model (Zahariadis 2007).

a problem in many different ways. The MS model emphasises that problem definition is a strategic process, and argues that the information used to establish the existence, scale and nature of a problem is not value-neutral but is strategically constructed and manipulated to create meaning (Kingdon 2003; Zahariadis 2007). Kingdon discusses two forms of information: indicators and feedback. Indicators may be monitored routinely by government or may be the subject of specific governmental or non-governmental studies and reports. As previously mentioned, the type of indicator used, and its interpretation, informs agenda setting and policymaking and therefore may be a source of conflict between interest groups. Feedback from existing programmes, professionals and the public also contributes to how a problem is understood (Kingdon 2003). The final components of the problem stream are focusing events (such as crises and disasters related to an issue area) and symbols, both of which are strategically constructed and interpreted by issue advocates and work to reinforce the perception that a problem exists.

The policy stream refers to the "primeval soup" of policy recommendations and the groups generating and supporting them (Kingdon 1984). Although the MS model does not include a formal analysis of the motives or strategies of actors and groups within the policy process, it rejects rational choice theories and argues that policymakers often do not have well-formed policy goals or a strong understanding of how their work fits into the more general work of the government (Simon and Alm 1995; Kingdon 2003). During the process of defining the cause of a problem and the population affected by it, however, some solutions begin to appear logical whilst others are ruled out. Other solutions fade because they are not technically feasible, acceptable to prevailing norms and values or in line with anticipated future constraints. Consequently, there may be very few policy options available for meaningful debate at the government level (Kingdon 1984; Bosso 2000).

Kingdon suggests that policy solutions are rarely wholly original, but are instead generated through the recombination and mutation of older policy elements (Kingdon 1984). Such a process allows policy advocates to "hook" their proposed solution to a number of different problems. Like Edelman, who argued that most policies come into existence to strengthen a particular ideology (Edelman 1988), Kingdon noted that advocates have "pet" solutions, and that they wait for problems to arise to which these solutions can be attached. Something akin to a bandwagon effect then occurs, with a proposal being taken increasingly seriously the more it is discussed. In the earliest formulation of the MS model this process of recombination and emergence was incremental, with policy community members and policymakers accepting ideas as viable policy

solutions only after a prolonged period of "softening up" (Kingdon 1984). Durant and Diehl argued later, however, that the MS model conceptualised the "alternative-specification" process too narrowly and claimed that although the model could account for the incremental development, emergence and acceptance of policy ideas, it failed to explain rapid, non-incremental change (Durant and Diehl 1989). They advocated the synthesis of gradualist natural-selection and punctuated equilibrium models of evolution and suggested four alternative scenarios: the rapid propulsion of new ideas, the gradual gestation of new ideas, the rapid gestation of old ideas, and the slow gestation of extensions to existing policies. Zahariadis extended this work to suggest that the size and structure of policy communities influences how ideas develop and surface (Zahariadis and Allen 1995).

The "political stream" runs rather separately to the other two and includes three core elements: the national mood, campaigns by pressure groups and the governing party. The national mood refers to the idea that large numbers of people within a country think along certain common lines and that shifts in the dominant patterns of thinking over time can be sensed and measured. Changes in the national mood prompt government officials to promote certain agenda items and policy alternatives over others (Kingdon 1984). Government officials also judge the level of consensus and conflict between interest groups: consensus may provide an impetus to move an issue forward in the favoured direction, but conflict requires political risks to be calculated and a suitable balance found. Finally, change in the governing party can affect agenda-setting and alternative specification, as can turnover in administrative personnel. This effect may be particularly noticeable in systems dominated by two parties and large legislature majorities, such as the UK.

The final two components of the MS model, policy windows and policy entrepreneurs, are crucial in facilitating policy change. The opening of a policy window presents an opportunity to "couple" the three streams to bring about policy change. A window may be open only fleetingly, prompted either by a compelling problem (a "problem window") or by events in the political stream (a "political window"). The two window types prompt different processes: a problem window requires that solutions be developed in response to the problem, whereas a political window stimulates an ideological process in which attention focuses on solutions prior to problems and policy ideas must search for a rationale (Zahariadis 2007). "Policy entrepreneurs" are actors who attempt to couple the three streams whilst a policy window is open and, in contrast to Sabatier's "policy brokers", play an important role in policy advocacy. Successful entrepreneurs are highly skilled, well resourced and have good access to decision-makers (Kingdon 1984).

Although MS has been used to aid analysis of policies spanning a wide range of sectors and settings, there has been little development or refinement of the model over the past 25 years and it continues to receive criticism for its lack of testable hypotheses and under-specification of how choices are made (Zahariadis 2007). Policy scholars have attempted to derive refutable hypotheses from the model and have also argued that the model can be used to identify potential windows of opportunity and to therefore evaluate the potential success of policy solutions against the currents of the three streams (Travis and Zahariadis 2002; Blackman 2005). The model does not claim to be predictive, however, and indeed emphasises the random nature of the policy process.

2.2.3 Punctuated Equilibrium Theory

The punctuated equilibrium model attempts to explain the processes underpinning long periods of policy stability followed by short periods of rapid change (Baumgartner and Jones 1993). The model has two key elements: policy image, which is akin to problem definition, and policy venues, which refers to the institutions or groups that have the authority to make decisions upon an issue. Policy images may be rejected or accepted depending on the institution in which they are raised, and policy losers thus have an incentive to "venue shop" by manipulating the policy image in order to bring in other policy venues.

Baumgartner and Jones argue that policy stability occurs when the essential features of a policy do not change ("equilibrium"), which is rare, but also where policy venues images are static. They also suggest that changes in either a policy venue or a policy image, or the interaction between the two, can produce self-reinforcing chance through a system of positive feedback. In contrast to Downs's Issue Attention Cycle in which issues are suggested to peak and then fade from the agenda (Downs 1972), the Punctuated Equilibrium model argues that, as a result of the creation and destruction of institutions around an issue, issues can endure even after the attention given to them has peaked.

According to the New Institutionalism literature upon which this model draws heavily (John 1998)[8], institutions can also act as bulwarks against the redefinition of problems and policy change, firstly, by embedding particular policy images into institutions and organisational practices ("discourse institutionalism"), secondly, by shaping the behaviour of policy actors, and finally, by facilitating

[8] The "New Institutionalism" approach to public policy analysis argues that institutions affect the power of networks and the circulation of ideas (John 1998).

some groups achieving their goals whilst blocking others (Hajer 1995; Fischer 2003). Gamson has suggested that indicators of the institutionalisation of policy advocacy groups include: the consultation and inclusion of their key leaders during policymaking; the provision of material support or resources; the introduction of legislation, institutions or agencies to address their concerns; and endorsement of the group's ideology (Gamson 1975).

2.3 Conceptual Framework for Data Collection and Analysis

2.3.1 Overview of the Conceptual Framework

The conceptual framework that was developed to guide this research drew primarily upon Kingdon's Multiple Streams model rather than upon Sabatier's Advocacy Coalition Framework (ACF) or Baumgartner & Jones's model of Punctuated Equilibrium (Kingdon 1984; Baumgartner and Jones 1993; Sabatier and Weible 2007).

The Punctuated Equilibrium model was felt to be of limited explanatory value for this particular case study: the model seeks to explain sudden periods of rapid policy change but, as discussed in Chapter 1, health-related developments in UK human trafficking policy have been limited. The ACF was not chosen as the basis for the conceptual framework of this research because of anticipated difficulties reconciling the highly empirical methodology advocated by Sabatier with analyses based on the principles of qualitative research (Hajer 1995; Fischer 2003). McBeth et al have suggested that an integration of the key principles of qualitative policy analysis and the ACF could help the model to explain the policy actors' strategic representations of beliefs and values and could encourage the ACF to focus on the political strategies used by actors to expand or contain the policy subsystem (McBeth, Shanahan et al. 2007). Efforts to do so, however, remain at an early stage (McBeth, Shanahan et al. 2007; Jones and McBeth 2010). Moving this agenda forward was felt to be beyond the scope of this research: although it was hoped that the policy case study would contribute to an improved understanding of the modern British policymaking process, the main aim of the research did not lie with the development of political theory.

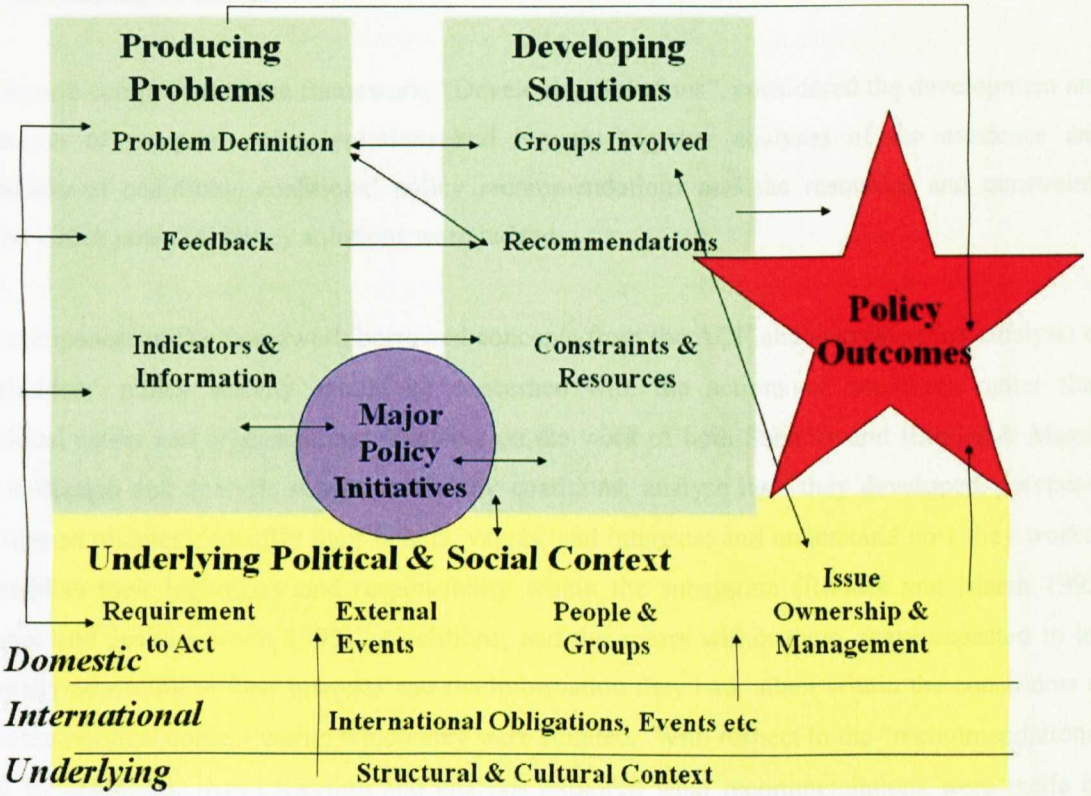
Although the usefulness of the MS model as a tool for understanding policy change is perhaps reduced by its lack of predictive power and testable hypotheses, it remained attractive as a conceptual basis for this case study. Firstly, the model's focus on agenda setting and policy formulation processes was appropriate for the questions this research sought to answer. Secondly,

the emphasis Kingdon places on the role of contextual factors within the policy process and his recommendation that policy analysts collect data through elite interviewing seemed to make the model amenable to qualitative research. A decision was taken, however, to augment the conceptual framework with concepts from the ACF and the theory of Punctuated Equilibrium. This provided additional substance to the MS framework and permitted later analysis of the case study against the principles and hypotheses of these two models.

The conceptual framework shown overleaf in Figure 2 informed the study design and data collection, and provided the initial basis for data analysis. The framework comprised four elements: how trafficking was produced or "constructed" as a problem, how policy solutions were developed by groups and individuals working in the trafficking policy subsystem, the underlying political and social context (at both the domestic and international level), and the influence of major policy-related events on future developments. For the purpose of this research, the "trafficking policy subsystem" is defined the network of stakeholders, from a range of organisations, who are concerned about human trafficking as a policy issue and are actively engaged in the development of the response to trafficking in the UK.

The four elements were suggested to be inter-related and interacted over time. For example, particular problem definitions could be closely associated with particular coalitions if coalitions defined trafficking as a problem for different reasons or proposed solutions that served different political or ideological agendas. A particular problem definition could also impact on the political context of a problem, for example by framing it in such a way that the government did or did not have a legitimate responsibility to act, or by determining the political ownership of a problem. Policy content was expected to be a function of the interactions of these four elements. Although policy implementation was not a focus of the research, the framework allowed for the effects of implementation on agenda setting and policy formulation through the inclusion of feedback, indicators and information in the "Producing Problems" element.

Figure 2: Conceptual framework for the analysis of health in UK human trafficking policy.



2.3.2 Producing Problems

The first component of the framework, "Producing Problems", was concerned primarily with the processes of problem identification and definition. It encompassed elements of problem definition reviewed in section 2.1 and considered the role of feedback, indicators and other sources of information in the problem identification and definition process.

As discussed in later chapters, data collection and analysis was concerned with both the dominant and alternative definitions of the trafficking "problem" and sought to explore not only *what type* of a problem trafficking was suggested to be and why, but also the process by which the problem was defined, who was involved in its definition, and whether definitions changed over time. When considering the role of information and indicators, attention was paid to how indicators and information were produced and used as well as to their availability and accessibility to members of the policy subsystem. Data collection and analysis relating to feedback sought to examine what was said by stakeholders within the trafficking policy subsystem, by whom, to whom, how, and why.

2.3.3 Developing Solutions

The second component of the framework, "Developing Solutions", considered the development and promotion of potential policy solutions and brought together analyses of the existence and interaction of coalitions, coalitions' policy recommendations and the resources and constraints against which potential policy solutions were judged.

This component of the framework borrowed concepts from the ACF and suggested that analysis of stakeholders' policy activity should be concerned with the actions of coalitions rather than individual actors and organisations. Drawing on the work of both Sabatier and Rhodes & Marsh, data collection and analysis sought to identify coalitions; analyse how they developed, competed and formed alliances; identify their beliefs, values, and interests; and understand how they worked to establish their legitimacy and responsibility within the subsystem (Rhodes and Marsh 1992; Sabatier and Jenkins-Smith 1993). Coalitions, and the actors within them, were expected to act rationally according to their interests and the information they had, albeit within the constraints of the socio-political context within which they were situated. With respect to the "recommendations" made by coalitions, data collection and analysis explored what recommendations were made by whom, to whom, and why; how support for, and opposition to, particular recommendations varied between coalitions; and which recommendations were accepted and rejected by key decision-makers. Further detail on this aspect of the research is provided in Chapter 6.

Policy scholars have drawn attention to the importance of a number of constraints to policy formulation, including: competing policy priorities; acceptability with respect to prevailing norms and values; budget pressures; and time (Hall 1975; Kingdon 1984; Sabatier and Jenkins-Smith 1993). Data collection and analysis examined the role of these factors on trafficking policymaking, but as discussed in Chapter 7, also identified other relevant policy constraints.

2.3.4 Political and Social Context

The "Political and Social Context" component of the conceptual framework acknowledges the importance of temporally and spatially specific factors in patterning agenda setting and policy formulation. Although both the ACF and the MS models suggested the importance of contextual factors, neither included substantial detail on the types of factors that should be considered. The

"political and social context" component of the framework was therefore supplemented by Leichter's typology of contextual factors. This typology names four categories of factors: situational factors (transient, impermanent or idiosyncratic conditions, including impacts from other policy subsystems) structural factors (the relatively stable elements of society and policy, such as the political system and the type of economy), cultural factors (the values of society or groups within it) and international factors (those leading to greater inter-dependence between states and influencing national sovereignty) (Leichter 1979). Drawing on Sabatier's model of beliefs and learning, structural and cultural factors (or "underlying factors") and situational and political factors ("surface level factors") were separately grouped in this component.

The MS model does not explicitly consider international influences on policymaking (Simon and Alm 1995) but, in line with Leichter's typology and in order to highlight the increasing importance of developments at the international level on national policymaking, the conceptual framework separates international and domestic contextual factors. As discussed in Chapter 1, international anti-trafficking instruments have placed direct policy obligations on the UK government and have shaped the framework within which the UK responds to trafficking.

2.3.5 Major Policy Initiatives

The first three components of the framework closely reflected the three streams found in Kindgon's MS model (Kingdon 1984). "Major Policy Initiatives" was a new addition to this model and drew upon Baumgartner and Jones's work and the wider New Institutionalism literature. Data collection and analysis in respect of this component sought to understand how major policy initiatives may, by institutionalising certain "policy images" and norms and values, have impacted upon how trafficking was defined as a policy problem (and therefore which solutions were acceptable, logical and feasible) and privileged the involvement of certain stakeholders within the policymaking process over others (Thelen and Steinmo 1992; Baumgartner and Jones 1993; Pierson 2000). Examples of major policy initiatives that were expected to be influential in shaping the development of the UK response to human trafficking include the decision to sign the Council of Europe Convention on Action against Trafficking in Human Beings, the development of new administrative procedures such as the National Referral Mechanism and the establishing of new strategic or operational anti-trafficking organisations such as the UK Human Trafficking Centre and the Poppy Project.

2.3.6 Policy Content

The four major components of the conceptual framework were expected to interact, much like the three streams of Kingdon's MS model (Kingdon 1984), and by doing so produce the content of human trafficking policy. For this research the particular content of interest was those policies and programmes that related to the health of trafficked people. The framework therefore suggested that the limited focus on health in UK human trafficking policy could be explained with reference to the absence of health in the four major components of the framework and/or the dominance of other approaches in these same components.

Chapter 3

Methods

This chapter details how the research was conducted. After briefly discussing the study site and the scope of the research, the chapter describes a qualitative study design was used in order to achieve an in-depth understanding of how health had been incorporated into the UK response to trafficking. The chapter then provides a detailed discussion of the methods of data collection used in this research (document collection, semi-structured key stakeholder interviews and participant observation at policy meetings and related events), the methods of data analysis, and the treatment of the ethical issues that arose. The chapter closes with my reflections on the research process and on my position as an observer/participant in the UK human trafficking policy subsystem.

3.1 Study Site

The initial aim of the research was to analyse the development of the response to trafficking across the whole of the UK. It soon became clear, however, that the policy response to trafficking was dominated by stakeholders and developments in England and that the policy and service response had developed predominantly in London. The majority of my interviews and observation events were therefore conducted in London, although I also visited Nottingham, Sheffield, Dover and Glasgow over the course of the research to conduct interviews and to attend policy events. No interviews were conducted in either Northern Ireland or Wales.

3.2 Study Scope

Although policies, services and research on human trafficking were shown in Chapter 1 to have focused predominantly on trafficking for sexual exploitation, the development of the response to trafficking for all forms of exploitation was included within the scope of this research. Data was therefore collected and analysed in relation to trafficking for sexual exploitation and labour exploitation and with regards to both trafficked adults and trafficked children.

3.3 Methodological Perspectives

The aims of the study were believed to correspond well with the principles of qualitative research. Snape and Spencer have suggested that the most common features of qualitative research include aiming to develop an in-depth and interpretative account of social phenomena; using small, purposively selected samples and interactive methods of data collection to gather rich and detailed data; and conducting analysis that is "open to emergent concepts" (Snape and Spencer 2003). Data collection and data analysis were aligned to these principles with the hope that this study design would provide for a nuanced understanding of how the key policy stakeholders conceptualised trafficking as a policy problem, the meaning they attached to health in relation to trafficking, and how they perceived and approached the potential barriers and opportunities that arose for the inclusion of health in the response to trafficking.

3.4 Data Collection

Semi-structured interviews were the primary source of data used in this research. Interviews are generally one of the key sources of case study information, but are subject to problems of bias, poor recall, and poor or inaccurate articulation (Yin 2003) and although useful in understanding how participants account for a phenomenon, they are less useful in accessing people's experience of the phenomenon itself (Stimson and Webb 1975). Interviews were therefore combined with participant observation at policy-relevant events and document collation in order to corroborate and enrich insights and to search for contrary information

3.4.1 Interviews

Sampling

Sampling for the interviews used a combination of purposive and snowball methods. Preparatory research included mapping the policy subsystem in order to generate an initial list of actors and organisations to invite for participation in the study.

The first stage of the mapping exercise was to create a list of academics, professional associations, non-governmental organisations (NGOs), public sector organisations and government departments that had been involved to date in responding to human trafficking. "Responding" was loosely

defined and could include, for example, conducting research or publishing reports; presenting at or attending trafficking-related meetings, seminars and other events; submitting oral or written responses to consultations and inquiries; providing services to trafficked people; or being named in policy documents as being involved in anti-trafficking programmes and services. This identified a large and diverse sample: trafficking policy was led by the Home Office but several other government departments and agencies were involved in its development, as were a considerable number of NGOs. In total, the exercise identified 74 NGOs and academics and 69 government departments, government agencies, local authorities and other public sector organisations.

The second stage of the mapping exercise used a number of criteria to rank the level of organisations' involvement in the development and implementation of UK human trafficking policy. The criteria are listed in full in Appendix B but included: giving evidence to the Joint Committee on Human Rights inquiry on human trafficking; participating in the consultation to the National Action Plan on Tackling Human Trafficking; and being responsible for an action point in the National Action Plan. Actors and organisations meeting a greater number of these conditions were deemed to be more involved in developing the UK response to trafficking than those meeting fewer. Through this process, a list of 22 NGOs, government departments and public sector organisations were identified as priority interview targets. A list of these priority targets is also provided in Appendix B.

A preliminary finding arising as a result of this exercise was that there was limited health sector involvement in human trafficking policymaking. Only a small number of healthcare providers featured on the long-list of potential interviewees and their apparent lack of involvement in trafficking policymaking meant that they were ranked too low to appear on list of priority interviewees. Healthcare practitioners were, given the aims of the study, expected to be key informants for this research. In an iterative departure from the original study design, a number of actors and organisations known to be concerned with trafficking and health were therefore added to the short-list of potential interviewees (see Appendix B). The general lack of trafficking-related awareness and expertise in the health sector, and the absence of healthcare providers from the trafficking policy subsystem, meant that this was a highly selected sample. Also unrepresented were organisations which worked with, or advocated on behalf of, sex workers. As earlier literature reviews had indicated that sex workers were a group who were likely to be affected by developments in human trafficking policy, a small number of these organisations were also added. The absence of healthcare providers and sex worker advocate groups from the human trafficking

policy subsystem, and the impact that their absence had on the development of the response to trafficking, was central to subsequent analysis and is discussed particularly in Chapter 6.

Once data collection commenced, snowball sampling was used to augment the list. At the end of each interview, participants were asked if, based on the aims of the research and the topics that we had covered, there were other people or organisations that they recommended I contacted. Due to resource constraints, priority was given to potential participants who were recommended more than once or who seemed likely to provide new or expert insights.

Recruitment

All potential interviewees were contacted by email in order to explain the purpose of the research and why it was hoped that they would participate in an interview. Further details of the study were provided via an attached Participant Information Sheet (see Appendix C). Potential participants were asked to respond to the email and to suggest convenient dates and times to meet. In most instances one or more follow up emails were subsequently sent to request an interview.

Due to the observation component of the research, I had established relationships with a number of people within the trafficking policy subsystem before contacting them to request an interview and several were already familiar with the aims of the research. Having these prior relationships seems to have assisted recruitment, which was relatively successful despite the general consensus that recruitment of "elite interviewees" can be challenging (Richards 1996; Berry 2002; Goldstein 2002; Green and Thorogood 2004)[9]. Only four of the potential participants refused to take part in the study: three junior civil servants and a children's services local government worker. Two of the civil servants and the children's services official claimed that this was due to their lack of expertise in this area. The final civil servant felt too junior to participate, and the relevant team leader later agreed to be interviewed for the research.

In a small number of cases, potential participants were interested in the research but it did not prove possible to schedule an interview. In other cases, the turnover of personnel meant that there was nobody suitable to interview during the period of data collection (Appendix B provides further

[9] Elites are people who are "influential, prominent, and/or well-informed in an organisation or community; selected for interviews on the basis of their expertise in areas relevant to the research" (Marshall and Rossman 2006).

details). Appendix D provides a full list of the organisations that participated in the research: a summary of this information, broken down by interviewee category, is shown below in Table 6.

Table 6: Number and type of key stakeholder interviews conducted for the research

Organisation Type	Number of Participating Organisations	Number of Interviews
Advocacy	10	10
Civil Service	7	7
Enforcement	7	7
Health	7	7
Legal	5	5
Service Provider	7	10
Total	**43**	**46**

43 semi-structured interviews were conducted between January 2009 and September 2009. This timetable had been planned to coincide with the ratification of the Council of Europe Convention on Action against Human Trafficking (ECAT), which occurred in December 2008. ECAT did not come into force, however, until the 1st April 2009 and the associated policy changes took effect from this date rather than from the date of ratification. Nine semi-structured interviews thus took place prior to these policy changes and 36 took place soon afterwards. Three service providing organisations also participated in second, supplementary, interviews in July and August 2010. These interviews were held in order to understand the "on the ground" healthcare-related changes that had occurred, if any, in the year following the ratification of ECAT.

The interviews were conducted in four broad phases, starting with NGO actors (including advocate groups and service providers), followed by other professionals such as police and lawyers, then civil servants and government agencies, and finally NHS-based healthcare staff. Interviews were phased in this way firstly because my earliest contacts in the trafficking policy subsystem were predominantly those working in civil society. Secondly, I felt that phasing the interviews would enable saturation (and information gaps) to be judged more accurately within categories of respondents. I also anticipated that because of the iterative nature of the research process and improvements in my interviewing technique and knowledge of the subject area over time, later interviews would be more useful than the earlier ones. I therefore expected that interviews with

civil service "elites" would be more valuable if scheduled during the later phases of the research (Manheim, Rich et al. 1995; Richards 1996).

As shown by Table 6, politicians were not interviewed for this research. I believed that the likelihood of scheduling an interview with any of the Ministers who worked on trafficking was remote and that, even if my efforts were successful, the investment in time that would be needed would not be worthwhile because Ministers would be briefed for the interviews by the same civil servants that I would be interviewing for the research. Observation at meetings chaired or attended by Ministers also indicated that they followed the official line (readily available in written reports) and only rarely indicated personal opinions and preferences relating to trafficking policy. I had initially hoped that it would be possible to schedule interviews with some of the parliamentarians who were interested in trafficking, for example with members of the All Party Parliamentary Group on Human Trafficking. I built relationships with some of the parliamentary assistants and researchers to these MPs and it initially seemed that some interviews would be possible. A combination of researchers leaving for new positions and a shutdown in communications following the 2009 MPs expenses scandal, however, meant that these interviews could not be scheduled.

Conducting the Interviews

Interviews were semi-structured and followed topic guides that were based on the conceptual framework presented in Chapter 2. Using semi-structured topic guides meant that the areas of interest, as defined by the conceptual framework, were discussed in each interview. This increased the comparability of the interview data between participants. Semi-structured interviewing also provided flexibility to follow up any areas of mutual interest which emerged during the interviews.

The key topics of discussion during interviews included:

1. Basic information about how and why an organisation worked on trafficking and the similarities and differences between trafficking and other issues on which they worked;
2. How trafficking had been framed as a policy problem and the benefits and drawbacks associated with this;
3. How, if at all, concerns about the health of trafficked people featured within an organisation's work;
4. How, if at all, organisations' used information about the health needs of trafficked people;

5. Perceptions of the most successful and unsuccessful aspects of the UK response to trafficking and organisations' key policy goals;
6. The nature of inter-organisational relationships and the extent of organisations' inclusion in policymaking processes; and
7. Perceptions about the importance of contextual factors in shaping the UK response to trafficking.

These seven areas remained the main topics of discussion over time, although questions were also added to later topic guides as issues and themes became relevant through current events or early analyses. Also, prior to each interview, the topic guide was tailored to the particular participant in order to focus the discussion on issues that the interviewee would have most familiarity with whilst retaining the broader comparability of the data. Two examples of topic guides that were used during the research are included in appendix E.

I conducted all of the interviews, which generally lasted between 60 and 90 minutes. Interviews took place in a location of the interviewees' choice, typically their workplaces, but also at the London School of Hygiene & Tropical Medicine and in public spaces such as cafes and bars. All but five interviews were digitally recorded: extensive notes were taken during the interviews in which recording did not take place.

In all instances only one person was asked to participate in each interview. In eight interviews, however, the interviewee had asked a colleague to participate alongside them in order that they could provide more detailed answers. Where this happened, informed consent to participate in the research was requested separately. Although I had initial concerns that joint interviewing might reduce people's willingness to speak freely about their opinions and experiences, I found, as others have similarly reported, that the interaction between close colleagues in the joint interviews brought out further depth and detail, as they corroborated or challenged each other's accounts of events and filled in gaps in each other's knowledge (Seymour, Dix et al. 1995; Arksey 1996).

Data Management

I transcribed all of the interviews verbatim from the digital recordings. Although the transcriptions did not include details such as word stress or intonation, I took care to ensure that the transcripts were faithful representations of interviewees' speech. In order to improve accuracy and to allow the

identification of areas of interest to follow up in later interviews, transcription was completed as soon as possible after each interview.

During proofreading, I anonymised the transcripts to as great an extent as was possible. All references to named colleagues and their organisation, and in some instances to location, were removed. Most interview participants had requested that they received a copy of the transcript following the interview. This provided an opportunity for interviewees to clarify details or to indicate if they felt a transcription error had been made, and also allowed interviewees to highlight any parts of the transcript that they did not want to be quoted or archived. The interview quotations presented in this thesis follow standard transcription conventions, as shown by Table 7.

Table 7: Transcription conventions used in the research

Symbol	Interpretation
I	Start of utterance by interviewer
R	Start of utterance by respondent
R_n	Start of utterance by one of multiple respondents
...	Material omitted from quotation
[]	Material added to quotation

(Green and Thorogood 2004)

The symbols 'I' and 'R' are used to indicate the speaker in a quoted interchange: where neither symbol precedes a quotation, the words should be attributed to the interviewee.

3.4.2 Participant Observation

Over the period of the research I was able to attend a range of trafficking-related meetings, working groups, stakeholder groups, conferences and seminars (a full list of the events that were attended can be found in appendix F). I attempted to attend all events that seemed relevant to the development and implementation of human trafficking policy and I worked actively to identify these events. Initially, my access to most events was mediated by my associate supervisor, Dr.

Cathy Zimmerman, who had previously conducted and disseminated research on human trafficking and had contacts with several organisations that worked in this area. These organisations were primarily NGOs. Over time, as I became familiar to many of the organisations and individuals working in the trafficking policy subsystem, I was increasingly invited to, or was able to request access to, events. Inevitably, there were certain events that I could not access. In some cases I was subsequently able to obtain the agendas and minutes of these meetings or discuss the content of the meetings with policy stakeholders. The content of other meetings (such as the UKBA-chaired Strategic Monitoring Group, which discussed the implementation of ECAT) was deemed to be confidential and participation was on a need-to-attend basis only.

Observation has been described as the "gold standard" for researchers' aiming to understand a phenomenon, rather than people's accounts of it, as it provides direct access to what people do and what they say (Green and Thorogood 2004). Such a statement assumes, however, that events can be both observed and recorded truthfully: although I made careful field notes during and immediately after each participant-observation event, the health focus of the research could have led me to over-emphasise health-related discussions at policy events. If this has been the case, however, it is likely to have had limited consequence for the analysis: this thesis will argue that there has been little discussion of the health needs of trafficked people in the UK trafficking policy subsystem.

The field notes from the participant-observation events have been particularly useful in providing context and depth to interviews and documents, and have improved my understanding of the personalities and power dynamics involved in the subsystem. They documented, for example, observations about the environment and the people present:

> The meeting was held in the UKHTC offices, which were brand new and smart. Several of the attendees had travelled on the same train from London and walked across to the venue together. At the meeting, Peter and Stuart seemed dominant amongst the representatives from the UKHTC, frequently stepping in to give further detail and to smooth over answers provided by Andy and David....Lorna (an children's NGO advocate), Catherine (a lawyer) and Michelle (a service provider) asked numerous questions of Peter and Stuart and of Alex and Daniel, the two civil servants who were attending the meeting. Their questions were often quite hostile, but although Stuart seemed irritated by the questions and interruptions, Alex seemed to almost enjoy the exchanges (Fieldnotes 2008a).

Field notes also recorded informal conversations and minuted discussions at events and meetings:

> Lorna, an advocate from a children's NGO, said that a particular issue around children and healthcare was that of consent. Parental consent was typically sought, but this was not necessarily appropriate. With emergency care and GP care, the accompanying adults may be the perpetrators, and medical professionals engage with the accompanying adults because of the perception that children cannot consent. For instance, she was aware of a girl who had been raped and had become pregnant, and taken by an adult for a termination of pregnancy. The medical records do not provide very much information, and the child had hardly been interviewed.
>
> Ramona, also an NGO advocate, added that this problem of accompaniment was also a problem for adults – especially if there were issues around translation.
>
> With regards to adults I said that there is existing good practice guidance around translation services – particularly with regards to domestic violence – which states that family, friends, and children should not be used to translate in medical settings (Fieldnotes 2009a).

By highlighting areas of divergence between what people say in interviews and what they do at policy events, my field notes also aided me to reflect upon on how interviewees construct their accounts of events and the behaviour of themselves and others at these events. Finally, although there was sometimes a distinction between what people were willing to say "on the record" compared to their discussions with in informal settings, the field notes of observations provided new lines of inquiry to follow up in interviews.

As shown by the second extract, I took particular care to record instances where I actively participated in a meeting, rather than passively observing the proceedings, and to document what my contribution was: I felt that this was important given my increasing involvement in the trafficking policy subsystem over the course of the research. I entered into the subsystem as, according to Gold's classic typology, an "observer-as-participant" (Gold 1958): I had minimal involvement in the proceedings and would not, save for my research, be part of the meetings and events that I observed. Yin, in discussing the potential for participant observation to introduce bias into research, notes that over time the relative emphasis on participant and observer roles may shift, leaving the researcher less time to act as an external observer and, in some cases, obliging the researcher to take on an advocacy role (Yin 2003). During the period of the research I felt that my

position moved closer to a "participant-as-observer": a role in which the researcher has a natural, non-research reason for being present in a particular setting. Over time, I was invited to attend and contribute to meetings and consultation events, such as the UKBA-led workshops to review the functioning of the National Referral Mechanism (NRM). This is discussed further in section 3.5.

3.4.3 Document Collection

Documents played a dual role within the research, firstly providing background information to organisations, events and processes and secondly supplementary data sources for analysis. My "document library" consisted primarily of official texts authored by government departments, public bodies and NGOs. Texts included, for example, consultation documents, inquiry testimonies, parliamentary debates, reports and evaluations, meeting minutes and agendas. Table 8 (overleaf) provides details of the key documents used in this research.

Table 8: Key policy documents collected and analysed for the research

Document	Publicly available	Reason for access if not publicly available
National Action Plan		
1. Consultation (2006)	Yes	
2. Consultation Responses (2006)	No	Individual consultation responses were not made publicly available. Thirty eight organisations provided copies of their responses on their websites or upon request.
3. Summary of Responses (2006)	Yes	
4. Action Plan (2007)	Yes	
5. Update to Action Plan (2008)	Yes	
6. Update to Action Plan (2009)	Yes	
Joint Committee on Human Rights Inquiry		
1. Inquiry Report	Yes	n/a
2. Written Evidence	Yes	
3. Oral Testimony	Yes	
Home Affairs Committee Inquiry		
1. Inquiry Report	Yes	n/a
2. Written Evidence	Yes	
3. Oral Testimony	Yes	
Parliamentary debates and written answers	Yes	n/a
Joint NGO Ministerial Stakeholder Group		
1. Agendas	No	Minutes for the first four meetings (up to July 2006, inclusive) were released under the Freedom of Information Act. I participated in the later meetings and was given copies of meeting documentation.
2. Minutes	No	
3. Ancillary documents	No	
Department of Health Violence against Women and Girls Taskforce (VAWGT)		
1. Final report	Yes	I participated in the Human Trafficking and Harmful Traditional Practices Subgroup of the VAWGT and was given copies of the interim reports.
2. Interim reports	No	
Evaluation of the Poppy Project	No	Provided by the Home Office, on request.
OSCE/ODIHR Review of the Protection of Trafficked Persons in the UK		
1. Draft discussion paper	No	Copies of the draft discussion paper were circulated at a linked OSCE/ODIHR workshop, which I attended.
2. Final report	Yes	

As shown by Table 8, many of the documents gathered were in the public domain; others were distributed at events that I attended for the research. I searched these documents for references to further relevant texts and attempted to obtain these additional documents. When documents were not publicly available I contacted their authors to request copies or, occasionally, asked my contacts in the trafficking policy subsystem to help. I also made a number of Freedom of Information Act requests, with limited success (see Appendix G). Requests were generally turned down because

documents had not been retained and/or could not be located or because the documents were exempt from release under the terms of the Freedom of Information Act.

The library of documents that I collected is not comprehensive and cannot be used to provide a complete account of how human trafficking policy developed or the range of opinions and positions of the key stakeholders involved (Bryman 2008). The documents are valuable, however, in augmenting the interview transcripts and field notes: in addition to providing useful contextual information for semi-structured interviews, the documents also demonstrated areas of convergence and divergence in the interpretations and explanations of key events and processes. Comparing the minutes of meetings with my own field notes, for example, highlighted how two accounts could differ in tone and their level of detail and interpretation:

> [Extract from the official minutes of the July 2009 meeting of the Joint NGO Ministerial Stakeholder Group on Human Trafficking]
>
> The Minister asked the group if anybody would like to declare any business for discussion and invited attendees to introduce themselves.
>
> (JNMG 2005-2010)

> [Extract from field notes for the same part of the meeting]
>
> The Minister started, announcing that this was the 9th NGO Stakeholder Meeting, and requesting that we went around the table to introduce ourselves. The Minister then stated that the primary purpose of the meeting was to allow "you" to tell "us" and asked if anyone had additional items to put on the agenda.
> Lorna (an advocate from a children's NGO) stated that she was sure no one would be surprised that she had an item to discuss, and requested that we discussed the NRM with respect to children.
> Susan (an NGO service provider) stated that she would like to talk about the issue of UKBA enforcement officers wanting to see trafficked persons prior to the end of the 45 day reflection period.
> Yvette (another NGO service provier) requested that we discussed adults who were missing out on support because they were not entering the NRM system.
>
> (Fieldnotes 2009b)

The contemporary nature of the policy meant that relevant documents continued to be produced, and opportunities for participant observation continued to arise, after the interviews had been completed. Participant observation and document collection began in September 2007 and continued until April 2010. This was a natural end to all data collection since I took up a three month ESRC-funded internship at the Home Office, which ended in April 2010. Furthermore, this timetable meant that data collection continued for a full year since the entry into force of ECAT. The timing of the research also meant, however, that all data collection was conducted prior to the General Election in May 2010. The analysis is therefore unable to assess the impact of the change from the Labour to the Conservative-Liberal Democrat coalition government on the development of the UK response to trafficking.

3.5 Data Analysis

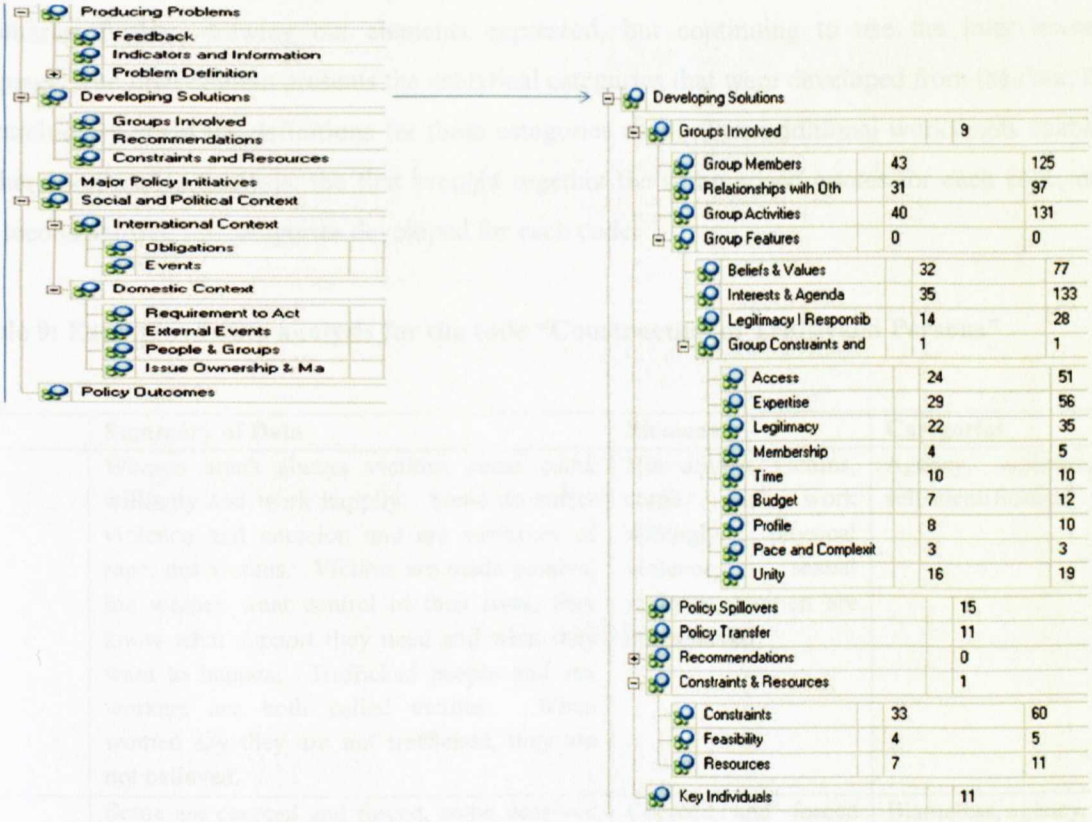
Data analysis was conducted in NVivo and Microsoft Excel and proceeded according to the five stages of framework analysis that were set out by Ritchie and Spencer: familiarisation with the data; thematic analysis, in which the researcher develops a coding scheme based on the themes in the data; indexing, in which the coding framework is systematically applied to the dataset; charting, whereby the data is rearranged according to its thematic content; and mapping and interpretation, a process of exploring the relationships between the codes (Ritchie and Spencer 1994; Ritchie and Lewis 2003). Although the five steps are described as discrete stages, in practice there was significant overlap between them.

Familiarisation: The process of familiarisation began with transcribing the interviews from the digital recordings and proofreading the transcripts against the interview tapes. Reading and re-reading the transcripts continued this period of immersion, during which thoughts and potential codes were noted in a research diary and periodically reviewed.

Thematic Analysis: The conceptual framework presented in Chapter 2 provided the basis for thematic analysis. The framework was used to identify the initial variables of interest, to suggest potential relationships between them and to guide the initial coding scheme (Hsieh and Shannon 2005). Thematic analysis therefore began with the naming and ordering of a series of thematic "nodes" in NVivo (see left-hand image of Figure 3). The potential themes that had been identified in the familiarisation stage of data analysis were then compared against this thematic framework.

Whereas some of these themes were equivalent to those suggested by the conceptual framework or could be incorporated as sub-themes within them, others represented new themes. New themes were either added into the thematic framework or, if it was unclear where they would best fit within the framework, added as floating "free" nodes. The relationship between the free nodes and the main thematic nodes was investigated further in later stages of the analysis. This phase was therefore one of refining themes from the conceptual framework on the basis of the data and of identifying new themes that had not been included in the framework.

Figure 3: Development of NVivo coding framework



Indexing: The thematic framework was then applied to the transcripts. Sections of text were "coded" as belonging to particular nodes if they illustrated the relevant themes. Each code was taken in turn and applied to the transcripts sequentially: this ensured consistency of coding and ensured that I remained highly aware of the data. The thematic framework underwent further revision and refinement during this stage: codes were added, amalgamated and subdivided and were checked against the data to ensure that they were not over-interpretive. The right-hand image in Figure 3 shows the "developing solutions" component of the thematic framework at a later stage of

analysis and demonstrates how codes were subdivided. Coding decisions and impressions about the data were recorded in my research diary throughout this phase of activity. The end of this phase of coding coincided with a three month break from analysis as I took up an internship with the Home Office's Strategic Policy Team. I reviewed the codes and the transcripts once more when analysis restarted in order to re-familiarise myself with the data and to reflect upon the analysis.

Charting: The codes were then taken in turn and analysed in Microsoft Excel. A worksheet was constructed for each code; Table 9 provides an extract from one of these sheets. The first column lists the interview number, the second summarises the interviewee's quotes for that code: summaries remained as close to the interviewees' language as possible. The third column distils the summaries further, drawing out elements expressed, but continuing to use the interviewees' language. The final column presents the analytical categories that were developed from the data; the research diary noted the definitions for these categories used. Two additional worksheets enabled further comparative analysis: the first brought together the summarised quotes for each code, and the second showed the categories developed for each code.

Table 9: Example of data analysis for the code "Construction of Trafficked Persons"

ID	Summary of Data	Elements	Categories
11	Women aren't always victims; some come willingly and work happily. Some do suffer violence and coercion and are survivors of rape, not victims. Victims are made passive, but women want control of their lives, they know what support they need and what they want to happen. Trafficked people and sex workers are both called victims. When women say they are not trafficked, they are not believed.	Not always victims, come and work willingly, physical violence, sexual violence, women are not believed	Agency, violence, self-identification
13	Some are coerced and forced, some deceived about the level of debt, the number of clients they'll have to see. They're exploited even if they knew they would be sex workers, even if they're happy to work in that way, because they're not getting their money. Some are totally deceived, think they'll do a different job. Friends, families, boyfriends might have tricked them. We pull them out of brothels, help and rescue them.	Coerced and forced into coming, deceived about conditions, still exploited even if happy to work, totally deceived about the job, tricked by friends family and boyfriends.	Blameless, agency,

Mapping and Interpretation: Analysis took place on a column-by-column basis ("within-case analysis"), which involved the systematic analysis of the code summaries and categories for each interviewee. Analysis also included extensive checking and reworking of analyses across the rows ("between-case analysis").

Combining within case-analysis and between case-analysis ensured that the analytical categories were rooted in the summarised data and that the potential for further analysis and categorisation was exhausted. Table 10 (overleaf) provides an example of the summaries of two codes for two consecutive interviewees: an enforcement interviewee (ID 19) and an NGO advocate (ID 20). In this example, within-case analysis examined whether there were emerging associations between an interviewees' institutional affiliation and how they either categorised trafficking as a problem *or* what they perceived the causes of trafficking to be, and also whether there was an association between how interviewees' categorised trafficking as a problem *and* what they perceived its causes to be. Between-case analysis re-tested the relationships between how themes related to respondents' characteristics, beliefs and opinions.

Table 10: Illustration of within case and across case analyses conducted for the research

ID	Categorisation of Trafficking	Causes of Trafficking
19	The Convention flagged trafficking as a crime in its own right. I know that we talk about trafficking and smuggling as separate, but they can blur considerably and can change -you can be facilitated and then become trafficked. And smuggling can lead to great harm too. So it's not as easy as drawing a line down the middle, it's about the level of cooperation and awareness, the level of exploitation. The dedicated team was set up using organised immigration crime money. But Clubs and Vice also find instances of trafficking, naturally, because they work in prostitution and the vice industry.	It can be difficult to disentangle the causes of trafficking from those of smuggling. There are not many people who come here illegally who do not have bad situations - poverty and all those issues - at home, driving them here. But you can't say that everyone who is being exploited is trafficked, or everyone becomes trafficked. One thing we need to address is the male approach to the sex industry: you are feeding an industry where people are exploited and put in danger, and that demand has to be reduced.
20	In reality, it still is seen as more of an issue of immigration than of human rights violations, whatever they say in the Action Plan. It is seen as organised immigration crime, and you don't see much effort from anyone other than the Home Office and UKBA.	There is a continuum of exploitation, and vulnerability exists before and after trafficking. You need to provide information and raise awareness about trafficking, but some people will always take a chance on the risks even if they understand them. You have to offer routes of regular migration for unskilled labourers and think about the effects systems like the PBS have on vulnerable migrants. You also need to protect and promote migrants rights for once they're here. There is demand for cheap and unprotected labour, and that has to be addressed, including by enforcing labour standards. Clients of sex workers in some cases may the ones to raise the alarm about abuse and exploitation. And then support and assistance for trafficked people would prevent re-trafficking.

3.6 Validity and reliability

A study's validity is derived from the extent to which its findings "accurately reflect the phenomenon under study as perceived by the study population" (Hammersley 1990; Ritchie and Lewis 2003) and its reliability from the degree to which the findings are independent of the circumstances of the research and therefore to how replicable the findings would be if the study was repeated using the same methods (Kirk and Miller 1986; Perakyla 1997). Researchers have questioned, however, the applicability of the concept of reliability to qualitative research, which emphasises contextual specificity and the importance of the relationship between the researcher and the researched (Lincoln and Guba 1985; Holstein and Gubrium 1997). These researchers have therefore proposed that the "dependability" and "trustworthiness" of studies, rather than reliability, should be considered when assessing the quality of qualitative research. This section describes the steps taken to increase the validity and dependability of the research, including: triangulation; purposive sampling; the consistent use of data collection methods; systematic data analysis; the sharing of coding decisions; and the use of illustrative quotations (Mason 1996; Mays and Pope 2000).

Although many academics advocate the use of triangulation as a method of increasing study validity (Denzin and Lincon 1994; Patton 2002), others have argued against the assumption that the strengths of one method can compensate for the weaknesses of another and have highlighted the difficulties that arise in adjudicating between the accounts provided by different methods when these accounts diverge (Mays and Pope 2000; Ritchie and Lewis 2003). Mays and Pope have therefore suggested that triangulation may be more valuable as a tool to increase the comprehensiveness and reflexivity of research (Mays and Pope 2000). This study used three methods of data collection: semi-structured interviews, participant observation and document collection. In the following chapters, I have endeavoured to show where the accounts provided by these methods converge and diverge. Where the methods have revealed divergence, this is highlighted.

Commentators have also drawn attention to the need to ensure that the study sample incorporates a wide range of perspectives and to minimise bias within the sample frame (Mays and Pope 2000). A purposive sampling frame that attempted to be representative of the trafficking policy subsystem was developed for the research and was supplemented with marginal and excluded organisations to

ensure that a full range of perspectives were included in the research. As shown in appendix B, no systematic non-response problems were encountered. Fieldwork was conducted in a consistent manner across the data collection period. Interviews, for example, followed semi-structured interview guides, which ensured both that similar topics were covered between interviews and that interviewees had sufficient opportunities to discuss their views and to explore areas of mutual interest.

The analysis paid attention to the diversity of perceptions, opinions, and beliefs expressed by the research participants, and in the following results chapters, attention is drawn to areas of commonality and variation. Section 3.5 provided a detailed account of the methods of data analysis used in this research and further information is given throughout the results chapters to increase transparency. Following the principles of framework analysis ensured that data analysis was systematic: the combination of within-case and across-case analysis was particularly useful in ensuring firstly, that the analysis considered the associations both between themes and between themes and interviewee characteristics, and secondly, that each account was given equal weight and was continually considered within the context of emerging findings.

The coding framework and examples of how the framework had been used to code the data were shared and discussed with my primary supervisor, and I used my research diary to reflect on the data collection and analysis processes and to document emerging themes, ideas for analysis, and coding decisions. The research findings were also discussed with my supervisors and advisory board members throughout the data analysis process. The results of the analysis are illustrated throughout the thesis with representative quotations from the interview transcripts, field notes and policy documents.

3.7 Ethical Considerations

3.7.1 Ethical Clearance

Ethical clearance was granted by the ethics board of the London School of Hygiene & Tropical Medicine prior to commencing interviews. Further clearance was granted by the National Health Service to interview healthcare providers. Copies of the ethics approvals can be found in Appendix H.

3.7.2 Vulnerable Participants

A decision was taken at the beginning of the research that no interviews would be conducted, or contact sought, with trafficked people. A number of interview participants suggested that they could put me in touch with trafficked persons to interview; these offers were declined in all instances.

It was clear at the start of the project, and it remained the case throughout the research, that trafficked people had not been invited to directly participate in the development of the response to trafficking. I therefore believed that they would not have been able to contribute significantly to the first three research objectives. Furthermore, as my only way of identifying trafficked persons for this research would be through the service providers that had already been interviewed, it seemed likely that interviews with trafficked persons would provide little in the way of additional information and that analysis of these interviews would have suffered from being based on such a highly biased sample.

3.7.3 Informed Consent

Prior to interview, and following the provision of information on the study, participants were asked to give their written consent to be interviewed. Participants were given an opportunity to ask questions about both the study and the terms of consent, and the consent form made it clear that having consented to participate in the study, the participant remained free to withdraw from the interview at any time and without needing to give reason.

The consent form also allowed participants to stipulate how their data may be used, whether they would like to see a copy of their interview transcript, and whether they would like to be sent a summary of findings upon completion of the research. Copies of the participant information sheet and consent form are provided in appendix C.

3.7.4 Anonymity and Confidentiality

Interview transcripts were anonymised to as great an extent as possible. Where interviewees had indicated on the consent form that they would like to see a copy of their transcript, this was sent to

them. Interviewees were also informed that if there were sections of the transcript that they did not wish to be archived or quoted, they could highlight these sections and return a copy of the transcript to me.

The represented organisations, rather than individuals, have been listed in Appendix D as having participated in the study. To further preserve anonymity, organisations have been grouped into categories for the purpose of quotation (e.g. "Civil Servant" and "Service Provider"), with a minimum of five participating organisations in each category. Direct quotes should thus not be attributable to representatives of particular participating organisations.

All information linking the transcripts to the participants was stored in one electronic document, which was password protected and to which only I had access. This document will not be archived with the transcripts at the end of the project. Transcripts and audio files were kept on a locked computer, which, again, only I had access to.

Extracts from the field notes that I took at policy events and meetings are also quoted throughout this thesis. The original field notes include the names and organisations of the people attending the meetings; in the thesis, the names of people have been replaced with pseudonyms and the names of organisations have been replaced with generic categories such as 'advocate' and 'civil servant'.

3.7.5 Data Archiving and Future Use.

The Economic and Social Research Council, the funders of this research, encourage grant recipients to deposit copies of datasets in the Qualidata archival resource centre. Qualidata aims to preserve the contributions of research participants once a research project has been completed. Deposited datasets can be subsequently accessed by academics, under strict terms and conditions. The consent form included a field for participants to indicate whether they consented for their anonymised transcripts of their interviews to be deposited with the Qualidata service.

I felt that because interviews were conducted with policy elites who were well known to each other and, in several instances, had given media interviews about the response to trafficking, there was a risk that the research participants could be identified from the audio recordings of the research interviews. A decision was therefore made that no audio recordings would be archived with

Qualidata (although recordings will be securely deposited with the London School of Hygiene and Tropical Medicine Records Management Service for the purpose of research governance[10]).

3.8 Personal reflections on the process and position of the researcher

This research was originally motivated by my beliefs that people who had been trafficked to the UK were likely to be suffering from a range of physical, psychological, and sexual and reproductive health problems as result of their experiences, that they should be given access to the healthcare that they required and that they should be treated in manner which is not detrimental to their health. Having come to the end of my research, I find that although the foundations and implications of my beliefs are less clear-cut than I had imagined three years ago, they still hold true. With respect to the health needs of trafficked people, my review of the literature on the health outcomes associated with human trafficking (presented in Chapter 1) highlighted to me the many limitations in what is known about the health needs of this group. The small number of interviews I conducted with organisations that have been excluded from trafficking policymaking activities (such as sex worker advocacy groups), and with groups that worked with people who had been trafficked but were not receiving support from the main post-trafficking support providers, also helped to demonstrate to me that the health needs of trafficked people are likely to be more nuanced than is currently reported in the medical literature. Furthermore, my understanding of what governments can do to respond to people's needs was tempered by the completion of an internship with the Home Office Strategic Policy Team. Although I was not working on trafficking issues during this placement, it provided me with an opportunity to see the dynamics of the policy process from the "inside" and gave me a greater understanding of how civil servants work to balance the often competing demands of the public, press, civil society, parliamentarians and Ministers for attention and resources. Finally, whilst analysing and interpreting my data, I have been led to critiques of "medicalisation" in the literature on policy and service responses to asylum seekers, refugees and people who have experienced domestic and sexual violence. These have demonstrated to me that

[10] For research governance purposes the London School of Hygiene and Tropical Medicine (LSHTM) requires researchers to deposit their data with the LSHTM record management service. Both the audio files and anonymised transcripts will be stored in a secure area with only the Archivist & Records Manager, Assistant Archivist and authorised individuals having regular access. Records are stored in anonymous boxes to increase security. The depositor (researcher) is given a copy of the list of their records in the storage area with reference numbers which is used to request records when required. Records can only be requested by using the reference number and are not given to anyone apart from the researcher responsible for the records without their permission.

the translation of concerns for people's health into responses that meets people's needs is not necessarily straightforward. This is discussed in detail within the context of the research findings in Chapter 8.

My thesis will argue that there were few directly health-related policy developments in UK human trafficking policymaking during the period studied and that those that did take place could not be attributed to domestic pressure for change. Although I mostly maintained an observation role throughout the research, I became gradually more involved with the policy process as the research progressed. In a number of meetings, for example, I asked questions relating to trafficking and health, or gave feedback relating to trafficking and health. These activities did not appear to prompt other non-governmental actors to engage with the health issues facing trafficked people. One NGO advocate interviewed for the research, for example, when asked "at any of the events that you attend to people talk about health or health services?", replied "mmm, no. Except you! I haven't heard anybody to be honest". Meeting minutes and the field notes that I made during and after observation events also show that the points I raised were not discussed in detail or followed up by other event participants.

On a number of occasions over the course of the study period I went "outside" of the research to provide health-related feedback and resources to trafficking policy leads in the Home Office, UK Border Agency (UKBA), Ministry of Justice and DH. Following my interview with an official at the DH, for instance, I was invited to participate in the Human Trafficking and Harmful Traditional Practices subgroup of the department's Violence Against Women and Girls Taskforce. The lack of representation from experts in trafficking and health (discussed further in Chapter 6) led to my growing engagement in the subgroup. With my associate supervisor, Dr. Cathy Zimmerman, I fed back recommendations for the health sector response to trafficking and for further research, and commented extensively upon presentations and evidence reviews. Later drafts of these documents showed that our comments had mostly been incorporated into the reports. In 2010, I was asked by the UKBA to provide feedback on the functioning of the NRM and on the basis of my submission I was invited to participate in a review workshop. I was also given to understand that the submission document informed discussions between the DH and the UKBA in a meeting that was subsequently scheduled.

Throughout the research, the feedback that I have provided to policymakers has been politely received. This feedback may have helped policymakers by providing a different angle from which

to consider trafficking, but it did not appear to increase the prioritization given to health. Instead, I believe that my involvement in the UK trafficking policy subsystem has served primarily to help me to schedule interviews and to access further events and documents. I also feel that my involvement in the trafficking policy subsystem affected the nature of interviews I conducted: the few interviewees with whom I had not previously spoken, or with whom I had had only limited contact, seemed more guarded in their conversation than were interviewees with whom I had regularly met.

As will be discussed in Chapter 4, trafficking policy decisions were often contentious and the relationships between people in the trafficking policy subsystem were frequently strained. I was careful throughout the research process not to comment on these relationships or to voice strong opinions in controversial areas, and it seemed to me that interviewees felt that I was a relatively neutral figure. I feel that my neutrality during the research process, and the promise of anonymity, improved the quality of my data; most interviewees were very open about their experiences and opinions. In analysing and presenting the results of the research I have made strenuous efforts to reflect the passion (and diverse opinions) of those in the trafficking subsystem and to honour the anonymity of all participants.

Chapter 4

Results I: Defining Human Trafficking as a Policy Problem

> "Whether you blame the immigrants, or you blame the system, or you blame the immigration enforcement, whoever you think is guilty, whatever you think the problem is, whatever you think the solution is, we can all agree that *human trafficking* is a bad thing. And we keep it as vague as we can just so that we have some common ground between people who can't otherwise agree on what the problem is and what the solution is" (Enforcement interviewee).

This chapter explores how trafficking has been defined as a problem in the UK and the answers that have been put forward to questions such as why does trafficking happen? Who is to blame? And, how should the UK respond to it? In doing so, it provides the context for understanding how the UK policy response to trafficking evolved.

Problem definition was a key component of the conceptual framework that guided the collection and analysis of data for this research. Although the Palermo Protocol definition of human trafficking was accepted by the UK following the government's signature and ratification of the instrument, the definition is general enough to allow domestic governments scope for interpretation and application and makes only limited prescriptions as to how governments should respond to human trafficking. In order to understand how stakeholders in the UK trafficking policy subsystem defined trafficking as a problem and their beliefs about the suitability of alternative definitions, interview questions and data analysis focused upon those elements that had been suggested in the policy theory literature to be components of problem definition. This chapter draws particularly upon analyses of the proposed causes of human trafficking and the construction of traffickers and trafficked people; other elements of problem definition, such as the severity and incidence of trafficking, are discussed in later chapters.

The chapter presents evidence from interviews and organisational documents to demonstrate, firstly, stakeholders' perceptions that the government had approached trafficking as a problem of

organised immigration crime. Secondly, the chapter shows that the implications of organised immigration crime-based analyses of trafficking for the prioritisation of the support and protection of trafficked people relative to, for example, prosecuting trafficking crimes and maintaining strict control of the immigration system, was a significant source of conflict between the government and NGO advocates, service providers, and lawyers. As stated in Chapter 2, causality is believed to be integral to the process of problem definition (Rochefort and Cobb 1994): this chapter therefore also provides an analysis of what stakeholders understood the causes of trafficking to be and shows, firstly, that stakeholders in the UK human trafficking policy subsystem identified multiple putative causal drivers of human trafficking and, secondly, that although different organisations varied in the level of emphasis they placed on these drivers they generally believed that trafficking was caused by the interplay of numerous categories of factors. Overall, the chapter draws attention to the dominance of organised immigration crime narrative in human trafficking policymaking and to the substantial levels of conflict that existed within the UK human trafficking policy subsystem.

4.1 Stakeholders' perceptions of the dominance of the organised immigration crime narrative in UK policymaking on human trafficking.

Researchers have previously noted how individuals and institutions involved in responding to trafficking have defined it as a problem for different reasons and have proposed solutions that serve different political or ideological agendas (Munro 2005; O'Connell Davidson 2006). In their 1997 report, for example, Wijers and Lap-Chew suggested that trafficking had been variously defined as a problem of human rights, labour, migration, morality, and organised crime (Wijers and Lap-Chew 1997). In this research, the overwhelming majority of interviewees stated that trafficking had been defined in the UK as a problem of organised immigration crime.

NGOs, service providers and lawyers frequently stated during interviews that the government had approached trafficking as a problem of immigration, organised crime, or as a combination of the two. One NGO advocate, for example, when speaking about how the UK had responded to trafficking, said that:

> So what we see within policy and government approaches are approaches to serious organised crime, when you talk about trafficking (Advocate).

A service provider similarly commented that:

> [Trafficking is] framed so much as an immigration thing, as a crime thing (Service Provider).

Civil servants concurred that this is how trafficking had been approached as a problem within the UK. One civil servant having stated that trafficking was a form of organised immigration crime suggested that although such a framing was not without its faults, a suitable alternative had not been developed. Furthermore, defining trafficking as an issue of organised immigration crime facilitated police engagement with the issue:

> I mean, trafficking is a form of organised crime, of immigration crime... It's clearly far more than immigration crime. A lot of the cases that we see, involve EEA nationals, where immigration is not really part of the package.... [but] it's difficult to see where else to fit it under a wider category...[and] if you didn't call it that, then when you wanted to get the likes of the police, or [the Serious Organised Crime Agency], involved in it, what else would you call it? Would you want to call it, put it into one little box, and say trafficking is unique? (Civil Servant).

One civil servant attributed the use of the organised crime-based definition of trafficking to the definition's prominence at the international level:

> The international community decided to take an approach that considered trafficking to be part of the organised crime agenda. And, we followed that, really. And in many ways it makes good sense. Because if you look at it in terms of other crime types, you're talking about it largely being the domain of – not always – but in many cases, being the domain of organised criminal groups. And you know, some of them will be transnational organised groups... you're talking about moving people from one part of the globe to the other, invariably. Sometimes in very sophisticated ways, which requires a certain degree of organisation (Civil Servant).

The apparent consensus on how trafficking had been framed as a problem in the UK was undermined, however, by further analysis. Civil servants argued that organised immigration crime was properly understood as a subset of serious organised crime rather than of immigration:

> Organised immigration crime is part of serious organised crime...so like drugs trafficking, or fraud, or cyber crime (Civil Servant).

Thus although they suggested that trafficking was framed, within government, as organised immigration crime, they disputed the claim that the government had taken an immigration-based approach to trafficking:

> I think initially, because a significant number or proportion of the victims are non-UK nationals I think externally there was probably a view that it's been seen as an immigration issue... And I don't think that's a reality. I don't think in government at all, in terms of the Ministerial lead, it wasn't seen as an immigration issue. That was secondary to what was happening.... So the fact that it was about migrants and immigration, again was an issue, a factor to take into consideration, but it wasn't the primary factor (Civil Servant).

The majority of NGO advocate, service provider, and legal interviewees, however, tended to talk about "immigration-based" and "organised immigration crime-based" approaches to trafficking as being functionally equivalent and argued that the government had taken an immigration-based approach to trafficking:

> You cannot actually see much effort coming from anywhere else except for the Home Office and the UKBA. And that sort of mirrors the fact that trafficking has been, and still is, considered an organised immigration crime, and more an issue of immigration than human rights violations, despite the proclamation in the UK Action Plan. If you look at the reality, it's still considered that way (Advocate).

These interviewees suggested, for example, that the government had implemented the Council of Europe Convention on Action against Trafficking in Human Beings (ECAT) in line with the priorities of the immigration system rather than with the principles of victim protection. One enforcement interviewee stated that:

> They interpret the Convention mmm [pause], from other ways I think, my view is that they interpret the Convention in other ways, as immigration. You know. They delivered it in an

> immigration way...my view is that the principle behind the Convention [as written] is victim protection (Enforcement).

An NGO advocate similarly stated her belief that the National Referral Mechanism (NRM), a key part of the implementation of ECAT, had been designed by the government to function as an immigration control mechanism:

> It's almost like there was a predetermined decision from a very early stage that this would happen, [the NRM] would be very much about immigration control, it is immigration control by the back door (Advocate).

Thus, although stakeholders from across the range of sectors represented in the research concurred that the UK had approached trafficking as an issue of organised immigration crime, the research found evidence of intersectoral disagreement as to whether this meant trafficking was considered to be a problem of crime or of migration.

4.2 Stakeholders' perceptions of the suitability of organised immigration crime-based approaches to trafficking

This section shows that many stakeholders, including government officials, did not approach trafficking as an issue of organised immigration crime and that for some, but not all, this was a source of significant conflict.

As previously stated, policy officials at the Home Office, UK Border Agency (UKBA), and the Ministry of Justice stated that they approached trafficking as a problem of either serious organised crime or organised immigration crime. The Department of Health (DH) worked on trafficking, however, within the context of its violence against women programme:

> What they've done, which they were quite right to do, is to just take on human trafficking as part of a wider issue. So initially the Department of Health had this Victims of Violence and Abuse Programme, and they included trafficking and exploitation in that programme of work (Civil Servant).

Civil servants reported that departments' different approaches did not cause difficulties within government. One stated, for example, that:

> There are different emphases. But there is no great harm in that. I don't think we have difficulties in understanding each other's agenda on something (Civil Servant).

Similarly, a second civil servant commented that although trafficking was "classed as organised crime", the department had worked successfully with teams elsewhere in government that worked on violence against women, prostitution, and immigration:

> There's a lot of overlap with the Violence Against Women agenda, the whole prostitution policy area, as I say, bits of immigration as well. We talk to each other quite a lot, and we try to make sure that the Violence Against Women strategy is kind of, that is informed by what we're doing about trafficking and vice versa ... So, sometimes it finds expression in joint activities...there was that famous poster, the walk in a punter walk out a rapist... the message that we want to give as a government is very, very similar, so it makes sense to cooperate with those areas (Civil Servant).

A different perspective was offered, however, by a third civil servant, who reported that although historically there had been difficulties between those working on immigration and victims issues, joint working with the UKBA had overcome some of the challenges posed by the immigration-based approach to trafficking:

> We set up a virtual trafficking team. So we all worked together around the table, so those leading on enforcement, those leading on victims issues... we took the evidence of how many victims there are, you know the [Poppy] project had been running as pilot for a couple of years, looked at how the realities of those cases and presented the evidence to the UK Border Agency....We quite quickly saw a change in attitude. Rather than taking a defensive role, and saying this is about immigration, it's about possibly pull factors, they saw it as being a very sort of specific problem, with relatively small numbers of victims (Civil Servant).

Internal documents also support this interviewee's analysis of initial tensions within the Home Office. The 2005 evaluation report of the Poppy Project pilot scheme noted, for example, that there

was "significant tension...between the Immigration Service (IS) and the Home Office Victims Unit (VU). Firstly, the IS and VU had taken different approaches to the government strategy on trafficking and secondly, changes made to the eligibility criteria affecting tenants' right to claim asylum had caused some problems for the IS" (Taylor 2004).

Other analyses of the response to human trafficking in the UK have reported a positive relationship between the police and immigration services (Taylor 2005; Balch and Geddes 2008) and this research found no evidence of frame-based conflict between the police and immigration services at meetings or in recent policy documents. During interviews, however, a number of enforcement officials reported practical frustrations with the demands of immigration-based approaches. One interviewee, for example, complained at the requirement that enforcement staff were required to report the exploited illegal immigrants whom they became aware of to the UKBA:

> We're being encouraged to use the credibility that we have with community organisations, for them effectively to come forward and tell us about illegal immigrants, in a way that we would then in theory be obliged to pass on to the UKBA, to have that information to go in and deport them. It puts us in a very difficult position, because our spirit is very much that we're here to help victims of exploitation and make sure that somebody isn't a victim of exploitation... we can't really play it both ways (Enforcement).

Another interviewee referred to the difficulties that had previously arisen of trafficked people being deported by the UKBA despite the police's hopes that they would provide intelligence or evidence against their traffickers:

> The NRM is obviously a big step forward, because...haven't got the problem of having victims of trafficking who should give evidence being deported (Enforcement).

Data from interviews and field notes indicated ongoing, frame-based conflict between UKBA and NGOs, service providers and lawyers. Asked to talk about her organisation's relationship with government departments, for example, one service provider representative stated that:

> [The UKBA] approach the issue from an organised immigration crime perspective and that's quite obvious and so we do tend to butt heads with them on more of a theoretical

> level more frequently because we just come at it from completely different perspectives you know (Service Provider).

When asked to talk about their relationship with non-governmental stakeholders, civil servants concurred that relationships were often strained and attributed this to stakeholders' unhappiness with immigration-based approaches to trafficking:

> A lot of partners have a real concern that trafficking is treated as an immigration issue and shouldn't be treated as an immigration issue and it should be about victims...there will always be a tension between border control, immigration control type responsibilities and a duty towards victims. And there are people out there who will never, ever accept that UKBA are doing things for the right reasons. Their whole reason for existence is to challenge UKBA (Civil Servant).

NGO advocates, service providers and lawyers drew attention to the shortcomings of the organised immigration crime approach in relation to people who had been trafficked to the UK but entered legally. The Amnesty International UK submission to the consultation on the National Action Plan to Tackle Human Trafficking, for example, noted that "the UK Action Plan also focuses largely on organised immigration crime so does not address the law enforcement response to those persons who have entered the UK legally (as workers, spouses or partners) but may then find themselves in an abusive situation that meets the definition of trafficking as used in the Palermo Protocol" (AIUK and Zimmerman 2006). Similarly, Anti Slavery International's (ASI) response to the consultation commented that "there is a structural weakness throughout the plan in that there is an assumption that all trafficking can be tackled as an organised immigration crime. This is not the case as people are trafficked through regular migration channels....Responses to trafficking must be through a broader prism than organised immigration crime otherwise many trafficked people will not be identified and assisted" (ASI 2006a).

Non-governmental stakeholders particularly criticised crime and immigration-based approaches to trafficking for what they saw to be a failure to fully take into consideration the support and protection needs of victims:

> The central contradiction that's really problematic at the heart of the government approach is that attitude around [pause] cracking down on illegal immigration. And they're trying to

> balance that and put victims first, but all of those professionals would have primarily been trained to crack down on illegal immigration, and not put victims first... the kind of default setting is that we don't trust these people and we think they're lying unless they can prove otherwise, which is not really the best mindset to be in if you're trying to identify trafficked people (Advocate).

NGO advocate, service provider, and legal stakeholders agreed that trafficking was a crime, but they called for the government to take a human rights-based approach to addressing the issue[11]. This approach required that human rights were placed at the core of anti-trafficking strategies and that initiatives did not adversely affect the rights of trafficked persons or those vulnerable to trafficking. Analysis of documents shows that NGOs made recommendations that the government moved away from an immigration-based approach to trafficking and to focus more upon the human rights of the victims of crime. In their response to the National Action Plan consultation, for example, ASI claimed that "responses to trafficking must be through a broader prism than organised immigration crime otherwise many trafficked people will not be identified and assisted" and suggested that "a framework that focuses on the exploitative outcomes of trafficking...would be more comprehensive and effective" (ASI 2006a).

Organisations also made recommendations as to how "victim-centred" approaches could be embedded into the UK response to trafficking. AIUK, when recommending to the Joint Committee on Human Rights inquiry (JCHR) into human trafficking that UKBA should "adopt a victim-centred approach to trafficking and implement strategies which are not focused solely upon the enforced removal of immigration offenders" suggested that "special training for work with victims should be required of all police and immigration officials likely to come into contact with trafficked persons" (JCHR 2006a). Questions about the role of UKBA within the response to trafficking were also raised during the Home Affairs Committee (HAC) inquiry into trafficking. The campaigning NGO Stop the Traffik, for instance, claimed that UKBA's ownership of the Competent Authority function "raise[d] many concerns" and that the government should appoint "Competent Authorities which show a demonstrable victim-centred human rights ethos as their primary priority, so that the focus will always be the wellbeing and best interests of the victims" (HAC 2009a).

[11] Many of the interviewed lawyers and NGOs additionally stated that not only should the response to human trafficking be rooted in the principles of human rights but also that human trafficking was itself a violation of human rights. They did not detail, however, either in interview or in documents produced by their organisations, why they believed that trafficking should be viewed in this way. The framing of trafficking as a human rights violation appeared to function more as a rhetorical device than as a model for understanding trafficking.

Despite these efforts, stakeholders seemed to be resigned to ongoing conflict with the government. One service provider, for example, predicted that tensions with the UKBA would continue into the future:

> We've been arguing [with UKBA] for ages to stop looking at this as an organised immigration crime issue and that is their world, they're not going to leave that place and neither are we so there is always going to be some sort of tension there (Service Provider).

Another interviewee, a lawyer, similarly expressed doubt that the Home Office could be dissuaded from approaching trafficking as an issue of organised immigration crime and stated that a more realistic aim was to move "slightly" to an approach that placed more emphasis on trafficked people's human rights:

> I guess for the Home Office they're coming at from their position of immigration control and it is a crime and you know, they come from more of a criminal mindset and less about protecting and human rights. But I'm not quite sure whether that would be changed. Perhaps the best we could hope for is slightly more emphasis being put on the human rights of the victim, pushing that slightly towards the forefront (Lawyer).

Civil servants recognised that addressing trafficking as an issue of organised crime created the potential for conflict with NGOs. They felt, however, that the government had been committed to a "victim-centred approach" to trafficking:

> You could conceptually argue that treating it [as serious organised crime] would mean you would put undue focus on the enforcement side to the detriment of the victim care side. But I don't think that's been the case here. Largely because we have taken this victim-centred approach, I know it sounds like a cliché but it is true (Civil Servant).

The interviewee continued on to state that the framing of trafficking by government as an issue of serious organised crime was therefore not a source of conflict between the government and external stakeholders. NGOs and lawyers argued, however, that the cultural and political context around immigration, and especially around immigration crime, created tension between the priorities of

human rights-based and immigration crime-based approaches to trafficking and meant that combining the two approaches would be challenging:

> I suppose you can construct scenarios where there's no problem from a human rights or an immigration perspective... a scenario where you could look at this person and say yes, you were a victim of a human rights violation, you are also an anomaly from the point of view of our immigration system because you're not allowed to be here and we need to return you home. But that's not a problem for the person because maybe she wants to go home. But that's an ideal scenario. And my understanding is that most cases don't look like that (Lawyer).

The consultation document for the UK Action Plan to tackle trafficking did not refer to human trafficking as an human rights issue and the summary of responses noted that "the majority of respondents raised concerns that there was also a need for the action plan to have at its core, a focus on human rights and an emphasis on the protection of victims as well as the prosecution of traffickers" (Home Office 2006b; Home Office 2006c). Also in 2006, the JCHR published the report of its inquiry into trafficking and stated that it considered the issue to be "one of the most serious human rights issues in the modern world." Although the JCHR acknowledged that the UK's legislative response to trafficking broadly complied with its human rights obligations, it also called for the protection of trafficked people to be placed "at the heart of the legislative framework" and for the government to "review immigration laws and policies in the context of their impact on trafficking victims" (JCHR 2006b).

In later policy documents, the government did refer to trafficking as a human rights issue and adopted phrases such a "human rights based approach" and "victim centred response". The 2007 National Action Plan to tackle human trafficking, for example, stated that the signature of ECAT would provide a "framework for the protection of all victims of trafficking and support a more human rights centred approach" and that a "central tenet" of the new UK Human Trafficking Centre (UKHTC) was "the development of a victim centred human rights based approach to tackling human trafficking" (Home Office 2007b). At the time of writing the government was still heavily criticised by external stakeholders who felt the policy response to trafficking was not human rights focused. In 2010, for example, a coalition of eight NGOs launched a highly critical report that argued that UK response to trafficking breached its obligations under ECAT and had, in a number of cases, led to the violation of the human rights of trafficked people (ATMG 2010).

4.3 Stakeholders' accounts of the causes of trafficking

Determining the cause of a problem is a key process in its definition. Establishing causality provides a "locus of responsibility" for the problem's existence (Stone 1989), thereby rendering certain policy options logical and others not. To gain a better understanding of how participants in the UK policy subsystem framed trafficking as a particular type of problem, their accounts of the causes of trafficking during interviews, meetings, and in policy and organisational documents were analysed. This section discusses the multiple putative causes of human trafficking that were identified through this analysis and which have been grouped into four broad categories: the willingness of the trafficked person to migrate, the trafficked person's opportunity to migrate, the opportunity for traffickers to profit, and the willingness of the trafficker to take the risk of profiting through the exploitation of the trafficked person's labour[12].

4.3.1 Willingness to Migrate

Following research with women who had been trafficked into sexual exploitation in Europe, Zimmerman developed a conceptual framework for understanding the recruitment of trafficked women which, through an emphasis on women's immediate experiences and qualities, individualises the recruitment process (Zimmerman 2007). This sub-section shows, however, that when considering why people decided to migrate, interviewees and the authors of trafficking policy documents focused on generic push and pull factors, and did not consider why certain individuals chose to migrate whilst others, in the same or similar circumstances, did not. Push and pull factor-based theories of the origins of international migration flows assume firstly, that migration exists primarily because of global inequalities and secondly, that the most disadvantaged in societies are the most likely to migrate (Portes and Borocz 1989). Push factors are the negative aspects of a person's country of origin that may encourage them to seek to leave (such as unemployment, poverty, or civil unrest) and pull factors refer to the features of another country which make it an attractive place in which to live or work (for example, that prospect of a good job or political freedoms). The research also found that interviewees also spoke about these factors as they related

[12] These conditions assumed that the trafficked person was not forcibly abducted. Although the abduction and trafficking of women and girls had been documented in some settings (e.g., Silverman and Decker 2007a), it was not thought to be a significant issue within the UK context (e.g., Home Office 2007b; EUROPOL 2007).

to migration, as well as how the factors may have contributed to a person's vulnerability to exploitation within the migration process.

Several interviewees, particularly NGO advocates, lawyers and service providers, spoke about people's decisions to migrate as being rooted in the problems of source countries, such as poverty, conflict, and natural disasters. For example, an NGO advocate stated that:

> Ongoing issues like conflict, but also new issues like climate change, create [the] conditions and ongoing poverty, where you have either forced migration and people who are vulnerable to abuses like trafficking or there'll be just you know the ongoing problems of trafficking that we've already identified (Advocate).

Analysis of consultation submissions and other advocacy documents also showed the emphasis NGOs placed on these factors in creating vulnerability to exploitation:

> Trafficking in human beings often flourishes in areas with poorly developed social and administrative infrastructures, such as post-armed conflict areas, areas recovering from humanitarian crises and countries in transition. Violations of individual security and the lack of economic development belong to the root causes of human trafficking (NSPCC 2006).

Only one of the five civil servants interviewed for the research spoke about poverty and other source country problems as causes of human trafficking, stating that "there are issues that make a certain country a poor country, a source country. So for example wider policy issues around poverty, issues within those source countries". Within the prevention sections of the government's National Action Plan on Tackling Human Trafficking series, however, poverty and source country factors are referred to as being at the root of people's vulnerability to exploitation:

> We recognise the need to address the underlying reasons why so many people are vulnerable to exploitation – poverty and social exclusion. The Department for International Development (DfID) is already playing a leading role, in the fight against poverty and social injustice through support for our long-term development programme and we will continue with this work (Home Office 2007b).

Parliamentarians also drew upon these factors to explain why trafficking happened. The report of the Joint Committee on Human Rights inquiry into human trafficking stated, for example, that "factors such as globalisation, poverty and humanitarian crises all impact on the problem of human trafficking" (JCHR 2006b). The report of the Home Affairs Committee inquiry into human trafficking similarly commented that "a common feature of many of the victims of trafficking is that their home countries are poor and there are few opportunities for employment" (HAC 2009b). Similarly, parliamentarians in several debates made reference to people's "desperation" and "poverty" as causing them to migrate and become vulnerable to exploitation (HC Deb 2006; HC Deb 2007; HC Deb 2008b; HC Deb 2008a; HC Deb 2010).

Advocates and service providers from NGOs, immigration lawyers, and parliamentarians also spoke about people's experiences of living as disadvantaged groups within particular countries as contributing to people's willingness to migrate. The report of the Home Affairs Committee inquiry into human trafficking stated, for example, that "the groups most vulnerable to this crime are those of low status, without powerful protectors (typically women and children— especially orphans or those subject to domestic violence—but also impoverished men), and those in debt bondage" (HAC 2009b).

Women's experiences of gendered violence and discrimination were suggested by a small number of interviewees, typically representatives of feminist NGOs, lawyers and gender experts, to motivate women's migration:

> Often, the women and girls that we see, have been fleeing another situation of gender based violence, persecution, and in fleeing that situation have come into the hands of traffickers, often we're not just dealing with women and children, actually in most cases not, it's very rare, in most cases there has been another example of violence which has then made that women very vulnerable. The process of fleeing gets caught up with this trafficking element, and brought here (Lawyer).

NGOs also made the connection between women's experiences of gendered violence and discrimination and their decisions to migrate in organisational reports and policy submissions. An early Poppy Project report titled "When Women Are Trafficked: Quantifying the Gendered Experience of Trafficking in the UK", for example, stated that of the 24 women supported by the project at that time, sixteen had experienced physical violence prior to having been trafficked and

twelve had been sexually abused or raped, and that three had travelled abroad "solely to escape abusers" (Dickson 2004b). The Poppy Project's submission to the National Action Plan consultation in 2006 drew on this report to state that 12% of women referred to the project were fleeing violence (Poppy Project 2006b).

Although the 2007 National Action Plan identified "gender inequality" within source countries as a factor that contributed to human trafficking, it did not discuss how gender discrimination or violence affected women's migration decision. Similarly, in relation to children's vulnerability to trafficking, government documents repeated the statement that poverty and social exclusion were key causal factors underpinning trafficking but did not relate this directly to children's migration:

> The UK recognizes that to end trafficking of children, governments and NGOs must work together to address the underlying reasons why children are vulnerable to exploitation – poverty and social exclusion (Home Office 2007b).

The submission documents of children's sector NGOs and of immigration lawyers tended to emphasise, however, the lack of choice and control that children had in the decision to migrate:

> In many instances family members or trusted elders may be involved in the trafficking chain and children are inextricably bound by familial obligation to what is happening to them. The question [how can we raise awareness among potential trafficking victims about the risks and realities of the exploitation they are likely to suffer through being trafficked] is not applicable to children unless it is part of a wider child protection strategy in source countries to enable all children to have equal access to justice, education and care systems (ECPAT UK 2006).

The quote above discusses how family members and acquaintances may be involved in the trafficking process. Organisations also stated that children's parents were frequently deceived into "handing over" their children to traffickers, believing that they would be provided with education or employment (NSPCC 2006).

The European Commission's Communication to the European Parliament "Fighting trafficking in human beings – an integrated approach and proposals for an action plan" stated that "many victims or potential victims of human trafficking are women, children and individuals belonging to ethnic

minority groups who may be subject to discrimination in their place of origin" (EC 2005). Analysis of interview data, field notes and documents showed, however, that stakeholders rarely referred to the discrimination and exclusion suffered by ethnic minority groups as a factor contributing to human trafficking.

The "pull factors" which encouraged a person to migrate (or, using the Zimmerman model, a person's "hopes" (Zimmerman 2007)) were understood within this context to be the prospect of overseas employment to improve one's dire economic situation and an escape from violence and discrimination:

> You find that people will often move quite happily with a trafficker, but it's on a basis that they're being deceived about what they're actually doing, you know, with what the end will be... and when I say of their own volition it's usually due to their extreme economic problems...they go along with it because it doesn't seem to be any other choices (Advocate).

Analysis of interview data, field notes and documents found that positive reasons for wanting to migrate, such as a desire for adventure or to learn new languages were not discussed. The third component of Zimmerman's reframed push and pull factors, an individual's "strengths", were similarly not spoken, or written, about by stakeholders in the trafficking policy subsystem.

4.3.2 Opportunity to migrate

Analysis found that the factors identified by participants in the UK trafficking policy subsystem, and in the literature on human trafficking, as contributing to a person's opportunity to migrate could be grouped into two sets: the dependence of the would-be migrant on the trafficker's migration offer and the features of the offer itself.

A small number of NGO advocates criticised the government for creating dependence on trafficking networks through the implementation of restrictive immigration policies that had limited provision for legal low-skilled migration. ASI's response to the consultation for the National Action Plan to Tackle Human Trafficking, for example, stated that:

> There should be specific policies to encourage the regular migration of unskilled labour and the new points based immigration scheme should be reviewed specifically to assess its possible impact on trafficking, particularly measures which could increase the vulnerability of would-be migrants. The introduction of a points based immigration system with its focus on skilled migrants, does appear likely to increase the risks of trafficking as the opportunities for regular migration are more limited (ASI 2006a).

Similarly, Stop the Traffik's consultation response warned that limiting the provision of visas to women who wish to migrate increased their vulnerability to being trafficked by forcing them into illegal migration channels:

> We endorse visa-issuing practices, which attempt to limit issuing of visas to traffickers and their potential victims, but are concerned that this may lead to the penalising of women who wish to legitimately migrate. The limiting of the mobility of women will only force them into illegal migration channels, which puts them more at risk of being trafficked. Restriction of visas to potential victims should be coupled with an extension of the availability of safe migration channels (Stop The Traffik 2006).

These sentiments were echoed by a handful of interviewees. One healthcare provider commented, for example, that:

> Women, the women who are not here legally, who are undocumented migrants, the reason they can be trafficked, by and large, is because they wouldn't normally get, they wouldn't easily get into this country. They certainly wouldn't get papers to be in this country (Healthcare Provider).

The research found, however, that this was a point made more consistently and forcefully by academic proponents of migration and labour rights-based analyses of trafficking than by the stakeholders in the trafficking policy subsystem (Kempadoo and Doezema 1998; Sassen 2000; Andrijasevic 2003; Berman 2003; Anderson and Rogaly 2005; O'Connell Davidson 2006; Anderson 2007). Anderson has highlighted, for example, the "role of immigration controls in constructing categories of people who are vulnerable to abuse" and the need for States to prevent "immigration controls from becoming part of the problem", whilst Andrijasevic has suggested that tightening immigration restrictions raises the level of control traffickers and employers are able to

exercise over migrants (Andrijasevic 2003; Anderson 2007). These arguments appeared to have found little traction in government. In documents, although not during interviews or at the meetings attended for the research, government officials stated that the *strengthening*, rather than loosening of immigration controls would contribute to efforts to tackle trafficking. The 2007 National Action Plan on Tackling Human Trafficking, for example, suggested that anti-trafficking efforts would benefit from the implementation of new offences of knowingly employing an illegal migrant worker; the e-Borders programme to identify people entering and exiting the UK; and raising awareness of trafficking amongst visa issuing posts to prevent visas being issued to potential victims of trafficking (Home Office 2007b). Whilst in opposition and since coming to power, the Conservative Party have also suggested that tightening border controls would help combat trafficking and proposed establishing a UK Border Force "to enhance national security, improve immigration controls and crack down on the trafficking of people, weapons and drugs" and introducing "separate interviews at all airports for women and children travelling alone with an adult who is not a parent, guardian, or husband" (Conservatives 2008; Conservatives 2010).

The second identified group of factors relating to people's opportunity to migrate were the features of the offer itself. The research found that interviewees did not spontaneously discuss what made a migration offer credible, attractive or opportune, three elements that Zimmerman has suggested to be important to trafficked people's decision-making (Zimmerman 2007)[13]. Analysis of interview data and documents did, however, show that civil servants, enforcement officials, service providers, NGO advocates, and lawyers claimed that the traffickers' deceived would-be migrants into entering into the trafficking process.

An emphasis on deception was apparent throughout the period of interest. In 1999, at a seminar organised to discuss the development of a new criminal offence of trafficking for sexual exploitation, Inspector Paul Holmes of the Metropolitan Police Clubs and Vice Squad stated that "90% of the victims are trafficked by deception" (Home Office 2000). Eight years later, the National Action Plan on Tackling Human Trafficking claimed that "although violence and force are often encountered in trafficking cases, evidence suggests that in the initial stages the vast majority of victims are recruited by deception" (Home Office 2007b). In April 2008, in an evidence session held by the Home Affairs Committee as part of their inquiry into trafficking, representatives of the

[13] An exception to this general finding was that a number of enforcement interviewees commented that although the public perceived most traffickers to be male, they had also identified female traffickers and suggested that trafficked people were more likely to trust a migration offer made by a woman.

Poppy Project, Kalayaan, and ECPAT UK each stated that deception was used to traffic women and children into sexual exploitation, domestic servitude, and other forms of labour exploitation (HAC 2009a).

Deception could firstly take place, stakeholders suggested, with regards to the type of work the trafficked person would be expected to do. This was particularly discussed in relation to women trafficked into the sex industry and the trafficking of children. In their response to the National Action Plan consultation document, for example, the Poppy Project claimed that the majority of the women supported by their service to date had been told by traffickers that they would be working in a variety of industries:

> The majority of women supported by the [Poppy] Project were actively seeking employment overseas when they were trafficked. Of these, eight believed they would be working in the restaurant industry (21%); seven believed they would be doing domestic work/childminding (18%); six believed they were being offered education or 'opportunities' (16%); and one woman believed she was coming to work in accountancy (3%) (Poppy Project 2006a).

Similarly, government documents stated that many women trafficked into sexual exploitation were not told that they would be working in the sex industry but that they were migrating for "legitimate" jobs:

> Victims are targeted using a variety of techniques, from advertisements in various media for legitimate employment such au-pairs, models or bar staff to traffickers posing as friends and offering either holidays abroad or presenting them with bogus job opportunities. There have been examples of women's involvement in such practices which has added to the plausibility of the traffickers (Home Office 2007b).

In an alternative scenario, stakeholders suggested that trafficked people were aware of the sector they were migrating to work in but deceived as to the conditions under which they would be working. The research found that enforcement officials were more likely to talk about women having purposefully migrated to work in the sex industry than were, for example, NGO advocates and service providers:

> Some of the women that we help knew what they were coming to do but whether or not they knew the amount that they were going to be indebted, the amount of coercion they were going to face, the amount of clients they were going to have to see in order to pay a small amount of the debt bondage off is another matter. Even though women knew what they were coming to do, they're still being exploited (Enforcement).

A very small number of interviewees, however, suggested that in some cases trafficked people were aware of both the type of work they would be undertaking and the conditions that they would be working under, and that they accepted the work once here. This tended to be spoken about in relation to trafficking for labour exploitation. One service provider stated during interview, for example, that:

> For instance, [trafficked labourers] have stood in front of us and said 'over the course of a week, that's good money for me and I can send it all home. Now, I can do nothing. You've ruined it for me.' So you get that sort of thing, and you think, well actually I can understand the logic there. You know, it doesn't mean to say that that is a good thing, or that what happens is acceptable, but I can see that person's logic. So they say 'I know what the deal was, I know I was being ripped off, and I know the others were getting double. But I'm happy with the end product, because I can send that home'(Service Provider).

A similar argument was also put forward in relation to women who had been trafficked for sexual exploitation, typically by the police and by interviewees who worked frequently with, or on behalf of, sex workers. One police officer, for example, spoke about how women who had been trafficked for sexual exploitation in the sex industry may accept their conditions of work, and the fact of their debt bondage:

> If someone is trafficked into the UK for sexual exploitation, they are being exploited. No matter whether or not they're happy to along, well, not happy to go along, but knew exactly what they were coming to do, even if they are happy in their work they are still being exploited. Still not earning all the money they earn, they're owed, and they're paying off the debt bondage (Enforcement).

Similar sentiments were expressed by organisations that worked with sex working women. One healthcare provider, for example, spoke about women's gratitude towards their traffickers despite working in "challenging" circumstances:

> I mean I've been around women in circumstances that I found really, really challenging, me personally. Where women have talked about their traffickers as their facilitators. And actually been quite, empathic with them and thankful that their traffickers have brought them here – because how would I have done it? I wouldn't have known how to do it. That's often how women view it. They say I would never have got here unless my trafficker had helped me get here, and you think bloody hell. Thirty thousand pounds later (Healthcare Provider).

These were minor discourses, however, and were infrequently expressed within policy documents or during the meetings and events attended for the purpose of this research. Although not universal, discourses of deception, and lack of resources for independent migration, dominated discussions of how trafficked people came to be in situations of exploitation.

4.3.3 Opportunity to Profit

Traffickers were believed to be motivated by the potential to profit from the exploitation of another's labour. Although the government frequently referred to human trafficking as an "evil" in its policy documents (Home Office 2007b; Home Office 2008), these documents also stated that human traffickers were motivated by economic considerations:

> This modern form of slavery is an evil practice perpetrated for profit with no regard for the personal or societal consequences (Home Office 2007b).

Analysis identified two elements, market demand and labour market features, which stakeholders used to explain how traffickers were able to profit from the exploitation of others. Stakeholders also used these causal factors to introduce alternative sources of blame for the problem of human trafficking. These sources, however, with the exception of the clients of sex workers, tended to be structural or diffuse and did therefore not provide a clear target for anti-trafficking initiatives.

Market demand created an opportunity to exploit a would-be migrant, providing, as it did, paid work. The nature of demand was understood differently, however, with regards to labour exploitation and sexual exploitation. When discussing trafficking for labour exploitation, labour advocates spoke about the specific demand for cheap and exploitable labour amongst unscrupulous employers:

> [We] understand the problem in terms of there being a demand for labour that can be exploited, and therefore then workers who are exploited, [you need to] cut this supply and demand by making sure that the demand side doesn't get away with the exploitation (Enforcement).

The issue of consumer demand for cheap products was not spoken about, and was only infrequently raised in the publications of these organisations. In contrast, service providers, advocates, and enforcement interviewees spoke about consumer demand for the services of sex workers *in general* being responsible for expanding the market, creating a need for sexual labour that was filled by trafficked women:

> So we need to start thinking about changing, this process, of the mindset, the mindset of that this industry isn't actually, it isn't acceptable. Because what you're doing is you're feeding also, it's difficult to ever regulate it effectively, but you're feeding an industry where people are undoubtedly exploited and people are put in danger, and you're part of it (Enforcement).

One interviewee went further and argued that as the sex industry demanded not only additional labour but variety and exoticism, migrant women would be trafficked specifically to meet this need:

> It was fairly clear that the demand for women in prostitution and men involved in prostitution was fuelling a demand for trafficked women. And, therefore, creating the problem if not expanding the problem. And you know, that it wasn't something that [cities were] choosing or not choosing, it was part of the sex industry. The sex industry demanded fresh women, variety, different ethnicities; it was the nature of the sex industry that was creating the problem (Civil Servant).

Sex industry users were therefore blamed for creating demand for trafficked people through their purchase of sexual services and later became a potential target of anti-trafficking initiatives. In 2008, for example, the Home Office launched a poster campaign to raise awareness of trafficking amongst men who paid for sex. The poster, piloted in men's toilets in clubs and bars in Westminster and Nottingham, carried the tagline "Walk in a punter. Walk out a rapist" and stated that "Trafficked women are forced into selling sex. Forced sex is rape" (Crimestoppers 2008). In 2009, the Policing and Crime Act made the purchase of sexual services from prostitutes who had been subjected to force, threats, coercion, or deception a strict liability offence (Great Britain 2009). In contrast, the consumers of cheap goods and other labour services were typically not censured for creating an analogous demand for trafficked migrant labourers.

Interviewees who analysed trafficking from a labour rights perspective highlighted a number of features of the labour and immigration systems that acted as facilitators of exploitation. One advocate, for example, spoke about the restrictions and requirements placed upon immigrant labourers as increasing their risk of exploitation:

> We're not very happy with the fact that the workers registration scheme is not being scrapped, because effectively you're – force is probably too strong – but there are very real incentives with A8 workers, who are perfectly within their rights to be here and effectively to work here, nevertheless they are being pushed into a quasi undocumented situation. And within that situation obviously up gross forms of exploitation can flourish (Advocate)[14].

Another interviewee, an enforcement officer, suggested that divisions between "British jobs", "immigrant jobs" (such as agricultural labour) and non-jobs (such as prostitution) had become entrenched in labour policies and had contributed to employers' demand for cheap and exploitable migrant labour in the lowest rungs of the labour market:

> Labour markets are generally separating out immigrant jobs...and policies are based on the assumption that these jobs are immigrant jobs, and these jobs are British jobs, below the immigrant jobs you then get the set of things that aren't meant to be accepted as a form of job, where you get the worst sort of human trafficking, whether that's prostitution or other

[14] A8 nationals are people from eight of the ten countries that joined the EU in 2004 (the eight are the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, and Slovenia). Workers from these countries must register with the Worker Registration Scheme within one month of joining a UK employer (UKBA 2010d).

> kind of jobs... [That's] the way that the labour market seems to be quite happily divided up...[and] it keeps the demand [for cheap immigrant labour] going (Enforcement).

Other interviewees commented upon the lack of enforceable employment rights for illegal workers and workers' fear of deportation, which arose from the unsympathetic immigration regime, as contributing to people's exploitation. Through this dialogue the government was blamed for creating, or allowing the continuation of, immigration and labour systems in which exploitation could flourish. The majority of interviewees, however, paid little attention to this element of the causal framework.

4.3.4 Willingness to Take Risk

The potential profit to be made from human trafficking was believed by civil servants, enforcement officials, advocates, and service providers to be extremely high. In contrast, the research found that the same stakeholders believed that the risks to traffickers were relatively low.

Stakeholders' recommendations suggested that they attributed the low levels of risk traffickers faced during the trafficking process to the limited likelihood of detection and prosecution (for instance because of limited policing capacity, the difficulties of policing organised crime, and corruption in source and transit countries) and to the potential for traffickers to receive low penalties if prosecuted. The National Action Plan on Tackling Human Trafficking, for example, detailed plans to train police officers in the UK; build policing capacity in source and transit countries; address corruption amongst overseas police forces; implement high custodial sentences and confiscation orders for convicted traffickers; and publicise successful convictions (Home Office 2007b). Analysis of field notes, organisational reports and policy submissions found that much of NGO advocacy activity regarding the policing of trafficking focused on the need to train police officers to work with trafficked people in a way that was sensitive to the trauma they had experienced and the ongoing risk of harm they faced. It also found, however, that NGOs believed that traffickers' low risk of detection and prosecution contributed to the continuation of trafficking and that they called for the enforcement response to trafficking to be strengthened. The Poppy Project, in their response to the consultation to the National Action Plan to tackle human trafficking, recommended that police forces developed anti-trafficking strategies and were measured on how well they tackled trafficking:

> Trafficking is not a new issue for the police, the immigration service and the Crown Prosecution Services (CPS). Procedures have developed in an ad hoc manner with some forces striding ahead while others need improving. To ensure consistency, a mandatory performance indicator on tackling human trafficking needs to be introduced for every police force throughout the UK. Police forces should prioritise introducing a joined-up strategy to tackle the rise in human trafficking (Poppy Project 2006a).

ASI also called for an improved enforcement response to trafficking in their consultation response and drew attention to the lack of prosecutions against trafficking for labour exploitation:

> A review as to why legislation has not been used to prosecute individuals for trafficking for labour exploitation should be carried out in order identify the reasons and remedy this problem (ASI 2006a).

Politicians and enforcement officials also called for the "high profit to risk ratio" to be reduced in order to deter traffickers. In 2005, for example, the then Parliamentary Under-Secretary of State for Policing, Security and Community Safety Paul Goggins MP stated in his speech to delegates at a 2005 conference that:

> To be effective in preventing trafficking we need to show that we are being tough on those groups orchestrating trafficking. Unless we can do this it will continue to be a lucrative, low-risk crime and we will continue to encounter victims who have been trafficked into the EU (Goggins 2005).

Similarly, at the UKHTC human trafficking conference in 2007, an executive director of the Serious Organised Crime Agency stated in his speech to delegates that:

> We need to change the risk/reward ratio...At the moment trafficking is as low risk and lucrative as it was last year: we are still where we were and we must do better (Fieldnotes 2007b).

The research found very little variation in how stakeholders spoke about traffickers' willingness to take risks and the anti-trafficking initiatives to increase the risks that traffickers faced. Although discussions of these factors could have led to the police and criminal justice services being held

responsible for the continuation of trafficking, this was not found. The focus of stakeholders' discussions with respect to traffickers' willingness to take risks remained the traffickers, who were constructed to be rational actors who would respond objectively to the relative costs and benefits of a course of action.

4.4 Evidence for causality-based conflict in the UK human trafficking policy subsystem

The previous section discussed the multiple factors that stakeholders in the trafficking policy subsystem had put forward during interviews, meetings, or policy documents as potential causes of trafficking. The policy literature suggested that actors would combine these factors, or sub-factors, to construct "causal stories" that would give rise to, or reflect, competing conceptual frameworks for understanding how and why trafficking happened, who was to be blamed, and which policy initiatives should be prioritised (Stone 1989). This section considers the evidence for causality-based conflict between stakeholders in the UK trafficking policy subsystem.

The research found that stakeholders in the trafficking policy subsystem did place differing levels of emphasis on the importance of the four categories of factors identified in section 4.3 and that, to some extent, a relationship could be observed between the causal factors that an organisation emphasised and the perspective from which they approached trafficking. The NGOs ASI and Kalayaan, both working from labour rights perspectives, for example, advocated the need to address features of the labour and immigration systems that enabled traffickers to exploit the labour of trafficked people and to address people's opportunities to migrate[15]. Five of the eleven recommendations that ASI made to the National Action Plan consultation, for example, related to causes of trafficking (i.e., rather than to the provision of post-trafficking support and protections). Of these, three related to the need to provide people with alternative opportunities to migrate, and two to traffickers' willingness to take risks by increasing prosecutions for trafficking for labour exploitation and by enforcing labour standards in high-risk industries through the Gangmasters' Licensing Authority (ASI 2006a). In contrast, recommendations made by the NGO CARE (a Christian charity which works on a range of issues, including trafficking, prostitution, abortion, euthanasia, and reproductive technologies) focused on reducing traffickers' opportunities to profit by targeting demand within the sex industry. Nine of CARE's seventeen recommendations related to causes of trafficking and, of these, seven related to the need to reduce demand (for example by

[15] Labour rights and migration framework overlapped, as proponents argued that the poor legal and social status of vulnerable migrant workers in the UK made them particularly vulnerable to labour exploitation.

introducing legislation making it "illegal to have sexual intercourse with a person where there are reasonable grounds to suspect that that person has been trafficked" and by developing "hard hitting campaigns to change male attitudes towards prostitution"), compared to just one recommendation to tackle traffickers' willingness to take risks and one to address the reasons why people migrate (CARE 2006).

The research did not find evidence to suggest, however, that differences in how organisations prioritised the various causal factors in their advocacy work created significant conflict either between organisations within the trafficking policy subsystem or with government.

4.4 Summary

This chapter began by demonstrating stakeholders' beliefs that the UK government had approached trafficking as a form of organised immigration crime. Although government officials suggested that this definition positioned trafficking as a form of serious crime, many stakeholders outside of government argued that it had actually been responded to as an immigration problem. Dissatisfaction with the perceived immigration-based response to trafficking was a cause of inter-stakeholder conflict, particularly between the government and NGO advocates, service providers and lawyers. The chapter demonstrated that significant levels of conflict in the trafficking policy subsystem arose from disagreements as to the emphasis that an organised immigration crime approach to trafficking should place on protecting and supporting trafficked people, relative to pursuing prosecutions of traffickers and to adhering to principles of immigration control.

A number of policy analysts have drawn attention to the difficulties of redefining a problem once it has reached the government agenda (Kingdon 1984; Hajer 1995). Despite external stakeholders' frustration with the suitability of the organised immigration crime approach to trafficking, and its implications for the welfare of trafficked people, it was not supplanted during the period of research. Civil servants' claims that alternative problem framings could be pursued across government suggest that there was unlikely to have been internal pressure for change. Furthermore, although the research found some evidence to suggest that non-governmental actors had varying analyses of the key causes of trafficking and, accordingly, emphasised different anti-trafficking initiatives, it was not clear that they expended significant energy in promoting alternative frameworks within which to address trafficking. Instead, NGOs, service providers and lawyers appeared to make policy recommendations that aimed to negate, or soften, what they perceived to

be the detrimental effects of the organised immigration crime approach on trafficked people's wellbeing.

The policy scholar Deborah Stone categorises causation as accidental (unguided action, unintended consequence), mechanical (unguided action, intended consequence), inadvertent (purposeful action, unintended consequence), and intentional (purposeful action, intended consequence) (Stone 1989). Analysing the causal stories used in the trafficking policy subsystem against this typology suggests that stakeholders positioned traffickers as "intentional" actors, who responded rationally to the opportunities to profit from the exploitation of others within a low-risk environment. In contrast, trafficked people were portrayed by NGO advocates, service providers, and lawyers as "inadvertent" actors, compelled by hardship to migrate and deceived into entering situations of exploitative and sometimes illegal employment. Although a minority of interviewees stated their belief that some trafficked people had knowingly entered into situations of exploitative employment, the construction of trafficked people as inadvertent actors was generally accepted by other stakeholders within the trafficking policy subsystem. The following chapter discusses how discourses of violence and trauma were used tactically in support of advocates' strategies to construct trafficked people as sympathetic figures and how these discourses were legitimated by information about the health consequences of human trafficking.

Chapter 5

Results II: Health, Violence and Trauma in Human Trafficking Policymaking

"I think for a lot of people they can become quite immune to umm, how do I say it?...a woman is raped, and they haven't got any sort of comprehension of what the sort of deprivation and violence might mean in physical terms, but when they know what the physical impact is, it kind of humanises it" (Advocate)

This chapter explores how trafficking policy stakeholders conceptualised the health needs and health-related experiences of trafficked people and applied this to their work on trafficking. The results presented in this chapter relate to three components of the conceptual framework that was presented in Chapter 2: feedback, indicators and information, and recommendations. Data collection and analysis with respect to these components aimed to understand firstly, how stakeholders produced and used health-related information, secondly, the feedback they provided to others on trafficked people's health needs and the extent to which the policy and service response to trafficking was meeting these needs, and finally, the recommendations that they made to policymakers on the basis of the health needs and experiences of trafficked people.

Due to the focus of the research, interview data may not provide an accurate representation of stakeholders' propensity to discuss trafficked people's health experiences and needs in their general work on human trafficking. Interviews necessarily included specific questions about stakeholders' perceptions of trafficked people's health needs; their experiences in assisting trafficked people to access healthcare; their impressions of how aware professionals in other sectors were of trafficked people's health needs; and whether they recalled health being spoken about during policy meetings that they had attended, which may have had the effect of bringing perceptions of health-related matters to the fore. The analysis presented in this chapter therefore also draws heavily upon the documents that stakeholders submitted to the consultation to the National Action Plan and to the inquiries held by the Joint Committee on Human Rights (JCHR) and the Home Affairs Committee (HAC), and also upon minutes and field notes from trafficking policy events. Interview data was analysed, however, and is used throughout this chapter to provide further detail and context to the findings.

The chapter firstly shows how violence, trauma, and health were spoken about by stakeholders in the trafficking policy subsystem. It then presents evidence on how anti-trafficking advocates used discourses of "violence" and "trauma" in support of their proposals for the provision of support to trafficked people. Within this, it shows how trafficked people's experiences of violence and subsequent physical and mental health needs were used to suggest that they had multiple support needs, that these needs were greater amongst people trafficked for sexual exploitation than for labour exploitation, and that trafficked people should be provided with support and protection in the UK for a period of not less than ninety days. Finally, the chapter demonstrates the importance of trafficked people's "credibility" in ensuring their access to support and protection (for instance under the terms of the Council of Europe Convention on Action against Trafficking in Human Beings (ECAT)) and shows how discourses of violence and trauma were used strategically by NGO advocates, service providers and immigration lawyers to decrease the likelihood that claims for support would be refused on the grounds that people were not credible victims of trafficking. In particular, it shows how these stakeholders used these discourses to explain the reluctance of trafficked people to escape their traffickers, why they sometimes returned to their traffickers or to the sex industry, and why they may be unable to provide a detailed and consistent account of their experiences during interview. Throughout the chapter, these stakeholders' use of health-based research to corroborate these violence and trauma-based advocacy strategies is highlighted.

5.1 Stakeholders' understanding of "violence", "health" and "trauma"

This section describes stakeholders' use of terms such as "violence", "health" and "trauma" in their feedback and recommendations to policymakers and parliamentarians. Each subsection includes analyses based upon text-searches of documents submitted to the consultation to the National Action Plan on Tackling Human Trafficking and to the human trafficking inquiries held by the JCHR and the HAC. Where appropriate, analyses of interview data are used to provide further detail on stakeholders' beliefs about the trafficked people's health and experiences of violence.

5.1.1 Violence

This subsection presents evidence to show how stakeholders in the trafficking policy subsystem suggested that trafficking for sexual exploitation was characterised by high levels of sexual and physical violence. It also demonstrates that although violence was discussed less frequently in

relation to people trafficked for labour exploitation, stakeholders tended to suggest that this group of people experienced lower levels of violence than did women trafficked for sexual exploitation.

Text searches for references to physical and sexual violence were conducted separately and found that physical violence was discussed less frequently by trafficking policy stakeholders than was sexual violence[16]. Five of the 38 accessible National Action Plan consultation responses reported on physical violence, as did seven of the seventeen NGO responses to the JCHR inquiry and five of the twenty NGO responses to the HAC inquiry. Trafficked women's experiences of rape featured particularly prominently in discussions on trafficking for sexual exploitation. Thirteen responses to the National Action Plan on Tackling Trafficking consultation specifically discussed rape, as did eleven NGO responses to the JCHR inquiry and nine NGO responses to the HAC inquiry.

Service providers, advocates, healthcare providers, enforcement officials and parliamentarians stated that women who had been trafficked for sexual exploitation experienced multiple and systematic rapes[17]. The research found that these stakeholders spoke about rape as being integral to the dynamics of trafficking and as occurring throughout the trafficking process: they reported that some trafficked women had suffered sexual violence prior to having been trafficked; some women experienced rape during transit, and nearly all trafficked women were repeatedly raped during the course of their exploitation. In their submission to the JCHR inquiry on human trafficking, for example, Amnesty International UK (AIUK) submitted an extract from a medical report which detailed the extreme level of violence endured by one child who had been trafficked for sexual exploitation:

> For six months she suffered rape or forced intercourse with up to five clients daily. If she resisted intercourse she was beaten, tied, gagged or spread-eagled and was obliged to accept vaginal, anal or oral rape, to pose to be photographed or videoed and abused in almost every sexual way. On occasion her pimp would throttle her during his rape . . . she was forced to have vaginal, anal and oral sex with customers— sometimes they used condoms, sometimes they did not (JCHR 2006a).

[16] Searches for references to physical health were conducted using the search term "hit OR hitting OR beat OR beaten OR batter OR battered OR slap OR slapped OR thump OR thumped OR kick OR kicked OR punch OR punched OR burn OR burned OR burnt OR throw OR thrown OR weapon OR whip OR whipped OR whipping OR torture OR tortured OR torturing OR injure OR injury OR injuries OR injured OR injuring OR "physical violence" OR "physical abuse""

[17] Several NGO, service provider, enforcement, and civil servant interviewees stated that trafficked women had not consented to sex work and therefore were effectively raped by each client.

Interviewees from across the participating sectors also spoke about how rape was used as a tool by traffickers to force women into agreeing to enter into prostitution:

> Many women get raped as soon as they've been trafficked to sort of, well, it's just what they do, what they're subjected to...Women have told me that they were brought here on the promise of work or whatever and then as soon as they've got to the destination they were raped and then they were told, it often seemed to happen in that sequence (Healthcare Provider).

Speaking about rape being used to break women's resistance functioned not only to demonstrate that women experienced violence but to indicate that they did not consent to work in the sex industry. The research found that in some instances, this took on an explicitly moral dimension:

> [She] believed she was going to work in a gym or something similar...[but] ended up not in a gym in a salubrious hotel, but in a less salubrious brothel in the centre of Paignton...I am glad to say that the girl was absolutely appalled by what she was asked to do. I think that she was raped at least eight or nine times on the first night that she was there (HC Deb 2009).

Sex worker advocacy groups that were interviewed for the research also emphasised trafficked women's experiences of rape and stated that women trafficked for sexual exploitation were "rape survivors":

> Victims of trafficking are treated in a separate category, but they're victims, they're rape survivors...Every rape survivor needs the same thing. And that's what a victim of trafficking is, a rape survivor (Advocate).

For these groups, identifying trafficked people as victims, or survivors, of rape appeared to work to distinguish trafficked people from non-trafficked migrant sex workers:

> I think we should call rape, rape...And trafficking really is something where you could say it's the moving across borders to force or coerce or trick or drug someone into doing sex

> work. But that's not really anything like prostitution. Prostitution, sex work, the vast majority are not raped, they're not falsely imprisoned, they're not kidnapped (Advocate).

The research found that the Poppy Project and AIUK were the organisations that commented most frequently upon trafficked women's experiences of physical violence and that in doing so they tended to draw upon the experience of women supported by the Poppy Project. In their response to the HAC inquiry, for instance, the Poppy Project submitted four case studies of women they had supported, each of which referred to the women's experiences of physical violence, for example:

> When she arrived in the UK, Katerina was held prisoner in a flat where she was repeatedly beaten and raped. Alex told her that she could have her freedom, but she would have to work as a prostitute to pay back the money...when she missed one payment she was dragged from the street into the boot of a waiting car (HAC 2009a).

The AIUK submission to the National Action Plan consultation drew on the findings of the "Stolen Smiles" report, which presented the results of a London School of Hygiene & Tropical Medicine (LSHTM) multi-country study on the health experiences of women trafficked for sexual exploitation (AIUK and Zimmerman 2006). In the UK component of the research, women were recruited from the Poppy Project (Zimmerman, Hossain et al. 2006). AIUK's submission to the JCHR inquiry also quoted from the 2004 Poppy Project report "When Women are Trafficked", which reported on the experiences of women they had supported (Dickson 2004b):

> [Women were] beaten, often with objects (chains, sticks, screwdrivers, household implements, bottles and knives were all mentioned). Women also mention being burnt with cigarettes, thrown from moving vehicles, locked in the boots of cars and threatened with firearms (JCHR 2006a).

A number of healthcare providers, lawyers, service providers and NGO advocates also likened trafficked women's experiences of physical, sexual, and psychological violence to torture. One healthcare provider, for example, stated that:

> "[The outcomes of] many of the coercive techniques and manipulations....both in terms of direct violence and the more subtle and sophisticated psychological coercion experienced

> by victims of trafficking... are very similar to that suffered by people who experience state sponsored torture" (Healthcare Provider).

Similar points were made by the Poppy Project and the Women's National Commission in their responses to the National Action Plan consultation and by AIUK and the Solicitors International Human Rights Group in their submissions to the JCHR inquiry (JCHR 2006a; Poppy Project 2006a; WNC 2006). Equating trafficked women's experiences with torture appeared to emphasise that the violence and abuse they suffered was extreme.

The research found that in both documents and interviews, stakeholders did not tend to comment on whether people trafficked for labour exploitation were subjected to sexual violence, and were less likely to suggest they experienced significant levels of physical abuse. An exception to this general trend was found in the HAC inquiry, in which four of the six NGOs that commented upon experiences of physical violence did so in relation to people who had been trafficked for domestic servitude. The submissions of Anti Slavery International (ASI) and the Anti Trafficking Legal Project (AtLEP) both stated that women who had been trafficked for domestic servitude often suffered physical violence at the hands of their employers. For example, ASI, citing statistics from the migrant domestic worker charity Kalayaan, stated that:

> Of the 340 migrant domestic workers registered with [Kalayaan] in the period April 2006 and March 2007, just under a quarter reported instances of physical abuse (e.g., beating them, slapping them, throwing things at them, spitting in their face, pulling their hair) (HAC 2009a).

Beyond these service user statistics, however, no other information was available that documented the extent to which people trafficked for domestic servitude and other forms of labour exploitation experienced violence whilst trafficked. Two anti-trafficking operations focusing on labour exploitation (Operation Ruby and Operation Tolerance) had been conducted prior to the interviews carried out for this research. Information from these operations was reported to have built upon the "low base of knowledge for labour exploitation", but NGO advocates, service providers, enforcement officials and civil servants reported during interviews that no evidence of physical violence was found during these policing operations:

> In [Operation Ruby] there was no mention, no evidence of [violence]... there were comments made, weren't there, that the gang-master was a 'tough man' and a 'hard man'. But I think that was in terms of he was inapproachable, there was no point in talking to him, there was no point in arguing. We certainly heard no suggestion amongst any of the people that there had been any physical assaults or abuse in that manner (Service Provider).

As discussed later in this chapter, stakeholders also spoke about trafficked women's experiences of sexual violence when making specific recommendations about the appropriate service response to trafficking for sexual exploitation. In contrast, statements regarding physical violence did not tend to be linked to particular recommendations, but instead were used more to support explanations of the dynamics of trafficking for sexual exploitation.

5.1.2 Mental health

The research found that several organisations suggested within submission documents and during interviews that women who had been trafficked for sexual exploitation suffered from poor mental health as a consequence of their experiences. The Poppy Project's and AIUK's submissions to the JCHR and HAC inquiries and to the National Action Plan consultation provided the greatest amount of detail on women's mental health symptoms and frequently drew upon the LSHTM "Stolen Smiles" study:

> A multi-country study...[found that] psychological consequences among victims of trafficking [for sexual exploitation] are often acute and frequently long-term. One of the primary outcomes of trafficking-related abuses are post-traumatic stress disorder, which commonly manifests as chronic fear, anxiety, chronic fatigue, nightmares, sleeping disorders, headaches, delusions, intrusive re-experiencing of the traumatic events, and memory loss. The study also demonstrated that suicidal ideation among trafficked women was not uncommon (Poppy Project 2006b).

The text searches found, however, that most organisations discussed the impact of trafficking for sexual exploitation on women's mental health in much more general terms. Most commonly, organisations stated that women experienced "trauma" as a result of their experiences. Ten of seventeen NGOs referred to trauma in their submissions to the JCHR inquiry (JCHR 2006a), as did the Home Office, CEOP and eleven of twenty NGOs in their submissions to the HAC inquiry three

years later (HAC 2009a). Furthermore, 29 of 43 interviewees spoke about trauma; police officials were the only group that did not use the term "trauma" during interview. Stakeholders' beliefs about the level of trauma experienced by women and the uniformity of trauma symptoms were found to vary, however, between sectors. NGO advocates, service providers and lawyers tended to suggest that *all* women who had been trafficked for sexual exploitation or domestic servitude were traumatised as a result of having been trafficked, as were *all* trafficked children. For example, AtLEP, in their response to the HAC inquiry, stated that:

> In our experience these clients frequently have extended dealings with police as witnesses; many of them have children and need social work assistance and without exception they suffer from trauma and depression (HAC 2009a).

During interviews, service providers also stressed the grave impact of violence and psychological abuse on the mental health of women who had been trafficked for sexual exploitation, stating, for example, that the women they supported often suffered from depression and post traumatic stress disorder (PTSD):

> Obviously we get behaviour problems because of the trauma, it's part of the post-traumatic stress disorder that they have...Depression, low mood, the sort of thing you would expect really (Service Provider).

Civil servants agreed that many trafficked people suffered from trauma as a result of their experiences, but tended to place more emphasis on the varying degree of trauma and subsequent need:

> [The recovery period] is flexible. So as [the Stolen Smiles] report suggested, some victims, due to the level of trauma, will need 90 days...if you need 90 days, if you need longer than 90 days for the recovery and reflection period, that's fine (Civil Servant).

Stakeholders generally made little mention of whether people trafficked for labour exploitation were traumatised as a result of their experiences whilst trafficked. Civil servants, NGO advocates, and service providers tended to imply, however, that people trafficked for labour exploitation did not suffer as significantly from mental health problems (in general) or from trauma (in particular) as a result of their experiences. One service provider, for example, when asked to comment on the

differences and similarities in the needs of people trafficked for sexual exploitation and domestic servitude, commented that:

> Generally I would say the mental health tends to be less prolonged, less severe, I think with labour exploitation. Every case differs depending on the level of abuse. But yeah generally I think, suffice to say, it's less severe for labour trafficking than it is for sexual exploitation (Service Provider).

A small number of interviewees, typically those who had worked with vulnerable migrant labourers for several years, suggested, however, that psychological abuse and psychological harm were very real features of trafficking for labour exploitation:

> Even if they are not necessarily physically abused they're often treated [badly]...they say things like "they treat me like a dog, it wasn't human, I felt like they'd bought my life rather than my work" and things like that (Service Provider).

Analysis of the situations in which advocates, service providers, and lawyers spoke about trauma found that these stakeholders often did so when criticising aspects of the current response to trafficking. In particular, these stakeholders suggested that several aspects of the criminal and immigration processes compounded the trauma suffered by trafficked people or were themselves traumatising, including the processes of being questioned, cross-examined or having to talk in detail about their experiences, delayed decision-making, incorrect decision-making, and having one's account of one's experiences disbelieved. The Trafficking Law and Policy Forum's submission to the HAC inquiry, for instance, included the following case study analysis:

> A's experiences of the appeal system compounded the trauma of her sex trafficking. She was repeatedly interviewed by police and her account discounted or disbelieved. She was twice detained and had at least three interviews with Home Office officials in detention; gave evidence and was cross-examined at length at two appeal hearings. She had interviews with her lawyer, three doctors, repeat examinations and consultations concerning her suicide attempts... On each and every occasion and with each and all professional she was required to retell and relive her story. The scepticism she encountered from certain professionals left her profoundly depressed and suicidal. Her case experiences are common. (HAC 2009a).

Stakeholders also stated that detention, removal and the fear of removal were traumatising for women who had been trafficked for sexual exploitation. In their submission to the JCHR, for example, AIUK stated that:

> For victims of trafficking, detention or imprisonment can be extremely traumatic. Detention is likely to be detrimental to the physical and mental health of trafficked victims, especially those suffering from post traumatic stress disorder as a result of being trafficked (JCHR 2006a).

The analysis found that the stakeholders did not tend to draw upon medical literature to support these claims. As discussed in section 5.3, NGOs, service providers and lawyers also drew heavily upon the concept of trauma to explain a range of behaviours, symptoms, and needs shown by trafficked people after their exit.

5.1.3 Physical Health

Analysis of documents submitted to the National Action Plan consultations and the two select committee inquiries found that the most detailed information relating to the physical health needs of women who had been trafficked for sexual exploitation was provided in the submissions of AIUK and the Poppy Project[18]. AIUK, for example, provided information on the physical health symptoms reported by women in the "Stolen Smiles" study in its response to the National Action Plan consultation and to the HAC inquiry:

> Physical health problems were prevalent and concurrent within the first fourteen days after a trafficking experience. Over 63% of women were experiencing more than 11 physical symptoms that caused them pain or discomfort. For example, eight in ten women report headaches and fatigue, between six and seven in ten women report dizziness, sexual and reproductive health symptoms, back and stomach pain, loss of appetite and difficulty remembering (AIUK and Zimmerman 2006).

[18] ECPAT UK also listed a range of physical health outcomes of child trafficking in their submission to the JCHR (including injury, sexually transmitted infections, and skin diseases) but did not give the source of this information. The Glasgow Inter Agency Working Group did not detail the physical health needs of trafficked women but pointed the committee to the "Stolen Smiles" report for information on women's health needs (JCHR 2006a).

Both AIUK and the Poppy Project drew on this information when making specific recommendations in relation to the UK response to human trafficking (this is discussed in detail in sections 5.2-5.3).

When asked specifically to talk about the health needs of trafficked people during interviews, participants from across the spectrum of represented sectors tended to speak about physical health issues arising as a consequence of violence and abuse. Service provider interviewees in particular suggested that women trafficked for sexual exploitation suffered from a range of physical injuries and sexual health problems that required urgent treatment. One service provider, for example, commented that:

> Health problems tend to be as a result of trafficking – so physical health problems, broken ribs, some kind of physical problem – or sexual health problem – which is either related to trafficking or pre-trafficking, but probably relating to trafficking (Service Provider).

The range of reproductive and sexual health problems women suffered a result of sexual violence and abuse was suggested to include unwanted pregnancy and infection with a range of sexually transmitted diseases:

> Obviously when they first come we get their sexual health checked. There's a lot of fear about HIV and AIDS. Some of our women are pregnant (Service Provider).

Service providers also suggested that physical health conditions could be bodily responses to mental trauma:

> They suffer a lot from headaches, violent bad headaches and stomach pains for quite a long...and obviously not being able to sleep when they first come for quite a period of time, really horrendous headaches. And that's all linked to the trauma (Service Provider).

A small number of healthcare providers suggested, however, that trafficked people's needs were relatively ordinary:

> I have to say they're quite general. Nothing specific would stand out for anyone who has been trafficked. Most of them are people who've been sold the story, this notion of you're coming here to work, and what they've found out is that they're just here on a tourist visa and they overstay or they're forced to overstay. And then just general complaints, so nothing specific (Healthcare Provider).

The physical health needs of people trafficked for labour exploitation were commented upon less frequently in submission documents and interviews than were the needs of women trafficked for sexual exploitation. Where health needs were commented upon, for example in the HAC submissions of AIUK and the construction union UCATT, they were suggested to arise primarily from poor health and safety standards:

> AIUK has also received enquiries relating to male and female victims of forced labour and domestic servitude where the victims have suffered physical injuries due to overwork and breaches in health and safety regulations (HAC 2009a).

This section has shown that two narratives existed within discussions about the health of trafficked people: firstly, a "high-harm" narrative that related to women trafficked for sexual exploitation, and, secondly, a comparatively "low-harm" narrative that related to men and women who had been trafficked for labour exploitation. Women trafficked for sexual exploitation were believed to experience higher levels of violence than people trafficked for labour exploitation, whose physical health needs were more commonly attributed to occupational accidents. These experiences of high-level violence amongst women who had been trafficked for sexual exploitation, particularly sexual violence, appeared to underpin stakeholders' beliefs that these women suffered from more serious physical and psychological health problems than did people trafficked for labour exploitation.

5.2 Drawing on descriptions of "violence" and "trauma" to establish trafficked people's need for support

This section presents evidence to show how discourses of violence and consequent physical and mental harms were used by NGO advocates, service providers, and lawyers in the recommendations they made in relation to the nature of trafficked people's support needs, the duration of these needs, and how these needs should best be met.

5.2.1 Establishing the support needs of trafficked people

Analysis of interviews with stakeholders who were active during the earliest years of the UK trafficking policy subsystem, and of documents and meeting minutes from that time, indicates that the provision of support services to women and children who had been trafficked to the UK was an early lobbying goal for NGOs. One advocate stated, for example, that:

> Eaves were paying for the support of trafficked women out of their own money back in '99. And then they, basically we lobbied the government, and they lobbied the government... for a pilot project whereby they would have bed spaces for [trafficked women]... Then we lobbied for an extension (Advocate).

In 2003, the NGO Eaves Housing was funded by the government to establish the Poppy Project, which would provide support and accommodation to women who had been trafficked to the UK for sexual exploitation (Taylor 2004). Meeting minutes from the Counter Trafficking Link Group and the Counter Trafficking Victim Subgroup (two early stakeholder groups that brought together a small number of NGOs, police officers and Home Office officials), show that the Poppy Project operated at or near capacity between 2003 and 2005 and that NGOs were concerned to secure further funding to maintain and expand the provision of support to trafficked women (CTLG 2002-2004; CTVSG 2002-2005).

Documents submitted to the National Action Plan consultation and to the two parliamentary inquiries into trafficking show that NGO advocates and service providers suggested to policymakers and parliamentarians that women trafficked for sexual exploitation (and trafficked children) had multiple and complex support needs. These needs included: accommodation; counselling and healthcare; legal support; liaison and advocacy within the immigration, criminal justice, and benefits systems; and language training, education, and skills development. The Poppy Project's response to the consultation to the National Action Plan on Tackling Human Trafficking stated, for example, that:

> Although each individual's needs are different, and the priorities and level of need vary at different stages of their post-trafficking situation, in the experience of the POPPY Project, trafficked women have the following support needs: safe accommodation, food and subsistence allowance; interpretation and translation services; physical, sexual and mental

> health assessment and services, including counselling, available as required; general support and advocacy; legal information and advice, including regarding asylum; educational opportunities; advocacy and liaison with police and immigration, including information about the implications of assisting the authorities; protection from prosecution for immigration, prostitution or drugs etc offences relating to the trafficking process; a reflection delay to allow them time to start to recover and to make informed decisions about their future; not be removed if there is a reasonable suspicion that they may suffer harm through reprisals, stigmatisation or discrimination; detailed information about options for returning and exploration of services available within the country of origin; law enforcement and NGO contacts in country of origin and the UK for returning women; assistance in developing safe options on return to reduce their vulnerability to re-trafficking; state funded witness support and protection for women who decided to give evidence in court against their traffickers; In-court support, protection and legal assistance; and compensation for all victims regardless of whether they participate in court cases (Poppy Project 2006a).

Similarly, the Salvation Army recommended that "a total of 100 beds are offered in 8-12 centres each with 8-12 beds. These should provide intensive assessment and ongoing support and care delivery on a 24hr-staffed basis along the lines of a safe house or refuge similar to domestic violence models" (Salvation Army 2006), and ECPAT UK, a charity that advocated on behalf of trafficked children, stated that it considered "the appropriate safe house model to be a holistic and integrated approach with other support services that can provide an interface with specialist legal, interpreting, medical and counselling services" (ECPAT UK 2006).

The research found that advocates and service providers suggested that trafficked people's support needs emerged from the physical and psychological harms they suffered as a result of being trafficked, their ongoing risk of harm from their traffickers, and their situation as migrants in the UK. Analysis showed that AIUK and the Poppy Project in particular called for the provision of specialist support services on the grounds that women trafficked for sexual exploitation required support to recover from the physical and psychological health consequences of their experiences:

> Psychological consequences among victims of trafficking are often acute and frequently long-term...POPPY recommend that the UK action plan on trafficking continues to provide

> support and assistance which enables women and children to overcome the trauma of their experiences of being trafficked (Poppy Project 2006a).

As shown in section 5.1, the majority of stakeholders in the trafficking policy subsystem believed that women trafficked for sexual exploitation experienced high levels of sexual violence. The research found that a number of advocates therefore argued that the response to trafficking should draw upon existing best practice models for working with female victims of violence. In particular, advocates and service providers suggested that post-trafficking support services should be based upon, or provided by, refuges for women who had experienced domestic or sexual violence. This recommendation was made, for example, in the National Action Plan consultation submissions of AIUK and LSHTM, the Poppy Project, the Salvation Army and the Anti Trafficking Alliance:

> Organisations such as Women's Aid, that have a history of providing women focused services and working with survivors of sexual violence, could potentially provide specialist care and support to victims of trafficking if appropriate funding and training was provided (Poppy Project 2006b).

The same advocates also made this point at policy meetings. At the February 2006 meeting of the Joint NGO Ministerial Group, for example, the AIUK representative "encouraged the use of specialist NGOs with proven records of supporting victims of violence – particularly sexual violence – to provide support for victims of trafficking (e.g., Women's Aid)", and in May 2006 the LSHTM representative queried why assistance was "not available through domestic violence groups, [which] are accustomed to rape and sexual violence" (JNMG 2005-2010). The minutes show that policymakers seemed to accept these arguments, and when the coverage of funded post-trafficking support was expanded in 2009 to include Sheffield and Cardiff the Poppy Project partnered with two NGOs who provided support to women experiencing domestic and sexual violence to do so (Eaves 2009).

Other best practice measures suggested by NGO advocates and service providers included the provision of same-gender interviewees and interpreters during police and immigration interviews and specialist training for asylum caseworkers and police officers on interviewing trafficked people. AIUK recommended, for example, in their submission to the HAC inquiry that:

> When trafficked persons who are reasonably suspected of having been subjected to sexual violence or sexual exploitation are interviewed to establish identification they should be entitled to the same "best practice" procedures from the police as other victims of rape and sexual violence in the UK, for example female victims should only be interviewed by female officers (HAC 2009a).

Recommendations were also made on this basis for the allocation of independent advocates in the criminal justice system, the inclusion of trafficked women on the list of witnesses who were likely to be vulnerable or intimidated and therefore entitled to special protection measures in court, and specialist training for prosecutors:

> Trafficked women should be accompanied by an independent support worker during police and immigration interviews...trafficking cases should be added to the list of cases likely to give rise to intimidated witnesses (Poppy Project 2006a).

In contrast, analysis of submission documents found that although a number of NGO advocates and service providers called upon the government to provide support services for people trafficked for labour exploitation, their calls did not have a comparable degree of specificity in terms of the services needed and did not draw on models of best practice provision:

> There is a complete absence of protection and support facilities available to people trafficked for labour exploitation...Other countries have already started to identify the needs of people trafficked into labour exploitation and indicate that they have a broader set of needs because of the variety of different settings in which they find themselves (ASI 2006a).

During interviews, service providers, NGO advocates and civil servants suggested that people who had been trafficked for labour exploitation had much lower support needs than women who had been trafficked for sexual exploitation, and attributed this to the differing levels of physical and sexual violence experienced by these two groups. One service provider, for example, stated that:

> Everyone's experience so far [is that] labour exploitation victims can be moved much more quickly through a system to a satisfactory outcome...You can have a victim of sexual exploitation who can be dealt with very quickly, who actually doesn't need a whole range

> of counselling and so on, and you know...Similarly, you can have labour exploitation cases who are deeply traumatised and need to be held in the system... [But in] general it would appear from the work that we've done so far, the work that other service providers have done, that there are those differences (Service Provider).

Similarly, a civil servant suggested that because of the lower incidence of violence amongst people trafficked for labour exploitation, the support needs of this group were less intense than those of women trafficked for sexual exploitation:

> The emerging findings are that victims [of trafficking for labour exploitation] particularly just want to go back to work. So even if they have health needs, they're not necessarily as willing to show it, and it might not be the same psychological or physical impact that sexual violence has on an individual (Civil Servant).

Contrasting the provision of government-funded services for people trafficked for labour exploitation and sexual exploitation suggested that discourses of violence may have been important in mobilising resources for the provision of support to trafficked people. Table 11 uses information published by the government and also information provided for the research by service provider organisations to compare the establishment, usage and funding of centrally funded post-trafficking support services in England and Wales.

Table 11: Comparison of centrally-funded support services for people trafficked for sexual exploitation and labour exploitation

Type of Exploitation	Date established	Number of supported cases	Funding provided for the period 04/09-03/10
Sexual	Piloted 2003 and funded thereafter	Feb 08-Feb 09: 101 (34 accommodation, 67 outreach)	£1,850,000
Labour	Piloted 2008 and funded from 2009	June 08-March 09: 75	£100,000

(Taylor 2004; Eaves 2009; HAC 2009a; Home Office 2009b; Migrant Helpline 2009; Personal Communication 2010b)

As shown by Table 11, whereas support for women trafficked for sexual exploitation had been continuously funded since it was first piloted in 2003, no centrally-funded specialist accommodation or support was available for either men or women who had been trafficked into forced labour until 2008 (Taylor 2004; Home Office 2009b). This did not, however, seem to be related to the demand for services: the Poppy Project, for example, provided accommodation and support to 34 women and outreach support to 67 women in the twelve months between February 2008 and 2009 (HAC 2009a), whereas the Migrant Helpline supported 75 people who had been trafficked for labour exploitation between June 2008 and March 2009 (Migrant Helpline 2009)[19]. There was also a substantial gap in funding. In April 2009, Migrant Helpline received £100,000 to support and accommodate men and women who had been trafficked for forced labour for one year (Personal Communication 2010b). This funding was exhausted by December 2009, and no further centrally-funded referrals were supported until the contract was renewed in April 2010. A contract equating to £1,850,000 per year was provided to a Poppy Project-led consortium of NGOs for the same period to support women trafficked for sexual exploitation and for domestic servitude (Eaves 2009).

Moreover, the tender issued by the Ministry of Justice in April 2009 for the expansion of support services for women who had been trafficked for sexual exploitation called for the provision of a large number of services that might be thought of as appropriate for victims of high-level suffering. These included: safe, flexible and gender-appropriate accommodation; living expenses; interpretative and translation services; individual risk and needs assessments; one-to-one advocacy and key-worker service; liaison with criminal justice agencies, UKBA, health services, social services, and voluntary return programmes; information on rights and options; information and support in reporting a crime; access to counselling services, health care, immigration advice, and employment opportunities; and assistance in claiming compensation (Dias 2008).

Although this list closely matches the Poppy Project's previously-quoted recommendations, which themselves appeared to have emerged out of the "high-harm" narrative used to establish the multiple and complex needs of trafficked women, analysis suggests that the similarities cannot necessarily be attributed to advocates' and service providers' use of such a narrative. The tender

[19] Figures for the number of people supported following sexual exploitation and labour exploitation are not directly comparable. In addition to the centrally-funded Poppy Project, a number of charitable organisations provide support for this group. Furthermore, people trafficked for labour exploitation tended to arrive at the Migrant Helpline in groups, following workplace raids. 54 of the 75 people supported in the period presented, for example, had been identified in two major police operations (Migrant Helpline 2009).

states that services' first aim should be "to provide safe and appropriate accommodation and support in compliance with the Council of Europe Convention against Trafficking in Human Beings", and, when analysed against the requirements of ECAT, the service specification can be seen to provide for little that exceeds what the UK is obliged to provide (Council of Europe 2005; Dias 2008)[20].

Indeed, further analysis casts doubt on the effectiveness of narratives of harm in persuading the government to establish support services for trafficked people. During interview, one service provider stated, for example, that she did not believe that the government's initial decision to provide support services for women who had been trafficked for sexual exploitation had been motivated by a concern for women's health and well-being:

> I think for them, part of the allure was one the immigration component and realising that this was one stream of undocumented persons in the country and the possibility of looking at it from an organised crime perspective and looking at criminal networks and gaining information about all of that and sort of cracking down on the criminal side of it. So, there were things for them, they were going to benefit (Service Provider).

This belief seems to find support in early policy documents on responding to trafficking. The 2002 White Paper on immigration, "Secure Borders Safe Havens", stated that the government's intention was to trial the provision of support to trafficked women who were willing to come forward and work with the authorities:

> We need to offer [forcibly exploited] victims particular support so that they can escape their circumstances and recognise they may be able to help law enforcement against organised criminals. Where such people are willing to come forward, we shall, where necessary, make special arrangements for their protection...we will work with the voluntary sector to put the necessary arrangements in place. This initiative will run on a trial basis for 6 months in the first place so that we can evaluate its impact (Home Office 2002).

[20] Article 12 entitlements include appropriate and secure accommodation; material assistance; translation and interpretation services; counselling and information, particularly as regards their legal rights; assistance in criminal proceedings against offenders; psychological assistance; emergency medical care (Council of Europe 2005). The research was unable to obtain previous service tenders to compare whether the level of required provision changed following the ratification of the Council of Europe Convention.

Furthermore, service providers and advocates in turn used information about the violence women had suffered, and about their consequent mental health needs, to support their lobbying for services to be provided for trafficked women in line with the priorities of the police and immigration services. They argued, for example, that providing trafficked people with appropriate support and protection would improve people's ability to provide evidence to the police and act as witnesses in court, and would similarly improve the quality and consistency of statements in support of asylum applications and leave to remain:

> Addressing health needs will mean that women will be more physically and psychologically capable of offering relevant, consistent and reliable evidence for criminal actions and judicial proceedings against traffickers, thus making the goals of assisting women compatible with that of prosecuting traffickers (AIUK and Zimmerman 2006).

The 2004 evaluation of the Poppy Project also indicated that both the police and immigration services had supported the project's establishment in part because they had hoped that the provision of support would, respectively, assist the prosecution of traffickers and the repatriation of trafficked women:

> [The] success of the project can be viewed in several ways. On the one hand, success could be measured in terms of the standard of service offered to the women admitted to the scheme. On the other, a key driver of the project was the prosecution and conviction of those responsible for trafficking women for sexual exploitation to the UK...Ultimately definitions of success depended on the perspectives of different stakeholders...[the police] focused on the lack of convictions for offences against POPPY tenants and were much less satisfied...For [the immigration service] success would have been to see women placed on the scheme, supported, debriefed and then repatriated (Taylor 2004).

Analysis of other, unpublished, documents also suggests that, having accepted their obligation to provide support and accommodation to trafficked people under ECAT, the government's decision to provide care through specialist services such as the Poppy Project may have been partially rooted in a reluctance to either open up the mainstream benefits system, or to extend the remit of the National Asylum Support Service (NASS), to trafficked people (IND 2006; Home Office 2007c).

5.2.2 Duration of Support Needs

ECAT required signatory states to provide identified victims of trafficking with a recovery and reflection period of at least 30 days, during which time people would be eligible to receive a range of support services and no action would be taken to remove them from the country (Council of Europe 2005). This section presents evidence that demonstrates how NGO advocates and service providers used discourses of health, violence and trauma to support their calls for the government to implement recovery and reflection periods that were set at a minimum of 90 days.

Over a period of several years, NGOs lobbied consistently for the introduction of 90 day recovery and reflection periods during which trafficked people would have access to support services, would be protected from removal by the immigration service, and would not be required to participate in criminal justice proceedings. Amnesty International and ASI had lobbied at the European level prior to and during the negotiation of ECAT for the introduction of automatic three month recovery and reflection periods for trafficked people (ASI 2002; AI 2004). They and other organisations repeated these recommendations at the domestic level. The Refugee Council, for example, recommended in their response to the National Action Plan consultation that:

> [We] believe that **all** trafficking victims should be able to access support, not simply those with international protection needs. At a minimum all trafficking victims should benefit from the following: Minimum of a three month 'recovery and reflection' period, six months for children (Refugee Council 2006, original emphasis).

Similar statements were made in the consultation responses of AIUK, the Poppy Project, the Women's National Commission, CARE, and Stop the Traffik (AIUK and Zimmerman 2006; CARE 2006; Poppy Project 2006b; Stop The Traffik 2006; WNC 2006). Also in 2006, the report of the JCHR inquiry into human trafficking recommended (on the basis of oral and written evidence provided by a number of NGOs) that 90 day recovery and reflection periods be implemented in the UK (JCHR 2006b). Even after the government announced that recovery and reflection periods would be introduced and set at 45 days, NGOs continued to recommend an extension: AIUK and the Refugee Council, for example, repeated their calls for 90 day recovery and reflection periods in their 2008 submissions to the HAC inquiry (HAC 2009a).

The research identified two ways in which NGO advocates, service providers and lawyers drew on discourses of violence, and of physical and psychological harm, to support their arguments for the introduction of substantial recovery and reflection periods and the provision of sustained periods of support. Firstly, these stakeholders suggested that trafficked people needed an extended period of time to recover from the harms they had suffered whilst trafficked. Secondly, they argued that trafficked people were at ongoing risk from traffickers and, if returned, would be vulnerable to both further violence and re-trafficking.

Analysis of the written submissions to the inquiry showed that AIUK, ASI, Women's Aid Northern Ireland and the Solicitors International Human Rights Group had each recommended the implementation of three month recovery and reflection periods to enable trafficked people to recover from the traumatic effects of trafficking:

> Anti-Slavery International believes that trafficked people should have access to a reflection period so that they can be referred to a specialised agency where they can receive assistance and protection. During this time they would have the opportunity to stabilize, to start recovering from their traumatic experiences, receive advice and support, and make an informed decision on whether to co-operate in a prosecution (JCHR 2006a).

Advocacy and service provider organisations also used these arguments to call for the introduction of 90 day recovery and reflection periods in their submissions to the National Action Plan consultation and the HAC inquiry. In the case of AIUK, the Poppy Project, and the Anti Trafficking Alliance, these recommendations were accompanied by information taken from the "Stolen Smiles" research. This research had reported that symptoms of psychological distress reduced much more slowly than did symptoms of physical ill-health. More than half of the women who were interviewed 28 to 56 days after they had entered into support services reported suffering between 10 and 17 concurrent symptoms of psychological distress. After 90 or more days receiving care, however, this dropped to just under one fifth (19%). Furthermore, comparing self-reported symptoms of depression, anxiety, and hostility against a standard female population showed that even after 90 or more days of support, trafficked women continued to show symptom levels well above population norms (Zimmerman, Hossain et al. 2006). The report's suggestion that initial levels of mental health distress amongst trafficked women were such that their cognitive functioning could be impaired, and that women could therefore not be expected either to functionally engage in police and immigration interviews or to make informed decisions about their

safety and future during the early stages of the support process, were repeated by service providers and advocates. The Poppy Project stated, for example, in its response to the HAC inquiry, that:

> Recent research into the health consequences of trafficked women [by Zimmerman et al] recommended that women who have been trafficked need time (up to several months) to recover from their trauma after they have escaped from their trafficking situation before they are able to provide accurate information to law enforcement officials or to make informed decisions about whether they want to risk cooperating with a criminal investigation or not.... victims of trafficking will need time to come to terms with the reality of their situation and the levels of trauma they have experienced. In countries with more established protection mechanisms in place for trafficked women, this is called a reflection period (HAC 2009a).

Analysis of policy submission documents also showed that a small number of advocates, such as ASI and Asylum Aid, commented upon trafficked people's ongoing risk of violence and harm from traffickers when making recommendations for the introduction of recovery and reflection periods. ASI stated, for example, that:

> Without a reflection period it will also be impossible to evaluate whether a victim's life is in danger or whether they may be subjected to rape, torture or some other form of punishment if deported. This is frequently the case for trafficked people and may occur because the victim is re-trafficked or because the traffickers punish the individual and their family (for co-operating with the authorities; as a warning to others; as a punishment for getting caught; or for not paying back the money they owe, etc) (JCHR 2006a).

These statements drew on discourses, discussed in section 5.1, which suggested trafficked people experienced violence and threats of future violence from their traffickers. They did not, however, reference information from the "Stolen Smiles", such as the threats and violence women reported experiencing whilst trafficked or on the high reported levels of pre-departure violence.

Interviews with service providers and NGO advocates supported the findings of the document analysis. Service providers suggested, for example, that the impact of the abuse and violence that trafficked people had suffered was argued to be such that trafficked people required relatively long-term support to recover from their experiences and reintegrate into society. One service provider,

for instance, felt that women trafficked for sexual exploitation would not be ready to return to employment after the 45 day period of support that the UK allowed:

> In terms of victim care as well, you've got to assess that someone is going to be able to work after their [45 day] reflection period has finished. Great, off you go - get a job! I mean that's not realistic for a lot of women, for probably the majority of women (Service Provider).

In informal conversations, service providers spoke about the Competent Authorities' failure to meet the guide times for reasonable grounds and conclusive grounds decisions as a "double edged sword", as it enabled women to stay in support services longer than the official timetable would have otherwise permitted (Fieldnotes 2010a).

Advocates also argued that the harms sustained during the trafficking process meant that the minimum 30 day reflection and recovery period guaranteed under ECAT was insufficient for people to recover from their experiences to the level at which they could make reasonable and informed decisions about their future, including in particular whether they wanted to cooperate with police investigations against their traffickers and whether they wanted to return to their countries of origin:

> We had an old, old case, it was two and a half years ago that she left us. It's only now that she's decided to talk to the police, she's ready. Whereas you get other women who are grabbed out of the brothel by the police, who take them for a 24 hour interview ...then they come to us and they don't know what the hell has happened, they don't realise that they've just given a statement let alone that they're going to have to go to court and give evidence against the traffickers. So for us it's really important that there's even a 30 day reflection period to allow them to weigh up if they can do it (Service Provider).

The potential ongoing risk of harm that women faced from their traffickers, including the risk of re-trafficking should they be returned home, meant that these decisions required serious consideration:

> I think in terms of convictions probably the police get more from women straightaway than they do if they let them have a bit of time to think. Which is difficult. Because on the one hand I think we've got to have more convictions, we've got to. But at the same time I know the risk on return is massive, or risk to the family (Service Provider).

Service providers, advocates and lawyers suggested that whilst women's fear of their traffickers necessitated their ongoing assessment, support and protection, some women were unaware, or unable to comprehend, the risks they face:

> We have a really vulnerable woman at the moment, who although is very good at her safety, she came into touch and is living beside, just perchance, by someone that is the brother of a childhood family friend...and it was well, can we talk about that? Is there an implication that that is maybe, that that person would maybe contact someone back in your home town? Because people are looking for her at the moment in her home town and over here...And she was like, oh, right. You could see it being processed. We might have to link in there and get her relocated with her flat (Lawyer).

The time required by service providers working with trafficked women to assess the risks they faced, as well as the needs they had, and to make arrangements to ensure the women's safety, was therefore a further reason for requiring an extended period of support and protection.

Comparing responses to labour exploitation and sexual exploitation demonstrates how concepts of violence and harm were also important in establishing the need for prolonged period of support and protection:

> The reflection period has got to be great, I mean it's absolutely fantastic, a real step forward. But I don't think there's any expectation, or in fact with any case of any type, that you actually need to use this up. It's not 45 days to make your decision. And it can be renewable. We would expect, based on experience, and they're always different so there'll always be the odd one, but in general terms we would expect victims of labour exploitation to make their decisions very, very quickly...I think, for good reasons, that there's an expectation that in the pure labour exploitation it's not really needed (Service Provider).

The efforts of NGOs and service providers to secure 90 recovery and reflection periods for trafficked people appeared to have been only partially successful. From the inception of the Poppy Project, women receiving the project's support had access to a four week recovery and reflection period, but trafficked people accessing support from other projects were not entitled to this support

until the entry into force of ECAT in April 2009[21]. Following the entry into force of the ECAT, a 45 day recovery and reflection period was introduced; 50% longer than the minimum required by ECAT, but only half as long as the NGOs had campaigned for. One civil servant acknowledged that research had suggested that women trafficked for sexual exploitation would need 90 days or more to recover from their trauma, but suggested that a 45 day period balanced the needs of trafficked people with the "risks" introduced by this provision:

> We held a workshop about the recovery and reflection periods, looking at the risks. And in terms of the decision to go for the 45 days, I think it's a time that has been used in other countries as well. But I think it's, the most important thing for me in that decision was around the fact that it's flexible. So as [the "Stolen Smiles"] report suggested, some victims, due to the level of trauma, will need 90 days. And I think our approach shows that it can be flexible enough to accommodate that. If you need 90 days, if you need longer than 90 days for the recovery and reflection period, that's fine (Civil Servant).

Other civil servants mentioned the need to assess the risk of setting the recovery and reflection period at different lengths. Further probing indicated that the government was nervous about providing too long a period of temporary admission, lest it become an incentive to make false claims:

> The risks are about avoiding people presenting as victims when they're not. So that we can get on with the business of looking after victims. So you don't really want a system that's being abused by people other than victims. But on the other hand, it's a temporary period, it's not going to be, it's not giving anybody a permanent right to stay. It's merely saying okay, you've got X days to recover from your ordeal before a final decision is made (Civil Servant).

This research thus suggested that advocates' and service providers' harm-based arguments were ultimately insufficient to fully overcome concerns about creating incentives to abuse the immigration and support systems, particularly where those arguments supported recommendations for introducing what policymakers saw as potentially overly generous provisions.

[21] The period of support that trafficked people could access from voluntary organisations was not time-limited per se, but these services could not offer protection from immigration removal. Recovery and reflection periods were piloted for people trafficked for labour exploitation during Operation Tolerance (May-September 2008) but were then withdrawn until ECAT came into force (Home Office 2009b).

5.3 Ensuring Access to Support

The research found that policymakers were concerned that arrangements for the support and protection of trafficked people would be abused by fraudulent applicants. In order to access support and protection, people were therefore required to prove that there were grounds to believe that they had been trafficked. This section discusses how advocates used discourses of violence and trauma to mitigate the risk that applicants would be deemed "not credible" within the claims process and shows how information about the health of trafficked people was used in support of this process.

5.3.1 Abuse of the System

As stated in section 5.2.2, documents suggest that the government feared that the support and protections required under ECAT would be abused either by people coming to the UK with the intention of making false claims of having been trafficked or by people who were already here but who had not been trafficked. In 2006, for example, the Home Office stated in its consultation for a National Action Plan on trafficking that:

> We have a serious concern that implementing [automatic granting of reflection periods and residence permits] might act as a "pull" factor to the UK. For example, they could be misused by individuals seeking to extend their stay in the UK, where they do not have a genuine claim as a victim of trafficking. Dealing with fraudulent applications will slow down our ability to respond to genuine claims (Home Office 2006b).

Internal Immigration and Nationality Directorate (IND) documents from the same time also illustrate fears amongst immigration officials that the provision of reflection periods and support to trafficked people would encourage fraudulent applications from people already present in the UK and act as a pull factor to those who wished to come to work illegally in the UK:

> Elements of the Convention such as the provision of a 30 day reflection period during which time removal is prohibited, a guarantee of support and protection, and a lack of built in safeguards to ensure that victims must maintain contact with the authorities will, it is believed, encourage those who wish to stay in the UK without genuine basis to make a claim to be a victim...[and] could provide a sufficient pull factor to those wishing to come

> and work in the United Kingdom illegally as there would be a "safety net" should they be apprehended (IND 2006).

Further documents also show that these concerns remained once the government had signed ECAT in 2007. For example, an internal Home Office paper assessing the relative advantages and disadvantages of potential models of support stated that:

> [The expansion of the Poppy Project model is] Convention compliant...[and would] place non UK national victims on a level playing field with UK national victims of crime...[but] support arrangements may be a 'pull factor' and will result in false claims (Home Office 2007c).

Although all interviewees tended to accept that some abuse of the support and protections made available to trafficked people under the terms of ECAT was inevitable, they disagreed as to the likely extent of the abuse and in their opinions of how this risk should have been managed. Civil servants and enforcement officials tended to suggest that the risk of abuse was higher than NGO advocates, service providers and lawyers did. One enforcement official asked to talk about what he believed to be the negative aspects of the UK response to trafficking to date stated, quite simply, that:

> Everyone has understanding [of the NRM], which does set us up for abuse. The worry is how many people...There's a danger, straightforward, of untrue claims. Where people abuse the system who haven't been trafficked and pretend they have (Enforcement).

A civil servant interviewee also commented that the risk of fraudulent claims was ongoing:

> In the early stages as well, there was obviously some of the concerns around whether if you open up specific support provisions for victims of human trafficking, whether it would result in false claims...it was always about whether you know, immigration lawyers, or exactly what happened perhaps with the asylum system – whether you'd be creating a new, a second asylum system. So, that's a risk. It is a risk and it still is a risk, it's something that you can't ignore. You will get false claims (Civil Servant).

The asylum system was believed by civil servants to be heavily abused by fraudulent applicants and, as illustrated by the quotation above, they were concerned that the NRM should not be vulnerable to similar levels of abuse. In contrast, most advocate groups, service providers and lawyers played down the risk of abuse and expressed frustration with what they saw as a system that had been designed according to principles of immigration control. One NGO advocate commented, for example, that:

> Already we're seeing problems with [the NRM]. And that's simply because we weren't listened to, because of a government agenda to do border control (Advocate).

Another interviewee, a lawyer, suggested that the Home Office's preoccupation with fraudulent claims could lead to genuine applicants being denied protection:

> I mean, any system yes, is open or vulnerable to being abused. But that doesn't mean that the genuine victims shouldn't be helped or afforded protection... the Home Office say they don't believe – their default position is that you're not credible, we don't believe you (Lawyer).

Conversely, a small number of NGOs did suggest that the support and protection arrangements for trafficked people were being abused. One NGO advocate, for example, believed that women were entering into support organisations in order increase their chance of regularising their status and implied that NGOs were "complicit" in this process:

> Someone else rang... the long and short of it was that it wasn't that they were trafficked, they were just annoyed that the person [they were working for] kept the money that they shouldn't have...I rang the Poppy Project, said I'd like to refer somebody, and they didn't need telling twice that the person was trafficked....They've got more chance of getting papers through going to the Poppy Project and saying the right things. So there's all kinds of abuses going on and complicity going on (Advocate).

A second NGO contact also stated that the NRM was being abused by fraudulent claimants and drew a connection between the misuse of the asylum system and the NRM. Field notes show that a service provider relayed, during a training day presentation, how "a lady from Sierra Leone presented in Belfast [and applied to the NRM] and her story had already been used, word for word,

sixteen times [by other asylum and NRM applicants] so far. It turned out that she had absconded from the asylum system six years ago" (Fieldnotes 2009f).

5.3.2 Questions of Credibility

Perceptions that the support and protection arrangements for trafficked people would be abused by fraudulent applications led to concerns about the credibility of people's claims to have been trafficked. This section presents evidence on the factors that were suggested by stakeholders to damage the credibility of trafficked people's applications for support and protection, and discusses how they used discourses of violence and trauma to overcome negative credibility issues. The NRM was not operational during the time in which the majority of the key stakeholder interviews were conducted, so detailed analysis of the extent to which credibility arguments were used within this particular system is not possible. This section therefore discusses the issue of credibility primarily in relation to trafficked people's claims for asylum in the UK[22]. Field notes and meeting minutes suggest that the credibility issues raised in relation to trafficked women's claims for asylum are also relevant, however, to their treatment within the NRM. The minutes of the six month NRM review workshop, for example, note that "attendees had concerns that the weight of credibility that is applied during the asylum process is also being applied in the trafficking process and that this is counter to some of the guidance provided" (UKBA 2009b).

Service providers, NGO advocates and lawyers stated during interviews that negative credibility was the most common reason for refusing trafficked people's claims for asylum in the UK. During interviews, one lawyer stated simply that:

> Credibility is a massive, massive issue. People are found not to be credible (Lawyer).

Similarly, an NGO advocate commented that:

> There's so much around credibility issues with people subject to immigration control, especially if at any point they're making allegations that they've been abused and they

[22] Statistics for the proportion of trafficked people who have claimed asylum in the UK are not available. Between March 2003 and August 2005, 32 women who were supported by the Poppy Project applied for asylum (Richards, Steel et al 2006).

> should be allowed to stay in the country or be able to access specialist services because of that (Advocate).

Current UKBA guidance on assessing the credibility of asylum claims highlights the importance of the internal coherence and consistency of claims, the level of detail provided by the applicant, and the claim's consistency with generally known facts and information about a person's country of origin. It also states that the benefit of the doubt should be given to claimants when "the person has made a genuine effort to substantiate his asylum claim; [and] all material factors at the person's disposal have been submitted; [and] the person's statements are found to be coherent and plausible; [and] the person has made an asylum claim...at the earliest possible time; [and] the general credibility of the applicant has been established" (UKBA 2010a). During interviews, NGO advocates, service providers and lawyers claimed that in the context of trafficked people's claims for asylum, credibility issues typically arose firstly as a result of trafficked people's late disclosure of their experiences, secondly because of their inability to provide a detailed and coherent account of these experiences, and finally because claimants were not believed to be "generally credible". One advocate noted, for example, that:

> There are issues around the Border Agency staff disbelieving women or saying well, you've only disclosed [that you're trafficked] now you're at the end of the asylum process (Advocate).

In their submissions to the JCHR and HAC inquiries and in organisational reports, NGOs and service providers also published extracts from the asylum decision letters given to trafficked women which highlighted these three issues. For instance, the Poppy Project report "Hope Betrayed" includes examples of decision letters that gave negative credibility decisions on the basis that women had not claimed asylum at the earliest opportunity:

> The Secretary Of State [...] notes that you only claimed asylum on 15th March 2002 after you had worked illegally as a prostitute in the United Kingdom. By making your application for asylum after several months without a valid believable reason for not claiming on arrival, you have failed to do so. He concludes that you have fabricated your basis of claim in an attempt to prevent your removal from, and remain in, the UK, and that your application is an abuse of the UK's asylum provision (Richards, Steel et al. 2006).

Extracts from the decision letters also showed that women's claims were rejected because they were unable to provide adequate details about their experiences:

> It is noted that at your asylum interview you were very unsure of dates, which, if your claim were true ... should have been firmly impressed on your memory. Failure to recollect dates integral to your asylum claim seriously undermine[s] the credibility and veracity of your account (Richards, Steel et al. 2006).

The remainder of this section demonstrates how immigration lawyers, service providers and NGO advocates have drawn upon trafficked women's experiences of violence and trauma when trying to explain patterns of seemingly inconsistent behaviour and reduce the likelihood of negative credibility decisions being made against them. Similar arguments were also used by enforcement officials in the context of explaining why trafficked women did not engage with the police service and why they may face difficulties giving evidence against their traffickers.

5.3.2.1 Not making a claim at the earliest opportunity

Enforcement officials, immigration lawyers, service providers and NGO advocates all claimed that the physical and psychological control traffickers held over the women they were exploiting prevented women from escaping, seeking protection and disclosing their experiences. Trafficked women's perceived fear of future harm to themselves or their families at the hands of their traffickers, for example, was suggested by non-governmental stakeholders to be a key reason why trafficked women may refuse to engage with services and disclose what had happened to them. One service provider stated, for example, that:

> They don't always tell you everything in the beginning; they change their story because they're too frightened to tell you about it, because it might track back to their family (Service Provider).

Moreover, analysis of interview data suggested that most stakeholders seemed to believe that trafficked women's risk of future harm was rational. Several interviewees (including advocates, service providers and enforcement officials) spoke about the ability of traffickers to locate, and harm, trafficked people both in people's country of origin and in the UK. One enforcement interviewee commented, for example, that:

> It might be in some countries that they've got extended families and the traffickers have got real control in the areas they come from, and being realistic there's hardly anything that we can do (Enforcement).

A number of service providers also spoke about the precautions they were required to take to ensure that their clients could not be located by traffickers:

> We don't disclose the house address unless we really, really have to. Obviously the ambulance service, if we ever need to call them, have to know, but we always get them to take it off the records. So we're very careful about where the address is stored (Service Provider).

A number of service providers and NGO advocates, as well as some enforcement officials and healthcare providers, also spoke about how women trafficked for sexual exploitation were refused control over the clients they saw and the number of hours they worked; were denied food, sleep, and contact with other people; and, in particular, had no freedom of movement:

> Certainly our experience is of women who've been terrified in the night... can't sleep in their own bedroom because they've been locked in a cellar for six months and brought up and raped twelve times a night and locked back down in the cellar (Service Provider).

A healthcare provider who received referrals from the Poppy Project similarly suggested that some women who had been trafficked for sexual exploitation were physically imprisoned by their traffickers:

> I think the only way that they can get access [to services] is when they get picked up by the Poppy Project or some other organisation, or the police. It's only when they kind of get out of that. The traffickers are not going to [let them out] because then they might run away...A lot of them just seem to be kept prisoner, really (Healthcare Provider).

An implication of believing that women were imprisoned by their traffickers was that they were physically unable to escape their traffickers. More often, however, stakeholders emphasised that

traffickers' psychological control of women prevented women from leaving or disclosing their experiences:

> Traffickers...create a complex web of control through debt bondage, psychological violence and threats...to put their victims into a situation of total dependence, where victims are scared or too intimidated to escape or reveal what happened to them (ATMG 2010).

Other control tactics that service providers, NGO advocates and enforcement officials suggested were used by traffickers included restricting women's access to their earnings, identity documents and other possessions, and instilling in women a distrust of the authorities. Trafficked people's fear of the authorities was believed by these stakeholders to be particularly relevant to understanding why they might not leave or report their experiences. They spoke about how traffickers convinced women that if they spoke to the authorities they would be arrested, deported, or even returned to the trafficking network:

> Particularly with the nature of trafficking, where a woman has been in a situation of exploitation in this country for a long period of time, one of the elements that has tended to keep them in that exploitative situation is this instilled fear of the trust of authorities. Of lawyers, Home Office, police, social work. So you have to really...that can take quite a while to combat that, and to bring that down (Lawyer).

In explaining why this threat might seem real to trafficked people, these interviewees generally made reference to the "corruption of overseas police forces" and the subsequent belief amongst many migrants that the authorities were not to be trusted. These stakeholders also reported, particularly during the earlier years of the response to trafficking, that traffickers instructed that if they came into contact with police or immigration officers they should refuse assistance and claim that they wanted to be returned to their country of origin:

> Reports from women on the scheme show that traffickers tell trafficked women that they must tell police that they want to go home, and that if they are with the police for a long time the trafficker will assume that they are speaking about the trafficking, and will consequently harm the family of the trafficked person. Trafficked women frequently may

> say they want to go home because of this, rather than because they have made a genuine decision to return (Poppy Project 2006a).

A number of NGO advocates and healthcare providers, however, also spoke about the potential for deportation as being a real risk that they had to consider when deciding whether to refer migrant sex workers who they suspected of having been trafficked onto support services:

> We would have reported [that the women were trafficked] and the flats would have been raided. Very unsympathetically, because that's the way it works. Immigration would have been involved. The women would not have dobbed in their traffickers. [Activists] never tell you about the times when immigration and the police come in, rescue trafficked women and the trafficked women go "fuck off, I don't want to be rescued". And guess what happens? They get deported (Healthcare Provider).

Finally, some interviewees also suggested that trafficked people might not leave their exploiters or engage with services because they did not believe themselves to be trafficked. Although most stakeholders suggested that people did not understand that they were being exploited because they did not realise that their pay and conditions would be considered unacceptable in the UK, a minority of NGO advocates partially attributed trafficked people's failure to self-identify to their experiences of trauma. In their submission to the HAC inquiry, for example, AIUK stated that "for trafficked persons difficulties including physical and mental health problems, shame, fear of removal from the UK, fear of being criminalized, fear of traffickers and of the authorities may prevent victims from recognizing they have been trafficked or from disclosing that they are trafficked especially to the police and immigration" (HAC 2009a).

5.3.2.2 Not providing coherent and detailed statements

The research found that information about trafficked people's experiences of trauma was used particularly in relation to why trafficked people might not be able to disclose what had happened to them or provide internally consistent and detailed statements about their experiences in the context of their claims for asylum.

NGOs advocates, service providers and lawyers spoke during interviews about how the psychological impacts of trafficking for sexual exploitation led women to suffer from memory

problems and from poor concentration, which in turn inhibited them from disclosing their experiences. One service provider, for example, stated that:

> If you're looking at all the impacts, or the potential impacts that trafficking will have on an individual, it already affects memory it affects your ability to recall things or to give a good interview if I can call it that....there is bound to be difficulties with memory and credibility issues (Service Provider).

A number of lawyers interviewed for this research had attended training on the impact and management of trauma within the context of an asylum claim. During interviews, immigration lawyers were able to go into detail about medical models of trauma processing and memory loss, and discussed the impact of trauma on concentration and engagement:

> The amateur view is kind of if something really traumatic happens to you, it must be imprinted on your memory. [Turner's] view, which is the view of quite a lot of psychiatrists, is quite the opposite. Which is if you think of your mind taking in information, if a traumatic event happens, the mind has a great difficulty integrating it into your normal memory. And therefore you're likely to miss, misremember when it happened and what happened. So, if you've got somebody who's still very stressed, it's very hard for them to recollect things correctly, all the details (Lawyer).

They also spoke about how they commissioned medical reports for their trafficked clients. These reports commented upon whether their clients' psychological symptoms were consistent with their having been trafficked and the likely impact of these symptoms on their ability to provide detailed information about their experiences. One lawyer stated, for example, that:

> It's more difficult for the Home Office to turn round and say, this client is wholly not credible, she's not a victim of trafficking, when she's been identified by [a psychotherapist] with massive amounts of expertise in this area, as somebody whose symptoms are consistent with being a victim of trafficking. So that's what I would, that's probably the main reason I get [the report] (Lawyer).

Another lawyer commented that she used the "Stolen Smiles" report during asylum claims alongside specific medical assessments that commented upon the mental health status of her client:

> We have used the report Stolen Smiles. Often [laughs]. We do use it. The problem is that it is general information, and actually what has much more impact is using that in conjunction with a specific report that has been done by a psychologist or something, or a psychiatrist, on our client...We get a psychologist or psychiatrist to specifically comment on whether or not our client is suffering from PTSD for instance, [and what] we also want to know is well, what are the effects of that....looking at for instance, PTSD and its effect on memory, being able to be consistent (Lawyer).

The "Stolen Smiles" report stated that women who had been trafficked for sexual exploitation displayed high levels of trauma symptoms and suffered from memory loss and difficulty concentrating (Zimmerman, Hossain et al. 2006).

Analysis of field notes and submission documents also highlighted lawyers' use of trauma-based arguments to explain why women and children who had been trafficked for sexual exploitation were unable to recall and disclose what had happened to them. The Trafficking Law and Policy Forum's submission to the HAC inquiry, for example, claimed that:

> It is also recognised that traumatic experiences lead to dissociation, i.e. inability of a person recall the details of their abuse. These factors affect both adult and child victims of trafficking. Although these facts are known, the credibility of trafficked persons vis-a-vis the asylum system is often doubted precisely for the reason of not being able to describe in detail from the outset what happened to them and when (HAC 2009a).

Field notes taken at a meeting of the Trafficking Law and Policy Forum in 2008 also show that the presenting speaker made a similar statement and commented that "in some cases a person is so traumatised that they cannot talk or remember. It is better to go down the medical route in these cases" (Fieldnotes 2008c).

5.3.2.3 Not appearing to be a credible "victim"

Service providers, NGO advocates, healthcare providers and lawyers identified two further factors which could damage a person's claim for asylum as a victim of trafficking. One related to the discrepancy between the popular image of trafficked people as young Eastern European girls

brought to the UK and forced, by violence and threats, to work in brothels and the often less sympathetic reality of claimants being older women who had previously worked in prostitution:

> Others [immigration judges] are very suspicious, especially when they're older [women]. And just see them as prostitutes. And some of the women will have been vaguely aware of what was going to happen to them but not to the extent... I think if you think there is some element in your client's past that indicates that they have been involved in prostitution before, you need to be up front about that because you've got to tackle that.... if you've got someone who is clearly quite sophisticated, you need to actually tackle that (Lawyer).

Interviewees did not, however, report attempting to mitigate these factors with arguments related to the violence and trauma experienced by trafficked people.

NGO advocates, service providers, lawyers and healthcare providers also commented upon how the credibility of women who had been trafficked for sexual exploitation could be jeopardised if they had returned to their traffickers, or had worked independently in the sex industry, after their initial escape:

> One of my clients did escape, and then went back to her brothel, and that's in her statement and that's in the evidence. And I haven't yet had the decision, but I'd be interested to see whether they kind of understand why she felt like she had no choice but to go back. But given their aim is to say that everybody is not credible, I doubt it (Lawyer).

During interviews, several of these stakeholders attributed women's decisions to return to sex work to their fear of further harm to themselves or their families and to the psychological impact of trafficking for sexual exploitation. The following exchange shows, for example, how one service provider believed that women she thought had been trafficked claimed that they were voluntarily working in brothels because they were too frightened to disclose what had happened to them, and that they returned to the sex industry because they were scared of their traffickers:

> R: They are threatened, they are scared, they fear for their families back home...some of them choose to go back, which is a shame, but it's very complicated.
>
> I: To prostitution?

> R: Yes. They tend to return, yes. But, it's – I mean my experience is that, I find it difficult, for example most of the Africans who are trafficked to the UK and forced into prostitution, they never want to go back to the brothels. They were held there captive and they don't want to go back there. It's more maybe about non-asylum seeking women who claim to say, after the raiding of a brothel, claim to say I'm here in this place with free will and I'm fine. So then we cannot engage with them. If they say I don't need your support, I'm fine, I've got a flat, I live with friends, I do this with free will, I'm not forced into this. Again this is not something we can challenge.
>
> I: Do you feel that those women are trafficked?
>
> R: Yes of course, yes, of course. Trafficked. And there are reasons for them being too scared to disclose this to us (Service Provider).

Analysis of interviews and field notes also found that two healthcare providers attributed women's decisions to return to sex work to the trauma that they had sustained during the trafficking process:

> How can you make an informed decision if you don't understand the reasons for late disclosure, for a continuing bond with the trafficker, for the continued work in sex work, for lying, for involvement illegal documentation? If you don't understand the nature of trauma, then you cannot understand the actions of people who are traumatised. Applying what would seem to be logic does not work (Healthcare Provider).

Other healthcare providers, however, claimed that women's decision to continue in sex work and to have ongoing contact with their traffickers could not necessarily be attributed to traffickers' physical and psychological control over women. Instead, they suggested that women returned to the sex industry because they needed to earn money, and criticised post-trafficking support services for requiring that women exit the sex industry and cooperate with the police as a condition of support:

> Women aren't stupid. Word gets out on the grapevine. So whilst they go yeah, yeah, yeah I want to get out of this situation and then they do and they might go and stay in one of the hostels, when women find out that they can't sex work anymore, and how the hell do you

> earn a living? And when they find out that there's quite a lot of pressure on you [to work with the police], it doesn't matter what these services say because the police and the Home Office do put pressure on...a lot of women disappear from those places (Healthcare Provider).

The research suggested that the use of violence- and trauma-based arguments to prevent negative credibility findings had mixed success. On the one hand, UKBA guidance for caseworkers assessing the claims of trafficked people stated that "women who have been sexually assaulted may suffer trauma. The symptoms of this include persistent fear, a loss of self-confidence and self-esteem, difficulty in concentration, an attitude of self-blame, shame, a pervasive loss of control and memory loss or distortion. Decision makers should be aware of this and how such factors may affect how a woman responds during interview and not automatically draw adverse inferences from a woman's inability to recount details of their experience when assessing credibility" (UKBA 2010b). Moreover, some interviewees reported that consistent lobbying had increased the receptiveness of UKBA case-owners to the effects of trauma on memory and disclosure:

> I guess that is changing, it's getting better, because definitely at the beginning – especially with the asylum process – [health] was never taken into consideration, which was actually a major thing, because it impacts on their credibility (Service Provider).

Others felt, however, that the guidance and training for UKBA case-owners had been insufficient to prevent negative credibility findings being handed down to trafficked people:

> For some reason the Home Office up in Liverpool and Leeds we've got great responses from them, they're like "yeah, she's a victim of trafficking, out go, she's yours, granted". But in then in London – Croydon – it's quite different. But then at the same time we've been into Comms House and Beckett House and we've trained up staff there, case owners, we would hope that they'd make better decisions around trafficking....[the majority of] people get refused at substantive stage and then they get granted at appeal stage – so there's obviously a long way to go (Service Provider).

Similarly, lawyers reported difficulties at immigration tribunals, suggesting that because the submission of medical evidence was by now commonplace in the asylum system, some judges doubted its integrity:

> Remember, an awful lot of asylum seekers are going to have medical evidence of one sort or another. Of variable quality. Which has made some judges more suspicious of it. Their view would be that it's just what the person has told [the doctor] anyway, they're just regurgitating what they were told [by the patient] (Lawyer).

5.3 Summary

This chapter has shown how trafficking, particularly for trafficking sexual exploitation, was understood by many in the trafficking policy subsystem to be characterised by violence and control, and how stakeholders generally believed that trafficked people suffered high levels of physical and psychological harm as a result of their experiences. The chapter also demonstrated how, within a context of government fears about support and protection measures being abused by fraudulent claimants, discourses of violence and trauma were used by many NGOs advocates, service providers and lawyers as a rationale for the introduction of these measures, and then as a means of reducing the likelihood of negative credibility decisions being made against trafficked people claiming support.

Health outcomes information, particularly that from the "Stolen Smiles" report, was believed by stakeholders to attest to the reality of violence and the impact of physical, sexual and psychological abuse on women's health, and its findings were cited directly in the work of immigration lawyers and a small number of service providers and NGO advocates. In particular, the report's suggestion that women's psychological state as a result of having been trafficked impaired cognitive functioning, and that recovery was protracted, was used by these stakeholders to argue for the introduction of 90 day recovery and reflection periods and also to overcome credibility issues within the asylum process.

The research found that discussions of trafficked people's health were, in general, limited to these efforts to augment recommendations to provide support and temporary leave to remain. The next chapter examines how the perceived primacy of immigration and policing priorities within trafficking policymaking shaped stakeholders' participation and advocacy activities within the policy subsystem.

Chapter 6

Results III: Health Representation and Advocacy in the Trafficking Policy Subsystem

"I can't remember anyone specifically saying 'I'm very worried about health needs of trafficked people'. I think the absence of people around the table with any medical expertise on health impacts, it means it just doesn't get raised, because everyone goes in with their particular issue they're concerned about" (Advocate).

This chapter draws attention to the lack of health sector participation in UK human trafficking policymaking and shows that despite stakeholders' rhetoric about the severe forms of abuse associated with trafficking, health was not prioritised as a topic of discussion within the trafficking policy subsystem and that the medical needs of trafficked persons were rarely mentioned.

Policy scholars have noted that "extensive consultation" is a deeply ingrained tradition within British policymaking (Greenaway 1992; Grant 2000) and have argued that the participation of organisations and departments in advisory committees, stakeholder groups, and other policymaking fora enables them to shape how problems are defined, influence the policy agenda, make recommendations, and effect how other recommendations are received (Jordan and Richardson 1987). The activities and interests of groups within the trafficking policy subsystem and their legitimacy to be involved in the response to trafficking were included within the conceptual framework for this research within the "producing solutions" component. It is to these parts of the conceptual framework that the results presented in this chapter primarily relate.

The chapter begins by presenting the various human trafficking policy groups that organisations could attend and demonstrates that the attendance and participation of Department of Health and health sector organisations in these groups was limited. Evidence on how individuals and organisations participated in the trafficking policy subsystem was collected from meeting minutes and attendance lists, field notes from observation at meetings and events, and interviewees' accounts of the groups and consultation events that they took part in. The chapter then shows how certain organisations and government departments appeared to be more heavily networked within the trafficking policy subsystem than others. In particular, it demonstrates that the Department of

Health and the health sector were marginal to the policy subsystem and poorly networked to other departments and organisations at the subsystem core. This section draws on interviewees' reports of their relationships with organisations and government departments, observation of these relationships during policy meetings and events, and on documentary evidence such as joint policy papers. Evidence is then presented to show how interviewees accounted for the variation in organisations' influence within the policy process. It then shows how non-governmental stakeholders spoke about their priorities for advocacy work within the trafficking policy subsystem and presents interviewees' accounts of why health-related issues, including medical service provision, were neglected as topics of discussion in policy groups and documents.

6.1 Opportunities for access and representation in the trafficking policy subsystem

Organisations working across multiple sectors were interested in the development of the UK's response to human trafficking. The summary of responses to the consultation on the UK National Action Plan on Tackling Human Trafficking, for example, stated that submissions had been received from, amongst others, 89 religious organisations, 55 charitable organisations, fourteen police forces, nine government departments, five local governments, four Crime Disorder Reduction Partnerships, three legal organisations and a trade union (Home Office 2006c). This section discusses the participation of the Department of Health (DH) and the health sector in the trafficking policy subsystem. It uses the presence (and absence) of representatives of the DH and the health sector at key policy group meetings as an indicator of their level of involvement.

The research found that multiple groups that worked on the development and implementation of human trafficking policy were established during the period 2000-2010. Based on participant-observation at meetings, analysis of meeting minutes and documentation, and interviews with key stakeholders it was possible to identify six types of group within the trafficking policy subsystem: formal policy groups such as the Joint NGO Ministerial Group (JNMG); agency working groups such as the UK Human Trafficking Centre (UKHTC) Working Groups; ad hoc groups such as the National Referral Mechanism (NRM) Review Workshops; local authority groups such as Local Safeguarding Children Boards (LSCBs); practitioner groups such as the Trafficking Law and Policy Forum; and parliamentary committees such as the Home Affairs Committee (HAC) and Joint Committee on Human Rights (JCHR). This analysis is summarised in Table 12, which gives examples of groups in each of these categories, details their key functions and highlights the participation (or non-participation) of the DH and the health sector.

Table 12: Opportunities for access to the human trafficking policymaking process

Type	Examples	Key Roles	Attended by DH	Attended by health sector
Formal Policy Groups	Inter Departmental Ministerial Group	Bringing together Ministers from across government to scrutinise policy, check progress, and coordinate activity[23].	Yes	N/a
	Joint NGO Ministerial Group	Bringing together Ministers, policy officials and NGOs to discuss proposed policy changes, implementation, and trends, typically with a victim focus.	Yes	No
	Strategic Monitoring Group	Monitoring the implementation of Council of Europe Convention against Trafficking in Human Beings (ECAT).	No	No
Agency Working Groups	UKHTC working groups	Informing policy formulation and implementation in relation to prevention, victim care, operations and intelligence, learning and development, and research	Yes	No
	Child Exploitation & Online Protection working group	Data not available	No	No
Ad Hoc Groups[24]	DH Violence against Women and Girls Taskforce	Developing recommendations to improve the health sector response to violence	Yes	Yes: (Helen Bamber Foundation)
	NGO Anti Trafficking Monitoring Group	Monitoring the implementation of ECAT	N/a	Yes (Helen Bamber Foundation)
	NRM Review Workshops	Reviewing the functioning of the National Referral Mechanism at 6 and 12 months	No	No
Local Authority Groups	LSCBs	Responding to child trafficking as part of local child protection duties	N/a	Yes (Misc)
	Glasgow Inter Agency Working Group	Developing Glasgow's response to trafficking for sexual exploitation	N/a	Yes (Base 75; Compass)

[23] In 2007, the Ministers listed as attending were the Parliamentary Under-Secretary of State for Children, Young People and Families (DCSF), Parliamentary Under-Secretary of State for DfID, the Solicitor General, Parliamentary Under-Secretary of State supporting the Minister for Women and Equality (GEO), a Minister of State for the Foreign and Commonwealth Office, the Minister of State for Public Health (DH), the Parliamentary Under-Secretary of State at the Department for Communities and Local Government, and the Scottish Executive Cabinet Secretary for Justice.

[24] A diverse array of ad-hoc groups, which worked on specific projects, also developed over time. An exhaustive list of these groups is beyond the scope of this section: the table includes the two groups that were known to have health sector representation.

Practitioner Groups	Anti Trafficking Legal Project	Developing advice, training and information on trafficking for legal representatives, conducting policy advocacy	N/a	No
	Law & Policy Forum	Discussing legal developments in relation to trafficking	N/a	Yes (Helen Bamber Foundation)
Parliamentary Committees	JCHR inquiry into human trafficking	Examining the UK response to human trafficking in relation to human rights	No	No
	HAC inquiry into human trafficking	Assessing the progress made by the UK in addressing trafficking	No	No

Table 12 shows that although the development of effective provisions for protecting, supporting and assisting trafficked people were amongst the key roles of several policy groups, the DH and the health sector were often absent. Further analysis of meeting documents and field notes showed that for the groups that the DH and the health sector *did* attend, representatives were few in number and made little contribution during meetings. The possible reasons for this are explored in section 6.3. For example, as shown by Table 12, the DH participated in the Inter Departmental Ministerial Group on human trafficking (IDMG), the JNMG, and in the UKHTC working groups. In each of these groups, however, the department has been represented by only a small number of junior officials and was not involved in establishing these groups or determining their terms of reference. It was not, for instance, an original member of the IDMG, which was established in 2005: meeting minutes show that a decision to invite the DH to participate was made in July 2006 at the suggestion of Vernon Coaker MP, the Home Office Minister with the portfolio for trafficking:

> Health plays an important role in victim care in terms of meeting needs and identifying victims. Vernon Coaker asked the group whether the DH should join. The group thought this was a good idea. The Home Office is to contact the DH to invite them to the group (IDMG 2005-2010).

The dates of the minutes show that the Minister's suggestion was made two months after a presentation by Dr. Cathy Zimmerman to the JNMG, at which he was present, on the health consequences of human trafficking (IDMG 2005-2010; JNMG 2005-2010). Informal conversations with civil servants over the course of this research, and the available meeting minutes, indicate,

however, that the health Minister generally did not attend IDMG meetings and that the department was instead represented by a civil servant (IDMG 2005-2010; Personal Communication 2009b).

The analysis of interview data found that civil servants emphasised the importance of Ministers in the development of the response to trafficking:

> I: Have there been any changes in personnel, either within government or outside of government, that you feel have been important in shaping the direction of trafficking policy?
>
> R: Not really, because I think successive Ministers and successive Home Secretaries have all been very much of one mind actually... I think Ministers is really where the decisions are made (Civil Servant).

The substitution of a policy official for the health Minister during meetings may have therefore reduced the influence of the DH within cross-government decision-making on human trafficking. Civil servants also spoke about the usefulness of the IDMG as a vehicle for checking progress against previously agreed action points. Asked to talk about the role of the IDMG, for example, one civil servant interviewee stated that:

> It's always useful to get a group of Ministers around a table. It's a good way of keeping it on everybody's priority... it also encourages officials, before those meetings, to get together. So you know, you know once a quarter you're going to have to report. So it pushes people to push their agenda further along. And it's useful. If you know you're going to be challenged, if a Minister knows they're going to be challenged by another Minister about an issue, you come with a solution to the table (Civil Servant).

The non-attendance of the health Minister may have therefore contributed to a de-prioritisation of human trafficking as an issue within the DH.

Similarly, the DH was not represented at the JNMG, which was established in 2005, until the tenth meeting of the group in November 2009 (JNMG 2005-2010). Of a total of thirteen civil servants represented at this meeting, one was from the DH, compared to seven from the Home Office and

three from the Office for Criminal Justice Reform (OCJR)[25]. Meeting minutes from the UKHTC show that the same junior DH representative also began to attend the UKHTC victim care subgroup meetings in 2009 (UKHTC 2009b). Whilst the reasons for the timing of DH representation at the JNMG and UKHTC subgroup meetings was not made clear during the research, attendance appeared to coincide with the appointment of this departmental trafficking policy lead in 2009:

> Now Chris has come on board at the DH to look at a more coordinated approach and is looking at taking it forward as part of this new Violence Against Women Taskforce...we kind of approached them and they recognised that there was a gap they needed to fill (Civil Servant).

As shown by Table 12, representatives of the health sector did not attend the JNMG or the UKHTC subgroups, both of which had a strong focus on the welfare of trafficked people. Although the JNMG was criticised by some NGO interviewees for having evolved into a "talking shop" in which everyone turned up and played their "one card", the group did provide a forum in which organisations could press their interests upon Ministers and civil servants. The trafficking of children into cannabis factories, the internal trafficking of British children and the proposed visa amendments for migrant domestic workers were issues which were frequently raised by attendees, and may have otherwise received less attention (JNMG 2005-2010):

> The trafficking of children for cannabis cultivation, trafficking of children for benefit fraud...two years ago it was still considered a non-issue... [I've been] very loud and persistent [laughs]. You've seen me in meetings, you probably know that. Well first of all, the way we will always work is on an evidence based agenda...But every single meeting that I ever go into, I continually mention it (Advocate).

Meeting minutes show that membership of the JNMG has increased substantially over the past five years, from seven organisations in September 2005 to twenty-three in July 2009. Although there are no clear criteria for participation in this group, healthcare organisations have never attended and

[25] Departmental attendance of the JNMG was dominated by the Home Office and Office for Criminal Justice Reform. The Crown Prosecution Service (CPS) and Attorney General's Office consistently attended, however, and from late 2008 the Scottish Executive and Northern Ireland Office often each sent a representative. Other government departments, including the Foreign & Commonwealth Office, Department for Work and Pensions and the Department for Trade and Industry attended sporadically in 2006 but not thereafter. The Department for Children Schools & Families attended in 2006, but not again until 2009 (JNMG 2005-2010).

therefore have not had an opportunity to push for their key issues at this level (JNMG 2005-2010). Documents also show that healthcare organisations did not take up the opportunities to provide feedback on existing human trafficking policies and make recommendations for change that were provided by the JCHR and HAC inquiries into the response to human trafficking in the UK. Written evidence could be submitted by any individual or organisation and the evidence lists of the reports show that three government departments (the Home Office, the Foreign & Commonwealth Office and the then Department for Education and Skills) and twenty NGOs and associations responded to the JCHR inquiry, whilst the Home Office and 35 NGOs and associations provided submissions to the HAC inquiry. Written evidence was not submitted, however, by the DH or by any healthcare organisation (JCHR 2006a; HAC 2009a).

Document analysis showed that representatives of the health sector did attend the Human Trafficking and Harmful Traditional Practices subgroup of the DH's Violence Against Women and Girls Taskforce (VAWGT), the Anti Trafficking Monitoring Group and the Trafficking Law and Policy Forum (Fieldnotes 2007a; Fieldnotes 2007c; Fieldnotes 2008b; Fieldnotes 2008c; Fieldnotes 2008e; Fieldnotes 2009e; ATMG 2010; VAWGT 2010). Representation at each of these groups was, however, provided by a single healthcare organisation: the Helen Bamber Foundation, a charitable organisation that provides psychological care to people who have experienced "gross human rights violations", including human trafficking (HBF 2010)[26]. Field notes show that a representative of this organisation suggested, at a 2008 meeting of the Trafficking Law and Policy Forum, that a mental health subcommittee be formed:

> Robin stated that there was a lack of consistency on the data that was captured and thus in understanding. Pooling our approach to instruments would strengthen our position, for example in legal and immigration cases: there is a need to generate clinically based evidence. This work should be done by a mental health subcommittee (Fieldnotes 2008b).

The field notes also show, however, that this suggestion was not discussed further by the attendees, who included post-trafficking support providers, advocacy-based NGOs and lawyers. To date no such health practitioner group or committee has been developed.

[26] Other healthcare providers with expertise in female genital mutilation, honour-based violence attended the VAWGT subgroup, but the Helen Bamber Foundation was the only healthcare organisation in attendance that worked with trafficked people.

Enforcement officials, local government interviewees and child trafficking advocates reported that healthcare providers attended the local trafficking policy groups that had formed in some areas, usually focusing on child trafficking and operating under the auspices of local authorities[27]:

> Certainly, the awareness of child trafficking has grown within the last five years. The Local Safeguarding Children Boards, to respond to that, has set up a child trafficking subgroup, child trafficking and exploitation. Which is very multi-agency. So it includes all of the statutory agencies. Health, children's social care, but also UKBA and some of the big NGOs, like ECPAT, and CEOP (Civil Servant).

Local authorities were required under the 2004 Children's Act to establish LSCBs, which brought together a range of professionals, including local healthcare representatives, to safeguard the health and welfare of children (Great Britain 2004b). Documentation from LSCB trafficking subgroups was not available for inclusion in the research, but interviewees who attended these meetings suggested that the health sector representatives rarely took a lead role:

> I: Do [health professionals] tend to contribute to the meetings when they're there?
>
> R: I can only think of two off the top of my head, but they mostly take a backseat. Yeah. Interested, very interested, but they take a backseat (Enforcement).

Furthermore, as indicated in Table 12, these groups focused on local policymaking and case management. They therefore provided limited opportunity for representatives of the health sector to speak into the national response to human trafficking.

6.2 Inter-organisational relationships within the trafficking policy subsystem

This section presents evidence regarding the reported and observed relationships between organisations and government departments within the trafficking policy subsystem, and draws upon analysis of interview data and field notes from observation at policy meetings and events. During

[27] Glasgow City Council was unusual amongst local authorities in that it had developed an Inter Agency Working Group on the trafficking of adult women for sexual exploitation. The working group included representatives from a local trauma counselling organisation and a sexual health drop-in clinic.

interviews, participants were asked to talk about the different policy groups they attended and also whether there were groups that they did not attend but at which they would like to be represented:

> I: So I'd like to talk about your relationship with decision making bodies. What groups do you attend that work on trafficking?
>
> R: We're part of the stakeholder group so we can speak into that, and the [government] is obviously aware that we're around...we do sit round the table at some groups. We're not around every group....
>
> I: There are some groups that you don't go to, which groups are they?
>
> R: Well we've not been part of the victim coordinator group, the victim care group based in UKHTC...and I mean I've had conversations with them, but they are re-looking at the groups and hopefully we'll get to be a part of that (Service Provider).

Interviewees were also asked about which organisations and government departments they most frequently worked with in relation to human trafficking:

> I: Could you tell me about some of the other groups that you work on, either with NGOs or more policy side?
>
> R: Well, with the NGOs there's the Poppy Project, Kalayaan, ECPAT, Migrant Rights Network, Amnesty, ILPA...and then there's TARA, in Scotland, we're also working with them...[and] there are people who we work for on an ad hoc basis or continuously, depending on what's going on. Of course there is the Home Office, the UK Border Agency, the All Party Parliamentary Group when it comes to the governmental system. Gangmasters Licensing Authority we are working with, and the trade unions. So that's the basic list (Advocate).

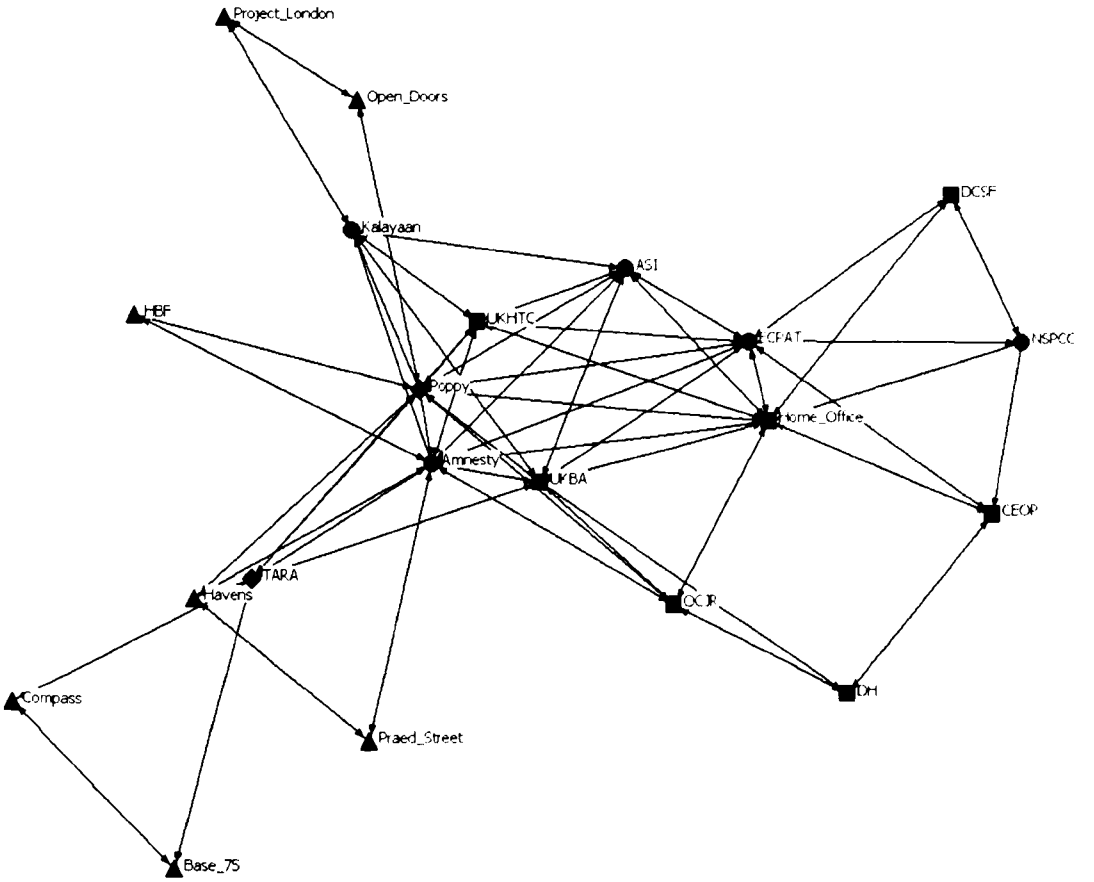
Field notes also documented my impressions of the relationships between policy stakeholders, based on observations at policy meetings and events or on informal conversations with attendees:

> UKHTC was represented only by Stuart, who arrived with and spent most of the time with Caroline (CPS) Everyone sat around large tables arranged in a rectangle, with the speakers positioned at the top of the table. Most people knew each other and the general mood was friendly. In conversation though NGO representatives commented upon the difficulty of working with others – with UKBA and the UKHTC for instance. The representatives of two service providing organisations conspicuously avoided each other (Fieldnotes 2009c).

The frequency and importance of inter-organisational contacts as reported during interviews and observed during meetings was tabulated for a sample of organisations and departments[28]. A copy of the tabulation is provided in appendix I. NetDraw software was then used to visually map these relationships. The resultant map is shown in Figure 4 (overleaf), in which each organisation is represented by a node and is linked by a straight line to its key organisational contacts. The greater the number of linkages a given organisation has, the more heavily networked it is considered to be within the trafficking policy subsystem.

[28] For the purposes of visual clarity, not all of the organisations and departments which were active in the human trafficking policy subsystem were mapped. Based on analyses of interviews, documents, and notes from meetings the most active departments, agencies, and NGOs were found to be the Home Office, Office for Criminal Justice Reform, UK Border Agency, the UK Human Trafficking Centre, Amnesty International UK, Anti Slavery International, ECPAT UK, the Poppy Project and TARA. These organisations were selected for inclusion on this basis. Due to the focus of the research, all the healthcare organisations for which I had inter-organisational linkage data were included, as was the Department of Health. Kalayaan, the NSPCC, and CEOP provide examples of organisations that are less well networked than the most active groups but better networked than the healthcare organisations. Their inclusion on the map is for illustrative purposes and is not on the basis of specific criteria.

Figure 4: Inter-organisational relationships in the trafficking policy subsystem



Shape key: government/government agencies are represented by squares, service providers by diamonds, advocacy groups by circles, and health agencies by triangles.

Colour key: government/government agencies are shown in black, core stakeholders in red, peripheral stakeholders in green and marginal stakeholders in blue. Excluded stakeholders are not shown.

Figure 4 suggests that the UKBA, OCJR and the Home Office are the key government departments, whilst the DH and DCSF (now the Department for Education) appear to be less heavily networked. Civil servants' more general comments during interviews about the role of the DH within trafficking policymaking supported this finding. One civil servant reported, for example, that DH's role within the response to trafficking, whilst it was increasing, was limited to a small number of action points:

> They have been engaged. And I think that engagement is increasing. [Pause] And I think we all recognise that they could do more.... they do attend the IDMG and they do actually have a couple of actions in the action plan, and we're right now talking with them about actions for the next action plan (Civil Servant).

A second civil servant also noted that although the DH had been supportive of developments in UK human trafficking policy, the issue had not been a priority for the department.

> Initially it may have been – no, I don't know whether it really was – obviously it may not have been as much of a priority for the Department [of Health]. But I think we've had, we have had buy in from the Department of Health from early on. And I think what they've done, which they were quite right to do, is to just take on human trafficking as part of a wider issue (Civil Servant).

Analysis of field notes from participant observation also suggested that the relevant DH officials were poorly integrated into trafficking policymaking. As discussed in detail in Chapter 7, this was noted even in relation to developments that were relevant to the health sector.

Figure 4 also illustrates the inter-organisational relationships of NGOs and healthcare providers. Analysis of interviews, meeting documents and field notes suggested that NGOs and healthcare providers had different patterns of inter-organisational relationships, which also corresponded to their participation in the various policy groups shown earlier in Table 12. Based on these patterns, and as discussed below, organisations were categorised as being core, peripheral or marginal to, or excluded from, the trafficking policy subsystem. In Figure 4, the colour of each organisation's node represents its categorisation according to this schema.

As illustrated in Figure 4, a small number of NGOs (the Poppy Project, Amnesty International UK, Anti Slavery International, ECPAT UK and TARA) appear to be well connected to government departments and agencies. Analysis found that these *core* organisations had membership of multiple policy and implementation groups and were invited by government to participate in small consultation events and workshops:

> In April, there was a consultation on how ECAT was going to be implemented. And it was a very closed group, about five NGOs...we were the only NGOs and the rest were all

> government officials. And that's where they first shared their proposals around the competent authority (Advocate).

These organisations also had good access to policy officials through informal meetings and reported that they favoured these meetings over larger forums such as the JNMG:

> I feel like we have that closer relationship with the Home Office, I know if I wanted to I could have a one hour meeting with [the UKBA policy lead] and [the OCJR policy lead], and just thrash out the detail. Whereas round the table, you're all kind of, you all have your one chance to say something ...you know, everyone has their kind of note they play around the table, and umm, and I don't see it as being....it's probably useful if you don't have that close relationship [with government] (Advocate).

Furthermore, these NGOs had strong inter-organisational links, which facilitated greater unity in messaging and advocacy activity: interviewees from these organisations spoke about, for example, organising pre-meetings to the JNMG and consultation workshops to coordinate responses and to decide upon the key messages and issues that they hoped to discuss.

Peripheral organisations existed as a diverse and populous cloud around the cluster of core organisations, with which they had links of varying strength. These groups had membership of one or more policy and implementation groups but were often not invited to participate in smaller consultative events and had poorer access to Ministers and policy officials on an individual level:

> [We have access to the Minister] through other people mainly. One of our contacts from the unions is able to get some fairly quick responses from the Minister, we don't get any response from him. Even though he says quite openly "oh yes, we're working with [the organisation]" (Service Provider).

Peripheral organisations are represented on the diagram by Kalayaan and the NSPCC, two NGOs which had links with government departments and other NGOs, but were less heavily networked than the core organisations. Numerous other organisations showed this type of engagement (including the post-trafficking support providers the Medaille Trust and the Salvation Army) but are not shown in Figure 4.

The research also identified a group of *marginal* organisations, which operated further from the centre of the policy subsystem and did not participate in national policy and implementation groups or engage directly with government departments or agencies. They tended to be connected to the subsystem through one or more of the core NGOs, often through their membership of local working groups or networks on related issues:

> R: I've got direct access to ring [the post-trafficking support provider] if I've got some information that needed...if we had any concerns, we could contact [them].
>
> I: What sort of information would you be feeding back?
>
> R: At that particular forum, the number of women who've come through the service, the nationalities, just the background of some of the women who were attending the service. From our organisation, if I'd had any intelligence...Really it's about what is going on within the service, feeding that back (Healthcare Provider).

The diagram shows only health sector organisations and health charities from this category, but other organisations – typically service providers and professionals who worked with trafficked people but did not provide them with accommodation – could also be grouped in this way.

Not shown in Figure 4, but apparent from the analysis of interview data, are *excluded* organisations. These organisations believed that their work was relevant to discussions around the response to human trafficking but that they had not been able to participate in national policy and implementation groups. Furthermore, they did not report having significant links with organisations that did attend these groups. This category included sex worker advocacy groups such as the English Collective of Prostitutes (ECP) and International Union of Sex Workers (IUSW), but may also include other organisations not interviewed for the research. During interviews, sex worker advocacy groups spoke about how they struggled to access information and their participation in the policy subsystem appeared to them to be blocked:

> Twenty-two people were consulted [during a review of the demand for prostitution]. Half of them were government agencies. Home Office, police, CPS. Eleven are the other stakeholders. Of those eleven, four are Christian charities, one is a sex worker charity. I just feel that it should be the other way around...[but] I think that they don't want to hear

> that voice. You know, they only want, they want to close down the voice of someone who says something different because it could mess things up. So don't let them have the information. Don't let them come to the meetings. Only have people who will get up and say I'm abused, my father abused me, I'm on drugs and I became a sex worker. Don't have anyone else who will come and say something different (Advocate).

It is not clear from the research whether there had been a conscious decision to exclude sex worker advocacy groups from the trafficking policy subsystem or, if such a decision had been made, which policy actors had been important in making it. Analysis suggests, however, that the exclusion of sex worker advocates from the trafficking policy subsystem was grounded in the unwillingness of participating organisations and officials to open the "sex work as work" versus "prostitution as violence" debate. One NGO interviewee discussed, for example, how, in the early days of coalition building, organisations had agreed to come to the table and discuss trafficking rather than their different views on sex work:

> I was quite strong in saying we are not here to discuss whether prostitution should be abolished or not, you can have whatever views you want and they can be different views, but we are all here to campaign against trafficking. And you can have a different view about what ultimately the best mechanism would be whether it's regularisation or penalisation of punters, that's for you to talk about but we don't talk about it here. And people signed up to that (Advocate).

Following the bitter divisions that emerged during the negotiation of the Palermo Protocol (discussed in Chapter 1), NGO stakeholders believed that this agreement was necessary if they were to come together as coalition and be effective in pushing the government for change. NGO advocates, service providers and lawyers suggested during interviews that they continued to believe that reopening the debate on sex work would be detrimental to the development of the response to human trafficking:

> You've probably come across this [sex worker advocacy group]? And they've always had a very strong line about prostitution being okay...It makes it more difficult for there to be a coherent debate because some of the people on that side don't have coherent debates (Lawyer).

Analysis of meeting documents and field notes found that there was very little discussion and debate about sex work or prostitution policy during trafficking meetings. For example, one of the agenda items for the July 2009 meeting of the JNMG was the Policing and Crime Bill, a clause within which would make it an offence to pay for sex with someone who had been subject to exploitative conduct (defined at that point as including force, threats, deception, or any other forms of coercion). The following extract from my field notes illustrates how, although the controversial nature of the clause was acknowledged, the Minister seemed to assume that the assembled NGOs supported the measure and the NGOs did not attempt to discuss the issue further:

> The Minister said that the Policing and Crime Bill was now stuck in the House of Lords and would not be through before summer recess...He stated that he realised that by accepting one position, or moving position, somebody is upset...He continued to say that he had been "very clear throughout" that we are trying to reduce demand by a strict liability offence and that holding men to account for buying sexual services from a person who had been coerced was an important step forward. He said that there had been a lot of pressure around this, from different perspectives. He continued to say that the measure is terribly important, and that we need to remain focussed on our intention, and not become "distracted" by the wider debate around prostitution. He concluded by saying that we are focussing on the darkest aspect of prostitution, which is the trafficking of women and girls for exploitation. We then moved onto the earlier points raised by the attendees (Fieldnotes 2009b).

Analysis of interviews suggested that this silence on sex work and prostitution policy continued despite stakeholders within the trafficking policy subsystem holding different positions on the issue: the service providing organisations with gender violence-based and faith-based backgrounds both held a prostitution-as-violence position (although as discussed later, they had their own inter-organisational tensions and did not work together), whereas others, particularly those with a labour-rights background, considered sex work to be work. One interviewee from this latter group spoke, however, about not raising the issue during working groups so as to avoid causing an argument:

> We tend to have a fairly liberal attitude on [prostitution], that it's always going to be with us. Which is always a difficult argument because you can say well labour exploitation is always going to be with us. Murder is always going to be with us. All the rest of it. But I think the further you drive it underground the harder it is for people both to get mutual protection but also for outside bodies to help and protect them. But we haven't had

> arguments because I haven't raised that. I didn't think the lady from Salvation Army would actually be on my side somehow (Advocate).

Just as immigration lawyers focused on immigration problems because they were the most relevant issue facing their clients, sex worker organisations prioritised advocacy around the blurring of the lines between prostitution and trafficking. Their inclusion would have forced the issue onto the agenda and jeopardised the "unity of purpose" that was valued by participants: field notes from events where the two sides came into contact with each other documented the poor relations between the two:

> Samantha (a representative from a service provider NGO) and Freya (an NGO advocate) clashed after Freya distributed leaflets that were critical of Samantha's organisation. Most of the delegates sided with Samantha and said that Freya's organisation's tactics did not help their cause. Samantha made a point of stating repeatedly that Freya's organisation was a lot more media-connected than they were and had the resources to cause a fuss (Fieldnotes 2008d).

Although not discussed by interviewees, it is possible that the exclusion of sex worker advocacy groups may have also contributed to the absence of healthcare organisations that ran sex worker outreach programmes and drop-in clinics, some of which publicly criticised the government for example in relation to the conduct of the Operations Pentameter 1 and 2 and the above-mentioned Policing and Crime Act (BBC 2010).

6.3 Understanding the access and influence of organisations in the trafficking policy subsystem

Sections 6.1 and 6.2 have demonstrated that organisations varied with regards to both their level of participation in the trafficking policy subsystem and the strength of their relationships with government officials and other organisations. These factors appeared to both reflect and contribute to some organisations having greater levels of influence within the trafficking policy subsystem than others. This section presents the results of analyses that sought to explore which factors influenced organisations' opportunities for participation in the trafficking policy subsystem, their level of influence in trafficking policymaking, and their access to key policymakers. Analysis was concerned particularly with how stakeholders spoke about their own organisation and other

organisations during interviews, and with how they presented the features of their organisations during meetings and in organisational documents. Two groups of factors were identified: organisations' expertise and the availability of resources for advocacy work on human trafficking.

6.3.1 Expertise

This section firstly presents evidence which demonstrates that the majority of interviewees who participated in this research believed that the level of trafficking-related expertise in the health sector was low. It then discusses the reasons stakeholders gave for why they considered certain organisations to have trafficking-related expertise and why this expertise translated into higher levels of access and influence within the trafficking policy subsystem.

NGO advocates, lawyers and service providers reported that healthcare providers had not developed expertise in relation to responding to trafficking. Service providers, for example, spoke about how they had had to provide training to local healthcare providers to ensure that the needs of the people they supported were appropriately met:

> We've set up service level agreements....I suppose some of them are formalised and some of them are not. So if we're going to a GP centre that's near to one of our safe houses for example, it's not that we would actually do an SLA with them, it's more that we would go this is trafficking, and this is what it means...a lot of it is training and information sharing (Service Provider).

NGO advocates and service providers also suggested that, more generally, healthcare professionals tended to have a poor understanding of the vulnerable migrant groups:

> It's probably down to the individual GP or doctor how they approach migrants' health needs. I'm talking not only about victims of trafficking but in general. But I think there is not huge awareness of their needs, no, from what I can see and how they are treated, how our clients are treated by medical professionals (Advocate).

During interviews, civil servants did not comment upon the health sector's level of expertise in responding to trafficking but did suggest that levels of awareness were low:

> I think awareness of the phenomenon of trafficking among the general public is quite low. And you can assume that therefore the awareness of trafficking among the staff nurses in an A&E department is relatively low as well (Civil Servant).

Successive government documents also stated that there was a need to raise healthcare providers' awareness of human trafficking and to train them in how to respond to the issue (Home Office 2007b; Home Office 2008; Home Office 2009b).

All of the healthcare providers interviewed for this research reported that they were comfortable in their ability to meet the clinical needs of trafficked people and to identify the additional patient needs that arose from being a migrant in the UK:

> No, most of the women that we see at our clinic, have, it's more the lack of choice about what's happening to them...I wouldn't say that the sexual health needs are particularly complex compared to other vulnerable adults (Healthcare Provider).

They suggested that the difficulties in providing care to trafficked people arose from their complex mental health needs and the need to work with trafficked people in a manner that was sensitive to their experiences of trauma. One healthcare provider, for example, stated that:

> The health needs are very complex. But they're mainly mental health needs, really (Healthcare Provider).

The sample of healthcare provider interviewees was highly selected, however, and comprised only providers who had knowingly provided care to trafficked people[29]. Health sector interviewees appeared to share other stakeholders' beliefs that the broader health sector had limited trafficking-related expertise. One interviewee suggested, for example, that the level of trafficking-related expertise and awareness within her particular organisation was unlikely to be representative of other healthcare providers:

[29] Health interviewees worked in either sexual health or services related to trauma. Some services, like the Sexual Assault Referral Centres, nominally had elements of both but providers reported that the trauma counselling required for one-off sexual assaults and more sustained periods of assault such as trafficking meant that their counselling services were not appropriate for trafficked people.

> [Expertise has been developed] really, it's really mainly through the Praed Street Project, the police, probably a bit of experience from cases on an individual level, the experienced doctors here have seen several [trafficked women]... I haven't been, well I'm not aware of anyone having been on a specific training thing or anything.... Yeah. It is limited. In terms of expertise. Definitely (Healthcare Provider).

Another healthcare provider commented more generally upon the varying levels of health sector expertise in relation to working with women who had experienced sexual violence:

> I think it very much depends on the professional. Some professionals have had very limited amounts of teaching on gender based violence. And will work from first principles (Healthcare Provider).

Analysis of how interviewees spoke about this factor identified four separate components of expertise: specialisation; operational knowledge; duration of experience, and organisational background. This remainder of this sub-section discusses each of these components and presents evidence on the extent to which the health sector was believed to meet them.

6.3.1.1 Specialisation

Interview participants from across the range of represented sectors suggested that value of specialisation was related to the multiple needs of trafficked people, which provided many potential niches for expertise including accommodation provision, immigration advice and advocacy, and policing. Speaking about an anti-trafficking police operation, for example, one enforcement official stated that addressing trafficked people's multiple needs required the expertise of several agencies:

> We might be able to broadly understand about employment law, health and safety, debt bondage, those kinds of things, but the problems that workers have in these kinds of severe situations of exploitation cut across the different areas of expertise (Enforcement).

Stakeholders from across the spectrum of sectors in the trafficking policy subsystem suggested that there was some overlap between the needs of trafficked people and those of other groups, such as people who had experienced sexual violence. They also commented, however, on the unique

features of trafficking and on the phenomenon's particular complexity. This complexity also increased the value of specialist skills and knowledge:

> I think it's crucial that people continue to be arrested and prosecuted and it needs dedicated units to do that.... I think it's such a difficult area to police, I think it needs that expertise (Enforcement).

The trauma counselling services and sexual health services interviewed for this research provided care to trafficked people as part of their broader health services remit. No healthcare organisation emerged during the period of research that specialised in providing care to trafficked people. As stakeholders' believed that healthcare was a specific and unmet area of expertise, it is possible that had specialist healthcare organisations emerged, they would have been granted some degree of input into the policy process. Stakeholders reported during interviews and meetings that because of the size of the health sector and the lack of trafficking-related expertise amongst healthcare providers, it was difficult to identify individuals or projects that would be well-placed to participate in policy discussions:

> Lorraine (an NGO advocate) stated the need for a senior NHS person to come on board. Natasha (an advocate from a children's NGO) suggested that it would be difficult to identify a single person within the NHS who would be able to help UKHTC because of the individual nature of implementation in the NHS (Fieldnotes 2007d).

Interviewees reported that similar problems were also experienced at the local level:

> I went to a [LSCB] subgroup meeting the other day at a local authority just outside of London, and there were multi-agency partners around the table and it was clear that health needed to be there from that particular authority. But everyone was just saying who on earth do we ask? Who do we ask within the Primary Care Trust? There are so many different levels, there are so many departments (Enforcement).

The police and immigration services appeared to have overcome ostensibly similar challenges of a large and decentralised staff to a greater extent than the health sector. The Metropolitan Police Service (MPS) Clubs and Vice unit, for example, provided an early focus for police work on trafficking, but in later years, with support from senior police officials, the police-led UK Human

Trafficking Centre and a MPS Human Trafficking Team were established[30]. These organisations acted as specialist tactical and operational anti-trafficking leads, trained and advised police forces on responding to trafficking, and attended a variety of policy meetings and events. UKBA developed an e-learning training package on trafficking, which is mandatory for all staff under assistant director grade, and have trained specialist case-owners to assess NRM applications (Home Office 2009b). Meeting minutes show that a number of these case-owners attended the NRM review workshops (UKBA 2009b; UKBA 2010c).

6.3.1.2 Operational knowledge

Civil servants, enforcement officials, service providers and NGO advocates commented that operational knowledge was a particularly valuable commodity within the trafficking policy subsystem. Professionals working on the frontline were well-placed, for example, to feed back to policymakers the "reality" of the problem to be faced and how well anti-trafficking policies were actually operating:

> I'm at an awful lot of meetings [laughs]. I think there's a hunger for the operational teams to be at these meetings, to say what the real problems are. And that's great, and I appreciate that and I really try to go to as many meetings and groups as we can. To show support and put in operational day to day reality. But there's more meetings and more strategic units and people than there are operational people (Enforcement).

The research found that this "hunger" for operational information was not limited to policymakers. Advocacy-oriented NGOs also reported that their relationships with organisations which worked with trafficked people were important to their effectiveness:

> We work really closely with a handful of NGOs who will give us information about their cases, so Poppy Project, Kalayaan, ECPAT I'd say are the three primary organisations...they're a really valuable source of information, not just in terms of cases but in terms of how government is dealing with victims of trafficking. So yes, they'd be our kind of primary source of insider information (Advocate).

[30] Both the UKHTC and the MPS Human Trafficking Team, however, received government funding via the Home Office Serious Organised Crime budget. The withdrawal of Home Office funding from the MPS Human Trafficking Team in 2009 prompted the closure of the unit and the transfer of its responsibilities to the Clubs and Vice Team (MPS 2009).

Relatively few organisations in the UK worked directly with trafficked people, but the prominence of direct service providers and frontline professionals in the trafficking policy subsystem supports stakeholders' suggestions that having operational knowledge was one way of gaining influence and access within the trafficking policy subsystem. Meeting minutes show, for example, that in 2009 organisations which had direct contact with trafficked people had made up between 63-70% of attendees at the meetings of the JNMG (JNMG 2005-2010). For the UKHTC Victim Care subgroup meetings in 2009, this proportion increased to over 80% (UKHTC 2009b). The Strategic Monitoring Group was attended by the Poppy Project, Migrant Helpline and TARA, three NGOs which received central funding to provide direct support to trafficked people.

Representatives of the excluded sex worker organisations suggested, however, that some organisations did participate in the trafficking policy subsystem despite having had little direct contact with either trafficked people or sex workers. These interviewees tended to be highly critical of this situation:

> [I asked] have you ever met a trafficked person? [Pause]. [They said] well, we met someone who was trafficked from Britain to Italy. Anyone else? No. Okay. I'm very uncomfortable about that, because you've set up this whole big thing...I would expect, if you're running an international network about trafficking that you've met a lot of people who are trafficked. That you meet them all the time... If you haven't met anyone, then I think it's a bit of a con (Advocate).

A number of the healthcare providers interviewed for this research reported that they had, over time, developed practical experience in working with trafficked people. Service providers also described during interviews how they had established local networks of healthcare providers (typically encompassing GPs, sexual health clinics and counselling services) to which they would refer their clients:

> The house managers have gone and you know, spoken to the practice manager within the GP surgery for example and spoken to the managers of the sexual health clinics, so they've actually, on the ground gone and actually spoken to people and built that relationship, explained what we were looking for, the type of work we were doing, how confidential we needed it to be (Service Provider).

There were, however, few healthcare organisations which regularly worked with a substantial number of trafficked people. The structure of the healthcare system and the lack of organisations working specifically with trafficked people are likely to have limited the development of operational knowledge in the sector. Specialist police teams, for example, could lead anti-trafficking operations and advise or liaise with local forces on theirs: no equivalent structure existed in the health sector to meet the needs of trafficked people or to advise and collate information from other healthcare providers working with trafficked people throughout the country. The immigration service was able to channel NRM applications to trained caseworkers, but trafficked people would not be similarly referred to specialists for healthcare across PCT boundaries.

6.3.1.3 Duration of experience

The length of time an organisation or an individual had been working on human trafficking appeared to play an important role in whether they were believed by other stakeholders to be expert in responding to trafficking. This was perhaps because of the perceived complexity of both human trafficking and the needs of trafficked people: a number of the more newly established service providers and NGOs commented that working on trafficking was a "steep learning curve".

One civil servant, speaking for instance about why the Poppy Project had authored the guidelines for the provision of post-trafficking support services, commented upon how the organisation had been working with trafficked women for several years:

> The Poppy Project had been running for a number of years so it made sense for the Poppy Project to be involved [in writing the minimum service standards]... they'd been running for a number of years and they'd got a lot of best practice that they can share (Civil Servant).

Another interviewee, an enforcement official, spoke about how he drew upon organisations with several years' expertise when planning anti-trafficking operations:

> I think with the partner agencies, social work, UKHTC especially, UKBA to a slightly lesser extent, and TARA, are absolutely invaluable for that. Because they're the people

> who have the expertise. They're the people who you call on. Who have been doing this for years (Enforcement).

The research also found that organisations which had worked on trafficking for a relatively long period of time (whether in an advocacy, service provision or enforcement capacity) often made reference to this when justifying their analysis of what they considered to be best practice. One enforcement officer, for example, speaking about the strategies that had been developed for working with trafficked people commented that:

> If you look at ACPO guidelines, those sort of things, it was our unit that actually wrote them because we've developed that experience over a long period of time because we've been dealing with these investigations constantly for the last twenty years (Enforcement).

One service provider similarly suggested that the expertise developed over several years at her organisation gave credibility to their preferred model of support and, furthermore, attributed her organisation's inclusion in decision-making processes to having worked on this issue for longer than the officials in government:

> I mean, there are people who disagree with our model and who will suggest other things but they simply don't have five years of experience and loads of data and publications and things to back it up. So to an extent we're quite lucky being included by decision-makers, but I don't think that at all speaks of the usual experience of a woman's charity or even of any service provider in being included in more formal decision making. It's almost kind of because we were there before the government was on this issue, and so they've had to take their cues from us, and get used to that (Service Provider).

Interviewees did not speak about the duration of healthcare organisations' experience of working on trafficking and it is therefore not clear from the analysis as to whether this component of expertise was relevant to healthcare providers' access and influence within the trafficking policy subsystem. With regards to the duration of civil servants' and Ministers' experience in working on trafficking, several NGO advocates and service providers lamented the frequency of changes in personnel. These changes were suggested to both disrupt the relationships that they had established with government figures and contribute to a loss of expertise within government. One service provider, speaking about a recent Ministerial change, commented for example that:

> It seems like [the Minister]is interested in learning about the issue and interested in being involved, but you know: blank slate. We are starting from square one (Service Provider).

Another interviewee, speaking about changing personnel within the civil service similarly commented that:

> [A couple of years ago] there were quite ambitious civil servants that understood the issues and were ready to push for things and make sure the minister is on top of things, and the people have changed. And so when new people come, it always takes a while (Advocate).

It is possible therefore, that the DH's appointment of a trafficking policy lead in mid 2009, several years after policy leads had been appointed in the Home Office, UKBA, and the OCJR, contributed to the continuation of the department's apparent lack of influence within the trafficking policy subsystem.

6.3.1.4 Organisational background

The research found that stakeholders' beliefs about the types of needs that trafficked people would present with, and the similarity of needs between trafficked people and other vulnerable groups, legitimised certain sources of knowledge over others. An organisation's background appeared, therefore, to affect the credibility of its expertise.

During interviews, service providers and NGO advocates suggested that organisations with a background in working with physically and sexually abused women, asylum seekers and refugees and vulnerable workers had expertise and knowledge that was partially transferable to the trafficking context. They reported that they had identified organisations to invite to participate in trafficking dialogues and service provision on this basis. One advocate spoke about, for example, having suggested that policymakers worked with Women's Aid and other refuge providers to increase the provision of accommodation and support for trafficked women:

> I remember making points at the time about support and accommodation and not reinventing the wheel ... and I remember saying to them, what about women's aid refuges, for example ... because they do come from that feminist perspective, but also those

> organisations were linked into a whole range of local services, be it substance abuse, be it health, sexual and reproductive health services, they also have a more cautious approach to dealing with police and immigration (Advocate).

Other service providers, NGO advocates, healthcare providers and lawyers stated that they had become involved in working on trafficking because the skills they had developed working with other vulnerable populations could be transferred to this field:

> The reason we were invited was through UKBA knowing of our involvement with asylum seekers in this area...initially they approached us to find out whether we could provide the accommodation...And from that evolved a kind of accommodation and support package (Service Provider).

A number of service provider and advocate interviewees complained, however, that the broader health sector response to violence against women and to asylum seekers and refugees was often unsatisfactory, whilst two civil servants suggested that the small scale of trafficking relative to these issues meant that it was unlikely to be prioritised within programmatic initiatives:

> The main focus and the main interest was in the much bigger issue of violence against women but in particular you know, although many people are being exploited, many, many more people suffer domestic violence, many, many more people suffer childhood sexual abuse, more people suffer sexual assaults. So the big numbers and the big impacts of the population were elsewhere, and we focussed on them (Civil Servant).

The credibility of faith-based organisations' and sexual health outreach projects' expertise was challenged by a number of service providers and NGO advocates during interviews. In the case of faith based organisations, this was partially based on fears that their analysis of violence could lead to the woman being blamed for her experiences and that women's use of emergency contraception and abortion services could be restricted or discouraged:

> We were concerned that women that might have been in prostitution shouldn't be judged or given any kind of messaging that made them feel any more guilty, but we were also concerned about the access to health care. Because some of those organisations that have

> positions that would be against abortion, so we weren't clear whether those women would be given access to emergency contraception and abortion if they needed it (Advocate).

Faith-based NGOs also reported during interviews and informal conversations that they did not have good relationships with the core group of NGOs:

> Wherever the faith community gets involved in secular Britain, certain participants – especially those working on gender issues – find it disturbing, concerning, disconcerting...because they don't know what may be the other discourses that accompany the faith involvement (Advocate).

Analysis of field notes indicates, however, that although faith-based and feminist NGOs did not appear to work together, open conflict was not apparent during policy meetings. The potential for conflict between sex worker advocacy organisations and other NGOs in the policy subsystem was much greater and may have contributed to the exclusion of sex worker advocacy organisations from the trafficking policy subsystem. Certain core group NGOs also questioned the ability of sexual health outreach projects to identify and respond to trafficking:

> R3: The brothels that actually open to sexual health outreach workers aren't likely to be the favourites for traffickers for obvious reasons. So I haven't personally, probably...I don't actually remember any case where...except one, which was referred through an outreach, a sexual health outreach project.
>
> R2: It's pretty rare though.
>
> R3: It's very rare.
>
> R2: But also, if they're coming from a harm minimisation point of view, they're going to treat what they see but they're not going to ask any questions. So if that person doesn't disclose, doesn't say "please help me!", then they're not going to refer them to us, so...whether or not they receive treatment or not is...and also I suppose you're looking at different kinds of trafficking. They might be off-street in a flat around the corner that no-one's ever going to find. It's not that many women who end up in big strip clubs in the middle of Piccadilly (Service Provider).

Outreach workers and sex worker advocacy organisations refuted these claims, however, stating that they did encounter trafficked women and that they provided women with outreach services and, where appropriate, assistance to leave exploitative situations:

> What happens for us, normally we meet people who aren't nice, neat victims, what happens is we have helped women to go home but it's been done in quite a controlled way. Quite a managed way (Healthcare Provider).

Amongst the many organisations that had emerged to campaign on issues of trafficking or to work with trafficked people, few met all of the four identified "criteria" of expertise (specialisation, operational knowledge, duration of experience and organisational background) to a high level. According to interviewees' stated understanding of expertise, organisations such as the Poppy Project – a specialist organisation, with a background in violence against women, which had been working directly with trafficked women for several years – were held to have high levels of expertise. This subsection has shown that, in contrast, healthcare organisations were judged to have poor levels of expertise: no healthcare services had emerged that specialised in providing care to trafficked people and most healthcare providers could expect to come into contact with very few trafficked people. Furthermore, although stakeholders' beliefs about the transferability of knowledge and expertise may provide future support for the inclusion of healthcare providers who work with asylum seekers, refugees and victims of sexual violence in trafficking policy dialogues, they may also contribute to the continued exclusion of sex worker outreach services.

6.3.2 Resources available for trafficking advocacy work

The research found that a second category of factors put forward by interviewees to explain the extent of organisations' participation in the trafficking policy subsystem concerned the resources that organisations had available for advocacy activities. This subsection shows firstly, that NGO stakeholders reported that participation was resource-intensive and secondly, that healthcare providers stated that they did not have the time, budget or staff to dedicate to anti-trafficking advocacy work.

Numerous policy and implementation groups had been established between 2000 and 2010 that had a role in the response to trafficking. Furthermore, although not shown in Table 12, there were also

numerous trafficking-related training events, seminars and fee-based conferences to which organisations could choose to send delegates. Several interviewees suggested that participating in these multiple trafficking-related groups and events was resource-intensive. An interviewee from one of the core group of NGOs, for example, commented upon the many hours her organisation had dedicated to working with the government on trafficking issues:

> We give up so much of our time for free to participate, which is not government funded. I've counted over 200 hours that I've spent in meetings over the past two years. A huge amount of time in meetings...and then behind closed doors [our input] gets dismissed, and we're asked to come back again as if the slate's been wiped clean, so we have to go in and start all over again (Advocate).

Marginal and excluded organisations reported that their lack of resources made their participation in the trafficking policy subsystem more challenging:

> The conferences that are called, [they] cost a lot of money. And the Vice Conference recently, £195 or whatever it was. So no one from [our organisation] can go. Because we don't have the money to go. Meanwhile everyone else is being paid by their organisation to go. And it's very common for us to sit in meetings where everybody in the room is being paid but us (Advocate).

Healthcare interviewees echoed these sentiments and reported that as their organisations existed to provide services to patients, they did not budget for advocacy activities. One interviewee, for example, suggested that his organisation did not have sufficient funds to dedicate to policy advocacy work:

> The government should be the one facilitating [our involvement], why should it be us? We offer services – and they should be helping us...They have much bigger budget for this sort of thing- they could facilitate our participation (Healthcare Provider).

Another healthcare interviewee stated that her organisation did not have time to attend trafficking policy meetings or to comment on papers and consultations:

> [The anti-trafficking movement], they're very clear on their policy, on how they're developing policy and sort of lobbying. It really, really, really is about time. When you manage a service and you're working within a service, we are really, really, really busy. It's patients, patients, patients, the whole time. We're seeing people the whole time. You could spend an awful lot of time sitting at policy meetings (Healthcare Provider).

Ironically, event attendance became more focused as organisations moved closer to the core of the policy subsystem and informal and closed-group meetings became more accessible. Core and peripheral organisations also commented on the demands that participation placed on their time, but analysis suggested that the relative importance of time constraints for at least some of these organisations was mitigated by other factors. For instance, although the Poppy Project was primarily a service providing organisation, they specialised solely in trafficking and had a separately funded research and development team, and although the NSPCC policy lead could dedicate only a portion of her working week to trafficking issues, she was an advocacy professional.

The decision to allocate resources to advocacy work was a strategic one. One interviewee spoke, for example, about how his organisation had increased the amount of resources available for anti-trafficking advocacy work during the early years of the policy response but partially withdrew them once the fundamental principles of the response had been established:

> [The] end of 2007 that's when [my organisation] had stopped prioritising UK advocacy on trafficking...But basically in those years from 2000-2007 it was a major part, I mean I was doing a lot of proactive lobbying on trafficking, and subsequently you know we said we've done, we've put a lot of resources into this we need to do other work (Advocate).

A number of organisations interviewed for this research, including healthcare services, did not have staff with advocacy skills upon which they could draw. Healthcare interviewees made reference to how the NHS was not a political, or politically savvy, organisation, and that the likelihood of individual clinics being able to allocate resources to advocacy work on this issue was slim:

> The NHS in my experience, is very, having come from an NGO background, is very, very, very naïve, in terms of advocacy and understanding what it has to do to defend its practice. So I'm talking about the NHS at a structural level. It's down to me, to be hammering all

> the time on my senior managers' doors to get them to understand, and I'm not sure that they necessarily do (Healthcare Provider).

Amongst other frontline providers, working groups of professional associations conducted trafficking advocacy work on behalf of their association's members. Meeting minutes and field notes collected for the research show, for example, that the Immigration Legal Practitioners' Association (ILPA) attended the JNMG, the Trafficking Law and Policy Forum, the 6 and 12 month NRM review workshops, and UKHTC briefing days, and were members of NGO coalition the Anti Trafficking Monitoring Group (JNMG 2005-2010; Fieldnotes 2007a; Fieldnotes 2008b; Fieldnotes 2008a; Fieldnotes 2008c; UKBA 2009b; ATMG 2010; UKBA 2010c). They also submitted responses to the National Action Plan consultation and to the inquiries conducted by the JCHR and the HAC (Home Office 2006c; JCHR 2006a; HAC 2009a). The Association of Chief Police Officers (ACPO) also had a considerable level of involvement in the response to trafficking. For example, the association championed the establishment of the UKHTC (Home Office 2007b), published a report estimating the scale of trafficking in the UK, (Jackson, Jeffery et al. 2010) developed early police guidelines for investigating trafficking (MPS 2002) and raised the profile of trafficking amongst police officers at their annual vice conferences. In contrast, the research found that professional health associations had only very limited engagement in the response to trafficking. The Royal College of Nursing and the British Psychological Society submitted brief responses to the consultation to the National Action Plan, but the research could find no other evidence for their involvement (BPS 2006; Home Office 2006c; RCN 2006). A number of potentially relevant healthcare providers were involved in the UK Network of Sex Work Projects, which participated in prostitution policymaking[31] but was not represented in the trafficking policy subsystem.

The research also found, however, that although the interviewed healthcare organisations were marginal to the trafficking policy subsystem, they were involved in policy and advocacy work to a much greater extent in relation to other issues. The remainder of this subsection presents evidence that demonstrates this and suggests that services' non-participation was at least partially due to trafficking not being a priority issue for them.

[31] The UKNSWP contributed to a number of consultations, including the "Tackling Demand" review (2008), the Coordinated Prostitution Strategy (2006), "Paying the Price" (2004), and "Setting the Boundaries (2003) (UKNSWP 2011).

Healthcare organisations reported that they were quite well-networked within their primary specialisation, for instance within sexual violence, asylum and refugee services and trauma care, and sex worker projects. One interviewee reported, for example, that:

> We're part of the London Sexual Health Network....We're quite lucky in that we're quite well connected and we have regular meetings with the Mayor of London's office, GLA, we've a good relationship with the Home Office and get invited to consultations. We've got the voluntary sector through the WNC. We've got [links with] the police (Healthcare Provider).

A second interviewee similarly stated that her organisation had good links with NGOs, public authorities, and parliamentarians:

> Well, there is a [asylum seeker] health management team, which meets once a month. And then there's a network meeting that meets once a quarter...there's very good links there. UK Border Agency have also involved us in various consultation events and we have a partnership project with the Medical Foundation.... I also sit on the Cross Parliamentary Group for asylum seekers and refugees which again has a lot of the key players there. So we see each other a lot [laughs], the same faces (Healthcare Provider).

The research found that the advocacy work conducted by these organisations tended to be orientated towards issues they faced in their primary areas of work. Sexual violence services, for example, reported working to secure the continuation of their funding. One asylum and refugee service stated that they campaigned against the restrictions on migrants' access to free healthcare:

> We lobby [government]. So we have given presentations to the Joint Committee on Human Rights and the Home Affairs Committee, we are trying to change their agenda essentially...we would work with the Department of Health on certain consultations that they have on accessing primary, secondary healthcare (Healthcare Provider).

A second healthcare provider who worked with asylum seekers and refugees talked about lobbying the government around the impact of immigration policies on their clients' health:

> We've done quite a lot of lobbying around ensuring that women see someone of the same gender. And a crèche for when they're giving their first interview. And we've been very involved in doing that as well (Healthcare Provider).

Organisations which worked with sex workers reported that their current priorities had been shaped by reignited debates around the legalisation, decriminalisation and criminalisation of sex work, the relative importance of outreach, drop-in and exit services; and changes in prostitution policy.

> The Lord Mayor's declaration on domestic violence and violence against women, if that gets ratified as a policy, as a Greater London policy, then our local authority will take that on board, our local authority who have their own fair share of abolitionists will start trying to railroad me to sign up to that, which I won't do, I will become persona non grata. It's quite tricky, it's quite tricky. You know, that's the sort of thing I'm fielding off all the time. So yeah. There will be pressure, definitely (Healthcare Provider).

Against the backdrop of these larger debates, and in the context of healthcare services having limited resources for advocacy activities, it appeared that engaging with the narrower issue of trafficking was not prioritised.

6.4 Health-based advocacy within the trafficking policy subsystem

Sections 6.1 to 6.3 have discussed the absence of health sector representatives from the trafficking policy subsystem. This section presents evidence which demonstrates that health was only infrequently discussed by those stakeholders who did participate in the trafficking policy subsystem and discusses interviewees' explanations for this.

During interviews, participants were asked to think about whether the health of trafficked persons was ever the topic of discussion at the policy meetings and events. In response to this question, interviewees from across all sectors, except the civil service, stated that health was rarely discussed at the policy events that they attended. One service provider interviewee, for example, replied "not really. It doesn't seem to be a topic of conversation", whilst an advocate answered "not in the [UKHTC] prevention working group, and at the UKHTC victim care group it only very occasionally it comes up." Asked the same question, civil servant interviewees suggested that health *was* one of the issues that were discussed during policy meetings:

> Yeah, it comes up at the NGO Stakeholder Group... And it depends on the issue, it's on an issue by issue basis really. It probably did come up on the consultation meetings we had – I don't know if you were there – about the action plan (Civil Servant).

Analysis of meeting minutes and field notes did not, however, support this civil servant's statement. With respect to the JNMG, health was mentioned four times over the course of ten meetings. The first instance was a presentation by Dr. Cathy Zimmerman on the findings of the "Stolen Smiles" study in May 2006. The remaining three occurrences appear to be discrete items of feedback, or questions, which did not prompt wider discussion amongst the group: a statement in the July 2006 meeting from the AIUK representative on the need to consider the implications of the "Stolen Smiles" report; a question that I asked regarding the changes to the overseas visitors regulations and access during the NRM referral period in April 2009; and an unattributed statement in the July 2009 meeting that it had been difficult to find leaders within health and education sectors to help raise awareness of the NRM (JNMG 2005-2010). Participants of the six-month NRM review workshop did not discuss health (UKBA 2009a) and I was the only attendee who raised the issue at the twelve-month review session (UKBA 2010c).

Interviewees attributed the absence of health-based discussion partially to there being insufficient health related expertise in the trafficking policy subsystem to permit meaningful dialogue on this issue. As shown by sections 6.1-6.3, health sector participation in the subsystem was very limited. Furthermore, although almost all non-health sector interviewees spoke about having a basic understanding of the physical and psychological harm suffered by trafficked people, they qualified this by saying they were not health experts:

> We would leave, or we would expect the health issues to be addressed by experts. I don't think we would claim to be or aspire to be experts on health (Civil Servant).

These interviewees also stated their belief that the complexity of health and medical issues was such that it would be inappropriate for them to be part of the response to health at either a policy or operational level:

> What we've trained on and what we've said is good practice, to make sure that the health needs, and also for example, we use Stolen Smiles, things like that, to actually point out to

> people this is, especially with victims of sexual exploitation, that this is the trauma, this is the psychological, the physiological position and you have got to look after that. You have got to make sure, even if outwardly there's nothing. This is it. So it's all the good practice. And then we rely on the experts to look into that...I would never dream, I would make sure that those people who are trained in counselling and those people who are trained in, people are referred to them (Enforcement).

Service providers, lawyers and NGO advocates also reported that other aspects of the response to trafficking were of more pressing concern than, for example, securing the provision of appropriate healthcare services for trafficked people. One lawyer commented, for instance, when asked whether people spoke about health at the meetings she attended:

> No. I think that's because there have been other, more broader concerns to be honest...I think that discussion will come, but I think it is a bit in the future, and I think that is because there's been more concern in making sure that it's being identified, that there's sufficient awareness of that (Lawyer).

During interviews, stakeholders from these sectors stated that their key advocacy priorities were the reform of immigration processes, improving the identification of trafficked people and increasing awareness of trafficking:

> The call for healthcare has not been at the centre of what we've been asking for because there were a few other things that we were focussing on ... [a] better system of identification, access to support services ... the reflection period of three months, ... non-criminalisation [of trafficked people for immigration offences], and residence permits (Advocate).

Stakeholders' accounts of their advocacy priorities were borne out by analyses of documents and field notes. The analyses considered the feedback and recommendations made by five core NGOs (AIUK, ASI, ECPAT UK, the Poppy Project and TARA) between 2002 and 2010[32]. Feedback was grouped into four timeframes: 2002-2005 (prior to the establishment of the JNMG and the publication of ECAT), 2005-2007 (up to the publication of action plan and signature of ECAT),

[32] The analysis used minutes from the Counter Trafficking Link Group and the JNMG, and submissions to the National Action Plan consultation and JCHR and HAC inquiries.

2007-2009 (up to the entry into force of ECAT), and 2009-date (post ratification of ECAT). A table summarising these recommendations can be found in appendix J. The analysis found that once a basic framework for responding to trafficking had been established, the agendas of these core NGOs were dominated by what they saw as a failure to identify victims of trafficking and provide them with permission to stay and access support in the UK.

The first period preceded the arrival of human trafficking on the UK policy agenda. Prior to 2002 there had been little to no programmatic or policy response to trafficking and NGOs focused on establishing a basic framework for the response to trafficking, adding detail over time. The role of the health sector and the provision of healthcare did not appear to have been specifically included in this work. NGO activity in the second phase focused on promoting the use of a human rights-based anti-trafficking framework; engaging government departments and external stakeholders; broadening the scope of trafficking policy to include labour exploitation and children; funding support services; developing the ability of professionals, particularly police and immigration officers, to identify and refer trafficked people; granting leave to remain to trafficked people; and improving the policing of trafficking. Later phases of activity added detail and complexity to these recommendations and included advocating the signature of additional relevant international protocols; increasing the responsibility of NGOs in developing and implementing policies, adding subcategories of forms of trafficking (e.g. labour exploitation in begging and DVD sales, child trafficking for benefit fraud and cannabis factories); extending support service provision; and developing an NRM (CTLG 2002-2004; CTVSG 2002-2005; JNMG 2005-2010; AIUK and Zimmerman 2006; ASI 2006a; ECPAT UK 2006; JCHR 2006a; Poppy Project 2006b; HAC 2009a).

The analysis also found that immigration-related issues formed a major part of NGO feedback throughout the period 2002 to 2010. Problems around detention, deportation and the handling of asylum claims and appeals, and the wider context of immigration policy featured heavily in NGO feedback in 2005-7 and 2007-9. The NGOs continued to make immigration-related criticisms in 2009-10, which focused particularly upon decision-making in the NRM and the overlap between the NRM and immigration systems.

During interviews, service providers reported that immigration processes gave rise to most of the more challenging problems facing trafficked people on a day-to-day basis:

> UKBA will always be the most important people in this issue because the bottom line is if you're not here we can't help you...We can only work with victims who you don't deport, we can only work with victims who you don't imprison. Therefore, if you've got them on a plane or you've got them in a cell, it's going to be hard for us to do our jobs (Service Provider).

In contrast, these interviewees reported that although they did encounter difficulties in accessing healthcare for their clients, they were usually able to overcome them. As previously mentioned in section 6.3, service providers had established good working relationships with small networks of local healthcare providers to ensure that trafficked people's healthcare needs could be appropriately met. One service provider spoke about how the training and client advocacy work her organisation had conducted with individual GP practices had reduced barriers to registration for the women they supported:

> When we [first] took service users to register with a GP for instance it was "no, you haven't got this, you haven't got that, how long have you been in the country? Can you give us your old address?" and all of these things that they would ask for, which obviously women could not provide. So they could not register with GPs. In some cases they could not even register with emergency appointments...as we educated more GP practices about trafficking and who we are, and we've used the fact that we are a supported housing organisation, we've used that kind of setup to then access support services for women (Service Provider).

Another service provider similarly spoke about how the relationships that they had established with local GP surgeries and sexual health clinics facilitated women's access to these services:

> They get quick access to GP surgery support ... [and] we can do quick access to sexual health clinics as well. So that's something that we've set in place for the women (Service Provider).

Service providers also stated that they tended to refer their clients to specific providers for mental healthcare. In contrast to their success in securing GP and sexual healthcare for trafficked women, they stated that they continued to face difficulties in accessing mental services. Some service providers attributed there being long waiting lists for psychological and psychiatric care.

> Most of the women we refer, we refer women basically to the Helen Bamber Foundation, Women and Girls Network, and the Maudsley clinic for a quick source for counselling. And we've got an in-house counsellor here. Because to go via the GP can just take too long, I mean that's probably the case whether you're a UK national or not (Service Provider).

Others, however, claimed that women's immigration status caused difficulties when trying to access hospital-level mental healthcare:

> We definitely have had to fight for some services. You know, especially with mental health, and them being hospitalised – we've had to use solicitors, especially if they are asylum seekers or EU (Service Provider).

Generally, however, service providers were able to overcome problems relating to accessing healthcare and there therefore appeared to be little incentive for them to allocate advocacy resources to lobbying on this issue. Furthermore, a number of service providers voiced their concern that pushing the government to clarify what trafficked people were entitled to could worsen a currently manageable situation:

> I mean you know, wouldn't it be nice if somewhere it could very clearly say "they are entitled this"? But then someone dissuaded me from doing that, saying there's a very possible chance that if in pushing them to outline what they're entitled to or not they might suddenly say they're not entitled to something and that would actually put them in a worse position. So sometimes perhaps it being vaguer is better (Service Provider).

The regulations that governed the access of overseas nationals to free NHS care had been tightened over the previous decade and there had been indications that they government might move to restrict access to care yet further (DH 2004b). Within this context, some service providers and NGO advocates believed that there was considerable benefit in continued ambiguity and made a conscious decision not to seek clarification from the government on which health services trafficked people could access for free and under what circumstances.

6.5 Summary

This chapter has shown that although multiple policy and implementation groups existed with the trafficking policy subsystem, the extent of health sector engagement in these groups was extremely limited. Interviewees believed that the level of trafficked-related expertise and awareness in the health sector was poor and reported that they would struggle to identify potential representatives for inclusion in policymaking activities. Furthermore, the few frontline health services that were involved in responding to trafficking had only a limited capacity for advocacy activities and, where these were undertaken, chose to focus their efforts on broader issues such as improving the healthcare access of marginalised groups, for example, migrants and sex workers. Although only limited data was available to understand the different levels of cross-departmental involvement in human trafficking policymaking, this chapter has also suggested that the DH has had a relatively restricted role and has poor links with external trafficking policy stakeholders.

A small number of healthcare providers were linked into the trafficking policy subsystem via their contacts with a handful of NGOs but the analysis presented in this chapter has suggested that this was not an effective way for healthcare providers to feedback their opinions and experiences to policymakers: NGOs did not prioritise health-related advocacy during meetings or policy submissions. NGOs reported that although trafficked people encountered difficulties in accessing appropriate healthcare services, they did not perceive these problems to be as pressing as those arising from the failure of public authorities to identify trafficked people and to grant applications for asylum and humanitarian protection. This may be, in part, because service providers had been able to overcome many of the barriers to healthcare by creating local networks of preferred healthcare providers and through sustained client advocacy. Other interviewees reported that they were reluctant to make recommendations relating to health, feeling that the health of trafficked people was an issue that fell outside their organisational remit and personal expertise.

Overall, this chapter has demonstrated that domestic pressure to develop a response to trafficking that incorporated the health sector and was sensitive to the health needs of trafficked people was extremely limited; the next chapter therefore examines the role of international factors in stimulating health-based change in the trafficking policy subsystem.

Chapter 7

Results IV: The intersection of international requirements and domestic politics

"The ratification of the Convention has been mammoth, because I think it sets out some really good criteria for the women. I think that other policy changes have been quite slow. Everything has been building up to the ratification" (Service Provider)

The preceding results chapters discussed the relative influence of problem definition, health information and research, and advocacy activities on human trafficking policymaking, showing that each were of limited relevance in prompting health-based policy change. As detailed in Chapter 1, the ratification of the Council of Europe Convention on Action against Trafficking in Human Beings (ECAT) prompted domestic policy change. This chapter examines the introduction of two changes that were relevant to health and analyses the impact of a series of policy constraints on the form these changes took.

The conceptual framework that was presented in Chapter 2 drew attention to the importance of international factors in setting the political and social context within which policy problems were defined and solutions were developed and evaluated. This research found that when asked to talk about the international events that had influenced UK trafficking policymaking, interviewees focused primarily on the signature and ratification of ECAT. Constraints and resources were also included within the framework, as policy scholars had suggested that they influenced which policy proposals would be considered by policymakers to be "feasible" and "acceptable" (Hall 1975; Kingdon 1984; Sabatier and Jenkins-Smith 1993). A review of the policy literature identified numerous potential policy constraints, including competing policy priorities, acceptability with respect to prevailing norms and values, budget pressures, and time.

Due to the timing of the research interviews, this chapter draws particularly on analysis of policy documents and field notes from participant observation at policy meetings and events. Analyses of interviews with civil servants are also heavily used within this chapter: as previously mentioned in Chapter 3, semi-structured interviews were conducted in broad phases and the civil servant

interviews were conducted later than were NGO interviews[33]. The chapter begins by reviewing two ECAT-related changes that my analysis found to be of particular relevance to the health sector: firstly, the introduction of the National Referral Mechanism (NRM) as an administrative structure for identifying trafficked people and referring them to support services and, secondly, revisions to trafficked people's entitlements to free medical care. Seven categories of policy "constraints" that were identified during the research are then defined: financial limitations, ideological constraints based on norms and values, incomplete information, institutional barriers, legal restrictions, the limited availability of skilled professionals, and time constraints. The remainder of the chapter presents analyses of the relevance of each of these categories in relation to the role of the health sector within the NRM and to the changes made to trafficked people's healthcare entitlements.

7.1 Overview of health-relevant changes following the ratification of the Council of Europe Convention on Action against Trafficking in Human Beings

This section reviews the implications of the ratification of ECAT for the health sector. ECAT provided policymakers and advocates with a framework within which a response to trafficking could be developed and granted trafficked people a set of enforceable minimum entitlements. It mandated, for example, the provision of specific assistance and protection measures for trafficked people, and stated that some of these measures must be provided without reference to whether people cooperated with the authorities; obliged governments to establish a formal identification processes; widened the scope of trafficking to include internal trafficking; and created a treaty monitoring body (Council of Europe 2005).

During interviews, civil servants claimed that the implementation of ECAT had focused predominantly on the introduction or extension of measures that purported to support and protect trafficked people:

> The Council of Europe Convention is actually quite a wide-ranging document, in many ways it's quite wide-ranging like the Palermo Protocol, but the focus of the Convention has been the victims. The 45 days, granting victim protection, rights, things like that (Civil Servant).

[33] All civil servant interviews took place between July and August 2009 i.e., after the implementation of ECAT.

This account of the ratification process was supported by analyses of government documents. Prior to the signature of ECAT, a legal and policy review undertaken by UKBA (then called the Immigration and Nationality Directorate, or IND) suggested that the main areas of non-compliance with the instrument related to the legislative definition of trafficking (Article 4) and procedures for the identification and support of trafficked people (Articles 10 and 12) and for the issuing of recovery and reflection periods and residence permits (Articles 13 and 14) (IND 2006). In 2008, in response to a parliamentary question, the Parliamentary Under-Secretary of State for the Home Office, Lord West of Spithead, similarly stated that the government expected limited primary legislation to be required to ensure full compliance with Articles 10 and 14, and that secondary legislation was required in respect of Articles 12, 13 and 14 (HL 2008).

ECAT was significant for the health sector in respect of its requirement that trafficked people were given access to emergency medical care and, in certain circumstances, to other necessary healthcare services. These requirements were addressed by an amendment to the NHS (Charges to Overseas Visitors) Regulations 1989 that exempted from charge anyone who had entered into the National Referral Mechanism (NRM) and was either in receipt of a current reflection and recovery period or had been conclusively identified by the Competent Authority as having been trafficked (S.I.2251/2008). People claiming to have been trafficked but who had chosen not to enter into the NRM or had not yet received a decision granting them the reflection and recovery period were not eligible for free medical care on the basis of this claim.

ECAT was also relevant to the health sector in respect of its requirement that certain public authorities should be able to identify trafficked people and refer them onto further support. The NRM was established to meet these obligations. From the 1st April 2009, people who claimed to have been trafficked could agree to be referred into the NRM by named statutory and voluntary First Responder (FR) agencies. Staff within one of two Competent Authority (CA) teams would then decide whether there were "reasonable grounds" to believe that the person had been trafficked. A positive decision granted the applicant a 45 day reflection and recovery period during which time they could access support services and no action could be taken to remove them from the UK. During this period, the CA teams would conduct a second assessment of the person's claim and determine whether there were "conclusive grounds" to believe that the person had been trafficked. A positive decision at this stage required a higher level of certainty and allowed claimants to access further support and to apply for a temporary residence permit (CJS 2009a). In practice, however, decision-making appeared to be much slower. The Poppy Project reported that for women they

were supporting between April 2009 and June 2010, the average time taken for a reasonable grounds decision to be made, and therefore healthcare entitlements to be granted, was 75 days. A Freedom of Information Act release in January 2010 did not give information on how quickly reasonable grounds decisions were made, but gave information on the timing of conclusive grounds decisions for 149 applicants: 23 had received their decisions within 45 days, 74 in 46 to 90 days, and 42 in 91 or more days (South Yorkshire Police 2010). As shown in Chapter 1, 706 applications were made to the NRM between April 2009 and March 2010. As of March 2010, just over half of these applications had been accepted at the reasonable grounds stage and, of these, a third were accepted at the conclusive grounds stage.

Currently healthcare providers have no role in either the referral or identification of trafficked people through the NRM. Healthcare providers were not initially listed as FRs to the NRM, which was described in the 2009 update to the National Action Plan on Tackling Human Trafficking as enabling "public bodies such as *UKBA, police and local authorities and third sector partners* to work together to identify individuals who may be victims of trafficking and provide appropriate protection and support" (Home Office 2009b, emphasis added). They did appear, however, on a revised list in November 2009: section one of the Criminal Justice System's Tackling Trafficking Toolkit listed "Statutory Qualified Health Officials" as First Responders alongside the police, UKBA, CPS, Local Authority Children's Services, the Gangmasters' Licensing Authority, and four designated NGOs (OCJR 2009). Conversations with civil servants in June 2010, however, suggested that healthcare providers had been removed from this list, however, and at the time of writing did not have FR status:

> James, a civil servant, stated that health practitioners were not currently on the designated first responder list and so they would therefore normally refer via another organisation (Fieldnotes 2010b).

Further conversations with civil servants involved in the implementation of ECAT suggested, however, that neither the UKBA nor the Department of Health opposed the inclusion of healthcare providers on the FR list. For example, in August 2010 both supported the request of an individual Leicestershire-based health clinic for First Responder status (Personal Communication 2010a). Healthcare providers have also not been involved in the NRM as CAs, which sit within the UKBA and UKHTC (the UKBA-based teams make decisions on third country nationals and the UKHTC

team makes decisions on British and EU nationals) and were reported by interviewees to be staffed entirely by UKBA.

7.2 Potential constraints on domestic policymaking

The research found that the changes that were made in response to the requirements of ECAT were influenced by a variety of domestic factors. Analyses of interviews, documents, and field notes identified seven categories of factors that acted as constraints to trafficking policymaking and the ratification and implementation of ECAT: legal restrictions, the limited availability of skilled professionals, institutional barriers, ideological constraints based on norms and values, incomplete information, financial limitations, and time constraints. This section defines each of these categories; the remainder of the chapter will analyse their relevance for the health-related policy changes that followed the ratification of ECAT.

Legal: The requirements of national and international legal instruments constrained the decision-making of government officials, by obliging, for example, the government to have certain policies and procedures in place and by establishing principles to which policies must adhere.

Skill: Limitations in the skill and knowledge base of the individuals and organisations that would be tasked with implementing a policy affected the feasibility of proposals and thereby acted as a constraint to policymaking.

Institutional: Policies, procedures, and targets in other issue areas (such as migration, crime, and prostitution) limited the range of policy options that could be feasibly implemented, as these pre-existing institutional priorities were likely to take precedence over the emerging priorities of trafficking policy. The pre-existing organisational structures of implementing agencies also constrained policy development, and have been categorised as institutional factors.

Ideological: The fundamental beliefs and values that were embedded in the culture of organisations acted as ideological constraints to policymaking. They structured how organisations in the trafficking policy subsystem thought about policy problems and the principles by which they appraised potential solutions: proposals that ran contrary to the dominant beliefs and values of an organisation were unlikely to be accepted and implemented.

Information: Incomplete and otherwise imperfect information about key aspects of the issue under consideration (for example, the scale of the problem, its distribution, causal drivers, and consequences) constrained the design and appraisal of potential policies.

Financial: The amount of financing that was available to allocate to addressing a problem constrained the scale and scope of policies and programmes that could be developed.

Time: Time constraints restricted the ability of policymakers to formulate and compare potential policy options and, later, to implement and evaluate the options chosen. They arose because policymakers had limited time within which to respond to particular issues: they were required, for example, to deliver policies and/or results within a given timetable and were often responsible for policies relating to multiple issues.

7.3 Legal Constraints

This section presents evidence to show that the decision to ratify ECAT acted as a legal constraint to the content and direction of the UK government's anti-trafficking policies and programmes. As previously stated, ECAT obliges governments to ensure that trafficked people are identified, given temporary protection from deportation and provided with appropriate support, including, under certain circumstances, access to medical care.

The research found that basic requirements of ECAT prompted the introduction of the NRM and the amendment to the healthcare charging regulations. For example, an impact assessment of the ratification of ECAT stated that the UK government would introduce an NRM because although the "development of a National Referral Mechanism is not a specific recommendation of the Convention...it is recommended international best-practice and the Convention does require the existence of a victim identification process and victim support arrangements which are the main elements of an NRM" (Home Office and BIA 2008). The same document also states trafficked people would be able to access "Convention compliant support" during the reflection and recovery period and that the government would therefore be "introducing secondary legislation to exempt non-UK national victims of human trafficking from being charged for 'emergency' health care during the reflection period." During interviews, civil servants also suggested that the ratification of ECAT had triggered these changes. One civil servant, for example, who was asked to talk about

the introduction of the new healthcare entitlements for trafficked people, stated that the regulations were amended to ensure compliance with ECAT:

> One of the first things I did was a sort of policy analysis, of the Convention and current processes and policies, and a sort of legal analysis. And sort of taking a sort of risky approach to it, so we could do it quite quickly. Health, or access to health, was a potential risk. It wasn't clear whether our existing provisions would have allowed all the access that the Convention required...And [so] we drafted amendments to secondary legislation (Civil Servant).

The research found, however, that trafficking policy stakeholders differed both in their interpretations of the requirements of ECAT and in their assessments of the UK's compliance. In particular, the NRM's two-tier system separating referrers (FRs) and decision-makers (CAs), which restricted powers to identify trafficked people and issue residence permits to UKBA staff, was found to have prompted considerable argument between the government and NGOs. CAs had been defined, in the explanatory report to ECAT, as the public authorities that may come into contact with trafficked people, such as the police, labour inspectorates, customs, the immigration authorities and embassies or consulates (Council of Europe 2005). Some NGOs claimed that the government were therefore legally required to include additional public authorities in decision-making processes. An NGO Submission authored by Anti Slavery International (ASI), Amnesty International UK (AIUK), ECPAT UK, the Helen Bamber Foundation, Kalayaan, and the Poppy Project in May 2008 stated, for example, that the UK's obligations under Article 10 of ECAT engaged "not only the police and immigration authorities but a range of authorities likely to come into contact with trafficked victims including the Crown Prosecution Service, the Gangmasters Licensing Authority, local authorities, prisons, detention facilities, *NHS trusts* and many educational establishments (AIUK, ASI et al. 2008, emphasis added). As shown in Chapter 6, ASI, AIUK, ECPAT UK, and the Poppy Project were key NGOs within the UK trafficking policy subsystem. Their interpretation of ECAT appeared, however, to have been rejected by the government. In the Explanatory Memorandum on ECAT, published later in 2008, the government stated that "the Convention leaves open exactly which government bodies should act as competent authorities...it is therefore open to Government as a matter of policy to decide how an NRM should operate" (FCO 2008).

Analysis of interview data and field notes suggests that the government argued that because the Competent Authority teams made decisions relating to the legal status of overseas nationals, the UKBA were legally required to participate in the Competent Authorities. One civil servant, speaking during interview about the design of the NRM, stated that:

> We always thought it had to be multi-agency in some way. But again, UK Border Agency has certain rules and regulations, so they have to be involved and they have to make some decisions around third country nationals. So we just had to work with some of those limitations as well (Civil Servant).

Similarly, field notes from a UK Human Trafficking Centre (UKHTC) NGO briefing day in 2008 recorded another civil servant's comments that "you can't take UKBA out of it if at some point it has an immigration angle...This flows from the legal advice. A decision on third party nationals has direct immigration consequences: the Secretary of State for the Home Department should make the formal decision" (Fieldnotes 2008a). Insofar as this did not preclude the design of a multi-agency decision-making body, however, this concern cannot explain either the composition of the CAs or the exclusion of the health sector from these teams.

The research also found that government officials, NGOs, and immigration lawyers appeared to hold differing interpretations of UK legal requirements as they related to FRs. It is unlawful in the UK for anyone other than an "accredited immigration adviser" to provide advice or information about an individual's immigration circumstances (Great Britain 1999) and both lawyers and NGOs argued that, as a person's entry into the NRM had immigration consequences, counselling somebody to enter the mechanism constituted immigration advice. As illustrated by the following exchange from a workshop held by the Office for Criminal Justice Reform (OCJR) and the Department of Health (DH), lawyers and NGOs therefore raised concerns that healthcare practitioners, and other professionals, should not be permitted to refer trafficked people into the NRM prior to the person receiving legal advice:

> Ramona, an NGO advocate, said that there would be difficulties around healthcare providers giving advice on the NRM because of the immigration implications – healthcare providers should refer people to either local authorities or civil society providers.
> Morgan, a service provider, added that in order to provide correct information about the NRM, one would also need to know about asylum. This could perhaps be subcontracted

> out: immigration advice was regulated. There was an issue that if the work was too complicated for doctors, they may not do it. Chris, a civil servant, wondered whether the NHS could act as a first responder, noting that it wouldn't be easy (Fieldnotes 2009a).

Although the research found no evidence that government officials directly rejected these types of arguments, questions regarding the legality of "unaccredited" healthcare professionals advising people to enter the NRM do not appear to have influenced their exclusion from the FR list. Guidance provided to prison staff in the Trafficking Toolkit, for example, states that they may refer people whom they suspect have been trafficked into the NRM but must not provide them with immigration advice (CJS 2009c). Legal constraints do not, therefore, seem to account for the absence of healthcare providers from either the FR list or the CA teams.

As previously stated, civil servants attributed the revisions to the NHS (Charges to Overseas Visitors) Regulations in 2008 to the ratification of ECAT. The research found, however, that these interviewees disagreed in their interpretation of the government's requirement to provide trafficked people with healthcare services and of the implications of the amendment to the NHS charging regulations: was the amendment generous or did it merely meet legal obligations? The government had been encouraged by NGOs to seek to exceed the "minimum standards" of support that ECAT required, for example in relation to the length of recovery and reflection periods. Some participants noted in interviews, although not in submissions or meetings, that the provision of healthcare was one area in which the government could exceed its basic obligations. One civil servant stated that trafficked people had been given free access to both emergency and non-emergency healthcare and that the government had therefore gone further than it was legally required to do:

> Well we've signed up for the Council of Europe Convention, and in fact we went one step further. And victims, I mean non-UK nationals can be charged for non-emergency healthcare, and now victims of human trafficking aren't going to be charged. Which means they have access to the full range of healthcare. So in that respect that barrier has already been broken (Civil Servant).

A second civil servant, who had worked with the Department of Health in developing the amendment, disagreed with the suggestion that the government had gone beyond their legal duties under ECAT:

> I'm not sure that we really have gone beyond the minimum requirements. What we were trying to do was make sure that there wasn't a grey area... you know, our intention was exactly as the Convention described (Civil Servant).

The amendment was constructed so that eligibility for free care was dependent on a positive decision in the NRM: until a person suspected of having been trafficked had been officially identified as a potential victim of trafficking, and granted temporary legal status on this basis, they were not entitled to receive free care beyond the emergency care available to all. This suggests that although the government sought to comply with the terms of ECAT with regards to the provision of healthcare services, it did not exceed its obligations.

Whilst the government did not appear to seek to exceed its legal obligations in relation to trafficked people's healthcare entitlements, the research suggested that the risk of legal challenge may have prompted civil servants to be cautious in making the amendment. One civil servant suggested that it seemed unlikely that "any trafficked woman [would take] a hospital to court because they haven't received a health service that they're entitled to", but another, more senior civil servant interviewee, reported that health was felt to be "the area that, frankly, we would be most likely to be challenged on if we got it wrong". Interviews with service providers, advocates, and lawyers indicated that they were ready to take legal action should the government fail to provide trafficked people with their entitlements, and service provider interviewees spoke specifically about having previously used welfare solicitors to ensure their clients had access to medical care:

> In one incident I took somebody to the hospital and they had to consider their status before they could section the person. And you know...and in another instance coming to think of it, we had to use a solicitor, a welfare rights solicitor, to get them to section her. Because she was an EU citizen and did not have recourse to public funds (Service Provider).

Furthermore, it is likely that policymakers were aware that, at the time they were drafting the amendment, a case was being brought against West Middlesex University Hospital NHS Trust in relation to their refusal to provide free care to a failed Palestinian asylum-seeker (Justice Mitting 2008). Judge Mitting's ruling that individuals who made their applications at the port of entry were lawfully resident in the UK attracted considerable media attention and required the DH to issue interim guidance to NHS trusts whilst it fought the ruling in the Court of Appeal (DH 2008). One legal interviewee, noting the synchronicity between the announcement of the amendment and the

appeal of the Mitting ruling, suggested that the decision to insert a "generous" amendment may have been taken not only to avoid legal challenge but to "placate" NGOs campaigning on migrant access to healthcare.

It seems less likely that fears relating to legal compliance encouraged the late addition of healthcare practitioners to the FR list or that the risk of possible legal action (for example, if healthcare workers failed to fulfil their duties as FRs) provoked their later removal. The research found that South Yorkshire Police were reluctant to host the UKHTC after it took on the CA role, fearing that it would be exposed to legal action on the basis of the decisions it made (Home Office 2009c). No evidence was found, however, to suggest similar concerns had existed in relation to a role for healthcare providers in identifying or referring trafficked people to the NRM. Overall, legal factors, whilst providing the impetus to introduce the NRM and to amend the NHS charging regulations, can, at best, only partially explain the form the changes took.

7.4 Skill Constraints

The majority of stakeholders in the UK trafficking policy subsystem believed that healthcare providers had only a limited awareness of human trafficking and little expertise in responding to it, and this perceived lack of expertise appeared to have hindered the participation of healthcare providers in the policy subsystem. This section shows that when analysed in relation to the development of policies following the ratification of ECAT, stakeholders' perceptions that healthcare providers lacked trafficking-related expertise also appeared to be relevant to healthcare providers' omission from the NRM.

In response to other forms of crime, healthcare providers currently participate in local multi-agency boards to assess and manage the risks posed by offenders and to vulnerable people. Multi Agency Public Protection Arrangements (MAPPA), for example, bring together the police, probation, and prison services with other agencies to manage the risks to the public posed by violent and/or sexual offenders living in the community. Primary Care Trusts, Strategic Health Authorities, and other NHS trusts are amongst those who have a duty to cooperate in these arrangements, and must nominate a senior manager to participate in MAPPA panel meetings and to act as a point of contact for operational and case-related matters (Probation Service 2003). Health authorities also participate in Multi Agency Risk Assessment Conferences (MARAC), which bring together statutory and voluntary agencies in responding to cases of domestic abuse (CAADA 2009). Civil

servants reported that they had rejected proposals for an analogous regional, multi-agency CA model during the development of the NRM, in part because trafficking expertise was insufficiently widespread:

> [The regional model] was never worked out in any detail because it wasn't the model that people really thought was realistic in the short term. I think people were attracted to it in the longer term...Partly I think the feeling was that there wasn't enough expertise around trafficking to be able to dilute it very much...And I guess also the practicalities of getting the sort of partners that we would have liked round the table, or into a room, or as a sort of virtual, to act as sort of MAPPA model (Civil Servant).

A more general lack of localised expertise was used to justify the separation of referral and decision-making functions in the NRM. Field notes show, for example, that at an OSCE-hosted meeting held in January 2009 to discuss the proposed NRM design, a civil servant discussed how a "second tier" of decision-makers would act as an expert authority, whereas the "first tier" of FRs was a wider group that needed to be aware of, but not expert in, trafficking. The civil servant went on to note that a consultation amongst government departments and authorities had concluded that "we do not have wide enough expertise to not have this second tier" (Fieldnotes 2009c). Notes from informal conversations also record that civil servants suggested that healthcare practitioners' "minimal awareness" of trafficking was likely to mean that they would not even be capable of fulfilling this first tier (Personal Communication 2009a). These civil servants attributed the initial decision to add healthcare providers to the FR list to the government's "aspiration" that healthcare practitioners should be able to participate in the NRM. They also stated that later discussions between the UKBA and DH had concluded that the lack of awareness in the health sector meant there was "little merit" in the entire NHS holding FR status and led to the removal of healthcare providers from the FR list (Personal Communication 2010a). The research suggests, therefore, that the level of health sector expertise was relevant to healthcare practitioners' status as FRs. The reasons why it was considered to be more or less important over time, however, are not clear.

Skill constraints did not appear to have been a relevant concern in relation to the changes to trafficked people's entitlements to free healthcare. This may be because healthcare providers would not be required to apply the newly amended NHS charging regulations: this responsibility fell to

hospitals' Overseas Visitors Managers (OVMs) (DH 2009)[34]. Furthermore, although stakeholders from outside the health sector questioned the ability of healthcare providers to identify trafficked people as such and to refer them onto appropriate agencies, they did not tend to have the same reservations about healthcare providers ability to meet the clinical needs of trafficked people. The analysis therefore suggests that whilst concerns about trafficking-related expertise limited healthcare providers' role in the identification and referral of trafficked people, these same concerns did not lead to a questioning of the ability of healthcare providers to meet trafficked people's healthcare needs.

7.5 Institutional Constraints

The research found that in the years preceding the signature and ratification of ECAT, government stakeholders identified a range of pre-existing systems, procedures, and polices that could be affected by its implementation. This section firstly presents analyses of whether the role of healthcare providers within the NRM was shaped by existing immigration and health system priorities and secondly shows how the existing regulatory framework for charging overseas visitors for healthcare services structured the changes to trafficked people's healthcare entitlements.

Civil servants, speaking about the design of the NRM during interviews and meetings, commented that they had been required to balance multiple interests and to ensure that its introduction did not negatively impact on the criminal justice system, the regulation of the labour market, or immigration processes:

> It ended up being really the only realistic option. It was something that could work; it was something that could improve victim protection, without screwing up existing immigration or criminal justice or market regulation processes, and without costing a fortune (Civil Servant).

The research found that of these competing priorities, particular emphasis was placed on the need to maintain the integrity of the immigration system against the potential risks risk that ECAT posed to it:

[34] Hospitals had previously been encouraged to appoint OVMs to "oversee the implementation of the hospital charging regime" (DH 2004a).

> There were risks that were recognised to be UKBA-owned around the Convention. Particularly the sort of reflection period, residence permits, and also the potential to conflict with the asylum and other immigration processes. So I think it was sort of if UKBA was in charge then it would be up to UKBA to manage the risks to its business. I think that was mostly, not because it was an immigration issue. But simply because there were known to be some risks that needed to be managed (Civil Servant).

Documents predating the signature of ECAT show that immigration officials believed that obligations to provide reflection and recovery periods and residence permits to trafficked people had the potential to negatively impact on the ability of the UK to meet the Tipping the Balance targets, make third country removals, use the detained fast track and detained non-suspensive appeals procedures, and operate the New Asylum Model[35,36,37, 38] (IND 2006). The potential risks that the provisions of ECAT were felt, by UKBA, to pose to the UK's immigration policies and procedures seem likely to have supported their claim to have a key role in the NRM. It is not clear, however, whether the risk to UKBA policies and institutional interests were relevant to the decision to have CA teams composed solely of UKBA staff. In respect of the health sector's omission from the FR list, the ready support given by the UKBA and DH to the Leicestershire clinic's request for FR status suggests that no potential risks to, or clashes with, pre-existing departmental programmes or policies was identified.

The research also found that the institutional priorities – and autonomy - of the NHS may have been relevant to the absence of healthcare providers from the NRM. In interview, one civil servant discussed the difficulties of mandating the NHS to respond to trafficking:

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[35] The Tipping the Balance target was announced in 2004 by the then Prime Minister Tony Blair, and requires that the immigration service removes more failed asylum seekers from the UK than register new claims.

[36] Third Country Removals are made where it is decided that it is not appropriate to consider an asylum claim in the UK, for instance because the applicant has previously applied for asylum in a "safe third county". The majority of these cases come under the arrangements of the Dublin Convention of the Dublin II Regulation, which aim to prevent "asylum shopping" within the EU.

[37] The fast track procedure is used when UKBA officials believe that an asylum claim can be decided quickly. This decision is often based on the person's country of origin. Asylum seekers whose claims are being fast-tracked are detained at an Immigration Removal Centre whilst their case is considered: a 'Detained Fast Track' (DTF) claim will usually take around two weeks to be determined. Applicants routed into the Detained Non Suspensive Appeal (DNSA) procedure are detained whilst their claims are considered and, if rejected, may only appeal the decision once outside of the UK. Asylum-seekers from over 20 countries are automatically entered into the DNSA process unless they can show on arrival that their claim is not clearly unfounded.

38 The New Asylum Model (NAM) was introduced in 2007. It provides asylum seekers with named case owners, who deal with all aspects of their case. NAM also places stricter reporting requirements on asylum seekers and established tighter timescales for case processing.

> A lot of power is devolved to local NHS organisations. And regional SHAs. So unless it's about waiting times or MRSA or something like that, then the chances of the department telling the NHS what it has to do on something like human trafficking is just not going to happen. So I suppose there's an issue there around what we can do is issue guidance or provide support or maybe some training or raise awareness or those kind of things, but we can't compel, or we wouldn't be able to compel somebody in the NHS to do certain things. Other than obviously if there's, well, when you get into territory about what the legal obligation is...So, the Department of Health/NHS relationship. That's probably quite a big one (Civil Servant).

Although the DH takes political responsibility for the NHS, management of the health service is currently devolved to the regional Strategic Health Authorities. Both civil servants and healthcare practitioners spoke about human trafficking and, more generally, violence, as an issue for which many in the health sector did not feel they had professional responsibility. One civil servant commented during interview, for example, that:

> To some degree, certainly in terms of identification and referral, there's probably a sense in which a lot of professionals might not see that as their number one priority. I mean obviously, it's not their number one priority. But umm, it's kind of [pause], the challenge is getting a healthcare professional to understand that even if they have nothing to do with the support services that a person needs, that by identifying them and referring them they're performing their job. Because some people might see their job or their responsibilities as being quite narrowly defined. And that might not necessarily include identifying and referring a trafficked woman, or if appropriate contacting police or other agencies to try and do something about the situation (Civil Servant).

The Department of Health's Violence Against Women and Girls Taskforce, which reviewed the NHS response to violence against women and made recommendations for its improvement, similarly concluded that many healthcare providers did not feel that the response to violence fell within their remit. The Chair of the Taskforce, for example, noted in his introduction to the final report that good practice, although identified, was not as widespread as it should be and that there had not been "the same rigorous and systematic approach to [the violence] agenda as has been applied to other areas of NHS work such as diabetes or stroke services" (VAWGT 2009). In this

context, the comment by one civil servant that the Leicestershire clinic's request represented a good opportunity to test the referral relationship in an environment in which the health sector "wanted to participate" may suggest that a broader institutional reluctance take on a FR role was relevant to the sector's exclusion (Personal Communication 2010a).

The healthcare providers interviewed for this research did speak about responding to violence as being a part of their professional responsibilities, but they represented a highly selected sample (of the seven healthcare provider interviewees, two were trauma counsellors and two worked in sexual assault referral centres) and it is not possible to generalise from their professional priorities to those of the wider health sector.

The change to trafficked people's access to free healthcare, whilst prompted by new legal requirements under ECAT, was clearly shaped by an existing policy regime that had been established by the NHS (Charges to Overseas Visitors) Regulations 1989 (S.I.1989/306). The regulations set out categories of people who were eligible for free care and certain types of medical services for which no charge could be made. Under the terms of the regulations, primary care is free and GPs have discretion over whom they register and treat. In respect of immediately necessary or emergency medical treatment, GPs have a duty to provide care regardless of whether the patient is registered with them or otherwise entitled to this care. Care received in hospitals, however, is potentially chargeable: all patients are exempt from charges for treatment received in the Accident and Emergency departments of hospitals but certain overseas visitors are liable to be charged for treatment received elsewhere in the hospital, regardless of whether or not the treatment is categorised as emergency care. Hospitals have a duty to establish whether patients are ordinarily resident and if they are either exempt from, or liable for, charge. Where patients are liable for charge, hospitals must attempt to recover payments for the care received. As discussed in Chapter 1, some trafficked people would be exempt from charge for care received prior to the amendment to the charging regulations but others would be liable.

The existing regulations provided a framework within which any changes to the healthcare entitlements of overseas nationals had to be integrated. Civil servants reported that the framework presented them with a series of questions: could emergency medical treatment under the Convention be limited to A&E treatment or did it also have to include in-patient treatment; how could those who were legally resident under the terms of the Convention but were not considered to be "ordinarily resident" for the purposes of the NHS regulations be exempted from charges; and

were there existing exemption categories within which trafficked people could be included? (Fieldnotes 2009g). The explanatory report to ECAT did not define what was to be included under the heading of emergency medical care and lawyers interviewed for the research noted that the term was not defined elsewhere in international law. Civil servants reported that they, in conjunction with government lawyers, had decided that medical treatment received under ECAT should not be limited to A&E treatment. During interviews, civil servants attributed this decision to their belief that as trafficked people were "victims of crime", they should be provided with medical care that was responsive to the health consequences of crime. One civil servant stated, for example, that:

> Our intention was exactly as the Convention described. There was no wish to deprive victims of trafficking of any kind of healthcare... someone who has been the victim of a very serious crime in the UK, as long as they're in the UK they should be entitled to the same sort of support, same sort of medical care as a British national (Civil Servant).

The issue of ordinary residence arose because whereas ECAT required care to be provided to trafficked people who were lawfully resident in the UK, the regulations exempted from charge all overseas visitors who have been lawfully resident for a year or more in the UK. Civil servants stated that this discrepancy created a "gap" in respect of people who had been lawfully resident in the UK for less than a year and, furthermore, judged that the existing exemption categories could not fill this gap. Having taken these constraining factors into account, a decision was made to draft a "straightforward" amendment to the regulations that exempted identified trafficked people from charges for all hospital treatment.

7.6 Ideological Constraints

This section presents the results of analyses of the extent to which the beliefs and values that were embedded within the UKBA and the NHS constrained policies regarding health sector involvement in the NRM and the entitlement of trafficked people to free NHS care.

Most civil servants and enforcement official interviewees suggested that protections and support made available for trafficked people would be abused by fraudulent claimants. NGO advocates, service providers, and lawyers suggested that a "culture of disbelief" permeated the UK Border Agency and that the NRM had been designed according to principles of immigration control. Although civil servants and enforcement officials tended to reject these accusations, they did report

that they favoured the development of rigorous identification and referral procedures that would deter, and detect, fraudulent applications:

> There was little point in creating a system that was open to misuse. Whether [NGOs] would agree that the risk was quite as profound as we thought it was, upfront, probably not. And it's probably true that some of them still would argue that that risk was small enough for us to virtually ignore and that we could have created a system that encouraged more victims to come forward. I think that's still a challenge to us (Civil Servant).

The research found that ideas about migrants abusing the provisions made for trafficked persons specifically to access *healthcare services* were played down by civil servants during interviews:

> Taking an extreme example, you want to prevent health tourism, prevent people presenting as victims in order to be able to gain access to healthcare...You don't want people to suddenly present as victims in order to get something more than just emergency medical treatment, something to correct a longstanding healthcare condition or whatever. But that's a deliberately exaggerated example, I don't think that anybody would do that, or does that (Civil Servant).

Furthermore, the research did not find evidence that "health tourism" had been a concept that was frequently spoken about within trafficking policy documents or at trafficking policy meetings. Analysis of field notes, for example, showed that the only instance of health tourism being discussed at the trafficking policy meetings and events I attended was in a presentation by the Deputy Director of SOCA at the Stopping Traffick conference in March 2009 (Fieldnotes 2009d).

More general beliefs about the likelihood of support and protection measures being abused, however, do seem to have shaped the nature of trafficked people's exemption from healthcare charges. People seeking recognition by the NRM that they were trafficked were not granted free care until they had been officially identified as such and the government therefore avoided providing free services to migrants whose claims were later rejected through the NRM. Guidance to hospital Overseas Visitor Managers (OVMs), who were responsible for collecting healthcare payments from overseas patients, recommended that patients who had entered into the NRM were "not asked to pay in advance for any treatment they might need before the UKHTC confirm them as a suspected victim (5 days)" and that trusts should not pursue charges for treatment given within the

5 day referral period if the CAs confirmed that there were grounds to believe that a person had been trafficked (DH 2009). If the CAs decided, however, that there were not reasonable grounds to believe that a person had been trafficked, OVMs were instructed to pursue any debts that had been incurred in this time period.

The research found, however, that the "culture of disbelief" was less relevant to decision-making around the extent of health sector involvement in NRM processes. NGO interviewees had suggested that the government's concerns about the abuse of support and protection measures, coupled with a preoccupation with managing immigration flows and meeting immigration targets, had led to the restriction of CA membership to UKBA staff:

> The fact that it's police and immigration who are the competent authority...because it's about immigration status, and it's about policing immigration rather than focussing on victim protection, and to be honest I think that if the government had made an NGO the competent authority, I think the opposition would have come down hard on them....if an NGO said, yes 75% of the people who've been referred to us we've decided are trafficked, I'm sure there would be people kind of saying, well that seems to be an incredibly high number and I'm sure they're letting people through who aren't really trafficked (Advocate).

Their line of reasoning, however, related to the exclusion of NGOs from the CAs. The research found that similar arguments did not appear to be relevant to the non-participation of healthcare professionals: one civil servant's comment, for example, that "there is no way that NGOs will make decisions on the trafficking status of a person" because NGOs did not bear the costs or consequences of that decision (Fieldnotes 2008a), points only to the government's position that the CA must be a public body, which would include NHS trusts.

Lawyers and NGO interviewees also criticised the restriction of FR status to a limited number of public authorities and voluntary agencies:

> Currently, there are no referral avenues for non-government agencies for children, so whereas with adults you have the Poppy Project, Migrant Helpline, Kalayaan, there is only two routes into the national referral mechanism for children – one is the local authority and the other is police or UKBA...So, [ECPAT] and even the NSPCC have been told, and the Refugee Council, that [they] can't make referrals... the government wants to control it to be

> only a local authority, they want to control the process. Once again, it's potentially because they want to limit the numbers, the official numbers (Advocate).

The research found that it may be the case that concerns about impartiality were relevant to the exclusion of NGOs and lawyers from the FR list: during informal conversations civil servants stated that they wanted to enable *public sector* employees, such as health officials, to make direct NRM referrals as they expected that they would be "unbiased" as to whether the person may or may not have been trafficked (Personal Communication 2009a). The apparent distinction drawn between public sector employees and advocacy groups indicates, however, that the "culture of disbelief" was not relevant in deciding *which* public authorities to include as FRs.

Analysis of interviews with healthcare providers suggested that although they had not been approached to participate in the NRM, their commitment to the principle of "doing no harm" is likely to be relevant to the extent to which they will be prepared to participate in future. The majority of these interviewees did not have sufficient understanding of the NRM to permit in-depth discussions about either the process in general or the potential for healthcare providers to have referral or identification roles within the process. Interviewees suggested, however, that they would have concerns about referring trafficked people into the NRM, in particular because a referral may put the person at risk of deportation:

> I would want to understand exactly where [the information] goes and if we would put the person at any risk for them to be deported, any negative impact that is outside of their control that they don't wish to have. That would be the terms and conditions for it, if you like (Healthcare Provider).

In explaining these concerns, healthcare providers noted that many asylum seekers had their claims rejected and that in relation to trafficked people a high proportion of asylum cases succeeded upon appeal. They therefore believed that the government's decision not to include an appeals mechanism within the NRM could place applicants at risk of removal after "alerting" the authorities to their presence in the UK:

> There's the downside to [the NRM] in that you've alerted people to yourself and that if you're not accepted then you would be removed much quicker than you necessarily would have been. So, again, I think it's just a case of it being difficult because the asylum system

> is a bit farcical at the moment... I know that a lot of [asylum] cases are won on appeal. There's no appeal mechanism [in the NRM]? ... I can understand why people wouldn't want to go into that mechanism for fear of being removed if they're not believed (Healthcare Provider).

The research suggested, therefore, the potential for conflict between an identification and referral role for healthcare providers within the NRM and their professional ethics regarding doing no harm and acting in the best interest of the patient.

7.7 Information Constraints

This section presents analyses which demonstrate that the lack of information about the scale of trafficking in the UK and the ways in which trafficked people came into contact with healthcare providers appeared to have had an indirect impact on the health sector's role within the NRM. It also shows that, in contrast, limitations in the knowledge base regarding the health needs of trafficked people did not seem to have been relevant to the decision to exempt trafficked people from all charges for secondary medical care in the UK.

The research found that a range of stakeholders believed that healthcare practitioners were likely to come into contact with trafficked people, either whilst still in the situation of exploitation or after they had left their traffickers. The summary of responses to the consultation on a National Action Plan to tackle trafficking stated, for example, that a number of respondents had commented that "victims of trafficking are likely to access service provision including sexual health services" (Home Office 2006c). Civil servants echoed these beliefs during interviews:

> I suppose healthcare professionals might be in a slightly better position to [identify trafficked people] than some others, because they might be treating them for perhaps sexual health related things, or be in a situation where they're able to get confidential information, or they've got a kind of, they can build a bit of a relationship of trust, even if it's just for a short period of time (Civil Servant).

It was not known, however, how many trafficked people did access care or which healthcare services were most likely to come into contact with trafficked people. Service provider interviewees tended to be sceptical about whether women were able to receive medical services whilst trafficked,

claiming that this had not been the experience of the women they had supported. Civil servants, when asked to discuss this issue further, stated that their beliefs about trafficked people's access to healthcare were based on anecdotal information and intuition:

> R: One of the few professional services that traffickers will allow their victims to see, are health workers. Because they need these women to be able to be in working order... so the healthcare workers are therefore a really, really good resource and opportunity for us to be able to identify victims...I think that's where healthcare workers are probably in a better position than a lot of others.
>
> I: When you say that's something that you're aware of, how has that become apparent?
>
> R: It's...it's a good question, I don't know how we know. But it's one of the, it's one of the things that we've known about for a while, but it's a good question. It might be anecdotal, but it is one of those things that actually, it makes sense. It is quite intuitive. You know. If people see healthcare workers as benign (Civil Servant).

Policy documents also stated that this knowledge was anecdotal in nature. The 2008 update to the National Action Plan to tackle trafficking, for example, stated that "anecdotally we know that women that are trafficked into sexual exploitation are often allowed access to sexual health services, which makes them a potential key location for victim engagement" (Home Office 2008). Despite proposals in the National Action Plan to implement training programmes for sexual health clinicians on the basis of this knowledge, civil servants reported that, in practice, the absence of data made it difficult to persuade the Department of Health and the NHS to become more involved in responding to trafficking and meant that it was possible neither to find support to finance sector-wide awareness-raising programmes nor to plan smaller-scale targeted training:

> The fact that [the UKHTC] hasn't been able to provide any kind of accurate data is definitely a big problem in terms of engaging health services and, generally, the Department [of Health]...if you're aware of the scale of the problem and the potential number of women or trafficked people that might come into contact with an accident and emergency department for instance, then you can use that as a basis to determine an appropriate response. Whether perhaps people in all A&Es need to be trained up to some, to have some basic level of training. Whether the numbers are sufficient to justify that.

> Whether people will present at sexual health clinics but not at A&Es, or walk-in centres but not at other health services. Kind of an idea of the overall numbers (Civil Servant).

The knowledge base regarding the likely health consequences of trafficking is also extremely limited. The research found that policymakers were aware of this lack of information. A Home Office review of the literature on trafficking for labour exploitation stated, for example, that:

> It is likely that victims of labour exploitation might have some similar and some differing needs [to people trafficked for sexual exploitation], especially given the abusive and dangerous conditions they can work in (although this is not qualified with any UK research in this area)....There is little knowledge focusing on victim outcomes both in the short-and long-term (Dowling, Moreton et al. 2007).

Similarly, one civil servant, speaking about a project to provide (as yet unpublished) guidance for healthcare practitioners on responding to child trafficking commented that:

> [Producing the document was] relatively straightforward in the sense that the material was there, there isn't a vast literature on the subject so it's not that difficult to summarise (Civil Servant).

Although the lack of information regarding the health consequences of human trafficking may have limited the potential for developing health-relevant indicators to assist healthcare providers to identify trafficked people, the research found that the absence of a "vast literature" did not appear to constrain decision-making in relation to trafficked people's healthcare entitlements. Civil servants reported that they drew on other sources of knowledge to conclude that trafficked people may present with a variety of healthcare needs and could require long term care:

> We've already been supporting victims for quite a number of years now. When they immediately present they may have A&E type of health needs. But in terms of, it tends to be longer term. It's about addressing their psychological needs, longer term health needs, that go far beyond just initial emergency care. And I think Cathy Zimmerman's [Stolen Smiles] report was good, it was the only evidence we really had. Firm research evidence. But also just thinking logically about what we know about victims of crime more generally,

> it just became more obvious that they'd need more than just emergency healthcare (Civil Servant).

Therefore, whilst information relating to the health needs of trafficked people and more generally to people who have experienced crimes seems to have been relevant to the decision to exempt trafficked people from charges for all NHS care, the lack of formal research into the health needs of trafficked people does not appear to have acted as a constraint to policymaking in this area. Although NGOs' use of the "Stolen Smiles" study findings did not include advocacy around the provision of healthcare services, it is likely that their use of health and trauma based arguments in relation to the provision of support services and immigration protections increased civil servants' familiarity with the potential health consequences of trafficking and may have also increased the extent to which they were comfortable basing decisions about healthcare entitlements on a limited knowledge base.

7.8 Financial Constraints

During interviews, although civil servants commented that "we can't throw lots of money [at trafficking], because there isn't money", they also noted that the government had invested a "significant amount of resource" into responding to human trafficking relative to the scale of the problem. This section draws primarily upon on government policy documents to suggest that financial considerations had limited direct relevance for the health sector's role within the NRM and the changes that were made to trafficked people's healthcare entitlements.

The impact assessment of ratifying ECAT shows that the provision of support to trafficked people represented the most significant cost within the proposed NRM. The cost of stage one of the NRM (the five day period between referral and a reasonable grounds decision being made) was estimated at £330,000 for year one, of which £289,000 represented the cost of temporary support. The costs of referral (i.e., FR costs) were estimated at £32,000. The low volume cost of stage two (the forty five day period in which trafficked people could access support and further assessments were made to support a conclusive grounds decision) were estimated at £1,280,000 for the first year: £1,178,000 of this total represented victim support costs compared to £103,000 for CA costs (Home

Office and BIA 2008)[39]. Home Office options papers suggest, however, that financial issues were less important than the potential for abuse of the immigration system (and public perceptions about the extent of abuse) in decisions regarding which model of support to use: continuing with the "Poppy Project model" was more expensive than either the "extension of asylum support" (whereby trafficked people would be added to asylum seekers and their dependents as people to whom the Secretary of State could provide support under the Immigration and Asylum Act 1999 (Great Britain 1999)) or "mainstream[ing] provisions into existing local arrangements" but appeared to be more politically palatable (Home Office 2007c). Given that the FR and CA costs were comparatively much lower than the victim support costs, it seems unlikely that financial constraints had a direct impact on health sector participation in the NRM in either a referral or decision-making capacity.

Civil servants also made limited mention during interviews of the role of financial constraints in relation to the design and functioning of the NRM. With regards to CA membership, civil servants spoke only about how a centralised model avoided the need to find local funding for supporting trafficked people:

> [A regional model] would require local authorities to be far more involved in the sort of trafficking side of things.... there's all sorts of funding issues to consider. Which is one of the reasons why we ended up going for the model that we've got, with a centrally funded support provider rather than locally funded ones (Civil Servant).

The research also found that financial constraints seemed to be relevant to the appointment of healthcare providers as FRs only insofar as they meant that the problems relating to health sector awareness and expertise could not be overcome. Health professionals' lack of trafficking-related expertise appeared to limit the potential for their involvement in the NRM and, to date, resources have not been provided to develop and roll out programmes to train healthcare providers to identify and refer trafficked people. This was in contrast to the systematic awareness-raising and training programmes that had been rolled out for police officers and immigration officials. The research did not find evidence to suggest, however, that the lack of health sector training was attributable to financial constraints per se. Civil servants instead suggested that it was difficult to make a case to

[39] The low volume costs are based on projections of 350 adult referrals and 360 child referrals per year. High volume costs are also provided in this document, based upon projections of 1000 adult and 1000 child referrals per year (Home Office and BIA 2008).

use departmental resources for training programmes because of a lack of *information* about how many trafficked people used healthcare services and which services they were most likely to use.

The influence of financial considerations on the changes made to healthcare access policy is not clear. As only a small number of trafficked people were expected to be identified as trafficked under the NRM, and therefore to become eligible for free healthcare, each year, the cost to the NHS of providing healthcare to trafficked people as per the amendment to the NHS (Charges to Overseas Visitors) Regulations was not expected to be high. The impact assessment for the ratification of ECAT stated, for instance, that "as the number of victims expected to meet the criteria after which they are able to access the healthcare support is likely to be around 350 a year, ratification is not likely to result in a significant demand on...health and social care services" (Home Office and BIA 2008). It went on to note that the total expected cost to the NHS could be higher or lower depending on the total number of victims granted temporary leave to remain[40]. Although one civil servant believed that the potential number of people eligible for extended care was high and therefore disputed the assertion that the costs to the NHS would be low, others concurred that relatively few people would access care under the new exemption:

> I mean we're talking about a really quite small number of people here, so I don't think, and when you're looking at it from a political point of view, the government is not going to start going after victims of trafficking who are frankly taking up too much of our care. It's just never going to happen...So I think what you're, in terms of long term healthcare, you're looking at the extreme end of the sexual exploitation, and [unclear]. So you're probably talking tens, possibly low hundreds, per year (Civil Servant).

It is not possible to assess, however, whether less generous provisions would have been made (for example, restricting emergency care to only that received in an A&E unit) had the numbers of trafficked people, and therefore the financial implications of providing healthcare, been greater.

[40] Although the impact assessment noted that the amount of healthcare a person required would vary, it estimated the likely healthcare and counselling costs to be £2,554 per person per year for stage 2 of the NRM (the 45 day recovery and reflection period) and £1,680 per person per year in stage 3 (residence permit) Ibid.

7.9 Time Constraints

The research found that, during interviews and policy meetings, civil servants reported that the implementation had been highly time pressured. They stated that the Home Secretary's decision to ratify ECAT by the end of 2008, motivated by the belief that "the story around trafficking and the government's response to it had become all about our slowness to ratify the Convention", had meant that policy changes were focused on areas of non-compliance:

> Our analysis of the Convention was that in terms of provision for child victims, we were already compliant. We didn't need to change anything to be compliant... given the remit that we had to ratify and ratify quickly, and we could make any longer term changes under the UK Action Plan, our focus was more on getting the adult protection side right first. Because that's where we had to make legislative and procedural changes (Civil Servant).

The research found no evidence to suggest, however, that time constraints influenced the level of health sector involvement in the NRM. The design of the NRM was piloted in two police operations and consulted upon over several months within government and with external stakeholders: it is not clear that a longer period of design, testing, or consultation would have increased the likelihood of health sector participation in the NRM. Time constraints were relevant to the changes to trafficked people's healthcare entitlements in that the UK's non-compliance with ECAT's healthcare requirements became more urgent, but did not seem to have affected the nature of the amendment.

7.10 Summary

This chapter has considered the role of the health sector in relation to procedures for the identification, referral and support of trafficked people, which were introduced in response to the requirements of the Council of Europe Convention on Action against Trafficking in Human Beings. It has shown, firstly, that the changes to trafficked people's healthcare entitlements were structured according to the pre-existing regulatory framework (the NHS (Charges to Overseas Visitors) Regulations 1989). The research suggests that the terms of the amendment to these regulations were heavily influenced by concerns about the potential abuse of support and protection systems. The chapter has also shown that although concerns for the integrity of the immigration system significantly affected the design of the NRM procedures, the limited participation of the health

sector is best explained with reference to the ambivalence of the Department of Health and NHS to addressing human trafficking, the poor levels of trafficking-related awareness and expertise amongst healthcare providers, and a lack of information about how and where trafficked people came into contact with the healthcare system.

The healthcare providers who were interviewed in this research could not be described as "ambivalent" to responding to human trafficking or other forms of violence and abuse. A mismatch existed, however, between them and other policy actors in relation to the role of the health sector in responding to trafficking. A number of non-healthcare interviewees felt that healthcare providers had a role to play in identifying trafficked people and referring them to the NRM or to support services. The healthcare providers interviewed for this research suggested that they would be reluctant to take on such a role, particularly because the referral brought the trafficked person to the attention of the police and immigration authorities, and were concerned more about the need to improve the standard of care provided to trafficked people. This suggests that even if the resource issues (lack of financing, skills, and information) that constrained the health sector's involvement in responding to trafficking could be overcome, the differing priorities of the NHS and the Home Office could make the health sector's integration into a Home Office-led response to trafficking problematic.

Chapter 8

Discussion

Over the past decade, UK human trafficking policy has been critiqued by both academics (O'Connell Davidson 2006; Anderson and Andrijasevic 2008; Mai 2009) and non-governmental organisations (Skrivankova 2007; ATMG 2010; X:talk 2010). The research presented in this thesis adds to these critiques and provides the first analysis of how the health, and indeed the broader welfare, of trafficked people has featured in the content of human trafficking policy, and of how these issues have featured in the policymaking process. This chapter begins by summarising the main findings of the research. It then reviews the steps taken to increase the research's validity and dependability and discusses the study's limitations and challenges. The chapter then considers the applicability of three major theories of the policymaking process in explaining the limited role of health within trafficking policymaking. The research findings, their implications, and their relationship to existing academic literature are then discussed in detail. The chapter closes by speculating upon the future for health within UK human trafficking policy.

8.1 Summary of Findings

The research found that stakeholders within the trafficking policy subsystem held competing analyses of the key causal drivers of trafficking and how it should best be approached as a policy problem. Chapter 4 showed how organised immigration crime-based analyses of trafficking dominated trafficking policymaking in the UK but were criticised by many external stakeholders, who devoted much of their advocacy efforts to mitigating what they saw as the negative consequences of such analyses for trafficked people's welfare. Whether organised immigration crime sat within a broader category of crime or migration was also disputed: either way, neither this conceptualisation nor other available analyses of trafficking lent themselves to the incorporation of health into the response. Chapter 5 presented evidence to demonstrate how stakeholders spoke about trafficked people's health within a context of highly violent and brutalising experiences in the trafficking situation. They primarily used health outcomes information to support their arguments for the provision of accommodation-based support services and immigration protections. As shown in Chapter 6, however, health outcomes information did not appear to contribute to either an improvement in health services provision or health-related policy change: neither the Department of

Health (DH) nor healthcare providers were engaged in the trafficking policymaking process, and there was no discernable domestic pressure to develop a health response to human trafficking in the UK. Chapter 7 presented evidence showing that stakeholders perceived the key barriers to health engagement to be the low levels of health sector awareness of human trafficking, the limited amount of information relating to how trafficked people used health services, and the limited capacity of the DH to direct the activity of the NHS. Interviews with healthcare providers suggested, however, that even if these barriers were to be overcome, tensions between public health and immigration priorities would limit the potential for health engagement so long as the organised immigration crime model was pursued.

8.1 Limitations and challenges of the research

8.1.1 Researching a contemporary policy process

There are few examples in the literature of real-time policy analyses, despite prospective policy analysis offering the opportunity of "immediate lesson learning and feedback to engage in policy processes" (Buse 2008; Surjadjaja and Mayhew 2010). In addition to potentially increasing the applicability of the research *outputs*, analysing a contemporary policy problem had a number of practical benefits for the research *process*. Firstly, the focus of the research on current events seemed to improve the extent to which documentary evidence could be collected. The research found that policy papers and organisational reports were often poorly archived by the government and by other public and charitable organisations. The response to my Home Office Freedom of Information Act request to access a copy of the 2004 Poppy Project Evaluation Report was delayed, for example, because an electronic copy of the report was not available and a paper version had to be located and photocopied. A number of Freedom of Information Act requests to police forces for copies of their responses to the 2006 National Action Plan consultation were rejected because they no longer held the responses on their systems. In other instances, decisions were amended and online guidance and documentation updated, making earlier versions of online documents no longer accessible. This was noted particularly in relation to the changing role of healthcare providers within the National Referral Mechanism (NRM) and amending of guidance to UK Border Agency (UKBA) caseworkers regarding trafficked people's claims within the NRM and asylum systems. Although a researcher attempting to conduct this research in the future might benefit from reduced restrictions on documents (i.e., because they would no longer be politically sensitive), it seems likely that they would face more significant challenges relating to the poor retention of documents.

Secondly, the timing of the research appeared to have had benefits for the successful recruitment of interviewees and conduct of interviews. Changes in the civil service, government agency and NGO personnel who worked on trafficking were relatively frequent, and although the UK response to trafficking was relatively new by the time this research was initiated, most of the civil servants who had been involved in the development of the National Action Plan between 2005 and 2007 had already left their posts by the time I conducted interviews in 2009. Over the course of the research, a number of service providers and NGO advocates who had been interviewed moved onto other organisations and the majority of the UKHTC senior management team retired. Conducting the research contemporaneously with the development of the response to trafficking meant that the most relevant stakeholders could be identified and recruited whilst they were still in post. Furthermore, the topics of discussion during interviews related either to current events or to the relatively recent past. This may have improved interviewees' ability to recall details and may also have reduced the extent to which they reinterpreted events and revised their assessments of the response to trafficking in the light of later developments.

Moreover, the third method of data collection, participant observation, was only possible because the trafficking policy process was ongoing. Data collection and data analysis each benefited from this component of the research. Firstly, attending policy events meant that I was able to build relationships with stakeholders in the trafficking policy subsystem, which may have contributed to the successful recruitment of interviewees and aided the development of trust and rapport during interview. Furthermore, issues that became apparent during participant observation could be explored further during (and used to inform) key stakeholder interviews. Following an ongoing policy process also permitted the data collection methods to be triangulated more effectively than would have otherwise been possible. For example, stakeholders' behaviour could be directly observed at policy events and compared to their interview accounts of these meetings and their relationships with others. Observing the behaviour of stakeholders also provided for a more nuanced understanding of the dynamics of the trafficking policy subsystem, providing context and detail to the picture that emerged from analysis of interview transcripts and documents.

Researching a contemporary policy issue also meant, however, that the environment that I was trying to study was in a continual state of flux. The pace of policy change was relatively rapid (Balch and Geddes 2010): within the two years following the signature of the Council of Europe Convention on Action against Trafficking in Human Beings (ECAT), the government had

established funded support services for people trafficked for labour exploitation; increased the number of bed spaces for women trafficked for sexual exploitation from 25 to 54; developed the NRM as an administrative mechanism for the identification of trafficked people; and introduced reflection and recovery periods and residence permits for trafficked people. The majority of these changes were introduced in April 2009, when ECAT came into force in the UK. This fell within the middle of my period of interviewing, which ran from January to September 2009, and meant that the policy landscape that interviewees were commenting upon shifted between the beginning and end of data collection period. Furthermore, at the time of data collection, the regulations that governed migrants' access to free healthcare services were being challenged in the courts and were subject to change: for example, the DH initially lost its case regarding the West Middlesex University Hospital NHS Trust's refusal to provide medical care to a failed Palestinian asylum seeker, but later won on appeal.

Nonetheless, in practice, this changing policy environment did not appear to cause significant problems for either data collection or analysis. Firstly, case by case analysis found that interviewees' perceptions of the positive and negative aspects of the response to trafficking, of how health featured within their advocacy priorities, and of the ways in which they worked to meet the health needs of trafficked people differed according to their institutional affiliation (e.g., service provider, civil servant, enforcement official), but not in relation to the timing of interviews. The decision to group interviews into broad phases according to institutional affiliations is likely to have contributed to this: all of the service provider interviews took place before the policy changes of April 2009 whereas all of the civil servant interviews took place at three or more months after the introduction of the changes. The lack of variation over time is also likely to be at least partially attributable, however, to the fact that although ECAT came into force in April 2009, it was ratified in December 2008. Key aspects of the policy changes that would occur in April 2009, such as the length of the reflection and recovery periods, had therefore already been discussed at length and decided upon by the time the interviews began. A further explanation for the lack of variation over time became apparent from analysis of the three repeat interviews conducted with service providers in 2010 and from ongoing participant observation and document collection: a number of non-governmental stakeholders believed that the changes had not translated into substantial benefits for trafficked people, and their advocacy priorities therefore remained relatively static over the period of study. Participant observation and document collection were also conducted prior to, during, and following the period of interviewing. These data sources provided further detail and context in relation to the changes that occurred between January and September 2009, thereby easing the

potential impact of policy changes on the analysis and interpretation of the interview data. Finally, my decision to use quite a structured framework for coding and analysing my interview data and to analyse the body of data at the end of data collection (rather than concurrent to data collection) avoided the analytical redundancy that could have stemmed from policy changes over the period of research.

A further challenge of conducting research within a changing policy landscape was that interviewees tended to place more emphasis on recent events than on events that had occurred further in the past. In particular, they stressed the importance of the signature and ratification of ECAT; the changes that were made in response to this instrument form the basis of Chapter 7. ECAT was in the process of ratification and implementation at the time interviews were conducted, and it is possible, therefore, that the timing of data collection meant that stakeholders over-emphasised its importance. As a piece of qualitative research, however, this study has not set out to establish an objective account of whether, for example, the ratification of ECAT was the most important development in the UK trafficking policymaking process, but instead to understand stakeholders' perceptions of what was important within this process.

8.1.2 Scope of the research

The absence of healthcare providers in the trafficking policy subsystem and the general lack of awareness and prioritisation of trafficking by UK healthcare providers meant that it was difficult to identify and recruit potential interviewees from the health sector. As previously mentioned in Chapter 3, the initial mapping and ranking of policy subsystem participants did not identify any healthcare providing organisations for inclusion in the research. The seven healthcare interviewees who were eventually recruited comprised representatives of two sexual assault referral centres (SARCs), two trauma counselling organisations, two sexual health services that worked with sex working women, and one healthcare advocacy organisation. Five of these interviewees worked for London-based services and two in Glasgow. The knowledge and experiences of these interviewees is not likely to be representative of that of healthcare providers more generally, and it is therefore extremely difficult to judge the applicability of the findings from these interviews to the broader health sector. Some themes did emerge particularly strongly across the healthcare provider interviewees, however, and are discussed below in sections 8.3.4 and 8.3.6. Recommendations for further topics of research in this area are made throughout this chapter.

The research focused on how human trafficking policy had developed in the UK and on the ways in which health had been a part of the policymaking process. No attempt was made during this research to systematically collect information about the impact the response to human trafficking had on the health of trafficked people or other groups (such as migrant sex workers) that may have been affected by the introduction of anti-trafficking programmes. Furthermore, the research does not incorporate trafficked people's views about the policies they were subject to or the services they received, or compare these views with those of the service providers who worked with them. The absence of trafficked people from the design of policies and services that targeted them meant that, given my research focus, I could not ethically justify interviewing trafficked people. As a result, the implications of the findings for the health and wellbeing of trafficked people and other groups require assessment through further research.

Interviews were not conducted with people from outside the trafficking policy subsystem, for example with stakeholders who worked on policies relating to other forms of violence against women (such as domestic violence or female genital mutilation), and did not address policy developments with respect to related issues such as migration and prostitution. It is not possible from this research, therefore, to compare the treatment of health and wellbeing in trafficking policy to its treatment in other policies or to assess the impact of anti-trafficking policies, programmes and dialogues on developments in other policy areas.

8.2 Using policy theory to understand changes in health and human trafficking policy

The research found that existing policy theories were of limited value in analysing how and why health featured in the trafficking policy making process. The Multiple Streams (MS), Advocacy Coalition Framework (ACF), and Punctuated Equilibrium models are orientated towards an analysis either of policy *change* or of why efforts to bring about change may be frustrated. The models therefore seemed to have less explanatory potential for analyses of case studies characterised by policy *inertia* and a lack of relevant advocacy activity. Furthermore, the lack of emphasis placed upon the use and distribution of power within the policy subsystem hindered analysis of why the DH played a marginal role in trafficking policymaking and why the organised immigration crime narrative remained dominant throughout the period of research.

The conceptual framework that guided this research was based upon the MS model of policy change and also drew upon the ACF and Punctuated Equilibrium theories. It was therefore

similarly unable to explain policy inertia and, although it pointed issues such as the failure of NGOs to organise into a coherent campaigning bloc and the political weakness of the DH relative to the Home Office, it did not fully account for power dynamics within the trafficking policy subsystem. In retrospect, making these power dynamics more explicit, for example through the use of a stakeholder mapping tool (Brugha and Varvasovszky 2000; Surjadjaja and Mayhew 2010), would have usefully augmented both the conceptual framework and the three policy theories. In spite of these limitations, this section discusses the contribution that these models can make to understanding changes in health and human trafficking policy, and does so on the understanding that there have been very few analyses that test or apply existing policy theories to real-time policy processes (and hence either validate these theories or indicate areas of weakness to guide further research).

8.2.1 Kingdon's Multiple Streams

Kingdon's MS model of agenda setting encourages policy analysts to look at the activity within three "streams" and suggests that change takes place when policy entrepreneurs take advantage of the policy "windows" which appear when the streams come together (Kingdon 2003). As discussed in Chapter 2, I believed that this model offered advantages over both the ACF and Punctuated Equilibrium models of the policy process for analysing the absence of health-related change in UK trafficking policymaking. Table 13 (overleaf) provides a summary of health-related activity in the three streams that Kingdon proposes within his MS model.

Table 13: Summary of health related activity in the trafficking policy subsystem against Kingdon's Multiple Streams model

Stream	Component	Comment
Problem	Problem Definition	Health was not a significant component of trafficking as defined as an organised immigration crime issue.
	Focusing Events & Symbols	No health-related focusing events were identified.
	Information	Stakeholders were familiar with some studies from the small body of research on health and trafficking. Data on health and trafficking was not, however, collected on an ongoing basis.
Policy	Communities	Department of Health (DH)/Healthcare providers did not participate in trafficking policy communities.
	Recommendations	No NGO advocacy related to improving the health response to human trafficking.
	Feasibility & Acceptability	Generous healthcare provisions may have had limited value acceptability but were technically feasible.
Political	Government	No change in governing party during period of study. The Minister for Health was replaced but this did not lead to a change in the DH's prioritisation of trafficking.
	Jurisdiction	The Home Office led on human trafficking throughout the period of study; the DH had minimal involvement in the formulation of trafficking policy.
	National Mood	Public and media sympathy for trafficked people but wider concerns about migrants' use of healthcare services.

Kingdon suggests that problem definition, focusing events and indicators are important elements of the problem stream (Kingdon 1984). This research has argued that the definition of trafficking as an organised immigration crime issue skewed the terms of the debate and constrained health-related advocacy. Advocates engaged with trafficking dialogues within the confines of the organised immigration crime narrative of trafficking and had little success in recasting the problem, for instance as a labour-rights or migration issue which may have placed greater emphasis on the health vulnerabilities of trafficked people. No health-relevant focusing events were apparent during the period studied; during interviews, post-trafficking service providers did sometimes relay shocking stories about failures to provide healthcare to trafficked people, but these stories were not used to generate focusing events. This was in contrast to other failures to protect and support trafficked people. A story about trafficked and unaccompanied children going missing from care, for example, was widely reported in the media, discussed at Prime Minister's Questions and formed the

basis of a supplementary evidence session to the HAC inquiry on human trafficking (BBCNews 2008; Booth 2009; HAC 2009b; HC 2009). Moreover, although a small body of research on health consequences existed, there was no mechanism in place to collect information on the health needs of trafficked people on an ongoing basis or to monitor how well the health sector was meeting these health needs. This is discussed in detail in section 8.3.

A range of health-related policy recommendations had been developed by researchers and international organisations and could have fed into the policy stream (e.g., IOM 2007; IOM, LSHTM et al. 2009). The absence of the DH and healthcare practitioners from the trafficking policy subsystem, and the non-prioritisation of health by other anti-trafficking advocates, meant, however, that there was no sustained advocacy with policymakers or influential stakeholders on the need to implement these recommendations. There was also virtually no interaction between the trafficking policy subsystem and people working on health issues in related areas (for example on migrant access to healthcare, sex worker healthcare or violence and health), reducing the possibility of policy transfer. Furthermore, it is likely that proposals calling for programmes to provide care to, and reduce the vulnerability of, migrant labourers and migrant sex workers would have suffered from limited "value acceptability" within the current context of migration and welfare policy.

There was also very little activity in the political stream during the period of study. There was no change in the governing party for the duration of the study period, and the government's stance on migrant access to health services seemed to match the nation's concerns about the consumption of healthcare and other resources by migrants.

Kingdon defines two types of "windows" which may open to allow change: problem windows, which open in response to the identification of "compelling problems", and political windows, which are opened by events in the political stream (Kingdon 2003). Problem windows which had relevance to health were not apparent during the period studied. Two potential political windows were the signature and ratification of ECAT and the development of the Cross Government Action Plan on Violence. The period of signature and ratification was used, however, to focus on the extension of accommodation-linked support services and the introduction of temporary leave to remain, and as discussed in Chapter 7, the entering into force of ECAT drove only limited policy changes in relation to health and trafficking. Trafficking was included within the Cross Government Action Plan on Violence and in the DH's violence and health strategy. It was,

however, a peripheral and relatively small-scale issue within this larger programme, and to date no changes to policy or service provision have followed.

Finally, policy entrepreneurs are an important part of the MS model. Entrepreneurs work to promote policy solutions, to couple the three streams, and to take advantage of policy windows when they arise. No figure emerged to take on the role of a policy entrepreneur for health-related issues within human trafficking policymaking; as discussed in Chapter 6, there was very little health advocacy and health sector participation within the trafficking policy subsystem.

The MS model provided a method of mapping the multiple barriers and limited opportunities for integrating health into the response to trafficking. As such, this research suggests that when the model is used to analyse policies in real time, it provides to advocates a method of planning future advocacy activities. Based on Table 13, for example, health advocates may prioritise developing systems to report on the health needs of trafficked people and identifying healthcare providers for engagement in policy activities. The model's usefulness is limited, however, by its failure to hypothesise whether there are conditions under which the streams are more likely to converge to open a window of opportunity, and by its failure to provide an insight into how policy change is achieved once a window is opened. Based upon quantitative analyses, Travis and Zahariadis have developed equations which model the interactions between variables within the three streams (Travis and Zahariadis 2002). The development of hypotheses that are amenable to both quantitative and qualitative analyses may support the future development and continued application of the MS model.

Furthermore, although it directs the policy analyst to the different factors which may be important in bringing about change in the three streams, it does not offer a method of weighing their relative importance. This research suggested that external events, particularly international developments, played an important role in human trafficking policymaking. The MS model may benefit from placing greater emphasis on these external drivers (e.g., in the political stream). Given the increasing importance of European supra-institutions in domestic policymaking (Greenaway 1992; Grant 2008), this is likely to be of particularly value for the analysis of European case studies.

8.2.2 Sabatier's Advocacy Coalition Framework

The ACF has previously been used to analyse the development of human trafficking policy in the United States of America (Footen 2007). The case study presented in this research would seem to meet the conditions of use for the ACF that have been suggested by Sabatier (Sabatier and Jenkins-Smith 1993): the research uses the subsystem as its unit of analysis and considers policy developments over the course of nearly a decade. Sabatier has also previously suggested that the ACF should work particularly well in subsystems characterised by "belief-driven conflict" and in subsystems that are relatively open to non-government participants (Sabatier 1998). The framework identifies three potential sources of policy change: the interaction of competing advocacy coalitions, policy oriented learning (POL) and external shocks to the subsystem.

Sabatier and Jenkins-Smith state that analysts should identify advocacy coalitions by systematically analysing public hearings and other public documents against ten predefined illustrative components of "policy core beliefs" (Sabatier and Jenkins-Smith 1993). Footen, in her analysis of the introduction of the Trafficking Victims Protection Act in the USA, however, found that this method of analysis did not perform as well as qualitative stakeholder interviews in identifying advocacy coalitions (Footen 2007). The ACF was not the primary framework which guided the research presented in this thesis, and a policy core belief-based content analysis has not been conducted. Nonetheless, analysis of data from interviews and field notes suggests that it is possible to categorise subsystem participants as belonging to one of two groups: a dominant "enforcement" group that comprised the Home Office, UKBA and police forces, and a "rights and welfare" group of NGOs and lawyers. It was not clear that either the "enforcement" or "rights and welfare" group met the ACF criteria for coalitions, as actors in these groups did not consistently share a set of causal beliefs about trafficking or engage significantly in coordinated activity over time in an effort to further their policy preferences (Sabatier and Jenkins-Smith 1993). For example, with respect to the "rights and welfare" coalition, faith-based NGOs and feminist NGO were both concerned with the rights and welfare of trafficked people but did not coordinate their advocacy activities.

Coordinated activity could, however, be identified for a smaller group of NGOs. Interviewees spoke about how Anti Slavery International (ASI), Amnesty International UK (AIUK), and UNICEF UK came together between 2005 and 2007 to lobby the UK government to sign ECAT. Between 2007 and 2010, ASI, AIUK, ECPAT UK, the Helen Bamber Foundation, the Immigration Law Practitioners' Association (ILPA), Kalayaan, the Poppy Project, TARA, and UNICEF UK also

periodically coordinated their activities, coming together to report on the UK response to trafficking as the Anti Trafficking Monitoring Group (ATMG 2010); to make proposals on the structure of the NRM (AIUK, ASI et al. 2008)[41]; and to discuss priority issues for discussion in meetings with government. Although all of these organisations had a fundamental concern for the welfare and rights of trafficked people, they had different policy priorities and analyses of the key causal drivers of trafficking. Speaking about efforts to establish the ATMG, one NGO advocate noted, for example, that "some of us come from slightly different perspectives on issues, and so we all have to come to an agreed set of standards, indicators, that will measure government performance, and we have to agree what it is we want the government to do. And each of the organisations may have priorities about what they want and a different focus."

Healthcare providers and the DH did not form a part of either of the loose "coalitions", and the Helen Bamber Foundation played only a minor role in the smaller NGO coalition. Recent versions of the ACF have paid more attention to how coalitions form and are maintained. Fenger & Klok argue, for example, that coalition formation and inter-coalition behaviour is related not only to the extent to which actors share policy core beliefs but also to whether actors are inter-dependent (Fenger and Klok 2001). Their model appears to account well for the relationship between the "enforcement" and "rights and welfare" coalitions. These groups have divergent policy core beliefs but are, to an extent, symbiotic: NGO groups depend upon the Home Office and UKBA for continued funding and access to the policy process, whilst the government depends on NGOs for information and to meet its obligations with regards to the provision of support to trafficked people. The model's predictions of unstable inter-coalition conflict and the development of an uneasy compromise in which actors work together but maintain their divergent beliefs were supported by this research. Applied to the relationship between NGOs and either the DH or the health sector, where beliefs are likely to be congruent but there is no inter-dependence, the model predicts weak coordination. Weakly coordinating actors are suggested to monitor each other's behaviour and strategically alter their activities to be complementary with respect to a common policy goal (Zafonte and Sabatier 1998). This research, however, did not find evidence for weak coordination between these actors. This may be because a further proposed condition of coalition formation – that actors interacted repeatedly – has not been fulfilled to date (Sabatier 1998). Ongoing DH and health sector engagement with trafficking policymaking, and in particular with NGOs working in this area, may promote future coordination.

[41] ILPA and UNICEF UK did not contribute to this submission.

It is feasible that the hypotheses of the ACF could be tested by a more general analysis of UK trafficking policymaking, for instance by an analysis of the nature and extent of the UK's transition towards a "victim-centred", "rights-based" response to trafficking. A full analysis of this kind is beyond the scope of this chapter, but preliminary findings in relation to five ACF hypotheses are presented in Table 14.

The ACF's emphasis on beliefs, values and stakeholder interactions meant that, excepting its preference for structured questionnaires and/or systematic content analysis of public hearings, it would have been a useful framework for this research. As shown by Table 14, however, this research supports McBeth et al's claim that qualitative, interpretative methods of policy analysis can also be used to test the ACF hypotheses (Sabatier and Jenkins-Smith 1993; Sabatier 1998; McBeth, Shanahan et al. 2007). Although Sabatier has focused on the generation of testable and generalisable hypotheses, qualitative research's attention to context may help the development of these hypotheses by providing greater insights into the extent to which the hypotheses are truly generalisable and under what conditions.

Table 14: Preliminary research findings in relation to selected Advocacy Coalition Framework hypotheses

Hypothesis	Supported by case study	Comments
On major controversies within a mature policy subsystem when core beliefs are in dispute, the line-up of allies and opponents tends to be rather stable over periods of a decade or so.	Yes	The negotiation, signature, ratification and implementation of the Council of Europe Convention on Action against Trafficking in Human Beings (ECAT) was the major policy controversy within the period studied. The supporters and opponents of the instrument were relatively stable for the relevant period (2004-2009).
Actors within a coalition will show substantial consensus on issues pertaining to the policy core, though less so on secondary aspects.	-	Systematic analysis of the policy core and secondary beliefs of actors and formal mapping of coalitions has not been conducted. Interview and field not data suggests, however, consensus on some policy core belief components amongst members of 'coalitions' (e.g., basic value priorities within the subsystem, identification of groups whose welfare is of greatest concern, overall seriousness of problem) but not on others (e.g., basic causes of the problem, priority accorded to various policy instruments).
The policy core (basic attributes) of a governmental programme in a specific jurisdiction will not be significantly revised as long as the subsystem advocacy coalition that initiated the programme remains in power within that jurisdiction – except where the change is imposed by a hierarchically superior jurisdiction.	Yes	The party of government remained constant throughout the period of study. Although there was turnover in Ministerial and civil service personnel in the trafficking policy subsystem, this did not lead to a change in the direction of UK human trafficking policy. The greatest policy changes appeared to be in response to the requirements of ECAT.
Significant perturbations external to the subsystem are a necessary but not sufficient cause of change in the policy core attributes of a governmental programme.	Yes	The ratification of ECAT prompted policy change, for example the introduction of the NRM, but the basic approach to trafficking as a problem of organised immigration crime did not change. The principles of this framework informed the structure of the NRM and the provision of support and protection for trafficked people.
Problems for which accepted quantitative data and theory exist are more conducive to POL across belief systems than those in which data and theory are generally qualitative, subjective or altogether lacking.	Yes	Attempts to quantify the scale and nature of trafficking were made throughout the period of study, with limited success. Advocates, service providers, lawyers, and civil servants reported their belief that the quantitative health outcomes information provided by the "Stolen Smiles" study was a useful advocacy tool, for example in lobbying for the introduction of reflection periods and in the context of asylum claims.

8.2.3 Punctuated Equilibrium

The theory of Punctuated Equilibrium seeks to explain why long periods of slow policy change may be "punctuated" by short periods of rapid change and argues that changes to the "image" of a policy and the "venue" in which it is considered can lead to fast and self-reinforcing changes to the content of policies. This thesis has argued that only very limited health-related change occurred in the human trafficking policy subsystem during the period studied: the Punctuated Equilibrium model suggests that this can be attributed to the absence of relevant changes in either or both of the policy image and policy venue.

Considering human trafficking policy more broadly, Balch and Geddes have suggested that policymaking has been "characterised by a high level and pace of legislative reform, inter-agency cooperation and policy change" (Balch and Geddes 2010). This research suggests that although there have been numerous developments in human trafficking policy over the past ten years (Appendix A provides a timeline of major developments), there has been little change in the principles that underpin trafficking policymaking. Interviewees from the civil service and advocacy organisations spoke, for example, about initial, immigration-based, opposition to the signature of ECAT as a hurdle that, once overcome, enabled the introduction of victim-focused measures such as the recovery and reflection period. Analysis of data from interviews, field notes and government documents suggests, however, that substantial work was undertaken to mitigate the risks that ECAT was perceived to pose (particularly to the immigration system), and that advocates, service providers and lawyers were disappointed by the continued primacy of immigration control principles in the UK response to trafficking.

Although the research identified multiple competing conceptualisations of human trafficking (e.g., as an issue of organised crime, migration, or of violence against women), the organised immigration crime narrative remained dominant in UK policymaking throughout the period of study. Information relating to the health of trafficked people was, as discussed in Chapter 5, used to aid the construction of trafficked people as victims, rather than criminals, and trafficked people's experiences of violence and harm were used to suggest that they did not consent to their situation. This primarily occurred, however, within dialogues that were shaped by the interests of the organised immigration crime agenda.

The research found no evidence of venue shopping during the period of interest. Although one advocate spoke about how they had lobbied Ministers from several departments to support the signature of ECAT, overall NGOs concentrated their advocacy activities on the Home Office and had limited contact with other officials and Ministers from other departments. Of interest to this research was the finding that NGO stakeholders did not attempt to build relationships with potential DH stakeholders. Advocates from a small number of NGOs spoke about their participation at the international-level, for instance through the Council of Europe, the International Labour Organisation (ILO), and the Office of Security and Cooperation in Europe (OSCE), as providing alternative venues for pursuing policy goals. The research found, however, that although obligations arising from international agreements prompted various policy changes, they did not displace the Home Office from the centre of the UK response or trigger changes in the principles which underpinned the response to trafficking in the UK.

8.3 Discussion of the research findings

8.3.1 The government's framing of trafficking as an issue of "organised immigration crime" was criticised by external stakeholders but not supplanted.

As discussed in Chapter 4, the organised immigration crime narrative dominated human trafficking policymaking in the UK during the period of the research. The primacy of this narrative seemed to have been prefigured by the negotiation of the Palermo Protocol within the UN Convention on Transnational Organised Crime. A number of interviewees, both inside and outside of government, remarked that the UK had come late to the issue of trafficking and had adopted the definitions that had been established at the international level. The trajectory of human trafficking policy in the UK may have been different had the initial framework for addressing trafficking originated within a rights-based treaty or indeed from the World Health Organisation. Chuang has noted, however, that it was "border security concerns and potential involvement of organized crime in trafficking [which gave] countries the political will to address trafficking that might not have existed had trafficking been framed as a human rights issue" (Chuang 2010). Similarly, analysis of interviews and government documents conducted for this research has suggested that although NGOs drew heavily on discourses of human rights, leveraging resources for supporting trafficked people and investigating trafficking would have been more challenging had the issue not been viewed through the lens of organised immigration crime.

Although much has been written about the involvement of organised crime groups in trafficking people for exploitation (e.g., Schloenhardt 2001; Tailby 2001; Kara 2009), the suitability of organised immigration crime-based approaches to trafficking was a frequent theme of debate in both the trafficking policy subsystem and academic literature (Beare 1999; Anderson and O'Connell Davidson 2003; Andrijasevic 2003; Berman 2003; Anderson and Rogaly 2005; O'Connell Davidson 2006). Criticisms of the approach could be made at two levels: with the government's analysis of the *causes* of trafficking, and therefore with the rationale for anti-trafficking initiatives, and with how trafficked people are *treated* within the response. In policy meetings and in organisational reports and materials, NGOs tended to critique what they perceived to be a failure on the part of the government and enforcement agencies to respect the human rights of trafficked people and to act to safeguard the welfare of trafficked people. Their advocacy work was conducted with reference to the organised immigration crime narrative, however, and they did not challenge the government's analysis of the causes of human trafficking and the rationales for government anti-trafficking initiatives. Although NGO advocacy seems to have increased policymakers' readiness to safeguard the rights and welfare of trafficked people, the narrow concerns of the organised immigration crime narrative means that the UK response to trafficking fails to address the reasons for why people choose to migrate and how they become vulnerable to exploitation within the migration process.

Interviews with key stakeholders from the trafficking policy subsystem revealed, however, competing analyses of the key causal drivers of human trafficking. Yet the contribution of other analyses of trafficking has, within the UK policy subsystem, been extremely limited. The attractiveness of migration-based analyses to advocates, for example, may have been limited by political, public and media perceptions of immigration in the UK, and the ease with which a migration approach could be confused with an immigration-crime approach. The potential impact of the labour rights approach seems to have been reduced by reluctance amongst some stakeholders to broaden trafficking debates into a wider dialogue about the exploitation of migrant labour, and by divisions over whether sex work could and should be considered within a labour rights framework.

The research also found that framing of trafficking as an issue of organised immigration crime appeared to contribute to the absence of the DH from the trafficking policy subsystem: such a framing placed the issue firmly within the remit of the Home Office and consequently reduced the need for other departments to become involved in the response to trafficking. It also meant that it was difficult for other departments to incorporate the issue into their existing programmes of work.

The DH ultimately chose to incorporate trafficking into its response to violence against women, a decision which had consequences for both the department's role within trafficking policymaking and the profile of trafficking as an issue within the department.

Treating trafficking as an issue of violence against women necessarily narrowed the scope of the DH's response to trafficking to a concern with only trafficked women and, given the widely held belief that experiences of violence were very low amongst people trafficked for labour exploitation, to the trafficking of women for sexual exploitation. This appeared to limit the role for the department within the broader response to trafficking; one civil servant noted, for instance, that "trafficking isn't all about violence against women...you have male victims of labour trafficking, you have women and children who are victims of domestic servitude". Speaking about the inclusion of human trafficking within the DH violence against women programme, civil servants stated that there was no clear alternative "home" for trafficking within the department. Field notes from a workshop held with the DH, Ministry of Justice and a small number of NGOs show, however, that discussions generated ideas for a range of teams that may be interested in the response to trafficking, including the asylum and refugee team; cross-border team; and the women, children, family and maternity team (Fieldnotes 2009a).

Secondly, it meant that the department did not engage with the fundamental principles of the UK response to trafficking, which were rooted in an organised immigration crime-based analysis of the issue. Civil servants noted that there were no conflicts between the respective approaches of the Home Office and the DH and felt that in some respects the two were complementary. The principles of public health and immigration control have been suggested elsewhere, however, to be in direct opposition: whereas public health is based on universality, participation and communication, immigration control is based on nationality, legislation and coercion (Mbaye 2009). Furthermore, the policy solutions that arise from the respective responsibilities of public health and immigration control regimes create problems for each other: expanding healthcare to all migrants to safeguard public health could be viewed as a pull factor for migration, whereas restricting healthcare for migrants as a form of migration control could create problems for public health. The decision of the DH to approach trafficking from the perspective of violence against women seems to have avoided difficult conversations within this policy subsystem about the priorities of the immigration and health systems and the relative weight to be given to each. Treating human trafficking as an issue of public health, or as one of migrant health, may have highlighted areas of incompatibility between the current response to trafficking and public health

principles. Interviewees in this research commented, as reported elsewhere, that the DH and UKBA are already in dispute about the migrant charging regulations (Rohan 2009). It is impossible to assess what would have happened had the DH chosen to challenge the Home Office on this basis: could the issue of trafficking have been used to push for bigger changes in the charging regulations? Might it have pushed the DH further outside the trafficking policy subsystem by introducing the potential for conflict?

Incorporating trafficking into the violence against women programme also caused problems in terms of the issue's profile within the department. Firstly, as noted by one civil servant, the scale of trafficking relative to the scale of domestic violence and other types of sexual violence was so small that it could only ever be a peripheral issue within the violence against women programme. It is likely, however, that trafficking would have faced prominence issues even if integrated elsewhere. A second problem was that, as noted elsewhere, engaging the DH and the health sector to commit to addressing violence against women has been an ongoing problem (Fisher, Hunt et al. 2007; HAC 2008). Interviewees in this research spoke about, for example, how the Victims of Violence and Abuse Prevention Programme (VVAPP), which had originated in the DH and included child trafficking within its remit, had struggled to gain profile and Ministerial support within the department. The later Violence Against Women and Girls Taskforce (VAWGT), which included trafficking for sexual exploitation and was ongoing at the time of the research, was reported to have been driven by Home Office ministers and hence to have had a much higher profile within the DH and across government. Interviewees also spoke about the difficulties engaging health in the service-level response to violence against women: the police, rather than the health sector, had pushed for the establishment of sexual assault referral centres (SARCs) and provided much of their funding.

8.3.2 Health needs and vulnerabilities of trafficked people have been insufficiently addressed within the response to trafficking.

An analysis of the content of human trafficking policy in the UK suggests that health had not been well integrated into the response to trafficking. In terms of *access* to healthcare, for example, the entitlement to free healthcare services is more stringent for trafficked people than for asylum seekers, who receive exemptions from care upon registering as an asylum seeker: trafficked people must wait to be recognised as such through the NRM before becoming entitled to free care. Although politicians have suggested that the provision of welfare acts as a pull factor to asylum

seekers and other migrants (Hubbard 2005), studies have found no evidence to show that the level of welfare entitlements impacts upon the number of asylum claims (Geddes 2000; Schuster 2000; Bloch and Schuster 2002). It therefore seems unlikely that the restriction of free medical care until a reasonable grounds decision has been given would influence migrants' propensity to abuse the NRM system through fraudulent applications. Furthermore, research into trafficked people's self-reported health symptoms suggests that it is in the days immediately after leaving the situation of exploitation that the need for healthcare is greatest (Zimmerman, Hossain et al. 2008a). Better participation of the DH and healthcare practitioners in trafficking policymaking could help to make this point more forcefully in discussions about the support provided to trafficked people.

The failure to integrate health into the response to trafficking meant that post-trafficking service providers had to devote resources into on-the-ground advocacy on behalf of their clients to ensure that their health needs could be met. Service provider interviewees spoke about, for example, accompanying their clients to make and attend healthcare and dental care appointments, developing local networks of knowledgeable providers, and in some cases even employing solicitors to argue on behalf of their clients' right to access mental health services. Yet, the NRM procedures do not require health assessments or healthcare services to be offered to trafficked people, and do not provide assistance in coordinating and accessing healthcare. Trafficked people who do not have access to assistance from advocates may therefore be experiencing problems in receiving the healthcare services they need. At a minimum, entry into the NRM should prompt the offer of a health assessment and assistance with coordinating healthcare if required. This research suggests that assistance may be required with registering with services; booking appointments; arranging for interpretation and translation services; paying for prescriptions and applying for exemptions from prescription charges; and providing written medical information in an appropriate language and format. It may also be necessary for the coordinator to provide the healthcare practitioner with basic information about trafficking. The integration of health within the NRM seems likely to require the involvement of the DH in the review process and its participation in the Strategic Monitoring Group which meets regularly to oversee the functioning of the NRM. Yet the research found that the DH had not initially been invited to participate in either the 6 month or 12 month reviews of the NRM.

Service providers reported having overcome, to varying extents, the difficulties in accessing suitable primary and secondary healthcare for women trafficked for sexual exploitation. In a context where immigration officials remained hostile and insensitive in their questioning of

trafficked women and identified exploited women as immigration offenders rather than as victims of trafficking, service providers and other NGOs did therefore not prioritise issues of healthcare access and availability within their advocacy activities. This may have allowed policymakers to assume that systematic problems in healthcare access and provision do not exist and that joint working between service providers and the NHS can ensure that the healthcare needs of trafficked people will be adequately met. Service provider interviewees reported, however, that problems do remain, particularly in respect of access to mental healthcare services. Data is needed to demonstrate this. Service providers have a wealth of untapped information relating to difficulties in registering as a patient, arranging interpretation and translation, charging and waiting times, and additionally note user satisfaction with the services received. Feeding back this information to PCTs and the DH would build a better picture of the issues surrounding access to and quality of healthcare services, as well as identifying areas of good practice.

Attempts to integrate health into human trafficking policy should, however, go beyond issues of access to quality healthcare services and consider the broader impact of the response to trafficking on people's physical, psychological, and social wellbeing. For example, although studies of asylum seekers and refugees tend to emphasise the impact of past events on mental health rather than post-migration experiences, a small number of studies indicate that existing health problems are exacerbated by, and that new health problems emerge in response to, their experiences in the country in which asylum seekers and refugees claim protection (Watters 2001). This research belongs to a body of literature which emphasises the multiple, cumulative health risks to which an individual is exposed throughout his or her migratory journey, and which moves beyond a narrow, infectious-disease based conceptualisation of migration and health (van der Veer 1998; Gushulak and MacPherson 2000). The health of asylum seekers and refugees may be negatively affected, for example, by experiences of poverty, poor social support, and racial discrimination in the destination country (Burnett and Peel 2001). A study conducted by Sundquist et al, for instance, found that economic difficulties and a "poor sense of control" were stronger risk factors for psychological distress amongst a group of 1980 immigrants in Sweden than pre-migration exposure to violence (Sundquist, Bayard-Burfield et al. 2000). Studies have also found a link between psychiatric disorders in this population and a range of socio-legal stressors, including: poor social support, loneliness and boredom; delays in processing applications; interviews and conflict with immigration officials and fears of repatriation; the denial of work permits; unemployment; dependency; financial difficulties; separation from families; and discrimination (Silove, Steel et al 1998; Gorst-Unsworth and Goldenberg 1998; Silove, Steel et al 2000; Ryan, Benson et al 2008).

Although policymakers, and government documents, frequently made reference to the response to human trafficking being "victim-centred" (Home Office 2006a; Home Office 2007b; Home Office and BIA 2008; Home Office 2008), to date no systematic analysis has been undertaken of how well this response meets the health needs of trafficked people or of whether aspects of the response negatively impacts upon trafficked people's health. Two NGO reports published in 2010 aimed to assess the impact of human trafficking policies on trafficked people and migrant sex workers, but neither provided detailed information regarding the impact of anti-trafficking policies on the health of these groups (ATMG 2010; X:talk 2010).

8.3.3 Stakeholders believed that trafficked people experienced health problems as a result of suffering from high levels of violence whilst trafficked.

Stakeholders from across the spectrum of sectors represented in this research spoke predominantly about the health consequences of trafficking in relation to people's experiences of violence, especially sexual violence, whilst trafficked. Trafficked people were suggested to suffer, in particular, from trauma, which was believed by several interviewees to be an almost inevitable consequence of sexual exploitation. A number of academics, however, noting the use of extremely violent narratives and imagery in anti-trafficking advocacy and campaign work, have questioned their representativeness (Aradau 2004; Saunders 2005; O'Connell Davidson 2006; Andrijasevic 2007; Brunovskis and Surtees 2010) and have suggested that experiences of extreme violence and trauma may not be common enough to warrant the types of programmes and policies that have been developed to respond to trafficking (Brunovskis and Surtees 2010). This section firstly discusses how non-governmental stakeholders used discourses of violence and trauma in their advocacy activities, and then secondly considers the implications of this both for the engagement of healthcare providers and other frontline professionals and for the provision of healthcare and support services.

Aradau has suggested that discourses of suffering have a redemptive function, transforming the trafficked person from a potential criminal and security risk into an object of pity (Aradau 2004). This research supports such an analysis. A number of stakeholders who worked as NGO advocates, lawyers and service providers used violence and trauma to demonstrate that trafficked people experienced substantial levels of harm as a result of their experiences. Analysis suggested harm was used by these stakeholders as an indicator of individuals' non-consent to their exploitation

(rather than an indicator of having been exploited) and that the fact of non-consent was important in establishing that trafficked people were not to blame for their situation and should therefore be afforded support and protection. Munro's analyses of the UK response to human trafficking (which draw upon legislation, policy documents, and interviews conducted with police officers in 2003) have also highlighted the importance of consent in the response to trafficking; she suggests that although UK anti-trafficking legislation appears to prioritise exploitation over consent, consent is integral to frontline professionals' understanding of trafficking (Munro 2005; Munro 2006).

The same stakeholders spoke about women who had been trafficked for sexual exploitation as being irreparably damaged as a result of their experiences, and used trauma to explain the aspects of trafficked people's behaviour that damaged their standing with the UK authorities (why they had not escaped; why they would not disclose or cooperate with authorities, and why they could not account for their experiences). The use of violence and trauma to explain behaviour and bolster credibility has also been noted in the literature on asylum seekers (Bogner, Herlihy et al. 2007) and "battered women" (Dutton 1996). In both of these fields, this tendency has come under considerable criticism, with critics noting that it risks pathologising its subjects and can give rise to disempowering services that both foster passivity in their service users and take away responsibility for deciding when recovery has taken place (Dutton 1996; Summerfield 1999; Watters 2001; Mardorossian 2002). This research did not attempt to assess the effect of trauma discourses on how services were provided to trafficked people. It did find, however, that organisations who worked with sex workers were critical of service providers' insistence that women gave up sex work as a condition of receiving support. Enforcement interviewees also reported that service providers' "control" of the trafficked people they supported was a source of frustration, for instance, when they advised victims "just say to the police you won't talk to them" because they believed that the trafficked person was not sufficiently mentally prepared for interviews.

The tendency for NGOs to seek to use the most dramatic and shocking case studies for use in their advocacy work is unsurprising, and has been noted elsewhere (Keck and Sikkink 1998). In the case of post-trafficking support providers it is also likely to be true that their immediate experiences of trafficking are skewed towards the extreme. One service provider suggested to me, for example, that the physical and mental health symptoms suffered by women receiving support through her organisation exceeded the very high levels of poor health reported in the "Stolen Smiles" study (which reported on women who had been trafficked for sexual exploitation) (Fieldnotes 2009d). In a resource constrained environment, service providing organisations must prioritise support for the

most vulnerable and the most in need, and it is in relation to these women that expertise is developed. Research has found that there are systematic differences between victims who accepted and declined assistance, and that men and minors tend to be particularly under-represented (Brunovskis and Surtees 2007). The stories of women who are not in such urgent need of support, who feel that they do not need support, or who will not accept it on the terms offered, are lost. Those services who may be working with them and who could tell their stories, such as sexual health outreach services, are also absent from the trafficking policy subsystem.

As discussed in Chapter 1, the dependence of researchers on post-trafficking service providers for access to either trafficked women or their medical records means that research on the health of trafficked people suffers from a lack of representativeness. The difficulties of conducting representative research with trafficked people have been discussed at length in the literature and include the bias because of gate-keeping by support providers; bias through self-selection; and the varying stages of trafficking at which people participate in the research (Ali 2005; Brennan 2005; Cwikel and Hogan 2005; Kelly 2005; Laczko 2005; Weitzer 2005; Brunovskis and Surtees 2010). This study suggests, however, that there is an urgent need for further research into the range of health experiences and exposures of a greater diversity of trafficked people. In particular, researchers must find ways of reaching those people who are not supported by the centrally funded post-trafficking support providers.

This research found that understanding the health consequences of trafficking as arising from extreme levels of violence and brutality within the trafficking situation has had important consequences for policymaking and service provision. Perversely, it seems that it has *reduced* the perceived need to engage the health sector, because, as shown by Chapter 7, policymakers believed that only a fraction of those who entered the NRM would make significant use of the health sector (Home Office and BIA 2008). Whilst this may have made the case for granting identified trafficked people free access to all healthcare services (rather than just the emergency services required under the terms of ECAT) more palatable, it may have also weakened the case for skills training and awareness-raising within the health sector. Furthermore, this understanding of health and trafficking has led to a narrowing in policymakers' perceptions of which services are likely to be accessed by trafficked people and may therefore be suitable targets for training and awareness raising. Policymakers repeatedly cited Accident and Emergency departments (A&E) and sexual health clinics as the points at which people would be likely to come into contact with the health sector whilst trafficked. This belief, and indeed the belief that trafficked people had access to

healthcare services at all whilst in the trafficking situation, was based on anecdotal information and intuition based on how they understood the nature of trafficking, rather than on research with either trafficked people or healthcare providers. Awareness-raising and training initiatives will, if incorrectly targeted at A&E and sexual health clinics, miss other healthcare providers who would benefit from them.

It may be the case that only a small proportion of trafficked people *do* require contact with the health sector and that the services of greatest relevance to them *are* A&E and sexual health clinics. This study suggests, however, that research is needed to examine these assumptions. If trafficked people are primarily accessing healthcare through A&E departments and sexual health, the research should consider whether this is because these services best meet the needs of trafficked people or because they are services for which no charge is made regardless of the person's migration status. Post-trafficking service providers are well-placed to begin closing this knowledge gap, although the previously mentioned problems regarding data representativeness would continue to apply. For example, information which disaggregates the healthcare services required by an anonymised sample of clients and gives the average number of appointments needed per person per service would help the DH to develop and target awareness-raising and guidance materials and to more accurately estimate the cost of providing care to trafficked people.

For healthcare providers and other frontline professionals involved in responding to trafficking, the "high harm" narratives that dominated human trafficking dialogues may risk their disengagement from the response to trafficking. Practitioners may feel paralysed by the implications of these narratives, believing that meeting the implied service needs are beyond their professional capacity, or that they cannot in fact assist in the response to trafficking. There is also a risk that if practitioners expect to see brutalised and highly damaged "victims", they may fail to identify (or may disbelieve the accounts of) trafficked people who do not exhibit the requisite symptoms. O'Connell Davidson's research suggested, for example, that physical suffering has come to serve as a "litmus test" for victimhood within the response to trafficking (O'Connell Davidson 2006), and she and others have noted that the failure to present ones experiences within an accepted victim profile is to risk not being believed (Summerfield 1999; O'Connell Davidson 2006). The UKBA guidance for caseworkers assessing the claims of potential victims of trafficking within the NRM and asylum system draws attention to the multiple physical, psychological and sexual health symptoms that trafficked people may present with, including "injuries apparently as a result of assault or controlling measures...expression of fear or anxiety, depression, isolation...suffering

from post-traumatic stress and/or a range of other trauma induced mental or physical illness...sexually transmitted diseases, [and] injuries of a sexual nature" (UKBA 2009c). The notes state that "this is not an exhaustive or definitive list but it does highlight the more common indicators that may be identified. They should assist officers/frontline staff in making a primary assessment of whether the individuals encountered are or may be potential victims of trafficking" (UKBA 2009c). This guidance should be amended to state that whilst these factors are indicative that a person may have been trafficked, their absence should not been taken to suggest that a person has *not* been trafficked, and the indicators should be revisited once further research into the health needs of trafficked people has been conducted. For trafficked people, the failure to be identified as trafficked or to have one's claim of being trafficked rejected has very real consequences for their health and wellbeing: as discussed in Chapter 1, access to healthcare and other services (as well as protection from potential criminalisation and deportation) is dependent on being recognised as trafficked.

The dominance of the "high harm" narrative may also mean that the needs of people who do not present with this extreme profile may not be met, as services may not be responsive to the full range of support needs or variations in the level and type of support need (Brunovskis and Surtees 2010). This research has highlighted how, for example, the support needs of men and women trafficked for labour exploitation went unmet until 2009 and continue to receive much less funding than services for women trafficked for sexual exploitation do. Interviewees tended to voice their belief that people trafficked for labour exploitation suffered less violence, particularly sexual violence, than did women trafficked for sexual exploitation, and that their needs were therefore greatly reduced. Trafficked people's right to healthcare and other forms of support under ECAT are not, however, dependent on the levels of physical and mental harm sustained whilst trafficked or upon the severity of a person's experiences (Council of Europe 2005).

Yet as O'Connell Davidson has noted, replacing the high harm narrative with a more nuanced and representative description of the dynamics and consequences of human trafficking is likely to be challenging: governments have no ostensible incentive to do so, and NGOs, having called upon the government to respond to trafficking *because* sexual and physical violence are ubiquitous features of trafficking, are "hostages to their own rhetoric" (O'Connell Davidson 2006). Including harm reduction outreach workers in trafficking dialogues and policymaking may begin to redress this balance: in the research, these workers suggested the harms suffered by trafficked people were frequently less severe but more varied than those identified by others. Chapter 6 discussed how

organisations that worked with on or behalf of sex workers were excluded from the policymaking process, and highlighted how their expertise was undermined by anti-trafficking advocates who suggested they would be unlikely to see trafficked people during their work (or to ask the sorts of questions to identify them). Other academics have noted the exclusion of sex workers and affiliated groups from trafficking policymaking around the world and suggested that engaging with trafficking as a issue of migration, human rights and public health would make sex workers more visible in trafficking dialogues (McDonald 2004; Saunders 2005). The DH is well-placed to bring sex worker outreach groups into policy discussions. The exclusion of sex worker groups may have facilitated a unified focus on addressing trafficking, but it has meant that valuable information about the various experiences of trafficked people, their needs, and their use of healthcare services has been missed.

8.3.4 Health outcomes information was not used to improve the responsiveness of UK human trafficking policy to trafficked people's healthcare needs.

Chapter 5 discussed how health outcomes information was used to support calls for the provision of multiple support services to trafficked people and for the introduction of reflection and recovery periods during which action to remove trafficked people from the UK would be stayed. Health outcomes information was not, however, used to advocate for the provision of appropriate healthcare services to trafficked people or, more generally, for UK trafficking policy to be more responsive to the health needs of trafficked people. The research suggested that this was due in part to NGO advocates not focusing upon health as a key advocacy goal and to the lack of healthcare provider representation at trafficking policy meetings.

It was not clear whether NGO interviewees had made a conscious decision to de-prioritise health-based advocacy, or whether their accounts during interviews of why an improved health response to trafficking had been omitted from their advocacy functioned more as post-hoc rationalisations. The research has shown, however, how NGOs made strategic use of health outcomes information to support policy preferences which were not health-focused. As suggested by Kingdon, the information from the "Stolen Smiles" study and from the anecdotal reports of post-trafficking support providers was used by NGOs to demonstrate that there was an underlying problem to which their preferred solution (e.g., the introduction of a 90 day recovery and reflection period) could be attached. Calls for the introduction of this recovery and reflection period preceded the publication of "Stolen Smiles" but the report was subsequently used by advocates to support their arguments

(Kingdon 1984). As discussed in Chapter 5, the research suggested that these strategies brought NGOs only limited success. The most substantial expansion of post-trafficking support provision and the introduction of recovery and reflection periods came after the ratification of ECAT, the length of the recovery and reflection periods introduced was half what NGOs had campaigned for and immigration-related concerns appeared to govern the implementation of these changes. This finding seems to support Sabatier's argument that "Policy Oriented Learning" does not lead changes in actors' fundamental beliefs or to significant overall change in the absence of external events (Sabatier and Jenkins-Smith 1993).

Although is difficult to predict what the impact of sustained health-based advocacy would have been, the finding that the DH was invited to attend the IDMG on trafficking shortly after a presentation by Dr. Cathy Zimmerman at the JNMG on the health needs of trafficked people does suggest that health-based advocacy may have had the potential to effect some degree of health-related change (IDMG 2005-2010; JNMG 2005-2010). NGOs' failure to use existing health outcomes information to improve the responsiveness of UK human trafficking policy to trafficked people's health needs suggests, however, that health-based advocacy will not actually occur unless healthcare providers participate in trafficking policy consultations and events. The liaison of healthcare services with the NGOs who are represented at policy meetings appears not to be an effective way of feeding back health related concerns, and whilst health sector participation in local working groups may assist the development of appropriate local responses, it does not contribute to the inclusion of health in national human trafficking policy. The DH may be best placed to take the lead in identifying organisations with interest and expertise in trafficking and facilitate their involvement in the policy process. Health sector representation at the JNMG, a diverse group which brings together civil servants and external stakeholders, would be particularly beneficial as it would provide direct access to civil servants and Ministers and increase various stakeholders' familiarity with the concerns of healthcare providers. The DH's legitimacy within trafficking policymaking and their responsiveness to the needs of trafficked people (and healthcare providers) would also be improved by increased contact with healthcare providers who have experience in working with trafficked people.

Several interviewees felt that the size and diversity of the health sector was a barrier to its involvement in trafficking policymaking, as it was difficult to identify potential participants and disseminate knowledge and expertise. Analysis of which organisations were represented in the policy subsystem suggests that engaging professional medical associations and societies, such as the

Royal College of Nursing and the British Psychological Society (both of which responded to the National Action Plan consultation), would be particularly efficient: by analogy, the Association of Chief Police Officers (ACPO) and the Immigration Law Practitioners Association (ILPA) have developed considerable expertise in how their profession relates to human trafficking and in turn provide substantial feedback to policymakers on proposals. Healthcare practitioners may also benefit from developing local "trafficking health and policy" groups similar to the Trafficking Law and Policy Forum operating in London, which updates local legal practitioners and other interested parties about recent developments in trafficking policy, shares best professional practice and coordinates feedback for consultations.

The absence of health-based advocacy in the trafficking policy subsystem also meant there was no domestic pressure on policymakers to improve the access and availability of healthcare services for trafficked people or to consider how the response to trafficking was meeting (or harming) trafficked people's health. It is possible that the lack of calls to improve the provision of health services meant that the ability of services and frontline professionals beyond the "local care networks" to meet the health needs of trafficked people did not improve. It is difficult to generalise from the interviews with healthcare providers, as they were a small and highly selected sample, but based on analysis of their interviews, the information currently available for healthcare practitioners and comparison with other fields, it seems that guidance is needed on: receiving and making referrals; working effectively across cultures and languages; and working in a trauma-sensitive manner. The guidance currently available to healthcare providers in the UK on making referrals was published in 2009 as part of the Criminal Justice System's Trafficking Toolkit (CJS 2009b). This drew heavily on the guidance jointly published by LSHTM and IOM earlier that year (IOM, LSHTM et al. 2009), but does not give specific guidance on how to refer into the UK National Referral Mechanism or information on referring trafficked people to other services. Healthcare providers may benefit from the development of more detailed and UK-specific referral guidance which addresses their concerns about information sharing and referring patients into the NRM and to other services (which include concerns regarding consent, confidentiality and patient safety). Referral and general contact information relating to non-governmental sources of support for trafficked people in each region of the UK should also be made easily accessible to healthcare providers.

8.3.5 Limited information about how trafficked people used health services and the lack of awareness and expertise in the health sector constrained the extent of policy change.

As noted by Balch and Geddes, following the signature of ECAT the overall pace of change in trafficking policy was rapid (Balch and Geddes 2010). The new legal requirements formed the basis of what health-related policy change there was, but in general the changes did not extend as far as they could have done and overall there was very little movement in health-related policy.

This research found that the lack of information about how and where trafficked people came into contact with the healthcare system constrained the extent of change, as it meant that no case for targeted or general training and awareness-raising could be easily made. If the DH is to have a greater role in developing policy and responding to trafficking, it will be necessary to overcome this lack of data. Future research should assess the level of knowledge and expertise that already exists in the health sector and seek to understand which health services trafficked people are accessing, as well as when and where. The research should include interviews with healthcare providers to properly identify the concerns they have about caring for trafficked people; good practice in the provision of care for this population; any particular difficulties they have experienced in providing care, for instance in relation to interpretation requirements and immigration-related restrictions on care; the care pathways and referral processes that were used; their experiences in working with other organisations who provide care to trafficked people; and healthcare providers' perceived training and information needs.

This study also found that policymakers' perceptions that the levels of trafficking-related awareness and expertise amongst healthcare providers were low acted as a constraint on health-related policy change. Following on from the research proposed above, training and awareness-raising should be targeted first at those service sites and personnel that are determined to be most likely to encounter a trafficked persons, be involved in policy discussions on trafficking, and be involved in planning and training for service provision in key service areas. Over time, this may have the effect of enabling more healthcare providers to participate in the development of the UK response to trafficking and to do so more effectively.

8.3.6 The clashing professional paradigms of health professionals and immigration officials may be act as a future barrier to health sector engagement

Despite the limited involvement of the health sector in responding to trafficking throughout the study period, most interviewees felt that healthcare providers had a valuable future role to play in the response to trafficking. In particular, interviewees from outside the health sector envisioned healthcare providers identifying trafficked people and referring them into the NRM or to support services and (potentially) gathering intelligence about local trafficking problems. When asked in interviews about taking on such a role, however, healthcare professionals expressed a number of reservations. Some questioned their own ability to accurately identify trafficked people in the absence of suitable indicators, and all were concerned about the relative benefits of doing so. For example, interviewees spoke about issues relating to safeguarding their patient's confidentiality and ensuring that people had consented to enter into the NRM, about highlighting their client's presence to the criminal and immigration authorities, about losing the trust of the women and the brothels they worked with, and about the suitability of referral options.

Over the past two decades, the provision, or withholding, of welfare has increasingly been used as a tool of immigration control (Bloch and Schuster 2002). In 1998, for example, the Labour government proposed arrangements to minimise the attraction of the UK to economic migrants whilst ensuring that "genuine" asylum seekers would not be left destitute. A parallel welfare system was introduced for asylum applicants, based on the premise that those who "have not established their right to be in the UK should not have access to welfare provision on the same basis as those whose citizenship or status here gives them an entitlement to benefits when in need. Any support for asylum seekers should operate on a separate basis, with provision offered as a last resort" (Home Office 1998). Provisions for asylum seekers were systematically reduced and restrictions on movement, economic activity and privacy were introduced, based on the principle that the relative ease of accessing welfare acted as a "pull factor" to potential would-be migrants. In later years, the government also positioned the withdrawal of welfare as a strategy to make life "uncomfortable" for people living and working illegally in the UK (Home Office 2007a). Arrangements (or lack thereof) for the provision of support to trafficked people also appear to have been predicated on the belief that support would attract fraudulent applications for assistance and act as a pull factor to the UK. The referral and identification procedures established in the NRM therefore work to screen the eligibility of claimants.

Should trafficking policymaking continue along as it has done (that is, employing an organised immigration crime-based analysis of the problem and failing to recruit the health sector to participate in policy dialogues), it is unlikely to allay healthcare providers concerns and is therefore likely to encounter difficulties in engaging the health sector in responding to trafficking.

The government has been heavily criticised by individual healthcare providers (Hall, van der Loeff et al. 2009; Yates, Moore et al. 2009), health advocacy organisations, and professional medical associations (BMA 2008; RCGP 2009) for its proposals to exclude failed asylum seekers from primary healthcare and its decision to appeal the definition of ordinarily resident. Critics have argued that the proposals to make GPs responsible for policing access to healthcare and turn away vulnerable people runs contrary to the stated duties of doctors according to the General Medical Council (ensuring the care of the patient is one's first concern and protecting and promoting the health of patients and the public) (Yates, Crane et al. 2007; GMC 2009; Taylor 2009)[42]. Academics have also noted the patchy implementation of the overseas visitors charging regulations and the refusal of some doctors to ask their patients about their immigration status (Yates, Crane et al. 2007; Rohan 2009). The difficulty of monitoring and regulating doctor-patient interaction means that even healthcare providers were *required* to take on such a role, enforcing this would be near impossible. Involving healthcare practitioners in policy dialogues would enable them to highlight areas they feel run against their professional principles and discuss the feasibility, and implications, of taking on a role in identifying and referring trafficked people into the NRM, to the police authorities, or to non-governmental service providers.

8.4 Conceptual tools for future use in human trafficking policymaking

Chapter 4 presented evidence on two forms of potential inter-stakeholder conflict within the trafficking policy subsystem. Firstly, stakeholders differed in their analyses of the key causes of human trafficking and, consequently, in their preference for particular anti-trafficking initiatives. Secondly, stakeholders placed differing levels of emphasis on the protection and support of trafficked people within the overall response to trafficking. This section presents a new conceptual framework that may allow a more systematic approach to discussions on the first point, and

[42] The proposals have also been criticised by some in the health sector as running contrary to good public health practice (e.g., Hargreaves, Holmes et al 2005; Yates, Crane et al 2007) and as making little economic sense, given that there is no evidence that migrants are abusing the health system and preventative care is more cost effective than later curative or emergency care (Yates, Crane et al. 2007; Taylor 2009).

discusses the need for further research to develop a further conceptual tool in relation to the latter source of conflict.

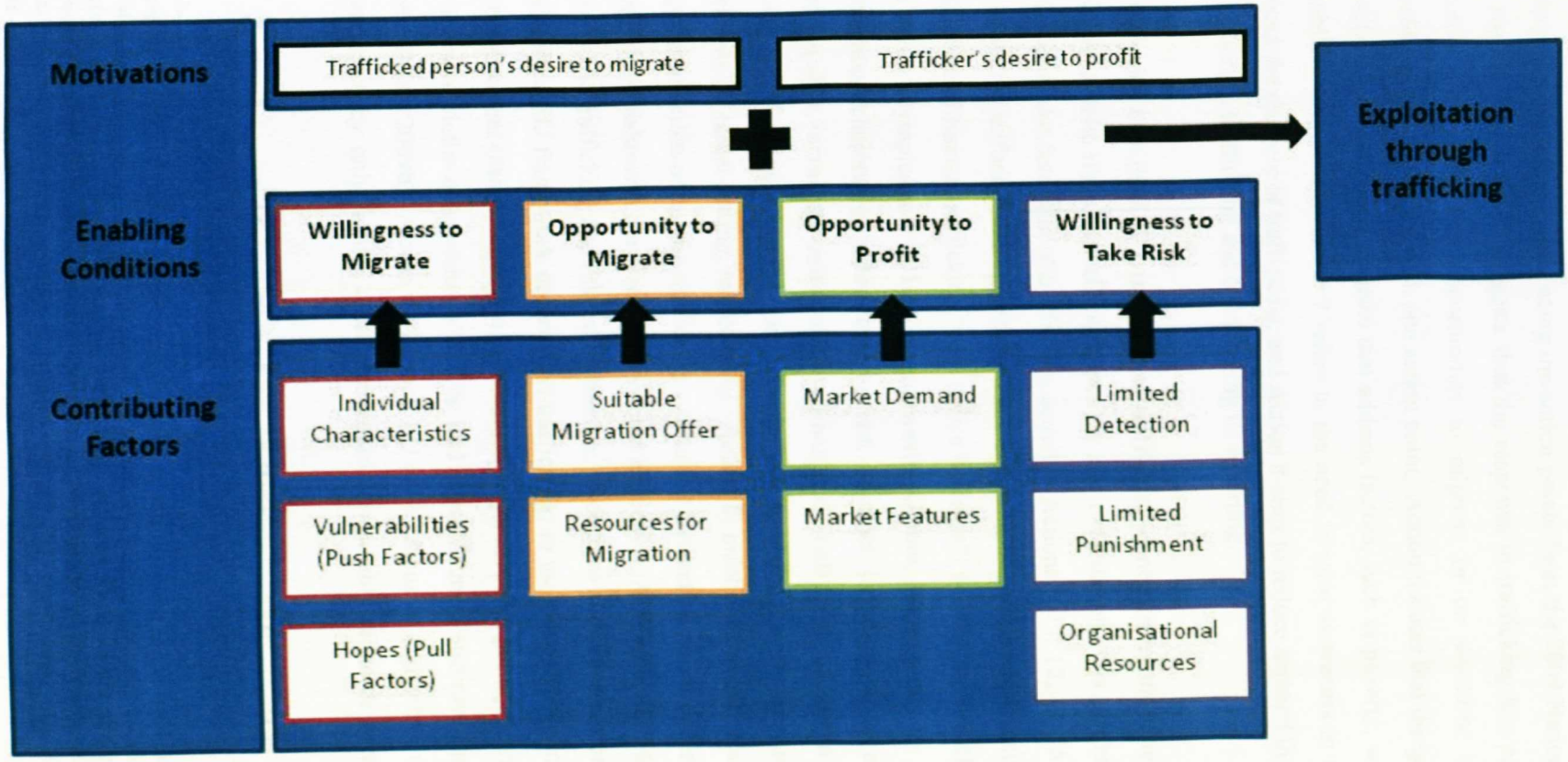
8.4.1 A framework for understanding the causal drivers of human trafficking.

The diagram shown in Figure 5 (overleaf) provides a more comprehensive framework for considering the causes of trafficking than has previously been developed for use in the UK, and brings together the multiple causal factors that have been suggested by interview participants and the literature as contributing to the continuation of human trafficking. The framework does not lend itself directly to efforts to improve the integration of health into the response to trafficking. By encouraging a more balanced approach to tackling trafficking, however, it may support greater use of lenses that emphasise migrants' vulnerability to exploitation and other forms of harm, and may therefore indirectly promote the inclusion of health in anti-trafficking strategies.

The framework is organised on three levels. The first two levels focus on the *motivations* of the trafficked person and the trafficker for entering into a "transaction" with each other, namely the trafficked person's desire to migrate and the trafficked person's desire to profit. As discussed in Chapter 4, four sets of *enabling conditions* are identified as needing to be met if the transaction is to take place: the trafficked person must be willing to migrate and have the opportunity to do so, and the trafficker must have the opportunity to profit and be willing to take the risks involved in doing so. The third level introduces the various micro and macro level *contributing factors* that enable these conditions to be fulfilled, and suggests that individual and structural factors (in both the source and destination countries) shape the likelihood of a person's exploitation through trafficking.

Policymakers and anti-trafficking advocates may find this framework to be a useful tool with which to assess whether the policy response to human trafficking is sufficiently comprehensive. Policymakers may, whether for ideological or pragmatic reasons, choose to place greater emphasis on certain causal drivers over others. The use of this framework could, however, encourage greater transparency about the reasons for these choices and hence the assumptions that underpin the response to trafficking.

Figure 5: A conceptual tool for understanding the causal drivers of trafficking



Preliminary analysis of the current situation using the action points from the 2009 National Action Plan on Tackling Human Trafficking[43] suggests that the response to trafficking has placed little emphasis on people's willingness and opportunities to migrate, or on would-be traffickers' opportunities to profit: each is addressed with one action point. Action 6 states that the government will continue to support anti-trafficking projects that address factors, such as poverty, which make individuals vulnerable to trafficking; Action 7 refers to the need to raise awareness in source and transit countries about the dangers of trafficking; and Action 8 aims to reduce demand in the UK by raising awareness of human trafficking and encouraging its reporting.

Instead, analysis indicates that the UK's response to trafficking concentrates most heavily upon traffickers' willingness to take risks by trafficking people into exploitation. Six action points are concerned with increasing the detection of trafficking activity. Actions 5, 11, 12, 13, 15 and 16 are concerned with: increasing enforcement against human trafficking in source and transit countries; making the investigation of human trafficking "core police business"; countering trafficking threats in relation to the 2012 Olympics and 2014 Commonwealth Games, for example by monitoring intelligence; developing relations with law enforcement in other jurisdictions to ensure joint working wherever possible; increasing enforcement actions against all forms of human trafficking; and examining ways of looking at police performance on combating trafficking in line with proposed commitments on target-setting, respectively. Action 8, mentioned above, also relates, in part, to increasing the detection of human trafficking. A further five action points address efforts to ensure that appropriate punishments are given to convicted traffickers: Actions 9, 10, 14, 17, and 18 refer to plans to keep UK trafficking and related legislation, procedures and processes under review; to implement the revised EU framework decision on trafficking; to use tax and revenue powers to investigate and prosecute and disrupt organised criminal networks involved in human trafficking; to identify ways to improve victim cooperation with CJS; and to enable more successful prosecutions, respectively (Home Office 2009b). Action 4 ("support EU policy focus on combating trafficking at source") is accompanied by only limited detail and could conceivably relate to several of these causal factors.

[43] This analysis excludes eight of the 24 action points relating to the response to the trafficking of adults: Actions 1 to 3 relate to efforts to improve knowledge on the nature and scale of human trafficking in the UK and do not, therefore, relate to the causal drivers of trafficking. Actions 19 to 23 are concerned with the provision of support to trafficked people once they have exited the situation of trafficking and also do not relate to the causal drivers of trafficking. Actions concerned with the response to child trafficking have been excluded from this analysis for ease of presentation.

The framework can also be used to highlight how departmental responsibility for addressing trafficking must go beyond the remit of the Home Office: the various elements of the framework fall within the remit of several government departments, such as the Department for International Development, Foreign and Commonwealth Office, and the Department for Business, Innovation and Skills. Although these departments are listed as owners of action points within the National Action Plans, this research found that their involvement in the development of the response to human trafficking has been extremely limited. Research is needed into the relative importance of elements in driving human trafficking, their responsiveness to policy interventions, and the value for money these interventions would represent. If this can be understood, the case for the greater involvement and resource commitment of the government departments other than the Home Office could be made much more strongly.

8.4.2 The need for a framework to assess the responsiveness of policies and services to the support needs of trafficked people.

This research found that the degree to which the response to trafficking safeguarded the rights and welfare of trafficked people was a frequent source of conflict within the UK trafficking policy subsystem. Notwithstanding this, stakeholders did not appear to have taken a systematic approach to analysing trafficked people's potential needs, planning responses to these needs or assessing to what extent these needs were being met (or compounded by) the UK response to human trafficking and other UK policies and procedures.

This study suggests, therefore, that there is a need to develop a framework to facilitate this type of analysis. Such a model would benefit both policymakers and service providers, who could use it to assess firstly whether they are considering the full range of potential health needs (and if these needs are being met within policy and service responses), and secondly what the positive and negative impacts of the policy are on the health of trafficked people. Such an exercise may direct civil servants in the DH, for example, to the areas in which they should challenge their colleagues to consider health more carefully and provide them with appropriate action points for their own work on trafficking. It would also provide a clearer analysis of the relevance of the health risks and consequences of trafficking for non-health professionals. The formulation of a framework to map policy responsiveness to trafficked people's needs is, however, beyond the scope of this thesis, which has sought to explore how trafficked people's health and wellbeing has been considered

within the response to trafficking to date rather than to instruct upon how people's health and related needs *should* be responded to.

The integration of models that conceptualise firstly the multiple potential influences on health and secondly the multiple stages in migration or trafficking processes during which people are exposed to health risks and accumulate health problems could provide a basic structure for such a framework (Gushulak and MacPherson 2000; Zimmerman, Yun et al. 2003). Further research will be needed to inform the framework's development. In particular, research is required into the needs of men and women trafficked for labour exploitation and of people who decline assistance from, or break contact with, police and post-trafficking support services. Research will also be needed to assess which needs are of greatest priority to trafficked people and have the most significant impact on physical and psychological health. As a preliminary step, existing health, needs and risk assessment tools used by services working with trafficked people and groups with overlapping needs could be used. Interviewees in this research suggested, for example, that trafficked people's needs were similar to those of victims of torture, sexual violence and domestic violence; asylum seekers and refugees; and migrant sex workers and other migrant labourers.

8.5 Thoughts on the future of health and human trafficking policy

The research found that a combination of international pressure, Ministerial commitment to trafficking and sustained advocacy from domestic non-governmental stakeholders moved trafficking onto the UK political agenda and kept it there. The government's decision to opt out of the recent draft EU directive on human trafficking and the absence of other new rights-based international instruments on the horizon indicates that international level events cannot now be relied upon to bring further policy change (EC 2010; HC 2010). This suggests that future health-related change within the UK response to trafficking is likely to be limited so long as healthcare providers fail to act as advocates within the policy process and the DH remains on the margins of the policy subsystem. How to build the DH's commitment to tackling trafficking in the absence of pressure either within or outside of government to do so is not a question that this research can answer. Neither can it point to how to begin to engage the health sector in the response to trafficking without leadership and resources from the DH.

The dominance of the organised immigration crime narrative has skewed trafficking policy dialogues away from considerations such as how to meet the health needs of trafficked people and

made it difficult for the DH and the health sector to carve out an effective role in responding to trafficking. It seems unlikely, however, that alternative analyses of human trafficking will supplant the organised immigration crime narrative. Working within this definition of trafficking, moving the focus of policy development and implementation away from immigration and towards criminal justice may provide greater opportunities for integrating health into the response to trafficking.

The relative weight afforded to immigration and health priorities (as evidenced by recent policies relating to migrants' access to healthcare services) suggests that the DH would have limited success in pushing, for example, for the provision of healthcare to be made less conditional on trafficked people's engagement with immigration-based procedures. Furthermore, the political and professional priorities of the health and immigration services are often in disagreement. In contrast, police authorities and local health services already have cooperative arrangements to respond to sexual violence (through Sexual Assault Referral Centres) and domestic violence (through Multi Agency Risk Assessment Conferences). Furthermore, other analyses of the UK response to trafficking have suggested that the police engaged with a "victim-centred" approach to trafficking much more easily that did the immigration service (Balch and Geddes 2010).

Policymakers commented that the lack of information to support the development of a health response to trafficking had constrained DH activity in this area. How to develop an appropriate response to the health needs of trafficked people, however, is yet to become the subject of serious inquiry within trafficking policymaking and research and it is not clear that this will be remedied without encouragement by the DH. Research is needed that goes beyond an assessment of the health needs of women who have been trafficked for sexual exploitation to consider the needs of people who have been exploited in other industries. Studies must also look at the training and support needs of healthcare providers and seek to map out the costs and logistics of a future health sector response to trafficking.

When asked to comment on the success of the campaign to sign ECAT, an interviewee stated that it had been a "coming together of everything". As this research shows, however, the ingredients of change lacked any meaningful engagement with health. Only if the DH, the health sector and researchers now commit to contributing to the trafficking response through sustained health-based advocacy and research will the UK start to fully understand and meet the recognised health needs of trafficked people.

Afterword

The UK response to human trafficking has continued to evolve in the few months since the submission of this thesis for examination.

Having maintained throughout 2010 that the UK would not sign the new EU Directive on human trafficking in its draft form, the Immigration Minister announced in March 2011 that the UK would, in fact, sign the newly finalised instrument. The Directive requires that Member States provide "necessary medical treatment" (including psychological assistance and counselling) to victims before, during and for an appropriate period of time after the conclusion of criminal proceedings. It also mandates Member States to attend to victims with special needs, in particular where those needs derive from "their health, a disability, a mental or psychological disorder they have, or a serious form of psychological, physical or sexual violence they have suffered".

The decision was widely welcomed by NGOs, but goodwill was short-lived. In April 2011, the Ministry of Justice announced that the national contract for the provision of accommodation and support to trafficked people was to be awarded to the Salvation Army. The Poppy Project, which had been centrally funded since 2003 to support women who had been trafficked for sexual exploitation, claimed that the decision was politically motivated and questioned the ability of the Salvation Army to provide appropriate care to trafficked people.

Meanwhile, human trafficking was quietly dropped from the Home Office's responsibilities under the cross-government violence against women and girls strategy. The Department of Health (DH), however, committed to undertake research on the health aspects of five areas of violence against women, including human trafficking, as part of its actions under the same strategy. In April 2011 the DH confirmed that they would commission a project to improve the health service response to human trafficking.

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Appendices

Appendix A

Timelines of events in the international, European and UK response to human trafficking

International Events

Year	Event
1895	• The first international conference on trafficking in women is held in Paris.
1904	• The International Agreement for the Suppression of the White Slave Trade is published.
1910	• The International Convention for the Suppression of the White Slave Trade is published.
1921	• The International Convention for the Suppression of the Traffic in Women and Children is published
1933	• The International Convention for the Suppression of the Traffic in Women is published.
1949	• The International Convention for the Suppression of the Traffic in Persons and the Exploitation of the Prostitution of Others is published.
1979	• The Convention for the Elimination of all forms of Discrimination Against Women (CEDAW) condemns trafficking.
1991	• The UN Working Group on Contemporary Forms of Slavery produces a draft programme of action on human trafficking.
1992	• The UN Commission on Human Rights endorses the draft programme of action on human trafficking.
1993	• The Vienna World Conference on Human Rights condemns trafficking as a form of gender-based violence.
1994	• The UN General Assembly issues a resolution condemning trafficking.
1995	• The Beijing World Conference on Women's Platform of Action condemns trafficking.
1996	• UN Commission on Human Rights adopts the draft programme on action against human trafficking. • UN commission on Human Rights adopts a resolution calling for trafficking to be addressed.
1998	• The UN General Assembly creates an Ad Hoc Committee to draft an international convention against organised crime. • The Ad Hoc Committee proposes to address trafficking in a separate protocol to the main convention on organised crime.
1999	• The Ad Hoc Committee holds eleven sessions to negotiate the convention on organised crime and its supplementary protocols.
2000	• The UN adopts the Optional Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children (the Palermo Protocol) as part of the Convention on Transnational Organised Crime.
2003	• The Palermo Protocol comes into effect following its 40th ratification.
2007	• The UN Global Initiative to Fight Human Trafficking (UN GIFT) is launched to enhance the cooperation and coordination of States in tackling trafficking.
2008	• The first UN GIFT international conference is held in Vienna

European Events

a) European Union

Year	Event
1989	• The European Parliament (EP) issues a Resolution on the Exploitation of Prostitution and the Traffic in Human Beings, OJ C 120
1993	• The EP adopts a Resolution on the Trade in Women
1995	• A report on trafficking is submitted to the EP Committee on Civil Liberties and Internal Affairs by MEP Svevo.
1996	• The EP adopts the Resolution on Trafficking in Human Beings, calling for member states to acknowledge trafficking as a serious crime and violation of human rights, to work towards a clear definition of trafficking, and to take action drafting a UN convention on human trafficking. • The European Commission (EC) and the International Organisation for Migration (IOM) organise a European conference on trafficking in women in Vienna. • The European Commission (EC) issues a Communication to the Council and the EP calling for the development of a comprehensive plan to tackle trafficking for sexual exploitation.
1997	• The EU issue a Joint Action on combating trafficking in human beings and the sexual exploitation of children. • The Treaty of Amsterdam names trafficking as a form of organised immigration crime.
2000	• The EU Charter of Fundamental Rights prohibits trafficking. • An EC Framework Decision on the criminalisation of human trafficking is proposed.
2002	• The Council adopts a Framework Decision on combating trafficking in human beings that Member States to criminalise human trafficking in their domestic legislation • The EU and IOM organise a European conference on preventing the trafficking of human beings, after which the "Brussels Declaration" is issued. • The EC establishes an Experts Group on trafficking.
2004	• The EC Experts Group reports back and makes recommendations for a new EC Communication • The EC issue a directive on the provision of short term residence permits to trafficked people.
2005	• The EC issues a Communication to the EP and the Council on developing an action plan to tackle human trafficking. • An EU Action Plan on tackling human trafficking is adopted.
2010	• The EC develop a draft directive to prevent and combat trafficking and to protect victims of trafficking.

b) Council of Europe

Year	Event
1991	• Council of Europe (COE) holds a seminar on forced prostitution and trafficking • The COE establishes a Group of Specialists to make recommendations on actions to address human trafficking
1993	• The COE Group of Specialists reports back
1996	• The COE Parliamentary Assembly adopts a plan of action on tackling trafficking in women, based upon the Group of Specialists' report.
1997	• The COE Parliamentary Assembly issues a recommendation calling for the development of a specific COE convention to address trafficking (Recommendation 1325/97).
2002	• The COE Parliamentary Assembly repeats their call for the development of a specific COE convention to address trafficking (Recommendation 1545/02).
2005	• The COE Convention on Action against Trafficking in Human Beings (ECAT) is adopted.
2008	• ECAT comes into force after its tenth Member State ratification.

UK Events

Year	Event
2000	• The Home Office publishes "Stopping Traffic", a commissioned piece of research into the nature and scale of trafficking for sexual exploitation in the UK. • The UK signs the Palermo Protocol.
2002	• Trafficking for sexual exploitation is criminalised in the Nationality, Immigration and Asylum Act 2002. • The Home Office outlines its strategy for combating human trafficking in the Immigration White Paper "Secure Borders, Safe Haven".
2003	• The earlier criminalisation of trafficking for sexual exploitation is superseded by the provisions of the Sexual Offences Act 2003. • A Home Office report estimates that there may be up to 4,000 women in the UK who have been trafficked for sexual exploitation. • The Home Office funds the Poppy Project as a pilot project to provide support for women trafficked into sexual exploitation.
2004	• Trafficking for labour exploitation is criminalised in the Asylum and Immigration (Treatment of Claimants) Act 2004. • The Gangmasters' Licensing Act is adopted. • The UK opts out of the EU Directive on issuing short term residence permits to trafficked people.
2005	• The Gangmasters' (Licensing Authority) Regulations are adopted. • The Joint NGO Ministerial Stakeholder Group on Human Trafficking is established.
2006	• The Home Office launches a draft consultation on a National Action Plan to Tackle Human Trafficking. • A nationwide anti-trafficking police operation - Operation Pentameter - is launched. • The Home Office funds the creation of the UK Human Trafficking Centre (UKHTC) following Operation Pentameter. • The UK ratifies the Palermo Protocol. • The Joint Committee on Human Rights launches an inquiry into human trafficking. • The Home Office increases the funding it provides to the Poppy Project to expand support provision to 35 bed spaces. • The Gangmasters' Licensing Authority is established.
2007	• The UK signs ECAT. • The Home Office publishes the National Action Plan to Tackle Human Trafficking. • Operation Pentameter 2 is launched as a second nationwide anti-trafficking operation. • The Home Office funds the Metropolitan Police Service (MPS) to establish a specialist human trafficking team. • The Child Exploitation and Online Protection Centre (CEOP) establish a Child Trafficking Unit.
2008	• The government ratifies ECAT in December 2008. • The Home Affairs Committee launches an inquiry into the UK response to trafficking. • The Home Office reviews the demand for prostitution in connection with its work on tackling human trafficking. • The Home Office issues an updated version of the National Action Plan to Tackle Human Trafficking. • Identification and support arrangements for people trafficked for labour exploitation

	are trialed during "Operation Tolerance". • A regional operation against trafficking for labour exploitation ("Operation Ruby") is launched.
2009	• ECAT comes into force in the UK on the 1st April 2009. • The UK introduces a National Referral Mechanism to enable the identification and referral of trafficked people. • The UK introduces 45 day recovery and reflection periods for people who are identified as trafficked through the NRM. • The UK introduces 1 year residency permits for people who have been identified as trafficked and need to stay in the UK for humanitarian reasons or to assist with the prosecution of their traffickers. • Changes to the National Health Service (Charges to Overseas Visitors) Regulations come into force so that people who have been identified as trafficked can access free primary and secondary medical services. • The Ministry of Justice provides additional funding to support the expansion of the Poppy Project to include 54 bed spaces across London, Sheffield and Cardiff for women who have been trafficked into sexual exploitation and/or domestic servitude. • The Home Office provides funding to the Migrant Helpline to support men and women who have been trafficked for labour exploitation. • The Home Office issues an updated version of the National Action Plan to Tackle Human Trafficking. • CEOP publish a Strategic Threat Assessment which reports that 325 children have been identified in the UK as having been potentially trafficked. • The MPS Human Trafficking Team closes and its responsibilities transfer to the MPS Clubs and Vice Unit.
2010	• A report by the Association of Chief Police Officers estimates that there may be up to 2,600 women in the UK who have been trafficked for sexual exploitation. • The UK Human Trafficking Centre, previously hosted by South Yorkshire Police, moves to be part of the Serious Organised Crime Agency (SOCA). • The UK announces that it will opt out of the draft EC directive on human trafficking.

Appendix B

Preparatory mapping of the trafficking policy subsystem to inform interview sampling

Preparatory research included mapping the policy subsystem in order to generate a list of potential actors and organisations to invite to be interviewed for the study. This identified 74 non-governmental organisations (NGOs) and academics and 69 government departments, government agencies, local authorities and other public sector organisations.

In order to refine this list, the involvement of these organisations in the trafficking policy subsystem was assessed according to a number of criteria (these conditions necessarily differ by category of actor e.g. civil servant vs. NGO). Actors and organisations meeting more of these conditions were deemed more influential than those meeting fewer and were prioritised for invitation for participation.

NGOs and academics were awarded points if they had:

- Authored publications have been referenced in policy or other government documents
- Invited to the Home Office pre-policy consultation meeting.
- Participated in consultation events.
- Responded to policy consultation document
- Responded to the Home Affairs Committee inquiry on trafficking.
- Responded to the Joint Commission on Human Rights inquiry on trafficking.
- Been invited to give oral evidence to the Home Affairs Committee inquiry on trafficking.
- Been invited to give oral evidence to the Joint Commission on Human Rights inquiry on trafficking.
- Membership of the NGO Stakeholder Group.
- An institutional link to the government or its agencies (e.g. in an advisory role, through funding etc.)
- Attended the Council of Europe 2007 Regional Seminar

Government agencies and departments were awarded points if they had:

- Responded to the policy consultation document
- Given evidence to the Home Affairs Committee inquiry on trafficking
- Given evidence to the Joint Commission on Human Rights inquiry on trafficking
- Submitted evidence or implementation plans to the Inter-Departmental Ministerial Group on Human Trafficking
- Membership of a policy team that is concerned with human trafficking.
- Attended stakeholder group meetings
- Been named as lead on a national action plan action point.
- Attended the Council of Europe 2007 Regional Seminar.

The table below lists the organisations, departments and agencies that were identified as key interview targets through the mapping exercise and provides details of whether the targets were contacted to participate in the research and successfully interviewed.

Category	Organisation	Contacted	Interviewed	Comments (if applicable)
NGO or academic	End Child Prostitution, Child Pornography and the Trafficking of Children (ECPAT UK)	Yes	Yes	
	POPPY Project / Eaves Housing	Yes	Yes	
	Anti-Slavery International	Yes	Yes	
	National Society for the Prevention of Cruelty to Children (NSPCC)	Yes	Yes	
	Amnesty International	Yes	Yes	
	Trade Union Congress	Yes	Yes	
	Immigration Law Practitioners Association (ILPA)	Yes	Yes	Two of the five lawyers interviewed for the research were members of ILPA.
	Kalayaan	Yes	Yes	
	Africans Unite Against Child Abuse (AFRUCA)	No	No	Limited time to complete data collection
	United Nations Children's Fund (UNICEF)	No	No	Limited time to complete data collection
	International Organisation for Migration (IOM)	Yes	Yes	
	Churches Alert to Sex Trafficking in Europe (CHASTE)	Yes	Yes	
Government department, agency, or other public sector organisation	Home Office	Yes	Yes	
	Foreign and Commonwealth Office (FCO)	No	No	Participant observation indicated limited FCO involvement.
	Crown Prosecution Service (CPS)	Yes	No	Application to interview CPS representative was withdrawn: permission to interview required that the thesis would be sent to the CPS for clearance prior to submission.
	Attorney General's Office	No	No	Turnover of personnel meant there was not an appropriate interviewee at the time of data collection
	UK Human Trafficking Centre	Yes	Yes	
	Department for Education and Skills (DfES)	Yes	No	Turnover of personnel meant that there was not an

				appropriate interviewee at the time of data collection.
	Child Exploitation and Online Protection Centre (CEOP)	Yes	Yes	
	Border and Immigration Agency (BIA)	Yes	Yes	At the time of data collection, BIA had become the UK Border Agency (UKBA)
	Association of Chief Police Officers (ACPO)	Yes	No	Although potential interviewees expressed interest in participating, it did not prove possible to schedule an interview.
	Serious Organised Crime Agency (SOCA)	Yes	No	Although potential interviewees expressed interest in participating, it did not prove possible to schedule an interview.

Actors who are concerned with the health of trafficked persons featured lower on the ranking lists or did not feature at all. In order to meet the research objectives, actors and organisations known to be concerned with trafficking and health were added to the lists of organisations to contact. The table below shows the organisations that were originally added to the list of priority interview targets.

Category	Organisation	Contacted	Interviewed	Comments
Health	Helen Bamber Foundation	Yes	Yes	
	Medical Centre for the Care of Victims of Torture	Yes	No	Organisation was not interested in participating in the research.
	NSPCC Sexual Exploitation Service (Street Matters/Bfree)	Yes	Yes	
	Women and Girls Network (WAGN)	No	No	Unable to identify an appropriate contact.
	Department of Health	Yes	Yes	
	Praed Street Project	Yes	No	Organisation was not interested in participating in the research.
	Open Doors, Hackney.	Yes	Yes	
	Project: London (Medicins du Monde UK)	Yes	Yes	
	Haven Clinic, Paddington.	Yes	Yes	

Appendix C

Participant Information Sheet and Consent Form

Centre for Population Studies,
London School of Hygiene and Tropical Medicine
49-51 Bedford Square,
London WC1B 3DP

Tel: 020 7299 4773
Mobile: 07792 427959
Email: sian.oram@lshtm.ac.uk

Participant Information Sheet:
Health, Wellbeing and UK Human Trafficking Policy

I would like to invite you to be interviewed as part of a research study that looks at how human trafficking is being addressed in the UK. This sheet provides information about the research being conducted and how you would be involved, explains the confidentiality and data storage arrangements, and gives details of how the research has been funded and reviewed. Please read the following information and if there is anything that is not clear, or if you would like further information, please contact the researcher.

The research is being undertaken as part of a doctoral degree at the London School of Hygiene and Tropical Medicine (LSHTM), and is supervised by Ms. Joanna Busza and Dr. Cathy Zimmerman. The research is funded by the Economic and Social Research Council. The main study objectives are to explore:

- How the response to human trafficking developed in the UK, and in particular how concerns for the health and wellbeing of trafficked people have been incorporated into human trafficking policy.
- The potential ways that UK human trafficking policy may affect the health and wellbeing of trafficked people and that of others indirectly affected by the policy.

The core research methods are:

- Interviews with service providers, other professionals, non-governmental organisations, unions, government agencies and policymakers.
- Analysis of documents gathered from service providers, other professionals, unions, non-governmental organisations, government agencies and policymakers.

I would like to interview you because of your interest in and experience of the response to human trafficking in the UK. I feel the study would benefit very much from your insights and I sincerely hope that you are able to participate. The interview will last approximately 60-90 minutes, and will be held at a location convenient to you.

If you decide to take part, you will be asked to sign a consent form. Having signed the consent form you will remain free to withdraw from the study at any time, without having to give a reason for this.

Confidentiality

With your permission, the interview will be digitally recorded and transcribed. You may request a copy of your transcript to be sent to you, and you can correct any part of the transcript that you believe to be in error.

Transcripts are anonymised during the transcription process. Direct quotes will only be used in the research reports with your consent, and all quotes will be anonymised. Only the researcher has access to audio files.

Data Storage

Audio files and anonymised transcripts will be securely stored by the researcher until the completion of the research project in November 2010. LSHTM research governance requirements stipulate that files are then securely stored with the LSHTM records management service for a further 10 years. During this time, only the researcher can access – or give permission to access – the stored files. After 10 years, the files will be disposed of securely.

The funders of the research – the Economic and Social Research Council (ESRC) – encourage researchers to archive data at the University of Essex Qualidata service. With your permission, the researcher will archive your anonymised transcript. Information about Qualidata can be found at: http://www.esds.ac.uk/qualidata/about/introduction.asp

Participant Access to Research Findings

A summary of the study findings can also be sent to you on completion of the research, scheduled for November 2010. A copy of the full thesis will also be deposited in each of the LSHTM and University of London Libraries.

Ethical Review

The research has been approved by the London School of Hygiene and Tropical Medicine Ethics Committee and by the National Hospital for Neurology and Neurosurgery and the Institute of

Neurology Joint REC. The research protocol has also been approved by the London School of Hygiene and Tropical Medicine.

Further Information and Complaints

If you have a concern about any aspect of this study, please contact me and I shall do my best to answer your questions. If you remain unhappy and wish to make a complaint, this can be done through the London School of Hygiene and Tropical Medicine.

If you would like to participate in the study, please contact the researcher on sian.oram@lshtm.ac.uk or 07792 427959.

Yours sincerely,

Siân Oram.

Centre for Population Studies
London School of Hygiene and Tropical Medicine
49-51 Bedford Square,
London WC1B 3DP

Tel: 020 7299 4773 / 07792 427959
Email: sian.oram@lshtm.ac.uk

Health, Wellbeing & UK Human Trafficking Policy
Participant Consent Form.

DATE:

Interview Number:
Researcher: Siân Oram.

1.	I have read and understood the information sheet.	Yes ☐ No ☐
2.	I have had the opportunity to ask questions about the study.	Yes ☐ No ☐
3.	I have had my questions answered satisfactorily.	Yes [illegible] No [illegible]
4.	I agree to be interviewed for the study.	Yes [illegible] No [illegible]
5.	I understand that I can withdraw from the study at any time without having to give an explanation.	Yes [illegible] No [illegible]
6.	I agree to the interview being audio-taped, and to its contents being used for research purposes.	Yes [illegible] No [illegible]
7.	I / my employer (delete where applicable) may be identified as having participated in the research in subsequent research reports and publications.	Yes [illegible] No [illegible]
8.	My anonymised words may be quoted in subsequent research reports.	Yes [illegible] No [illegible]
9.	My transcripts (in line with the conditions outlined above) may be archived and used by other Economic and Social Research Council-registered researchers.	Yes [illegible] No [illegible]
10.	I would like to be sent a copy of my transcript.	Yes [illegible] No [illegible]
11.	I would like to be sent a summary of the research findings upon completion of the study	Yes [illegible] No [illegible]

Name of Participant (PRINT) **Date** **Signature**

Name of Researcher (PRINT) **Date** **Signature**

Appendix D

List of interviewed organisations

Service Providers

1. Poppy Project
2. Medaille Trust
3. City Light
4. Migrant Helpline
5. Kalayaan
6. TARA
7. There2Here Project

Enforcement

1. CO14 Clubs and Vice
2. Metropolitan Human Trafficking Team
3. Operation Maxim
4. Strathclyde Police
5. UK Human Trafficking Centre
6. Gangmasters Licensing Authority
7. Child Exploitation and Online Protection Centre (CEOP)

Advocates

1. Amnesty International UK
2. Anti Slavery International
3. Independent Consultant
4. IOM London
5. CHASTE
6. ECPAT
7. NSPCC
8. Trade Union Congress
9. English Collective of Prostitutes
10. International Union of Sex Workers

Lawyers

1. Fisher Meredith LLP
2. Glasgow Legal Services Women's Agency
3. Pierce Glynn LLP
4. AIRE Centre
5. Garden Court Chambers

Healthcare Providers

6. Helen Bamber Foundation
7. Base 75
8. Compass
9. Open Doors
10. Project London
11. The Haven, Camberwell
12. The Haven, Paddington

Civil Servants

1. Home Office
2. Ministry of Justice
3. UKBA
4. Department of Health
5. Department of Health
6. Hillingdon Local Authority
7. Glasgow Local Authority

Appendix E

Examples of topic guides used during semi-structured interviews

a) Topic guide used for an interview with a healthcare provider.

Theme	Possible Prompts
SECTION 1 PROBLEM DEFINITION/ BASIC INFORMATION	
Could you tell me what you understand by the term 'trafficking'?	• How would you distinguish between migrant workers who were/were not trafficked? • How would you describe the causes of trafficking? • As far as possible, could you describe a typical trafficked person?
When did you become aware of the issue of human trafficking as something that you may need to respond to?	• Dialogue or through the service? • What was happening at that time?
How did you become involved in responding to human trafficking?	• Who approached? • What was your response? • Change over time? • Challenges of engaging with response • Positive aspects of engaging with response
How would you describe your model of care?	• Strengths/weaknesses in relation to trafficking • Benefits vs. Other sexual health services

Where do you receive trafficking referrals from?	• Differences between the referral types (i.e. type of services wanted? Health needs?)
SECTION 2: YOUR WORK **HEALTH**	
Could you talk me through the services that you provide to women who have been trafficked? a) Counselling b) Psychological therapy c) Basic medical treatment d) Sexual and reproductive health testing and treatment e) Forensic examination f) Liaison with police g) Referral	• Take-up of counselling and therapy • Complex needs? • Fears around sexual and reproductive health • Usefulness/challenges of forensics with trafficking • Do women tend to want to have contact with the police? Why? • Do women tend to want to be referred into support services? Why?
What do you feel may be some of the barriers which prevent trafficked women from accessing your service?	• How could they be overcome?
Can you tell me about some of the most common health concerns and needs amongst the women you work with?	• Less common needs? • Any patterning in needs (i.e. by nationality)
How do you feel these needs are most appropriately met?	

Are there similarities between the health needs of trafficked persons and other service users?	
Are there differences between the health needs of trafficked persons and other service users?	
What sort of access have trafficked people had to healthcare (physical/sexual) whilst in the trafficking situation?	
What are the challenges you face in providing these services to trafficked women?	• Interpretation/cultural • Services required • Coordinating multiple needs • Referral onto further services • Working with other healthcare providers • Working with post-trafficking support services • Immigration status?
Are there similarities in experiences of working with trafficked people compared to other victims of assault?	
Are there differences in experiences of working with trafficked people compared to other victims of assault?	

Do you identify people through your work that may be trafficked?	• How do you respond?
INFORMATION	
What information is available to help people/services to gain an understanding of the **consequences** of trafficking for health and wellbeing and how to address them/implications of?	• Adequate? Quality? • Who produced? • How used? • What is missing? • Who should provide it?
What information is available to help people/services to gain an understanding of **how to address** the health and wellbeing needs of trafficked persons?	• Adequate? Quality? • Who produced? • How used? • What is missing? • Who should provide it?
What sources of information do you draw on in your work on trafficking?	• Care models/best practice?
What type of information do you collect on the women you work with?	• How is it shared with other organisations?
Are you able to share your expertise/knowledge on caring for trafficked	• How? • Who with?

persons/needs?	• What limits?
SECTION 3: THE ROLE OF THE HEALTH SECTOR	
What do you feel the role(s) for the health sector should be in the response to trafficking?	• Care/ Identification/Needs Assessment/Building information? • To what extent have those roles been realised? • How could they be realised?
What are the challenges that the health sector faces in engaging with the development of response to human trafficking at a policy level?	• How could these challenges be overcome?
What would be the challenges that the health sector faces in responding to human trafficking at an operational level?	• How could these challenges be overcome?
SECTION 4: FEEDBACK	
What is your perception of the commitment of organisations /institutions to meeting the health needs of trafficked persons?	• Police • Criminal Justice System • Immigration • Service Providers • Policymakers
What is your perception of the understanding of organisations /institutions around the health needs of trafficked persons?	• Police • Criminal Justice System • Immigration • Service Providers • Policymakers

What level of awareness do you feel there is about trafficking in the health sector?	• Why/why not improved? • How to increase? • Barriers to increasing? • Services to target?
What recommendations would you make to improve the UK response to human trafficking?	• Why do you feel these changes are necessary? • Why do you think these changes have not yet been made? • How are you/ others working to promote these recommendations? • What levels of support have you received/anticipate receiving with regards to these recommendations? • From whom? • What opposition have you received/anticipate receiving with regards to these recommendations? • From whom?
SECTION 5: COORDINATION **GROUPS** **Which other groups or organisations do you regularly work with operationally on issues around trafficking?**	• What did you collaborate on? • Why did you work with these particular groups? • Do you work with these groups regularly?
Which other groups or organisations do you regularly work with at a strategic or policy level on issues around trafficking?	• What did you collaborate on? • Why did you work with these particular groups? • Do you work with these groups regularly?
How have you worked to establish relationships with organisations supporting women that are outside of the health sector?	• Challenges? • Why successful? • Which organisations and why?

Could you tell me about how, or if, you work with: • Police service • Criminal Justice System • Immigration service • Any trafficking specific organisations **ENGAGEMENT** **What is your perception of the ways in which decision-making bodies have tried to include organisations like yours in making decisions about providing services to trafficked persons?** **What opportunities do you have to feed back your opinions about human trafficking to decision-makers?** Which meetings or events about human trafficking do you attend? Are there meetings that you would like to attend but are unable to?	• How invited? Who attends • How regular? • Purpose of group • Strengths/weaknesses • Why are you unable to attend?
SECTION 6: CONTEXTUAL FACTORS **The final section I'd like to talk about is about other factors which might have affected how trafficking is addressed in the UK....**	

Firstly, how do you think the **media** has shaped how trafficking is addressed in the UK? How has **parliamentary attention** affected the development of trafficking policy? In your opinion, how have the **public** been engaged in efforts in address trafficking? Why do you think this is? How do you think events at the **international level** have affected the UK's response to trafficking? What would you say have been some of the landmark policy-related events or key changes for you since you became involved in work on human trafficking? Are there any other factors which we haven't talked about that you feel have been important in shaping how trafficking is addressed in the UK? Are there any people who you feel it would be useful for me to talk to, based on what we've spoken about today?	

b) Topic guide used in an interview with a Civil Servant

Theme	Potential Prompts
SECTION 1 PROBLEM DEFINITION/ BASIC INFORMATION	
Could you tell me what you understand by the term 'trafficking'?	• How would you distinguish between migrant workers who were/were not trafficked? • How would you describe the causes of trafficking? • As far as possible, could you describe a typical trafficked person? • To what extent is this consistent across government? • Benefits/drawback of definition
When did the department become aware of the issue of human trafficking as something that it may need to respond to?	
How did it become involved in responding to human trafficking?	• Profile in the department • Relationship to other work the department does • Key anti-trafficking programmes/initiatives within the department
Relative to other departments, what do you feel the role of your department has been with regard to the response to trafficking?	
What would you say are the main constraints or difficulties you face as an department in trying to address trafficking?	
How is your work on trafficking affected by other policies that the department has/government has?	
SECTION 2: HEALTH	

Health What do you feel are the main health issues facing trafficked persons? How do you think the health needs of trafficked persons can be best addressed? What do you feel the role of the health sector should be in addressing trafficking? What challenges do you feel the health sector faces in responding to human trafficking in this way? How do you think these challenges could be addressed?	• e.g., caring, identification. • Why is the health sector well placed to carry out these roles?
SECTION 3: INFORMATION How adequate is, do you feel, the available knowledge base on human trafficking? Which sources of information on trafficking do you use? Why? What information on trafficking is available to the health sector? What information on trafficking may the health sector have that could be useful in addressing trafficking?	• Impact of uncertainties on work • Strengths/limitations • Key documents?
SECTION 4: FEEDBACK	

From a health and wellbeing perspective, what do you feel have been the successes to date in how trafficking is being addressed in the UK?	• Why?
From a health and wellbeing perspective, what do you feel have been the less successful aspects to date in how trafficking is being addressed in the UK?	• Why?
What are the key developments you would like to see happen in the Department going forward?	• Why do you think they are necessary? • Why do you think they have not happened yet? • How are you working to achieve them? • What levels of support have you received with regards to these developments? From whom? • What difficulties or opposition have you received? From whom?
What are the key developments you would like to see happen beyond the Department going forward?	• Why do you think they are necessary? • Why do you think they have not happened yet? • How are you working to achieve them? • What levels of support have you received with regards to these developments? From whom? • What difficulties or opposition have you received? From whom?
SECTION 5: COORDINATION **Groups and Events** Which are the groups or fora that you (or others in the department) attend that discuss policy on trafficking?	
Of the various groups and fora that you participate in, which do you feel are the most important/useful? Why?	
Are there meetings or events that you feel it would be useful to attend but are unable to?	• Why are you unable to?

At the trafficking events you attend, do people talk about health? Access to health services?	• What are the concerns that are raised? By whom? • Consensus/ disagreement?
Government Which are the teams within the department with which you work with regards to human trafficking?	• How do you work with them? • What do you work on?
Which departments of government do you work with on trafficking issues?	• How do you work with them? • How often are you in contact with them? • What do you work on? • How do you coordinate your work?
How effectively do you feel that you work with these departments on trafficking issues?	• What does effective working mean to you? • What do you think explains the effective/ineffective working relationship? • Variation between departments? • Has this changed over time? • Why?
How do you feed back your opinions and experiences about human trafficking to government?	• What level of influence do you feel you have relative to other organisations/teams? • Why do you think this is?
Public Bodies Which public bodies do you work with on human trafficking?	• What do you collaborate on? • Why do you work with these particular organisations? • How is your work coordinated? • How effectively do you feel you work?
How have you worked with the NHS on the issue of human trafficking?	• Successes/challenges

Outside Government Which non governmental groups do you tend to most often work with on human trafficking?	• Plans going forward • How have you worked with them? • How often? • Informal/formal? • Why do you work with these particular groups? • Any health-based orgs? Why/why not?
SECTION 6: CONTEXTUAL FACTORS **The final section I'd like to talk about is about other factors which might have affected how trafficking is addressed in the UK....** How do you think **media attention** has affected how the UK responds to the health and wellbeing of trafficked persons? How do you think **civil society** has affected how the UK responds to the health and wellbeing of trafficked persons? How do you think **parliamentary attention** has affected how the UK responds to the health and wellbeing of trafficked persons? How do you think events at the **international level** have affected how the UK responds to the health and wellbeing of trafficked persons? What would you say have been the key events or changes for you, since you became involved in work on human trafficking, with regards to how the UK responds to the health and wellbeing of trafficked persons? Are there any other factors which we haven't talked about that you feel	

have been important in shaping how trafficking is addressed in the UK? Are there any people who you feel it would be useful for me to talk to, based on what we've spoken about today?	

Appendix F

List of meetings and events attended during participant observation

Date	Meeting Title	Meeting Organiser	Meeting Location
September 21st 2007	UKHTC Research Subgroup Meeting	UKHTC	Salvation Army House, London
October 4th 2007	Law and Policy Forum: Child Trafficking	Anti Trafficking Legal Project (AtLEP)	Devereux, London.
November 14th 2007	UKHTC Conference	UKHTC	Sheffield
November 28th 2007	Tackling Prostitution and the Damage it Does	CARE/ Fiona MacTaggart MP	Houses of Parliament, Committee Room 8.
December 4th 2007	All Party Parliamentary Group (APPG) Meeting: UKHTC & SOCA	APPG	Houses of Parliament
December 7th 2007	Law and Policy Forum: The Council of Europe Convention	AtLeP	Devereux, London
January 29th 2008	APPG Meeting: BIA	APPG	Houses of Parliament
February 2008	UN GIFT Conference	UN Global Initiative to Fight Trafficking	Vienna
February 19th 2008	Law and Policy Forum: Trafficking and Health	AtLeP	Devereux, London
March 7th 2008	Garden Court Conference	Garden Court Chambers	Garden Court
June 5th 2008	Law and Policy Forum: Immigration Law	AtLeP	Devereux, London
June 18th 2008	Time for an Independent Trafficking Rapporteur in the UK?	ECPAT, ASI,	Garden Court Chambers, London.
June 24th 2008	APPG: Pentameter	APPG	Houses of Parliament
July 7th 2008	JCHR Mini Conference on the Health of Asylum Seekers and Trafficked Persons	Joint Committee on Human Right (JCHR)s	Portcullis House
November 27th 2008	Stop the Traffik: International People's Lecture	Stop the Traffik	Oasis House, London.
December 10th 2008	UKHTC NGO Briefing and Consultation Day	UKHTC	UKHTC Offices, Sheffield
December 16th 2008	Law and Policy Forum: European Law & Ongoing Cases	AtLeP	Devereux, London
October 21st 2008	Home Affairs Committee Oral	Home Affairs Committee (HAC)	Houses of Parliament

	Evidence Session		
October 31st 2008	NGO Meeting on Development of Human Rights Report	Amnesty International UK (AIUK)	AIUK Offices
January 30th 2009	OSCE/ODIHR Meeting on the UK NRM	Anti Slavery International, Trades Union Congress, Office for Security and Cooperation in Europe	TUC Office
March 30th 2009	Metropolitan Police Human Trafficking Team Training Day	Metropolitan Police Service	New Scotland Yard
April 22nd 2009	Joint NGO Stakeholder Meeting	Home Office/Ministry of Justice	Westminster Palace
May 14th 2009	Home Affairs Select Committee Report Launch and Seminar	HAC	Portcullis House
June 23d 2009	AFRUCA Launch of Child Trafficking Project	AFRUCA	County Hall, London
June 24th 2009	Migrant Helpline Training Day	Migrant Helpline	Ashford
June 29th 2009	APPG: Director of Public Prosecutions	All Party Parliamentary Group on Trafficking	Grand Committee Room, HoC
July 7th 2009	Training Session for Immigration Lawyers: Trauma and Credibility	1 Pump Court	St Bride Centre, London
July 10th 2009	ISET Project Launch: Migrant Sex Workers in the UK	London Metropolitan University	Grad Centre, London Metropolitan University
July 16th 2009	Joint Ministerial NGO Stakeholder Meeting	Home Office/Ministry of Justice	Office for Criminal Justice Reform
August 11th 2009	Meeting the Health Needs of Trafficked Persons Workshop	Office for Criminal Justice Reform, Department of Health	Office for Criminal Justice Reform
September 17th 2009	Violence against Women and Girls Taskforce (VAWGT) Harmful Traditional Practices Subgroup	Department of Health	Work Foundation, London
September 22nd 2009	Law and Policy Forum: Implementation of ECAT	AtLEP	Devereaux, London.
October 13th 2009	VAWGT Taskforce Harmful Traditional Practices Subgroup	Department of Health	Work Foundation, London
October 23rd 2009	Metropolitan Police Service Human	Metropolitan Police Service	New Scotland Yard

	Trafficking Team Conference		
October 29th 2009	Meeting to discuss potential research into health and trafficking	Department of Health	Department of Health, Skipton House, London
November 2nd 2009	ECP Briefing on Policing and Crime Bill	English Collective of Prostitutes	Houses of Parliament
December 16th 2009	VAWGT Taskforce Harmful Traditional Practices Subgroup	Department of Health	Park Plaza Hotel, London
January 26th 2010	JCHR Update Session with Alan Campbell	JCHR	Houses of Parliament
May 24th 2010	SOCA/UKHTC Concept Session	Serious Organised Crime Agency (SOCA)	SOCA, Old Queen Street
16th June 2010	ATMG Report Launch	Anti Trafficking Monitoring Group	Houses of Parliament
5th July 2010	NRM 12 Month Review Workshops	UK Border Agency	Admiralty House, London

Appendix G

Details of the formal requests made for copies of documents during the research

The table below details documents that were formally requested from a range of institutions over the course of the research and the outcomes of these requests. Information was also requested informally from the organisational contacts I developed during the research; details are not provided here for reasons for confidentiality.

Information Owner	Date requested	Information requested	Outcome of request	Reason given, if refused
Home Office	10/2007	Membership of the Inter Departmental Ministerial Group on Human Trafficking	Received	-
Department of Health	05/2008	Documents relating to the Department of Health's response to the UK National Action Plan on Tackling Human Trafficking, including guidelines for responding to child trafficking	Received	-
Council of Europe	08/2008	Documents pertaining to the drafting and negotiation of the Council of Europe Convention on Action against Trafficking in Human Beings	Refused	Confidential information
Home Office	09/2008	Attendance of events held to inform the consultation on the UK National Action Plan on Tackling Human Trafficking	Received	-
Home Office	09/2008	Poppy Project evaluation report Inter Departmental Ministerial Group minutes Documents relating to the questionnaire, issued to EU countries in July 2005 which sought information on methods of support for trafficking victims	Received Refused Refused	- Exempt until S35 of Freedom of Information Act No records held
South Yorkshire Police	09/2008	Response to the consultation on the National Action Plan on Tackling Human Trafficking	Refused	No records held
Devon and Cornwall Police	09/2008	Response to the consultation on the National Action Plan on Tackling Human Trafficking	Received	
Humberside	09/2008	Response to the consultation on the	Refused	No records held

Police		National Action Plan on Tackling Human Trafficking		
ACPO		Guidelines for investigating human trafficking	Refused	Operationally sensitive
UKHTC	02/2009	Business Plan Membership of advisory board	Refused Refused	Confidential information Confidential information
Metropolitan Police Service	10/2009	Copy of the report Trafficking in Women and Children for the Purposes of Sexual Exploitation: Situation Report (CO14, 1999)	Refused	Information deleted as obsolete

Appendix H

Ethical approval documents

This appendix provides copies of the ethics submissions to, and approval provided by, the ethics committees of the London School of Hygiene & Tropical Medicine (LSHTM) and the NHS National Research Ethics service.

Submission to the LSHTM ethics committee

For use of Ethics Committee only	**Application No.**	
This form should be completed, signed by the Principal Investigator and Head of Department, and returned to **Gemma Howe**, 8 Bedford Square, LSHTM. An electronic version (MS word format) must also be submitted to ethics@lshtm.ac.uk. Both versions must be received before the application can be processed.		

Title of Project UK Human Trafficking Policy: its development and the absence of health.	
Name of Principal Investigator (PI) at LSHTM	Siân Oram
Appointment Held (or Research student)	Research Degree Student
Unit/Department	CPS/EPH
Medically qualified	NO
Are you a member of a medical protection organisation?	NO
Other personnel involved	-
Signature of Principal Investigator	
If Research student: Name, signature and approval of Supervisor	

Is this a DrPH Professional attachment ?	NO
Is this study using anonymised secondary datasets only	NO
Fastrack — Applications in these categories will be dealt with by Chair's action	

Does this study involve the taking of blood and/or any other tissue?	NO

I approve this project scientifically.	Approval
Signature of Head of Department Date	Signature of Chair of Ethics Committee
Received by Ethics Committee	
Signature of Ethics Committee Administrator Date	Date

1.	Give an outline of the proposed project. Sufficient detail of the protocol must be given to allow the Committee to make an informed decision without reference to other documents. (Additional material should only be attached if considered absolutely necessary). *Max 300 words*
Answer: Expand box to fit	Human trafficking is a problem thought to be increasing in scale and scope around the world. The UK is primarily a destination country for human trafficking, and people have been reported as being trafficked to the UK for the purposes of prostitution, domestic service, work in the agricultural, construction, hospitality sectors, begging, benefit fraud and others. The harms and exploitation suffered by trafficked persons violate their human rights and can result in a multitude of poor health consequences. The UK has recently developed a national policy on tackling human trafficking, and has signed a number of international agreements on actions against human trafficking. The proposed project will analyse the development of human trafficking policy in the UK, and consider why concerns for the health of trafficked people have not been given greater prominence during the policy process. In order to do this, the applicant will conduct interviews with people involved in the development of human trafficking policy and with people whose work is affected by human trafficking policy, such as those in the police force, criminal justice system, care service providers, and the health sector (no interviews will be conducted with trafficked persons). Document analysis will also be used, but it is anticipated that all documents used will be readily available in the public domain. Documents likely to be used include policy documents, consultation documents, inquiry reports and such like.
2.	State the intended value of the project. If this project or a similar one has been done before what is the value of repeating it?. Give details of overviews and/or information on the Cochrane database. *Max 300 words* *This area is of increasing importance – please ensure you give a full response.*

	There a body of published research on the detrimental health consequences of trafficking for those persons who have been trafficked, including poor physical, sexual and psychological health outcomes. However, the UK human trafficking policy makes little reference to these health outcomes and does not commit to alleviating them. It is anticipated that this project will highlight the reasons why health has not been comprehensively considered in UK human trafficking policy, and demonstrate the consequences of this. It is also hoped that the study will identify ways in which concerns for health could be better integrated into the policy in the future. More broadly, the UK policy on human trafficking has been developed only very recently, and it has not yet been analysed. The applicant is not aware of any published studies or ongoing research which specifically considers how and why health has been considered in trafficking policies either in the UK or elsewhere in the world.
3.	Specify numbers, with scientific justification for sample size, age, gender, source and method of recruiting participants for the study. *Max 300 words*
	Earlier work mapped and ranked the actors and organisations involved in the development and/or implementation of UK human trafficking policy, using conference attendance lists, consultation reports etc. This allowed the applicant to both gauge the approximate number of key informant interviews needed and identify those who would be invited to participate. Consequently, approximately 70 participants will be interviewed as part of the study. The sample will include civil society organisations, academics, Members of Parliament, civil servants, government agency staff, health service providers, and post-trafficking service providers. The applicant will make contact with the potential participants either in writing or by telephone, explain the aims of the study and ask them to participate in an interview.
4.	State the likely duration of the project, and where it will be undertaken.
	Interviews will be conducted between December 2008 and December 2009, and will take place in the UK, mainly in London, Sheffield, and Nottingham.
5.	Specify the procedures, including interviews, involving human participants with brief details of actual methods.
	Semi-structured interviews lasting approximately 60-90 minutes will be conducted with each participant. The interview will follow a detailed topic guide, but there will be some flexibility to follow up issues raised by the participants during interview. The interviews will be tape-recorded with the consent of the participant, and transcribed and analysed at LSHTM by the applicant.
6.	State the potential discomfort, distress or hazards that research participants may be exposed to (these may be physical, biological and/or psychological). What precautions are being taken to control and modify these? Include information on hazardous substances that will be

	used or produced, and the steps being taken to reduce risks.
	It is not anticipated that research participants will experience discomfort, distress or exposure to hazards. Questions are not of a sensitive or upsetting nature, and the majority of respondents will be active in the area of human trafficking policy and very familiar with the issues being raised. Trafficked persons will not be asked to participate in this study.
7.	LSHTM risk assessment procedures are set out at http://intra.lshtm.ac.uk/safety/ (Travel Safety). Please confirm that all necessary procedures will be completed for all staff before fieldwork commences.
	YES
8.	Specify how confidentiality will be maintained with respect to the data collected. When small numbers are involved, indicate how possible identification of individuals will be avoided. *See guidance notes at:* http://intra.lshtm.ac.uk/committees/ethics/
	The confidentiality and anonymity of the interviewees will be preserved to the best ability of the applicant. Personal identifiers will be replaced with codes for data presentation. Although it is thought there will be only 70 interviews conducted, the participants can be grouped into broad categories such as 'politician', 'civil servant' and 'service provider' to avoid their identification, and at least 5 people will be interviewed per category. Direct quotes should thus not be attributable to a given individual. There will be one master file listing the names and codes of respondents, and this will be password protected and only accessed by the applicant. Audio files and transcripts of interviews will be password protected. Much of the transcription will be carried out by the researcher, but where assistance is required no identifying information will be contained on the file. Any interviews conducted with media-visible participants whose voice may be recognised will be transcribed by the applicant. Paper records, including field notes and signed consent forms, will be stored securely.
9.	State the manner in which consent will be obtained and supply copies of the information sheet and consent form. Written consent is normally required wherever possible. Where not possible, a detailed explanation of the reasons should be given and a record of those agreeing kept. *See guidance notes at:* http://intra.lshtm.ac.uk/committees/ethics/ If research is on human tissue samples, PIs must refer to guidance notes at http://intra.lshtm.ac.uk/committees/ethics/ If any photographs are to be taken, whether for teaching or research purposes, ensure that the participant's consent to their use has been given in line with the provisions in *British Medical Journal, 1998, **316,** 1009-1011.*
	Each participant will be provided with an information sheet detailing the purposes of the

	study, the interview process and how the data will be used. Written consent will then be obtained from each participant prior to interview. Copies of the information sheet and consent sheet are attached.
10.	State the personal experience of the applicant and of senior collaborators in the study in the field concerned, and their contribution to the study.
	The applicant holds a Masters degree in Reproductive and Sexual Health Research from LSHTM, and has completed a number of modules at the School which are specifically relevant to the research (Principles of Social Research, Qualitative Methods, and Health Policy Process & Power). The applicant has also completed the course 'Interviews and Oral History' (GradSchool Skills Development) and will complete the course 'In Depth Interviewing' (NatCen) in June 2008.
11.	State what medical supervision is available and its location in relation to the participants.
	It is not anticipated that medical supervision will be required in this study.
12.	Will equivalent service or support to participants be available after the study ends? If NO, give details and describe steps to minimise loss of service or support.
	N/A
13.	If the aim of the study is to improve treatment or management indicate how successful treatment would be continued or expanded. See Guidance notes at http://intra.lshtm.ac.uk/committees/ethics/
	N/A
14. a)	Does the project involve pre-marketing use of a drug/appliance or a new use for a marketed product?
	NO
b)	Does the company producing or providing any drug/appliance (whether pre-marketed, new use for marketed product or licensed use of marketed product) agree to abide by the guidelines on compensation for non-negligent injury of the Association of the British Pharmaceutical Industry (ABPI) ? If YES, a written statement from the company to this effect should be attached.
	NO
15.	Does this study involve the taking of blood samples and/or any other tissue?
	NO
16.	If YES

a)	Please list samples which will be taken
	N/A
b)	Please confirm that you have undertaken the on-line training programme available at http://intra.lshtm.ac.uk/support/research/humantissueact.html and that you will ensure that any staff involved in the procedures for taking consent will also have undertaken an agreed training programme.
	N/A
c)	If samples are taken overseas, will the samples be brought back to the UK
	N/A
17. a)	Is the study a clinical/intervention trial ? If YES please note the policy being applied by the International Committee of Medical Journal Editors (from 1/7/2005) that all trials must be registered before the enrolment of the first patient. Registers currently in operation are www.prsinfo.clinicaltrials.gov operated by NIH and www.biomedcentral.com/clinicaltrials *Lancet Vol 365 no 9474 1827-1831*
	NO
b)	Does the trial comply with Good Clinical Practice (GCP)?
	N/A
c)	For clinical trials of medicines in the UK or EU please give details of CTA (Certificate of Clinical Trial Authorization).
	N/A
d)	For clinical trials outside the UK or EU, please give details of regulatory approval.
	N/A
18.	Will payments be made to participants? These should usually not be for more than travelling expenses and/or loss of earnings and must not represent an inducement to take part. If YES give details and justification.
	NO
19. a)	Where the research is to take place overseas, the Principal Investigator **must** seek ethical approval, through his/her overseas collaborators, in the country(s) concerned. Approval from the LSHTM Committee is dependent on local approval having been received. Please list the countries where research is being undertaken and arrangements being made to obtain local ethical approval:
	Research will be conducted in the UK.
b)	Where the research is taking place in the UK, please list other UK Committees from which approval is being sought.
	National Health Service Research Ethics Committees.

20.	Please give details of sponsor for research taking place in the UK or EU.
	Economic and Social Research Council.
21.	Any other relevant information including ethical issues not already addressed.
	-

Approval from the LSHTM ethics committee

LONDON SCHOOL OF HYGIENE
& TROPICAL MEDICINE

ETHICS COMMITTEE

APPROVAL FORM
Application number: **5354**

Name of Principal Investigator	**Sîan Oram**
Department	**Epidemiology and Population Health**
Head of Department	**Professor Laura Rodrigues**

Title: **UK Human Trafficking Policy: its development and the absence of health**

This application has been approved by the Committee.

Chair ..... T. W. Meade .....
Professor Tom Meade

Date ..... 6 August 2008 .....

Approval is dependent on local ethical approval having been received.

Any subsequent changes to the consent form must be re-submitted to the Committee.

Protocol submitted to the NHS National Research Ethics service

PROTOCOL v1.0
Health, Wellbeing and UK Human Trafficking Policy
24/04/2009
Siân Oram

CONTENTS

1. Background

1.1 What is human trafficking?

Trafficking in persons for the purposes of exploitation is an issue thought to be increasing in scale and scope around the world, and is most often defined as:

> *"the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs"*
>
> (United Nations 2000)

1.2 How has the UK responded to human trafficking?

The UK is known to be primarily a destination country for human trafficking, and the issue has recently become a feature on the domestic political agenda. Although human trafficking was

discussed in international and European political arenas during the 1990s, the UK did not begin to respond to trafficking until the early years of the 21st century. UK policy developments have, thereafter, been rapid. After criminalizing trafficking for sexual exploitation and labour exploitation in 2003 and 2004 respectively, in March 2007 the UK government simultaneously published its National Action Plan (NAP) to tackle trafficking and signed the Council of Europe Convention on Action Against Human Trafficking (ECAT). The NAP set out how the UK would work to prevent trafficking, prosecute traffickers, and protect the victims of trafficking. ECAT sets out the minimum obligations of signatory States towards the victims of human trafficking and came into force in the UK on April 1st 2009 after its ratification in December 2008.

1.3 What are the health consequences of human trafficking?

A review of the literature found a limited but increasing body of research demonstrating that trafficked persons experience a complex array of poor health outcomes as a consequence of trafficking for sexual exploitation. Many of these health outcomes were the result of high levels of physical and sexual violence experienced in the trafficking situation, but other factors such as poor living and working conditions, and chronic fear and stress are also likely to have led to poor health outcomes.

Research into the physical health consequences of trafficking indicated that a range of physical health symptoms are often suffered, including but not limited to injury and acute pain (Chudakov et al. 2002; Raymond et al. 2002; Cwikel et al. 2003; Zimmerman et al. 2003; Cwikel et al. 2004; Chatterjee et al. 2006; Zimmerman et al. 2006). Studies that enquired about injury reported broken bones, fractures, contusions, head and neck trauma and bruising (Raymond et al 2002; Cwikel et al. 2003; Zimmerman et al. 2003; Zimmerman et al. 2008). Pain and numbness were also frequently reported (Chudakov et al. 2002; Cwikel et al. 2003; Zimmerman et al. 2008). Pain was located in a number of areas of the body, including the back, stomach, pelvis, vagina, and mouth. Numbness was also reported in the back, pelvis, vagina and hand. Also reported were dental and visual problems (Chudakov et al. 2002; Raymond et al. 2002; Zimmerman et al. 2003; Cwikel et al. 2004; Zimmerman et al. 2008). Pain and numbness may result from violence and injury, but also from chronic fear and stress (Campbell 2002). Neurological health consequences, again which may result from violence and injury, fear and stress, were reported in a number of studies and included headaches, dizziness and memory loss (Chudakov et al. 2002; Zimmerman et al. 2003; Cwikel et al. 2004; Dickson 2004; Chatterjee et al. 2006; Zimmerman et al. 2008). Fatigue, weight loss, malnutrition and anorexia were also reported, which may be due to chronic stress and fear, poor living and working conditions, and inadequate nutrition (Zimmerman et al. 2003; Miller et al. 2007)

Gynaecological problems are consistently found amongst women experiencing violence (Campbell 2002) and the review found that persons trafficked for sexual exploitation reported a range of problems, including infection with HIV/AIDS and STIs, vaginal discharge, heavy bleeding, damage to the reproductive tract, pelvic pain, pain during urination, and pain and bleeding during sexual intercourse (Raymond et al. 2002; Cwikel et al 2003; Zimmerman et al. 2003; Dickson 2004; Chatterjee et al. 2006; Silverman et al. 2006; Miller et al. 2007; Tsutsumi A 2008)

The studies also showed the complex psychological needs of persons trafficked for sexual exploitation, with high levels of Post Traumatic Stress Disorder (PTSD) (Chudakov et al. 2002; Cwikel et al. 2003; Tsutsumi A 2008; Zimmerman et al. 2008), depression (Chudakov et al. 2002; Raymond et al. 2002; Cwikel et al. 2003; Cwikel et al. 2004; Dickson 2004; Chatterjee et al. 2006; Tsutsumi A 2008; Zimmerman et al. 2008) and anxiety (Cwikel et al. 2003; Zimmerman et al. 2003; Dickson 2004; Tsutsumi 2008; Zimmerman et al. 2008). Levels of suicidal ideation and suicide attempts were high amongst the samples. The prevalence of suicidal ideation ranged from

28-66% (Raymond et al. 2002; Cwikel et al. 2003; Zimmerman et al. 2003; Cwikel et al. 2004; Zimmerman et al. 2008) and the prevalence range of reported suicide attempts was 18-19% (Raymond et al. 2002; Cwikel et al. 2003; Cwikel et al. 2004). Other mental health issues reported included disordered eating (Chatterjee et al. 2006; Miller et al. 2007), sleep disturbance and insomnia (Raymond 2000; Dickson 2004; Chatterjee et al. 2006; Miller et al. 2007), aggression and violence towards others (Dickson 2004; Zimmerman et al. 2008), and guilt, shame and low self-esteem (Raymond et al. 2002; Dickson 2004; Miller et al. 2007).

No peer-reviewed literature was found that specifically addressed the health consequences of trafficking for non-sexual exploitation, but a number of NGO reports did discuss this issue (ASI 2001; ASI 2003; HRC 2004; Anderson et al 2005; ILO 2005; ASI 2006; ASI 2006; GAATW 2007). Physical health consequences of trafficking included back pain, repetitive strain injury, visual problems, respiratory problems and injury in persons trafficked into the agricultural and construction industries (HRC 2004; Anderson et al 2005; ASI 2006), and back pain, skin infections, malnutrition, sleep deprivation, exhaustion, headache and dizziness amongst those trafficked into domestic service (ASI 2003; HRC 2004; ILO 2005; ASI 2006; ASI 2006; GAATW 2007). Amongst persons trafficked into factory work, physical health consequences included headache, eye-strain, respiratory problems, back and body pain, repetitive strain injury, malnutrition, allergy and skin infection (HRC 2004; GAATW 2007). Mental health problems were only discussed in relation to trafficking for domestic service, in which stress, depression and loneliness were consistently reported (ASI 2003; HRC 2004; ILO 2005; ASI 2006; ASI 2006; GAATW 2007)

1.4 How has the UK responded to the health consequences of human trafficking?

1.4.1 Provision of healthcare

ECAT requires signatory States to ensure the access of trafficked persons to emergency medical treatment. The government has gone beyond this obligation, amending in October 2008 the NHS (Charges to Overseas Visitors) Regulations 1989 so that once a person has been formally identified as a victim of trafficking they are exempt from charges for all primary and secondary medical care. Formal identification can be carried out either by the UK Human Trafficking Centre (UKHTC) or the UK Border Agency (UKBA) and triggers the granting of a 45 day 'recovery and reflection period' during which trafficked persons may access health services. Persons subsequently granted residence permits either to assist with police investigations or on humanitarian grounds may also access services. Prior to the implementation of ECAT the access of trafficked persons to health care depended on their immigration status rather than their experiences of having been trafficked.

1.4.2 Guidance on healthcare

Guidance for health practitioners on caring for trafficked persons in the UK is nearly absent. Department of Health (DH) recommendations are to be produced as part of the wider Victims of Violence and Abuse Prevention Programme (VVAPP), but are likely to focus primarily on sexual violence rather than describing the full range of medical needs of trafficked persons.

1.4.3 Health sector involvement in the development and implementation of trafficking policy.

The DH is represented on the Inter-Departmental Ministerial Group that oversees UK human trafficking policy, but has had limited participation in the development and implementation of the UK trafficking strategy. Few medical practitioners have been involved in policy dialogues or in the broader planning of services for trafficked persons. Proposals have been made to raise awareness

about trafficking in GUM and family planning clinics, but few other practitioners have been included for information and involvement.

2. Research Questions

The research project aims to understand the dynamics of UK human trafficking policy development, with particular reference to how concerns for the health of trafficked persons have been incorporated into national policy.

The specific research questions are as follows:

1. How was the issue of trafficking able to move onto the UK political agenda?
2. How did UK trafficking policy develop? How did health feature in the development of policy?
3. What is the potential impact of the policy on the health of trafficked persons and that of others indirectly affected by the policy?
4. How can health be better integrated into UK trafficking policy?
5. What are the wider lessons for understanding the policy process and for qualitative policy analysis?

3. Data Collection

3.1 Methods

NB. The ethics application for which this protocol forms a part requests approval to conduct semi structured interviews only. However, for the purposes of transparency, this section also discusses the document collection and observation phases of the broader study.

3.1.1 Document Collection

Documents have a crucial part to play in this research, both in providing background orientation to the study and as part of the body of data, in which they may corroborate, augment or dispute other sources of evidence, and give rise to new questions and inferences to be explored.

Specific key documents include:

- Drafts of and the final version of the National Action Plan
- Consultation submissions to the National Action Plan.
- Submissions to, and reports of, the Joint Committee on Human Rights on human trafficking
- Submissions to, and reports of, the Home Affairs Select Committee inquiry into human trafficking.
- Debates and parliamentary speeches on the issue of human trafficking.

These documents are in the public domain.

Other documents of interest are likely to include:

- Other government publications
- NGO reports
- Academic publications
- Agendas and meeting minutes
- Letters and memos
- Service programme evaluations
- Media articles

Some of the documents in this category are likely to be in the public domain. Others, for instance internal memos, may not be. Efforts will be made to collect all available documentation during observation events, and during interviews participants will be asked if they have any documentation on trafficking policy that they are willing to share with the study. Any confidentiality requirements placed on these documents will, of course, be respected.

3.1.2 Semi-structured Interviews

In this research, semi-structured interviews, in which the researcher sets the agenda but the conversation is co-produced (Green and Thorogood 2004), will be used as they can be more useful than in-depth interviews in addressing policy-oriented research questions (Rhodes 2008).

Potential participants will be provided with an information sheet about the research study to assist them in deciding whether to be interviewed for the study. The sheet provides full contact details for the researcher and the potential participant will be encouraged to ask any questions that they may have about the study.

The potential participant will be contacted again to follow up after a period of not less than 24 hours. If a decision is made to participate they will be asked to select the time and location of their interview.

Before the start of the interviewee will be given a further opportunity to ask questions and asked to complete the consent form. If consent is not given the interview will not be conducted. With the consent of the interviewee, the interview will be digitally recorded. The interviewer will use a semi-structured interview schedule to direct the interview whilst allowing for flexibility to follow up topics of interest to the participant. All interviews will be conducted by the Chief Investigator (CI).

3.1.3 Observation.

Observations from meetings and conferences related to human trafficking and human trafficking policies will be used to provide additional evidence for the study. Observation has been described as the research gold standard when aiming to understand a phenomenon (Green and Thorogood 2004), although this assumes that 'reality' can be observed and recorded truthfully. Inevitably the recording and interpreting of observations is affected by the standpoint of the researcher, but by keeping careful field diaries and discussing my observations with others I hope to be reflexive in my research.

3.2 Timing

Data collection will take place between October 2008 and December 2009, with interviews being conducted between January and December 2009. This is a particularly policy-relevant period in which to collect data, as ratification of the Council of Europe Convention on Action Against Human Trafficking took place in December 2008 and came into force on April 1st 2009.

Focusing on the policy process as it happens means that the policy climate is directly observable, but information on outcomes is likely to be limited. However, prospective data gathering and analysis make it possible to collect good documentary evidence that can readily coincide with relevant key informant interviews. Gaps remain in current UK policy with regards to the health of trafficking persons, and by conducting the study in the suggested timeframe, there is the chance that recommendations arising from this research could be incorporated into policy and practice.

3.3 Sampling for Semi Structured Interviews

3.3.1 Potential Participants

The policy analysis is to be carried out at the level of the policy subsystem, defined as the broad set of actors involved in addressing the policy problem. It is therefore important to recognize the breadth of groups that have been involved in the development of the response to human trafficking when sampling: the sample will include policymakers, politicians, health professionals, other professionals (e.g. police, criminal justice, and social services), academics, civil society groups etc.

The planned research within the NHS is an integral part of the project. Through interviews with health care providers and managers in a variety of health service settings (e.g. outreach projects; sexual assault referral centres; hospital departments such as A&E, paediatrics, GUM; community mental health teams, GPs) the research will identify how respondents have been engaged in the development and implementation of human trafficking policy and in meeting the health needs of trafficked persons.

N.B. It is not anticipated that interviews will be conducted with trafficked persons, as they have not participated in the policy process to date.

3.3.2 Identification of Participants

Preparatory research included mapping the policy subsystem in order to generate an initial list of actors and organizations to invite to be interviewed for the study. Snowball sampling may augment the list once data collection commences, and theoretical sampling – the process of choosing new research cases to compare with the ones that have already been studied (Glaser and Strauss 1967) – will also be used. Theoretical sampling can help in gaining a deeper understanding of the data and in developing an analytical framework, and also provides a way of triangulating the data.

The mapping exercise used a number of criteria to assess involvement in the policy subsystem (these conditions necessarily differ by category of actor e.g. civil servant vs. NGO). Actors and organizations meeting more of these conditions were be deemed more influential than those meeting fewer and will be invited to participate in the study. Actors who are concerned with the health of trafficked persons featured lower on the ranking lists or did not feature at all. In order to meet the research objectives, actors and organizations known to be concerned with trafficking and health were added to the lists following completion.

The recruitment of potential health sector participants will therefore focus initially on health practitioners and managers known to have an interest in human trafficking, based on previous contact with the CI/supervisor or their attendance at meetings on human trafficking. At the end of interviews participants will be asked to recommend further people who may be interested in participating in the project (snowball sampling).

3.3.3 Approximate Sample Size

I aim to conduct interviews with around 60 members of the policy subsystem, but as theoretical and snowball sampling will be used, this is subject to change. Of this 60, it is approximated that 15 interviewees will be conducted with health care providers and managers.

4. Analysis

Data analysis will be organized according to the principles of framework analysis. Framework analysis involves coding the data according to a framework that uses the research questions, conceptual framework, and issues that emerge from the data (Ritchie and Spencer 1994; Green and Thorogood 2004).

The framework analysis approach has five major steps (Ritchie and Spencer 1994). The first of these is familiarization with and immersion in the data – including documents, interview transcripts, observations, and field notes- although in practice this is a constant process rather than a discrete stage. Secondly, a framework for coding the data is developed. The coding framework is based on the research questions and conceptual framework, but also issues that recur in the data and themes from the literature. A coding framework will be developed early in the data analysis phase to allow data analysis to inform data collection. In the third stage, the data is coded according to the framework. The framework is still flexible at this stage however, and can be extended or refined as dictated by the data. The data is then charted by rearranging the data into matrices according to how it has been coded. Finally, the data is mapped and interpreted: the charts are used to identify key themes and emerging theories. These steps will be conducted in NVivo 8.0.

5. Ethics

Ethical approval has been granted by the London School of Hygiene & Tropical Medicine (LSHTM) ethics board. NHS ethical approval is being sought in order for interviews to be conducted with health professionals.

Anonymity will be maintained by removing names and identifying features from the transcripts. Confidentiality will be maintained by keeping the information linking the transcript to the participant in a separate file, locked and only accessible to the CI. This document will not be archived with the transcripts at the end of the project. Transcripts and audio files will be kept on a locked computer, and only members of the research team will have access to them.

Around 60 interviews are likely to be conducted in total (including approximately 15 from the health sector). Participants can be grouped into broad categories such as 'politician', 'civil servant' and 'service provider' to avoid their identification and at least 5 people will be interviewed per category. Direct quotes used in the research reports should thus not be attributable to a given individual.

6. Costs

I will be conducting this research as part of my PhD and therefore all labour costs will be met. All transcription is conducted by me. Administrative costs, such as photocopying, are met by my department. The interviews will be conducted at a location of the interviewees' choice and there is no anticipated cost for the use of interview spaces.

My funding body – the Economic and Social Research Council (ESRC) provide a research and training grant of £750 a year, used for the digital recorder, transcribing equipment and travel expenses.

7. Feedback and reporting

The research will be presented primarily in a PhD thesis, and from this thesis academic papers will be developed and submitted for publication in peer reviewed journals. Targeted publications will include public health, health policy, and public policy journals.

With the permission of the interviewees, anonymised transcripts will be archived in the UK Data Archive (Qualidata) (http://www.esds.ac.uk/qualidata/about/introduction.asp) at the University of Essex. Access to these transcripts is restricted to bona fide researchers only. Audio files will not be archived due to the challenges of maintaining anonymity with this format.

All participants will be asked to indicate on the consent form whether they would like to be sent a copy of their typed interview transcript. Any consequent clarifications or corrections to the transcript, or requests not to quote portions of the transcript, will be respected. Interviewees will also be asked to indicate whether they would like to receive a summary of the research findings upon the completion of the research.

8. The Researcher

In this study all interviews will be conducted by me, a PhD student at LSHTM. I will also conduct each step in the data collection, transcription, and analysis processes.

I have completed a 5 week LSHTM course on qualitative research methods and a NatCen short course on in-depth interviewing techniques. I also attend a fortnightly qualitative analysis workshop held at LSHTM.

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END OF PROTOCOL

Approval from the NHS National Research Ethics service

NHS
National Research Ethics Service

The National Hospital for Neurology and Neurosurgery
& Institute of Neurology Joint REC
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Sian Oram
London School of Hygiene and Tropical Medicine
Keppel Street
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WC1E 7HT

Our Ref: 09L.186

10 June 2009

Dear Ms Oram

Study Title: **Health, Wellbeing, and the Development of UK Human Trafficking Policy.**
REC reference number: **09/H0716/36**
Protocol number: **1.0**

The Research Ethics Committee reviewed the above application at the meeting held on 21 May 2009. Thank you for attending to discuss the study.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

After the committee's initial deliberations you were invited to join the meeting to clarify some issues. Thank you for agreeing to attend.

The committee was impressed and commended the applicant on a very well written application.

The committee was unclear if the comparison were between carers and the managers?

- The applicant confirmed that is the comparison groups.

The committee felt the funding received as part of the PHD should be stated in the Patient Information Sheet.

The applicant confirmed the funding will be included.

General Advice Given to the Researcher:

Patient Information Sheet:

- Under the heading 'Who reviewed this study'? The incorrect Ethics committee is stated, the correct committee is the National Hospital for Neurology and Neurosurgery & the Institute of Neurology Joint REC

Regarding the Consent Form

The following paragraph should be included. "I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from [company name] (if appropriate or delete), from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk. Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
C.V - Joanna Rose Busza	1	24 April 2009
Participant Consent Form	1.0	24 April 2009
Participant Information Sheet	1.0	24 April 2009
Interview Schedules/Topic Guides	1.0	24 April 2009
Compensation Arrangements	1	20 April 2009
Peer Review	1	10 June 2008
Covering Letter	1	28 April 2009
Protocol	1.0	24 April 2009
Investigator CV	1	27 April 2009
Application	5.6	27 April 2009

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the

attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/H0716/35	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Ms Katy Judd
Chair

Email: S.Vandeyar@ich.ucl.ac.uk

Enclosures: *List of names and professions of members who were present at the meeting.*
After ethical review – guidance for researchers

Copy to: *Ms Joanne Busza*

Appendix I

Data underlying the NetDraw mapping of inter-organisational relationships in the UK trafficking policy subsystem

The NetDraw programme was used to draw the map of inter-organisational relationships in the UK human trafficking policy subsystem (figure 6.1, in chapter six). The data used for creating the map is shown below.

The first set of data ("node data") provides basic information on the organisations that were selected to be included in the map. This information includes the organisation's name, the type of organisation (advocate, health, service provider, government department/agency), category (core, peripheral, marginal, or excluded – for a definition of these categories please see section 6.2) and location (London or Glasgow).

The second set of data ("tie data") lists the relationships between each organisation described within the node data. This dataset has many more entries than does the node dataset because each relationship must be listed separately. An organisation with two recorded linkages, for example, will be listed four times, e.g., organisation A organisation X, organisation A organisation Y, organisation X organisation A, organisation Y organisation A.

***Node Data**

ID	Name	Type	Category	Location
Amnesty	Amnesty	Advocate	Core	London
ASI	ASI	Advocate	Core	London
Base_75	Base_75	Health	Marginal	Glasgow
CEOP	CEOP	Government	Government	London
Compass	Compass	Health	Marginal	Glasgow
DCSF	DCSF	Government	Government	London
DH	DH	Government	Government	London
ECPAT	ECPAT	Advocate	Core	London
Havens	Havens	Health	Marginal	London

HBF	HBF	Health	Marginal	London
Home_Office	Home_Office	Government	Government	London
Kalayaan	Kalayaan	Advocate	Peripheral	London
NSPCC	NSPCC	Advocate	Peripheral	London
OCJR	OCJR	Government	Government	London
Open_Doors	Open_Doors	Health	Marginal	London
Poppy	Poppy	Service_Provider	Core	London
Praed_Street	Praed_Street	Health	Marginal	London
Project_London	Project_London	Health	Marginal	London
TARA	TARA	Service_Provider	Core	Glasgow
UKBA	UKBA	Government	Government	London
UKHTC	UKHTC	Government	Government	Sheffield

***Tie Data**

Actors Named

Poppy	OCJR
Poppy	Home_Office
Poppy	UKHTC
Poppy	ECPAT
Poppy	Amnesty
Poppy	ASI
Poppy	Kalayaan
Poppy	HBF
Poppy	Open_Doors
Poppy	Havens
Amnesty	HBF
Amnesty	Havens
Amnesty	Praed_Street
Amnesty	TARA
Amnesty	ASI
Amnesty	Kalayaan
Amnesty	ECPAT
Amnesty	UKBA
Amnesty	OCJR

Amnesty	Home_Office
Amnesty	UKHTC
ASI	Amnesty
ASI	Kalayaan
ASI	UKHTC
ASI	ECPAT
ASI	Poppy
ASI	UKBA
ASI	Home_Office
ECPAT	NSPCC
ECPAT	DCSF
ECPAT	ASI
ECPAT	Amnesty
ECPAT	Poppy
ECPAT	Home_Office
ECPAT	UKBA
ECPAT	CEOP
ECPAT	UKHTC
TARA	Base_75
TARA	Compass
TARA	UKHTC
TARA	Amnesty
TARA	Poppy
TARA	UKBA
Kalayaan	ASI
Kalayaan	UKHTC
Kalayaan	Project_London
Kalayaan	UKBA
NSPCC	ECPAT
NSPCC	CEOP
NSPCC	DCSF
NSPCC	Home_Office
Open_Doors	Poppy
Open_Doors	Project_London

Project_London	Open_Doors
Project_London	Kalayaan
Compass	TARA
Compass	Base_75
Base_75	TARA
Base_75	Compass
Praed_Street	Amnesty
Praed_Street	Havens
Havens	Praed_Street
Havens	Amnesty
Havens	Poppy
HBF	Amnesty
HBF	Poppy
UKHTC	Home_Office
UKHTC	Kalayaan
UKHTC	Poppy
UKHTC	ECPAT
UKHTC	Amnesty
UKHTC	ASI
UKHTC	TARA
CEOP	Home_Office
CEOP	ECPAT
CEOP	DH
Home_Office	DCSF
Home_Office	UKBA
Home_Office	CEOP
Home_Office	UKHTC
Home_Office	OCJR
Home_Office	ECPAT
Home_Office	ASI
Home_Office	Amnesty
Home_Office	Home_Office
UKBA	OCJR
UKBA	Home_Office

UKBA	DH
UKBA	Kalayaan
UKBA	Poppy
UKBA	ASI
UKBA	ECPAT
UKBA	Amnesty
UKBA	TARA
DCSF	Home_Office
DCSF	ECPAT
DCSF	NSPCC
DH	OCJR
DH	CEOP
OCJR	DH
OCJR	Home_Office
OCJR	UKBA
OCJR	Poppy
OCJR	Amnesty

Appendix J

Trafficking-related feedback and recommendations made by five key NGOs between 2002 and 2010

The information in this table is based upon analyses of minutes from the Counter Trafficking Link Group and Counter Trafficking Victim Support Group (2002-2005) and the Joint NGO Ministerial Group (2005-date), and on the recommendations made by organisations within their submissions to the National Action Plan (NAP) in 2006, Joint Committee on Human Rights inquiry into trafficking also in 2006 and the Home Affairs Committee inquiry into trafficking in 2008. Where recommendations are drawn from meeting minutes the date of the relevant meeting is given in brackets (mmyy).

Organisation	Issue Area	2000-2005	2005- April 2007	2007-2009	2009-date
Anti Slavery International	Establishing Frameworks	• Issues around legislation criminalising labour exploitation (CTLG 0704) • Concerns around S2 of Asylum and Immigration (Treatment of Claimants) Act 2004 (arriving with false documents) • UK should not dilute the Convention and should support reflection periods, permits, and support (CTVSG 0904) • Proposals to strengthen Convention (CTVSG 1104) • Write to MPs on supporting EDM on reflection periods and support (CTVSG 0105) • Push for the UK to sign the 2004 Council Directive on residence permits (CTVSG 0904)	• Ratify ECAT	• Remove CRC reservation • Sign UN Convention on Protection of Migrant Workers and their Families	

	Stakeholder Engagement	• Issues around identifying a police lead (CTVSG 0105) • Can't access debates around the Council of Europe Convention.	• Revive Counter Trafficking Link Group (0905)		
	Increasing Knowledge Base			• Full report from P1 should be released (1008)	
	Labour Exploitation	• Issues around exploitation of MDW (CTLG 0704)	• Issues around labour exploitation: 5 years behind TSE. Withholding documents (0905). identification by agencies (0706). treat as victims not offenders (0706). no incentive (support or reparation) to come forward (0706). address demand (0905)	• Retain 1998 MDW rule(0207, 0708) • Allow TLE to remain in UK to pursue compensation • Establish Fair Employment Commission	
	Improving identification. referral & support	• Funding concerns relating to Poppy (CTLG 0704) • Write to MPs regarding Poppy Project expansion (CTVSG 0305)	• Training to improve identification and referral • Support must be provided by specialists (0506)	• Training for all agencies on identification and referral • Introduce referral mechanism	• NRM should encompass coordinating role to ensure all relevant support is provided (1109)
	Improving immigration processes				
	Improving policing processes				
	Monitoring policy implementation			• Introduce National Rapporteur	
Amnesty International UK	Establishing frameworks		• Ratify ECAT (0206 and NAP)		
	Stakeholder Engagement				

	Increasing knowledge base		• Potential issue around trafficking of Irish children (0206)		
	Prevention		• Proposal for mini-brothels could cause problems (0206)		
	Labour exploitation			• Retain 1998 MDW rule	
	Improving identification, referral & support		• Mandatory identification, interaction and referral procedures (0206 and NAP) • Police and immigration training, cooperation with NGOs • TSE to have best practice procedures wrt rape and SV • UKBA adopt victim centred approach • No forcible removal of suspected people before id and referral • Funding for independent support – services with experience in GBV, SV, and trafficking (0206 and NAP) • Broaden eligibility criteria for support • Access to necessary medical care (0706 and NAP)	• Implement NRM: multi-agency CA, • entitlement of TSE to best practice wrt rape and SV, • refer to support without undue delay • Continue to fund Poppy, expand outreach to DS and FL • Fund only orgs with proven experience in GBV/SV and trafficking • NASS funded accommodation in refuges for asylum claimants	
	Improving immigration processes		• 3 month reflection period (NAP) • Address problems in asylum system (gender and trafficking guidance, immigration judge training, legal representation and legal aid, time limits, age disputes, hostile interviews, anonymity, third country removals,	• 90 day RR, flexible RP • Address asylum issues (access to legal representation, caseworker decisions, immigration judge training, inaccurate CoO reports, safe country list and NSA, time limits	

			white list and non-suspensive appeals, fast track, possession of documents (0206 and NAP)	• Must have access to asylum, must reconcile Convention requirements with detention and fast track processes (0208)	
	Improving policing processes			• Preliminary identification by CA should sufficient to discontinue prosecutions against trafficked people	
	Monitoring Implementation			• Introduce National Rapporteur	
Poppy Project	Establishing Frameworks		• Ratify ECAT		
	Stakeholder Engagement				
	Increasing knowledge base	• Publishing research mapping the London sex industry (CTLG 0704)			
	Prevention		• Gender equality programmes in source countries • Targeted awareness programmes in source countries • Targeted information for new migrants • Research into demand and scale and nature of prostitution		
	Labour exploitation		• Include domestic servitude in NAP	• Source country poverty alleviation programmes	
	Improving identification, referral and support	• Developing protocol on identifying victims (CTLG 0704)	• Training and guidance for IND • Protect privacy and confidentiality for women	• Further police and immigration training • Formal identification and referral	• NRM functioning: lack of appeal, inadequate CA training, poor

		• Poppy Project at capacity (CTLG 0704) • Police have turned down the offer of a further house on safety grounds (CTSVG 0604) • 'Move on' is difficult because of no cooperation with NASS (CTSVG 0604) • No funding available for people trafficked for other forms of exploitation (CTSVG 0604) • Poppy Project have proposed 5 bed expansion plus outreach (CTVSG 0305) • Discussions around eligibility (CTSVG 0604	testifying in court • Right to compensation • No detention of trafficked women • Expand specialist support	mechanism with role for NGOs	decision-making (0409)
	Improving immigration processes	• Relations with immigration have declined (CTVSG 0305)	• Implement 3 month reflection period • Provision of legal advice and interpretation services for asylum and compensation • Mechanism to stay in country to assist prosecution/humanitarian reasons • Improve access to asylum	• 3 month reflection periods • Introduce residence permits	•
	Improving policing processes	• Sapphire very good with trafficked people (CTSVG	• Stronger law enforcement response • Repatriations only after		

		0604) • Setting up protocols, with ASI, for working with the police (CTSVG 0604) • Police support for the project has declined (CTSVG 0604) • Relations with police have declined (CTVSG 0305)	appropriate risk and needs assessments and support • Specialist police team and national information desk • Trafficking police performance indicator • Guidelines for police on interviewing		
	Monitoring Implementation			• Coordination of stakeholders (terminology, methods of identifiying and recording)	
ECPAT UK	Establishing frameworks	• DfES guidance on child abuse to be updated to include trafficking (CTLG 0704)	• Ratify ECAT • Withdraw UN CRC reservation • Separate child trafficking strategy • Child trafficking strategy must use child protection perspective • NAP to have clear targets and nominated leads • Appoint lead coordinating agency to implement and coordinate with government and voluntary sector • Identify inconsistencies between immigration and child protection policies • Existing policies made relevant to trafficking	• Begin to implement ECAT • Remove UN CRC reservation • Ratify Optional Protocol on Sale of Children • Sign COE Conv on Sexual Exploitation and Abuse of Children • UASC should complement UKBA CT work but can't be all of it (0707, 0208) • Identify inconsistencies between Convention and existing policies (0707)	
	Stakeholder engagement	• DfES reluctant to see CT as a problem (CTVSG 0904)	• DfES to be equal partner and appoint policy lead		

	Improving knowledge base	• Barnardos mapping CSE in London (CTLG 0704) • Cause for Concern report had just been published (CTLG 0704) • Recent ECPAT Europe research on child trafficking in Europe (CTLG 0704) • Collating information on potential cases (CTVSG 1104)	• Research nature and extent of internal trafficking and child trafficking • Trafficking of Irish children (0206) • Trafficking of Vietnamese children not being recognised (0506) • Links between different forms of trafficking (0206)		• Inclusion of forced marriage and witchcraft as issues (0709)
	Prevention		• Awareness campaign in source, funded by FCO/DFID		
	Improving identification, referral, and support	• Difficulties finding funding for safe accommodation for children (CTSVG 0604) • Safe house had closed in West Sussex (CTLG 0704)	• Multi-agency framework, guidance and protocols for all relevant professionals • Indicators of CT to be included in existing safeguarding mechanisms • Multi-agency training and targeted enhanced training (0206) • Multi-agency port safeguarding teams • Ensure airport and airline CP measures compatible with identifying and supporting CT • Multi-agency panel working in best interests of the child • Guardianship system • Legal representation	• Establish guardianship system • Establish multi-agency port safeguarding teams • Treat age-disputed people as minors until assessment • Children should have separate provisions under ECAT and access to RP (1008)	• Certain children's NGOs should be first responders (1109) • NRM: relative roles of CA and LA (0409) • NRM: child-centredness, delayed decisions, inappropriate UKBA involvement during RR, triggering enforcement process, poor relationships (0709) • Discontinuation of DCSF training funding – ongoing need (0709)

			• Age disputed children treated as minors until assessed • Children assessed under S20 of the Children's Act • Appropriate accommodation • Support for males aged 16-18 problematic (0706) • National helpline for professionals • BME community education		• Need for safe accommodation standards (0709)
	Improving immigration processes		• Withdraw policy of enforced returns of failed UASC • Reassess application of Dublin II • Voluntary returns only • UKBA to be subject to S11 Children's Act	• Withdraw policy of forcibly removing under 18s with failed claims • Remove child victims of trafficking from immigration system • Review use of Dublin II agreement wrt trafficking • Don't support specialist authorities at ports (honeypot) (0208) • Learn lessons from P1 ahead of P2 – victim care, source country work, LA preparation. (0707)	• Dual trafficking/asylum interviews not appropriate (1109)
	Improving policing processes		• Enforcement agencies to share and gather intelligence on CT • Safeguarding to be a community policing priority • CEOP child trafficking portfolio (0206 and NAP)	• Children should not be prosecuted for crimes committed whilst trafficked, but it is a growing problem (1008)	• Discontinuation of Op Golf funding (0709)

	Monitoring implementation	-	• National focal point for gathering, analysing and reporting • Systematic collection and reporting via LSCB and DfES • Retrospective analysis of failed asylum seeking children for evidence of trafficking		
Glasgow Inter Agency Working Group	Establishing frameworks		• Sign ECAT		• Inclusion of trafficking as gender issue (0409)
	Stakeholder engagement	-	-	• Include NGOs in prevention, identification, and protection processes • Include NGOs in developing and implementing policy • Scottish stakeholders group needed (0208)	• NGOs – role in NAP update, formal meetings to discuss NRM problems (0409, 0709)
	Improving knowledge base			• Need qualitative information about P2 (1008)	
	Prevention		• Criminalise purchase of sex from women being commercially sexually exploited • Address demand for sexual services (0905)		
	Improving identification, referral, and support				• NRM support: problems for women claiming asylum(0409) • UKBA staff must reform attitude to trafficking (1109)