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# **Adapting to survive: facilitating recovery after human trafficking**

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I, Roderik Floris Viergever, 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.

# Abstract

Human trafficking is a crime that can result in both acute and chronic physical and mental health problems for victims. Additionally, victims are often faced with various social challenges. In recent years, many countries have recognized victims of human trafficking as a target population for their social and health services. In the Netherlands, the number of victims of human trafficking that seek shelter has more than doubled in the last decade and 3% of placements in shelters for victims of violence are now for victims of human trafficking. Despite the increasing relevance of victims of human trafficking for the Dutch social and health services, there is a dearth of evidence on how to best facilitate recovery for this population, both in the Netherlands and internationally.

This thesis makes a contribution to redressing this knowledge deficit and explores the Dutch post-trafficking social and health services from the viewpoints of service users and service providers. By analysing their experiences with post-trafficking service provision and by building on theories of both service needs and system development, the thesis provides insight into these services from different empirical and theoretical perspectives. Its findings are based on data collected from interviews, observations, literature reviews and documentary analyses, mainly making use of qualitative methods of analysis.

The thesis is situated in the field of social and health services research and makes two main contributions to this field. First, it advances insight into how recovery is conceptualized and experienced by victims themselves. Second, it provides lessons about how that recovery can be best facilitated by countries' social and health services. Finally, the thesis also contributes to the qualitative research methods literature by reflecting on the challenges that were encountered in interviewing victims of human trafficking.

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# Abbreviations

<i>Abbreviation</i>	<i>English full name or translation</i>	<i>Dutch full name (when abbreviation is Dutch)</i>
AZC	Asylum Seeker Centre	Asielzoekerscentrum
CoMensha	Coordinating Centre for Human Trafficking	Coördinatiecentrum Mensenhandel
COSM	Categorical Shelter for Victims of Human Trafficking	Categorale Opvang Slachtoffers Mensenhandel
GGD	Municipal Health Services	Gemeenschappelijke Gezondheidsdienst
KNMG	Royal Dutch Medical Association	Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst
MO	Social Shelters	Maatschappelijke Opvang
NGO	Non-Governmental Organization	-
NVMW	Dutch Association of Social Workers	Nederlandse Vereniging van Maatschappelijk Werkers
OECD	Organisation for Economic Co-operation and Development	-
OGGZ	Public Mental Health Care	Openbare Geestelijke Gezondheidszorg
VNG	Dutch foundation of municipalities	Vereniging van Nederlandse Gemeenten
VO	Women's Shelters	Vrouwenopvang
WHO	World Health Organization	-
Wmo	Dutch Social Support Act	Wet maatschappelijke ondersteuning

# **Chapter 1**

## **Introduction**

## What is human trafficking?

---

Each year, 1.2 to 3 million people fall victim to human traffickers and globally there are 21 to 36 million adults and children who live in conditions that are often referred to as ‘modern-day slavery’.<sup>1-4</sup> While this term is frequently used to describe these exploitative practices,<sup>4,5</sup> the more formal term is ‘human trafficking’.<sup>6</sup> Human trafficking is a broad and global phenomenon: it includes trafficking of children in Haiti for domestic labour; slave raids in Sudan, grounded in ethnic and religious differences; forced labour and debt bondage in India; exploitation of men and women in Bangladeshi garment factories; international organ trafficking; and the trafficking of men, women and children for sexual exploitation.<sup>5</sup>

Various terms are applied internationally to describe situations in which individuals are exploited through coercive or deceptive means.<sup>7</sup> ‘Forced or compulsory labour’ means all work or service which is exacted from any person under the menace of a penalty and for which the said person has not offered himself voluntarily.<sup>7</sup> ‘Slavery’ resembles the concept of forced labour, but also implies ownership. All slavery is forced labour, but not all forced labour is also slavery.<sup>7</sup> ‘Debt bondage’ is often identified as a practice similar to slavery but involves a debt that cannot be paid off in a reasonable time, which people are forced to accept (people are often born into debt bondage).<sup>7</sup>

‘Human trafficking’ encompasses all three abovementioned types of exploitation, except that the definition has been restricted to cases where a victim has been moved from one location to another.<sup>8</sup> However, this facet of trafficking is being revisited. The US Department of State, the publisher of the periodical *Trafficking in Persons* reports,<sup>2</sup> which describe governments’ efforts to combat human trafficking around the world, has recently clarified that victims do not need to be physically transported from one location to another in order for the definition of human trafficking to apply.<sup>2</sup> International organizations are supporting this view.<sup>3</sup> This expansion of the concept has been relevant, since the grooming of minors or young women and men into sex work within Western European countries is now broadly viewed as a form of human trafficking.<sup>9</sup> As a consequence, such groomers can be prosecuted under human trafficking laws. Other forms of internal or domestic trafficking (trafficking that takes place within the boundaries of a country) are now also seen to fall under the definition of human trafficking.<sup>10</sup>

To explain the term ‘human trafficking’ it is important to unpack the purpose of human trafficking: exploitation. While human trafficking has been previously conceptualized and described primarily as trafficking in women and children for the purpose of sexual exploitation,<sup>11,12</sup> the term is now widely recognized to include multiple kinds of exploitation. According to the *UN Protocol to Prevent,*

*Suppress and Punish Trafficking in Persons, Especially Women and Children*, which includes the most universally accepted definition of human trafficking, these kinds of exploitation include, at a minimum:<sup>6,8</sup>

- prostitution of others or other forms of sexual exploitation
- forced labour or services
- slavery or practices similar to slavery
- servitude
- the removal of organs

To understand the term human trafficking, it is equally important to unpack the different means by which trafficking can take place. These are often summarized by noting that trafficking can happen through coercive or deceptive means, but this can be subclassified further into the following means by which trafficking can take place:<sup>6,8</sup>

- the threat or use of force
- coercion
- abduction
- fraud
- deception
- the abuse of power or of a position of vulnerability
- the giving or receiving of payments or benefits to achieve the consent of a person having control over another person

These different means of trafficking have been relevant in defining the breadth of the concept of human trafficking. For example, more subtle means of trafficking such as deception and abuse of a vulnerable position – often employed by domestic traffickers and groomers – are explicitly included in this definition.

Based on these definitional components, the term ‘human trafficking’, then, might be viewed as an umbrella term. What all the different forms of human trafficking have in common is that they occur for the purpose of exploitation, through coercive or deceptive means.

## Human trafficking and health

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The first studies on the health problems of trafficked persons were published early in the 21<sup>st</sup> century.<sup>13,14</sup> In the past decade, several others followed.<sup>15</sup> Despite this, our knowledge of the health problems of trafficked persons remains very limited. A recent systematic review of the health problems of trafficked persons found only 16 reports of studies that met their inclusion criteria.<sup>15</sup>

Several groups are particularly under-researched in this regard, including trafficked men and victims of labour trafficking.<sup>15,16</sup> Certain problems have also received relatively little attention, such as mental health and social problems (as compared to victims' sexual health, in particular HIV, which has been studied more extensively).<sup>15,16</sup> Furthermore, the generalizability of much of the existing research evidence is limited, since health problems are likely to vary considerably between trafficked persons based on differing trafficking experiences, socio-demographic factors, pre-trafficking health status, pre-trafficking experiences, and the geographical context of both the origin and the destination country.<sup>17</sup> As an example, in the recent systematic review that included 16 studies, 11 were conducted in Asia.<sup>15</sup> For the reasons mentioned above, it is difficult to generalize the findings of those studies to Western European or Northern American contexts.

Yet, there are valuable lessons to be learned from the studies that are available. All studies show a high prevalence of violence and a range of different physical and mental health and social problems among people trafficked for sexual exploitation.<sup>14,18</sup> The few studies that have researched the mental health of victims of human trafficking suggest a high prevalence of post-traumatic stress syndrome (PTSD), anxiety disorders and depressive disorders.<sup>15,18–20</sup> These symptoms are especially prevalent in the acute post-trafficking phase, but have also been shown to endure longer-term.<sup>19</sup>

These studies have also shown that trafficked persons' trafficking experiences are associated with their health outcomes. Experiences such as repetitive physical and psychological abuse, rape and confinement have been shown to have a profound impact on the mental health of victims of human trafficking.<sup>21</sup> Similarly, pre-trafficking experiences such as childhood sexual abuse and domestic mental and physical violence are relatively frequently seen among victims of trafficking.<sup>14</sup> These may play a role in the aetiology of health problems among this group and even in the factors that led to the person being trafficked in the first place.

Besides mental health problems, a large variety of physical health problems has been found among victims of human trafficking attending post-trafficking treatment services. These can include:<sup>14,18,22–25</sup>



- psychosomatic trauma-related problems (e.g. headaches, abdominal symptoms, sleeping problems, chronic fatigue, and backache);
- problems directly related to the type of exploitation (e.g. sexually transmitted infections, contusions, broken bones, pregnancy, and (unwanted) abortions); or
- problems associated with health neglect (e.g. dermatological problems, unhealthy weight loss, and dental problems).

Finally, there are several other factors that further complicate social and health care for this group. Examples are:

- pregnancy or care for children among some trafficked women;<sup>26</sup>
- legal procedures against traffickers and immigration procedures for victims that impact the mental health of victims;
- cultural and language barriers;<sup>27</sup> and
- other social problems such as difficulties with finding work or education, a lack of social support, feelings of shame and guilt, and social stigma.<sup>14,26</sup>

See Appendix 1 for a more extensive review of what is known about the health consequences of human trafficking.

## Social and health services for victims of human trafficking

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In the past decade, there has been a growing awareness of a need for social and health services for victims of trafficking.<sup>28-30</sup> Several factors may have contributed to this, including: increasing recognition of the human trafficking problem;<sup>31</sup> the newly established legal imperatives to protect victims of trafficking;<sup>2</sup> the increasing judicial attention for the crime of trafficking, leading to an increasing number of convictions for human trafficking and increased identification of victims;<sup>32</sup> and the development of knowledge about the health problems of victims of trafficking.<sup>14,15</sup> Since victims of human trafficking are often in urgent need of shelter after exiting a trafficking situation, the development of post-trafficking services has focused on the shelter sector. In many countries, shelter and care for victims of trafficking have been provided under the umbrella of more established shelter care sectors, such as for victims of domestic violence, the homeless, or refugees / asylum seekers. Very recently, however, several countries have started to establish specialized shelters for victims of human trafficking.<sup>30,33,34</sup>

To date, research to support the development of social and health services for victims of human trafficking has been scarce. There are important gaps in our knowledge of the social and health care needs of victims of human trafficking. One key gap constitutes what victims of trafficking themselves perceive to be their social and health care needs. Furthermore, our knowledge of existing post-trafficking care services in specific country contexts is limited, in particular with regards to the experiences of both service users and service providers with these services.<sup>30</sup> Research on both the service needs of victims of trafficking and service users' and providers' experiences with existing services is needed to help these services mature and develop further in the future.<sup>30</sup> Yet, currently, literature in this area remains almost completely limited to grey reports.<sup>30</sup> A more detailed review of this social and health services research literature is provided in Chapter 2.

## Human trafficking in the Netherlands

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There were several reasons why I chose the Netherlands as my research location. Partly, this was a personal consideration; I am Dutch and this made it easier for me to read relevant policy document and speak to care providers. Furthermore, my pre-existing knowledge of the Dutch social and health care system was advantageous. Besides this, the Netherlands is also a good study location as, since 1990, it has been at the forefront of anti-trafficking efforts.<sup>35</sup> The Netherlands has decriminalized sex work, providing a legal context that facilitates effective responses to human trafficking.<sup>36</sup> Moreover, before this research commenced the Netherlands had just undergone a shift in policy from providing care to trafficked persons in general shelters for domestic violence and the homeless, to providing specific shelter and care for victims of trafficking in specialized shelters (see later section "Post-trafficking shelter and care provision in the Netherlands"). This provided an interesting and unique opportunity to study these services soon after they had been established.

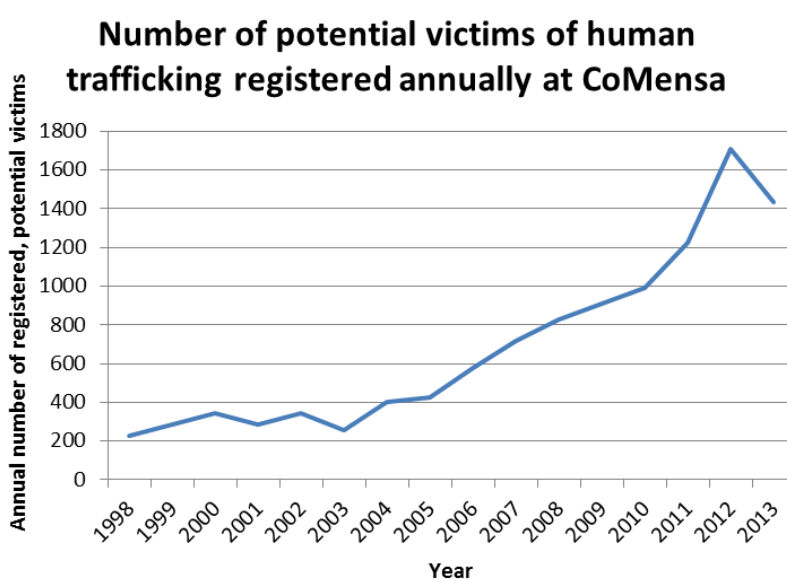
Before elaborating on the Dutch social and health services for victims of human trafficking, I will provide some background on the scale of human trafficking in the Netherlands and the legal framework that underlies anti-trafficking efforts in the Netherlands.

### Scale of human trafficking in the Netherlands

The number of potential victims of human trafficking identified annually in the Netherlands has risen steadily over the past years (see Figure 1.1). Potential victims are registered with the Dutch Coordinating Centre for Human Trafficking (CoMensha). The number of registrations was 1711 in 2012 and 1437 in 2013.<sup>37</sup> Of these, 274 and 212 made a request for shelter and care respectively.<sup>37</sup>

These numbers have more than doubled in the past decade<sup>38</sup> and constitute 3% of all placements in shelters for victims of violence.<sup>39</sup>

These numbers likely underrepresent the actual annual number of victims of human trafficking in the Netherlands. The hidden nature of the population makes identification of victims difficult. Internationally, it is estimated that only a small percentage of victims is identified.<sup>1,2,40,41</sup> FairWork, a Dutch civil society organization working on human trafficking-related issues, estimates the number of people trafficked in the Netherlands to be 30,000, of which 9,000 are exploited in the sex industry.<sup>42</sup> This number, however, should be considered a ‘guesstimate’; a strong evidence base for estimates of this kind does not exist.<sup>41</sup>



**Figure 1.1. Number of potential victims of human trafficking registered at CoMensa**<sup>37</sup>

Identified victims were most often trafficked for sexual exploitation. This was especially true for women (72%). Men were more often exploited in other sectors (23% trafficked for sexual exploitation). Victims were most often (32%) of Dutch nationality (i.e. victims of domestic/internal trafficking; a large proportion of these victims are ‘groomed’ into sex work by so-called ‘loverboys’<sup>9</sup>). Women constituted 88% of the total number of registered victims, men 12%. Of the total, 18% were minors (<18 years of age).

## Legislative framework for trafficking responses in the Netherlands

There are three laws that are relevant to human trafficking in the Netherlands:<sup>43</sup>

1. Section 273f of the Dutch Criminal Code specifies what exactly ‘human trafficking’ is under Dutch criminal law and the appropriate punishment.

2. Chapter B8/3 (formerly B9) of the Aliens Act implementation guidelines specifies:<sup>44-46</sup>
  - The right of victims to a reflection period of three months, in which the victim can decide whether or not to cooperate with police and prosecutor and/or press charges.
  - The right to a temporary residence permit for the time the trial of the offender(s) lasts. Cooperation with police and prosecutor in the prosecution of the offender(s) is a precondition for the temporary residence permit.
  - The right of victims to receive (both in the reflection period and when temporary residence status is obtained):
    - medical care;
    - social benefits;
    - legal assistance; and
    - shelter.
  - A detailed overview of the responsibilities of different organisations and agencies that come into contact with victims of human trafficking.
3. Chapter B9 (formerly B16/7) of those same guidelines sets out that continued residence (after temporary residence status on the basis of B8/3 has expired) can be requested if the victim has cooperated in the prosecution of an offender, which led to a conviction; if the criminal procedure lasted more than three years; or on the basis of humanitarian circumstances.<sup>47</sup>

## Post-trafficking social and health services in the Netherlands

### *The COSM programme*

Previously, shelter and care was provided for victims of trafficking in the Netherlands in shelters for victims of domestic violence, the homeless or migrants.<sup>33,34</sup> In recent years, recognition has grown that the provision of shelter and care for victims of trafficking among these other populations cannot be tailored to their specific service needs.<sup>33,34</sup> Therefore, a new programme, called the 'Categorical Care for Victims of Human Trafficking' (COSM),\* was established in 2010.<sup>33,34,45,48,49</sup>

The COSM programme started in June 2010 as a two-year pilot, was extended for two and a half years in 2012, and again in 2014. In 2010 and 2012, three ministries, the Ministry of Health, Welfare, and Sports, the Ministry of Security and Justice, and the Ministry of the Interior and Kingdom Relations,<sup>50</sup> jointly extended funds for shelter and care services under the COSM programme to

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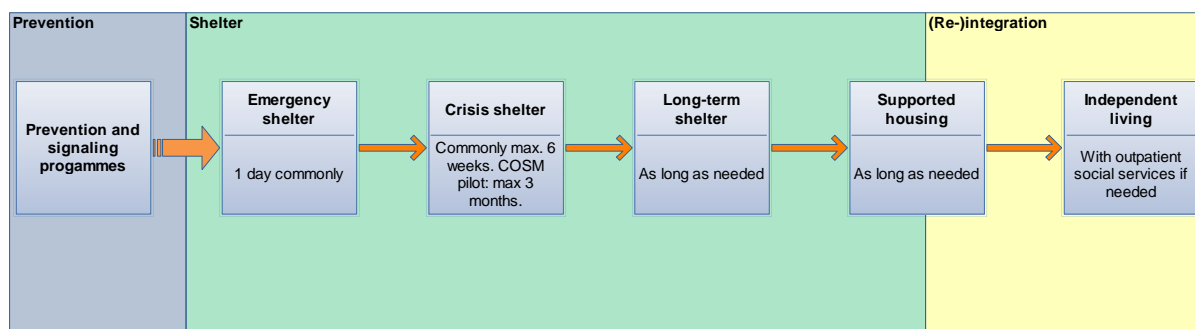
\* 'Categorical care' refers to care that is provided exclusively for one population, in this case for victims of human trafficking.

three different shelters by means of a public tender. The three shelters that won the tender in 2010 were the same three shelters that won the tender in 2012. In 2014 the Ministry decided to continue care provision through the three shelters that had won the tender in 2010 and 2012 without a tender, pending decisions on the integration of the COSM into the regular social care framework of the Netherlands (see Chapter 6 for more detail on these developments).

At the time of the study, the three shelters in the Netherlands that were part of the COSM pilot had a total of 50 beds. Two shelters were for women only and had 20 beds each; one shelter was for men only and had 10 beds. Since then, these numbers have increased to 27 and 16 respectively, bringing the total number of beds for the COSM to 70. All shelters provide shelter exclusively to adults (and their children). Different shelter arrangements are available in the Netherlands for victims of trafficking who are minors.<sup>51</sup>

In 2012, 113 victims of human trafficking were placed in one of the three COSM shelters. Although a substantial percentage of trafficking victims identified in the Netherlands are of Dutch nationality, the majority of victims who entered the COSM shelters at the time of this research were of foreign nationality (>95%) (later this became 100%, because the entry requirements for the COSM shelters were restricted and only foreign victims were allowed to receive shelter under the COSM programme).<sup>50</sup> Most victims in the COSM shelters at the time of the research were trafficked for the purpose of sexual exploitation (both women (>95%) and men (75%)) [personal communication T. van Driel from CoMensha d.d. 24 May 2011].

The COSM shelters are a form of crisis shelter (Figure 1.2). They are intended to provide shelter and care for a maximum of three months. After this, the intention is that victims move towards long-term shelters, supported housing facilities or a house of their own in the Netherlands, or travel back to their home country. The period of three months coincides with the reflection period that victims are entitled to, during which they can decide to cooperate with law enforcement or not (see earlier section “Legislative framework for anti-trafficking efforts in the Netherlands”). There are individual differences between the three shelters, but they all offer secure and safe crisis shelter; facilitate the provision different types of social and health care (either in the shelter or by service providers outside the shelter); and provide information on legal matters and assist service users in acquiring a legal counsellor if required.



**Figure 1.2. Dutch chain of social care**

The Dutch chain of social care comprises five steps: Emergency shelter (one day commonly; crisis shelter (commonly maximum six weeks to sometimes three months); long-term shelter; supported housing; and independent living (if necessary with provision of outpatient social services). Note: Not all service users go through all steps in the chain.

### *Other shelters and services*

The COSM shelters are not the only shelters that provide care to victims of human trafficking.<sup>29</sup> The regular shelter sector still has places for this group, mostly in shelters for a broader group of victims of violence or homeless people (and sometimes categorically). When both crisis-shelter and long-term shelter placements are included, the number of shelter placements for victims of human trafficking in non-COSM shelters was 447 in 2012 (numbers not available for 2013).<sup>52</sup> This number appears high compared to the aforementioned 274 victims who requested shelter and care in 2012, because victims who received shelter in multiple non-COSM shelters are double counted.<sup>52</sup> An important difference between this group of victims and the victims of human trafficking that receive care in the COSM shelters is that this group includes Dutch victims and victims below the age of 18 years of age, who are not eligible for the COSM programme. Most non-COSM placements for foreign, adult service users consisted of long-term shelter care.<sup>33</sup> Besides shelters, there are outpatient social services for victims of human trafficking in the Netherlands. In total, 798 victims of human trafficking made use of some type of outpatient service in 2012.<sup>52</sup>

## **Terms, punctuation, notation and chapter format**

There are various terms in this chapter that require further explication, such as ‘recovery’ and ‘victim’. I define these terms and all others that are relevant to my doctoral research in Chapter 2.

I also wish to make a brief note here on punctuation and notation. I have consistently used the inverted commas (‘ and ’) for highlighting terms that I wished to discuss, such as ‘recovery’. To quote people or documents, I have used the double quotation mark (“ and ”). In quotes, (...) means that I omitted a section of the quote, [...] means that I omitted a section of the text for confidentiality

reasons, and [word] means that I added a word to clarify the quote. Words that I have quoted in CAPITAL letters were emphasized by participants. Words that I have written in *italic* are words that I wished to give emphasis.

Finally, the chapters that present results, that is Chapter 4, 5, 6, 7 and 8, are mostly written in an ‘article format’, structured in four sections (Introduction, Methods, Results and Discussion) and providing a Summary at the beginning. I chose this format because I wanted these chapters to be readable independently from the rest of the thesis and to facilitate later publication of the chapters. Chapters 4 and 7 are written in variations to this format: Chapter 4 is a methodological article that presents most of the results and discussion together in one section; and Chapter 7 is written as a policy commentary (rather than a research article) and therefore adheres to a freer structure than the other results chapters.

## Rationale, aim and objectives

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The rationale for this research is:

There is a dearth of evidence on the social care and health care needs of victims of human trafficking and the experiences of service users and providers of existing social and health services. More research is needed to improve our understanding of how to provide appropriate shelter and care for this population.

The aim is:

To improve understanding of how social and health services can provide appropriate shelter and care for victims of human trafficking.

The objectives of this thesis are:

- 1) To investigate how service users of the Dutch COSM programme conceptualize and experience their own process of recovery.
- 2) To explore service providers’ views on the challenges encountered in providing social and health services for victims of human trafficking as part of the COSM programme.
- 3) To investigate how the broader set of social and health services for victims of human trafficking is monitored in the Netherlands.
- 4) To discuss how these investigations improve understanding of how social and health services can provide appropriate shelter and care for this population.

These objectives are further discussed in the next section (“Research outline”), which also provides a description of how the objectives link together.

Furthermore, the thesis addresses a separate methodological objective:

- To describe the challenges of interviewing victims of human trafficking in the COSM shelters and the measures that I took to address these challenges.

## Research outline

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*Chapter 2* provides a review of several topics, terms, concepts and theories that are of importance to this thesis. In section one, I explore the political economic theories in which the research has been grounded. In section two, I discuss several relevant terms and concepts and bring these together in a conceptual framework. In section three, I review the literature on social and health service provision for victims of human trafficking in Western Europe, the United States, Canada, Australia and New Zealand.

*Chapter 3* provides a detailed description of the methods and methodology employed for my research. While Chapters 4 through 8 also contain methods sections, this chapter describes all methods that I used in my doctoral research, provides more detail about the methods than I could give in the individual chapters, and offers additional justification for the methods that I employed.

*Chapter 4* provides an account of the methodological challenges that I encountered in interviewing victims of human trafficking in the COSM shelters, the measures that I took to address these challenges and the dilemmas that I faced in doing so. The chapter adds to the methodological discourse on conducting interview-based research among this population.

*Chapter 5* addresses the first objective of this thesis. Based primarily on interviews with 14 service users in three COSM shelters, it provides an analysis of service users’ conceptualizations and experiences of their journey to recovery.

*Chapter 6* addresses the second objective of this thesis. Based primarily on interviews with 25 service providers, civil society members and policymakers in the COSM programme, it provides an analysis of the challenges that emerged in developing service provision as part of the newly established COSM programme, the changes that took place in how these challenges were addressed, and the factors that facilitated or impeded those changes.



*Chapter 7* addresses part of the second objective and provides an in-depth study of a key challenge that emerges from Chapter 6: developing expertise among service providers. It does so by exploring what would be needed to ensure adequate professional responses to victims of human trafficking in the Netherlands. The chapter was written as a policy commentary and, as a result, is shorter than the other chapters.

*Chapter 8* addresses the third objective of this thesis. It goes beyond the COSM programme, taking a more inclusive view of all social and health services for victims of human trafficking in the Netherlands. Since it was beyond the scope of this thesis to study the other parts of the social and health care system in as much detail as the COSM programme, this chapter investigates how the Dutch government *monitors* the availability of social and health services for victims of human trafficking throughout the country. This chapter is the only chapter that did not follow directly from my investigation of service users' or service providers' experiences with service provision, but is instead based on a documentary analysis of public health monitoring documents published by municipal health councils.

*Chapter 9* addresses the fourth objective of this thesis and explores how Chapters 5 to 8 improve understanding of how social and health services can provide appropriate shelter and care for victims of human trafficking. Although this objective is addressed in part in the Discussion sections of Chapters 5 to 8 for their respective topics, this chapter brings together the findings from these chapters and provides a discussion of the dominant theme in my doctoral research.

## **Chapter 2**

# **Political economic background of the research, terms and concepts in human trafficking, and a review of the health services literature on human trafficking**

This Chapter consists of three sections.

In the first section, I explore the political economic theories in which this research has been grounded. This section explicates the preconceptions with which I entered this research and uncovers the question that has driven the development of my aim and objectives.

In the second section, I define the terms and describe the concepts that have played a key role in my doctoral research. At the end of this section, I present a conceptual framework that combines many of these concepts. This framework shaped my aim and objectives and provides a conceptual context for the other chapters. The Discussion, Chapter 9, demonstrates how my views on this framework have changed over the course of my research.

In the third section, I review the research that has been conducted on social and health service provision for victims of human trafficking, which provides the scientific background for this thesis.

## Section 1: Political economic background

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I was born in 1983. I am a child of a generation that has never seen a non-welfare state in Western Europe and other countries belonging to the Organisation for Economic Co-operation and Development (OECD). It is my own belief in, and perhaps even tacit acceptance of, a public responsibility for the vulnerable in society that has driven the research in this thesis and has led me to ask the question that underlies all other research questions in this thesis – *what knowledge might help to make social and health service provision for this vulnerable group better?*

Therefore, to explicate these preconceptions, I describe the rise of the welfare state in this section, and its consequences for society, particularly for social and health service provision.

The rise of the welfare state in the previous century in what are now the OECD countries has its roots in the rise of social liberalism in the late 19<sup>th</sup> century and of social democracy in the early 20<sup>th</sup> century in Western Europe. At the end of the 19<sup>th</sup> century, liberalism – a prevailing political perspective of the time – began to divide into two streams. On one side were the classical liberalists, who felt that individuals' freedoms were endangered by too large a state and whose ideal was "a state that left us alone to get on with our lives".<sup>53</sup> On the other side, there was the social (or 'new' or 'modern' or 'social justice') liberalism, which "also valued political freedom, also thought that the state should as far as possible leave us alone to make our own decisions on how to live our lives, also opposed militarism and also believed that international free trade was a way to preserve peace, but it believed in addition that liberalism required a commitment to a fair distribution of wealth and

power.”<sup>53</sup> The rise of social liberalism was followed by the rise of social democracy in the early 20<sup>th</sup> century.<sup>54</sup> Social democracy had its roots in socialism and constituted a political ideology that “advocated a peaceful, evolutionary transition of society from capitalism to socialism using established political processes”.<sup>55</sup> The ideological socialist foundation of social democracy was in stark contrast with the focus on individual freedom in social liberalism. Despite these ideological differences, the two political ideologies shared several important practical considerations around statesmanship that led to the rise of the welfare state in the 20<sup>th</sup> century.

The welfare state is a “concept of government in which the state plays a key role in the protection and promotion of the economic and social well-being of its citizens.”<sup>56</sup> For social liberalism, moving towards a welfare state constituted a way of fairly distributing wealth, which it views as “a condition for meaningful freedom”.<sup>53</sup> For social democracy, fair distribution of wealth constituted an end-goal in itself and it saw the welfare state as an opportunity to humanize the political system.

The welfare state is characterized by several concrete policy directions, including redistributive taxation and public services such as the public provision of basic education, health services and housing.<sup>56</sup> Both redistributive taxation and public services constitute approaches to redistributing wealth.<sup>57</sup> But perhaps the most fundamental component of the welfare state is social insurance.<sup>56</sup> Although the foundations for these policies were laid at the beginning of the 20<sup>th</sup> century, the second part of the 20<sup>th</sup> century saw a vast expansion of these policies, with especially insurance programs increasing in coverage from basic to comprehensive and overall social expenditures by states doubling in most of Europe and growing by 40/50% in other OECD countries between 1960 and 1985.<sup>58</sup>

These developments had far-reaching consequences for the development of social and health service provision in these countries. The welfare state “is based on the principles of equality of opportunity, equitable distribution of wealth, and *public responsibility for those unable to avail themselves of the minimal provisions for a good life*” (emphasis added).<sup>56</sup> This “public responsibility” for the vulnerable in society has its roots in social liberalism. Providing care for the vulnerable in this political perspective is not an end-goal, but a means to an end, i.e. the meaningful freedom of every individual. As Howarth writes:

“Nearly all social liberals accept that the existence of formal political rights cannot be enough by itself to create a liberal society. Citizens need to be in a position to exercise their rights. That principle, which sounds modest, in reality implies a far-reaching programme of public services that goes beyond the classical liberal list of ‘public goods’ (such as defence). It implies in particular a commitment to the broadest possible provision of education, not for

the sake of economic development, as in the socialist and utilitarian traditions, but to ensure that citizens can exercise their democratic rights in practical ways and not fall victim to political fraud and demagoguery. It also implies government guarantees in health care, since citizens who are ill or constantly in fear of illness are hardly in a position to give their time to public affairs.”<sup>53</sup>

With these principles of the welfare state and social liberalism in mind, it is useful to observe that all modern governments of what are now the OECD states, as they grew richer, have become welfare states. There are hardly any classical, minimalist liberalists left. The difference today between liberalist parties and social liberalist parties lies more in the relative priority that they place on social justice and fairness, rather than whether the redistributive policies of the welfare state should exist at all. It is this advent of social liberalism and social democracy, ultimately resulting in the creation and further development of the welfare state over the course of the 20<sup>th</sup> century, that lies at the root of the development of social work as a profession over that same period<sup>59</sup> and the acceptance of a public responsibility for the vulnerable in society. This is the political economic background against which my research is set.

## **Section 2: Terms and concepts**

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Here, I present several terms and concepts of importance to my research. The concepts are combined into a conceptual framework that I present at the end of this section.

### **Health**

The concept ‘health’ was defined by the World Health Organization (WHO) in 1946 as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.<sup>60</sup> Since then, this definition has been a matter of debate.<sup>61–63</sup> Although most agree that “the conjunction of the physical, psychological, and social remains powerfully relevant to this day” some have criticized the static conceptualization of ‘health’ in the WHO definition.<sup>64</sup> They have expressed support for what was first described by Canguilhem in 1943, that there are no normal or abnormal states of health, but that health should be defined as “the ability to adapt to one's environment”.<sup>64</sup> Huber has recently advanced these ideas and proposed the following definition of health: “The ability to adapt and self manage in the face of social, physical and emotional challenges”.<sup>61</sup>

For victims of human trafficking, a range of social problems (such as social stigma, isolation, and difficulties with finding work and education) lies central to their physical and mental health problems and influences strongly their post-trafficking service experiences (see Appendix 1 and Chapter 5).<sup>14,18</sup> As Huber et al's definition of health allows for an inclusive view of the broad spectrum of challenges that victims of trafficking face I have chosen to adopt this definition for my research.

## Health consequences of human trafficking

The health consequences of human trafficking are discussed in Chapter 1 and are reviewed more extensively in Appendix 1. Here, I wish to describe specifically a publication by Zimmerman that I have found particularly useful in considering the health consequences of human trafficking. She writes: "The health risks, consequences, and barriers to services for trafficked women are similar to those experienced by other marginalised groups, including:

1. migrant women;
2. women experiencing sexual abuse, domestic violence, or torture;
3. women sex workers; and
4. exploited women labourers."<sup>14</sup>

In this thesis, I draw comparisons at various points to other vulnerable populations with overlapping needs profiles, especially to these groups.

## Victims

Use of the term 'victim' when referring to trafficked persons has been criticized for several reasons. Many trafficked persons do not consider themselves to be victims. Referring to them as such can be confusing and potentially judgmental, and may even result in inappropriate intervention strategies.<sup>65</sup> Moreover, the term may imply powerlessness and fail to recognize the survival and coping strategies that a trafficked person develops at the time of an assault.<sup>66</sup> The term 'survivor' has been suggested as a more suitable alternative.<sup>67</sup> However, this term also has its problems. Most importantly, its use across the scientific discourse on human trafficking is not consistent. Some talk about the transition of victim to survivor in the context of post-trafficking recovery, suggesting that one starts as a victim and recovers to be a survivor.<sup>68</sup> Others explain that during the long periods of abuse, violence, and rape that can occur in trafficking situations one ceases to be a victim at some point and becomes a survivor, using the term to describe a change in psychological state that results from a coping strategy.<sup>5</sup> Yet others refer to survivors simply as those who have exited a trafficking situation.<sup>69</sup>

I have chosen to use the term ‘victim’ throughout this manuscript to avoid potential confusion about the meaning of the term ‘survivor’, because the term ‘victim’ offers a better reflection of the fact that people have been the victim of crime<sup>66</sup> and because in Dutch discourse on human trafficking, the term ‘victim’ is common and the term ‘survivor’ is hardly ever used.<sup>28,70</sup> I have also used the term ‘trafficked persons’ interchangeably with the terms ‘victims of human trafficking’ and ‘victims of trafficking’ to refer to my study population.

## Vulnerability

In this thesis I frequently refer to victims of human trafficking as a ‘vulnerable group’. Therefore, I explain my use of the term vulnerability here. The definition that I adhere to is the following definition of vulnerability in the context of health: “Vulnerable populations are those at risk at any particular point in time for unequal opportunity to achieve maximum possible health and quality of life”.<sup>71</sup> The “unequal opportunity” that may lead to vulnerability can be caused by either different or increased health care needs or by decreased access to prevention or care.<sup>71–73</sup>

## Recovery

While the term ‘recovery’ is sometimes used as synonymous with recovering from some specific problem, such as from mental health problems or addiction, my use of the term in this thesis is broader. The definition of ‘recovery’ that I adhere to is: “The act or process of returning to a normal state after a period of difficulty”.<sup>74</sup> I have found this broader definition to be more appropriate because, as my definition for health, it allows for an inclusive view of the spectrum of challenges that victims of human trafficking face after having exited a trafficking situation.

It has been noted that recovery is a personal journey, different for everyone, that it can and does occur without professional intervention, and that it emphasizes the role of the subject as a self-determining agent of change.<sup>75,76</sup> These descriptions fit well my view of what recovery entails.

## Social and health service needs and experiences

In the context of health care provision, ‘service needs’ have been defined as “the ability to benefit in some way from healthcare”.<sup>77</sup> Different types of need can be distinguished:<sup>78,79</sup>

- Felt need: This constitutes the views of care consumers on their own health care needs.
- Demand: Based on their felt need, consumers can make a demand for health care, also known as expressed need.

- Professionally defined need: This constitutes the views of health professionals on the health care needs of service users.
- Met / unmet need: When services are provided or not in accordance with what is needed.

I have defined 'service needs' in this thesis as the need for any service that can help service users to recover. What the different types of need indicate is that service users' and service providers' perspectives on service needs may differ – one of the prime reasons why I explored both service users' and service providers' perspectives on post-trafficking service provision.

Similarly, service users' and providers' *experiences* of social and health services differ. Service providers are generally more able to provide insights into aspects of a clinical, managerial, or organisational nature.<sup>80-83</sup> Service users' accounts of their experiences with service provision are generally focused more on the humaneness of care.<sup>82,84-86</sup>

## **A system of social and health service provision: a 'system of care'**

To describe the system of social and health services that is in place for victims of human trafficking in the Netherlands, I have made use of several theoretical frameworks.

There are numerous frameworks that provide insight into different aspects of health systems, such as the actors in that system or its different functions.<sup>87,88</sup> The best-known and most-used framework is the WHO Health Systems Framework.<sup>89</sup> This framework is useful because it describes the six building blocks of any health system: leadership / governance; financing; workforce; products and technologies; information and research; and service delivery.<sup>89</sup> These building blocks were helpful for me in considering in which areas various challenges to service provision might exist, as will become clear in Chapter 6.

However, what defines social and health service provision for victims of human trafficking is that a broad range of social and health services is needed for this population in the post-trafficking stage (see later section "Review") and that these services are interdependent. This complex arrangement of services and the interplay between them is not captured well by general health system frameworks. In search for a term to better describe the coordinated network of services that is in place for victims of trafficking in the Netherlands, I came across a body of literature around social and health service provision for children with mental health problems.<sup>90,91</sup> For this group, a broad range of interdependent social and health services is also needed. In this literature, the term 'system of care' is used to describe the coordinated network of social and health services available for these children. It emphasizes the broad range of services that is needed, the need for coordination



between these services, and that there are many factors outside these services (e.g. in broader society or children's families) that influence the wellbeing of the children who use the services. The term has given a common language and coherence to the scientific debate on social and health service provision for this group.<sup>92-98</sup> Because I felt that this description was a particularly good fit for the services needed and in place for victims of human trafficking in the Netherlands, I have used the term 'system of care' at various points in this thesis to describe the social and health services available to this group. I have used the terms 'COSM pilot' and 'COSM programme' interchangeably to refer to the entire system of care that has been built around the COSM shelters for victims of human trafficking in the Netherlands.

Finally, there are different 'levels' in the system of care for victims of human trafficking in the Netherlands at which actors influence service provision. If the 'building blocks' from the WHO Health Systems Framework described above are a horizontal delineation of those services, these levels are the vertical delineation. There are multiple frameworks that have described such levels for health systems.<sup>90,98-105</sup> Based on these frameworks, I have defined three levels at which actors can influence social and health service provision in a system of care. These are:

- Policy and governance level
- Organizational level
- Service delivery level

These three levels have especially helped me to consider at which levels of the system of care for victims of trafficking in the Netherlands various challenges to service provision might exist (see Chapter 6).

## Conceptual framework

The conceptual framework described here combines the concepts discussed above and has assisted me in various stages of my research (Figure 2.1). For example, it led me to arrive at a focus on both service users' and providers' experiences with service provision in my Aim and Objectives, it provided me with the background for drawing comparisons to social and health service provision for other populations in various chapters, and it provided the structure for identifying challenges to providing social and health services in the COSM programme as part of Chapter 6.

The framework consists of four components:

- *Health problems*

This section is placed in the upper-left corner of Figure 2.1. It describes that the health problems that victims of human trafficking can face are characterized by a complex spectrum of physical and mental health and social problems that are partly similar to the problems of four other vulnerable groups. The figure also makes clear that there is individual variation in experienced health problems between different service users and that health problems in one area often influence health problems in other areas (comorbidity).

- *Social and health service needs and experiences*

This section is placed at the middle-left of Figure 2.1. It shows that social and health service needs follow from existing health problems and that these needs influence each other. It also makes clear that service users' perspectives (felt needs) and service providers' perspectives (professionally defined needs) on service needs are different. The existence of individual variation in the social and health service needs of different service users is also recognized.

- *Society and the health system*

This section is placed in the upper-right corner of Figure 2.1. It shows that the system of care for victims of human trafficking in the Netherlands consists of three different levels, the policy and governance level, the organizational level and the service delivery level. It also makes clear that all these levels influence each other and, ultimately, service provision. Finally, it demonstrates that service provision is not influenced by factors in the system of care alone, but also by broader societal factors.

- *Service experiences*

This section is placed at the bottom of Figure 2.1. It makes clear that service experiences follow from whether existing services match needs for service provision. It also shows that service users and service providers have a different focus in speaking about their experiences with social and health service provision. Finally, it recognizes that individual differences among service users and among service providers will lead to different service experiences.

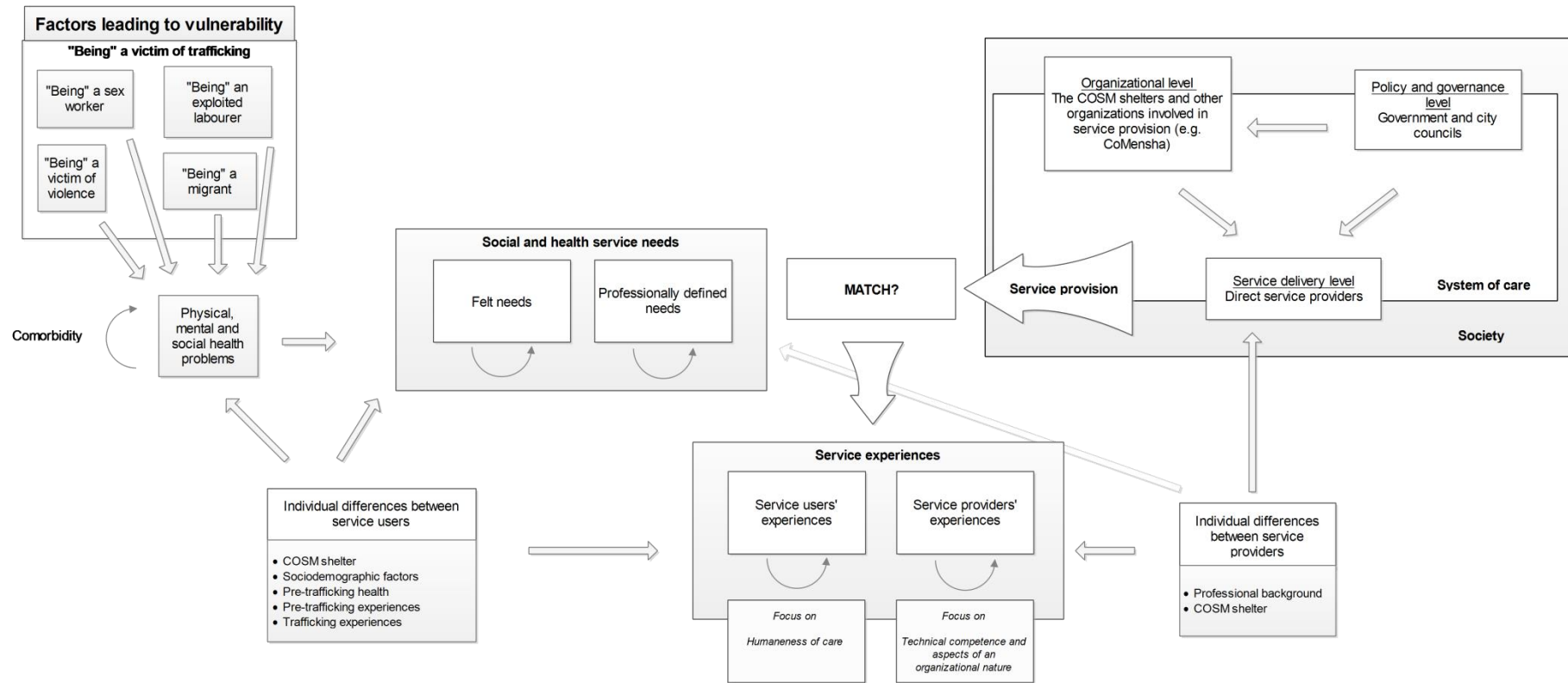


Figure 2.1. The conceptual framework that has been the background to my research. Arrows indicate a direction of influence; circular arrows indicate that the concept influences itself (various health problems can influence each other (comorbidity), as can people's social and health service needs and experiences).

## **Section 3: Review of social and health services research on post-trafficking care for victims of human trafficking**

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This section describes the results of a review of the literature on research that has been undertaken to investigate social and health service provision for victims of human trafficking.

### **Methods**

I conducted a search of the following journal databases on 26 August 2011 and updated this review on 4 March 2015:

- Medline
- Embase
- Social Policy and Practice
- Global Health
- Psychinfo

In searching these databases, I combined search terms for human trafficking (such as 'human trafficking', 'sex trafficking', and 'trafficked persons') and for social and health services research (services, needs, audit, satisfaction, experiences, quality). I also conducted a grey literature search by searching Google using similar keywords. The search included publications and reports from all years. Only English- or Dutch-language publications were included. Precise search terms are provided in Appendix 2.

I screened the titles and abstracts of identified articles and reports and included those that complied with a set of inclusion criteria that limited the scope of the review and matched the characteristics of my own study population. The inclusion criteria were (all had to be met for inclusion):

- Studies (or reviews) that evaluated service users' or service providers' experiences with post-trafficking shelter and/or care facilities
- Studies (or reviews) that included investigation of shelter and/or care facilities for adult, foreign victims of human trafficking, who were trafficked for the purpose of sexual exploitation
- Studies (or reviews) that investigated shelter or care provided in Western Europe, the United States, Canada, Australia or New Zealand

Exclusion criteria for the title/abstract screening process comprised:

- Studies researching solely health problems of victims of trafficking (e.g. <sup>19</sup>)
- Reports providing only descriptions of shelter and care programmes (e.g. <sup>106,107</sup>)
- Studies researching solely services for victims below the age of 18 years (e.g. <sup>51,67,108–112</sup>)
- Studies researching solely services outside Western Europe, the United States, Canada, Australia and New Zealand (e.g. <sup>66,113–123</sup>)
- Studies researching solely services for victims of other types of exploitation than sexual exploitation
- Studies researching services that are not post-trafficking but provide interventions to (potentially exploited) sex workers (e.g. <sup>124</sup>)
- Studies researching solely services for domestic victims of trafficking (i.e. victims who come from the country itself, often trafficked via grooming practices; e.g. <sup>112,125</sup>)
- “Viewpoint” articles, opinion pieces, or reports that are not based on primary research (e.g. <sup>126–128</sup>)

After title abstract screening was completed, full texts of the articles that were included based on their title and abstract were screened using the same in- and exclusion criteria as for the title/abstract search.

## Results

Here I describe the main outcomes of this review. There are three parts to these outcomes.

First, an overview of the post-trafficking service needs of victims of human trafficking. While the service needs for victims of trafficking have been reasonably well described and reviewed,<sup>30</sup> I aimed to develop a framework of those social and health service needs with relevance to the Dutch context as background for my thesis.

Much less evidence is available on best practices for service provision and barriers to service provision. Second, I provide a summary of what the documents in my review said about best practices for and barriers to good care provision.

Finally, I describe my conclusions from this literature review and highlight key research gaps.

### *Post-trafficking social and health service needs*

Because of the wide range of different, yet interrelated, physical and mental health and social problems in this population, a comprehensive range of social and health services needs to be in

place for this population after they have exited a trafficking situation. Several studies have assessed the needs of victims of human trafficking for post-trafficking social and health services<sup>13,14,18,26,30,33,41,65,124,129–139</sup> and have suggested frameworks to create structure in the range of services that needs to be available.<sup>14,26,30,41,134–139</sup>

In order to create a framework of these services that was relevant both to the study population and to the Dutch context, I have combined frameworks from international research on the service needs of victims of trafficking with frameworks for service provision by Dutch shelters to comparable groups.<sup>14,26,136,140–142</sup> The resulting framework is presented in Table 2.1.

**Table 2.1. Needs for services in a shelter for victims of human trafficking and descriptions of provided services in the Netherlands**

<b>Services that are needed</b>	<b>Descriptions of services that are provided in the Netherlands as part of the COSM programme</b>
Physical health care	Care that is provided when service users experience physical health problems. This care can be provided by social care workers in the shelter or by a GP that is affiliated with the shelter. Service users are offered separate screening for sexually transmitted infections (STIs) (voluntary) and tuberculosis (obligatory) with the municipal health services.
Mental health care	Care that is provided when service users experience mental health problems. This care can be provided by social care workers in the shelter. Additionally, mental health care is offered via mental health care institutions.
Safety	This service consists of advice to service users on how to increase safety, ensuring security at the shelter itself, accompanying service users to places if necessary, and assisting service users in contact with the police if necessary.
Emergency shelter	Shelter is provided by the COSM programme. All three shelters have sleeping quarters and communal areas that are arranged in varying manners.
Longer-term housing	This service consists of helping service users with looking for a different place to live after they have to leave the COSM shelter and wish to remain in the Netherlands.
Legal assistance	Service users receive legal assistance. This is offered in the form of basic advice by social care workers in the shelter. Service users are referred to a counsellor for more advanced legal assistance. Assistance includes help with acquiring residency status, representation of the service user in the trafficker's criminal case, and other matters such as acquiring financial compensation from the government.
Translation	Translation services by the Tolk- en Vertaalcentrum Nederland (TVcN) are freely available to the COSM shelters.
Daytime activities	A range of day activities is offered by the COSM shelters. The nature of activities differs by shelter, but can include cultural orientation such as help with understanding the Dutch culture, language training, occupational skills training and arts classes.

Help with education / employment	Services differ by shelter but can include occupational skills training, advice on possibilities for (voluntary) employment during stay in the COSM shelter, help with finding education, and referral to organizations that assist people in finding employment.
Financial and administrative assistance	Services include help with getting subsidies and social benefits, help with filling out papers and forms, advice on how to get by with little money, and help with debts.
Empowerment	Key to services that aim to empower service users is that they are founded on service users' strengths. The central goal of empowerment is that service users (re)gain control over their own life and their surroundings, so that full participation in society can be achieved.
Self-maintenance and -care	Helping service users take care of themselves. Services can include help with cooking, grocery shopping, and laundry.
Child care	Services differ by shelter but can include helping service users with taking care of their children, advising on possibilities for helping children, helping to establish contact with relevant agencies.
Social contacts	Help with establishing rewarding and fruitful social contacts (including family and friends but also others such as care providers or colleagues). Services can include advice on ways to get to know other people, advice on discussing problems with people, learning how to say no, and learning how to ask for support.

Finally, three crosscutting, broad characteristics of the social and health service needs of this population became clear from the review:

1. *Needs bear resemblance to other vulnerable groups*

In line with the similarity between the health problems experienced by victims of trafficking and other populations (see earlier section “Health consequences of human trafficking”), the service needs of trafficked persons resemble those of several other vulnerable groups.<sup>14</sup>

2. *Needs differ by individual*

In line with the variation in health problems experienced by victims of trafficking (see earlier section “Health consequences of human trafficking”), the social and health service needs of victims of trafficking vary depending on their trafficking experiences, socio-demographic factors, pre-trafficking health status, pre-trafficking experiences and the geographical context of both the origin and the destination country.<sup>33,34,143–145</sup>

3. *Needs change over time*

Finally, victims’ needs change over time and several stages of need can be described (e.g. immediate needs, ongoing needs, and long-term needs).<sup>14,30</sup>

### *Post-trafficking social and health service evaluations*

Social and health services research that goes beyond identifying the social and health service needs of this population appears very limited. I found no interventional studies comparing various medical or social treatment approaches for this population. However, reports presenting evaluations of post-trafficking programmes based on service users' or care providers' experiences were available. I found 48 reports, articles or theses that presented such evaluations. Ten were published articles,<sup>30,65,129,137,145–150</sup> 34 were published reports,<sup>13,14,26,33,34,41,66,130–132,135,136,138,139,143,144,151–168</sup>, one was an unpublished report (received via email from the author)<sup>169</sup> and three were PhD theses.<sup>170–172</sup>

The remainder of this section discusses the best practices and barriers to good care provision that were discussed in these 48 documents.

### *Best practices for social and health service provision to victims of trafficking*

There were several best practices for social and health service provision that emerged from this review. These were that social and health services should:

- be comprehensive
- be integrated and/or coordinated
- allow for continuity of service provision
- be population-specific
- provide individually tailored care
- provide culturally appropriate care
- be trauma-informed
- offer case management

These best practices are described in more detail below.

#### *Comprehensive social and health services*

In addition to potentially experiencing a wide range of physical and mental health and social problems, victims of trafficking have the status of migrant, often with a wish for residency status, and are frequently involved in legal proceedings against their trafficker. Therefore, a comprehensive range of services needs to be in place for this population after they have been able to exit a trafficking situation, that can address the myriad needs of victims.<sup>145</sup> As one report states: “The complex needs of victims of human trafficking appear to require a comprehensive approach to service delivery that includes the provision of core services such as housing, legal assistance, medical assistance, social services, trauma therapy, and substance abuse treatment.”<sup>138</sup> And: “Ancillary services, including safe housing, parenting and other life skills, health care, legal services, and



vocational supports, are critical to comprehensively meeting the needs of individuals who have experienced trauma.”<sup>138</sup> The range of services that needs to be available has been discussed extensively in the previous section “Post-trafficking social and health service needs” (Table 2.1).

#### *Integrated and/or coordinated services*

The physical and mental health and social problems that victims may suffer are often interconnected. As a result, the various social and health service needs of victims are interconnected. Because of this, it is important that within the comprehensive spectrum of services that should be available, services are integrated or at least well-coordinated.<sup>148,150,166</sup> This applies to the collaboration between social and health service providers and other related service providers, such as lawyers. As one report notes: “The importance of collaboration in meeting the needs of victims of human trafficking cannot be overstated. Law enforcement and service providers stress the importance of working together to meet the diverse and complex needs of this population.”<sup>26</sup> Some reports mention the potential for comprehensive care centres,<sup>14,135</sup> akin to centres for rape victims that have emerged in recent years where victims receive all available care in one place.<sup>173</sup> Integration appears to be preferred by most reports, but reports also stress that “because victims’ needs are complex and extensive, it is impossible for a single agency to respond effectively to this population”.<sup>138</sup> In that case, the development of service networks is considered as beneficial for stimulating collaboration and coordination.<sup>138</sup>

#### *Continuity of service provision*

As explained earlier, trafficked persons’ social and health service needs vary over time. Several reports indicate distinct needs-phases each with its own characteristics.<sup>14,30</sup> From this, several best practices result. First, services should be available both in the short term and in the long term. Second, service provision should be stable, to allow victims to develop relationships with care providers. This is of particular importance given the particularly dented sense of trust among many victims of trafficking. Third, service provision should be flexible, addressing changing needs over time.<sup>14,30</sup>

#### *Population-specific services*

Many reports discuss the importance of population-specific service provision, i.e. that services should be provided exclusively to victims of trafficking and not be integrated with services for other target populations such as victims of domestic violence or refugees.<sup>30,33,34,41,132,151,174</sup> This best practice is synonymous with the ‘categorical’ nature of the COSM programme in the Netherlands (see Chapter 1). The importance of population-specific services is discussed in particular with reference to shelters.

Benefits of the provision of population-specific services that are discussed in these reports include:

- It allows for specialization by care providers.
- Some reports note that population-specific shelters may be able to better implement security measures.
- It is better if victims of trafficking are housed with others who have had similar experiences as some reports report discrimination of victims in other care facilities.

#### *Individually tailored services*

In addition to the broad recognition that victims of trafficking constitute a unique group with unique needs requiring specialized care, several reports also stress the differences between subgroups of victims and the variation between individual service users.<sup>33,34,143–145</sup> Many note the need for individually tailored care, i.e. client-specific, flexible approaches. One report noted specifically that the involvement of victims in developing and providing services is beneficial.<sup>138</sup>

#### *Culturally appropriate services*

One component of the social and health service needs of victims of trafficking is caused by migration-related issues.<sup>14</sup> Victims of trafficking are in an unfamiliar country, with an unfamiliar culture, around people who speak a language they may not understand. As a result, many reports mention the necessity for culturally appropriate care.<sup>148,164</sup> Reports speak in less detail about what this should entail, but mention availability of translation services, the ability to recognize culturally-specific physical and mental health problems (e.g. the somatization of mental health problems in African cultures is sometimes mentioned), culture-specific methods of communication, and even traditional food. Some note innovative care approaches such as involving churches in responding to voodoo practices utilized by traffickers on the African continent to control victims.<sup>154</sup>

#### *Trauma-informed services*

Another component of the service needs of victims of trafficking is related to the trauma that many victims have experienced. Several reports suggest the need for trauma-informed care.<sup>30,135,138,145,162</sup> Trauma informed services are described as entailing knowledge of “the history of past and current abuse in the life of your clients” and understanding of “the role that violence and victimization play in the lives of most consumers of (...) services and to use that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allow services to be delivered in a way that will facilitate consumer participation in treatment.”<sup>162</sup> Another report suggests that the characteristics of trauma informed care include: understanding that trauma is a defining and core life event; understanding that the victim’s complaints are coping mechanisms and original sources of strength; understanding that the primary goal of services is empowerment and recovery;

understanding that the service relationship is collaborative and that it is important to involve service users in making decisions about care provision; screening and assessment for trauma; training all staff about trauma and its impact; hiring staff members who are knowledgeable about trauma dynamics; and reviewing agency policies and procedures to identify any that are potentially harmful to trauma survivors.<sup>138</sup>

### *Case management*

Case management – one point of contact for the service user – was frequently mentioned to be one of the most beneficial developments in service provision for victims of trafficking.<sup>148,161,168,172</sup> The benefits are often related to the best practices outlined above. The presence of a case manager makes it more likely that service users have information about and access to a comprehensive package of services, and is likely to improve collaboration between different social and health service providers and other stakeholders (such as lawyers, the city council, insurers). Similarly, a case manager can see to it that service provision for a victim is continuous over time and galvanize smooth transitions in provided services in response to the changing needs of a service user. A case manager is also likely to have the specialist skills needed to address the needs of trafficked persons and a case manager can develop a trusting relationship with service users because he or she remains the same regardless of where the service users receive care. Case managers are also, because of their positions, well suited to raise attention to systemic problems in the provision of care for this population and to advocate for change.

### Barriers to good service provision

The barriers to good service provision ('good' as defined by the included documents) for victims of human trafficking that emerged from my review can be categorized as the following groups:

- Demand-side barriers
- Supply-side barriers
  - Policy and governance-level barriers
  - Organizational-level barriers
  - Service delivery-level barriers
- Broader societal barriers

These are discussed in turn below. The individual barriers are *italicized* in the text.

### *Demand-side barriers*

Demand-side barriers consist of barriers that exist because of certain characteristics of the service user population, which prevent them from accessing or utilizing available care.

*Language and culture* are often-mentioned demand-side barriers and may impede service access and effectiveness. Service users may return from visits to health clinics without receiving care simply because they could not make themselves understood at the clinic; explaining what services are available to service users can be challenging because of language and the service user's lack of knowledge of the destination country's society; and language can be a barrier in expressing emotions and in discussing sensitive issues.<sup>153</sup> The problem of *illiteracy* in the native language among some service users may further exacerbate language problems.<sup>138</sup> Furthermore, several reports specifically note the importance of cultural differences as a barrier in accessing health care provision, in particular mental health services.<sup>162</sup> Some reports also note that placing victims of varying cultural backgrounds in one shelter can result in tensions.<sup>34</sup> *Isolation* – in itself an undesirable health outcome – was also noted as a barrier to health service access related to language and culture.<sup>131</sup> One report notes: "Isolation due to these language barriers as well as cultural differences can be hard for any new immigrant but are particularly devastating for trafficking victims by reinforcing their captivity."<sup>162</sup> Linked to the issues of culture, language, and isolation, several reports noted that service users have a *limited knowledge of their entitlements, rights, and ways to access services*.<sup>130,132,146,166,167</sup> The social networks that service users have access to may have similar limitations.<sup>130</sup> Given the prominence with which language and culture are noted as barriers to access or effectiveness of care in many reports, it is noteworthy that many also describe an absence of translation services and a lack of culturally appropriate care (see later section "Supply side: Organizational- and service delivery-level barriers").

*Transportation* was noted as a pragmatic barrier to social and health service access for services users. One report explains, for example, that service users may have difficulties in finding transportation in smaller communities and in navigating the transportation systems of large cities, resulting in missed appointments with other service providers.<sup>26</sup>

Several reports noted that the *limited ability to pay* for services results in limited access to paid care for victims, including access to dental care, medical care, and certain social care provisions.<sup>131,132,146,154</sup> One report notes the long waiting lists for people with limited ability to pay.<sup>132</sup>

*A fear for one's safety* and a fear of traffickers were also noted as barriers.<sup>66,130,166,167</sup> Some mention specifically a *lack of trust*, in particular of authoritative institutions or persons.<sup>65,146,156,165–167</sup> *Shame* and *stigma* are also identified as barriers particularly present for this population.<sup>138,162,165</sup> As one report writes: "For most victims, shame is seen as one of the greatest barriers preventing them from seeking mental health services. Providers note that the stigma associated with mental illness is an especially prominent challenge in engaging foreign born and male victims in treatment."<sup>162</sup> This

quote also reveals the interrelatedness of several barriers outlined in this section (such as culture and stigma) and makes clear that certain subpopulations of victims of human trafficking (such as trafficked men) may experience different barriers to others.<sup>175</sup>

Another barrier is that *victims sometimes do not see themselves as victims*, impacting on victims' help seeking behaviours. This may be due to denial of traumatic experiences. However, it may also be because women do not consider the exploitative conditions as defined under national laws to be victimizing or, indeed, exploitation.<sup>138</sup>

Finally, some reports noted that service users are sometimes *disinclined to ask for help*<sup>129,132</sup> and may need persuasion to access care.<sup>14</sup> One report noted that this occurred because service users did not want to further burden overstressed staff.<sup>132</sup> However, another noted that victims did not seek out help, particularly mental health care, despite its ready availability.<sup>129</sup> The authors speculate that this might be due to cultural factors, since similar patterns have been found in research among immigrants.

#### *Supply side: Policy and governance-level barriers*

I identified two main reported barriers to good service provision at the policy and governance-level.

First, in several countries, *an imbalance between the focus on protection (of victims) and prosecution (of traffickers)* is noted – with a disproportionately large focus on prosecution:<sup>34,41,138,146,151,176</sup> “[Non-governmental organizations (NGOs)] in some countries report that their goals contradict those of governmental policy. On the one hand, the NGOs work on the integration of victims of [trafficking in human beings] into society, on the other hand a residence permit is not issued unless certain conditions are met which are related to the results of the criminal proceedings (e.g. the testimony of the victim has to be considered relevant and the crime qualified as [trafficking in human beings]).”<sup>34</sup> Policies that make service provision for victims conditional on their cooperation in the judicial process against the trafficker are reported by several others. One article called “Health care for victims of human trafficking – a human right or a reward?” is devoted to this issue entirely.<sup>177</sup> Another author, Rijken, writes: “The current practice of forcing victims of trafficking to testify against their will and repeatedly about their traumatic experiences does not seem therapeutically defensible.”<sup>41</sup> She continues: “Although the protection of victims is an explicit target of international and Dutch human trafficking policy, victims of this grave crime have much fewer entitlements than victims of other crimes.” She concludes by making a plea for an independent, multidisciplinary committee of experts to judge whether someone deserves to have access to help for being trafficked, rather than this being dependent on judicial procedures.

Second, in many countries, a *policy focus on border protection* is noted.<sup>14,34,146,151,164,170,178</sup> Schofield writes: “The imperative to control border transgressions to maintain state sovereignty and integrity is the main driver of policy related to trafficked women. Virtually no women who are publicly identified as victims of trafficking are allowed to stay in Australia. As a consequence, while trafficked women are rendered victims, they are nevertheless also perpetrators of border violations.”<sup>146</sup>

For victims, policy foci on prosecution and on border control together shape a situation in which *legal status* – or rather the lack thereof – is an impediment to receiving a range of services.<sup>34,149,150</sup> Legal status can impede service provision because: delays in receiving a status can impede access to services; temporary residency status as asylum seeker or victim of trafficking sometimes only provides limited access to services; sometimes there is a complete absence of status because a person is undocumented (e.g. because a victim refused to cooperate with judicial procedures). Van Selm writes: “It is useful also to draw out the central role of status in terms of access to rights and entitlements, in addition to its importance as a foundation to integration, and how the different statuses (...) result in sometimes non-intuitive distinctions in access to those elements that together produce an integrated society.”<sup>151</sup> The ineligibility for employment because of residency status was noted as a particular problem by some reports. Van Selm writes again: “Status, having the official papers permitting residence and employment is key to the security of the individual, allowing them to embark on a process of integration.”<sup>151</sup> The problems around status may even prevent organisations from providing care to whom they wish. Zimmerman writes: “Organisations may risk legal or funding penalties and be accused of harbouring illegal immigrants if they assist women who have not regularised their immigration status”.<sup>14</sup>

#### *Supply side: Organizational- and service delivery-level barriers*

I discuss the organizational- and service delivery-level barriers jointly here because they often overlap. The most prominent organizational-level supply side barrier that emerged from my review is the *lack of availability of a range of different services* for victims of human trafficking during the post-trafficking stage.<sup>165</sup> Access to the following services was mentioned as being absent or limited in at least one post-trafficking service context: availability of housing,<sup>34,168</sup> in particular of post-shelter follow-up housing (“this group is labour-intensive, you get no money for them, and you can’t get rid of them anymore”<sup>153</sup>); categorical shelter; categorical / specialized care; comprehensive service provision (multiple services) in-house; mental health services<sup>154</sup>; psychosocial support; extensive services (only basic care available); daytime activities; dental care; parenting help; language classes; translation services; physical health care services<sup>34,168</sup>; outreach services for those not residing in a shelter; family re-unification; opportunity for contacting family in origin country; long-term service provision (services only available short-term – which was noted to be “insufficient

to allow clients to work through their trauma”<sup>135</sup>); and specific services that may be needed for specific subpopulations of human trafficking, such as those who are illiterate, those with mild mental retardation, domestic victims of trafficking, undocumented migrants (or more broadly – those with different entitlements because of their residency status), those in ‘extreme situations’,<sup>153</sup> those below the age of 18 years, those with addictions, those with children, pregnant girls or women, male victims, transgender victims,<sup>168</sup> and those with severe psychiatric problems. In addition, services were sometimes noted not to be well-equipped to adapt to individual differences in needs, or changing needs over time.<sup>41</sup> The most extreme form of lack of access to services that was noted was that victims of trafficking were sometimes imprisoned after they had exited their trafficking situation.<sup>163</sup> In short, all necessary services (see Table 2.1) have been reported to be absent in one or more contexts.

Many reports noted that in-shelter services could not always be offered, or were limited, because of *inadequate funding and capacity for the provision of services by shelters*.<sup>34,131,146,153,154,167,172</sup> It was also noted that in comparison to other vulnerable groups, such as victims of domestic violence, service provision for victims of human trafficking was extremely undervalued by policymakers. One key consequence of this was that at shelters the majority of service providers’ time was spent on making basic administrative arrangements essential to service provision, leaving little time for psychosocial care.<sup>153</sup>

Three reports, all from the Netherlands, noted that *lengthy administrative procedures* hampered the efficient provision of care – and took up too much of care providers’ time.<sup>153–155</sup> Linked to this, service users indicated in several reports that the slow rate with which the legal case against the trafficker progressed, and the slow rate of progress on the application for residency visa, were unhelpful.<sup>14,152,169</sup>

*Translation services* were one of the services that were frequently reported to be absent or of poor quality.<sup>14,131,132,143,146,171</sup> Organizations were often also ill-equipped to provide *culturally sensitive care*, or to provide care providers with the opportunity to develop skills for providing culturally sensitive care (often due to a lack of resources).<sup>14,26,41,131,132,138,143,146,155,161,171</sup> Schofield writes, for example: “As our interview participants stressed, specifically dedicated accommodation and the provision of linguistically accessible and culturally sensitive psychological/mental health services for trafficked women are critically important, but there have been no reports to date of such developments by the Australian Government.”<sup>146</sup> As noted before, given the foreign nature of this service user population, it is noteworthy that so many reports describe translation issues and a lack of culturally sensitive care. This problem is linked to the issue of isolation (see earlier section

“Demand-side barriers”). Some reports highlight specifically the importance of cultural sensitivity in mental health care provision.<sup>146,162</sup>

*A lack of knowledge about human trafficking* among care providers was often noted as a concern, in particular with regard to providing culturally sensitive care.<sup>26,41,138,143</sup> Reports mentioned that training is needed to redress that knowledge deficit. Yet, a lack of training for service providers was often signalled as a barrier to good care provision.<sup>26,131,135,136,138,139,147,154,155,157,160,164,166,167,171,172</sup> Training was mentioned to be lacking in the following areas: training for medical care providers specifically; training on victim identification, victims’ needs and rights; and training on providing culturally sensitive and trauma-informed care.

A lack of knowledge was also noted to be a problem among service users, as noted earlier (see section “Demand-side barriers”). Some reports noted *inadequate information provision about legal procedures* related to the case against their trafficker and their migration case.<sup>41,162,169</sup> *Inadequate information provision about available social and health services* was noted in other reports.<sup>41,66,131,135,144,146,158</sup> In addition, *service users’ participation in decision-making* processes is often lacking.<sup>66,113</sup>

*Balancing victim autonomy and dependency* also emerged as a difficulty at service delivery- and organizational level, in particular with regards to ensuring victims’ safety. Many reports noted the issues that victims have with the rules that many of the shelters have put in place to ensure victims’ safety; Brunovskis and Surtees even devoted an entire article to this issue.<sup>147</sup> Difficulties for shelters in striking the right balance between providing safe environments for victims, while also leaving victims’ sense of autonomy intact, were frequently described. Multiple reports mentioned that there had been very few security incidents in shelters, with a few important exceptions where the *safety of victims was at stake*.<sup>51</sup> Besides the balance between autonomy and safety, one report warned against mandated mental health care treatment as an issue that jeopardizes victim autonomy.<sup>162</sup> Related to the difficulties involved with striking the right balance between victim autonomy and dependency is that service providers were reported to *conceptualize victims of trafficking as people in need of rescue and rehabilitation*, including the conception that entry into sex work is a consequence or sign of pathology.<sup>34,41,147</sup>

A conceptualization issue of a different order is that mainstream service providers are reported to *discriminate* against victims of trafficking in certain countries, potentially due to stigma about sex work.<sup>14</sup>



*Communication and collaboration among and between various social and health service providers and other stakeholders* (such as the police, city councils, lawyers, insurers) was also often mentioned as a barrier to good care provision.<sup>14,26,34,131,135,136,138,143,146,147,154,156,161,171</sup> Given the complex spectrum of comprehensive services that is needed for this population, it can be challenging to ensure that all service providers communicate and collaborate. One specific problem relating to collaboration is the lack of proper assistance for victims in origin countries upon return.<sup>151,179</sup>

Another organizational-level barrier is that organizations were noted to *lack policies, procedures and protocols for assisting victims of trafficking*.<sup>113,131,136,160</sup> This was true in particular for non-categorical care providers for whom care provision for victims of trafficking was only one part of their responsibilities. When policies, procedures and protocols did exist, some reports noted that different organizations adhered to different policies, procedures and protocols, caused by the dearth of evidence that exists on best practices for service provision for this population.<sup>33,34</sup> One aspect of deficient protocols deserves specific mentioning for this population, namely the concerns that exist around *confidentiality and privacy* in health service provision in many countries.<sup>14,66,143</sup>

A problem relating to all the other barriers to good care provision is that *quality assurance mechanisms* were sometimes noted to be lacking in shelters for victims of trafficking.<sup>66,147</sup>

#### *Broader societal barriers*

Broader societal barriers to good service provision are not frequently mentioned in reports. Surtees, however, notes the importance of the re-integration environment (family and community) and more systemic obstacles to re-integration, such as a lack of economic opportunities or education.<sup>113</sup> The latter is mirrored in other reports that note the lack of employment opportunities for victims as a barrier to good care provision. This is partly in relation to an ineligibility to enter employment because of residency status (see earlier section “Supply side: Policy and governance-level barriers”). Moreover, as one report notes, “beyond the right to work, in actually seeking employment former victims of trafficking face some of the same barriers regarding equivalence of qualifications, documentation of past work or professional experience, as many other immigrants.”<sup>151</sup>

#### **Conclusion and research gaps**

The main conclusion from this review is that there is a dearth of evidence on best practices and barriers in social and health service provision for victims of human trafficking.<sup>14,30,65,131,138,146</sup>

Some distinctions can be made in the availability of evidence for service provision for this population. Needs frameworks are generally well developed. Social and health services research beyond needs evaluations is almost exclusively limited to qualitative evaluations of service users’

and service providers' experiences with service provision, the majority of which is published as grey reports. A critical research gap is the absence of interventional studies that provide evidence for the effectiveness of specific interventions. Until such research is conducted, practitioners will be forced to make inferences about appropriate treatments for victims of human trafficking based on research among other vulnerable populations<sup>138,162,178</sup> and based on findings from service evaluations.

Moreover, the quality of the available evidence is concerning. The majority of available evidence is published as grey reports. Often studies, in particular the grey literature, do not distinguish between different contexts (such as destination and origin country services), between different subpopulations (such as minors and adult victims, victims of sex-trafficking and labour-trafficking, and foreign and domestic victims of trafficking), and between service providers' and service users' perceptions of service provision. Finally, studies' conclusions often remain general. For example, while many reports noted the importance of providing 'culturally appropriate care', few described what that should entail.

In addition to the lack of interventional research and the concerns about the quality of the available evidence, there are several other research gaps in the available social and health services literature that merit mentioning:

- Several reports have included the perspectives of trafficked people on their own process of recovery and on post-trafficking social and health service provision, however, few peer-reviewed articles have been published that have included service users' views.
- Some subgroups of victims of human trafficking have received less attention than others:
  - Men: Almost all studies focused on evaluating shelter and care for women.
  - Parents and their children: Few reports focused on what services should be provided for victims of trafficking who are parents (and their children).<sup>65,180</sup>
- The needs for, experiences with, and outcomes of long-term social and health service provision for victims of human trafficking is an important knowledge gap.<sup>130</sup>
- Since the outcomes of service evaluations are highly contextualized, it is important that existing programmes of social and health service provision for victims of trafficking are evaluated. However, while social and health services are provided to victims of human trafficking around the world, few programmes that do so have been rigorously evaluated.<sup>30</sup>

# Chapter 3

## Methods

This chapter consists of the following sections:

- Method of inquiry
- Theoretical perspective
- Methodological approach
- Data collection procedures
- Data analysis procedures
- Ethics approval

## Method of inquiry

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My aim in this PhD has been to improve understanding of how social and health services can provide appropriate shelter and care for victims of human trafficking. Given the paucity of research on social and health service provision for victims of human trafficking (see Chapter 2) I felt that an exploratory approach to address the aim and objectives of my research would be most appropriate. Moreover, because of the small size and heterogeneous nature of the study population in the Netherlands, a quantitative approach might have been problematic in terms of feasibility. For these reasons, I adopted a qualitative method of inquiry for the research.

## Theoretical perspective

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My approach to data collection and analysis has been in accordance with pragmatist perspectives on research.<sup>181–184</sup> Pragmatism "seeks to produce consequences in our lived realities based on the observations made in inquiry"<sup>182</sup> and because of this focus on achieving change, it has been suggested to be specifically suitable for more applied areas of research such as social and health services research<sup>184</sup>. Here I describe the most important assumptions that stem from this perspective.

My first assumption is that perceptions of events and processes vary by observer. Pragmatism notes that "we are the experiences we have"<sup>182</sup> and that we are all inherently biased in perceiving the world around us because of those experiences. When a social worker, a service user, another service

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\* The aim of health services research is to provide evidence to influence health services policy at all levels so as to improve the health of the public;<sup>412</sup> it seeks knowledge which will lead to improvements in the delivery of health care.<sup>413</sup>

user, and I, all observe a social worker shouting to one of the service users, we will all perceive that event differently; we will each interpret the event against a background of our own experiences. Another way of saying this is that knowledge is created through subjective interpretation and that, epistemologically, I assume a relativist approach in this research. Moreover, to use the same example, if we all see the same service provider shouting to the same service user one month later, we will perceive the event differently than before, because we interpret it against a new set of past experiences. Therefore, perceptions of events not only differ by individual, but also over time.

From the perspective that I have taken in this research follows another assumption: that as a result of my past experiences I have entered this research with preconceptions, values and interests. I agree with Charmaz that it is impossible to enter a research project with an empty head, but that one can still have an open mind.<sup>185</sup> Many of my preconceptions about service provision for this population were shaped by my review of the literature. My personal background has also shaped my preconceptions and defined my values and interests. I am from the Netherlands; I trained as a medical doctor and as a public health professional; I am interested in vulnerable groups as a research subject; and I have certain political views and opinions, in particular about the welfare state (see Chapter 2). All these things, and many others, have led me to where I am today and have influenced my data collection and analysis.

Potentially as a result of my medical and public health background, I have placed my research within the field of social and health services research, whereas it could have certainly also been situated in a number of other research fields, such as sociology or psychology. I went into my data collection phase with a focus on service users' social and health problems and the corresponding services that were needed to address those problems. This has changed a little bit: when I think about my research now I also see people's stories and my view of what 'health problems' are has changed and broadened (as will become clear in Chapter 5). However, my main focus in this thesis remains on social and health services research. All chapters focus on investigating post-trafficking shelter and care for victims of human trafficking in the Netherlands, be it the goals that that these services should have according to service users (Chapter 5), the challenges that were experienced by service providers in establishing these services (Chapters 6 and 7), or the manner in which the broader set of services available to victims of human trafficking is safeguarded by the Dutch government (Chapter 8).

Besides influencing the direction of the research, I will have also influenced the data itself. Schrödinger said that "the act of observing disturbs the observed", a statement that is, apparently, true for many areas of research.<sup>186</sup> One way in which I have affected the data is that I will have had

an effect on how participants presented themselves. In the words of Gheorghiu: “Interviewees’ accounts are constructed in the interaction between narrator and interviewer.”<sup>187</sup> A consideration is that people might have had agendas in their conversations with me. Service users may have established certain stories about themselves that they felt increased the likelihood of them attaining certain goals, such as residency status, either consciously or unconsciously. Service providers may have wanted to realize certain changes in social and health service provision. I explore these limitations in more detail in Chapters 5 and 6, respectively.

Finally, I should note that I never divulged that I was a medical doctor unless specifically asked. I felt it was important to be viewed as a researcher and not as a service provider, in particular by service users. Being viewed as a service provider might have resulted in unwanted associations between me and the other service providers in the shelter in the eyes of service users. It would also have likely changed my relationship with them, which now was one in which I aspired to learn from their experiences (rather than a relationship in which they may have called on me for medical advice).

## Methodological approach

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To develop new knowledge about service users’ and service providers’ experiences with post-trafficking social and health service provision (Objectives 1 and 2), I have mainly used grounded theory as my analytical approach, although I incorporated elements of other approaches where appropriate. I chose grounded theory as my main approach because it fitted well with the aim and objectives of my research. Creswell writes that the intent of a grounded theory study is “to generate or discover a theory”.<sup>188</sup> He also notes that “participants in the study would all have experienced the process, and the development of the theory might help explain practice or provide a framework for further research. A key idea is that this theory-development does not come ‘off the shelf,’ but rather is generated or ‘grounded’ in data from participants who have experienced the process.”<sup>188</sup> This approach fits well with the aim and objectives of my research for two reasons. First, although I had a well-defined direction for my research when I started my data collection (see Chapter 1), my research questions were not yet precisely defined at this time. I knew I wanted to write about how service users viewed their own recovery and how service providers experienced challenges in the service provision system, but I was unsure about what would emerge from these explorations. This lack of certainty about a study’s precise research questions suits a grounded theory approach, because it allows researchers to start with a topic that they wish to study, and for theories around that topic to be developed inductively from the data. Second, I specifically wanted my research to be grounded in data from participants, shedding light on service users’ views of their own recovery and

on service providers' experiences with challenges in the service provision system. Grounded theory, as explained by Creswell, is well-suited to do that.

In terms of data collection, my methodological approach meant that I took an open, relatively unstructured approach to data collection. This approach matches well with grounded theory because it is conducive to theorizing about themes that emerge, inductively, from the data. A specific element of grounded theory that I incorporated was that I performed preliminary analyses during data collection to see what themes were coming out of the data. As a result, the topic guides that I used in my interviews changed over the course of the research and were modified to accommodate themes emerging from the data (see later section "Data collection procedures").

In terms of data analysis, my methodological approach meant that I open-coded a number of interviews, identified a core phenomenon in my analysis (axial coding), and developed my analysis around that core phenomenon (selective coding). These steps are common in a grounded theory approach to data analysis, because they allow the researcher to 'fracture' or break up the data and develop theories inductively<sup>189</sup> (see later section "Data analysis procedures").

As I noted in the beginning of this section, I also incorporated elements of other methodological approaches where appropriate, in particular for the interviews with service users. My main reason was that some approaches apply techniques that have been described as particularly appropriate for use in data collection among vulnerable groups or for research on sensitive topics (see later section "Measures to safeguard the ethics of the research"). An example of such a technique was self-disclosure, advocated by feminist approaches.<sup>190</sup> This is a technique by which the researcher shares information about him- or herself to the research participant, just like the research participant shares information. It is aimed at reducing power differences between the interviewer and the research participant. I did not decide to adopt the feminist approach fully; I felt that overall a grounded theory approach was more suitable given my aim and objectives. However, I did decide to incorporate the self-disclosure technique, because I felt it would be conducive to rich and ethical data collection given the nature of the population. Similarly, in my analysis of my interviews with service users, my approach included elements of narrative research. I decided to include these elements because I found that service users' stories about their pasts, presents and futures were very important to the themes that were emerging from my data. Therefore, I wrote individual narratives about service users. This helped me to familiarize myself further with the data and think about how service users were experiencing their lives in the shelters. Later in this chapter I will outline in more detail how I incorporated elements of narrative research in my grounded theory approach to data analysis (see section "Writing Narratives").

Finally, I made use of different methodological approaches when one of my research questions called for this. To investigate how the broader set of social and health care services for victims of human trafficking is monitored in the Netherlands (Objective 3), I took an approach that compared how social and health care services for this group were monitored between the 28 municipal health services in the Netherlands. I made use of a documentary analysis to develop this comparison. To describe the challenges of interviewing victims of human trafficking in the COSM shelters (my Methodological objective), I took an approach that specifically collected data on these challenges during my interviews and employed a thematic analysis to analyse these challenges and the measures that I took to address them. The data collection and analysis methods for both these objectives are described in more detail below (see sections “Data collection procedures” and “Data analysis procedures”).

## Data collection procedures

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My data collection procedures were different for each chapter:

- Chapter 4 is a supplement to this chapter and explicates the ethical and methodological challenges I faced in interviewing victims of human trafficking. The data consist of interviews with COSM programme service users.
- Chapter 5 sheds light on service users’ views of their own recovery process and the data consist of interviews with COSM programme service users, a review of their case records and participant observation.
- Chapter 6 sheds light on the challenges that service providers encountered in delivering and developing service provision as part of the COSM programme. The data for this chapter consist of interviews with service providers from the COSM programme and participant observation.
- Chapter 7 provides a policy commentary on what is needed to enable adequate professional responses to victims of trafficking by social and health providers in the Netherlands. This chapter is based on interviews with service providers from the COSM programme, participant observation and an exploration of the literature around expertise development among social and health service providers.
- Chapter 8 provides insight into how the Dutch government monitors the broader set of social and health services for victims of human trafficking in the Netherlands. It is based on a documentary review of public health monitoring documents published by all Dutch municipal health services.



Thus, for Chapters 4 to 8 my data collection consisted of interviews, participant observation, case record review, literature review and documentary analysis. Below, I describe these approaches to data collection, why they were used, and how they were used to address the objectives of my research. Each individual chapter also contains a description of the methods that were used to develop that chapter.

## Interviews (Chapters 4, 5, 6 and 7)

I chose to conduct interviews to collect data for my research, because interviews are known to be more likely to elicit information about sensitive discussion topics than other methods of data collection, such as focus groups.<sup>191</sup> With service users, topics could be sensitive because they were receiving shelter and care because they were victims of human trafficking; with service providers, topics could be sensitive because we spoke about the services provided in the shelters, which is a topic employees of the shelter may have felt less comfortable to discuss in the presence of their boss or colleagues.

Participants were interviewed between 14 February and 12 December 2012.

### *Study population*

Interviews were conducted with 14 service users in all three shelters of the COSM programme and with 25 of the service providers.

The study population of service users consisted of adult, male and female victims of human trafficking of foreign nationality, who were trafficked for the purpose of sexual exploitation, received shelter and care in one of the three shelters that were part of the COSM programme, and had entered the shelter at least six weeks prior to the interview. I defined the study population as such prior to data collection for theoretical and practical reasons. The theoretical reason was that there are differences in social and health care needs between various subgroups of victims, such as victims of sexual exploitation and victims of labour exploitation<sup>41</sup> and adult victims and victims below the age of 18 years<sup>51</sup>. Focusing on one subgroup allowed me to draw more precise conclusions about the group's service experiences. The practical reason was that the study population in the three COSM shelters consisted largely of adult, foreign victims of human trafficking for the purpose of sexual exploitation (two shelters were for women; one for men). The reason why I interviewed service users only after they had stayed in the shelter for a minimum of six weeks is explained in the section "Measures to safeguard the ethics of the research" later in this chapter.

I defined the study population of service providers as all actors in the service provision system of the COSM programme, including those employed in the COSM shelters, the social or health services linked to the shelters (e.g. general practitioners, mental health care institutions), employees of non-governmental organizations (NGOs) engaged in work on human trafficking issues, or employees of the government engaged in work on human trafficking. I realize that not all these groups provided services directly. However, it is useful to be able to talk about this group as a whole. Because they were all involved, directly or indirectly, in the system that provided social and health services for victims through the COSM programme, I refer to all these actors as service providers throughout my thesis.

### *Interview format*

The primary method of data collection consisted of semi-structured interviews with service users and service providers. I chose to use semi-structured interviews because I felt these would allow participants to tell their stories, while focusing on themes around service provision that I wanted to explore.

Usually, I conducted interviews with one participant at a time. With service providers, I usually conducted one interview, while with service users I usually conducted two interviews at different dates to enable the development of rapport and trust and to allow for enough time for service users to tell their stories. I considered it important to take time to develop rapport and trust, given the vulnerable nature of the population under study and the potential sensitivity of interview topics.<sup>192-</sup>

<sup>194</sup> Linguistic barriers and the use of interpreters during the interviews complicated data collection and often necessitated longer interview times with service users (see later section “Measures to safeguard the ethics of the research”).

The reason I have written “usually”, is because these decisions were applied flexibly. One service provider was interviewed twice and some service providers were interviewed together. One service user had only one interview and with two others had three interviews. Guiding these decisions were participants’ preferences and the nature of the data derived from the interviews.

### *The sequence of interviews*

In preparing my data collection, I thought about what would be the most appropriate sequence. I considered the advantages and disadvantages of interviewing service providers first or interviewing service users first or interviewing both groups simultaneously. I concluded that it was undesirable to interview service users and service providers at the same time, because the two sets of interviews would produce different kinds of data. As I wanted to focus on one group at a time I decided to

interview five service providers first, then the service users, followed by the remainder of the service provider interviews.

This approach had several benefits. First, interviewing several service providers at the beginning of my data collection allowed me to gain an understanding of the type of care that was provided in each of the shelters, which was important baseline information for the service user interviews. It also allowed me to gain a better understanding of the nature of the service user population through the eyes of the service providers. Furthermore, it provided me with practical tips from service providers about interacting and communicating with service users. An additional advantage of my expressed interest in service providers' expertise in these matters was that this interest was generally appreciated. Perhaps it made them also feel better about me – an outsider – coming into the shelter and interviewing their service users. Second, for the most part, service users were interviewed before the service providers. This allowed me to build a sense of priority into my data collection for the voices of service users. This was an important consideration to me, because victims' voices are largely absent from the health services literature on post-trafficking care services<sup>129</sup> (see Chapter 2).

### **Recruitment**

Service users were selected in consultation with the shelter managers and/or other service providers. This was mainly for safety reasons. Given the potential vulnerability of the group, I felt that it was necessary to incorporate a check with service providers to see if they felt a service user was able to take part in an interview. Although a concern might be that service providers only chose service users with positive opinions about the shelter,<sup>193</sup> this was not my experience, as will become clear in Chapter 5. I made efforts to include a diverse sample of service users, in terms of sex, region of origin and the shelter where service users resided. After a service user was identified, I would explain to the service user the purpose of the interview and what the interviews would entail and ask her or him whether she or he wanted to participate. In doing so I was accompanied by a service provider who would introduce me.

Service providers were selected mostly by me and sometimes in deliberation with the shelter managers, who provided some insights about who might be willing to be interviewed and be able to provide a rich account of the services provided in the shelter. I made efforts to include a diverse sample of service providers, in terms of discipline and the shelters (and other locations) where service providers were employed, to be able to include a diverse range of views in my research.

### *Preparation*

I prepared for the interviews in several ways. My initial literature review provided helpful background knowledge. In addition, I always carried with me several syntheses of information, which I reviewed before an interview took place. These consisted of:

- a table outlining the different social and health services that, according to the literature, are needed for this population (see Table 2.1);
- descriptions of the three COSM shelters and the types of services they provided; and
- a 'lifhacking list', on which I summarized the most important things to remember with regards to data collection, constituting two or three pages with bullet points. I continually updated this list. Its purpose was to keep reminding myself of my own lessons and ensure there was a progressive line in applying these lessons throughout the research. A translation of my latest lifhacking list is appended to this thesis as Appendix 3.

### *Informed consent*

All service providers spoke Dutch. Therefore, for this group, information sheets and consent forms were prepared in Dutch (Appendix 4). Separate consent forms were prepared for those who were employed by the shelters and those who were not.

For service users, the preparation of consent forms was less straightforward. In preparation on the research, I mapped out all the countries where service users originated from in 2010. I found that service users came from almost 40 different countries. Their country of birth was most often in Africa (70%), followed by Europe (14%), Asia (8%), and South America (6%) [personal communication T. Van Driel 10 June 2011]. When I mapped the official spoken languages of these countries in concordance, I found that 46% of service users came from countries where English is the official language. All other official spoken languages each corresponded to less than 10% of service users. Participants from English language countries did not necessarily speak English (often people speak only local languages). The composition of the group of service users varied every year.<sup>28,37,195</sup>

In preparation for the research, I explored possibilities for acquiring consent from such a variable and varied population in terms of language. Although consent forms should preferably be written in the preferred language of the participant, it has been suggested that for research with people from multiple language groups where not all languages can be predetermined prior to recruitment, oral translation of consent forms is acceptable.<sup>196</sup> This method for obtaining consent has been used for example in studies with immigrants<sup>197</sup> and is supported by articles that argue that reading out the details of the consent form to participants is acceptable for cross-cultural research.<sup>198</sup>

I adhered to this approach. Information sheets and consent forms were prepared in Dutch and English (Appendix 4). If the participant could read Dutch or English, the information sheet and consent form were given to him/her to read. If the participant could not read Dutch or English, I read out the forms, or the forms were translated with the help of an interpreter into the participant's preferred language. During this procedure I regularly checked whether things were clear and provided further explanation if things were not clear.

Participants were then asked to sign the consent form. Previous research among victims of human trafficking has shown that, for various reasons, victims are not always willing to sign or mark consent forms even though they do consent to participating in the research.<sup>199</sup> When this occurred, verbal consent was acquired, which was tape-recorded.

The information sheets and consent forms were adapted after several interviews to improve their clarity. The main changes were that I simplified the text and added explanations of terms that turned out not to be self-explanatory (e.g. "quoting"). Renewed ethics approval was requested for these changes, which was received (see later section "Ethics approval").

### *Topic guides*

The main topics in the topic guides for the interviews with service users were: Non-threatening conversation / getting to know each other; acquiring informed consent and explanation of the research; socio-demographics; feelings about previous interview (only during second interview); daily lives / personal story; interaction with other service users; perceived needs for social and health services; descriptions of service provision; and experiences with service provision. I felt that both service users' stories as well as more specific questions about service experiences might be able to help me understand how service users viewed their own recovery process. However, over time, my focus shifted toward understanding service users' stories, because I felt these gave me a better insight into how service users viewed their own process of recovery. Therefore, my approach in these interviews became increasingly unstructured. In a course that I once attended on qualitative research methods, a lecturer described semi-structured interviews as interviews where the "agenda or questions is set, but conversation is co-produced" and in-depth-interviews as "topic-guided, but interviewee account-driven". I do not believe these two to be very sharply delineated, but the descriptions from that particular lecturer describe well how my thinking about my interviewing approach changed during data collection; there was a switch in focus for me from the interviews having a set agenda to the interviews being interviewee account-driven.

The main topics discussed in interviews with service providers were: Non-threatening conversation / getting to know each other; informed consent and explanation of the research; socio-demographics; personal history with regards to study population; perceived social and health service needs; differences between service users; descriptions of service provision; and experiences with service provision. I chose these topics because I felt they would be most likely to help me explore the challenges that were encountered in social and health care provision for victims of human trafficking as part of the COSM programme.

The full topic guides are provided in Appendix 5.

Finally, I should note that these topic guides were applied flexibly. They were always reviewed in advance of the interview and adjusted, if necessary, to accommodate the nature of the interview, the characteristics of the interviewee, and to get more depth on certain themes that emerged from my data analysis. In addition, topics were not discussed in a fixed order. I adopted a fluid approach, in which most topics came up in a conversation between me and the participant, preferably raised by the participant. During the interview, I kept track of which topics were discussed and initiated discussion of topics that had remained undiscussed. This flexible approach worked well for me, as I will discuss in more detail in Chapter 4.

### *Transcription*

All interviewees could choose to agree or not to being recorded during the interview. Service user interviews, when recorded (7 out of 14), were all transcribed by me. Service provider interviews, which were all recorded, were transcribed by an administrative assistant.

When interviews were not recorded, I took detailed notes by hand during the conversation. Interestingly, some researchers prefer coding from written notes rather than from transcribed interviews. Charmaz writes that there is something to say for both: "Coding full transcriptions can bring you to a deeper level of understanding. In contrast, coding from and across notes might give you a wider view."<sup>185</sup> In my own experience, it is possible to keep good track of the things that are discussed during the interview by making hand-written notes, but transcribed interviews do provide a more detailed account of the interview. Moreover, by having to focus on making notes during the interview, it is more difficult to keep the conversation going at the same time. When interviews were recorded, I also made notes, but these were memos relating to content or methods and needed not be near-complete descriptions of what was discussed. In the interviews where participants did not consent to being recorded, I tried to remedy the potential disadvantages. First, I reviewed, synthesized and digitalized my notes from the interview on the day itself. This helped me to re-

construct the interview from my notes and my memory. I felt this provided me with the most possible detail for later analysis. Second, when I felt what someone was saying was important, I stopped taking brief notes and took my time to write down a full quote. Third, to make that possible, as well as taking detailed notes of the interview in general, I frequently told participants that taking detailed notes was a challenging task to combine with interviewing and that I might need a brief pause here and there to write something down.

### **Memos**

I made memos both during and directly after each interview. I reviewed, synthesized and digitalized all memos on the same day as the interview to allow for expansion and enrichment of the memos from memory. I wrote memos about content-related thoughts, but also about methodological reflections. This resulted in day-by-day logs of content-related and methodological memos for each interview.

## **Participant observation (Chapters 5, 6 and 7)**

Besides conducting interviews, I conducted participant observation for my research. I spent several days in the shelters, joined in group activities and participated in training organized at the shelters. I also participated in staff meetings, meetings of actors in local networks of people working in service provision for victims of trafficking, expert working groups on human trafficking and periodic meetings that brought together the ministries involved with the COSM programme, the COSM shelter managers and CoMensha. In total I recorded observations during 56 days.

Before I commenced this research I considered whether to use the observational data as my primary or secondary data source. In the first option, I would analyse the data (i.e. I would code and assess it for themes); in the second, the observational data would help to guide data analysis of my primary data (the interviews) by providing ideas for that analysis, but would not be analysed itself. I decided to let this depend on the nature of the data that I collected during my research.

During my research I decided that the second option was the most appropriate. The main reason for this was that I wanted to provide insight into the perspectives of both service users and service providers on post-trafficking service provision and recovery (also see later section “To triangulate or not”) and that my observational data were laden with my own thoughts, ideas and considerations about events. I decided these were not suitable to be analysed in the same way as I analysed my interview data. They were very useful as a source of ideas for analytical directions, but I did not code or assess them for thematic categories.

The manner in which I collected observational data differed by occasion. In the shelters, as in other places when observing daily practises, I tried making notes frequently, using a pocket-size notebook. At the end of the day, I reviewed, synthesized and digitalized these notes and added additional thoughts from memory. In more formal meetings I often made notes directly on my laptop, although I let this depend on whether other meeting participants were also taking notes on laptops or tablets.

Finally, observational research comes with several challenges in terms of acquiring informed consent from research participants.<sup>200</sup> Here, I outline how I ensured that no-one participated in the observational part of the research without wanting to do so:

- Written consent was obtained from the shelters' managers (the 'gate keepers' <sup>200</sup>) for participating in day activities in the shelter upon their invitation and for taking field notes of my observations during any of my visits to the shelter.
- Information sheets available in Dutch and in English were provided to the shelters to be placed in the common room of each shelter.
- During my first visit to the shelters I explained during one of the communal moments when all service users were together who I was and what the purpose was of my research.
- Because of the challenges associated with language in conducting research among this multilingual service user population, I could not rely as much on general announcements about my identity and the purpose of the research as in other research contexts. Therefore, I made it a particular point to explain who I was and what the purpose of my research was when I collected my data during smaller meetings or in individual contacts. Keeping in mind the concept of 'process consent',<sup>199,201,202</sup> I attempted to repeat regularly this information, also particularly because new service users arrived regularly at the shelter.
- Finally, service providers were also participants in the proposed research. In order to ensure that the service providers were well informed of the proposed research, I introduced myself and my research during one of the staff meetings. In addition, just as for service users, when I encountered a staff member who I had not yet met individually, I explained who I was, what the purpose of my research was and what my data collection procedures were.

The English versions of the information sheets are appended in Appendix 4.

## Case record review (Chapter 5)

The COSM shelters keep detailed case records of all service users. These records varied in format per shelter but generally included background information about the service user and daily notes from



service providers on duty. As part of the informed consent procedure, service users could choose whether or not I could access their case records and make use of the data in the records (11 out of 14 consented).

My reasons for collecting these data were that I thought they would be able to provide additional information on service users' backgrounds and experiences in the shelter. Indeed, I found this to be a useful data source, for two reasons. First, sometimes, the information contained new data that had not been discussed in the interviews. Second, often things that were discussed in the interviews also emerged from the case records, providing a source of confirmation of the accounts that I had received during the interviews.

I assessed service users' case files after the interviews were conducted. I piloted reading the case record before the interview once, but felt this led me to have an undesirable base of pre-existing knowledge about the service user going into the interview. As I noted in the section "The sequence of interviews", I desired to give priority in this research to service users' own stories and therefore I decided to go into all other interviews without any prior knowledge about the service users. Moreover, there are ethical challenges associated with having knowledge about interview participants prior to the interview (see Chapter 4).

The data from service users' case records were analysed alongside the data from the interviews (i.e. coded and assessed for thematic categories). In doing so, I always kept in mind that these data were not derived from service users themselves, but were denoted by service providers.

## **Literature review (all chapters, especially Chapter 7)**

For all chapters, I conducted more focused explorations of the literature to base the Discussion sections of the chapters on, in addition to the reviews I conducted for Chapter 2. These consisted of small, focused explorations of one topic or several topics. For one chapter, Chapter 7, these data make up a larger part of the chapter than with the other chapters.

Chapter 7 presents a more in-depth analysis of the policy implications of one of the service provision challenges that followed from Chapter 6: expertise development. Expertise development was a theme that emerged in many of the interviews that I conducted for my research. Simultaneously, it was an area in which much development had taken place recently in the Netherlands for other victims of violence, such as victims of domestic violence and victims of child abuse. Therefore, I decided to develop a policy commentary to describe how expertise development for service

provision for victims of human trafficking could be improved, building from the lessons learned from these other populations. Chapter 7 presents that policy commentary.

## **Document collection from municipal health services (Chapter 8)**

For Chapter 8, I wanted to look beyond the COSM programme and explore the broader range of social and health care services for victims of human trafficking in the Netherlands, to assess whether these service were available and of sufficient quality to be able to meet the needs of trafficked persons throughout the Netherlands. Because it was not feasible as part of my doctoral research to analyse these broader services in detail on the basis of interviews with service users and providers, I chose to assess instead how these services were being safeguarded in the Netherlands by the Dutch government. I performed this analysis by comparing how all 28 Dutch municipal health services (GGDs) monitored the availability and quality of social and health services for victims of human trafficking. To do so, I collected publications from GGDs that described the GGDs' public health monitoring efforts and conducted a documentary analysis of these publications (see "Data analysis procedures"). I collected documents by identifying relevant documents on the GGDs' websites and by approaching each GGD to inquire for additional relevant documentation.

## **To triangulate or not?**

Mixing qualitative approaches to data collection can be complementary<sup>191</sup> and bring new insights.<sup>203</sup> However, it is important to be aware of the different roles the various methods play in data collection and to explicate how the data collected from the different sources were combined to develop results.

In preparation for my research, I considered whether I should triangulate my data or not. I decided to let this depend on the data that I collected. Over the course of my research, it became increasingly clear to me that I wanted to present several perspectives of the social and health services for victims of human trafficking in the Netherlands, in line also with my epistemological perspective in this research (see earlier section "Theoretical perspective"). While I could have chosen to triangulate these data, trying, for example, to assess areas of differing views between service users and providers, I opted for treating each data source as a separate entity.

In hindsight I feel this choice has been right because the data that emerged from each source were of a different nature. To take the service user and service provider interviews as an example, because I was quite inductive in my approach, the topics that were discussed were determined for a

large part by participants in the interviews: service users spoke about their histories, their lives, their daily experiences and their futures, while service providers spoke about the needs for service provision and the challenges encountered in providing services. To triangulate these two data sources would have meant that I would have had to take a much more deductive approach to data collection, trying to make participants from both groups speak about the same topics. This might have led to interesting chapters as well. However, I am happy that I did not opt for this approach; my inductive approach has led to different, yet complementary, perspectives on post-trafficking social and health service provision in the Netherlands that are grounded in the data from participants who experienced those services.

## Measures to safeguard the ethics of the research

In preparing my data collection, I developed several measures to safeguard the ethics of my research. Besides exploring the best ways to acquire informed consent from my study population (see earlier sections and Chapter 4), I also took measures to protect participants' anonymity and confidentiality:

- Notes that I made from case records, observations, and interviews never contained names or birth dates. Names were replaced with anonymous IDs.
- I only reviewed case records at the shelter.
- I deleted audiotapes and I stored the interview recordings on a password protected LSHTM server.
- I stored NVIVO files and MS Word files that contained transcribed interviews on a password protected LSHTM server. I kept consent forms and ID-sheets at the shelters till the end of data collection after which I transferred them to LSHTM for safe storage.
- Taped conversations and transcribed texts were only accessible to me. Only service provider interviews were given to an administrative assistant for transcription. I asked the assistant to sign a confidentiality statement.
- I anonymized quotes from individuals during write-up. Any information that could lead to the identification of an individual was omitted from quotes.
- I only used interpreters from a trusted and often-used translation agency, the *Tolk- en Vertaalcentrum Nederland (TVcN)*.

Furthermore, because of service users' recent traumatic experiences and because of their position as a migrant with uncertain residency status (see Appendix 1), in preparing my research I reviewed methodological considerations on conducting research among vulnerable groups and on the risks of

discussing sensitive topics in qualitative interviews. On the basis of this review I implemented several additional measures to safeguard the ethics of my research: <sup>17</sup>

- I conducted two interviews with each service user, a recommended strategy for research on sensitive topics because it allows for increased building of rapport and trust.<sup>(199, p118)</sup><sup>204</sup>
- I stressed, at multiple points, the right to withdraw, and that the interview could be stopped or continued next time.<sup>202</sup>
- For research involving multiple populations and discussing sensitive topics, it is important to consider the sequence of interviews and decide which population should be interviewed first <sup>205</sup> (see earlier section “The sequence of interviews”).
- When discussing sensitive topics during interviews, it is recommended to start with benign questions that are perceived as non-threatening,<sup>205</sup> and so I always attempted to make some casual conversation before the interview started.
- Inclusion of service users for interviews was limited to those who had been admitted to the shelter at least six weeks ago, because victims of trafficking who have just exited a trafficking situation might still be afraid and be trying to adjust to their new life circumstances.<sup>193</sup>
- Interviews with service users took place in the shelters where help, if needed, was close by.<sup>202,205,206</sup>
- Elements of the feminist interviewing approach were applied that were specifically recommended for research among vulnerable groups to reduce power differences (see earlier section “Methodological approach”).<sup>190</sup>
- It has been suggested by research participants that for research among vulnerable groups interviewer training and topic-specific knowledge are most important for interviewers.<sup>207</sup> Therefore, before data collection commenced, I attended several courses of relevance to communication with the study population including a training course on communication with victims of human trafficking and cross-cultural communication skills, as well as a summer course on Mental Health Policy and Services, and a Master class in Mental Health, Race, and Ethnicity.
- Several guidelines for research among victims of human trafficking and other vulnerable groups and for research on sensitive topics recommend to "always work closely with organisations that are knowledgeable about trafficking and can provide assistance".<sup>199,205,206</sup> Therefore, I worked together with service providers in participant selection and in developing the methods for data collection (e.g. managers of the shelters were invited to review these protective measures).

- Given the vulnerable nature of the population, there was a risk of some aspects of the research being less well understood. Moreover, in case of misunderstandings, the consequences might be graver than with other populations. Hence, I made special efforts to simply and clearly explain the research and to ensure at several points during data collection that things were well-understood.
- By making the ethical and methodological considerations around conducting a qualitative health services study among this population a primary outcome of the research, I put a strong emphasis on continuously evaluating the appropriateness of my data collection and analysis techniques.
- It is common for patients or service users in general to object to forms of group identification. For victims of a crime more particularly, stressing their victim status can have adverse effects.<sup>199</sup> Therefore, I never referred to service users as victims.
- Given the potentially sensitive nature of the interviews, if the interviewee was a mother or father, I preferably did not conduct interviews with the children present.
- I prepared standard responses for potentially difficult interviewing situations (e.g. service users crying, getting angry or falling silent).
- Trafficking experiences and participants' histories were only discussed if service users indicated clearly that they wished to do so.
- Before this research was planned, I discussed with the shelter managers whether they felt having a male interviewer in a shelter for female victims of sexual violence posed risks. They felt it did not. Still, I remained aware of the fact that I was a male researcher in a shelter for female victims of trauma and was watchful for signs of discomfort.

Finally, I implemented the following measures for the service user interviews because of the multilingual and multicultural nature of the population:

- Interpreters were only hired from the Tolken- en Vertaalcentrum Nederland (TVcN), an organisation recognized as the official organization for translation services in the health and social services sector.
- I was constantly aware of the possibility of misunderstandings. This point is not very concrete, but I think it is important, nonetheless. During the interviews in which interpreters were used or when participants spoke in a language that was not their own, I made an effort to be extra aware of the possibility of misunderstanding (see also Chapter 4).
- I kept formulations as simple as possible to prevent misunderstandings.

- Two interviews were conducted with service users because in interviews where an interpreter was needed, communication was slower (consent, for example, took on average 45 minutes when an interpreter was used compared to usually less than 15 minutes without interpreter).
- I constantly reviewed and adapted my methods for data collection and analysis. This resulted, for example, in simplification of the language in the consent forms. I also adapted my interviewing techniques for the interviews with interpreters (I found that probing techniques to get more depth, such as ‘uhuh-ing’ or repeating someone’s words worked less well, for example, when an interpreter was used). This also resulted in my development of the aforementioned ‘lifehacking list’ (Appendix 3).
- Interviews were analysed in Dutch or in English, depending on the language in which the interview was undertaken, to optimize data integrity.
- I conducted briefings and debriefings with the interpreters before and sometimes after the interviews.

In Chapter 4, I will expand further on the ethical and methodological challenges of interviewing victims of human trafficking and discuss them in more detail.

## Data analysis procedures

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My data analysis procedures were different for each chapter:

- For Chapter 4 I used a thematic analysis to analyse the ethical and methodological challenges encountered while interviewing service users.
- For Chapters 5 and 6 I used a grounded theory approach to data analysis.
- For Chapter 5 I also incorporated elements of narrative analysis.
- For Chapter 7 I used the analyses conducted for Chapter 6 and added an exploration of the literature.
- For Chapter 8 I used a documentary analysis.

## Thematic analysis for analysing ethical and methodological challenges of interviewing service users (Chapter 4)

For Chapter 4 I used a thematic analysis to analyse the ethical and methodological challenges that I encountered while interviewing service users. I used a thematic analysis, rather than a grounded

theory approach to analysis, because the research question addressed here was well-defined in advance. Rather than aiming to develop theories around a topic, for this chapter I aimed to develop an overview of the ethical and methodological challenges that I encountered while interviewing service users and of what I did to address them. This narrowly defined research question lent itself well for a thematic analysis.

Data analysis in thematic analysis consists of several stages: <sup>208</sup>

1. Familiarization
2. Initial coding
3. Developing a coding scheme
4. Coding the data

### ***Familiarization***

Familiarization with the data was conducted through:

- Transcribing the interviews.
- Reviewing, synthesizing and digitalizing memos made during the interviews on *methodological* considerations. As noted before (see earlier section “Memos”), I made memos about content-related thoughts, but also about methodological reflections. The latter were used for this analysis.

During this stage, I denoted and kept track of additional analytical thoughts, ideas, and other considerations as memos.

### ***Coding***

My next step was to start coding the interviews with service users for ethical and methodological challenges that I had encountered. I coded both transcribed interview data and methodological memos and developed codes both for challenges that I encountered as well as measures that I took to address those challenges in my research.

I found that the various steps of thematic analysis were not sharply delineated for me. Over time, my initial codes developed more and more into a ‘coding scheme’, i.e. an overview of codes that are sorted into categories and subcategories. In the final stage of my data analysis, the coding scheme did not change any longer, but interviews did continue to add content and detail to each of the codes. I conducted all coding on a computer, for which I used NVIVO versions 9 and 10.

## Grounded theory approach to data analysis for analysing service users' (Chapter 5) and service providers' (Chapter 6) experiences with post-trafficking recovery and service provision

For Chapters 5 and 6 I used a grounded theory approach to data analysis. Data analysis in grounded theory consists of several stages: <sup>188,189</sup>

1. Familiarization
2. Open coding
3. Axial coding
4. Selective coding

### *Familiarization*

Familiarization with the data was conducted through:

- Reviewing, synthesizing and digitalizing memos made during the interviews on *content* considerations.
- Transcribing the interviews (for the service user interviews).
- Listening to and checking interviews transcribed by the administrative assistant (for the service provider interviews).

During this stage, I denoted and kept track of additional analytical thoughts, ideas, and other considerations as memos.

### *Coding, theorizing and writing*

I started by open coding in an attempt to fracture the data <sup>189</sup> and open coded six interviews with service users and four with service providers. At this stage, I did not limit my ideas and analytical thoughts or focus them in one direction, so this process resulted in a wide range of different codes. I used 'in vivo' codes whenever possible, which was quite often, i.e. codes that were named after things said by participants in my interviews. I also started to think about links between the codes at this stage (for example, for various codes I wondered what had caused them, what consequences they had, or what smaller codes they consisted of). I conducted my open coding on printed transcripts (i.e. not on a computer), because I found writing (physically, with a pen) to be more conducive to developing ideas about the data than typing on a computer (for example, I found that writing allowed me to quickly identify links and structures using arrows). I provide an example of my open coding process in Figure 3.1. This shows a segment of transcript from an interview with a



service user and contains: memos that I made as I familiarized myself with the interview; new memos; underlined sections that I thought were particularly salient to my analysis; codes in the margins (some new and some already established in previously coded interviews); and links between those codes. Toward the end of the open coding stage I started consolidating my open codes into more definitive codes and categories of codes. This task I performed on a computer because it helped me to sort codes and create overarching categories. I used NVIVO versions 9 and 10 to do this.

Creswell describes the next stage of coding in grounded theory analysis as follows: “The researcher begins with open coding, coding the data for its major categories of information. From this coding, axial coding emerges in which the researcher identifies one open coding category to focus on (called the ‘core’ phenomenon), and then goes back to the data and creates categories around this core phenomenon.”<sup>188</sup> Axial coding is also the stage in which the researcher particularly looks for relationships or links between the various codes. I had already started this process during my open coding and progressed on it during this stage. I applied the codes that I had developed from my open coding on the remainder of the interviews and started my writing process, which I found to be quite helpful in gaining further clarity on links between codes. This helped me to advance my thoughts on what the core phenomenon of my analysis should be. For the interviews with service users, the core phenomenon became service users’ stunted road towards goal pursuit (Chapter 5); for the interviews with service providers it became the development and evolution of service provision as part of the newly established COSM programme (Chapter 6). I chose these core phenomena for three reasons. First, the phenomena emerged prominently from the data. Second, I found that these core phenomena were able to link many of the other codes together. Finally, on the basis of my literature review (Chapter 2), I felt that writing about these phenomena would result in a contribution to the literature on service provision for victims of human trafficking.

My next stage in the coding process was to develop further the links between the various codes and my core phenomena. This step is called selective coding in grounded theory analysis. The goal of this, according to Creswell, is to “interrelate the categories in the model or assemble a story that describes the interrelationship of categories in the model.”<sup>188</sup> For me, this stage consisted of asking myself a set of questions about the core phenomenon. For Chapter 5, for example, I asked myself: What were the goals that service users pursued? What was it that drove them to pursue these goals? What was it that held them back? What were the consequences of being stunted in their goal pursuit? Answering these questions allowed me to “assemble a story” around my core phenomenon.

me maybe into trouble, something like. So I know he must be using artificial way to fight me, so by reading this Bible, for sure I know he will not be able (...). If you get the words, that is what this psalm 35 is saying, it's a prair against all those things

4; it's like protection from evil, (...) call upon you

1; yeah! And anyone that is there and that will... I'm sure God will rescue me from that (...) every net that that person hid for me, the net will entangle that somebody of course, that what exactly the verse is saying. Yeah.

12904; yeah

I; I am sure the Lord is contending for me here. He's right there for me, since I started reading these verses Rik, it is helping me a lot, now I am not dreaming any one of those dreams again. But before Rik... every... as soon as I asleep, even I get 10minutes sleep, I will dream that dream again. I said (damn), I will be in fearfully (...) (snake). So they chasing me, I dream somebody with knife to go and chasing me, you know? Why? Being chased

Memo: hier weer – dit pleit ook voor andersoortige zorg dan wij gewend zijn. In NL stuur je iemand niet snel naar de kerk voor zorg. Bij hem lijkt het echter enorm te helpen.

13004; and why do you think? Why do you think?

I; well because of my past, I knew that for sure. Every day I think about my past every day, every day, just as I said earlier, I wanted, I do wanted to forget but it can't go easily Rik. Every day, I think about, EVERY DAY, every day thinking about my mom, my dad, that if they had been passed I should not have been in this situation. You know? It was not easy Rik, it was not easy. I think a lot about that, look at my situation, what I'm going through, I'm here now, I don't even know what my plans, I don't, I don't know what... you know? My future now, I don't know about my future.

Memo: uncertainty about the future – where am I going?

Memo2: "Every day I think about my past, every day, every day, just as I said earlier, I 1310 wanted, I do wanted to forget but it can't go easily Rik."

I; Because for now, I have not been having access to so many things. So I am looking at my future as being (bleak). You know? So. Where am I going? You know? And at my age now, the age I'm now, either you make it or you break it, something like that. Say, you have to decide now. With my age, maybe you got a family, you need to try, (wife)... At the age you cannot decide what you (...) when do you decide. So that all keep boiling inside me, (...) so. It's like that. Pfew (sighs)

Long silence

*Handwritten notes:*

- Being chased
- Must violate sense of justice via hatred (I did a thing to wrong)
- protection
- Call for rescue
- Being protected from future
- "nets" (net = 1. exploitation + 2. bad experiences with uncle)
- sense of family isolated.
- The Lord is the pillar, the main thing he holds on to, to stabilize.
- Thinking about the past
- Wanting to forget but not being able to.
- Things could have been so different by turning point.
- Not knowing future
- Remarkable that he says this in 1 paragraph with not being able to forget the past. The 2 seem linked?
- Black future
- Uncertainty about future
- Making it or breaking it.

Figure 3.1. Section of transcript with open coding

## Writing narratives (Chapter 5)

As part of my analysis of service users' interviews, I also incorporated elements of narrative analysis, by writing narratives about service users.<sup>209,210</sup> I decided to write these because in the interviews service users often provided me with a story of their lives, telling me about where they had been, their daily lives in the shelters and where they envisioned themselves to be in the future (Chapter 5 provides more detail on these narratives). Writing these narratives was an additional way of familiarizing myself with the data; they helped me to think further about what was going on in the dataset and to understand service users' views of their own recovery.

To write these narratives, I first coded each interview (see earlier section "Coding, theorizing and writing") and subsequently wrote a summary about each service user, including a brief description of

the their key baseline characteristics, background, my impressions of the participant during the interview, and what I perceived to be key phrases, sections and themes from the interview. Following this, I wrote narratives about the individual service users that reflected my perceptions of the salient themes that emerged from the interviews. By structuring the narratives in a thematic manner, rather than as a literal account of what service users had told me, I could include linked themes, such as causes and consequences, in a paragraph that discussed a certain theme, which allowed me to advance my understanding of what certain themes meant to service users. After going through these steps, the narratives did not fulfil any further purpose in my analysis. However, in writing them they had served their purpose: to help me understand better how service users' viewed their lives.

## **Analysis of interviews, observational data and literature**

### **(Chapter 7)**

Chapter 7 is a short chapter and provides a policy commentary on what is needed to enable adequate professional responses by social and health service providers to victims of human trafficking. The chapter is based on my analysis of the interviews and observational data around this theme for Chapter 6, on an exploration of the literature on expertise development for social and health service providers on the issue of human trafficking (and for service providers for related populations), and on the findings of an international study that investigated a training programme on the topic of human trafficking for health providers.<sup>211</sup>

### **Documentary analysis (Chapter 8)**

For Chapter 8, as explained above, I collected publications from the 28 municipal health services in the Netherlands that described their public health monitoring efforts, in order to compare the manner in which social and health services for victims of human trafficking were being monitored by these services. For this comparison, first, I assessed whether information was presented about the social and health services available to victims of human trafficking in these documents. Second, I assessed if from the information that was provided suggestions could be made for improvement of the existing services. More detail on these methods is provided in Chapter 8.

## Ethics approval

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This research project was approved by the London School of Hygiene and Tropical Medicine Ethics Committee and by the Medisch Ethische Toetsingscommissie Slotervaartziekenhuis en Reade in the Netherlands.

Copies of the approval letters are provided in Appendix 6.

## **Chapter 4**

# **Interviewing victims of human trafficking: explicating my dilemmas and practices**

## Summary

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### Introduction

Victims of human trafficking are a challenging population to interview as part of research studies, because of the potential of traumatic experiences in their pasts, their status as a migrant, the multicultural and multilingual nature of the group, the potential for discussion of sensitive issues, and a high degree of variability between participants. This chapter aims to explicate the challenges that I encountered in conducting my interviews, the measures that I took to address these challenges and the dilemmas that I faced in doing so.

### Methods

Interviews were conducted with fourteen service users of the COSM programme, a shelter programme for victims of human trafficking in the Netherlands. Interviewed service users were all foreign, adult victims of human trafficking to the Netherlands, trafficked for the purpose of sexual exploitation. I undertook a thematic analysis of the challenges that I encountered in conducting these interviews.

### Results

I encountered challenges in preparing the research, in collecting the data (with regards to the researcher-participant relationship, the interview process, and the interview environment and context), and in analysing and reporting the data. In addressing these challenges, flexibility was my leitmotif, enabled by reflexivity. Many of the challenges that I encountered were common to qualitative research in general, but were challenges of increased importance because this study population was vulnerable, because sensitive topics were discussed and/or because the population was multicultural and multilingual. Other challenges were unique to this population (and other vulnerable populations with overlapping characteristics).

### Discussion

Interviewing victims of human trafficking is about striking the right balance between a range of methodological measures that can be taken to protect research subjects and to elicit rich data. That balance, applying research methods that are ethical and result in rich data, can be struck by identifying and explicating challenges specific to the research context and by adhering to the combined and related practices of reflexivity and flexibility to address those challenges.

## Introduction

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Victims of human trafficking are a challenging population to interview as part of research studies, owing to the potential of traumatic experiences in their pasts, their status as a migrant, the multicultural and multilingual nature of the group as a whole, the potential for discussion of sensitive issues, and a high degree of variability between participants (see Chapter 3 and Appendix 1). Each of these challenges on their own complicates interview-based research in a population. It is of importance that such challenges are explicated and solutions discussed.

Several reports and articles have described challenges associated with conducting research among victims of human trafficking, including: the challenges of identifying victims of trafficking and making estimates of their numbers;<sup>193,212–214</sup> overviews of different approaches to this research (e.g. observation or longitudinal studies) and their challenges;<sup>193</sup> assessments of challenges associated with using large databases of information on trafficked persons collected by service providers;<sup>215</sup> and explorations of ethical issues associated with conducting research among victims of human trafficking.<sup>199,214</sup> Only rarely do these documents describe challenges specifically associated with interviewing (or conducting other primary research) with this population.<sup>216</sup> When they do they tend to focus on broad ethical standards or general methodological issues, such as ensuring anonymity and confidentiality, doing no harm, and acquiring consent.<sup>174,193,214</sup>

Therefore, in this chapter I describe the challenges that I encountered during a study in three shelters for foreign, adult victims of human trafficking in the Netherlands, and the measures that I took to address these challenges. As part of the preparatory work for this research I prepared an extensive list of measures to safeguard the ethics of my research (see Chapter 3). These measures provided the background to the challenges that I faced and, hence, to this chapter. Therefore, the chapter will not focus on broad ethical standards or general methodological issues, which were used to develop the list of measures in Chapter 3, but will rather describe the practical challenges that I encountered while doing my research despite having prepared this list, my dilemmas in addressing those challenges, and the solutions that I chose. For example, while general considerations around anonymity and confidentiality are not discussed, a specific dilemma in relation to anonymity and confidentiality (see section “Did he/she want me to know about this?”) is part of this chapter.

## **Methods**

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### **Data collection**

From 28 February 2012 to 18 October 2012, I conducted 29 interviews with 14 service users in three shelters for foreign, adult victims of human trafficking in the Netherlands. The primary aim of these interviews was to explore how service users conceptualized and experienced their process of recovery while in the COSM programme, a Dutch post-trafficking shelter programme. A specific secondary aim of the research was to assess and describe the challenges associated with interviewing this group. Therefore, I made specific ‘methodological memos’ of the challenges I encountered and the measures that I took to address them. After every interview, I denoted my impressions of the research methodology as applied during the interview and reviewed, synthesized and digitalized my methodological memos.

### **Analysis**

I conducted a thematic analysis of the challenges that I faced while interviewing victims of trafficking and of the measures that I took to address those challenges. The data for my analysis consisted of the interview transcripts and my methodological memos. I developed this method of analysis myself – treating my applied methods as a topic of analysis – but there are other investigators that have applied similar analytical techniques.<sup>217</sup>

## **Results**

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In this section I describe these challenges and measures for each of the stages of my research process: preparation, data collection and data analysis & reporting, discussing my own experiences and dilemmas and drawing in relevant literature. Therefore, this section departs from the traditional Results - Discussion format and discusses most relevant literature in the Results section. The general Discussion will be brief and be limited to presenting my conclusions.

Before I move to discussing them, I will briefly consider why I have taken any measures to address these challenges to begin with.



## The goals of good methods

There are two goals of generating good methods for any qualitative research study: 1) To safeguard the ethics of the research; and 2) to elicit rich data from the study.<sup>189,208</sup> As will become clear in the sections below, I took several measures because they safeguarded the ethics of the research, others because they helped me to elicit rich data. Most measures did both.

The ethics of a research study can be defined as aiming to “promote and ensure respect for all human subjects and protect their health and rights”.<sup>218</sup> Karnieli-Miller et al have defined five conditions that commit qualitative researchers to ethical guidelines: voluntary participation, which among others requires participants to be well-informed; adequate representation of the participant’s story; anonymity of participants’ data; beneficence for the participant; and non-maleficence for the participant.<sup>219</sup> Acquiring rich data in itself might be said to be an ethical responsibility towards research participants.<sup>174</sup> However, in considering the challenges associated with conducting qualitative research, getting rich data is a distinctly different goal from safeguarding the ethics of a research study, because sometimes these two goals conflict with each other (as the sections below will show). When that is the case, it should be remembered, as noted by the Declaration of Helsinki, that “while the primary purpose of medical research is to generate new knowledge, this goal can never take precedence over the rights and interests of individual research subjects”.<sup>218</sup>

## Challenges in preparing the research

### *Reviews of research methods among vulnerable populations, on sensitive topics, and with multicultural and multilingual populations*

The first challenge that I was faced with in interviewing victims of human trafficking was how to prepare for my data collection and analysis. My study population was complex and there were several characteristics of the population that in their own right necessitated a range of measures to address the challenges associated with them. These were:

1. This was a vulnerable population. The Declaration of Helsinki defines vulnerable populations in the context of health research as: “Some groups and individuals are particularly vulnerable and may have an increased likelihood of being wronged or of incurring additional harm. All vulnerable groups and individuals should receive specifically considered protection.”<sup>218</sup> Victims of human trafficking fit this definition because they have been the victim of a crime, with the potential for traumatization, and because many have the status of

a migrant, potentially seeking to acquire residency status, which places this group in a position of uncertainty, dependency and without a secure base (as Chapter 5 will show).

2. In my interviews with this population sensitive topics were likely to come up, because of their recent exploitation (although this point might seem linked to or even part of the first point, there is a distinct literature on how to deal with sensitive topics in qualitative health research, which is why I mention it separately here).
3. Victims of human trafficking are a multicultural and multilingual population.

To prepare for interviewing this population I consulted many articles, reports and guidelines that provide guidance on conducting research among populations that have one or more of these characteristics. Two sub-bodies of literature were particularly useful.

First, articles that provided advice for conducting research among victims of violence,<sup>207,220</sup> and specifically victims of human trafficking,<sup>174,193,214</sup> I found useful. But also more general papers providing advice on methods that might be used for qualitative research among vulnerable populations more broadly described useful considerations for the research I was planning.

Second, there is a substantial literature on how to conduct cross-cultural and cross-lingual research.<sup>196,221–223</sup> For research among victims of human trafficking, the literature that discusses research among people from multiple cultural and linguistic backgrounds is particularly useful. Fryer writes, for example: “Including people from multiple language groups in a qualitative study, when the languages spoken are not determined before starting the research, is a unique situation in qualitative cross-language studies and clearly different from the traditional anthropological ethnography of one cultural group with established discrete languages. It restricts a researcher’s ability to immerse in a single culture and its language(s) or to have sole reliance on the language skills of research team members.”<sup>196</sup> With respect to working with a multilingual population an excellent review was written by Squires on the possible challenges of cross-language research and possible solutions for addressing these challenges.<sup>221</sup>

My reviews of these various bodies of literature resulted in a range of measures that I took to safeguard the ethics of my research (see Chapter 3).

### ***Training courses***

Besides reviewing papers, reports and guidelines, several other things can be done to be well-prepared for interviewing this population. In research among vulnerable groups, research participants have suggested that interviewer training and topic-specific knowledge are the most important for interviewers.<sup>207</sup> Therefore, before data collection commenced, I attended several

courses about communication with my study population including a training course on communication with victims of human trafficking and cross-cultural communication skills, a summer course on Mental Health Policy and Services, and a Master class in Mental Health, Race, and Ethnicity.

### ***Involving service providers***

Another way to acquire ideas for how to address the challenges of working with victims of trafficking is by involving service providers who have developed experience with communicating with the population in the preparation of the research. I found that they had useful advice to provide on how to conduct my interviews, which they gave to me as part of the interviews I conducted with them. I also asked service providers to review the ethical measures in my research protocol and to review Table 2.1, the framework for provided services in the COSM shelters (see Chapter 2). Involving care providers had an additional advantage in that it fostered involvement and a degree of ownership in my research. This is advantageous for social or health services research studies because it increases the likelihood of implementation of conclusions following from the research.

## **Challenges in data collection**

In the section below, I discuss the challenges that I faced in conducting my interviews, which I have broadly divided into three groups: challenges associated with the interview process; with the researcher-participant relationship; and with the research environment and context.

### ***The interview process***

#### ***Being extra clear***

Research among this group is associated with a higher potential for communication difficulties and misunderstandings, because of the multicultural and multilingual nature of the population of victims of human trafficking.<sup>224</sup> The vulnerable nature of this population may lead to further increased potential for misunderstandings (service users might wonder, for example, if participation could increase their chances of residency status). As a result, service users may consent to something they did not wish to consent to, or indicate that they have understood something, when in fact they have not. Other more specific problems may also arise (service providers noted, for example, that there is a 'fear of forms' among this group, because victims of human trafficking are often reluctant to put down their name). Finally, the vulnerable nature of the population increases the chance of detrimental consequences in the case of misunderstandings. Therefore, it is important that extra attention is paid to minimizing misunderstandings and communication problems.

To do this, I found that it was crucial to be extra clear and to make an extra effort to ensure that information, for example as part the consent form, was understood by service users. Even ‘regular’ interview participants often do not fully understand consent procedures, but understanding such procedures when there are cultural differences and language barriers can pose particular difficulties.<sup>224</sup> For example, I realized in conducting my first interviews that many service users did not understand what ‘quoting’ meant and that some had trouble with the concept of ‘research’ or a ‘researcher’.

‘Being extra clear’ is something that I operationalized as part of the consent procedure of this study by taking a lot of time to explain what the purpose of the research was, what participation would entail, what would happen with the information that participants provided, and what choices participants had. On average, the consent procedure took 45 minutes when interpreters were involved. Just asking a participant to read and sign the consent form did not suffice with the majority of participants. It was often necessary for me to add explanations (e.g. about what a researcher is and how that is different from the service providers), to check whether things were understood by asking people to explain something in their own words (when doing this, there is a risk of one’s questions sounding like an exam, which I tried to prevent), to re-explain certain things on the consent form in my own words, and to really take time for the consent procedure. I always started with explaining why a form was necessary (to address the ‘fear of forms’). Moreover, I acquired ethics approval for adapting the consent forms after a few interviews to accommodate some of the problems that I encountered (e.g. after the change they explained in layman’s terms what ‘quoting’ meant).

In my operationalization of ‘being extra clear’, my approach varied per service user. I adhered to a flexible approach in this regard for several reasons. First, the multilingual setting of the population meant that the consent form sometimes had to be read out via an interpreter, while other times service users could read it themselves. Moreover, there were stark individual differences between participants in their ability to understand the consent form immediately and in showing that they understood. For example, some could read, others could not; and some asked many questions and indicated they found certain things (such as confidentiality) important, whereas other just listened, in which case I had to ask more questions to confirm they had understood the information.

As much as possible, I let participants decide how they wanted to discuss the consent form: whether they wanted to read it themselves, preferred that I read it out to them, or wanted to read it together (in a mix of me reading out the consent form and them reading along with it). The latter, in some cases, worked particularly well, and established an atmosphere of ‘figuring out together’, in detail,

what the research was about and entailed. In this way, I also minimized shameful feelings of not being able to read; I made clear all options were fine and normal.

I also considered it important to be extra clear outside the consent procedure, for example with regards to making the appointment, which I always wrote down on a piece of paper for service users. Furthermore, I asked participants at several points in the interview – but in particular at the beginning and end of each interview – whether they had any remaining questions about the research, about what would be done with the information, or about anything else. Deliberately giving participants the opportunity to ask such questions is important for the reasons outlined earlier: the increased potential for misunderstandings and the increased potential for harm in case of misunderstandings. These continued checks for whether the research was understood edges towards ‘process consent’.<sup>199,201,202</sup> Lastly, I used simple words (e.g. good care / bad care instead of speaking of satisfaction or quality of care), and adapted my word usage to that of the service user (e.g. using words the participant used for various concepts such as the shelter, the service providers, etc.), as additional approaches to being extra clear.

Finally, I feel it is important to note that being extra clear is not the same as emphasizing something more than normally. For example with confidentiality, there are risks in emphasizing too strongly that the interview will be confidential, which might evoke questions, doubts or concerns with the participant about why confidentiality is being stressed to such a degree. Being clear means conveying a message, sometimes in resourceful ways due to the cultural and linguistic barriers that characterize this population, and ensuring that the message has been conveyed.

### [Dealing with misunderstandings](#)

Despite being extra clear, there is still an increased potential for misunderstandings with research participants from this population, because of the use of interpreters and the multicultural nature of this population. My view on dealing with such misunderstandings, perhaps surprisingly, has become that it is OK that they occur every now and then. Immersion in a different culture only goes so far, especially when research participants come from many different cultures. For example, I interviewed one service user in this study when she was pregnant. My second interview with her was cancelled because her pregnancy had advanced too far, and after that she gave birth to her baby. When I came back for the second interview several months later, she was sincerely offended that I had not come to visit her and her baby after the birth. In her country, she explained, “even your worst enemy comes to visit you when you have a baby”. I realized that the researcher-participant boundary was different for me than for her. This was a lesson for me, but I think this example also shows that there is not always a perfect way to handle ethical issues – often it is less about avoiding

ethical traps, and more about finding the optimal way to mitigate ethical issues that will exist nonetheless. By ensuring that such misunderstandings did not make me feel uncomfortable, by being transparent about my actions and motivations, and by offering apologies easily, I tried to ensure that the interviewer-participant relationship was strained as little as possible by any misunderstandings.

## **Managing emotions**

### *Managing emotions of participants*

Given the recent experiences of victims of trafficking and their uncertainty about the future (see Chapter 5), interviews with this population are potentially laden with increased emotions. In my research, this was not the case with all participants, but certainly with a proportion. Several service users cried during the interviews, others were angry or frustrated. Anyone who conducts interviews with a vulnerable population should be prepared to manage such emotions. As well put by DeMarrais and Tisdale: “The key point here is to carefully consider all the possibilities that may arise in the study of difficult emotions and to plan strategies accordingly.”<sup>225</sup> I prepared for managing such emotions in two ways. First, I always held interviews in locations where help would be quickly available (in the shelters). Although I think this was an important safety measure, it was never necessary to call on service providers during my interviews. Second, I prepared for standard potentially problematic situations, mostly relating to emotions (sadness / crying, anger, discomfort and falling silent) and I practised some of these situations in a course on communication with this study population.

### *Managing own emotions*

Some have recommended me to have professional help on stand-by when conducting research among vulnerable populations in case of emotional distress. While I was quite moved by some of the stories of participants, it is my sense that for most this will not be necessary, but I would recommend talking to people about it (to a degree that does not break confidentiality of course). For me it was a relief that I was able to discuss my research data with my supervisors. I also feel that speaking to friends and family about how I felt about conducting the research in general terms helped me deal with the stories that I heard from participants.

## **Deciding on the interviewer(s)**

### *1 or 2 interviewers*

One shelter in my research was willing to participate, but only on the condition that I always interviewed their service users with a second interviewer, because it was also their own policy to

speak with service users during official conversations with two service providers present. From this I have learnt that there are advantages and disadvantages to having a second interviewer present. Advantages include that with two interviewers, it is easier to take notes while conducting the interview (which helps particularly when the participant does not consent to the interview being recorded). Furthermore, an extra interviewer might add content to the interview and provides an effective mechanism for feedback and methodological reflection after the interview. Finally, the chances of some ethical problems are smaller with two interviewers. For example, the shelter noted it had this policy to protect people against the risk of false accusations.

However, I found that with two interviewers, it is also more difficult to establish trust and rapport with participants. Another disadvantage is that interviewing service users with two interviewers is potentially more threatening than with one and might result in a more pronounced perceived power imbalance. Finally, on a more practical note, it is also more resource-intensive.

Whether it is appropriate or not to use one or two interviewers will differ per research context and is dependent on the preferences of the researchers, the service providers and the service users.

*Does the gender of the interviewer matter?*

Given the locations where I recruited my research participants – shelters for victims of human trafficking and often of sexual exploitation and violence – I carefully considered the appropriateness and desirability of having a male interviewer. I assumed in advance that a male interviewer in a shelter for female victims of human trafficking was not desirable. In general, publications about the preferences of victims of sexual abuse and effects of the gender of the interviewer differ in their results, but show a tendency towards a preference for female interviewers, both among female and male research participants.<sup>226</sup> So the answer to the question in the title of this section is: yes – the gender does matter.

So should a male researcher not conduct this type of research? In my view, that is not the case. For me the views of the service providers were pivotal in deciding whether I should conduct the interviews myself or not. In the shelter for men, there were also male social workers and my gender was not an issue in their view. However, the two shelters for women only employed female social workers. In discussing my thoughts on this with the managers of the two shelters for women they surprised me by saying that they were generally positive about having a man in the shelter, because they felt the women needed to experience normal relationships with men. They explained that they were looking to hire male service providers, but had difficulty in finding male applicants. In addition, they indicated that service users also had general practitioners and psychiatrists that were male. Therefore, I decided to conduct all the interviews in this research myself. To mitigate potential

problems related to my gender, I always made extra clear that participation in the interviews was voluntary, and during the interviews I was extra watchful for signs of discomfort. On the request of the shelter managers, I also participated in several day activities of the shelter before the interviews commenced, so that the service users could become acquainted with me.

## Optimizing the data

### *Making the most of hand-written notes*

Half of the participants in my research did not consent to the interview being recorded. When this was the case, I had to take notes by hand. Because this affects the manner in which data are collected, I would recommend for those who conduct interviews with this population to develop and practice a system for making hand-written notes during interviews. A stenography course might be advisable.

To try to limit data loss because I had to make hand-written notes, I digitalized the hand-written interview notes directly after the interview, on the same day. As part of digitalizing, I expanded on the notes from my (recent) memory of the interview. In this way, I reconstructed the interviews from a combination of my notes and my memory. Although this is standard practice for handling interview data, I found that going through this process on the day of the interview itself was particularly useful for enriching the data from non-recorded interviews.

### *Listen, but also look*

As explained earlier, given the nature of participants' recent experiences and current situations in my research, interviews were often laden with emotion. Several service users were sad and cried during the interviews, others were angry or frustrated. Sometimes service users whispered when finding it difficult to talk about something. These emotions became apparent from the volume and pitch of people's voices, from facial expressions, and from their movements. Making specific memos of these non-verbal data enriched my analysis of whatever topic elicited the emotion. Taking into account non-verbal data has received relatively little attention in the qualitative research literature, but a good overview is provided by Onwuegbuzie et al, including a framework for collection of non-verbal data (I did not use this framework myself; I only found it after I concluded my data collection).<sup>227</sup>

### *Using interpreters*

As I noted earlier, Squires has written an excellent review on the possible challenges of cross-language research and possible methods for addressing these.<sup>221</sup> However, because interviewing victims of trafficking involves speaking to people from multiple language groups, and because the



precise languages are not known before the research, several measures suggested by Squires were not feasible in my research (for example, working with one trusted interpreter).

However, there are other measures that can be taken to optimize the quality of translation in this setting. First, it is preferable to work with a well-known, recognized translation agency. In my case, the shelters all worked with the same translation bureau, which I also used.

Second, one of the most important approaches that I took to minimize cross-cultural and cross-lingual misunderstanding in my research became to keep terms simple (see earlier section “Being extra clear”).

My third measure had to do with another recommendation by Squires that I decided not to follow. The recommendation was to “allow participants to speak in their native, first language. This will not only increase their comfort level, but can also result in richer data”.<sup>221</sup> Squires recommends this because speaking in a non-native language can be tiring for participants, as well as produce difficulties with explaining things. While I have found this to be true in my own interviews, there are also advantages to working without an interpreter in a language that both the interviewer and the participant understand (but are less fluent in). For example, when there is no interpreter, there is less risk of interpreter bias. Moreover, the absence of an interpreter promotes trust and confidential communication and encourages direct contact between the researcher and the participant.<sup>46</sup> In my research, I found that when participants were fluent enough, that I preferred conducting the interviews in English or Dutch, even though it was not the participant’s first language. This was also the preference of most service providers who worked in the shelters where I conducted my interviews. However, my preference did not determine the language of the interview; I always let participants choose (see later section “Giving participants decision power”). I did not indicate my preference for English or Dutch, but I also did not automatically arrange for the interview to be conducted in the participant’s native language.

Finally, when using an interpreter, there are several other relevant challenges that I was faced with and which should be considered when preparing the research. First, as I noted earlier, I found that the interview was slower with an interpreter, resulting in less data within the same amount of time. Second, it was more difficult to develop rapport with the participant when an interpreter was present. Third, I found that interviewing techniques, such as probing techniques like “uh-huh-ing” or the “echo-probe” were more challenging with an interpreter.<sup>228</sup> Fourth, I learned that choices had to be made about how to use interpreters. Notably, I had to decide whether to use phone interpreters or in-person interpreters, both of which have advantages and disadvantages. I found that the former

can be technically more challenging due to non-optimal connections. However, on the other hand, phone interpreters are cheaper, more easily arranged and hence more practical and feasible. In addition, I found that in-person interpreters can sometimes be dominant, producing a less trusting research environment, and can create more pronounced tensions in case of ethnic, religious or cultural differences between the interpreter and the interviewee. These considerations should form a part of the preparation of the research and measures should be developed to address them if necessary (for example, taking more time for the interviews by scheduling multiple interview sessions and piloting interviews with interpreters).

### **Deciding on the interviewing approach**

There are many different interviewing approaches that can be used to optimize qualitative research interviews in general,<sup>189,208</sup> and interviews with vulnerable populations in particular.<sup>190,199,217,219,229,230</sup> In preparing for this research, I reviewed these approaches, and decided to mainly use a grounded theory approach to data collection and analysis, but to also incorporate elements of other approaches and specific research techniques.

One example of this was that I incorporated elements of the feminist approach to qualitative research, which has been described as a useful approach for reducing power differences between the interviewer and the interviewee and has been recommended specifically for research among victims of sexual violence.<sup>190</sup> I did not apply this approach as a whole, but I selected aspects that I felt were appropriate for this study. For example, I felt that participants should have a major say in the conditions of the interview (see later section “Giving participants decision power”). I also made it a point to react empathically to participants’ stories, the importance of which is emphasized in the feminist approach.<sup>190</sup> Finally, I applied self-disclosure, which is also recommended by the feminist approach, and changed the degree to which I applied this over the course of my research (this is discussed later in more detail in the section “the researcher-participant relationship”).

I also piloted and applied specific research techniques during my data collection. One example of this was the ‘devil’s advocate’ technique.<sup>231</sup> This is an interviewing approach whereby the interviewer purposively takes the opposite stance of the interviewee in a discussion, to evoke further discussion and depth of argument. With a vulnerable population such as the one interviewed in my research, this may seem to be an unusual or even an undesirable approach. As Tracy notes about this approach: “Several notes of caution regarding devil’s advocate questions: First, they are best used with respondents who are confident and relatively high-power – people who are comfortable explaining themselves without feeling threatened.”<sup>231</sup> For this reason, the devil’s advocate approach was not an approach that I prepared for or that followed from my reviews of

appropriate approaches for research among this population. However, I use the devil's advocate approach quite regularly in normal discussions and therefore it occurred to me to use it during one interview. The woman whom I was interviewing at the time had clear and well-articulated views about the social and health services provided in the shelter. We had spoken for quite a while and had good rapport. Therefore, I decided to try the approach. First, I introduced it, to see how she felt about it: "I'm purposively going to take an opposite stance now for a minute, for the sake of our discussion, would that be alright?" It worked well. I applied it on a number of other occasions after that. I felt it was always perceived in a good way, but I was always selective with whom I applied it (only with participants who were confident in voicing their opinions) and about the time when I applied it (only after a while, when some rapport and trust had developed between me and the participant). Moreover, I always introduced that I was going to apply the technique.

Another example of an interviewing technique that I started to use during data collection related to 'totems'. During my interviews, I encountered one service user who mentioned her personal motto ("What does not kill you makes you stronger") and another who made mention of two religious verses that had helped him a lot (see Chapter 5). I found that these provided strong metaphors or descriptions of an aspect of the participants' state of mind. Because this was very useful for my analysis, I explored this motto and the verses in-depth with the participants. I came to call them 'totems', the definition of which is "a device, design, or figure used as an identifying mark". I feel that totems might be mottos or verses, but can also be, for example, favourite songs, or books, or anything else that fulfils a function as an identifying mark for a part of the participant's experiences or state of mind. I discovered the significance of totems relatively late in my research, but in future research projects I will likely incorporate a specific question in my topic guide about totems.

I drew several lessons from applying these interview approaches and techniques. First, I found it useful to be knowledgeable about different interviewing approaches and techniques that might help to improve data collection for my study population and to be able to apply those when appropriate (see earlier section "Challenges in preparing the research"). Second, I found it useful to prepare and apply multiple approaches, and to not blindly apply a whole approach, but to critically consider which elements of an approach were appropriate for use in my research. Third, I found that there is value not only in applying techniques that one has prepared, but also in following your instinct, and to be innovative in trying new techniques. Fourth, not all approaches and techniques were appropriate for each participant. This suggests that an approach is needed that adapts the approaches and techniques applied in an interview to each individual participant. Finally, I found that critical evaluation and subsequent adaptation of the interviewing approaches and techniques is

crucial throughout the research process. More than a strictly defined method, I have found it to be useful to have a 'toolkit' of the different (aspects of) approaches that might be beneficial for interviewing this population, to be able to apply these when appropriate, and to reconsider and revise this toolkit as my research progressed. This approach may be valuable for qualitative researchers in general. Indeed, some have argued that all qualitative researchers should be able to "utilize, adapt and devise methods of inquiry and bodies of literature as the need arises through a project".<sup>189</sup> However, given the increased number of challenges that exist in interviewing this population, the high degree of variability between participants, and the increased potential for detrimental consequences when the approach is incorrect, applying a methodological toolkit in such a manner is of extra importance among this population. I come back later to several of these considerations in the section "The leitmotif: flexibility".

### ***The researcher-participant relationship: power imbalances, building rapport and keeping professional distance***

Power imbalances between the interviewer and the participant, building rapport and keeping a professional distance are important considerations in any research study.<sup>219</sup> With vulnerable groups, these considerations are of extra importance, because the balance that the investigator strikes between these three aspects of the researcher-participant relationship may result in additional vulnerabilities.

Unequal power balances between the investigator and the participant are an issue of general concern in qualitative research interviews.<sup>219</sup> With vulnerable groups, there may be an increased power imbalance between the interviewer and the participant. With foreign victims of human trafficking, this is the case because participants are often in a dependent position due to their migration status and because participants have potentially been traumatized by their experiences. Many qualitative researchers feel that power imbalances need to be reduced as part of all qualitative research interviews. Karnieli-Miller writes, for example: "Qualitative inquiry, in general, though there are significant variations between its different paradigms and traditions, proposes to reduce power differences and encourages disclosure and authenticity between researchers and participants".<sup>219</sup> When vulnerable groups are interviewed, reducing power imbalances between the interviewer and the participant is seen as particularly important: it is one of the chief underlying reasons for applying interviewing approaches such as feminist approaches in interviews with vulnerable populations.<sup>190</sup> However, there are also potential disadvantages to reducing power between the interviewer and interviewee, such as blurred boundaries and problems with ending the research relationship.<sup>199,232</sup>

Building rapport is important because it improves communication between the researcher and the participant. Several benefits follow from improved communication, such as extra clarity and increased richness of the research data. However, some rapport building tactics have also been described as a “a mask for some type of manipulation or exploitation carried out to obtain the data needed for the study”<sup>219</sup> and building rapport may even accentuate participants’ vulnerability (for example, there is a risk of participants divulging more information than they might feel comfortable with in hindsight).<sup>219,230</sup>

Keeping professional distance is, in practice, in many ways the opposite of reducing power differences and building rapport. Some have even described professional distance in research interviews as a characteristic of positivist research that has been let go as part of constructivist-interpretivist perspectives.<sup>192</sup> However, I have found that this is not necessarily the case, and that sustaining a clear professional distance between the interviewer and interviewee may actually be empowering in its clarity, thus reducing power imbalances (see later section “Keeping a professional distance”).

Striking the right balance between reducing power differences, building rapport and keeping a professional distance was an important challenge for me. I took several measures to reduce power imbalances and to build rapport, but I also took measures to sustain a professional distance. In doing so, I always tried to keep in mind the overall goals of these measures: reducing power differences, building rapport and keeping a professional distance are not goals in themselves, but rather a means to achieving beneficence and non-maleficence for interviewees and, secondarily, to achieving rich data.<sup>219</sup> In the sections below, I describe my approach, the dilemmas that arose, and how I tried to find the right balance between them.

### **Power imbalances**

An unequal power balance has been noted to be inherent to the investigator-participant relationship.<sup>199</sup> That said, there are things that can be done to reduce this. Researchers have differing opinions about how power imbalances should be mitigated.<sup>233</sup> In this study, I applied several approaches:

- Being extra clear
- Being transparent
- Giving participants decision power
- Acknowledging the power imbalance
- Self-disclosure

*Being extra clear*

Participants had many rights in their role of participants, such as the right to terminate the interview at any time and the right to decline to answer certain questions. However, since such rights may not always be as clear to vulnerable groups (see earlier section “Being extra clear”), being extra clear was one way in which I reduced power imbalances between me and the research participants. This was particularly important as part of the informed consent procedure, for which I took a lot of time (also see previous section, “Being extra clear”). As Harrison notes: “Accustomed to exploitation and abuse for non-compliance, the principle of freedom to consent to participate in research and the right to refuse and/or withdrawal from research is an important consideration in FTSE [Female victims of Trafficking for the purpose of Sexual Exploitation] research.”<sup>199</sup>

*Being transparent*

I felt that a good way to reduce power imbalances was by being as transparent as possible with participants about the research and the way in which it was being conducted. Being extra clear, as explained above, is an important component of this. I made additional small gestures of transparency to further create an atmosphere of openness, such as: I regularly showed the participants the topic guide and explained its function; I showed participants my hand-written notes, when appropriate; and I explained interviewing techniques or approaches to participants. An example of the latter was that once when I found myself talking too much, as opposed to asking questions and listening, I said that it was a good thing that my supervisors could not hear me do so, because it would not make them happy. After all, I explained, in an interview the researcher is mainly supposed to ask questions and listen. Although intended partially as a joke, I feel that explaining the interviewing approaches and techniques as such may also help to normalize and rationalize the non-standard, research-specific dynamics between the interviewer and interviewee, in this case of me asking the participant questions most of the time and the participant sharing information.

*Giving participants decision power*

By giving participants as much decision power as possible over the manner in which the interview was conducted within the basic rules and objectives of the interview, thus departing “from the traditional conception of quantitative research, whereby the researcher is the ultimate source of authority”,<sup>219</sup> I also tried to reduce power imbalances between me and the research participants. I presented participants with a range of different choices. I also emphasized that the participant could decide. Choices were offered on: the time and date of the interview; signing the consent form or giving verbal consent; recording of the interview or me taking hand-written notes; participating in a third interview, if necessary; giving me access to their case records; being quoted; usage of the data

for writing narratives about service users; the length of the interview; the language in which the interview was conducted; and which topics were discussed as part of the interview. Moreover, participants were asked at both the end of each interview and at the beginning of the second (and third) interview how they felt the interview went. My experience with providing people with these choices was good; they were usually seriously considered and in several cases participants voiced their opinions on certain choices strongly.

#### *Acknowledging the power imbalance*

As part of thanking someone for participating, I made it a point to explicitly mention that it had been a privilege to gain insight into the participant's life and experiences. Acknowledging the power difference as such, by thanking someone for giving those insights (without the reciprocal having taken place), has also been described as an approach to addressing power differences.<sup>233</sup>

#### *Self-disclosure*

Finally, I attempted to reduce power imbalances in my interviews through the method of self-disclosure. In this approach, the interviewer also shares information with research participants, instead of only the other way around – thus reducing power imbalances.<sup>190</sup> Campbell, writes, for example: “In feminist interviewing, researchers make a concerted effort to reduce the hierarchy of the interviewer–interviewee relationship by engaging in mutual dialog and disclosure.”<sup>190</sup> While many authors advocate self-disclosure as an appropriate approach to interviewing, in particular with vulnerable groups, my own experiences with this approach were less positive in this study. I will explain this in more detail in the section on blurred boundaries under “Keeping professional distance”. I did engage in some self-disclosure, but to a limited degree. I decided to share general information when that felt appropriate, for example about the Netherlands (see later section “Building rapport”), but to be hesitant with sharing information about myself. This worked well for me in this research context. The following extract from the literature on self-disclosure in physician-patient-relationships resonated with me for my research: “Physician self-disclosure can be used both positively and negatively in the doctor-patient relationship. Like any ‘drug’, it should be used carefully, consciously, and always transparently in the patient's best interest.”<sup>234</sup> Having said that, despite not proactively sharing personal information about myself, when asked a personal question by a service user, which happened rarely, I have always had great difficulty saying that it was none of their business. I think I feel that way because it represents a strong confirmation of the power difference between the researcher and the participant. I have not found a satisfactory way to negotiate that situation yet.

## Building rapport

Building rapport has been defined as “the development of a good relationship” between the researcher and the participant, “a relaxed interchange in which interviewees feel able to talk without feeling judged and have the space to tell their story.”<sup>208</sup> This section will discuss various measures that I took to build rapport, and my experiences with these measures, which included:

- Communication and interaction
- Adapting appearance and word use
- Interviews, focus groups, or...?
- Multiple interviews
- Honouring trust

### *Communication and interaction*

Much has been written about approaches for establishing rapport between interviewers and research participants.<sup>230,235</sup> Ryan and Dundon offer the useful advice to be prepared, be credible, be patient, be engaged, be aware and be sensitive.<sup>235</sup> These approaches are often about how interviewers should communicate with research participants. Here below, I describe several such approaches that I found particular useful.

First, I have found that small talk and making jokes is important and should be a two-way process. Service users should be able to engage in casual stories (as opposed to being directed back immediately to the topic guide). On the other hand, I also made an effort to tell some casual stories, which I found to considerably increase the rapport between myself and my research participants. The cultural and language differences between me and the participants offered good opportunity for small talk: there are many stories to exchange about food, sayings, customs, etcetera. As part of my research I was taught how to make sugar cane tea as they do in certain African countries and I learned that the number four is to the Chinese what the number thirteen is to Dutch people. But I also explained Dutch sayings to participants and told about certain geographic particularities of the Netherlands. The importance of small talk has been noted by others as well for interviewing specific populations, for example young children.<sup>217</sup> However, not everyone agrees on the importance of small talk. Some researchers have described it to be “over-rapport that is sub-optimal and leads to a ‘comfort zone’ which can result in voluminous irrelevant data being divulged”.<sup>236</sup> In this research context, I considered ‘irrelevant data’ to be an important aspect of the interview and a necessary by-product of getting rich data that are on-topic. Hence, over the course of data collection, I developed specific approaches to establishing opportunities for small talk, such as offering all participants coffee, tea or water at the start of the interview. I always invited participants to walk with me to the



coffee / tea machine, which provided an opportunity to engage in some small talk in a casual manner, outside the formal arrangement of the interview room.

Furthermore, I made it a point to thank participants for how openly they spoke about their experiences (see later section “Recognizing trust”). I did so because I sincerely felt that this was worthy of my gratitude. Participants also appeared to enjoy participating in the interviews because it allowed them to contribute to something meaningful. I felt I needed to stress that they had and regularly made compliments about how clear they were in speaking about their service experiences and how helpful this was for my research (see later section “The researcher vs. therapist vs. human boundary”). It was my sense that a side effect of this was that it also increased the rapport between me and the participants and thus resulted in richer data. I do not think it is ethical to engage in expressing gratitude and giving compliments for this reason, but it is good to be aware that it might have this result.

I also found showing empathy for participants’ concerns, worries and past problems to be an important part of establishing rapport (see earlier section “Deciding on the interviewing approach”). As for some of the other rapport-building approaches, this is of particular importance with vulnerable groups and when speaking about sensitive topics.<sup>190,230</sup>

#### *Adapting appearance and word use*

In conducting the interviews, I took several measures to adapt my appearance. I avoided formal attire and always dressed casually, because I felt that formal attire could hinder building rapport. Moreover, I avoided the unnecessary use of complicated words, in particular professional terms. I also adapted the words that I used to the words that participants used. I particularly copied phrases, terms, labels or designations used by participants (examples were the labels that service users gave to the shelter or the care providers) (see earlier section “Being extra clear”). Corbin stresses that “in painful interviews, it is important that participants be able to choose the words with which to tell their stories”.<sup>224</sup> Adapting to that word usage was one way to do that for me.

#### *Interviews, focus groups, or...?*

As part of my research, participants explained that while the other service users in the COSM shelters were a source of support and distraction, they hardly spoke to each other about their problems. This finding strengthened me in my belief that interviews, rather than focus groups, were the appropriate primary approach to data collection among this population, because they allow for building rapport and trust, which is needed to speak about sensitive topics. This is corroborated by Rijken et al, who conducted focus groups with this population in a health services study, but realized during the study that “using focus groups for trafficking victims was not the most suitable way of

collecting information because victims felt ashamed or their experiences were too painful to share in such a forum.”<sup>41</sup> Kaplowitz has also shown, for research on sensitive issues in general, that “interviews were 18 times more likely to raise socially sensitive discussion topics than the focus groups”.<sup>191</sup> Besides research interviews, it is noteworthy that other qualitative data collection approaches have also been applied with success among this population, for instance, ethnographical and anthropological approaches.<sup>67,133</sup>

### *Multiple interviews*

I conducted at least two interviews with each service users. I chose this data collection approach because I felt that there might be a lack of trust among service users given their past experiences and because of the sensitive nature of certain research topics, and because this might make it more difficult to establish rapport. Knox and Burkard write: “Multiple interviews (...) may foster a stronger relationship between researcher and participant, such that the latter may feel more comfortable deeply describing difficult or emotionally laden experiences to someone with whom he or she has had prior contact and established at least some level of trust.”<sup>192</sup> Besides this consideration around trust, when building rapport is more complicated than normally, for example in research with young children, the use of multiple interviews has also been recommended.<sup>217</sup> The cultural and linguistic barriers in my research constituted a similar complication and are also a good rationale for conducting multiple interviews.

My experience with conducting multiple interviews in this research was positive, yet mostly for reasons different from those discussed in the previous paragraph. Developing a trusting relationship, although theoretically more likely to happen over a multiple interviews, happened quickly in my research, and most service users were very happy to contribute in any way they could – also in the first interview. However, there were several other reasons why, in hindsight, multiple interviews were a good approach. First, for practical reasons; the maximum amount of time for an interview was set at 1.5 hours (see later section “Keeping a professional distance”) and thus in a single-interview scenario where there was a lengthy consent process there would have been little time left for discussing participants’ experiences in the shelter. Moreover, small talk (see earlier section “Communication and interaction”) and the increased likelihood of emotional episodes (given the sometimes sensitive topics) took up additional time during interviews. Second, it was a positive experience for me that I could take ample time to discuss topics of interest with participants (or even topics that were not of so much interest to the research, but were important to participants). Third, there were no consequences for the richness of the data collection if a participant wished to end the interview earlier; the discussion could just be picked up next time. Finally, doing multiple interviews meant that both I and the participant could reflect on what was discussed the previous

time. I always made it a point to ask participants how they felt about the previous interview (see Appendix 5).

#### *Recognizing trust*

Throughout the research, I was truly amazed at the level of trust both service users and care providers placed in me. Service users often told me highly personal stories; service providers entrusted me, first, with interviewing the service users in their care, and second with reading their confidential case notes when service users had consented to this. Such a realization is not uncommon for qualitative researchers.<sup>230</sup> I felt that as part of building rapport with my research participants, it was important to be consciously aware of this high level of trust and to show that I was aware of it. I felt this was particularly important because a lack of trust, after having been deceived as part of their trafficking experience, is a frequent problem among victims of trafficking (see Chapter 5 and Appendix 1).

#### *The potential disadvantages of building rapport*

Lastly, I feel I need to stress again that building rapport also has disadvantages. Participants in research, in particular vulnerable participants, may be 'persuaded' by a good rapport with the interviewer to tell more than they would have normally wanted to or in hindsight feel comfortable with. In particular when talking about sensitive topics, it is part of the ethical responsibility of a researcher to signal if this might be the case.<sup>230</sup> Good ethical conduct does not stop at acquiring consent (see later section "Did he/she want to me to know this?").

### **Keeping a professional distance**

#### *Blurred boundaries*

One of the things I have noticed as part of this research was that for several participants, the interviewer-participant relationship was not as clearly professionally defined as for me. This may have been in part a cultural difference. Another part of the reason may be that recently rescued victims of human trafficking are in a phase when they are searching for and in need of meaningful connections with other people (see Chapter 5). This resulted in several challenges for me. One service user, as explained earlier (see section "Dealing with misunderstandings"), was insulted that I had not come to visit her after her daughter was born. Similarly, she referred to me sometimes as "my friend Rik". I found this to be a difficult situation to manage appropriately, because a refusal of friendship might be considered an insult. In my view, being transparent and clear about the research process is a good way to demarcate the professional research relationship. When misunderstandings arise nonetheless, one should be prepared for how to deal with those (see earlier section "Dealing with misunderstandings").

That said, I should note that I also did not merely view my research participants as sources of data in my research. Through their stories, I came to care about their plights. With two service users, whose stories spoke to me in particular, this led me to consider keeping in touch with them after the research was completed. I felt that I might be able to help them a little with getting by in the Netherlands (as I had seen several volunteers do in the shelter). The continuation of friendly relationships after the formal research relationship has ended has been described by others.<sup>237</sup> To me, at the time, it felt appropriate to do so. I felt I wanted to help and that I could help and, to the best of my judgment, that this would be appreciated. However, there were also ethical concerns associated with keeping in touch. In particular, the change of my research relationship with these participants to another form of contact would have resulted in that contact not having started on an equal footing. I, as the previous researcher, would have had intimate knowledge of their lives, but not the other way around. In addition, they may well have had expectations of such an interaction with which I might not have been able to comply. These are serious concerns that should not be taken lightly. In the end, this situation was one of the rare occasions where I and my supervisors did not agree on the appropriate course of action. For them, their concerns with the ethics of the situation outweighed the potential benefits; for me it was the other way around. Perhaps, the main lesson to draw from that is how difficult it can be to negotiate the multifaceted ethical issues associated with this kind of research in a good way. Therefore, it is important for a primary investigator to have a strong research team to rely on, to be able to exercise reflexivity not in a solitary manner, but in discussion with others.

In the cases described above friendship was the boundary that was under deliberation, which I found a complicated boundary to consider and to manage. In another case, a participant asked whether I had a partner, which I also found difficult to manage. It occurred to me this might have been asked out of some form of romantic interest. This made me realize that there was a potential ethical issue of tremendous proportions here that I had not prepared for at all (in my preparation, I had focused more on the potentially traumatic effects of having a male interviewer in a shelter for female victims of sexual violence, see section “Does the gender of the interviewer matter?”).

Being a male interviewer in a women’s shelter, I should have been prepared for such a question. I have wondered in hindsight why I was not. As well as I can remember, the potential for something like this to occur had simply not come to my mind, but it is interesting that in my review of the challenges associated with qualitative research I had not come across a discussion of anything along the lines of flirting. Although articles on this issue do exist,<sup>238</sup> there appears to be a bit of a taboo on

this topic in the literature. This is unjustified; as with any other potential ethical issue, one should be prepared to encounter it and consider the most appropriate approach for dealing with it.

In response to the events described above I decided to only apply the self-disclosure method that I had prepared to a limited degree (see earlier section “Power imbalances”), i.e. I decided to share general information with participants, but was hesitant about sharing personal information. Besides limiting the amount of information that I shared about myself, I took another measure to build in professional distance that I called the ‘maximum time rule’. While there was no minimum time for an interview, I set the maximum time for each interview at 1.5 hours. This may seem like a small methodological detail, but it was an important tool for me to establish clear boundaries as part of the research interview (the idea for this came from a clinician who worked with similar populations and who adhered to this rule in his clinical practice for the same reason). I have spoken before about having ‘toolkits’ that one should be able to have at one’s disposal, to apply when appropriate. Just like one should have at his or her disposal several measures to increase rapport and to reduce power imbalances, one should also have at one’s disposal measures to increase professional distance. This was one of them for me, and one that I felt to be suitable in this research context. For other researchers, such as Korsby, who spent a long amount of time in a shelter for victims of trafficking conducting an anthropological study, this would have likely been a less suitable approach.<sup>133</sup>

In summary, there are ethical challenges around establishing a human relationship with research participants. These ethical challenges are magnified when working cross-culturally and both these challenges and the consequences of an inappropriate interviewing approach may be magnified when working with vulnerable participants. Since building rapport is a condition for rich data, and reducing power imbalances is generally considered the norm in qualitative research,<sup>219</sup> there are several goals at odds with each other here for a researcher. It is important to be aware of that and to consciously and continuously try to strike the difficult right balance between establishing rapport, reducing power imbalances and keeping professional distance.

#### *The researcher vs. therapist vs. human boundary*

There is another specific type of potential boundary conflict that merits discussion when vulnerable groups are interviewed, which I called the ‘researcher vs. therapist vs. human’-boundary. This boundary conflict arose because of situations in which service users spoke of their problems. In many of these situations, I felt a desire to help or to provide advice. Depending on the problem at hand, the type of advice that sprung to mind could have been medical advice or just your ‘friendly neighbour’ type of advice (e.g. on library passes and the location of the library). In addition, the research interview itself served a therapeutic role for some participants (see later in this section).

This raised the following question for me: should a researcher also be allowed to be a therapist? And how about a friendly neighbour?

The literature on whether or not researchers may have a therapeutic role is not in agreement.<sup>233</sup> Some feel researchers may serve a therapeutic role; others feel it should be avoided. In this research, I decided it was not appropriate, because: it carried the potential of role confusion in the eyes of participants; my advice might be different than the advice of the service providers in the shelter; and I lacked a legal basis for providing medical care. When I noticed that a participant had a social or health problem that I felt needed to be addressed, I did not provide advice, but I did urge or recommend people to see someone about that, and sometimes, who to see. Others agree that this is an ethical way of addressing concerns about a participant's welfare that does not cross the "researcher vs. therapist"-boundary.<sup>229,233</sup>

However, not being a therapist as a researcher does not mean that one cannot provide human support in case of difficult stories or problems. I have felt urged to do so during this research and to listen and respond empathically even if it did not serve a research purpose, as have others<sup>190,229,230</sup> and as one should, in my view, considering the ethical responsibilities of a researcher (see earlier section "The goals of good methods"). Dickson-Swift writes: "If caring is a basic human trait, then it is vital that researchers are able to care for another person during the research process."<sup>230</sup> Such 'human' support, or even just participating in a research interview, is often experienced as being rather therapeutic or helpful by participants, in particular in interviews about sensitive topics or with marginalized or vulnerable participants.<sup>229,230</sup> While it is not possible for me to say if my research participants felt the same way, they often spoke at length about their difficulties in life, so it is plausible that at least some did. Service users also mentioned to have enjoyed participating in the interviews because it allowed them to contribute to something meaningful (improving services for others in the future). These findings are in line with the benefits of participating in research interviews noted by others.<sup>224,239</sup> Nonetheless, it has been argued by some that the "interviewer's role is not a cathartic one".<sup>233</sup> In my view, whether the interviewer sees it as his or her role is beside the point. The interview will likely *be* cathartic and feel as an activity that carries purpose to the participant. It is, therefore, the responsibility of the interviewer to take that into account. The practical implication of this is that it is important that participants are given the freedom and the time to tell their story and that the interviewer acknowledges that they have made a valuable contribution to the research.

## ***The interview environment and context***

### ***Interview environment and time***

It is important to take into account the particularities of a study population when considering what will be an appropriate interviewing environment. Irwin and Johnson describe, for example, how their experiences with ‘standard’ approaches for creating a good interview environment were quite different when they interviewed young children (intimate, private rooms did not work well at all for them).<sup>217</sup> For my own research, I found it useful to spend time on establishing a physical environment for the interview that promoted trust and comfort. Optimally, the room was private and sound-proof. Privacy is an important concern for research interviews in general, but arguably even more so for this population. I also made sure I paid attention to other common-sense aspects of the room, such as giving the participant a comfortable chair, not leaving the laptop on the table / not making notes on a laptop during the interview, and arranging the table and chairs in a preferred interview arrangement (which is personal; I preferred a 90 degree angle). King and Horrocks provide a good description of things to consider in establishing a comfortable and private interviewing environment.<sup>240</sup>

While this was my prepared plan for the interview environment, in practice, such an environment was not always available. In one shelter there was indeed a dedicated interview room that I could use. However, one other shelter had several different locations; there I had to be more flexible in where the interview could be conducted. The third shelter relocated during my research, also necessitating the use of various and changing interview environments. In these cases, I deliberated with service providers and with participants about where to conduct the interview. In short, I found that in considering the interview environment, it was important to consider the population, the interview location context and participants’ preferences.

Besides the physical environment of the research I also consciously considered how to decide on the date and time for each interview. I always let service users suggest a date and time for the interview, which I felt was important in terms of giving them decision power over the manner in which the interview was conducted (see earlier section “Power imbalances”). After arriving in the shelter for an interview, the interviews often did not commence at the agreed time. Often people would arrive late, needing to finish something else first, or, for example, were still having lunch. I made it a point to be flexible about participants’ timeliness. Although this might seem trivial, it immediately set a relaxed atmosphere for the interview and gave participants a degree of control over the interview – it would start when they were ready. As a result, it was important for me not to schedule the

interviews too tightly. I preferred to schedule only one interview per day, and when I scheduled two, I made sure they were spaced widely apart.

### **The grapevine and other pre-existing knowledge**

I noticed during some of the interviews that service users had been informed about me and my research by other service users or service providers. This is not necessarily a bad thing; it might even be a good way for participants to become informed about the research. Service providers, in my case, had often provided some explanation about what the research was to service users. Moreover, service users had spoken to each other about who I was and what my research entailed. I think it is important to be aware of such communication lines, if only to check that what has been relayed is correct and to correct any misunderstandings.

Sometimes, I also had pre-existing knowledge about service users. During my observations, for example by sitting in on staff meetings, I sometimes overheard discussions about service users. To go into an interview with pre-existing knowledge about a service user is ethically precarious. With one service user, for example, I entered the interview knowing that she currently had a hard-drugs addiction for which she was being seen by a special clinic. She never brought this up during the interview, so neither did I. Although considerations around confidentiality are a common part of qualitative research, I found the situation in which I knew something about the participant, but in which I did not divulge that information because she did not, unusual (in that I had not read about it often). This aspect of confidentiality deserves to be stressed more in the literature, because it would very likely be considered a grave invasion of privacy by the participant if the researcher brings up such information.

A similar challenge that I encountered, yet also slightly different, occurred when I noticed that different service users had different ideas about who the shelter that they were staying in was for. While some could name or explain the concept of human trafficking, many others simply referred to the shelter as a place for “people with problems” or used other descriptions. I never dispelled such notions and always just recorded how people conceptualized their care environment. In hindsight, I wish I had taken the title of my research project (which spoke of “victims of human trafficking”) out of my consent forms as well.



## Challenges in analysing and reporting the data

### *Stereotypes*

During my research, service providers frequently used stereotypes to describe attributes of (subgroups of) service users. Examples of stereotypes that were mentioned were that: African service users do not want psychological help for mental health problems; Chinese service users are very difficult to communicate with; Chinese service users do not trust other Chinese people (for fear that they might belong to a trafficking ring); trafficked men have less severe health consequences of trafficking than trafficked women; and trafficked men do not want to talk about their problems. In the research that I conducted for this thesis, I found none of these generalizations to be valid descriptions of the entire subgroup they intended to describe, and in some cases I found that quite the opposite was true. Several African service users specifically voiced a desire to speak to a psychologist or mentioned having appreciated being able to do so; I interviewed one Chinese service user who was able to communicate very clearly her experiences with the shelter; the same service user indicated that having a Chinese speaking service provider would generally be considered an improvement by the Chinese service users in the shelter and could create increased understanding between service users and service providers; and I interviewed five men, some of whom spoke extensively about their problems, which were severe in several cases. The lessons that I took away from this is that it is important to be wary of stereotypes and to never implicitly accept them.

### *Writing narratives*

Part of my research consisted of writing narratives about service users, as explained in Chapter 3 (section "Writing narratives"). For this thesis, I have only used these narratives as a way of additional familiarization, to understand better how service users of the COSM programme viewed their lives and their recovery process. However, earlier in my research I planned to use these narratives as an output of my research, after reading two books that used a narrative reporting format to increase understanding about service users from two other vulnerable populations (victims of honour-based violence and boys under the age of 18 years who engage in sex work).<sup>27,175</sup> In my view, these books shed much light on the problems that people in these populations faced and I wanted to do the same for my study population. In the end, I decided not to include the narratives as an output in my thesis, because I felt the format of a PhD thesis was not suitable for presenting such narratives.

In planning to use the narratives that I wrote about service users as an output for the research, I ran into several additional challenges, because there are additional ethical implications to narrative analysis.<sup>241</sup> Elliot writes: "It is clearly not only the interview itself that may have an effect on the research subject. The way in which the researcher interprets and analyses the narratives produced in

the interview also may have an impact (either positive or negative) on the interviewee. If the production of personal narratives is seen as a central process by which people comprehend their own lives and establish a unified and coherent sense of self, a researchers' deconstruction and interpretation of those narratives, if not presented sensitively, may undermine the work being done by the interviewee to maintain his or her ontological security."<sup>241</sup> This problem was exacerbated in my study by the fact that there was a lot of uncertainty in participants' lives; "ontological security" was already a problem for many (see Chapter 5). Moreover, when personal narratives are told, more personal information is presented about someone than when participants are quoted, and as a result there are additional concerns about securing interviewees' anonymity. Given that victims of trafficking have recently been victims of a crime, protection of anonymity is a prime concern in research among this population. In short, there were increased risks associated with using narratives as a research output.

I took several measures to address these concerns. First, participants were specifically asked on the consent form whether they agreed to the writing of a narrative about their stories (see Appendix 4).<sup>\*</sup> Second, in writing these narratives, I have been extra careful to not include information that could lead to the identification of service users. Third, I regularly changed important socio-demographic characteristics of service users. For example, I always changed participants' names, their countries of origin, and sometimes other characteristics such as the number and gender of their children. Finally, when service users did not agree to a narrative being written about their accounts, I tried to do justice to the themes that emerged from their stories by integrating these into other service users' narratives. Another possibility for ensuring the ethics of research that aims to report narratives is to let participants read their individual narratives before they are published or to even co-produce these narratives with research participants.<sup>241</sup>

### *Analysis language*

In my research, I conducted eight of the interviews in English, one interview in Dutch, and for five of the interviews a Dutch interpreter was hired to translate. This meant that about half of my data were in English and the other half of my data were in Dutch. I thought about how I could best analyse these data and considered translating the English data to Dutch or vice versa. However, I decided to analyse the interviews in the language in which I had them. Any translation would have made the data less like what participants had originally told me. Only at the stage of coding did I

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<sup>\*</sup> The term 'story' is usually used to describe what interviewees tell a researcher, while the term 'narrative' is used to describe the researcher's account of those stories.<sup>414</sup>

start using one language (English). I kept in-vivo codes in the original language and only translated these at write-up. In this way, I tried to optimize my data integrity.

### ***Did he/she want me to know about this?***

As explained in Chapter 3, I found that service users' case records were a useful data source for collecting socio-demographic baseline characteristics, for getting additional information on service users' backgrounds, and for reading service providers' accounts of the recovery processes of service users. Given the personal and sensitive nature of the information contained in these records, it was also important to explain clearly to service users what this aspect of my data collection entailed and what precisely is in the case record. Therefore, in my consent forms, I asked for specific approval to access service users' case records.

However, during the research I increasingly felt that acquiring service users' consent to access these records was not enough. This was caused by the fact that sometimes the records contained information that service users had not spoken about during the interviews, often of a very private nature, regarding, for example, the trafficking experiences of the service users. I have wondered, in hindsight, whether service users were completely aware of what was in these records. I described this as "all the notes the service providers have about you", which is what they were, but it is conceivable that it was difficult for service users to gauge the type of information that was in the records. Given my concerns, I treated this information with the utmost care, and mostly only used it as background information to my analysis, in particular the information about service users' trafficking experiences and other traumatic events in their history. It was a clear example for me of how ethical data collection does not end with acquiring consent, but that one needs to continuously carefully consider whether one's data collection and analysis practices might in any way harm participants.

To a lesser degree, these considerations also apply to the interview data. As I have noted earlier, some authors have described that participants in research, in particular vulnerable participants, may be 'persuaded' by good rapport with the interviewer to tell more than they would have normally wanted to or in hindsight feel comfortable with. It is part of the ethical responsibility of a researcher to signal if this is the case, even when consent has been provided.<sup>230</sup>

## **The leitmotif: Flexibility**

In the sections above, I have described the challenges that I was faced with in preparing my research, in collecting my data, and in analysing and reporting my data. Throughout the measures

that I took to address these challenges, a leitmotif (“a dominant recurring theme”<sup>242</sup>) emerged: *Flexibility*. My approach was flexible because it varied on three aspects: 1) over time; 2) per research location; and 3) per individual service user.

First, I have noted in several places in this chapter that my methodological approach to interviewing this population changed over time. For example, as I learned more about the population I was interviewing, it became clear to me that I needed to change the consent forms and adapt my wording to be more in accordance with service users. Furthermore, I tried out various interviewing approaches that I had not considered before (including the need to be flexible in my approach).

Second, there were differences in how I interviewed participants between the shelters, mostly because of shelters’ preferences or routine ways of operating, as I noted earlier. Moreover, in each shelter the service providers adhered to different routines and different standards. All of these things influenced my research approach in each shelter.

Third, many of the recommendations in this chapter are based on generalizations that allowed me to formulate an approach for conducting research among ‘victims of human trafficking’ as a group with specific traits. Such generalizations are useful in preparing one’s methodological ‘toolkit’ for the research. However, they do not do justice to people individually. My approach to different aspects of the interview differed quite substantially by participant. Examples included that with some I needed to be extra clear, with some there was an increased risk of blurring boundaries, and that the interviewing techniques that I took from my methodological ‘toolkit’ differed by participant. Examples of differences between individuals that led to me to adopt different approaches were their personalities, level of intelligence, medical history, language, and culture. In a way, I applied fourteen different methodological approaches to interviewing in my research – one for every participant.

Flexibility in applying methodological approaches has been advocated by others for qualitative research in general<sup>189</sup> and more so for specific populations<sup>217</sup> and in dealing with sensitive discussion topics.<sup>224</sup> Because the study population in my research was so heterogeneous, and because of the relatively large amount of unexpected situations and challenges that I encountered, flexibility became one of the key aspects of my methodological approach.

Flexibility does not have to be an abstract characteristic or goal of one’s research approach. Besides explicating the aspects of a flexible approach, as I have tried to do in this section, concrete measures can also be described that can make flexibility work in practice. Here below, I describe these.

### ***Making flexibility work***

Making flexibility work, for me, started with preparation and piloting. Preparation does not necessarily entail having a laid out plan for the different data collection approaches; this is not possible if one wishes to be flexible. But it should result in a 'toolkit' of approaches that the researcher is going to start with (and that he will evaluate as the research progresses). Moreover, merely reading about different approaches that exist is useful and might prompt ideas during data collection. "Expecting the unexpected", is what Irwin and Johnson advise, which seems like a good approach to prepare for a flexible research approach.<sup>217</sup> Conducting pilot interviews, both with research colleagues and with participants, is a great way to learn about the unexpected.

Furthermore, the key enabler of flexibility is reflexivity. Evaluation of every aspect of the applied approaches is the only route through which those approaches can evolve as the research progresses. Moreover, it is important to keep doing this from the beginning till the end of the research. Although, initially, I had built in several pilot interviews with participants in my research, these are currently not described in this thesis. I left them out because, as stated above, flexibility became increasingly important in my data collection. As a result, every interview became a pilot interview. Each was evaluated methodologically for challenges that I encountered. In the end, my pilot interviews were not any different from the rest of my interviews, which is why I have not described them separately in this thesis. My approaches for being reflexive are described in more detail in the section below, "Making reflexivity work".

To help me make adaptations to my research methods I developed a tool for myself which I called my 'lifhacking list'. 'Lifhacking' is a term that is sometimes used to describe strategies that help people manage their time and activities. To help me keep track of all the methodological aspects of the research, and the changes therein, I summarized a range of methodological considerations on this lifhacking list, which consisted of two or three pages with bullet points. I continually updated this list and always read it on the train on my way to the shelters to keep reminding myself of my own lessons (see Appendix 3).

However, no 'lifhacking list' can cover all the individual variations between service users and the subsequent methodological adaptations that I made. In making many of the micro-adaptations during the interviews in how rapport was established, how questions were posed, etcetera, I have found it useful to trust my instincts.

Finally, a very important component of flexibility in my research was that the decision-making power for many choices lay with participants. Planning up front for many of the aspects of the research not

to be fixed, but open to the preference of the service user, automatically resulted in a flexible approach, and also provided an ethical decision making mechanism for methodological choices.

### ***Making reflexivity work***

Reflexivity is an important component of any qualitative research study.<sup>233</sup> It has been my experience, that with a vulnerable and heterogeneous population such as victims of human trafficking, and when discussing sensitive topics, flexibility in one's research approach is key, and that therefore reflexivity needs to be even more in the foreground. Because I planned to write this chapter from the very beginning of my research, I was able to make reflexivity a dominant part of my data collection and analysis. I did so by making methodological memos and summaries throughout my data collection and analysis. For example, at the end of each interview, I would write down an overview of my general impression of the interview content, but also an overview of my impression of the research methodology as applied during the interview.

Furthermore, I took specific moments to reflect on those notes and memos, during which I evaluated and reconsidered my methods for data collection and analysis. Moreover, I discussed these considerations in detail with my supervisors. I also planned from early on to involve service providers in my research preparation (see earlier section "Challenges in preparing the research"). I found they were helpful in discussing particular methodological challenges with individual service users, further contributing to my process of reflexivity. Finally, I always asked service users how they felt about the interviews, both at the end of each interview, and at the beginning of the second interview.

## **Discussion**

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Victims of human trafficking are a challenging population to interview. Many of the challenges that I have described in this chapter are common to qualitative research in general, but were challenges of increased importance because this study population was vulnerable, sensitive topics were discussed, and/or the population was multicultural and multilingual. Other challenges were unique to this population (and other vulnerable populations with overlapping characteristics). By explicating my dilemmas in addressing these challenges, I have aimed to make a contribution to the sparse work that has been conducted in this area, which has been mainly focused on broad ethical standards or general methodological issues.<sup>174,193,214,216</sup> In my view, the main contribution of this chapter lies in the practical challenges that it describes, as well as some of the solutions that I devised (such as the 'lifehacking list'). My approach to this chapter, using my methods as a unit of analysis, has enabled

me to describe these challenges. To summarize my findings, I developed a model for achieving research methods that are ethical and result in rich data when interviewing victims of human trafficking, that I present in Figure 4.1.

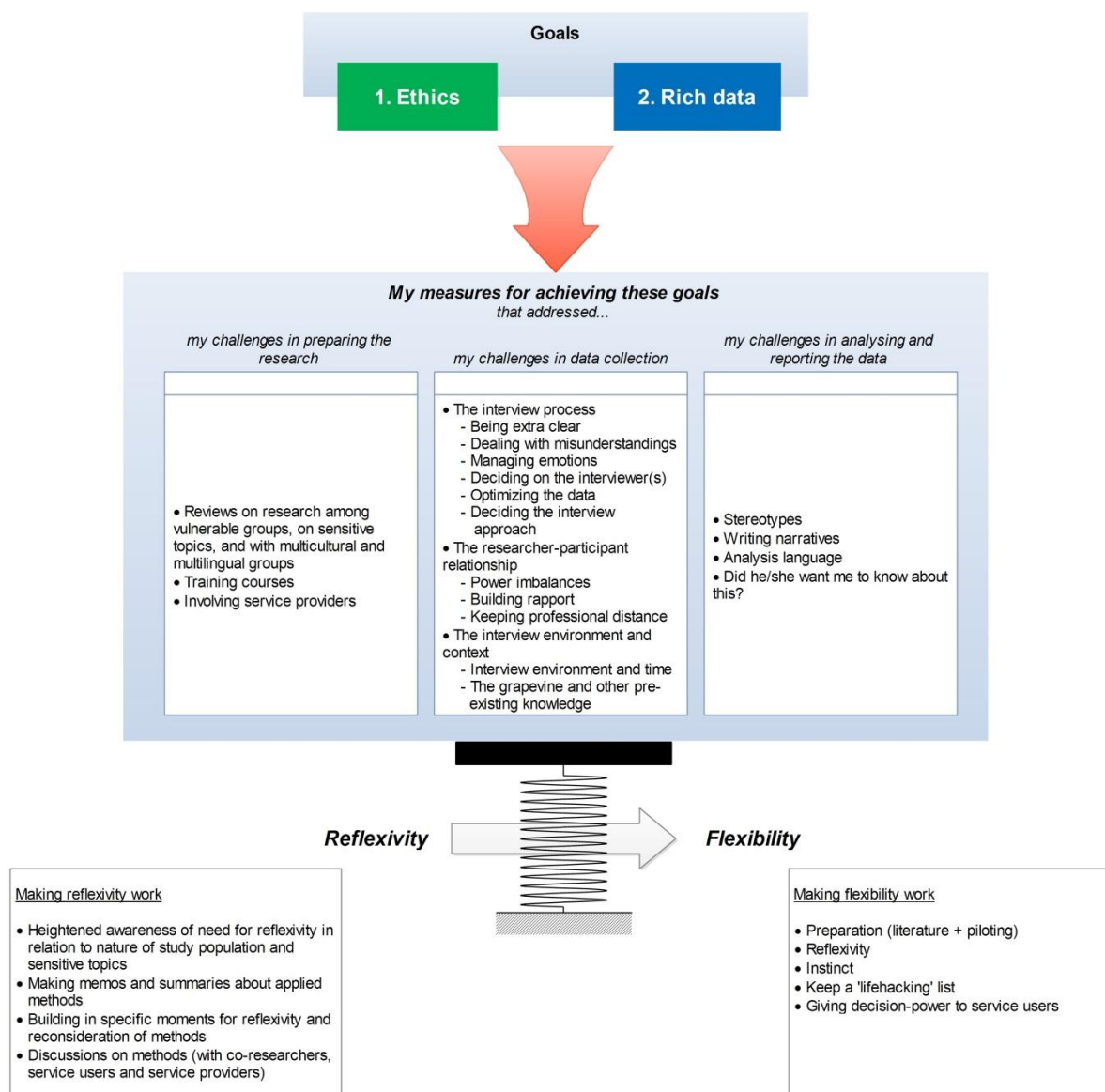


Figure 4.1. A model that I developed for how to achieve research methods that are ethical and result in rich data in conducting interviews with victims of human trafficking, focusing on the combined and related practices of reflexivity and flexibility

What I have found in reflecting on my own research process is that conducting research among victims of trafficking in a way that is ethical and elicits rich data is a balancing act (Figure 4.1). Several of my challenges involved striking the right balance between measures that were at odds with each other or even with themselves. Reducing power differences and keeping a professional distance, for example, were at odds with each other. Similarly, building rapport is part of an ethical

approach to data collection and is needed to arrive at rich data, but there is a point where too much rapport may have negative consequences for the participant and the interviewer. With other challenges, I had to find a new balance in my approach, because I was faced with a situation that I had not expected. For example, I realized in the beginning of my data collection process that I needed to make extra arrangements to make sure that information about my research was clear to participants. Finally, the majority of my challenges related to the process of data collection. In that process every research interview was a new balancing act, because every participant was different.

To decide where the balance should lie, I have found it useful to keep in mind the five conditions that I mentioned earlier that commit qualitative researchers to ethical guidelines: voluntary participation, which among others requires participants to be well-informed; adequate representation of the participant's story; anonymity of participants' data; beneficence for the participant; and non-maleficence for the participant.<sup>219</sup> Furthermore, I found that a flexible approach to conducting research helped me to find that balance in conducting my interviews with this vulnerable, heterogeneous population. Flexibility, in turn, was enabled by a high degree of reflexivity, which also in itself helped me to adhere to the ethical guidelines listed above. Therefore, in my view, achieving ethically produced rich data in interviewing victims of human trafficking requires the combined and related practices of reflexivity and flexibility (Figure 4.1).

Finally, there are several limitations to this research. First, this chapter is not intended as an exhaustive overview of the possible challenges and dilemmas that one can face in interviewing victims of human trafficking. It merely explicates the challenges that I encountered, the measures that I took to address these challenges and the dilemmas that I faced in doing so. It is possible, or even likely, that other researchers, who will apply their own research approaches, will encounter different challenges and dilemmas. Second, I interviewed victims of human trafficking in a specific context, that of the post-trafficking COSM programme in the Netherlands. It is possible that in other contexts, other challenges and dilemmas will play a more dominant role. Lastly, because my research aimed to investigate post-trafficking social and health service provision, many of the challenges associated with other research among victims of trafficking, such as representative sampling and the risks of interviewing someone who is still in an exploitative situation, were not relevant to my research and were not discussed.<sup>193</sup>



## **Chapter 5**

# **Victims of human trafficking in recovery: the stunted road towards goal pursuit**

## **Summary**

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### **Introduction**

In the Netherlands, more than 200 victims of human trafficking seek social and health services from a shelter every year. In 2010, a new national shelter programme for victims of human trafficking was established to be able to provide specialized shelter services for this population: the Categorical Care for Victims of Human Trafficking (COSM) programme. This chapter presents a study of how service users in all three COSM shelters conceptualized and experienced their own process of recovery.

### **Methods**

Fourteen service users were interviewed at all three shelters of the COSM programme in the Netherlands. The study population consisted of foreign, adult male and female victims of human trafficking to the Netherlands, trafficked for the purpose of sexual exploitation. A grounded theory approach to data analysis was taken.

### **Results**

Service users felt a strong need to turn over a new leaf in life, leaving the negative experiences of the past behind and moving towards a life with a job, a family, and friends. In contrast with their willingness to work towards realizing such a future, service users experienced a lack of autonomy over many life decisions, resulting in feelings of uncertainty about the future and a thwarted sense of agency in redressing their present situation. Together with the ostracized nature of their place in Dutch society this left service users in a state of limbo, where they felt they were standing still (while wanting to move forward). This feeling of standing still led service users to find it more difficult to deal with problems related to their pasts and worries about the future. Service users particularly appreciated Dutch language training, vocational skills training and opportunities for volunteer work, all of which helped service users feel they were getting one step closer to their envisioned futures.

### **Discussion**

Service users exhibited strong desires to fulfil the basic psychological needs of autonomy, competence and relatedness, but were stunted in pursuing those goals. Seemingly against all odds, service users found ways to pursue their goals within the boundaries of their limited autonomy, through their enthusiasm for activities that helped them get closer to their envisioned

**futures. Identifying pathways toward attaining their goals allowed service users to hope for a better future. That hope and pursuing their goals helped them to cope with the problems of their past and their worries about that future. To facilitate service users' recovery in a post-trafficking setting, there is a need to provide them with opportunities to hope for, pursue and attain their personal goals within the structural boundaries of their situation. A future-orientated, strengths-based approach may help to redress the thwarted sense of agency over goal attainment currently experienced by victims of human trafficking resident in shelters of the COSM programme in the Netherlands.**

## Introduction

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The violence and abuse that accompany human trafficking frequently result in both acute and chronic mental and physical health problems for victims and social problems such as stigma and shame (see Chapter 1).<sup>14,15,18</sup> In the Netherlands, more than 1000 potential victims of human trafficking are identified every year<sup>37</sup> and over 200 victims seek social and health services from a shelter.<sup>37</sup> In 2010, a new national shelter programme for victims of human trafficking was established to provide specialized shelter services for this population: the Categorical Care for Victims of Human Trafficking (COSM) programme.

While social and health services for victims of human trafficking have been established in various countries in Northern America and Europe,<sup>34,243</sup> the evidence that exists for best practices for that service provision is extremely limited (see Chapter 2). Although several studies have shed light on the post-trafficking service needs and experiences of victims of human trafficking, most have been published as grey literature.<sup>30</sup> The views of service users themselves on their own recovery process have received particularly little attention (see Chapter 2).

Therefore, to increase our knowledge of what service users themselves feel the goals of post-trafficking social and health service provision should be, and of what approaches to that service provision should be taken to help them achieve those goals, this chapter explores how service users in three Dutch COSM shelters conceptualized and experienced their own process of recovery.

## Methods

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### Data collection

Interviews were conducted with fourteen service users who stayed in one of the three shelters of the COSM programme. Participants were interviewed from 28 February 2012 to 18 October 2012. Usually, participants were interviewed twice. Two service users were interviewed three times (at my request, because two interviews left many topics on my topic guide undiscussed). One service user was interviewed once (in mutual agreement between me and the service user because most topics on my topic guide had been discussed in the first interview). In total, 29 interviews were conducted with 14 service users. Eight service users were interviewed in English, one in Dutch, and five using a translator (one time in person, the remainder via phone-based translation).

An overview of the main topics in the topic guide is provided in Chapter 3; the topic guide itself is provided in Appendix 5.

## **Context: the COSM programme**

See Chapter 1 for a description of the COSM programme.

## **Study population**

The study population consisted of foreign, adult victims of human trafficking, who resided in one of the three COSM shelters at the time of my research. Interviews were limited to people who were trafficked for the purpose of sexual exploitation, because the health problems and challenges faced by people trafficked for other purposes can be quite different. As a safety measure, interviews were limited to service users who had resided in one of the COSM shelters for at least six weeks. Service users were selected for inclusion in the study in agreement between me and the employees of the COSM shelters. These considerations are described in more detail in Chapter 3.

The interviewed service users were nine women and five men. Their median age was 26 [IQR 23-31]. Nine service users were from Africa, three were from Eastern Europe, one was from Asia and one from the Middle East. Seven service users had no children, five had children, and three were pregnant (total is not 14 because one had children and was pregnant). The median time that service users had spent in the shelter prior to the interview was 2.4 months [IQR 2.0-3.5].

Table 5.1 below provides further information on the research participants as background information to this chapter. The information provided is not consistent across all participants because my research methodology (see Chapter 3) specified that it was up to participants to decide what to speak about in the interviews, particularly with regard to their backgrounds.

## **Data analysis**

To analyse the data for this chapter I mainly adhered to the grounded theory approach and also incorporated some elements of narrative analysis (see Chapter 3).

## **Terms**

The terms 'recovery' and 'health' are particularly relevant for this chapter; these are discussed in Chapter 2.

**Table 5.1. Background information on participants**

<b>Participant</b>	<b>Background information</b>
Participant 1	Woman in her mid-twenties from West-Africa, who has children in her home country.
Participant 2	Woman, around 30 years old, from West-Africa. She quit her educational programme to earn money for her family.
Participant 3	Woman, around 30 years old, from East-Africa. Back home, she owned her own business. Her country saw a lot of violence and she had to flee. At this vulnerable point in her life, she was trafficked to the Netherlands. She is pregnant during the first interview.
Participant 4	Man in his late twenties, from West-Africa. He has been in the Netherlands for several years when we speak. After he was able to escape his traffickers, prior to being moved to the shelter he is now in, he stayed in a centre for asylum seekers and was put in prison for being undocumented.
Participant 5	Man in his early twenties, from the Middle East. He has been in the Netherlands for almost ten years.
Participant 6	Woman, the youngest of all participants and from West-Africa. She is pregnant when we speak.
Participant 7	Woman in her early twenties from West-Africa who has been in the Netherlands for about two years. She is pregnant when we speak.
Participant 8	Woman from Eastern Europe in her early twenties who has been in the Netherlands for less than a year. She is one of the few among the participants who notes to have a tertiary education. She came to the Netherlands to work in the sex work sector but ended up having to give the money she earned to her trafficker.
Participant 9	Woman from Eastern Europe, around 30 years old. She has children in her home country and has just given birth to a child here in the Netherlands. She left her country to earn money.
Participant 10	Woman from South-Eastern Asia in her forties, who left her country 5 years ago to earn money for her child (who is still in her home country) and her mother. Her traffickers abused her vulnerable position as an undocumented migrant in the Netherlands.
Participant 11	Man from West-Africa in his early thirties who has been in the Netherlands only for a few months. He has a university degree from his home country.

Participant 12	Man from West-Africa in his early twenties who has been in the Netherlands only for a few months. His country saw much violence when he was young and he lost his parents. He went to school till the age of 18; he had no money for university.
Participant 13	Man from West-Africa in his mid-twenties who has been in the Netherlands for 1,5 years. He came to the Netherlands to study, but there was no educational programme for him here (he was deceived by his trafficker).
Participant 14	Woman from Eastern Europe in her mid-twenties who has been in the Netherlands for two years. She studied at a university.

## Results

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### The core phenomenon: a stunted road towards goal pursuit

In their stories, service users frequently compared who they were now, to who they were in the past, and who they envisioned themselves to be in the future. In other words, they described various temporal states of self-representation.<sup>244</sup> For example, when I asked one service user why she was here, in the shelter, she replied: “I need help and support, also on the psychological level, to re-find myself and to recover. What I also need is guidance in concrete things, steps that are needed to be able to live a safe life in this country.” As this quote exemplifies, service users also attributed value to the different temporal states of the self (this is also called self-evaluation). I found that they spoke about themselves as being in a transitional state, an ‘in-between state’. When I think now of the people I interviewed, they almost seem to me to be like runners in the starting blocks, waiting for the gun to go off to allow them to take off and to start building their futures.

‘Allow’, however, was the operative word in this sentence, I discovered. Service users ran into a lot of barriers in pursuing their goals. This became the core phenomenon of my research: service users’ stunted road towards goal pursuit.

### Operationalizing the core phenomenon

After developing this core phenomenon, I embarked on a more selective coding process, designed to fit my core phenomenon. I assessed people’s experiences with service provision, their ideas about what care was needed, and the underlying problems that they were faced with. This allowed me to analyse why people felt stunted in pursuing their goals. What were the goals that they pursued? What was it that drove them to pursue these goals? What was it that held them back? What were the consequences of being stunted in their goal pursuit?

Answering these questions has given rise to this chapter.

Because the temporal comparisons that service users made were so prominent in their narratives and because these comparisons led me to my core phenomenon for this chapter, I decided to adopt a theoretical framework in my analysis and reporting that provided more insight into how, and why, service users’ narratives were structured this way. I found that people who experience rapid change, particularly when the affective quality of the present is negative, are more likely to draw temporal comparisons, confirming my own analysis of service users’ narratives.<sup>245</sup> To provide more insight into



how narratives can be structured in a temporal manner, I made use of a framework suggested by Gergen, whose main article on this subject starts with: “This is a story about stories – and most particularly, stories of self”.<sup>244</sup> Gergen expands on the concept that people’s narratives can sometimes serve to unite their pasts and presents and to signify their envisioned future trajectories. He does so by showing that people’s narratives can be typified to various categories when they make temporal comparisons (e.g. the stability narrative, the progressive narrative or the regressive narrative). This temporal form of self-representation and self-evaluation matched well how services users spoke of and attributed value to their pasts, presents and envisioned futures in my research. Moreover, service users often noted how their conceptions of the past and of the future influenced their present state of mind.

In the following section, I provide an analysis of how service users viewed their past selves, their present selves and their envisioned future selves, and of how the representations and valuations of their past and future influenced them in the present.

## **The past, the present and the envisioned future**

### *The past*

I did not initiate discussion with service users about their pasts unless they indicated clearly that they felt comfortable talking about it. This was an ethical consideration; some had had very difficult experiences. Talking about their trafficking experiences can be difficult for victims of trafficking.<sup>193</sup> I did not want to initiate conversation about something that they did not want to talk about. Rather I asked general questions, such as: “Can you tell me a little bit about yourself?” or “Could you explain to me why you are here in the shelter?”. If service users started to speak about their pasts themselves, I carefully weighed how much to ask.

That said, many service users did speak about their pasts. In speaking about the time before they were trafficked, most described mainly negative life events. Some examples were: the general dire situation in the home country in terms of economic development, educational and employment opportunities, and health; working as a sex worker from a very young age; coming from a broken home; being in a forced marriage; being wrongfully imprisoned; various forms of violence, including rape; and the murder of parents and spouses. However, not all the stories service users told about their pasts were negative. Interestingly, several described a defining moment when things turned for the worse, ‘a turning point’, distinguishing between one past state of the self in which all was still good and another for whom all went downhill to the present. One service user, for example described how she was happily married, and had her own business, before her husband was

murdered and she had to flee her country, which ultimately led to her being trafficked. "I'm trying to change, to be back to the way I was. But it's difficult! Sometimes I think I am on my way", she said. Similarly, another service user described a turning point when his parents were murdered: "Since then, since that day, let me not lie to you, up to now, since that day up to the time I'm talking to you, I don't... I cannot recognize myself well, you know?" For a third, a sequence of negative life events started when she was married off to an older man as a teenager. Not for all was the turning point something that happened before they were trafficked; for some the turning point in their past was the trafficking experience itself.

Some service users also spoke freely about what happened during the time they were under the control of their trafficker. However, when they did, they mostly referred to their experiences in general words without discussing details, such as one service user who simply stated that she was abused and another who spoke of "the one who hurt her". Some spoke about the physical consequences of the abuse but not about the abuse itself. Finally, some indicated that it was not something they could speak about: "They ask me to... they force me to... That one I will not be able to explain, that one".

Almost all service users came to the Netherlands hopeful for a better life. Some were deceived: they were expecting to get a job (not as a sex worker), thought they were coming on a student visa and were expecting to enrol in a university, or came with someone they had fallen in love with. Some came to the Netherlands themselves to find work, ended up working illegally, and thus became vulnerable to exploitation. And some came to the Netherlands to work as a sex worker but ended up being financially exploited or having to pay back a huge 'debt'.

Service users linked their trafficking situation to a range of negative emotions, including shame, fear, anger, distrust, and depression. Studies that have focused more specifically on the health consequences of trafficking have found results that confirm these sentiments.<sup>14</sup> However, a minority of service users did not display any such negative emotions in relation to the trafficking situation. In particular one service user was thankful to her trafficker for having helped her escape from her home country and spoke about him in positive terms. However, she also said that at some point she was forced by him to have an abortion, which she did not want to do, and then she had to flee.

It is also noteworthy that some service users resided somewhere else in between exiting the trafficking situation and entering the shelter. Three specific situations were described. One service user described having stayed with a friend after exiting her trafficking situation, but before entering the COSM. Two service users mentioned that they had been in prison before they came to the

shelter. One of the two described: “I was in prison here for five weeks. (...) Without committing any crime! Because they say I don’t have any documents.” Another resided in an asylum seeker centre (AZC) in the Netherlands for several years before entering the COSM. This was not a good experience for him. When he confided in a friend about the physical problems that were bothering him – haemorrhoids, a consequence of his abuse – word spread quickly. “The people in the AZC said I was crazy. (...) They also told me I was gay, after they said I was crazy. I am not gay!” “When I left the camp I had no friends anymore. They were my enemies.” This experience was not an isolated incident, AZCs have been more frequently reported to be intolerant environments with regards to men who have sex with men.<sup>246</sup>

In summary, service users spoke about three phases in their past: the time before the trafficking situation; the trafficking situation itself; and time spent elsewhere after having exited the trafficking situation but before entering the COSM shelter. Many spoke of negative life events even before they were trafficked and several described a turning point from when things turned for the worse. The trafficking situation itself was regarded negatively by those who spoke about it, as was the time experienced by some who were detained or sheltered elsewhere before coming to the COSM.

### *The present*

In many ways, the present self was an ‘in-between state’ for service users. As one service user said: “I’m still in recovery, I cannot see outside here!” On the one hand, service users had left a past behind them, of which many spoke negatively, and were now in the shelter, away from the influence of their traffickers. One service user explained, for example, that when she just arrived in the shelter, she was kind of nervous, but that after that, she became more relaxed. Another noted how he was very afraid after he just entered the shelter and had sleeping problems and nightmares. However, after he was put in touch with a church and received some verses, he was able to calm down. Thus their entry to the shelter started a transition period that brought safety – not being afraid anymore –, having the knowledge that help and support was available when needed, and the opportunity to catch their breaths and de-stress.

On the other hand, all service users were not quite where they wanted to be yet either, for two reasons. The first reason was that many service users struggled to deal with the mental and physical consequences of their trafficking experiences. This made, in a manner of speaking, the past protrude into their present. One said, for example: “And also you have to think of the past, what happened to me. Am I going to be like this all the time?” I asked: “Like what? What do you mean...?” He replied: “Not happy. With all the things that have happened, I have not been happy. All the time fear”. While this study was not at all designed to conduct any formal evaluation of people’s mental or physical

health status, in the interviews many service users described suffering from various problems. Several indicated that they had not been able to speak with a psychologist but would really appreciate that opportunity. Others described depressive feelings, fear and anxiety, sleeping problems, nightmares, suicidal thoughts, and headaches and stomach aches. One service user said, for example: "It's very difficult to sleep. I've never slept like I used to sleep. When you start to sleep you see this, when you dream you dream about it. [...] I can never sleep. You can never sleep! This is a problem. You cannot stop thinking." Another said: "I am supposed to fall asleep then in one or two hours. But sometimes I lie awake for ten hours, until the morning." I asked: "How come you have trouble sleeping?" He said: "When I do something, I am distracted from the past. When I lie down, things come in my head, from different sides." In particular sleeping problems and headaches and stomach aches, common psychosomatic problems, were regularly mentioned. Studies by other researchers have shown that these are all common health problems among victims of human trafficking.<sup>14,15,18</sup> However, the degree to which service users mentioned suffering from such problems varied. Some did not mention any such problems at all (which of course does not mean they were not there).

As some of the quotes above show, forgetting about the negative events in the past was a daily challenge for many service users. This became clear from many service users expressing a desire to 'be busy' – being busy offered distraction from the problems of the past. Being busy could come in various shapes and forms. One form was, for instance, engaging in social interaction. Many cited the group dynamics in the shelter as a positive influence. One said, for example: "We are here as girls amongst each other, we talk together, joke together, that makes you set your worries aside. It provides distraction." Another form of distraction was participating in activities organized by the shelter. One shelter offered many activities, and the other two very few. Service users in the latter two felt that the lack of activities was a factor in them not being able to stop thinking about the past: "Sometimes happens (...) and you are reminded. You cannot stop thinking about it. And you cannot forget. You don't think too much when you're with people. You think about it when you're alone in a room. You cannot do anything; that is the problem. Maybe if I had something to do, I would have distraction." Another service user from the same shelter said: "Maybe if we have opportunity to maybe arrange a football or the opportunity to go for swimming, another places, meet with other people, you know, that would tend to, to make us forget about the past, maybe. Because if you're involving in any activity, social activity I mean, you will forget about the past. But say for instance you met me in my room, I lying there in my couch. What next you think. I will start thinking about my past, definitely, that one for sure, if I not sleep, if I cannot sleep, then what's next to come to you, you be start thinking AGAIN, for sure, that one for sure."

Perhaps the clearest expression of the fact that service users felt they were in an 'in-between state' was that multiple service users noted: "I cannot recognize myself". This appeared to be caused by incongruences in how service users viewed themselves. Partially, these stemmed from disbelief, shame and a sense of injustice about how they had let themselves end up in a situation like this. One service user said, for example: "Since I find myself in this place, sometimes I see myself stupid, trust me." "Why?", I asked. "Because... if I'm not stupid, the person does fool me. (...) Sometimes I wonder, or I imagine, if I am, if this me [...], in this house. If I am the one facing this problem." For others it stemmed from the fact that they had changed because of what had happened, particularly when they were betrayed or deceived by people they knew: "There are some times when you never trust anyone in your life, because if you consider what you go through, you know you will not trust too many people." One service user even noted: "Friends cannot be trusted. (...) And I don't trust myself either." The final reason why service users felt they were not themselves also brings me to the second reason why service users felt they were not quite where they wanted to be yet (see beginning of this section): there was a gap between the reality of service users' presents and where they envisioned themselves to be in the future. However, to be able to explain the effect that envisioning the future had on participants in the present, I first need to explain how service users envisioned their futures.

### *The envisioned future*

The futures that service users envisioned for themselves were all different. Yet, there were similarities in how service users spoke about the future. One key characteristic of service users' narratives was that all service users envisioned a future that was *better* than the present. What 'better' meant to service users also showed similarities. Many mentioned the desire to find a job. Some pragmatically wished for a job already in line with what they could do. One service user said, for example: "I would like to work with children and I could help elderly people; because I think that that does not require a long education." For others, part of their envisioned path towards finding a job was getting educated: "In a while, when I see things more clearly, at a time when I am stronger, then I could get an education." This was particularly true for the male service users that I interviewed. Furthermore, a characteristic of several service users' aspirations for a job was that they wanted to do work in which they could help others. One, for example, described how she would like to help others, by becoming a paediatrician or a psychologist. "A psychologist needs to have been through a lot, to be able to understand other people. Like me." Finally, some of the women viewed having a job as necessary to be able to support their children, while some of the men viewed acquiring an education and getting a job as a precondition for finding a wife and establishing a family. For example, when I asked how one service user viewed the future, and what she would

want to do, she said: "I would like to have a job." "Why?", I asked. "I have two children." Another noted: "Maybe I finish getting my certificate. Ja? Then maybe I will get a job. Then I will start thinking of getting a family."

The latter brings me to the second trait of a 'better' future that was mentioned frequently by service users: finding a partner and establishing a family. Those who had had to leave their children behind in their home country spoke of them specifically with regard to future plans for their family.

Finally, besides finding work, a partner and establishing a family, making friends was viewed as important in achieving a successful life in the Netherlands. "You need their support", one service user remarked to me. And according to another: "If you know a little Dutch then at least you'll be able to communicate. To make friends."

Another thing that service users mentioned frequently was that they would like to have a house for themselves in the future. Having one's own house was part of a broader theme in my analysis that consisted of the desire for autonomy. One service user said, for example: "I would like to go to an independent house, but now I need time. After that we will see." This also became clear from the joy over small steps in attaining autonomy, such as getting one's own bank account, and from service users' portrayals of how they viewed the future. It felt to me as if service users were looking to establish 'a life', with a job, a family and friends. One service user said, for example, when I asked how she viewed the future: "With my chin up, work, my own house, and the children next to me. And to find a true love." Moreover, some service users, particularly several men, expressed a sense of urgency in achieving that life: "I have not been having access to so many things. So I am looking at my future as being bleak. You know? So. Where am I going? You know? And at my age now, the age I'm now, either you make it or you break it."

For those from outside the European Union (EU), which was the majority of the service users I interviewed, being able to stay in the Netherlands and acquiring a residency permit was a precondition for their envisioned futures and hence an issue of priority concern. Service users provided several reasons for not wanting to go home, including the unsafe situation back home, the lack of economic prospects there, and that they had become a little bit Dutch in the time they were in the Netherlands. The consequences of this desire to belong in Dutch society will become clear in the next section, which will show that service users gathered meaning from working towards a life in Dutch society, but that the gap between their reality and that envisioned future was also a source of difficulty.

### ***Looking forward***

Thinking about the future was not of immediate concern to most service users when they had only just entered the shelter. Several stated that they first needed to 'catch their breath'. However, there was a moment at which this changed for service users. As one service user said: "The longer you stay here, well, the more your mood changes, so to speak. (...) There comes a moment when your mood changes, when you start thinking, where do I go from here?" Some service users appeared to transition quickly to this new state of mind in which the future took up a more dominant part of their thoughts: "I could press charges immediately, but I was really afraid. I had to take my time and three days were enough to take a decision." Others needed more time; one service user in particular stated at the time of her interview: "I don't have any plans for the future yet; I need to catch my breath first."

However, this service user was an exception; with all other service users their envisioned futures, and issues around those futures, took up a significant proportion of the interview. Interestingly, thinking about the future for service users meant thinking about the past. One service user said, for instance: "The most important things is, ehm, I just want to get rid of my life, you know, living in places where I will forget about my past, you know, my past, just think about what the future holds for me, you know?" Forgetting about the past and moving towards a better future seemed almost inextricably linked concepts for service users (demonstrating again the 'in-between state' they were in). A particularly striking example of this link between the past and the future was that one service user noted that two religious verses had particularly helped him to calm down in the shelter: one asking God for protection from evil men ("Contend, O Lord, with those who contend with me; fight against those who fight against me. Take up shield and armour; arise and come to my aid. Brandish spear and javelin against those who pursue me"); another asking God to help him be a vessel for change in the future ("Lord, make us a channel of thy peace"). The need to 'turn over a new leaf' indicated well the linked nature of the past and the future – in one move, leaving the past behind and moving to the next page of life. This theme, like most of the themes in my analysis, was suggested by one of the service users, who said about the interview that she was scheduled to have with the police the next day (in which she would be asked to give statement about her trafficker): "I am nervous. I don't know what kind of questions I'm going to get. Moreover, it is a difficult issue to talk about for me. I do not want to talk about it at length. I do not want to go back in my memories. That was a difficult time in my life, which is why I would like to turn over a new leaf now."

As I noted at the end of the section “The present”, that leaf had not been turned over yet for service users. Thinking about the future had both positive and negative consequences for service users, which I will describe in the following two sections.

### The effect of looking forward: agency over goal attainment

A salient characteristic of service users' presents was that almost all exhibited signs of *working towards* a better future. This was expressed in some of the activities that the service users noted appreciating. Dutch lessons, particularly, were appreciated by almost all service users, as were the integration courses offered by Dutch municipalities to people in asylum procedures. Service users felt these activities would help them establish their future in the Netherlands. Language was seen as a pre-requisite for integration, finding a job, getting an education and, in turn, establishing a family and a social network in the Netherlands. As one service user said: “This is a different country, you know you have to learn the language, you have to mix with the culture, believe traditions, and all the rest of it.”

Skills training and the opportunity to volunteer were other activities that were broadly appreciated. One service user, for example, explained that activities that you can learn from are good, “such as self-defence, where you learn to protect yourself and control a situation”. Another explained that she appreciated vocational skills training, because it kept her busy, gave her more passion about life and was good for her development, making her more independent. With regards to volunteer work, a third said: “I said I can look for work or volunteer work? I said that is ok. Because you cannot be depending on someone for your whole life. I need to do something by myself. I cannot say: give me something to eat, give me this/that... Someone must think: this is someone who can take care of herself. (...) Sometimes it's good to be busy. To be busy with something good. Or with something better than some of the activities, with things that are necessary.”

What all these activities have in common is that they allowed service users to learn and that they were useful: they helped service users get one step closer to their envisioned futures. Volunteer work, for example, brought service users one step closer to finding a job, a quintessential part of those futures. As one service user noted: “When I go out from here, living on my own, I need job also, so I need only that job from [name shelter] to help me.” Moreover, volunteer work gave service users a sense of competency, a feeling they could contribute to “things that are necessary” – also a part of their envisioned futures. In other words, doing volunteer work, learning Dutch and learning skills allowed service users to have a *meaningful day*, mainly by giving them a sense of agency over pursuing their future goals.



Like 'having a meaningful day', 'putting down roots' was an important theme in my research in terms of looking forward. It indicated that service users were, in a sense, already starting to move towards their better future. There was more to this theme than merely settling in; over time service users anchored themselves more and more to their environment, in various ways. Service users put down roots both in terms of their relationships and in terms of the activities that they were engaged in. In terms of relationships, service users started making friends both in- and outside the shelter. Making friends outside the shelter happened via churches that service users visited, but also via other groups, such as for one service user who was introduced to a peer-support group of former victims of human trafficking: "Imagine you meet people who speak the same language, eat the same food as home – I was so very happy that day." And for another service user, who preferred to get out of the shelter, seeing her friends was her most important daily activity. Some service users had also grown attached to certain care providers, such as their psychologist.

Putting down roots was a positive experience for service users. This might have been because the ability to develop a network of friends and to establish customs and familiarity with people who they interacted with allowed them to develop a secure base for themselves. As migrants in the Netherlands, this was likely a development of significant relevance to service users, and as victims of trauma, arguably, even more so. While the activities mentioned (language lessons, skills training and volunteer work) were considered positive by service users because they might help them in attaining their future goals, putting down roots must have felt for service users like they were already moving forward: step by step, the present and envisioned future were blending together.

However, this positive development had the potential to turn into a negative one. As I explained in the Methods section, the COSM shelters were a form of crisis shelter, intended to shelter people for a maximum of three months. As became clear from how long several service users who participated in my research stayed in the COSM, service users' period of stay was regularly longer. In Chapter 6 I will explain why this occurred. The consequence of these long stays in the COSM shelters was that many service users started to put down roots. However, all at some point had to leave the shelter, and frequently the long-term shelter to which they moved was in an entirely different city. Interviewing service users at this stage was not planned as part of my research. However, I did interview one service user after she had moved to a long-term shelter because our second interview was postponed when she was still in the COSM shelter. After having moved, she said that she travelled back regularly to the city where she was originally sheltered to see her friends and she noted that several others did the same. She said: "It's very far from the people you know, from my church, from the activities I started."

Several other service users also moved during my research, not because they moved out of the COSM shelter, but because the COSM shelter moved. Two of them described that they had developed a fruitful relationship with a psychologist in their first place of residence, which they were not able to continue after they had to move. Thus, although putting down roots meant for service users that they could start moving forward, when service users suddenly had to move, they were set back, not allowed to take off into their envisioned future, having to start anew again somewhere else.

### The effect of looking forward: the gap between reality and the envisioned future

Setbacks like these were not uncommon for service users. For most, there was a large gap between their realities and their envisioned futures, between their present selves and their envisioned future selves, a sign of the 'in-between state' they were in – showing that although they had left behind a lot of negative experiences, they also were not quite where they wanted to be yet either. This gap between their realities and envisioned futures became most clear from the fact that the future for all service users was characterized by great uncertainty. “Do you think I have a future?”, one asked me at some point. Later she said: “You will never know your future here”. Similarly, another service user described: “Look at my situation yeah. Where am I going to? Where is my future? What will happen to me?” There were several different reasons for service users' uncertainty about the future: doubts about residency status were a common concern; as were doubts about being able to find work or an education, and a family and friends; the legal case against the trafficker was often a source of uncertainty because the outcome was linked to victims' rights to residency in the Netherlands, but it was also a source of uncertainty in itself; and for some, uncertainty about the future was linked to the whereabouts of loved ones, such as for one service user, who lost track of his siblings years ago and still was uncertain of their whereabouts, and for two service users who left their children behind in their home country and were uncertain whether they would ever be reunited.

All this uncertainty led service users to *worry* about the future. One service user explained, for example, that she had trouble forgetting about the past, but that her worries about the future were particularly difficult to deal with: “First, I have no residency status here. I'm afraid they're going to send me back. Besides that, I have no education or work experience, so that's why I'm worried.” These worries about the future were a source of stress that added to the stress that came from the past protruding into service users' presents (see earlier section “The present”). When service users spoke of 'being busy' as a form of distraction from their problems, they did not speak only about distraction from thinking about the past, but also from worrying about the future. As one service

user noted: “Everything is sometimes stupid, you just have to be quiet sometimes, and think about the future, and the past, and everything in your life. That is not going to be happy.” Another described well how these various stressors could accumulate: “Sometimes it’s just too much. I thought: Why? Why me? One thing come, and then the other.”

A key facet of service users’ feelings of uncertainty was the lack of autonomy that they experienced, i.e. a lack of control over decisions that concerned their own lives. Indeed, in many decisions of importance to their futures, the locus of control did not lie with service users themselves, and service users experienced a great sense of dependency on the police, lawyers and social and health providers. This was a particularly salient point, because one of the key features of being trafficked – the period before they entered the shelter – is that one also loses the freedom to make one’s own decisions. Examples of such dependency for service users while they resided in the COSM shelters were: that several women had their children taken away from them by the Dutch child services, because they were considered to be unfit to take care of them (one participated in my research); that residency status was decided upon by the police and by lawyers; that procedures around human trafficking are complicated and often ill-understood; that service users were mostly legally not allowed to look for work and education; and that service users had to abide by various rules and regulations in the shelters. One service user remarked, for example: “You’re the one who needs help, so you’re the one who needs to accept everything”. And: “I am here but I don’t know what is going on. They will never tell you what will happen. You’re just here and never know what is next.” The most striking demonstration of the lack of power that service users had over their own lives occurred when they received a letter that the police did not have enough evidence to prosecute the trafficker. The consequence of non-prosecution is that service users most likely will not be allowed to stay in the Netherlands if they are from outside the EU; the right to permanent residency for a victim of human trafficking in the Netherlands is reserved by law almost exclusively for those victims whose traffickers are prosecuted and convicted. In one letter, the service users’ hopes for the future were destroyed. This was devastating to some. For example, the newborn child of one service user, who the care providers spoke about as a strong person and a lovely mother, had to be placed under child care surveillance for a while because her mother had made threats to kill herself after she had received the letter. She herself said: “The police stopped my appointment [for pressing charges]. I was planning to kill myself.”

In some instances, the shelters contributed to the lack of experienced autonomy. The shelters where service users resided had rules and regulations, by which service users had to abide. Examples were: mandatory activities, curfews, mandatory visits to psychologists, not being allowed to have a phone,

having no choice in the assignment of roommates, not having ownership over one's own government benefits, and being asked upon arrival at the shelter to sign a form (in Dutch) agreeing with the shelter rules. One service user that I interviewed continued to clash with service providers over these rules. She said: "My social worker forced me to sign a protocol. And if I break the protocol three times I am removed from the house. I told her: You can make five more protocols, but this is the worst house I have ever lived in." In the end she decided to leave the shelter. The number of rules and regulations did differ considerably by shelter; one in particular had more rules than the other two. The effect of this I will discuss further in the Discussion section of this chapter.

Another part of the gap service users experienced between reality and their envisioned futures was that service users were ostracized in the Netherlands; they generally knew little about the country and still had to adapt to the language, the culture and the traditions. Service users also *felt* ostracized, because belonging in Dutch society, building a life there, and making friends were part of service users' vision for the future. Service users' lack of integration into Dutch society was demonstrated most extremely by the fact that several service users told of instances when they were met with considerable hostility and racism. Such instances appeared to occur more frequently for service users who were sheltered rurally than in a large city. With one rural shelter in particular, there were several examples of service users being discriminated against, including being denied by the city council parts of their benefits to which they were legally entitled and being denied care by a general practitioner and a dentist. Several service users also encountered hostilities from local residents, such as being bullied by local teens and being maltreated, ignored or shied away from by adults. One service user explained that the effects of being treated as such were dehumanizing: "Imagine the situation wherein, you know, some people don't want to talk to you, then you feel you are left out, you feel maybe I'm not in this world, or maybe I'm a different human being, you know?" Another noted: "Me, I am not from Holland. I am nothing." The antithesis of such dehumanizing treatments was found by some service users to lie in their interaction with service providers in the shelters. As one service user explained: "They refer to us as maybe say we are *asielzoeker*, which means something like refugee, something like that. But because of some [service provider], they come closer to us, we feel as if we are amongst them. (...) You know, so we feel as if really we are part of this society." This particular sentiment appeared to be part of what service users more broadly considered being the most important aspect of a good care provider: somebody who shows interest, listens, understands, and gives advice when needed.

Thus, while service users desired strongly to move towards a better future, they lacked agency in bringing about that future, resulting in uncertainty about the future and leaving service users

stunted in their goal pursuit. The rules and regulations in the shelters added to service users' lack of self-determination and their ostracized place in Dutch society increased the gap that they experienced between their realities and their envisioned futures. The result of all this was that service users felt as if they were 'standing still' while wanting to move forward, as in a state of limbo. This feeling did not stem so much from the gap between reality and their envisioned futures, but from the gap between wanting to work towards better futures, pursuing their goals, and being stunted in doing so. One service user said, for example: "The things that make me happy, I don't find here in the house." And another: "Everything goes so slowly." A third: "I'm seeing my days here as something like, what can I say, perhaps I should say it's my waste days, you know, like I'm wasting my time here." In making appointments with service users for interviews, it was remarkable how some stressed that I could come at any time, since their calendars were empty. One service user perhaps made clear best the degree of 'standing still' that they experienced, by explaining about a trip to the general practitioner: "If I have an appointment with my doctor for, for... I mean that would be my happiest moment. Because, the reason, I look at it that I need to get up early, I need to go down to get bus station, go get bus, you know, that time that we spend in the bus, I will see different people, then the time it will take to go to [...], I will see different places, then when I reach [...] again, before my appointment with the doctor, I need to see different people, you know? You know, that different environment alone that I've seen, you know, that create a new different thing in my mind." The state of limbo that service users found themselves in was a negative experience in itself, but also resulted in service users not 'being busy', resulting in turn in a lack of distraction from past problems and future worries. As one service user explained: "But sitting here all day, you know, since morning evening, morning evening, morning eve – you don't get any other places you just sitting down in one particular place, it's very, very, very difficult, in fact that one make the situation more difficult than the situation is."

## **Discussion**

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In the previous section I presented the results of my analysis of service users' accounts of their own recovery process in the three COSM shelters. Service users' self-representations and self-evaluations showed a clear temporal pattern: the past was generally evaluated negatively, deemed as something to forget and not to return to; the present was an 'in between state'; and the future was envisioned positively, as a life with a job, family and friends. This pattern matches the 'progressive pattern' in Gergen's theories of temporal self-evaluation.<sup>244</sup> Looking forward, and being able to work towards a better future, gave meaning to service users' presents. However, in the pursuit of those goals service

users were often stunted, because many decisions that were made about their lives were outside the locus of their control. As a result, there was also a lot of uncertainty about the future and thinking about the past and worrying about the future were causes of stress for service users in the present. This left service users in a state of limbo; not quite in the past, yet not quite in the future either, and being stunted in pursuing their goals. Despite this, service users found ways to work towards a better future, for example through language classes, skills training and volunteer work.

In this Discussion section, I will first elaborate on the theoretical basis for the envisioned futures of service users, in particular discussing the theory of self-determination and various theories around hope. I will then explore further the notion of being 'in limbo', and I will specifically discuss the concept of bounded agency and how it was possible that service users pursued their goals, seemingly against all odds. I will finish by discussing the implications of the findings of this chapter for service provision.

## Self-determination and hope

Service users' envisioned futures consisted of a life with a job, family and friends. Integral to these aspects of their future lives was a desire for achieving autonomy. These findings are not unique to this population. When other marginalized groups, such as the homeless, are asked they also indicate the lack of fulfilment in these areas to be most salient.<sup>(247,p15)</sup> The apparent broader relevance of these findings can be explained through the theory of self-determination, which postulates that all human beings have three basic psychological needs: autonomy, competence and relatedness, and that fulfilment of these three needs is associated with increased well-being.<sup>248</sup>

The need for *competence* ("individuals' inherent desire to feel effective in interacting with the environment"<sup>249</sup>) by service users in this research became clear from their future goal to find a job. Service users also strived for competence in the present. Often these short-term competence goals enabled them to pursue the longer-term goals of work, family and friends. Examples of such short-term goals were learning Dutch, doing well in integration classes, or learning other practical, potentially beneficial skills. But competence in the short term was not always driven by long-term goals: some service users indicated deriving satisfaction from having done volunteer work simply because it mattered.

Service users' need for *relatedness* ("individuals' inherent propensity to feel connected to others"<sup>249</sup>) showed from their future goals of having a family and friends. This need was not independent from the need for competence, which was viewed by several service users as a precondition for

having a family. As with competence, service users also exhibited a need for relatedness in the present, as became clear from the signs of putting down roots, the joyous descriptions of connecting with people from the same country, and the negative descriptions of being ostracized in Dutch society.

Deci and Ryan, who laid the foundations for self-determination theory, write that “autonomy occupies a unique position in the set of three needs: (...) being able to satisfy the need for autonomy is essential for the goal-directed behaviour to be self-determined and for many of the optimal outcomes associated with self-determination to accrue.”<sup>248</sup> The need for *autonomy* (“individuals’ inherent desire to feel volitional and to experience a sense of choice and psychological freedom when carrying out an activity”<sup>249</sup>) was a key theme throughout service users’ descriptions of their envisioned futures. Examples in the present were the pride that one service user took in opening a bank account and the negative experiences of autonomy-limiting rules in the shelters, such as not being allowed to have a phone.

Self-determination theory provides an explanation for the predominance with which themes such as work, family and friends emerged from my analysis. The theory explains why people strive towards these goals in general: the fulfilment of the three basic needs of autonomy, relatedness and competence has been shown to be associated with increased well-being.<sup>250</sup> However, the theory may apply particularly to this population, because of the traumas experienced by many service users. Researchers have found that the fulfilment of these three basic needs is not only associated with increased well-being, but also with better *coping*.<sup>250</sup>

Lazarus distinguishes between two types of coping: emotion-focused and problem-focused coping.<sup>251</sup> He writes: “When stressful conditions are viewed by a person as refractory to change, emotion-focused coping predominates; when they are appraised as controllable by action, problem-focused coping predominates”.<sup>251</sup> This may well explain why several service users in this research spoke of ‘turning over a new leaf’. By pursuing future goals, service users made their stress about the past controllable (since it was linked for them to leaving the negative experiences of the past behind), allowing them to take a problem-focused approach to coping. This suggests that not only fulfilment, but even the mere pursuit of the three basic psychological needs is associated with better coping, as is indeed confirmed by Deci and Ryan who speak of the importance of both *goal pursuit* and *attainment* in predicting behavioural quality and mental health.<sup>248</sup>

Related to the concepts of goal pursuit and goal attainment is the concept of *hope*. Hope for the attainment of goals is an integral part of goal pursuit, but this is not necessarily the case vice versa.

Snyder et al define hope as “the perceived capacity to produce pathways to desired goals (this is called pathways thinking), along with the motivation to begin and continue the use of those pathways (this is called agency thinking)”.<sup>252</sup> Similarly, Averill has posited that hope can only occur when the goals are also “under one’s control”.<sup>253</sup> In other words, hope is the wish for a possible goal under the conditions that one is motivated to work towards that goal and that one considers autonomous pursuit of that goal possible. Thus, hope does not necessarily involve goal pursuit (only the possibility thereof), while goal pursuit always involves hope. Hence, hoping for goal attainment is one step further removed from actual goal attainment than the act of goal pursuit (and wishing yet again one step further).

Interestingly, even merely *hoping* for the fulfilment of the three basic needs has been shown to be associated with better coping.<sup>254</sup> This has interesting consequences when viewed in light of the findings of this chapter. However, since hope is strongly linked to agency over goal attainment, to discuss these consequences I first need to discuss the agency experienced by service users over the attainment of their goals.

## In limbo?

The salient characteristic of service users’ presents was that they felt they were ‘standing still’, as in a state of limbo. A lack of agency (“the capacity, condition, or state of acting or of exerting power”<sup>255</sup>) in changing that situation was experienced. There were many external regulators that forced service users to accept decisions about their lives that lay outside their control (as one service user said: “you’re the one who needs to accept everything”) and sometimes even outside their knowledge (“You (...) never know what is next”). The most prominent expression of this was the dependent position service users occupied in the migration system. Migration to the Netherlands was considered by service users from outside the EU to be a precondition for a better future. The decision-making mechanisms for a residency permit were outside their control, and many service users were not knowledgeable about the procedures involved.

A variety of policies, rules and regulations at the shelters also contributed to the experienced lack of agency because they blocked service users in being autonomous, even leading to one service user leaving the shelter. Brunovskis and Surtees have written in detail about the restrictions regularly put upon victims of trafficking in shelters.<sup>147</sup> They conclude: “Restrictions may infantilize program beneficiaries and impact their agency and ability to dissent and negotiate within the program framework.”<sup>147</sup> A further complicating factor was that most service users, unlike the one that left, felt there were few possibilities for leaving the shelter. Administrative procedures often meant that



they could not apply for follow-up housing until several months (see Chapter 6 for how this situation could arise) and the lack of a social network in the Netherlands limited their options for seeking alternative housing.

In a way, service users were bound to the migration system and the COSM shelter system, and had little to no power to negotiate the conditions of either. Their ostracized place in Dutch society and the general lack of relatedness to people outside confined them even more to the shelter. It is noteworthy that service users' lack of agency in changing their situation because of a lack of autonomy was not new for most. Non-autonomy is a key aspect of trafficking experiences and many experienced a 'turning point' even before their trafficking experiences that signalled the beginning of an era of non-autonomy. Lacking the freedom to make decisions over one's own life at various stages in the past and present (and about the future) (Figure 5.1), it is, perhaps, no wonder that service users felt trapped between the events that befell them. As one said, "life just happens to me". Several other authors also refer to the recurring nature of external negative regulators for victims of human trafficking, such as Wilson, who speaks of victims "running a gauntlet".<sup>256</sup>

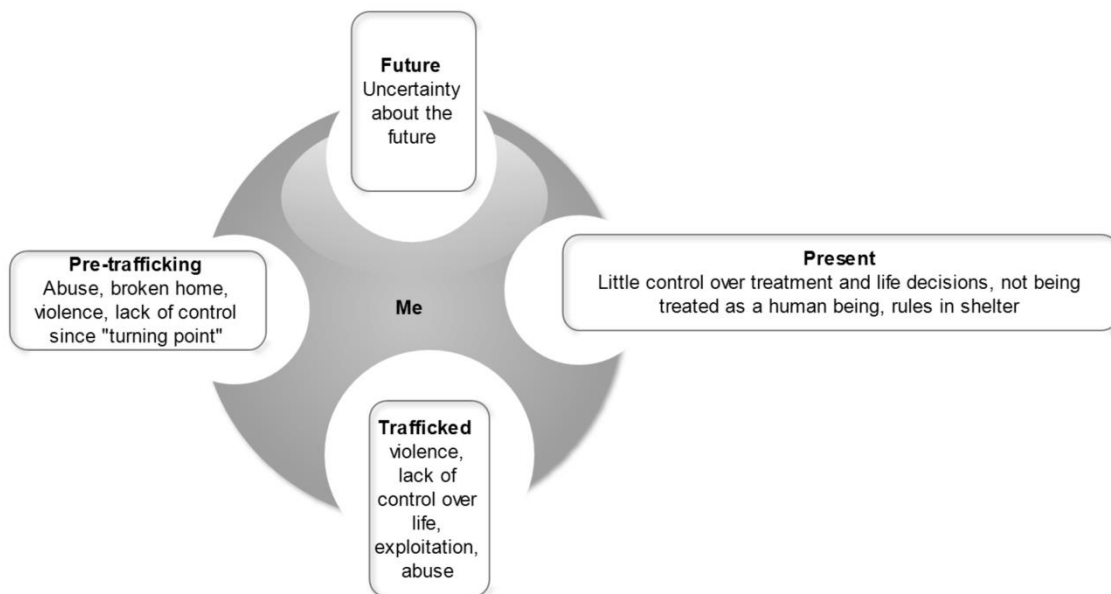


Figure 5.1. Loss of autonomy in different phases of the lives of victims of human trafficking because of various external negative regulators

The consequences that such a lack of experienced agency in goal attainment can have on people are well explained by self-determination theory, which states that the strong presence of external regulators prevents self-determined behaviour and stunts the intrinsic motivation towards goal pursuit.<sup>248</sup> Deci and Ryan write that when "in spite of people's persistent attempts to satisfy the

fundamental needs for competence, relatedness, and autonomy, if the social world provides no reliable paths that allow fulfilment of these critical needs, and if people have to stay in situations that consistently block need satisfaction (e.g., children often have to stay in non-nurturing homes and schools), self-determination theory predicts significant psychological costs and accommodations".<sup>248</sup> Service users' remarks that they could not "recognize themselves" might be an expression of these detrimental consequences.

Interestingly, however, parallel to the lack of experienced agency in goal attainment, service users also showed a strong drive to develop competences that could help them achieve their future goal of a life in the Netherlands with a job, a family and friends. As noted previously, shelter activities that involved learning Dutch were much appreciated, as was learning English, vocational skills, and engaging in volunteer work. This presents us with a conundrum: how can service users exercise agency in goal pursuit, while they simultaneously experience little agency over goal attainment?

The answer to this question might be found in theories about self-deception. Self-deception in the face of uncertainty about the future is not only common, but it is human.<sup>257</sup> Robinson writes that "in perceiving the future self, most of us appear to be great optimists, overestimating the likelihood that positive events will happen to us as well as underestimating the likelihood that negative events will happen to us."<sup>257</sup> Having overly positive illusions about the attainability of goals provides us with a sense of agency over goal attainment. It offers the possibility of goal pursuit and thus allows us to hope. We are all wired, it seems, to hope for the best.

Yet, service users' accounts did not show any signs of such self-deception. Service users did not display what Snyder describes as being "overly positive"<sup>254</sup> or Robinson's description of overestimations of likely outcomes of positive events.<sup>257</sup> Service users were distinctly aware that many decisions lay outside their control and that those decisions may result in non-attainment of their goals. Despite realizing this, service users established pathways toward goal attainment (e.g. learning Dutch) and actively pursued those goals, even though a decision on migration status might stop any chance of their envisioned futures in the Netherlands. It is not so much that they ignored or deceived themselves into believing that the external loci of control did not exist; but that despite of the existence of these external loci of control they chose to focus on the pathways that they *could* control. This behaviour can be explained through theories on the concept of bounded agency.<sup>258</sup> Evans, in explaining this concept, states that the concept sees actors as "having a past and imagined future possibilities, which guide and shape actions in the present, together with subjective perceptions of the structures they have to negotiate, the social landscapes which affect how they act."<sup>258</sup> The fact that service users still showed agency in pursuing their future goals, despite being

bounded to the migration system and the COSM shelter system, with little power to negotiate the conditions of either, provides testament to the fact that even in a context with highly binding external regulators, people will continue to exercise agency to pursue their goals; in a way, agency against all odds.

This leaves the question of why service users were so driven in their goal pursuit. The answer to that question can be found in the effects of hope and goal pursuit, discussed in the previous section. By focusing on the pathways that they can control, service users enabled themselves to hope for goal attainment (remember that hope requires both a pathway and agency over that pathway – the possibility for goal pursuit) and to actually pursue their goals in the context of a large degree of external regulation. Also recall that both hope for goal attainment and goal pursuit are associated with better coping and well-being. This suggests that by fighting the fights that can be fought, service users gave themselves a fighting chance.

## **Implications for service provision**

So what does this all mean in practice for service provision for victims of human trafficking? The main lesson that follows from the two previous sections is that to facilitate service users' recovery as part of the COSM programme, there is a need to redress the thwarted sense of agency over goal attainment currently experienced by victims of human trafficking in the programme. This can be achieved by providing service users with opportunities to hope for, pursue and attain their goals within the structural boundaries of their situation.

### ***Lessons for service provision approaches***

This conclusion is not only relevant to the COSM programme, but also to the wider literature on the service needs of victims of human trafficking in a post-trafficking setting. Existing frameworks for the post-trafficking social and health care needs of victims of human trafficking generally adhere to a model that consists of a thematic categorization of different social and health care needs, sometimes differentiated to two or three different stages of recovery (see Chapter 2).<sup>14,26,30,41,134–139</sup> These frameworks are useful for helping service providers to consider the different kinds of services that need to be in place. However, the frameworks exhibit a strong focus on practical needs, protection and helping people to deal with traumatic events of the past,<sup>14,26,136</sup> suggesting a conceptualization that victims of human trafficking are people in need of rescue and rehabilitation.<sup>34,41,147</sup> While these are all indispensable components of the broad spectrum of social and health services that need to be available for this group, the relatively minor attention that service users' goals for the future receive in these frameworks is in discordance with the importance

of hope and goal pursuit for service users themselves. Some frameworks do mention one or two service needs that relate to the three basic psychological needs from the self-determination theory, such as job training and employment, or developing a social network.<sup>26,136</sup> Yet, commonly, these needs are described to be “long-term needs”, suggesting that service users first need to stabilize.<sup>26</sup> While stabilization certainly should be the priority in the short-term, my findings suggest that service users start thinking about their future goals after a short period of time. They also suggest that if the need to look forward is not accommodated, service users will feel themselves to be standing still and to be in a state of limbo, with potential negative consequences for their recovery. Moreover, Snyder et al have shown that people may need help with goal-setting, pathway development and developing agency over goal attainment.<sup>254</sup> Therefore, a more prominent focus on creating opportunities for services users to pursue the goals of autonomy, competence and relatedness would likely make a valuable addition to the existing social and health care provision frameworks for victims of human trafficking.

The next question is then how such a more prominent focus on service users’ goals for the future could be established. For this, lessons can be learned from other vulnerable populations. Victims of human trafficking have been conceptualized as a population that shares characteristics and service needs with several other vulnerable groups.<sup>14,178,259</sup> In this chapter, service users displayed both migrant perspectives and perspectives belonging to victims of violence, as became clear from the difficulties that many service users experienced around residency status and the difficulties that service users had in dealing with their violent pasts. Therefore, looking towards lessons from service evaluations for these groups may provide useful insights for service provision for victims of trafficking.

When discussing such research for victims of violence in the Netherlands, it is important to note that in the area of service provision for this group of victims a shift has just taken place in social care policies. For years, the dominant model of guidance for care provision was the ‘8-phase model’, which describes a staged approach to care provision, including a thematic categorization of different social and health care needs. Recently, after extensive research by Wolf on the social care practices for victims of violence in the Netherlands, this model was replaced by the Strength-based practice model.<sup>260–262</sup> This model has a strong focus on helping service users to establish a meaningful existence and on helping people develop agency in working towards that future, by taking their strengths (instead of their problems) as the starting point for service provision. This approach aligns with the future-orientated view of service users displayed in this chapter. As one service user noted:

“I want to start taking care of myself; I don’t always want to be a social case. I have capacities too! (...) It’s just, I have no anchor point currently, which is why I can’t do it.”

When looking at social and health services research in the Netherlands for asylum seekers, two recent studies in particular bear relevance to the findings of this chapter. The first, aptly titled “small steps of great meaning”, investigated shelter and care provisions for asylum seekers and advocated for a more humane policy in service provision for this group.<sup>263</sup> It too speaks of an in-between state that service users are in, discusses the importance of agency in goal attainment, and concludes that “only when people are not limited to one aspect of their identity, that is being an asylum seeker, but when dreams, ambitions and talents are given the opportunity to develop, can we speak of a truly humane approach to care.”<sup>263</sup> The second, a report of minors seeking asylum in the Netherlands, called “Waiting for your future”, speaks of the uncertainty that children are faced with and the difficulties they experience in “dreaming about a future, let alone shaping that future”.<sup>264</sup> The findings of these reports show striking resemblances with the findings of my research presented in this chapter and provide important confirmation of these findings from a group that is partially comparable in terms of service needs. Moreover, this also suggests that while the health consequences of violence associated with human trafficking have received a lot of attention in the literature,<sup>15,265</sup> the migrant narratives of victims of human trafficking may have not received enough attention. A greater focus on this part of their service needs may help to achieve a more future-orientated approach to service provision for victims of trafficking. The Belgian NGO Flemish Refugee Action has recently proposed a model for what a future-orientated service provision approach for asylum seekers should look like, called “Make the future puzzle”.<sup>266</sup> This model, which describes itself as “future guidance”, advocates “paying attention to the whole story of your service user and the future that he envisions”.<sup>266</sup> This formulation resembles the principles of the strength-based model that has recently become the dominant social care approach for Dutch social care shelters, described in the previous paragraph. Moreover, the approach specifically takes into account the uncertain residency status of service users and provides guidance whether services users’ futures entail residency in Belgium, return to their country of origin or migration to a third country.

In 2014, the Dutch Shelter Federation also acknowledged that there was a need for specialized guidance for foreign victims of human trafficking in shelters and published a document called “Safe Future: A complementary methodology for social workers providing assistance to foreign victims of trafficking and victims of domestic violence, who remain uncertain about whether they can stay in the Netherlands.”<sup>267</sup> Importantly, the Safe Future approach builds from approaches in service provision for asylum seekers and refugees, such as the Flemish Refugee Action model,<sup>266</sup> and from

the Strength-based practice model.<sup>260–262</sup> The document aims to open “discussion about future options and counselling for return and reintegration for clients who return to their country of origin”.<sup>267</sup> While it is quite focused on counselling for return to victims’ origin countries, this approach advocates a specific future-orientated approach, which may help to address some of the problems raised in this chapter. It is not clear yet to which degree this approach will be adopted by the shelters. It will be interesting to evaluate the impact of this report on service provision as part of the COSM programme and to assess whether it will help to tailor service provision more to the future-orientated needs of service users.

### *Lessons for the COSM programme*

Besides lessons for service provision approaches, several lessons also follow from this chapter for the Dutch COSM programme. First, what this chapter makes clear is that victims of human trafficking are faced with a complex array of problems, which show overlap with the problems facing both victims of violence and migrants. It is now broadly accepted that a specialized approach to service provision is necessary for this population.<sup>30,135</sup> Yet, the Dutch COSM programme started as a ‘bed-bath-bread’ programme (a Dutch term), financed only to provide the most basic service provision to victims. In the next Chapter, Chapter 6, I will elaborate on these arrangements and how this has affected service provision given the complex needs profile of victims as shown in this chapter and in Chapter 2.

Second, Ntoumanis et al write that “psychological need satisfaction can be promoted or thwarted by different facets of the social environment.”<sup>250</sup> A non-conducive environment to need satisfaction, they argue, consists of a controlling and coercive context. On the contrary, autonomy support, structure and interpersonal involvement support need satisfaction. There are various ways in which autonomy support, structure and interpersonal involvement could be achieved in service provision. Direct service provision practices, the shelters’ vision and approach to service provision, and the availability of additional services outside the shelter all play a role. The previous section makes clear that lessons might be learned from various service provision models in considering these aspects of service provision.<sup>260–262,266</sup> Hence, it deserves recommendation that the COSM shelters evaluate the degree to which their service provision practices adhere to the best practices advised by these approaches. The new Safe Future methodology might particularly provide practical suggestions for the Dutch service provision system for this group.

To make insightful what such lessons and suggestions could entail, I provide two examples here. The first example relates to the shelters’ overall visions. The three COSM shelters that participated in this research had strongly opposing visions for service provision. I found that one took a structured

approach, with many rules and daily schedules, proposing that structure promotes activation and, as a consequence, recovery; while the other two shelters took a personal freedom approach, with few rules and no daily schedules or activities, proposing that personal freedom and regaining agency were key to recovery (see Chapter 6). As compared to Ntoumanis' recommendation for autonomy support, structure and interpersonal involvement, both approaches have their strengths and weaknesses. Many service users in the first shelter felt controlled and experienced a lack of self-determination, which even caused one service user to leave. However, service users in the shelters with no activities felt 'not busy', which also had detrimental effects for their recovery. Ntoumanis et al suggest that the optimal approach might lie somewhere in the middle. Structure and interpersonal involvement are important, yet the manner in which these are provided is crucial – in a way that supports service users' autonomy. To find this middle ground, the COSM shelters might look at the Strength-based practice model and the Future guidance model, which both put strong emphasis on providing service users with agency over their goal attainment.<sup>260–262,266</sup>

A second example of how measures could be taken to promote a service environment that provides autonomy support, structure and interpersonal involvement, relates to the shelters' direct service practices, in particular the daytime activities. This chapter has shown that for service users, these activities are much more appealing when they are 'useful', i.e. when they help them pursue their goals. More emphasis should therefore be placed on the provision of such activities, rather than those that are mainly aimed at distraction.

Lastly, there are several lessons for the COSM programme that follow from this chapter's finding that service users regularly experienced feelings of standing still and being in limbo. These experiences were exacerbated by a number of challenges in the service provision system. These challenges, and what might be done to redress them, are discussed in Chapter 6. In this chapter, Chapter 5, I have made clear how important it was for service users to be able to hope for and pursue their own personal goals. The fact that service users were stunted in doing so, partially owing to existing challenges in the service provision system, demonstrates the significance and impact of some of the challenges that will be discussed in the next chapter.

## **Limitations**

The research conducted for this chapter has several limitations.

An important limitation is that service users were interviewed at least six weeks after their first entry to the COSM shelter, with a median of 2.8 months (this was a safety measure). As a result, the

findings of this chapter, including my analysis of service users' goals for their own recovery and of their experiences with service provision, apply particularly to the later stages of victims' stays in the shelters. In the earlier stages, safety and stability have been shown to take up a more prominent place in service users' needs profiles.<sup>41</sup>

It is also important to stress other limitations of this research's study population. First, this study only included victims of human trafficking who received post-trafficking shelter and care, which is only a small percentage of all victims of trafficking.<sup>37</sup> Moreover, this research was limited to adult, foreign service users and to those who were trafficked for the purpose of sexual exploitation. The transferability of this research beyond this population is limited.

Another limitation is that this research was conducted solely in the three COSM shelters, a setting with a specific programmatic, social, medical and legal context. Therefore, the findings of this chapter only bear direct relevance to this population and this context. This limitation is especially important given the time-limited nature of the COSM programme and the uncertainty about its future (see Chapters 1 and 6). However, that said, Green and Thorogood have argued that the overarching themes that emerge from qualitative research are often more transferable than studies' context-specific findings.<sup>189</sup> By linking these overarching themes, which consisted of my descriptions of service users' goals for their recovery process and their experiences with that process, with theories of hope and goal pursuit in my Discussion, I have tried to further increase the transferability of my findings. Doing so, I hope to have argued that the strong drive for goal pursuit experienced by foreign victims of human trafficking can be expected to exist in other contexts as well.

Furthermore, I have only rarely made mention of differences between men and women in this chapter with regard to the goals they formulated for their recovery or their experiences of service provision. Although this might seem to be a limitation of the research, in fact I encountered few differences between men and women in the problems they faced, in how they envisioned their futures, and in how they experienced service provision. This may be surprising to some; one service provider noted, for example, when I asked whether he had provided care to male victims: "Oh, just a few. (...) But with all, as far as I can remember, I wondered how this could have happened to them." "Why?", I asked. "Because I just cannot imagine it. <laughs> (...) There was one, for example, he was clearly a heterosexual guy, but he was exploited in the gay sex industry." This comment signifies the taboo that exists on sexual exploitation of men, which has been described by some as a triple taboo: a taboo on doing sex work, a taboo on homosexuality and a taboo on male victimization.<sup>175</sup> Both past research and numbers from CoMensha show that sexual exploitation of men does take place in the Netherlands.<sup>33,37,175</sup> The fact that I found no differences between the problems that male and



female service users were faced with, nor in how they envisioned their futures, makes this chapter shed light on the consequences of sexual exploitation for men and women equally. Importantly, it also stresses that male victims must be included in debates about service provision after human trafficking for the purpose of sexual exploitation.

Lastly, it is a limitation that the findings presented in this chapter have likely been influenced both by me and by what service users wished to convey.

With regard to the former, according to Gheorghiu, “interviewees’ accounts are constructed in the interaction between narrator and interviewer”.<sup>187</sup> I concur with this. It is important that I am explicit about my own standpoint in this research, which my work on the political economy in which this research is grounded helped me clarify (see Chapter 2). My research focuses on vulnerable groups, from the perspective that all deserve equal opportunities for participation in society and for achieving an optimal state of health. It is also important to take note of my background, which is in the medical sciences and in public health, which has undoubtedly shaped the direction of both data collection and analysis for this chapter.

With regard to what service users wished to convey, because it was a specific objective of this research to assess what was important to service users during their stays in the COSM shelters, this research relied for a large part on service users’ accounts. Hence, it is important to recognize that these accounts reflected how service users have wished to tell their stories to me. As part of this research I have sometimes wondered whether service users’ accounts may have been influenced by their agendas or goals. Did they feel that a certain narrative would give them a better chance of attaining certain goals, such as residency status, than others? Had they made those narratives their own and were they the accounts that I was listening to? As my supervisors stated at one point: “They all want to learn Dutch? Really? *Dutch*? How many people speak that language in the world?” This is, of course, a possibility. On a note of reflection, I have noticed that I find myself having a hard time doubting the stories of most service users. It feels, in a way, wrong to doubt the people who have just opened the books of their lives to me (with service providers I noticed I was much less inclined to refrain from doubt, perhaps owing the fact that their accounts are much less personal). As a service provider, I feel it is also not one’s task to doubt. However, as a researcher – it is. Having said that, I have no means of proving or disproving the stories that service users told me. Some things I do know. I found little discrepancies between service users’ accounts and what was written about service users in their case records by their care providers. Similarly, service users’ stories matched what I was told by service providers (e.g. that Dutch lessons were immensely popular among service users). This might, of course, just mean that service users were consistent in

presenting their fictional narrative, but I do not believe that to be the case. Another thing I know is that in terms of twisting the truth to acquire residency status, there is more reason to lie about the past, than about how you feel in the present, or how you see your future (which is what this article is mainly concerned with). Finally, it occurs to me that if service users have presented me with fictional accounts, then the purpose of that would have been to achieve their future goals. In other words, if service users faked wanting to learn Dutch, it was because they desired a life, with a job, a family and friends in the Netherlands. Ironically, this supports the main message of this chapter, rather than undermining it, i.e. that service users had an incredible strong drive for goal pursuit and showed great agency in pursuing those goals.

## **Conclusion**

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In conclusion, my findings have shown that service users of the Dutch COSM programme exhibited progressive temporal patterns of self-representation and -evaluation. They strongly desired to fulfil the basic psychological needs of autonomy, competence and relatedness, but were stunted in pursuing those goals. Finding ways to pursue their goals, seemingly against all odds, meant that service users could hope for a better future. Both pursuing these goals and hoping for their attainment helped service users to cope with the problems of their past and their worries about the future. To facilitate service users' recovery in a post-trafficking setting, there is a need to provide them with opportunities to hope for, pursue and attain their goals within the structural boundaries of their present situation. Future-orientated, strengths-based approaches may help social and health services in that setting to do so.

## **Chapter 6**

# **Challenges, changes and facilitating factors in developing a system of care for victims of human trafficking in the Netherlands**

## **Summary**

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### **Introduction**

Since the early 2000s, victims of human trafficking have become a target population of increasing relevance for the Dutch social and health services. To address their need for specific shelter and care, a new system of care was established for this population in the Netherlands in 2010: the Categorical Care for Victims of Human Trafficking (COSM) programme. This chapter presents the results of an investigation into what challenges were encountered in providing social and health services to victims of trafficking as part of the COSM programme.

### **Methods**

Interviews were held with 25 people who worked in the COSM programme. The interviews were analysed using a grounded theory approach. The core phenomenon of this analysis was the impact of the newness of the COSM programme on service provision: challenges to service provision were assessed with a focus on the system's newness and development, changes made in the system of care to address these challenges were identified, as were factors that facilitated the development of services as part of the COSM programme.

### **Results**

Five challenges in developing service provision as part of the COSM programme were identified at the policy and governance level: elucidating responsibility, financing, defining the population, governance for a complete chain of care and shelter identity issues. Three were identified at the organizational level: achieving coverage of a broad range of services, overcoming administrative barriers, and evaluation and feedback cycles. One was identified at the service delivery level: developing expertise. Eight factors were identified that facilitated or impeded the development of the COSM programme: political and societal attention, interest groups, a service user-centred approach, (de-)centralization, network development, an active change attitude, specialization, and evaluation and feedback cycles.

### **Discussion**

The introduction of a novel system of care for victims of human trafficking in the Netherlands was accompanied by a range of challenges in developing service provision that spanned all levels of the system of care. In the years after its establishment, these challenges were increasingly resolved – a process that was facilitated and impeded by several factors. Taking note of the challenges that

**were encountered in developing service provision as part of the COSM programme, the changes that were made in the system of care to address these challenges, and the factors that facilitated that change, might help to facilitate the introduction of systems of care for this population in other countries.**

## Introduction

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*“The story really starts a couple of years ago; I was not working here yet at the time. That was around 2007 I think, or 2008. It was determined that there were really not any good specific shelter provisions for victims of human trafficking. The existing shelters at the time, they were not ready to provide shelter for this group. The Social Support Act too did not take this group into account. They were referred to as a new population. So the pressure increased to do something for them.”*

– A service provider in a shelter during one of my interviews

In the Netherlands, shelter for victims of human trafficking was arranged prior to 2010 through the same system as for victims of domestic violence and the homeless. Some victims of trafficking also resided in asylum seeker shelters.<sup>33,34</sup> However, with increasing numbers of victims of trafficking seeking both shelter and care, and with increasing recognition of the unique service needs of this population,<sup>14,15,18</sup> calls emerged for the establishment of a more specialized system of care.<sup>33,34,45,48,49</sup> In 2010, these calls were heeded and the Categorical Care for Victims of Human Trafficking (COSM) pilot was established. ‘Pilot’ meant that the COSM programme was established initially as a pilot, awaiting evaluation of the programme before its formal implementation two years later in 2012.

This aim of this research was to explore the challenges that were encountered in social and health service provision for victims of human trafficking as part of the COSM programme.

## Methods

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### Data collection

Interviews were conducted with 25 people working as part of the service provision system of the COSM programme, including 8 social care workers, 4 shelter managers, 3 general practitioners, 3 mental health care providers, 3 civil society members, and 4 employees of three ministries (the Ministry of Health, Welfare and Sports; of Security and Justice; and of the Interior and Kingdom Relations). I mostly refer to all actors as ‘service providers’ or ‘participants’ to protect the anonymity of the participants (for some professions I interviewed only a few participants). Only when it added value to my results and the anonymity of participants was not at risk I named specific professions.

Participants were interviewed from 14 February 2012 to 12 December 2012. Usually, participants were interviewed once and alone. Three interviews included two participants (at the request of the invited participant), and two participants were interviewed twice (at my request, because one interview left many topics on my topic guide undiscussed). In total, 24 interviews were conducted with 25 participants.

An overview of the main topics in the topic guide is provided in Chapter 3; the topic guide itself is provided in Appendix 5.

## **Context**

### *The COSM programme*

See Chapter 1 for a description of the COSM programme.

### *Other forms of shelter in the Netherlands*

The broader shelter system in the Netherlands is targeted at several different groups. As part of one legal framework for Dutch social care (the Social Support Act; Dutch acronym 'Wmo'),<sup>268</sup> shelter is provided for victims of domestic violence (referred as 'women's shelters'; Dutch acronym 'VO') and for the homeless (referred as 'social shelters'; Dutch acronym 'MO'). This shelter sector is divided into sequential stages (see Figure 1.2 in Chapter 1). As part of a second legal framework, shelter is provided for asylum seekers (referred to as 'asylum seeker shelters'; Dutch acronym 'AZC').<sup>269</sup>

## **Data analysis**

To analyse the data for this chapter I adhered to the grounded theory approach (see Chapter 3).

## **Terms**

The term 'system of care' is particularly relevant for this chapter; it is discussed in Chapter 2.

## Results

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### The core phenomenon: developing service provision as part of a newly established system of care

#### *The core phenomenon*

In my research for this chapter I started with a broad aim: to explore the challenges that were encountered in providing social and health services for victims of human trafficking as part of the COSM programme. However, over the course of my research this aim became more focused through the development of my core phenomenon.

When I first started interviewing service providers, I quickly started wondering about the underlying causes for the challenges that service providers spoke about – what drove them to exist? Participants noted that some challenges were unique to this population, that others were unique to the Dutch context, and that various aspects of service provision were more difficult for them because this was a ‘new group’. One service provider noted, for example: “I (...) think that in advance people did not think really well about what the best approach would be [for service provision as part of the COSM]. It was all established really quickly, of course.” The ‘newness’ of the system of care became an important theme in my analysis.

After this, I started wondering: if the newness of the system of care resulted in challenges for direct service delivery, could the same have happened on the organizational level and at the policy and governance level? My interviews with service providers at other levels in the system confirmed that this was the case. I also noticed that there was a lot of change in the manner in which challenges in service provision were being addressed by actors in the system of care; the system of care seemed to be in a very dynamic state.

Thus the newness of the system of care, the consequences of that newness for the challenges that the service provision faced, and the changes that service providers made to the system to address those challenges, became the core phenomenon of my analysis of my interviews with service providers.

I should note here that while this core phenomenon emerged from my data, it was also a choice. I used the newness of the system of care as my core phenomenon because it was a dominant theme in my data, because I felt it was of importance to the COSM and to similar programmes, and because I could not find much literature on newly emerging systems of care for vulnerable groups, suggesting



that I would be able to use this angle to produce research that was relevant and would make a contribution. It also had my interest; I was intrigued by this seemingly obvious characteristic of the system – its newness – that appeared to receive relatively little attention in terms of implementation of the programme and in the literature.

### ***Operationalization of the core phenomenon***

Here, I describe how this core phenomenon drove my data collection and analysis.

In terms of data collection, I added a question to the topic guide about recent changes in the system of care. I also allocated an increasing amount of time in my interviews to the newness of the system.

In terms of data analysis, the core phenomenon represented a direction of thought that guided my analysis in several ways.

First, it resulted in my taking a systems-approach to identifying challenges. I did not limit myself to direct service provision challenges, but specifically looked at challenges at organizational and policy and governance levels as well.

Second, because of my focus on the newness of the system, whenever I encountered a challenge in my analysis, I asked myself: Was service provision in this area lagging behind more established shelter programmes in the Netherlands? For example, if service providers noted that a specific treatment guideline had not been developed yet for victims of human trafficking, I checked whether it *had* been developed for victims of domestic violence. Such a lag between service provision for victims of trafficking and other populations might provide an indication that the challenge that I was analysing was being driven by the newness of the system. I also looked at differences between the COSM shelters, because further development of service provision at one shelter than at another might also provide an indication that this challenge was being driven by the newness of the system.

In addition, I assessed whether service provision was changing over time to better address each specific challenge I was analysing, including changes that had already taken place and planned changes that still had to be implemented. This allowed me to gain insight into if and how the system of care was developing to better address existing challenges in service provision. Moreover, I also assessed if there were factors that facilitated or impeded these changes.

In other words, the development of a core phenomenon allowed me to formulate more precise research questions for this chapter. These were: What were the challenges that social and health service provision as part of the COSM programme was faced with? How was the newness of this system of care driving these challenges? Was service provision changing to improve how these

challenges were being addressed, and if so, how? And finally, what factors facilitated or impeded such developments in service provision?

## **Challenges, Changes and Facilitating Factors**

Here, I provide an overview of the challenges that were encountered in developing social and health service provision as part of the COSM programme after its establishment in 2010, the changes that had taken or were taking place in the system of care to address those challenges, and the factors that facilitated or impeded these changes. I have categorized the challenges as originating at the policy and governance level, organizational level or service delivery level.

These results are summarized in Table 6.1.

To avoid any confusion about the source of the data, I note that the findings in this section emerged inductively from my data. I have added references to provide background, documentary confirmation, or additional detail on themes that emerged from my analysis. Although I realize that this is an uncommon format because it is normally reserved for the Discussion, I have found it to be more appropriate for this chapter to include these references per challenge and facilitating factor in this Results section. This allowed me to provide a broader discussion of the findings of this chapter in my Discussion section.

**Table 6.1. Challenges in developing service provision as part of a new system of care for victims of trafficking in the Netherlands (the COSM programme), including what changes occurred in the system to better address those challenges, and factors that facilitated or impeded those changes**

Challenge	Description of challenge	How did services change to better address the challenge?	Factors that facilitated or impeded change
<b>Policy- and governance-level challenges</b>			
1. Elucidating responsibility: 'It is not my problem'	Victims of trafficking were not recognized to be eligible for services by various service providers.	Key service provider organizations grew to recognize the group as a target population for their services.	<p>Factors that facilitated change:</p> <ul style="list-style-type: none"> <li>• political and societal attention</li> <li>• interest groups</li> <li>• vertical network development</li> <li>• active 'change attitude'</li> <li>• evaluation and feedback cycles</li> </ul> <p>Factors that impeded change:</p> <ul style="list-style-type: none"> <li>• lack of a service user-centred approach</li> <li>• centralization</li> </ul>
2. Financing	The COSM was financed separately from the regular shelter sector, via a national tender, which had several undesirable consequences.	Plans to integrate the COSM programme with the regular shelter sector are under discussion.	
3. Defining the target population	Eligibility for the COSM shelters was not determined by need: not all victims of trafficking who needed shelter were eligible to receive it.	No changes.	
4. Governance for a complete care chain	Not enough attention was paid by governing actors to ensuring a complete chain of care.	More possibilities for accommodation after the COSM were established.	
5. Shelter identity issues	There was confusion about whether the COSM shelters should perform the functions of a crisis or a long-term shelter.	The average length of stay in the COSM shelters decreased. No change in confusion about the COSM shelters' role.	
<b>Organizational-level challenges</b>			
6. Achieving coverage of a broad range of services	Given the broad range of services needed for this population it was a challenge for the COSM shelters to ensure coverage.	COSM shelters increased coverage of services by further developing a network of service providers outside of the shelter.	<p>Factors that facilitated change:</p> <ul style="list-style-type: none"> <li>• interest groups</li> <li>• a service user-centred approach</li> <li>• vertical network development</li> <li>• horizontal network development</li> <li>• active 'change attitude'</li> <li>• specialization</li> </ul>
7. Overcoming administrative barriers	Administrative barriers were a barrier for service providers in arranging services.	Administrative barriers were increasingly overcome through lobbying and network development.	
8. Evaluation and feedback	There was a lack of sustainable evaluative mechanisms.	Although mostly one-time efforts, various	

cycles		evaluations were conducted. The number of feedback cycles, aimed at propagating information from evaluations to decision-makers, increased.	<ul style="list-style-type: none"> <li>• evaluation and feedback cycles</li> </ul> <p>Factors that impeded change:</p> <ul style="list-style-type: none"> <li>• lack of a service user-centred approach</li> <li>• decentralization</li> </ul>
<b>Service delivery-level challenges</b>			
9. Developing expertise	There was a lack of expertise about victims of human trafficking among service providers.	Social care providers in the shelters developed expertise quickly because they were able to specialize. Through network development, service providers outside the shelters also increasingly developed expertise in working with this population.	<p>Factors that facilitated change:</p> <ul style="list-style-type: none"> <li>• interest groups</li> <li>• a service user-centred approach</li> <li>• horizontal network development</li> <li>• active 'change attitude'</li> <li>• specialization</li> <li>• evaluation and feedback cycles</li> </ul>
<b>Factors that facilitated change</b>			
<p>External factors:</p> <ul style="list-style-type: none"> <li>• <i>political and societal attention</i></li> <li>• <i>interest groups</i></li> </ul> <p>Factors that brought actors closer together:</p> <ul style="list-style-type: none"> <li>• <i>a service user-centred approach</i></li> <li>• <i>(de-)centralization</i></li> <li>• <i>network development</i></li> </ul> <p>Internal (within-organizational) factors:</p> <ul style="list-style-type: none"> <li>• <i>active change attitude</i></li> <li>• <i>specialization</i></li> </ul> <p>Factors that enabled 'learning':</p> <ul style="list-style-type: none"> <li>• <i>evaluation and feedback cycles</i></li> </ul>			

## **Policy- and governance-level challenges**

### **Challenge 1: Elucidating responsibility: 'It is not my problem'**

Elucidating who is responsible for providing shelter and care is something that has long been clarified for populations in the regular shelter sector in the Netherlands, such as victims of domestic violence or the homeless (it is even enshrined in legislation<sup>270</sup>). However, this was not the case for victims of human trafficking. This challenge is characterized by the 'it is not my problem'-problem: after the COSM programme was established various groups of service providers felt that providing services for victims of trafficking was not their responsibility.

There were several examples of this. First, and foremost, several participants noted that for a long time victims of human trafficking were not recognized as part of the target population by the Dutch shelter system for victims of domestic violence (VO). There are two legal stages for victims of trafficking that have exited a trafficking situation that are of importance in further unpacking this example. First, in the 3-month 'reflection period' that victims of trafficking are entitled to after they have exited a trafficking situation – during which they can consider whether to cooperate with law enforcement or not (see Chapter 1) – trafficked persons have a type of residency status that does not qualify them for shelter as part of the VO.<sup>48,271</sup> In this period they require shelter under a separate legal framework, which was part of the reason for establishing the COSM programme.<sup>48,271</sup> Second, the obligation for the VO to provide shelter *after* the 3-month reflection period was also not clear. Even when victims of human trafficking had a residency permit that in principle made them eligible for the VO, they were not specifically named as a target population in the Dutch Social Support Act (Wmo; the legal framework for care provision in the VO). A formal evaluation of the VO in 2010, for example, noted that under the legislative framework for service provision to victims of domestic violence, the VO could not be seen as being responsible for this population.<sup>270</sup> As one policymaker noted: "Let me put it like this: the regulations are not formulated well. So there is a discussion every time: do they fall under the Social Support Act or not. (...) Some shelters say, well yes we do shelter them. We feel they are included, victims of human trafficking. And you have shelters in certain municipalities who do not, because in these regulations victims of human trafficking are not specifically named."

This lack of clarity about victims' rights to service provision in VO shelters in the first three months and thereafter had important consequences. First, it resulted in the establishment of the COSM programme, outside of the regular shelter system, with a unique national-level governance and financing arrangement. These unique arrangements resulted in a range of challenges, which are described later in this chapter (see Challenge 2). Second, the lack of clarity on the role of the VO left

individual shelters free to consider victims of trafficking ‘not their problem’ – and so they did. One service provider noted, for example, that on the Dutch ‘Shelter Web’, where shelters place announcements for free places, many VO shelters openly stated: “No victims of human trafficking”. Another service provider noted that it allowed shelters to “hide behind” the lack of national recognition of this population as a target group. As a result, many service providers in the COSM shelters stated that it was very difficult to find long-term shelter for their service users after the initial maximum 3-month stay in the COSM.

When I asked service providers why shelters refused to admit victims of trafficking, participants explained that victims of trafficking were commonly viewed to be a ‘difficult population’. One policymaker noted: “Why the VO shelters do not want that? Yes, that is because it is a difficult group of victims. They need a relatively large amount of support, of course. Often they do not speak the language. And they often linger in the shelters, because they have little access to ordinary housing.” And a service provider said: “Yes, well, look I think the long-term shelters should receive much more explanation about what this target group of victims of human trafficking entails. And what it means. Because many shelters are scared off by human trafficking. (...) Then, on the other hand, they do of course also have the problem of service users that remain in the shelter for a long time, resulting in a lack of throughput for them.” These quotes contain several of the reasons that were given by service providers as to why this population was considered a difficult population by long-term shelters. One was the multilingual and multicultural nature of the population, requiring more time and attention from service providers. Another was that service provision for victims of trafficking is characterized by particular administrative procedures. Because the population is small, there was little experience with those procedures in most regular shelters and complying with those procedures meant extra work. Furthermore, victims of human trafficking regularly had to stay in the shelters for a long time, because of a lack of available accommodation for this group after the shelter, blocking access for other victims in need of shelter. One document reads: “[Victims of trafficking] however do not have a right to a house and sometimes stay in a shelter for years as a result. This is a highly undesirable situation for the women concerned and for the other women in the shelter.”<sup>272</sup> Finally, in the Netherlands, the right to residency status for a victim of trafficking is dependent on the success of the criminal lawsuit against the victim’s trafficker. When victims of human trafficking lose their residency status because the lawsuit is either dropped or lost, which happens frequently, those victims lose their right to financial and social support from the Dutch government. When this happens, this presents shelters with a choice of either putting service users out on the streets, or to provide shelter but to receive no financial compensation. Service providers noted that this financial risk further contributed to this group being seen as a difficult population.

The first expression of the challenge of elucidating responsibility concerned the shelter system for domestic violence (the VO). A second expression of this challenge concerned the Dutch affordable housing corporations that refused to recognize victims of human trafficking as a target population, thus limiting possibilities for victims of human trafficking to move to independent accommodation after their stay in a COSM shelter or in a long-term shelter. One service provider noted that “it is perhaps even harder to find independent housing [than shelter places]” for service users.

A third expression of the challenge of elucidating responsibility was that many municipalities adhered to an eligibility criterion for access to shelters that prescribes that potential service users have to be registered at the city council’s register as having a home address in the municipality. This created difficulties for the three COSM shelters in arranging long-term accommodation outside their own municipalities. A member of civil society explains: “The reason it needs to be arranged at a national level is that the problem of our target population as compared with victims of domestic violence is that with our population there is not necessarily a regional link. Victims of domestic violence are often people who already live in the Netherlands and as a consequence they have a link to a municipality (...). Victims of human trafficking usually do not have such a link to a region. They are exploited in a certain region. But they are not registered neatly as a citizen in that municipality.”

Other examples of organizations that were noted by participants as refusing to see victims of human trafficking as their target population were the Dutch Violent Offences Compensation Fund, the Dutch general social work organizations (outpatient services) in several municipalities, the Dutch organization that provided social work for refugees (Vluchtelingenwerk), and organizations that provided victim aid in certain municipalities (Slachtofferhulp).

Finally, participants noted that several service users had been refused medical care by various health care providers, such as general practitioners and dentists, and that it was challenging to get service providers outside the COSM shelters to collaborate with the COSM shelters. As one noted about their collaboration with a general practice: “In the beginning it was very difficult. (...) Because the doctors who were there, they felt that these patients were very bothersome. These are very multi-complex patients, really.” One of the general practitioners interviewed for this research confirmed this sentiment and noted: “[Human trafficking] really is not one of the areas we focus on and we really do not have the time to attend all sorts of training to expand our knowledge in this area.” While the country-wide lack of recognition of victims of human trafficking as a target population by the organizations and institutions listed above is a policy- and governance-level problem, refusal of individual shelters, general practices or dental services to provide care for this population is more an organizational-level problem. Therefore, I explore this point in more detail under Challenge 6.

## Changes

Many of the challenges described above were addressed between 2010 and 2013. A 2010 evaluation of the Dutch shelter sector recommended broadening the definition of the target populations for the VO in the law to make broader inclusion of newly emerging vulnerable groups possible.<sup>270</sup> While this has not happened, the Dutch association for shelters for victims of domestic violence explicitly recognized victims of human trafficking as a target population in 2012. As one civil society member noted: “What is a good development is that the VO is now thinking about what they should do with victims of human trafficking. And they have said, yes, they belong to our target population.” However, the VO also stressed the problems that exist around housing this population, in particular their long stay in the shelters.<sup>273</sup> The Dutch policy that defines which groups are eligible for affordable housing has also been revisited and since 2013 explicitly states that victims of human trafficking are a target population.<sup>274</sup> Service providers indicated that these two measures have opened up possibilities for victims of trafficking to find shelter or independent living accommodation after the COSM. The Violent Offences Compensation Fund too changed its policies in 2012,<sup>275</sup> recognizing victims of human trafficking as a target population and even hosting an ‘expert-day’ about this population.<sup>276</sup>

## Challenge 2: Financing

As explained under Challenge 1, the governance arrangements for this population are, uniquely so in the Netherlands, developed at ministerial level. Responsibility for the population is shared by three ministries: the Ministry of Health, Welfare, and Sports, the Ministry of Security and Justice, and the Ministry of the Interior and Kingdom Relations.<sup>50</sup> The COSM programme is also financed at the national level. There are several other examples of national financing for specific, often newly emerged shelter populations in the Netherlands, yet for these groups other aspects of governance are decentralized.<sup>270</sup> As one service provider put it: “[The COSM] is of course the odd one out compared to other shelters. That a specific service is developed at national government level. (...) The shelter sector has of course been established over many years and now you’re adding something.”

This arrangement came about because the legal framework for the regular Dutch shelter sectors does not provide for shelter arrangements for victims in the initial 3-month reflection period (see Challenge 1). In addition, the regular shelter sector in the Netherlands, the VO and MO, is decentralized; if specialized shelter for victims of human trafficking were integrated in this sector they would have had to follow this decentralized model. However, the small size of this population means that decentralizing shelter and care is complex – not all regions need a shelter specifically for



victims of human trafficking.

For these reasons, a national programme was established to provide shelter and care for victims of trafficking. As noted above, this aspect of the system of care had several important consequences. One consequence was related to how the COSM was financed. While with other shelters in the Netherlands the costs of running the shelter are discussed and negotiated between the shelter and the municipality, the COSM programme was awarded to three shelters through a tender (at a national level) for an initial period of two years from 2010 to 2012 and then for a further two years from 2012 to 2014. I asked the policymakers that I spoke to for this research why the programme was tendered, to which all replied that this had to do with European requirements for public tendering of such programmes by national governments. This is, in fact, a fallacy. There are exceptions to the European requirements for public tenders, among which are care provision services.<sup>277</sup>

While it cannot be inferred from this research why the programme was tendered, the consequences can be discussed. Multiple service providers noted that the act of tendering resulted in poorer quality of care for several reasons: First, the shelters that won the first tender were uncertain whether they would also win the next tender. If they would not win, this meant that care provision would be taken over by a new organization and that the experience that was developed by the first organization was lost. Second, because shelters could lose the next tender, service providers noted being hesitant to make long-term investments into developing care provision for this population. Third, one participant suggested that the competition created by tendering discourages collaboration between shelters working with the same population. And finally, shelters offered at very low prices because a significant part of the tender consisted of points for cost. One service provider noted: “We can offer at a higher price, but then we will not be awarded the tender. And where will it go then? Will the service users get what they need then? Because we have built up the experience by now. So then you say: no, the service users would be better off if they can keep coming to us. So then you keep the price in the tender offer low.” The result was that the annual funding for each COSM shelter was lower than the average annual amount for shelters for victims of domestic violence, while the population is more complex.<sup>155</sup> The annual funding for each COSM shelter was also lower (varying slightly per shelter but approximately 50%) than the amount that was agreed in advance of the start of the COSM programme as being a reasonable amount needed to run a COSM shelter.<sup>(29,p137)</sup>

### *Changes*

Shelter provision as part of the COSM programme was publicly tendered for a second time in 2012, after the first time in 2010 (the three organizations that won in 2010 won again in 2012). However, in 2014, there was no tender and the COSM programme was continued at these three shelters through the same nationally funded arrangement. This happened after my data collection period, so I cannot deduce from my data why this happened. However, the resistance by service providers against the tender approach may well have played a role in this decision. One shelter even had a consultancy firm draw up a report why public tendering for social care shelters is not a requirement for the Dutch government under EU regulations.<sup>277</sup>

Another factor that may have played a role is that the system of governance for the COSM is changing at the moment of writing this thesis (early 2015). Policymakers at the ministries who were interviewed for this research indicated that the COSM programme will be decentralized in the future. This is also in line with a 2010 report that made recommendations about the future of the Dutch shelter system as a whole, which stated: “Continue to shelter new target groups at a central level when needed, but evaluate every four years whether a new target group in terms of size and expertise can be integrated into the decentralized system”.<sup>270</sup> Participants indicated that it is not clear to which shelter sector the COSM should be decentralized: the shelter system for victims of violence (the VO) or the shelter system for asylum seekers. This choice may have far-reaching consequences, because the former falls under the responsibility of the Ministry of Health, Welfare and Sports, but the latter falls under the responsibility of the Ministry of the Interior and Kingdom relations, and these ministries may not be equally service user-centred in their approach (see later section “Factor 3: A service user-centred approach”). Some participants viewed the decentralization of shelter for this population to be part of a larger problem of effectively decentralizing governance and financing for small vulnerable groups (e.g. victims of human trafficking, victims of grooming, victims of honour-based violence, asylum seekers with severe mental health problems) for whom shelters do not need to be created in every municipality because the groups are small in size. These participants noted that the Ministry of Health, Welfare and Sports was exploring with the Dutch foundation of municipalities (VNG) whether a jointly funded mechanism for financing a limited amount of shelters for these groups throughout the country could be set up.

### **Challenge 3: Defining the population**

Initially, in 2010, the heterogeneous population of victims of human trafficking was fully entitled to enter the COSM shelters, with the exception of victims below the age of 18 years, large groups and service users with severe mental health problems. However, this changed over time.

Participants indicated that first, victims of Dutch nationality were not entitled to receive care any longer in the COSM shelters.

They noted that following a second revision, in 2012, only people in the 3-month reflection period were entitled to receive shelter as part of the COSM programme, as is confirmed by official COSM documents.<sup>33</sup> While, as explained earlier, one of the reasons for establishing the COSM programme was to be able to provide shelter and care especially for this group, eligibility previously had not been limited only to this group, but included victims of human trafficking more broadly. This new limitation meant that those who had already pressed charges were not eligible any longer (when one presses charges the reflection period ends), nor were those who had already entered in an asylum procedure at an earlier time (this gives people a different temporary residency status than the status that those in the reflection period have). These eligibility criteria created a distinction in access to the COSM programme between victims with potentially similar needs. For example, now, when out of two service users with similar profiles of need, one decides to press charges immediately, and the other decides to make use of the 3-month reflection period, only the second would be eligible to access the specialized services provided by the COSM programme. The other service user would need to be sheltered in the regular (non-COSM) shelter sector. Doubts were raised about the appropriateness of this situation by participants, who noted that someone may still be severely traumatized, or need services for other reasons, even when they are not making use of the reflection period. Moreover, this policy resulted in bizarre service practices. One service provider noted: "So now, we try to hold off on [service users pressing charges] a bit, because otherwise, when they have pressed charges, they have to leave the shelter soon to somewhere else." Another service provider, at a different shelter, noted: "The police says now that they stopped with processing her pressing charges when they heard that then she would not be allowed to stay in the COSM shelter."

In terms of defining the population that was eligible for services, it also needs to be noted here that victims' right to receive access to long-term shelter and care (as opposed to the crisis shelter that the COSM programme offered) was dependent on their cooperation with the criminal proceedings against the trafficker and on the outcome of these proceedings. In the Netherlands, a victim of human trafficking is only eligible for a residency permit if he or she decides to press charges against the trafficker and if the trafficker is convicted. Without a residency permit, victims are not eligible to receive any social services, including shelter. As one civil society member put it: "Then you do run into the legal system. Because you only have a right to stay in the Netherlands and to make use of the services we have here if you provide your cooperation with the criminal proceedings. So then

those criminal proceedings really become leading in whether one can or cannot have access to services.”

Even when people were officially eligible for services, service providers sometimes ran into problems arranging services for people because of this strong link between the outcome of the legal proceedings against the trafficker and a victim’s right to services. One participant explained what happened when a victim ‘receives a dismissal’ (note the use of language here, when the lawsuit against a trafficker is dismissed, providers say that the *victim* has ‘received a dismissal’, making clear the consequences of this decision for them): “Because you see then all the services and everything stops. The moment we know someone has a dismissal, it becomes almost impossible to arrange a place [in a shelter] for that person. Despite the fact that at that moment you are still entitled to an appeal and all sorts of procedures can follow. And that the official right to shelter does not end when you remain in the procedures. But that dismissal, man, the whole procedure has been juridicialized. The dismissal has such a strong status in the service chain that, ummm...” “And how come that it does?” “Yes, well, because there is the image, and that has to do with the current political climate, that if you had a dismissal, that you are not a victim. That is what is being said. But that is not how it is at all. A dismissal means there were no grounds to prosecute. (...) So the whole status of the dismissal has become leading and what is so bad about that is that you can make that legally the leading argument, but as a result people draw the conclusion that you are not telling the truth. You are being labelled a liar.”

### *Changes*

The definition of which people were eligible to receive care in the COSM shelters has changed rapidly from 2010 to 2012. It is not clear if the definition of the target population for the COSM shelters will soon stabilize or what the consequences of the planned decentralization of the COSM programme (see Challenge 2) will be for the eligibility criteria. Many service providers indicated that further changes are needed, given the current exclusion of victims potentially in need of care. In line with these views by service providers, in 2013 Rijken proposed establishing independent committees to judge whether someone is a victim or not and requires service provision or not, independent of the outcomes of the lawsuit against their trafficker.<sup>41,177</sup> Such committees were not established yet at the time of writing this thesis (early 2015).

### **Challenge 4: Governance for a complete care chain**

The COSM shelters constitute a form of crisis shelter, with a theoretical maximum duration of stay of three months. This crisis-nature of the COSM programme raises the following question: where can

victims go after they leave the COSM? What provisions were made by the initiators of the COSM programme to ensure post-COSM shelter, accommodation and care?

To start, it is uncertain whether such long-term provisions should be of a categorical nature (exclusively for victims of trafficking). While the general literature recommends this<sup>30</sup> and many of the arguments for categorical crisis shelter also apply to long-term shelter, interviewees from the COSM shelters generally considered both a few categorical long-term shelters for this population and shelters for broader populations to be appropriate long-term shelters for their population. The challenge was that there were only very few categorical long-term shelters for victims of trafficking and that regular, non-categorical shelters felt this population was 'not their problem' (see Challenge 1). As a consequence, the shelters experienced great difficulty in finding long-term accommodation for service users, in particular in finding places in long-term shelters or supported housing facilities. One service provider remarked, for example: "That's the problem, we just can't find places [in long-term shelters] to transfer people to." And another said: "It is almost never possible to transfer from a COSM shelter to supported housing." This is confirmed by an analysis from 2012 that found that in the first 15 months of the COSM (from June 2010 to September 2011), more than half of all female services users in the COSM programme resided in a COSM shelter for longer than three months, and more than half of all male service users stayed longer than six months.<sup>33</sup>

In terms of governance this means that while the regular (non-COSM) Dutch shelter system contains provisions for crisis shelter, long-term shelter, supported housing and outpatient social services, in establishing the COSM programme no measures were taken by the Dutch government to ensure that victims of trafficking would be guaranteed shelter and care after the COSM. No specific long-term shelters or supported housing facilities were established for this group, nor did the government ensure that the regular shelter sector and social services would take up service provision for this group. In other words, a comprehensive assessment of what was needed and available in terms of shelter and care across the whole care chain does not appear to have been conducted. Despite this, the Dutch government spoke of the COSM programme and related provisions as a "structural solution" for the shelter needs of victims of human trafficking in a letter to Parliament in 2012.<sup>278</sup>

The lack of available long-term places resulted in several problems.

First, as noted earlier, service users were not able to transfer at a time that would have been best for them. One shelter manager noted, for example, in response to my question of how the duration of three months stay for the COSM shelters had been determined: "That's just the reflection period. I think myself that for the one... You know it is also a question of providing individually tailored

services. One service user you are done with quicker than with the other. That sounds a bit odd, but with that person everything is just arranged more quickly. That person has fewer problems that need to be solved. That person is ready to move on much faster than another. For another three months is not even enough, you know. They are so scared and so insecure and need so much, that you think, yeah 6 months would really be better.” I asked, in reply: “Interesting. And how do you notice this in practice then – does someone like that with whom everything goes faster move on after six weeks? Or after two?” She replied: “Yes that would be possible. But no, in practice, it happens, but it happens only very rarely.” “And why? What stands in the way?” “Because there are simply not enough places in long-term shelters to place people”. So, both the lack of legal possibilities for placing a service user in a long-term shelter during the reflection period (see Challenge 3) and the lack of places in long-term shelters and supported housing resulted in people not being able to move on when they were ready to.

Second, in some cases, not being able to transfer to a long-term shelter took more extreme forms. As a shelter manager noted: “If there are few places available, then, well, it stops at some point. At that point you might have been looking for a place for someone for seven or eight months already.” Service providers indicated that this had resulted in service users leaving for independent housing while they were not ready and a long-term shelter placement would have been preferable.

Third, when service users could be placed in a long-term shelter, the lack of available places had detrimental consequences for whether an *appropriate* place was found for service users. Several service providers indicated that while needs assessment was a key function of service provision in the COSM shelter (as is confirmed by the literature<sup>30</sup>) followed by placement of service users in a shelter that best suited their needs, that such selective placements only happen in the margin because the availability of specialized places is limited.

Fourth, service providers sometimes let service users move to a long-term shelter when they felt they were not quite yet ready to leave the COSM shelter: “Well sometimes people move on to the next shelter with us because otherwise there might not be a place for that person anymore in the future. So then you let them leave somewhat early, while you think pffffff. But ah well. My god, sometimes you just have to take what you can get.”

Finally, participants noted that because it was difficult for service users to move on from the COSM shelters to long-term shelters or independent accommodation, the COSM shelters developed a waiting list themselves.

### *Changes*

Several measures were taken, both at a policy level and by the COSM shelters and other organizations, to improve the completeness of the care chain for this population. As explained under Challenge 1, the population was recognized as a target group by the regular shelter system (long-term shelters) in 2012.<sup>273</sup> Several participants noted that placing participants in long-term shelters had become easier towards the end of my data collection (end 2012). This was confirmed by objective data on service users' average duration of stay in the COSM shelters, which was 17, 22 and 20 weeks in 2012 for the three shelters respectively, and 15, 21 and 18 weeks in 2013 [personal communication from CoMensha, d.d. 31 July 2014].

As I explained above, there are only very few long-term shelters in the Netherlands that provide long-term shelter exclusively for victims of human trafficking. However, interestingly, service providers at one COSM shelter noted that regular long-term shelters that took in their service users started to develop expertise in providing care for this group, after they had let several service users move to that shelter. The shelter's manager indicated: "There are a number of shelters that have specialized in this population by now." Service providers of the other two shelters did not note such specialization among long-term shelters in the regular shelter system. One shelter was still hardly able to place service users in long-term shelters and the other shelter only placed its service users in long-term shelters that took one or two victims of trafficking at a time. And, as one of the service providers noted: "Two places, that's really not a lot. You need to have more to be able to create specialization".

With regards to independent housing, the government implemented a programme aimed at creating independent living accommodation specifically for this population and, as noted earlier, Dutch housing associations were mandated to recognize victims of human trafficking as a target population in 2013.<sup>274</sup>

The capacity of the COSM programme was expanded from 50 to 70 in 2012 to address the waiting list that had developed.<sup>50</sup>

Finally, the COSM shelters themselves contributed to improving the lack of availability for housing after the COSM, by setting up long-term collaborations with long-term shelters, and by founding new supported housing facilities themselves specifically for their COSM service users that were ready to move on to a more independent housing situation.

### **Challenge 5: Shelter identity issues: crisis or long-term?**

The Dutch shelter system is divided into several components, among which crisis shelter and long-term shelter (see Figure 1.2 in Chapter 1). Officially, the COSM shelters are crisis shelters. Therefore,

as part of the first tender in 2010, the intention for the COSM programme was to provide only 'bed-bath-bread care', i.e. the most basic care provision.<sup>34</sup> Such care is appropriate for general crisis shelters, because the main aim of these shelters is to provide basic services for those who suddenly cannot return home and/or to provide a safe, stabilizing environment for service users after a potential traumatic experience. After a stay of several weeks in a general crisis shelter, service users often move on to a long-term shelter, where a more extensive set of services is provided, aimed at assisting service users in (re-)integrating into society.<sup>140</sup>

What set the COSM apart from other crisis shelters is that service users resided there longer than in regular crisis shelters. This was partially because of the 3-month reflection period discussed during which victims of trafficking legally cannot reside in other shelters (see Challenge 3).<sup>48</sup> This was exacerbated by the fact that in practice service users on average stayed longer than three months because there was a lack of places in long-term shelters for service users (see Challenge 4) and because of administrative barriers in getting service users placed in long-term shelters (see Challenge 7). The COSM shelters have responded to the relatively long stay of service users by providing services that are normally only provided by long-term shelters (such as providing help with finding (voluntary) work, help with establishing a network, daytime activities of all sorts, and fostering collaboration with mental health care providers).

The long stay of service users in the COSM and the additional services that were provided as a consequence resulted in a number of challenges in service provision.

First, for service providers, it resulted in a lack of clarity about what the nature of the shelter was – crisis or long-term. Crisis and long-term shelters have distinct responsibilities in the Netherlands, crisis shelters fulfilling mainly a stabilization function and long-term shelters mainly aiming to help people to (re-)integrate in society. Officially, the COSM was a crisis shelter. However, as one service provider put it: "We are a crisis-shelter in that we take care of all the first needs, but in my opinion we do just as much as a long-term shelter, because all the long-term steps that need to be taken, we also take." Many service providers also described the goals of the COSM shelters as two-fold: 1) helping service users to stabilize, 2) helping service users to make steps towards (re-)integration in Dutch society. Thus, the practical reality of what service users needed and the COSM shelters provided did not match the official nature of the shelters. Hence, there was a lack of clarity on the nature of the shelters and their related functions. This lack of clarity was exacerbated by the fact that while service users were mostly intended to move to long-term shelters from the COSM shelters, they regularly did not and moved to independent housing directly, because of a lack of



available places in the long-term shelters (see Challenge 4), necessitating more expansive service provision before they left.

A second challenge that resulted from service users' long stay in COSM shelters is that service providers experienced difficulties arranging services for service users, such as mental health care services and volunteer activities. These difficulties arose because the COSM was officially a crisis-shelter and hence service users were officially intended to stay only for a limited amount of time. One service provider said, for example, about screening patients for mental health problems: "Treatment is not going to take place anyway in the end, because they are only here for such a short time." Another said: "If we could, we would like to establish better mental health care services [in the COSM], but there isn't really a point if someone is leaving again three weeks later. Because, then, when they are just starting to build rapport with their mental health care provider, they have to leave again."

A third challenge related to the long stay of service users in the COSM shelters, and the provision of additional services there, was that while policymakers let go in 2012 of labelling the needs of victims of human trafficking as 'bed-bath-bread care' and have recognized the need for additional service provision,<sup>34,50</sup> the funding arrangements for the COSM did not change. As a result, the desire to provide a broader package of services is not matched by the funds that would allow more extensive service provision. As one shelter manager noted: "I have 2.5 full-time equivalents to run the entire COSM shelter. If I let all these people dive into issues in-depth then I have a problem."

A fourth challenge was that service providers noted that service users started to put down roots in the COSM shelters when they stayed there for a long time. This led to several problems for service users, particularly when they did have to move to a long-term shelter elsewhere after a longer period of time (see Chapter 5). As one service provider noted: "I do not think that it's really healthy to spend three months in a crisis shelter. Crisis should be crisis. And people, you just notice that they start to put down roots after... I don't even really know how those three to six weeks [of stay in regular crisis shelters] originated. No idea. But you see a similar pattern in how people's behaviour develops, so to speak. And in how they adjust. And after something like ten weeks, they start to put down roots." According to other service providers this process of rooting started much earlier even. As one said: "After two weeks they say, I want to do something, I want to do something."

### *Changes*

Several changes took place with regard to this challenge. As noted above, policymakers let go of labelling the needs of victims of human trafficking 'bed-bath-bread care' in 2012.<sup>34,50</sup> Also, toward

the end of this research various service providers noted that it had become easier to find a long-term shelter, supported housing facilities or independent affordable housing for services users (see Challenge 4). As a result, participants noted that the length of stays of service users in the COSM shelters decreased. A notable reason for this was that both shelters and affordable housing corporations changed their policies and started to accept victims of trafficking as one of their target populations (see Challenge 1).

However, the root of the problem was not dealt with. Several service providers and policymakers noted that the intended maximum period of stay of three months for the COSM was based on the 3-month reflection period provided under Dutch law for victims of human trafficking. They explained that the decision to make this period three months was made because under the existing legislative arrangements for shelter provision in the Netherlands, it would be difficult to find alternative shelter accommodations for service users during this period because of victims' temporary residency status. However, there seemed to be no care-related reason for adhering to this period. As one care provider put it: "[We have this arrangement] because the Ministry has determined that is how it should be". Another noted: "They linked the duration of the COSM to the three months of the reflection period, of course. That's really the only difference [with regular crisis shelters]. (...) If you had enough places, then you could let everyone migrate to a long-term shelter after six weeks. There are exceptions, of course. (...) I think the Ministry just hasn't thought about it. They just said, three months reflection period means three months shelter. And they haven't considered at all that in the domestic violence shelters three to six weeks is common." The same service provider noted: "Because you have more time with the COSM [than with regular crisis care], you also take that time. It could be shorter, of course."

Various service providers advocated for a system with swifter movement to a long-term shelter, with the moment of movement being determined by the *need* of service users, rather than by legal or administrative reasons. They noted that this would also allow service users to put down roots in a place where they would be able to stay for a while. One shelter had already implemented such needs-based, swifter movement to long-term shelters while service users were still in their 3-month reflection period. Moreover, even before the COSM programme commenced, there were regular crisis shelters that accepted victims of trafficking in the Netherlands. This shows that such measures may be more easily implemented than Dutch legislative arrangements suggest (city councils can choose to be lenient in terms of paying for shelter for victims of trafficking during the reflection period).

Finally, the governing ministries of the COSM decided in 2012 to only admit victims of trafficking in their reflection period to the COSM programme (previously, the eligible population was broader, see Challenge 3). This does not appear to make change likely with regard to the confusion that exists about the COSM shelters' identity (crisis or long-term), because it continues the existing focus on legal status rather than on service users' needs. It is uncertain how crisis- and long-term care for this population will be organized after the planned decentralization of the COSM programme (see Challenge 2). When that happens, it is my view that a discussion should be initiated about the most appropriate duration of stay in the COSM shelters. Such a discussion should take into account when it is best for service users to move on to long-term shelter from the COSM, and whether that is feasible in terms of the financial arrangements that follow from the legal exclusion of victims of human trafficking from the regular shelter system in their reflection period. On the basis of the desirable duration of stay of service users in the COSM shelters decisions should be made about the types of services that the COSM shelters should provide (crisis or long-term shelter services).

### ***Organizational-level challenges***

#### **Challenge 6: Achieving coverage of a broad range of services**

Achieving coverage of a broad range of services was challenging for shelters because of the large variety of different actors and services that is needed in the service provision for this group.\* One service provider said, for example: "You really need that network of partners. Something needs to happen in every area of their lives. From a permit that needs to be sent somewhere to opening a bank account and you can go on like that for a while. If you do not make appointments with all those people separately and make sure that you can reach them quickly, then everything will stop working."

Just like this service provider, many others noted that a good way to achieve that broad coverage was by entering into formal collaborative arrangements with service providers outside the COSM and to build a network of such service providers. Another service provider said: "We are well equipped [to provide care to service users with severe problems]. We can provide that intensive

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\* Relevant actors in the Netherlands for the shelters to collaborate with included: the three ministries that governed the COSM programme, city councils, CoMensha, health care insurers, the regional human trafficking care coordinators, other organizations that provided shelter, lawyers, the police, the Immigration and Naturalisation Service, volunteer networks, and, last but not least, organizations that provided social care or various forms of medical care, such as general practice care, mental health services, gynaecological care, midwifery services, dental care, STD screening, and youth services.

care and support.” “How come, that you are good at that?” “Ummm, well, because of experience, I guess. But also because we work with a large network of partners in providing service provision, with whom our communication is very good.”

Two types of service providers who were mentioned particularly often by participants in this context were mental health service providers and general practitioners. While occasionally other (non-COSM) shelters in the Netherlands employ mental health service providers themselves, participants indicated that this was financially not a feasible option for the COSM shelters. Because both were not employed by the shelters, the shelters had sought to develop formal collaborative arrangements with mental health services and general practitioners. However, developing such collaborations was not always easy. One service provider noted, for example, about setting up a screening process together with the general practice that was linked to their shelter: “We tried to do that with [name shelter] before, but the general practitioners there, they did not want that.” (As will become clear later, other general practitioners did specialize in working with this population).

In terms of looking for a mental health care provider to collaborate with, a service provider from one of the shelters noted: “Ummm well, I think we have found for some time now [that this is necessary]. (...) Ummm but till now we did not have an organization to collaborate with. Yes, there was one organization, (...) but it did not want to make exceptions for us or set up a special trajectory for this population.” And a general practitioner noted about the challenge for shelters to establish such collaborations: “It also a question of money and... Well, before you get something like that on the road in terms of organization. I think that’s challenging too.”

In some cases, the problems with establishing coverage of services went beyond limited collaboration, to no access at all. One shelter was forced to move location several times during the research and, as a result, participants described problems with ensuring access to health services for their service users. For example, service users were refused medical care by the local general practitioner after the shelter had just moved to a new location.

There were marked differences between the shelters in how they had developed such collaborations at the time of my data collection (2012). One shelter had had collaborative arrangements with both general practitioners and a mental health service for a while. It was even actively piloting new (intensified) forms of collaboration with the mental health care provider. Another shelter, as stated above, was forced to move location during the research and, as a result, experienced issues with access because they had to redevelop their network of partners. At the time of my research their collaboration with general practice varied depending on their location and they did not have a

mental health service with whom they collaborated. The third shelter was more stable in terms of location and was in the process of developing collaborative agreements with both mental health providers and general practitioners.

Establishing collaboration with mental health service providers and general practitioners, however, were only examples of the broader challenge of achieving coverage of a broad range of services. One service provider, for example, made note that “it takes a lot of time” to establish collaborations with organizations to let service users do volunteer work. In terms of these other services, there were differences between the shelters as well. For example, participants from the shelter that had recently moved location also indicated that there had been problems with access to dental care, volunteer work and local long-term accommodation.

The differences between the shelters can be explained by how much time they had had to establish a network of services. The shelter that moved had to rebuild its entire network of services after it had moved. Additionally, one service provider noted that developing services at the shelter that had progressed the furthest in establishing a network may have benefited from the fact that this COSM shelter was housed within a larger building where shelter and services were also provided for other populations, mainly victims of domestic violence. Another service provider noted about this shelter: “They have, they take care of multiple, ummm... They also have another target population for whom several day activities have already been developed and then they just have their [COSM] service users join in those activities.” And the general practitioner who was associated with this shelter noted: “Now [victims of trafficking] have become a larger population. And they have specific attention. But before that... I have a house here right next to me with 400 beds of course. Those were not all victims of human trafficking. Those were mostly people who needed shelter from [name city]. With a lot of problems. So before that I really already had the conversations and the communication lines [with the shelter] because those people are also often people with problems that, with whom that help is needed. In that sense I occupy a special position in that we, yes as long as I have been here, we have had contact with [the shelter].” This same shelter may also have benefited from the fact that besides the COSM shelter it had in the same building a separate shelter specifically for victims of trafficking that was part of the regular, non-COSM shelter system of the Netherlands (financed through city council arrangements, instead of the national COSM programme). This shelter was one of the few non-COSM shelters in the Netherlands exclusively for victims of trafficking and had existed for three years before the COSM was started.<sup>279</sup> This, too, likely allowed this shelter to develop a network of services for the COSM quicker than the other two shelters.

### *Changes*

Service providers at two of the three shelters described increasing network development with various partners over the duration of my research. The shelter with a fairly well-developed network of services, for example, developed additional collaborations to increase the number of volunteer opportunities and intensified their collaboration with the mental health service provider. They intensified communication between their social care workers and the psychologists / psychiatrist, to improve exchanges of expertise and to allow for joint assessments of who might need psychological help. A psychological counselling group was also initiated for those who needed it. According to a service provider: “We hope that the women will be able to better handle their traumas because of this.”

The shelter that took the middle ground in terms of setting up a network of services improved their collaboration with their general practitioners, implementing, for example, standard pregnancy tests for anyone who had a consultation with the general practitioner. The general practitioner noted: “We see a lot of people who are pregnant with an unknown term. (...) They come here and so we said: let’s do a pregnancy test with everyone. Just so we know. And that leads to a lot of positive tests.” The same shelter also found a mental health service provider to collaborate and set up a special treatment trajectory with.

The exception was the shelter that had moved location, which set them back in terms of network development and access to services for their service users. They did report at the end of my data collection (late 2012) to have an agreement with a mental health service provider to start collaborating in the future. After my data collection ended, however, they moved again.

These changes were driven in part by an intrinsic drive by service providers in the shelters to improve coverage of services (see Factor 6 later in this chapter). Setting up a network of service providers was noted by many service providers in the COSM shelters to be of primary importance in achieving a comprehensive coverage of services for their service users. However, besides this, there was also an external driver. The developments in collaboration between the shelters and mental health service providers were particularly pronounced during my research and what drove these developments, at least partially, was the renewal of the COSM tender in 2012. In 2012, the description of what the COSM services should entail changed slightly as compared to the tender of 2010, newly including a provision about “diagnosis of victims” and the “psychosocial support and psychiatric help (to be provided by external parties)”.<sup>50</sup> I asked several ministry employees what had driven these changes in the new tender. They indicated that feedback during the periodic meetings

with the shelter managers, their visits to the shelters, feedback from CoMensha and research had had an influence in those decisions (see Challenge 8).

### **Challenge 7: Overcoming administrative barriers**

Administrative barriers were noted as a challenge by service providers in various situations. Some service providers noted that having to spend a lot of time on administrative procedures left little time for providing psychosocial assistance. They were also noted to be an obstacle, or at least a delay, in arranging non-COSM based services for service users. For example, applying for long-term housing was noted by service providers at one shelter to only be possible when service users had a residency permit. However, their service users only received a residency permit after pressing charges or cooperating with law enforcement. Given the 3-month reflection period for pressing charges described earlier, service providers could regularly only start the process of getting someone placed elsewhere after those three months (the theoretical maximum duration of stay in the COSM). Before that time, it was not possible to put their service users on lists for long-term housing, because they did not have a permit yet. Each step could only be started when the previous had been completed. This was an administrative barrier in itself, but in addition participants noted that this process was delayed further by the sometimes significant time it could take for service users to actually get their residency permit after having decided to press charges. Administrative barriers such as these contributed to the long stays of service users in the COSM shelters (see Challenge 5). As one civil society member said, in arguing for a more needs-based approach to letting service users move from the COSM shelters to long-term shelters: “And then you can take an approach to put the problems of service users much more central in your considerations. It would allow you to take as your focus: how is the service user doing. And when should we move her to a long-term shelter. Instead of: Oh no, we still have to wait because this pass has not arrived yet.”

Similarly, for access to some long-term shelters a mental health care indication was necessary from a central agency that provided such indications (the agency determines eligibility for insurance that is needed to pay for these shelters). This indication took time to arrive and had to be preceded by a psychiatric assessment. One service provider explained that it was worthwhile getting someone placed in such shelters that specialized in mental health care, but that it took a long time to arrange that: “No that is very good, that we have been able to place multiple women in the [name shelter]. It is a lot more work, of course. Because first they have to go to [name mental health service]. That takes a while. Then, you have to wait for the diagnosis to come. And then you have to request an indication for care. Then you have to wait another six weeks. But then you do have something.”

In another example, from another shelter, one service provider said about a new initiative by the

government to increase access to affordable housing for victims of trafficking (see Challenge 4): “Yes this [new initiative]. No, I do not get why they, eh, what is really the idea behind that. Because by the time you can get affordable housing via that programme, [service users] will have left here already angrily because it is taking so long.” Another, at yet a different shelter, noted: “Yes I received an email [from the new affordable housing initiative] today, that they had a place. But it was like five months ago [that we applied for that place for someone]. Yes, that person has left already.”

In terms of accessing health services, participants indicated that an insurance card was often necessary, which took time to arrange, leading to difficulties with access.

Finally, a report from 2011 noted that in some cases municipalities had denied benefits to victims of trafficking, because employees were not knowledgeable of (the relatively new) legislation for victims of human trafficking.<sup>154</sup>

### *Change*

Participants indicated that administrative barriers were increasingly redressed by lobbying for shortened turnover times for several passes (residency / insurance). As one policymaker noted: “It just takes very long now, to give out a residency pass at the Immigration and Naturalisation Service. That has to be quicker. The Ministry of the Interior and Kingdom Relations is also working on that.” Such lobbying was facilitated by research that CoMensha had commissioned, which highlighted many administrative barriers.<sup>153–155</sup> Service providers also noted that increasingly they were able to convince service providers outside the COSM to accept service users regardless of certain administrative barriers and that it would take less long to get certain things done. Both were made easier by network development with the relevant organizations. As one civil society member noted: “Potentially that has to do with the fact that you have to make agreements with many network partners. (...) And if you have been working on this for a longer time, then you already have some contacts and you can move on toward the next step.”

### **Challenge 8: Evaluation and feedback cycles**

Several service providers noted a lack of evaluation mechanisms in the COSM programme during the interviews. This was noted both at the service delivery level, by civil society members, and by policymakers in the Ministry of Health, Welfare and Sports. I include it in this section on organizational-level challenges because evaluation is mainly an organizational responsibility, although it can be enforced at the policy- and governance-level as well.

Service providers spoke about lacking evaluation in several areas: they noted a lack of mechanisms



for taking into account service users' views of service provision; a lack of formal mechanisms for their own ideas to be taken into account; and a need to increase the evaluation of new policies. One service provider noted, for example, that the shelter had wanted to map the needs of services users better and take the experiences of services users on board in planning future care, but that the envisioned evaluations had never taken place. Another noted that service user feedback was only acquired informally: "Yes, we often do that when we are having coffee". One civil society participant pleaded particularly for evaluations that were oriented at influencing decision-making, rather than doing just counts of people who received services: "That would allow one to make targeted recommendations."

In addition, many service providers noted that learning from other COSM shelters did not happen enough (or at all). One service provider said, for example: "I do think that everyone is reinventing the wheel at the moment. Or at least, we have. We have never had any discussion with [name other COSM shelter] or exchanged any experiences. We did it our way. They did it their way." Others suggested that the lack of collaboration between the COSM shelters may be due to the competition created by the public tender process by which the COSM programme was governed, as I noted under Challenge 2. One noted, for example, that "there is of course a large game being played and everyone is fighting for their right to exist".

Some service providers also noted that there was little learning from other countries in terms of providing care for victims of human trafficking. A civil society member, for example, said: "I do strongly have the idea that each country is inventing the wheel itself." And one service provider noted there was also little learning from other care sectors (e.g. for refugees). She said: "You are in this shelter for a different reason than the reason for which you would be in a refugee centre or something of the sorts. But well, it does resemble... I think it resembles that the most, yes. But we never sat around the table with them or something. To exchange experiences. We never really did that."

### *Change*

Several developments took place regarding evaluation from 2010 to 2013. In all COSM shelters, a process description was conducted by an independent consultant hired by CoMensha around halfway through the COSM pilot, to chart what services were being delivered and in what way.<sup>153–155</sup> There were various small internal studies in the shelters, mainly as part of Bachelor or Master theses. As one service provider noted: "We adapted the activities that we offer, we have less creative activities now. (...) Now we have more training things, activities that you can learn from, and

several mornings that the service users can choose from a range of activities. I think that what we do now better matches what they need.” When I asked why they had changed that, she replied: “Because a small research project, an internal study was conducted into, amongst others, service users’ self-reliance and the activities and what people like.” Several evaluations were also initiated at a policy level. There was a formal evaluation of the COSM programme that was conducted in 2012 with the intention of informing the contents of the renewed tender for that year (but it was not finished in time).<sup>33</sup> Also, the responsible employee for the COSM at the Ministry of Health, Welfare and Sports ensured that a service user satisfaction questionnaire was undertaken in all three COSM shelters in 2013.<sup>144</sup> Furthermore, a more advanced and long-term registration system for service users was being developed at the time of this research by CoMensha.<sup>33</sup> And finally, my own research as well as other research studies, such as by Rijken,<sup>33,41</sup> investigated service provision in the shelters. It is important to note that most of these evaluations and studies were one-time efforts. Thus, the sustainability of these developments is not clear.

Some of the results of these evaluations and studies appear to have been used to improve service provision. For example, the number of places in the COSM was increased in response to the reporting of a waiting list; arrangements were made at a policy level to make victims of human trafficking eligible for affordable housing after it was reported that there were few options for service users to move on after the COSM shelters; several administrative hurdles, such as the long time it took to get a residency card, were being taken up at the governance level in response to feedback from evaluations; and more intensive mental health service provision was made a part of the second COSM tender in 2012 after many had noted that ‘bed-bath-bread care’ did not suffice for this population. However, some service providers also doubted the degree to which information from evaluations was being used. A civil society member noted when we spoke about one of the evaluations that “the results of that evaluation were not taken forward. What you should really do then, you need to put it on the agenda time and time again.”

Perhaps particularly for this reason, feedback cycles were also considered important by participants for getting the information that resulted from various evaluative processes to decision-makers. The number of periodic meetings aimed at propagating information about bottlenecks in service provision to decision-makers increased from 2010 to 2013. One shelter manager noted when I asked what they discuss during a new meeting initiated by CoMensha that brings together all shelters that provide shelter for victims of human trafficking: “Well, predominantly about the input and the problems that we all encounter. But we also discuss who has already found solutions for those problems. And ummm, well to learn from that, to learn from each other.” But this person also noted

that this initiative was still in its infancy and that further development in this area was possible.

### ***Service delivery-level challenges***

#### **Challenge 9: Developing expertise**

The establishment of the COSM presented the majority of social care workers who were hired to work in the COSM shelters with a new area of work; they had never provided care to victims of human trafficking before or only sporadically in shelters for victims of domestic violence. One social care worker noted, for example: “I do not think that there has (...) been a place before where people could gain experience [with providing care for this population].” Several social care workers indicated that it was difficult for non-specialized service providers to provide appropriate care for victims of human trafficking. When I asked one whether they ever hear back from service users who have left, she replied: “Well, what we hear the most really, is women who started living independently and then call on the general social work for help and they end up calling us because they do not understand anything about it.”

Besides work experience, there had been few other opportunities for service providers to acquire knowledge or skills in working with this population. One social care worker noted about her educational curriculum: “I have studied social and pedagogical support, in that study you learn a lot about the different thoughts about service provision within psychiatry or within... But this target population is so small. (...) In my education I could do very little assignments, because when I said what I was working on, everyone thought: What is that? How should I view that? Is that even part of the shelter system? ”

Finally, several service providers, social care and mental health care providers particularly, noted that consensus on appropriate care provision and the availability of care provision protocols lagged behind other populations that receive care in the shelter sector. One service provider noted, for example: “There is not really any unity [in approaches to service provision]. (...) Yes, everyone is just playing it by ear, I find. (...) I’m not sure if you can change anything about that, because it is just such a small population and because... Yes, there is not much known about them either.” This last comment is confirmed by my findings in Chapter 2, where I reported that before the past decade, there was almost no research on how to approach care provision for this population, both in the Netherlands and internationally.<sup>167</sup> The lack of consensus on service provision approaches also became clear during my research because different approaches were regularly taken by service providers to address the same problems. Two of the mental health service providers, for example, took different approaches to mental health care provision, with one preferring group-based

approaches and the other preferring individual sessions. One particularly prominent example of diverging service provision approach concerned the overall visions of the shelters. Although the shelters all had the same goal – to facilitate the recovery of their service users – they took different views on how that goal could be best achieved. One shelter took an approach with many rules and daily schedules with mandatory activities, for safety reasons, but also proposing that structure promotes activation and, as a consequence, recovery. The other two shelters took an approach that was more focused on personal freedom, with little rules and no obligatory daily schedules or activities, proposing that personal freedom and regaining agency were key to recovery.

### *Change*

Several social workers noted that by being able to specialize, they had developed more expertise in working with this population over the past years. One service provider noted, for example: “We have the knowledge now. (...) Yes, we kind of found our way in that. That did take a long time.” When I asked in what areas their expertise developed, most frequently mentioned were: the improved ability to deal with the specific administrative requirements for this population; generally being able to better tailor care to the needs of this population through a better understanding of their (varying) needs; and being increasingly able to provide culturally sensitive care. Several service providers also remarked that increasing experience with the population resulted in a greater understanding of the needs of the various subpopulations of victims of trafficking receiving shelter, such as mothers with children and those with severe mental health problems.\* Finally, it is noteworthy that most social workers that I interviewed worked with victims of domestic violence or asylum seekers before the COSM. For both, social workers noted that their background had been advantageous in developing

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\* Subpopulations of service users that were mentioned in this research as having specific needs were: various cultural subpopulations, notably Chinese and Nigerian service users; service users that came from asylum seeker shelters and had resided in the Netherlands for a longer time post-trafficking; victims of grooming; service users with no mental health problems, those with severe mental health problems, and those in between; service users with personality disorders; service users with intellectual disabilities; illiterate service users; highly intelligent service users; teenagers or young adults; pregnant service users; service users with children in the shelter; children of service users; service users with children in the origin country; female and male service users; those who were deceived or forced into working as a sex worker vs. those who were already sex workers and were subsequently exploited; service users that have been sexually exploited vs. those that were trafficked for other purposes of exploitation (e.g. labour); service users that have been exploited vs. those that were able to escape before the exploitation occurred; service users that were trafficked in various ways, often related to the country of origin, e.g. the frequent use of voodoo among African service users.

expertise about caring for victims of human trafficking.

Through the development of networks (see Factor 5 later in this chapter), social workers from the shelters also noted specialization and resulting expertise development in a range of service providers who were not directly employed by the shelter. This included general practitioners, psychologists / psychiatrists, midwives, youth care workers and gynaecologists in hospitals. One service provider said, for example: “Over time [the general practitioners] got to know our target population, both physically and mentally. But that took a while.” In agreement with this observation, some of the general practitioners and psychologists / psychiatrists that I spoke to for this research noted that their enduring exposure to this population had helped them to advance their service provision for this population, both in terms of organizational collaboration with the shelters and in terms of direct care provision. One general practitioner noted: “I have to say, I started with people from Eastern Europe. At some point, I thought: I get them a little bit. With them, I find it to be somewhat easier to get clear what their demand for help is. The African group is much more difficult in that regard. That takes practice. And it does help when you see them somewhat more often. That is an added value, when you get to know that group a little over the course of the years, you start to see through that and understand them more easily.” Some service providers also noted that the employees of several long-term shelters, shelters where service users move to after the COSM, were becoming more specialized in providing care for the population, making it easier for the COSM shelters to place service users in those shelters.

Another interesting change in the area of expertise development has been the development of guidance documentation for service provision for this population in recent years. Internally, the COSM shelters were actively developing service provision protocols over the course of my research, amongst others for specific subpopulations. One service provider, for example, noted: “I am in the process of developing a pedagogical protocol”. She also noted: “I made a standard list for (...) all the things you need when you are going to be in labour. We go through that list with the service user to prepare her for giving birth.” Moreover, various civil society organizations in the Netherlands have published guidance documents in recent years on various aspects of service provision for victims of trafficking, ranging from comprehensive guidance for the whole population<sup>35,46,267</sup> to more specific guidance in the area of mental health<sup>127,280</sup> or the brochure “Communicating with Chinese victims of human trafficking”.<sup>281</sup> This development is in line with an increasing amount of international guidance on service provision for this population (see Chapter 2).<sup>282</sup> However, key care disciplines such as general practitioners and mental health service providers in the Netherlands still do not have treatment protocols or guidelines for this population (these do exist for other populations, such as

victims of domestic violence,<sup>283,284</sup> child abuse<sup>283,284</sup> and rape victims<sup>285</sup>). A listing of available guidance documents and training materials does not exist yet for victims of human trafficking in the Netherlands. It deserves recommendation to create one and make it publicly available. To do so, example could be taken from similar lists that already exist for other shelter populations in the Netherlands.<sup>286,287</sup>

Besides the development of guidance documents, service providers also increasingly had the opportunity to participate in training on human trafficking. Some shelters organized training sessions themselves internally. Moreover, in 2012, two civil society organizations, CoMensha and FairWork, developed a training curriculum on human trafficking.<sup>288</sup>

Lastly, there are signs of increasing consensus among service providers in certain social and health areas. In the area of mental health, service providers initiated a concerted effort in 2013 to achieve more consensus on treatment protocols for this population in the Netherlands. Work was initiated too on the development of a reporting code for health providers in 2013, which is described in more detail in Chapter 7. Also, over the course of 2012, the shelters moved closer to each other in their visions of how recovery might be best facilitated in victims, or perhaps rather in the operationalization of those visions. The shelter with the structured approach with mandatory activities took a more flexible approach and started offering service users more choices with regards to which activities they wished to pursue. Around the same time, one of the two other shelters that adhered to an approach focused on personal freedom was starting a programme of day activities that was not mandatory but “strongly encouraged”.

Approaches to expertise development among service providers on the issue of human trafficking have received little exploration in the literature, yet emerged as a dominant theme in my analysis. Therefore, in Chapter 7 I take this section on developing expertise forward and provide a policy commentary that outlines what is needed to ensure adequate professional responses to victims of human trafficking.

### ***Facilitating or impeding factors***

Here, I provide a description of the factors that facilitated or impeded the changes that took place in how the challenges listed above were being addressed. I found that participants frequently spoke of such factors: some were mainly factors that facilitated change, others mainly factors that impeded change, some were both, and some even changed from being an impeding factor to being a facilitating factor over time. Most of these factors facilitated, or impeded, such changes at multiple levels of the health system. Therefore, although the factors below are broadly organized from a high

level (policy and governance) to the lower levels of the system of care (service delivery), I have not categorized them to the three levels of that system as I did for the challenges in the previous section. Every facilitating factor (e.g. network development) has an equivalent impeding factor (e.g. a lack of network development). To allow me to report consistently, I have formulated all factors that influenced the change process below as facilitators. Their descriptions will make clear whether they were mainly a facilitating factor, an impeding factor, or both, as does Table 6.1. Lastly, in Table 6.1, I provide an overarching categorization of these factors into: external factors; factors that brought actors closer together; internal (within-organizational) factors; and factor that enabled learning. It will become clear in the Discussion of this chapter where this categorization comes from.

### **Factor 1: Political and societal attention**

Participants reported that the strong political and societal attention that existed for this population in the Netherlands in the years leading up to 2012 was a helpful facilitator in achieving improved service provision for victims of human trafficking. One service provider stated: “We often notice the consequences of that directly. Of what people’s views are of human trafficking. Of how much money there is for it. How much attention there is for it.”

This facilitating factor mainly influenced change at the policy and governance level. For example, participants noted that the establishment of the COSM programme itself had been the result of a years-long lobby by civil society organizations. Other examples were that such lobbying helped to get victims recognized by various organizations that denied responsibility for this group at earlier stages and helped to increase the number of places that were financed at each COSM shelter.<sup>50</sup> Increasing international pressure, particularly European, and the need to comply with European treaties, were also noted as drivers of change in this area by participants.

### **Factor 2: Interest groups and persons**

At the policy and governance level, participants noted that there was an important role in shaping political and societal attention for human trafficking for interest groups, such as the civil society organization CoMensha (a civil society organization that coordinates services provision for victims of trafficking, including placements in the COSM shelters). Policymakers noted CoMensha as a key partner in discussing policies around the COSM programme. CoMensha also initiated evaluations of service provision, aimed at identifying gaps, and participated in and organized various evaluative meetings (see Challenge 8). Other organizations that were named as having an influence were FairWork (a civil society organization that aims to create awareness about human trafficking) and the Office of the National Rapporteur on Trafficking in Human Beings (the governmental, yet independent monitoring organization for the Dutch response to human trafficking). These

organizations all produced periodical status reports of the Dutch response to human trafficking that were regularly reviewed in the national press.<sup>37,45</sup>

At the organizational level, CoMensha also fulfilled an important role by coordinating service provision for victims of human trafficking. When someone was identified as a victim by the police or another entity, CoMensha would be notified, who would then arrange shelter and/or other services if needed. Other important actors at this level were the regional care coordinators for human trafficking that existed in many regions in the Netherlands. Participants from the interest groups discussed above noted how important these regional care coordinators ('interest persons') were and that such posts needed to be created where they did not exist yet. Reasons provided for their importance were that: they fulfilled a galvanizing role in the identification of victims of trafficking by educating various actors and paying visits to, for example, shelters for asylum seekers; they ensured continuity in service provision by monitoring service provision long-term beyond the walls of one shelter; they helped to establish local care networks; and they participated in lobbying on local levels.

Finally, participants noted that at the service delivery level CoMensha and FairWork contributed to expertise development among social and health service providers, by providing direct advice to service providers (CoMensha operates a helpline) and by organizing trainings for service providers (a joint programme by CoMensha and FairWork).<sup>288</sup>

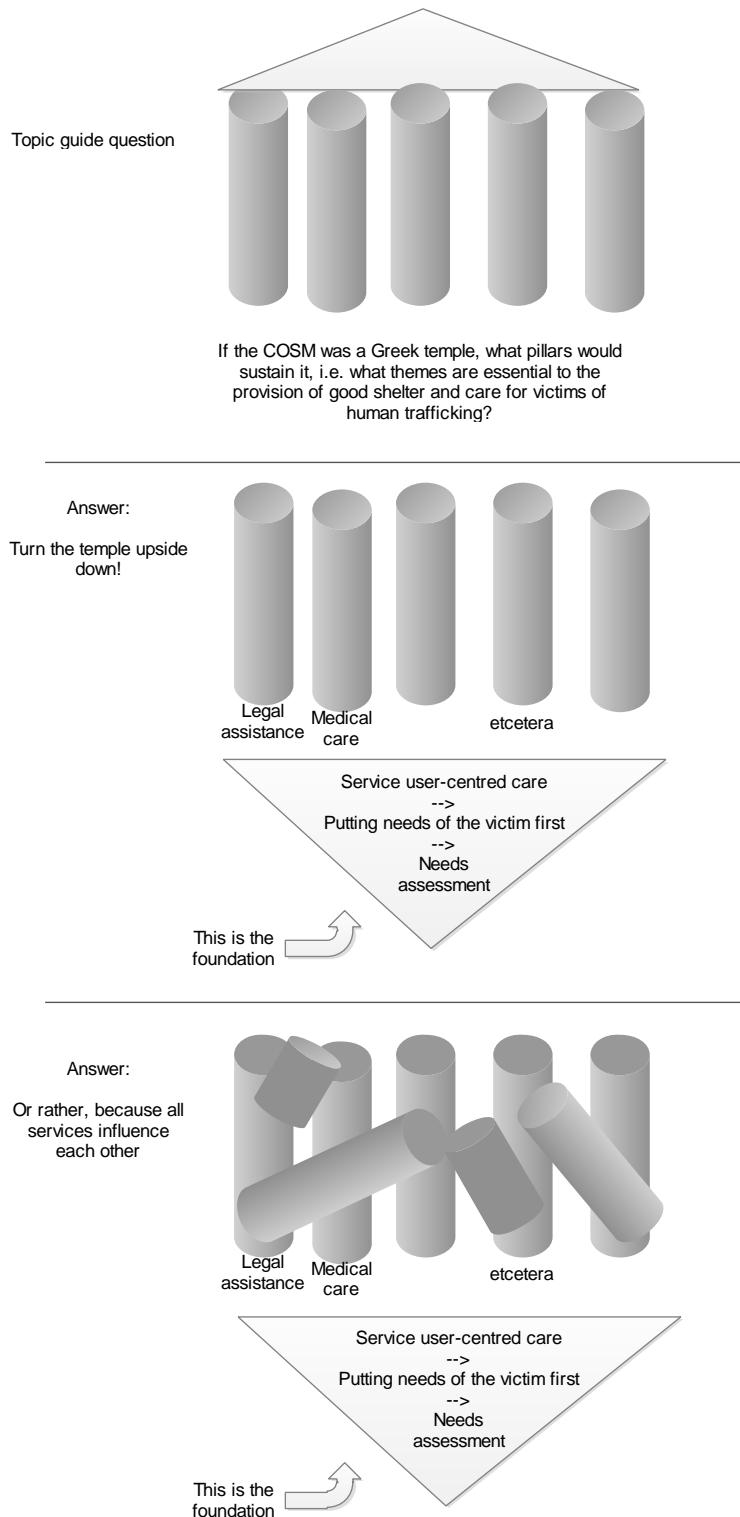
### **Factor 3: A service user-centred approach**

Some participants spoke extensively about the importance of applying a service user-centred approach in providing social and health services for this population. Participants noted that such an approach was needed because of the wide range of services needed for victims of human trafficking and the diversity in victims' needs. One participant provided a visualization of what a service user-centred approach entails (Figure 6.1); others confirmed that it starts with a needs assessment and good collaboration between partners in achieving a comprehensive package of services.

At the service delivery and organizational level I found that participants in my interviews were commonly highly service-user centred in their considerations about service provision. With direct service providers, most of my interviews revolved around the needs of this group, what it was currently receiving, where the gaps were, and how things could be improved. The service user-centredness of their considerations becomes clear from many of the quotes that I have used in this chapter, all focusing on what is currently good or bad about service provision for service users. At an organizational level I also found participants commonly spoke about what was best for service users.



For example, such a service user-centred approach drove the shelters to develop a more extensive network of services and to overcome administrative barriers in arranging non-shelter based services.



**Figure 6.1. The 'upside-down temple'**

In response to a topic guide question asking about the essential pillars of the COSM programme, one participant responded: "I would want to turn that temple upside down. I think it's essential in service provision that an assessment of service needs takes place. So that (...) a needs assessment is conducted of: what does this person need?"

Contrary to this, participants from all level of the system of care noted that in decision-making processes at the policy and governance level service users' needs were not always a priority and that other priorities played a role. As one service provider noted: "So I think that the system there allows the needs of the system to come before the needs of the victim. And the needs of the system are at that moment to make sure that the trafficker is caught." A policymaker noted: "In the end, for the Ministry of Security and Justice the goal is certainly to prevent human trafficking." The prosecution of traffickers was a priority that sometimes contradicted with the priority of protecting and providing services for victims. An example of this was that victims of trafficking were only eligible to receive long-term shelter and care if they collaborated with law enforcement in the lawsuit against their trafficker – a demand that is made of no other population of victims of violence in the Netherlands. Another policy priority noted by participants to clash with putting service users first was immigration policies. For example, in 2011 there were concerns that the immigration procedures for victims of human trafficking were being abused. This led to several measures by the government to prevent abuse.<sup>289</sup> One of these was to promote extra fast dismissal of charges that were considered to have a low chance of resulting in a lawsuit. However, several participants noted that this had an undesirable consequence: many victims were not provided the 3-month 'reflection period' any longer. A civil society member also described his objections against this measure: "Here too it is really the system that is to blame. There will undoubtedly be a few rotten apples that try to abuse the system. The thing is, what is not right, is that I feel you should never build a system on the basis of the rotten apples. You should build the system around the people who need it. That should be the point of departure." One participant specifically noted related to these alternative priorities that of the three governing ministries, one (the Ministry of Health, Welfare and Sports) was more likely to take a service user-oriented perspective than the others. That same participant also stressed the importance of policy cycles. He noted that ministers wish to announce new plans at the beginning of a term, wish to end the term successfully, and that 'not looking bad' is in general important to policymakers.

Several examples of the consequences of the lack of a service user-centred approach have been discussed in this chapter. One example were the strict eligibility criteria that were set for the COSM shelters, based more on legal and administrative considerations than on service users' needs, limiting access to the shelters (see Challenge 3). Such considerations also led to the current format of the COSM shelters (3-month crisis shelters), leading in turn to confusion among service providers about their nature: are they crisis or long-term shelters? (See Challenge 5) Another example was that while the original proposal for the COSM programme included a mental health care component,

participants noted that this was taken out to save costs, leading to a first tender for the COSM programme in 2010 that only included 'bed-bath-bread care'.

The lack of a service user-centred approach was not unique to the government. Several organizations, such as the federation for domestic violence shelters in the Netherlands, did not take responsibility for the population at first, but changed their position later. Financial motives may have played a role in the initial decisions not to take responsibility (in particular since the population was considered a 'difficult population'). As one service provider put it during my interviews: "It's always about money." Besides these larger overarching organizations, there were also individual practices and organizations that did not want to take responsibility for this population, showing a lack of willingness to make these service users' interests central.

#### **Factor 4: (De-)centralization**

Decentralization and centralization were both mentioned as impeding factors of service development by participants, the former mainly at the organizational level and the latter at the policy and governance level.

The decentralized nature of many social services was noted to impede the development of services because, for example, when shelters moved, they had to make large efforts to rebuild their network of services. In addition, CoMensha needed to lobby separately with regional governments to fund regional care coordinators for human trafficking. Most importantly, decentralization of shelter services meant that it was difficult in the Netherlands to provide shelter for smaller groups, such as victims of human trafficking, in a coordinated manner. In the regular, non-COSM shelter system, there was no mechanism for sharing the costs of a few specialized shelters throughout the country with all municipalities. Each municipality financed its own shelters.

On the other hand, centralization was also noted sometimes as an impeding factor of service development. At a national level other priorities than the needs of service users played a role in the governance of service provision (see Factor 3). Moreover, centralization also led to different financing arrangements for the COSM (through a tender), which had consequences for the amount of funding that the COSM received (see Challenge 2). One participant suggested that a successful feedback cycle may have been more difficult to realize for the COSM programme given its centralized form of governance. Indeed, the increased capacity for self-regulation by decentralized systems was one of the prime reasons for the Dutch government to further decentralize the Dutch social care system as a whole in 2015.<sup>290</sup> In line with this, a report about the Dutch shelter sector

from 2010 recommended to regularly evaluate the possibility for decentralization of shelters services for new target groups (see Challenge 2).<sup>270</sup>

### Factor 5: Network development

Many participants highlighted network development as an important facilitator for developing service provision as part of the COSM programme. Network development helped to overcome barriers in access to services (see Challenge 6), assisted in developing collaborations with non-COSM based services (see Challenge 7), and prompted expertise development among non-COSM based service providers (see Challenge 9). Participants remarked that it may be beneficial to establish the COSM shelter as a subcomponent of a larger shelter, so that the COSM shelter could make use of the network of this larger shelter (see Challenge 6).

Besides these horizontal approaches to network development, participants also related vertical network development to improvements in service provision, particularly through evaluation and feedback cycles (see Challenge 8 and Factor 8). The managers of the COSM shelters and civil society organizations, for example, collaborated in a number of evaluative meetings to discuss current challenges in the COSM programme. Similarly, periodic meetings were held between direct service providers, civil society organizations and the ministries that governed the COSM programme to discuss progress and current challenges in the COSM programme.

### Factor 6: Active 'change attitude'

Throughout my research, at various points, I encountered what I can best describe as an active 'change attitude'. All participants engaged actively in the interviews and liked being able to philosophize about how to improve care for this population. One service provider noted, for example: "I rather enjoyed this, you know. Reflecting a bit on your own practices."

I noticed this willingness to think about change at all levels, from direct care providers to policymakers. At the policy and governance level, this became clear from the changes that were made to the second COSM tender requirements in 2012 as compared to 2010, from the service user satisfaction questionnaire that was initiated by employees from the Ministry of Health, Welfare and Sports (see Challenge 8), and from the fact that at this level significant changes to the governance structure of the COSM were being considered (see Challenge 2).

At the organizational level, the efforts that were made by the COSM shelters to expand their network of collaborating actors and organizations struck me as particularly change-oriented (see Challenges 6 and 7), as well as the efforts by civil society actors to continuously identify aspects of service provision that needed improvement and to lobby for those improvements (see Factor 2).

At the service delivery level, it struck me that service providers spoke enthusiastically about having been able to develop expertise in providing services for this population (see Challenge 9 and Factor 7). Moreover, in my interviews many service providers expressed ideas for how service provision could be improved at various levels of the system of care.

### **Factor 7: Specialization**

Service providers viewed specialization (i.e. being able to focus on the population victims of human trafficking) to be a facilitating factor for the development of service provision. Specialization was mentioned as a factor that facilitated change both at the organizational level and at the service delivery level.

At the organizational level, the categorical nature of the COSM shelters was noted to allow for population-specific network development, thus increasing and improving collaboration with organizations outside the COSM shelters (see Factor 5). One service provider noted: “There are very specialized places now, with us and [name COSM shelter]. We know what to do. It is, eh, it works fast and you have quick contacts.”

At the service delivery level, specialisation was noted to allow service providers to develop their expertise, by gaining experience, being able to have focused discussions about their target population and being able to engage in relevant trainings. One service provider said, for example: “Well, so I think (...) that it is very good to be talking about these things. For example about what are these people’s demands from service provision? What is the demand and the need for service provision? And you do have that when you are a group that starts developing their skills in that area. Because you continuously ask each other questions and keep each other sharp. So I think there is an added value there.”

### **Factor 8: Evaluation and feedback cycles**

There was one theme that emerged in my research as both a challenge and as a factor that facilitated change: evaluation and feedback cycles. Here, I will provide a brief description of this theme’s relevance as a facilitating factor. More detail on this theme as a challenge is provided under Challenge 8.

Several participants noted evaluation mechanisms to be a key facilitator for the development of service provision. One noted that evaluation mechanisms ensured engagement of direct service providers in policy development. Another noted: “Only then can you identify the problems with the current system.” While some noted that there was still room for improvement and that a lack of evaluation mechanisms and feedback cycles sometimes impeded changes in service provision,

others noted that changes in service provision had been made because of evaluation mechanisms and feedback cycles (see Challenge 8). A noteworthy aspect of those changes was that evaluation and feedback cycles were not only relevant in driving change at all levels of the system of care, but they specifically facilitated change that required action *across* (all) levels.

## **Discussion**

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This chapter has identified challenges that emerged in developing service provision as part of the newly established COSM programme, described changes that occurred in how these challenges were addressed by actors in this system of care and identified factors that facilitated or impeded such change. Here, I will discuss how my findings relate to those of others who have followed similar lines of inquiry, the degree to which my findings are transferable to other contexts and the limitations of my research.

### **Literature on challenges in service provision for victims of human trafficking in the Netherlands**

I have identified nine challenges in developing service provision as part of the newly established COSM programme in this chapter. Several of these challenges, or more specific expressions of the challenges, have been described by other researchers and evaluators who have studied service provision for victims of human trafficking in the Netherlands. Rijken, for example, has spoken about the lack of a service user-centred approach in defining this population's eligibility for services in the Netherlands.<sup>41,177</sup> Muntendam has provided detailed accounts of the various administrative barriers that service providers run into and notes several issues related to service users staying in the COSM shelters for too long.<sup>153-155</sup> Van London has remarked that eligibility criteria for the COSM shelters narrowed between 2010 and 2012; that although the intention was to develop a specific treatment approach for working with victims of human trafficking in the COSM shelters, such an approach had not been developed yet in 2012 and that instead (an adjusted version of) the general model for service provision for victims of domestic violence had been applied; that legal and administrative support often take up so much time that little time remains for providing psychosocial support to service users; and that there are challenges in finding long-term housing for victims of human trafficking after they leave the COSM shelters.<sup>33</sup>

Several other challenges that I identified have received less attention elsewhere: the matter of elucidating responsibility across a range of actors (Challenge 1); the unique financing mechanism of

the COSM and its consequences (Challenge 2); the COSM shelters' identity issues (Challenge 5); achieving coverage of a broad range of services (Challenge 6); and the lack of sustainable mechanisms for evaluation (Challenge 8). These challenges deserve a more prominent place in discussions about service provision as part of the COMS programme.

## **Literature on challenges in service provision for victims of human trafficking in other countries**

Several of the challenges that I have described in this chapter have also been identified in other countries. My review in Chapter 2 demonstrated that at a policy and governance level, policy foci on prosecution and on border control in human trafficking policies together shaped a situation in which legal status, or rather the lack thereof, can be an impediment to service provision for victims, resembling some of the issues that I discussed under Challenge 3 and Factor 3. With regard to organizational-level and service delivery-level challenges, my review in Chapter 2 also described reports noting a lack of quality assurance mechanisms (Challenge 8) and various challenges related to service access and expertise development that I grouped under Challenge 6 and Challenge 9.

This means that despite countries' unique human trafficking and social and health service contexts, other countries shared many of the challenges that also emerged in the Netherlands. This has an important policy implication for countries that have not implemented specialized shelter services for victims of human trafficking yet: challenges in developing service provision for victims of human trafficking may be prevented or at least ameliorated, by taking note of and learning from the challenges that have emerged in other countries with similar policy contexts.

However, when we do not take the broader challenges that I identified in this chapter (e.g. Challenge 2: Financing), but the more specific expressions of these challenges (e.g. the national tender approach that led to the COSM shelters being underfunded); we do find that these are unique to the Dutch context. While Chapter 2 showed that others have noted issues with acquiring adequate amounts of funding for shelters for victims of trafficking, the problems with the tender system in the Netherlands were not mentioned elsewhere. Moreover, several challenges, particularly at the policy- and governance-level, were context-specific to the Netherlands all together, such the shelter identity issues (Challenge 5) that arose from the unique format of the COSM shelters, which in turn was a result of its unique governance mechanism.

This means that while the broader challenges that are identified in studies like these might be transferable to other country contexts, the more specific expressions of those challenges may not

be. This conclusion is in line with how Green and Thorogood describe transferability (the equivalent of generalizability in qualitative research): they note that although narrow findings from research may not be transferable, broader concepts arising from the qualitative analysis of such findings may well be.<sup>189</sup> This too has a policy implication: in taking note of the lessons that emerged from service evaluations for victims of human trafficking in other countries, it might be most useful to take note of the broader challenges and to assess how the particularities of a country's context may give rise to local expressions of those broader challenges.

Because several of the policy- and governance-level challenges that emerged in this research might be dependent on the specific governance context that has been established for the COSM programme in the Netherlands, I feel that in terms of transferability these might be better grouped under a broader theme called 'Governance and accountability'. This leads me to conclude that in terms of the transferability of the findings of this chapter to other countries, five broader themes of potential challenges might be important for those countries to take note of when they establish a new system of care for victims of human trafficking: governance and accountability; achieving coverage of a broad range of services; overcoming administrative barriers; evaluation and feedback cycles; and developing expertise.

## **A focus on system newness and development**

### *A developing system of care*

What sets this chapter apart from the other investigations that have been conducted in this area both in the Netherlands and abroad is its focus on the newness and developing nature of the COSM programme. This had several benefits.

First, it allowed me to show that the challenges identified here not only emerged as a consequence of the nature of the population and its specific service needs, but also as a result of the recent establishment of the COSM programme. I made this evident by providing detailed descriptions of the changes that took place in how the various challenges in the system were being addressed, by showing that service provision as part of the COSM programme lagged behind service provision for other populations, and by showing that there were different trajectories of service development for the three COSM shelters. My descriptions of the changes in service provision also showed that these changes took place quickly, many over the course of my doctoral research, providing an indication of the dynamic state that characterized this system of care during my research. Moreover, many of these changes were substantial, such as the planned changes to the governance structure of the COSM and the service providers gaining more expertise in working with the population. Together,



these findings demonstrate that the COSM programme was rapidly developing from a recently established, immature system of care to a system of care in which the challenges specific to its immaturity were increasingly resolved.

Given that an entire research field (implementation science) is devoted to investigating the challenges that are associated with the implementation of new interventions, this finding may have been expected. Yet, this characteristic of newly established services for victims of human trafficking and its consequences constitute a gap in the literature; to my knowledge this is the first study that has specifically focused on the challenges of developing a system of care for victims of human trafficking and on how that system adapted over time to address those challenges. This gap in the literature also shows in my conceptual framework in Chapter 2, which was developed on the basis of my literature reviews. In the framework, an element of change or adaptation of the system of care is notably absent (in hindsight).

Adding a focus on the newness of the COSM programme to my conceptual framework has some interesting implications. For example, it places victims of trafficking within a broader group of newly emerged vulnerable groups, with which service provision for victims of human trafficking indeed shares several challenges.<sup>270</sup> In Chapter 9, I explore in more detail the lessons that follow from adding a focus on the newness of the COSM programme to my conceptual framework.

### ***Factors that facilitated change***

A second benefit of focusing specifically on the COSM programme's newness and its developing nature was that I could take stock of the factors that facilitated or impeded service development to take place. To make sense of my findings about these factors, I consulted the implementation science literature.<sup>291,292</sup> Given the complex, multi-actor, multilevel nature of the COSM programme, I particularly explored a specific subset of this literature on large system transformations, which concern "interventions aimed at coordinated, systemwide change affecting multiple organizations and care providers, with the goal of significant improvements in the efficiency of health care delivery, the quality of patient care, and population-level patient outcomes."<sup>293</sup>

One key article in this body of literature by Best et al argues that "to improve processes and outcomes, the key is to create positive conditions for change by supporting a work environment conducive to harnessing both relationships and the skills and capacities of individuals in the system".<sup>293</sup> The article suggests five 'simple rules' for achieving this: 1) Engage individuals at all levels in leading the change efforts; 2) establish feedback loops; 3) attend to history; 4) engage physicians; and 5) involve patients and families.

Notably, these five rules are all about enabling ‘learning’ to facilitate the change process – be it learning from actors within the system (service providers and service users), learning from history, creating the right feedback cycles to propagate lessons from those people to the leadership, or creating the right leadership to act on such lessons. I described that ‘learning’ under Factor 8, evaluation and feedback cycles, in this chapter. From my findings with regard to this factor, I conclude that the five simple rules by Best et al need to be extended with a sixth: ‘Learning from others’, be it from other shelters, shelter sectors or countries. This might be viewed as the ‘present-day’ form of Best et al’s simple rule 3 (attend to history) or an ‘external’ variant of simple rules 1, 2, 4 and 5. It stresses that it is also important to look for lessons outside the system itself.

Besides evaluation and feedback cycles, I identified several other facilitators of change in this chapter. Some of these can be understood through what two other authors, Harrison and Kimani, call external conditions that can create pressure for change.<sup>294</sup> Political and societal attention (Factor 1) and interest groups and persons (Factor 2) fall in this group. Another group of authors, Lukas et al, note that impetus for change can also come from within organizations.<sup>295</sup> Shelters’ and other service providers’ ability to specialize in providing care for this population (Factor 7), as well as the active change attitude among service providers (Factor 6), may be understood as such within-organizational factors.

Harrison and Kimani note another issue of importance, namely that “transformation initiatives typically require a set of shared beliefs and values”.<sup>294</sup> The service user-centred approach (Factor 3) is a good example of this. More generally, the importance of using a person-centred approach to service provision has been the topic of many recent publications, both for the social<sup>296</sup> and health services<sup>297</sup> sectors.

(De-)centralization (Factor 4) and network development (Factor 5) appear to fall outside the literature described above. However, centralization emerged in my research as a factor that placed decision-makers far from the users and implementers of services, thus impeding effective feedback cycles. Paradoxically, decentralization also emerged as an impeding factor of change. This may well be because decentralization results in dispersed leadership. Keeping in mind Best et al’s simple rule 1 (“Engage individuals at all levels in leading the change efforts”), the practical difficulties of engaging all such individuals in a context of dispersed leadership may have been what made decentralization a prominent barrier. The same practical difficulties in engaging all individuals might have resulted in network development being an important facilitator. This factor may well be more applicable to the social care sector than to the medical care sector; target populations for shelters are unique in their need for a broad range of both social and health services. This may be why this

factor was not prominently mentioned in the literature on large transformations in health care. These factors 3, 4 and 5 can be grouped: they facilitate change by bringing actors closer together (or impede it by keeping them apart).

In summary, I identified eight facilitators of service provision development, that might be allocated to one of the following four categories: external factors that facilitated change (Factors 1 and 2); factors that brought actors closer together by forming networks or by formulating shared beliefs and values and as such facilitated the change process (Factors 3, 4 and 5); internal (within-organizational) factors that facilitated change (Factors 6 and 7); and factors that were about enabling 'learning' to facilitate the change process (Factor 8). These categories can be found at the bottom of Table 6.1.

## **Limitations**

The research conducted for this chapter has several limitations.

First, this research was conducted in three new shelters for victims of human trafficking, a population with specific characteristics (see Chapter 2), in a specific programmatic, social, medical and legal context in the Netherlands. Therefore, the most important limitation of this chapter is that its conclusions only bear direct relevance to this population and this context. I have discussed my views on the transferability of my findings to other contexts above.

A second limitation is that I only investigated challenges in providing services as part of the COSM programme. However, the COSM shelters are not the only service providers for victims of trafficking in the Netherlands (there are also other crisis shelters, long-term shelters, supported housing facilities and outpatient social services). The challenges for this broader system may well differ from those experienced as part of the COSM programme. Additionally, the identification of victims of trafficking, as opposed to post-trafficking service provision, has distinct challenges. One participant described, for example, how signalling of victims of human trafficking, i.e. the process leading to their identification as a victim, was frequently deficient. Describing such challenges was beyond the scope of this chapter, but I do come back to some of these issues in Chapters 7 and 8, which take a broader perspective.

Lastly, my findings have likely been influenced both by me and by what service providers wished to convey. My views on how I have influenced the data I have already described in the limitations section of Chapter 5. With regard to what service providers wished to convey, many providers indicated having enjoyed being able to 'take a step back' and consciously consider their activities. Because of my role as a researcher, it is possible that they have seen me as a 'change facilitator' and

that they hoped to achieve policy changes through me. It is thus important to recognize that my data reflect how service providers wanted to tell me their stories. Therefore, I have tried in my analysis not to describe opinions or viewpoints, but rather to assess the reasons and structures behind those viewpoints. With regards to financing for the COSM programme, for example, I have refrained from stating that the level of financing is not enough (as many service providers did), rather I have observed that it is less than what it was agreed to be, less than what was considered necessary to provide shelter and care for this population, and less than what other shelter programmes in the Netherlands receive. I have tried to determine how this situation came about (the unique tender-based approach to financing this programme), which, ultimately, was linked to the core phenomenon that underlay the analysis of this chapter: the newness of this system of care. In this way, I have hoped to avoid the pitfall of merely presenting service providers' opinions in this chapter.

## **Chapter 7**

# **Enabling adequate responses by social and health service providers to victims of human trafficking in the Netherlands**

## Summary

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To adequately assist victims of human trafficking a spectrum of social and health services is needed, both in terms of identification and referral and in terms of post-trafficking treatment and care. Awareness campaigns, training programmes, protocols for treatment and reporting codes for identification and referral can help social and health service providers to respond adequately to victims of human trafficking. However, the development of campaigns, training, protocols and codes for the population of victims of human trafficking has lagged behind that for other populations in the Netherlands. I provide suggestions in this chapter for how this lag can be addressed. In doing so, I pay particular attention to the development of a reporting code for identification and referral of victims.

## Introduction

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The following is a result of a more in-depth exploration of one of the themes that emerged in Chapter 6: social and health professionals' expertise development in the area of human trafficking. As that chapter made clear, service providers regularly spoke of the lack of opportunity for developing expertise in relation to this group. Several spoke of potential interventions to redress this situation, such as training programmes. Simultaneously, I was aware that in the area of expertise development for service provision for other victims of violence, such as victims of domestic violence and victims of child abuse, much progress had recently been made in the Netherlands, but that similar developments had lagged for victims of human trafficking. This led me to wonder: what was being done in the Netherlands to enable social and health service providers to provide adequate care for victims of human trafficking? What is it that *should* be done to enable service providers to provide adequate responses to victims of human trafficking? And what could be learned in this area from the experiences gained in service provision for other populations, such as victims of domestic violence and victims of child abuse?

Because of the dominance of this theme in my interviews with service providers, and because I felt answering these questions may result in practical recommendations for improving service provision for victims of human trafficking, I decided to explore this theme in more depth. Answering the questions above has resulted in a policy commentary, which I present here as a brief chapter. Although the previous chapters in this thesis have predominantly focused on post-trafficking social and health service provision, this chapter takes a broader view. Efforts to improve the expertise of social and health service providers on human trafficking always include both identification and referral functions and post-trafficking treatment functions. Therefore, this chapter also includes the role of social and health service providers in identifying and referring victims. It describes how the Netherlands can enable service providers to have the knowledge and skills needed to identify and refer victims of human trafficking and to treat victims in a post-trafficking setting.

As noted at the start of this section, this chapter draws from my interviews and my observations of various meetings of policymakers on human trafficking in the Netherlands. However, to be able to answer the questions raised above, I needed to also draw in literature on this topic, i.e. literature on expertise development for those who provide social or health services for victims of human trafficking and for care providers for related populations. Finally, the chapter makes use of the findings of an international study of a training programme for social and health service providers on human trafficking that I have been involved in and that was published in 2015.<sup>211</sup>

## Expertise that is needed for social and health service providers

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To adequately assist victims of human trafficking a spectrum of well-coordinated social and health care services is needed that take a trauma-informed and culturally sensitive approach.<sup>30</sup> As a result of these specific needs, service provision for this population requires specific knowledge, skills, and as a consequence, training, for the social and health care professionals engaged in providing care for this population.<sup>282</sup>

Most social and health service providers in the Netherlands do not provide care on a regular basis to victims of trafficking in the post-trafficking stage. The group is relatively small; the annual number of victims of human trafficking requesting shelter services in the Netherlands was 212 in 2013. Social and health service provision for victims of trafficking is mostly limited to a small number of specialized shelters with associated social and health services, and some specialized mental health care institutions.

In contrast, the chances for service providers of encountering a victim of human trafficking during the period of exploitation are higher.<sup>110,282,298–305</sup> Two studies have shown, for example, that many victims come into contact with the health care system during their period of exploitation without being identified as a victim of human trafficking.<sup>282,306</sup> When that happens, service providers need to know how to identify a victim (there are specific ‘red flags’ to watch out for<sup>265,307–309</sup>) and what steps to follow to refer victims.<sup>305</sup> For some service providers, who have an increased likelihood of encountering victims of trafficking (e.g. employees of abortion clinics or sexual health clinics, social workers providing outreach services for sex workers, and general practitioners), these skills are of particular importance.

In this Chapter, I discuss what should be done to enable adequate responses by social and health service providers to victims of human trafficking in the Netherlands and compare that with what is currently being done.

## Expertise development in the Netherlands to date

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As demonstrated in Chapter 6, expertise development has been a challenge for social and health service providers in establishing the Dutch response to human trafficking. In key areas, such as the availability of training, guidance materials and treatment protocols, expertise development for this



population lagged behind that for other populations, such as victims of domestic violence. Safeguarding adequate professional responses to victims of human trafficking thus constituted an aspect of the system of care for victims of trafficking in the Netherlands that required further development. This situation is not unique to the Netherlands. My literature review in Chapter 2 showed that knowledge deficits about human trafficking among service providers were often noted as a concern in studies, in particular with regards to providing culturally sensitive care,<sup>26,41,138,143</sup> and in particular for service providers outside shelters.<sup>(34,p162)</sup>

## **Guidance on expertise development for victims of human trafficking**

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The literature on service provision to victims of human trafficking provides little guidance on how this might be achieved. Besides several articles that shed light on what the contents of training programmes on human trafficking for social and health providers should be,<sup>211,282,310</sup> little work has been conducted to describe how adequate professional responses to victims of trafficking can be best enabled from a policy and systems perspective.

Therefore, to be able to understand what should be done to enable adequate professional responses to this group in the Netherlands, I describe here below what lessons can be learned from expertise development among service providers for other groups that are victims of violence, such as victims of domestic violence. Because these groups have been recognized as a target population for the social and health services for a longer time, more experience has been gained with expertise development for professionals who provide care for these groups.

## **Treatment function and identification and referral function**

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Professional expertise development for providing care for victims of violence is generally subdivided into two components: 1) treatment, and 2) identification and referral. This distinction is made because the professionals involved in these two functions are generally different and require different expertise.

## Treatment function

The World Health Organization (WHO) guidelines on responding to intimate partner violence and sexual violence against women highlight the need for specific training for professionals that deliver interventions to victims of such violence.<sup>311,312</sup> In line with these recommendations, and given the specific expertise needed to provide care to victims of human trafficking, training programmes for care providers who regularly provide care to victims of trafficking in the post-trafficking stage are likely beneficial, although little evidence exists to support the effect of such training programmes.<sup>211,282</sup> As explained in Chapter 6, in the Netherlands, such a training programme has recently been developed.<sup>288</sup> Other countries have also started to develop training programmes for social and health service providers around human trafficking,<sup>282</sup> although many of the service evaluations that I reviewed in Chapter 2 noted a lack of training for service providers as a barrier to good service provision.<sup>26,131,135,136,138,139,147,154,155,157,160,171</sup>

While the establishment of a training curriculum on human trafficking is a good development, when the curriculum is compared to training curricula for other vulnerable populations in the Netherlands, it becomes clear that two improvements could be made to the programme to increase its usefulness. First, when a training programme has been developed, it is of importance that service providers attend the training. This can be achieved in several ways, but offering continuing education credit to service providers is a key strategy for optimizing uptake of training programmes.<sup>282</sup> Accreditation that guarantees such credits is in place for training for other populations, but not for training related to human trafficking.<sup>313,314</sup> Second, it is important that training is geared towards specific professions. However, the training programme on human trafficking in the Netherlands is currently a generic one, for all professions alike. A training programme for medical doctors, for example, has not been developed yet. Without specific training programmes for such groups, the programmes cannot be tailored to the specific needs of service providers. For instance, to make it possible for medical doctors to attend, training programmes would likely have to be shorter than the 1- or 2-day programmes that are currently offered.<sup>288</sup>

Finally, as became clear in Chapter 6, there is also a lack of consensus on what constitutes appropriate social and health service provision for the population of victims of human trafficking. In terms of expertise development, this is an important gap; such consensus might even be said to be a prerequisite for training service providers on providing care. Therefore, it will be important to stimulate research to clarify what constitutes appropriate care for this population, followed by the development of consensus in the form of guidance documents and/or treatment protocols. This might be done by bringing together professionals in specific areas together to discuss research

possibilities and protocol development, as is already happening in the Netherlands in the area of mental health. CoMensha, the Dutch Coordinating Centre for Human Trafficking, could play a coordinating role in bringing professionals from various backgrounds together.

## **Identification and referral functions**

Knowledge about human trafficking among general social and health service providers is limited.<sup>211</sup> During one of my interviews, for example, a shelter manager noted that she had received questions from an abortion clinic about what to do when they suspected someone of being trafficked. Several measures could be taken to redress the lack of knowledge about human trafficking among general social and health providers in the Netherlands to improve their ability to identify and refer victims.

First, awareness campaigns, targeted at the general public or at social and/or health providers specifically, may help to sensitize service providers to the issue of human trafficking and the likelihood of them encountering a victim in their practice.<sup>315</sup> Such campaigns are a good tool to raise awareness on the topic of human trafficking for social and health service providers who work in a profession in which they are only moderately likely to encounter a victim of trafficking (which is the majority of all social and health service providers).<sup>316</sup>

Second, for social and health service providers who do work in professions in which they are highly likely to encounter victims of trafficking in their practice, such as employees of abortion clinics or sexual health clinics, social workers doing outreach work to sex workers, and general practitioners, training programmes are likely to help to develop such expertise, as they have been shown to do for service providers who need to be able to identify victims of domestic violence.<sup>311,317</sup> Skills to identify and refer potential victims are different from the skills needed to care for this population, and are needed by a separate group of social and health service providers, warranting separate training programmes for this function. Separate training programmes are indeed available in the Netherlands for these functions.<sup>288</sup> The same improvements as for the training programmes on treatment could help to improve the impact of these programmes.

Third, from the general literature on violence against women it becomes clear that it is important that there is a protocol to guide social and health service providers on how to identify a potential victim of violence and what steps to follow in case there is suspicion.<sup>318</sup> Such a protocol would form a part of the abovementioned training programmes, but would also be particularly important for all social and health service providers who have not had training on this topic, yet might encounter a potential victim of trafficking in their practice. To decide what such a protocol should look like,

lessons can be learned from measures that have been taken to assist service providers in the Netherlands in responding to other forms of violence. A national ‘reporting code for victims of domestic violence and child abuse’ helps social and health service providers in the Netherlands, as well as various other professions (e.g. teachers), in identifying victims of domestic violence and child abuse by listing potential signals of violence (‘red flags’).<sup>283</sup> Besides helping service providers to identify a potential victim, this reporting code also helps service providers to take action if signs of abuse or violence indeed exist. It helps care providers deal with crucial questions such as: Can I share information about this person with anyone else? Who can I call for help or more information? How do I balance confidentiality with my concern for the patient? In which situations should I wait and monitor the situation and in which should I notify the authorities? What do I need to discuss with the (potential) victim? And with the perpetrator? The reporting code does not oblige service providers to report; it merely provides guidance on how to make a well-founded decision about whether to report, and if so, when, how and to whom. The decision to report or not remains with the service provider.<sup>283</sup>

Research on the effectiveness of reporting codes is limited. A recent observational evaluation of the reporting code for child abuse in the Netherlands showed that professionals who use the reporting code are three times as likely to refer children to the Dutch reporting point for child abuse than professionals who do not use the code.<sup>319,320</sup> However, the non-interventional nature of this study makes it difficult to make certain assertions about the effectiveness of the reporting code on the basis of the study’s results. Internationally, the amount of evidence for reporting codes is also limited; a review of interventions to reduce domestic violence found only one health system intervention that did not include training, which was an intervention of case management rather than a reporting code.<sup>317</sup> The WHO guidelines on responding to intimate partner violence and sexual violence against women also only discuss the provision of referral guidance in combination with training of service providers.<sup>311</sup> In combination with training, identification and referral support has been found to be effective in increasing the rate of referral of victims of domestic violence,<sup>311,317</sup> such as with the Identification and Referral to Improve Safety (IRIS) programme in the UK.<sup>321–323</sup> The WHO guidelines stress that training on identification and referral that is limited to identification is likely not effective, and that beneficial effects of such training are predominantly incurred when training comprises the whole process of identification, safety assessment and planning, communication and clinical skills, documentation, and provision of referral in a comprehensive manner.<sup>311</sup>

Notwithstanding the lack of evidence for the effectiveness of reporting codes, professionals are positive about the quality of the reporting codes in the Netherlands and the codes are broadly considered an important tool to help professionals act appropriately when suspecting child abuse or domestic violence.<sup>319,320</sup> Several professional organizations, such as the Royal Dutch Medical Association (KNMG) and the Dutch Association of Social Workers (NVMW) have taken the generic reporting code and have tailored it more specifically to the professions they represent.<sup>319,324</sup> The Netherlands is not unique in using such a model, in the UK for example, similar referral guidance is available through the local Safeguarding Adults Boards<sup>325</sup> and Safeguarding Children Boards<sup>326,327</sup> and is provided through the aforementioned newly tested IRIS programme.

Clearly, the benefits of a reporting code are not limited to the populations of victims of domestic violence and child abuse, for who such codes commonly exist, but extend to victims of human trafficking as well. Johnson notes, for example, about identifying victims of human trafficking in the United States: “We keep our eyes open to battered women, women involved in dating violence, people that are being manipulated because they might be weaker than someone mentally or physically. (...) Those are things we look for and refer people on for help, so why not human trafficking also?”<sup>328</sup> Moreover, it is important that a *separate* reporting code is developed for human trafficking, because there are differences both in terms of appropriate identification and in terms of referral mechanisms for victims of human trafficking:

- the signals that indicate that someone may have been trafficked are different (the ‘red flags’);
- several other characteristics of the population are different with potential consequences for service provision (victims of trafficking are often from abroad, so translation might be necessary, for which it is relevant to know that firstly, service providers should make sure to use independent translators when interviewing potential victims,<sup>211</sup> and secondly, while translation services are normally not reimbursed to health care providers in the Netherlands, they are for victims of human trafficking via CoMensha);
- organizations with expertise about the target population are different (in the case of human trafficking in the Netherlands this is CoMensha, while for domestic violence it is the Focal Point for Domestic Violence (SHG));
- the organization to report the crime to may be different (for human trafficking one should report to CoMensha and/or the police, which is different from the referral pathways for domestic violence and child abuse);

- considerations around reporting may vary (e.g. with domestic violence, service providers should be more careful than with child abuse to break confidentiality to report, when the victim does not wish for the violence to be reported,<sup>319</sup> and with trafficking such considerations are different yet again);
- and the consequences of reporting for both the victim and the service provider may be different (with human trafficking the involvement of organized crime changes the potential consequences for both and what actions the service provider should take to safeguard him- or herself and the victim from such consequences).

Notably, I have so far spoken about ‘victims of human trafficking’ as one population, but this population is highly heterogeneous itself, and it would be appropriate if a reporting code took into account the differences between various subgroups of victims of human trafficking, such as domestic victims of trafficking for the purpose of sexual exploitation (often victims of loverboys / grooming), foreign victims of trafficking for the purpose of sexual exploitation, and victims of human trafficking for other types of exploitation.

In November 2014, a reporting code for human trafficking was published in the Netherlands,<sup>304</sup> following similar reporting codes in other countries.<sup>303,329,330</sup> However, given the small size of the population of victims of human trafficking, the implementation of this reporting code might be challenging. As opposed to the reporting codes for victims of domestic violence and child abuse, for example, there has been no uptake to date of the code by the KNMG and NVMW. Every general practitioner in the Netherlands has a copy of the reporting codes for domestic violence and child abuse by the KNMG in their offices – which is what should be the goal for the reporting code for human trafficking as well. How this might be achieved is a difficult question, but one solution might lie in the fact that victims of human trafficking are not the only subpopulation of victims of violence in the Netherlands for which specific expertise is needed.

## Reporting codes for other subpopulations of violence

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There are various other subpopulations of victims of violence in the Netherlands with specific needs profiles, for whom specific expertise is needed in terms of identification and referral. These other groups are often relatively small or have newly emerged as a target population for the Dutch social and health services. Examples of such groups include: victims of honour-based violence,<sup>27,270</sup> victims of female genital mutilation,<sup>319</sup> people at risk for forced marriages,<sup>331</sup> undocumented victims of

violence,<sup>332,333</sup> men who are victims of violence,<sup>334</sup> elderly victims of violence,<sup>335</sup> and parents who are victims of domestic violence by their children.<sup>336</sup>

As for victims of human trafficking, there is a need for separate reporting codes for each of these populations, given that various aspects of the identification and referral process differ by population. The Dutch reporting codes for domestic violence and child abuse recognize this to some degree; they note that for several groups (victims of honour-based violence, female genital mutilation, forced marriages and sexual violence) the reporting code may diverge from the reporting codes for victims of domestic violence and child abuse.<sup>283,319,324</sup> The reporting code by the KNMG provides three separate lists of signals for ‘violence against adults’, ‘violence against senior citizens’ and for ‘child abuse’. Although the other groups mentioned above are specifically noted as being target groups for the reporting code, separate signal lists and referral mechanisms are not described, and only for some of the groups does the document refer to specific reporting codes developed by other organizations or to organizations where service providers can find extra information on that particular group. Other subgroups of victims of violence, notably victims of human trafficking, are not mentioned at all in the reporting codes for domestic violence and child abuse.

## **One reporting code, with different subcodes**

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For some of these groups, as noted in the sections above, separate reporting codes have been developed by other organizations, separate from the KNMG and NVMW reporting codes for domestic violence and child abuse. The recent development of a reporting code for human trafficking is one example,<sup>304</sup> as are the various codes, signalling lists, and other guidance documents for identifying and reporting victims of loverboys / grooming.<sup>337–341</sup> The establishment of these guidance documents is a good development, yet their dispersed nature decreases the likelihood of service providers successfully accessing guidance on identification and referral pathways for these groups. If such guidance is not easily accessible, in a familiar location and in an appropriate format, it will likely not be read, in particular if the population is comparatively small and unknown (as many of these groups are). There appears to be an easy solution to this problem, that would ensure access for social and health service providers to all available reporting codes for victims of violence: the

development of one ‘master’ reporting code for all situations involving violence,<sup>\*</sup> with subcodes for specific subpopulations of victims of violence (with separate lists of signals and referral pathways).

Such an overarching reporting code to provide guidance on all situations in which violence is suspected is not a new concept. It is a proven model in other areas of social and health care practise. Dutch general practitioners, for example, make use of the Dutch College of General Practitioners (NHG) guidelines; a collection of standardized protocols for more than 90 common health problems.<sup>342</sup> Dutch physicians in general also have access to the ‘pharmaceutical compass’, which provides guidance on indications, dosing and side-effects of all available medicines in the Netherlands.<sup>343</sup>

However, as explained in the previous section, the Dutch reporting code for domestic violence and child abuse is limited in its scope and falls short of being an overarching reporting code for victims of violence. It is important that its scope is expanded to include guidance on all relevant subpopulations of victims of violence. The reporting code should become the standard reference source for social and health service providers who are faced with a potential victim of violence in their practise. For each subpopulation, this standard reference source should provide easily accessible summaries of signals or ‘red flags’; specific things to pay attention to with this population (e.g. the need to use independent translators for victims of trafficking); organizations where one might request additional information on the population; and referral pathways. It should be available online and in print, with clear sections for each subpopulation, so that care providers can immediately access information about the specific population they need more information on.

Such an expansion of the coverage of the reporting code is in line with recent recommendations to widen the scope of the term ‘domestic violence’ in the Dutch Social Support Act (Wmo),<sup>268</sup> in order for the law to accommodate service provision for newly emerged subpopulations of victims of violence.<sup>270</sup> Moreover, if these recommendations to widen the scope of the Wmo are followed, the KNMG and the NVMW would be legally obliged to expand the scope of the reporting codes for domestic violence and child abuse to all victims of violence, since according to Dutch law it is mandatory for social and health care organizations to have a reporting code for the populations that fall under the remit of the Wmo.<sup>344</sup>

An additional advantage of expanding the scope of the Dutch reporting code for domestic violence and child abuse and adhering to the format of one overarching code with several subcodes would be

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<sup>\*</sup> ‘Violence’ should be broadly interpreted here to include any type of violence and abuse; neglect of children, vulnerable adults and elderly; and criminal forms of exploitation (i.e. human trafficking).



that all reporting codes for victims of violence would then follow the same, tested design. By deliberately taking stock as part of the implementation of such a new reporting code model (a 'master' reporting code with various subcodes) for which subpopulations of violence reporting codes are *needed*, creating an overarching reporting code may also help to minimize the risk of absence of a reporting code for populations for whom such a code is needed.

## **Conclusion**

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Victims of human trafficking are a population that has newly emerged as a target population for the social and health services in the Netherlands. To ensure that social and health service providers are able to identify and refer potential victims of human trafficking and that they are able to treat victims of human trafficking, a combination of awareness campaigns, training programmes, protocols for treatment and reporting codes for identification and referral is needed (Figure 7.1). Not all of these strategies for expertise development and knowledge advancement are needed for all social and health service providers. For example, only a select group of service providers who regularly provide care to victims of trafficking in the post-trafficking stage require training on treatment functions and only service providers who have a high chance of encountering victims of trafficking in their practice require training on identification and reporting functions. Awareness campaigns fulfil an important function in sensitizing service providers to the issue of human trafficking. Reporting codes may be used in tandem with training programmes, but might also fulfil a particularly important function as a resource of information for service providers who are not trained on the topic but suspect they are faced with a potential victim of trafficking in their practice. A large part of this chapter focused on discussing the benefits and implementation options of reporting codes. This was because there is less literature available on this topic than for other expertise development strategies, such as training.

To realize expertise development on human trafficking among service providers through these methods, valuable lessons can be learned from other vulnerable populations that have been targeted by the Dutch social and health services for a longer time. Moreover, to do so, it is important to consider victims of trafficking in conjunction with other subpopulations of victims of violence in the Netherlands. For example, integration of the reporting code for victims of domestic violence and child abuse with the reporting code for victims of trafficking and other subpopulations of violence, thus creating one overarching reporting code for all situations involving violence, would create an inclusive resource of information for social and health service providers who are faced with victims of violence in their practise.

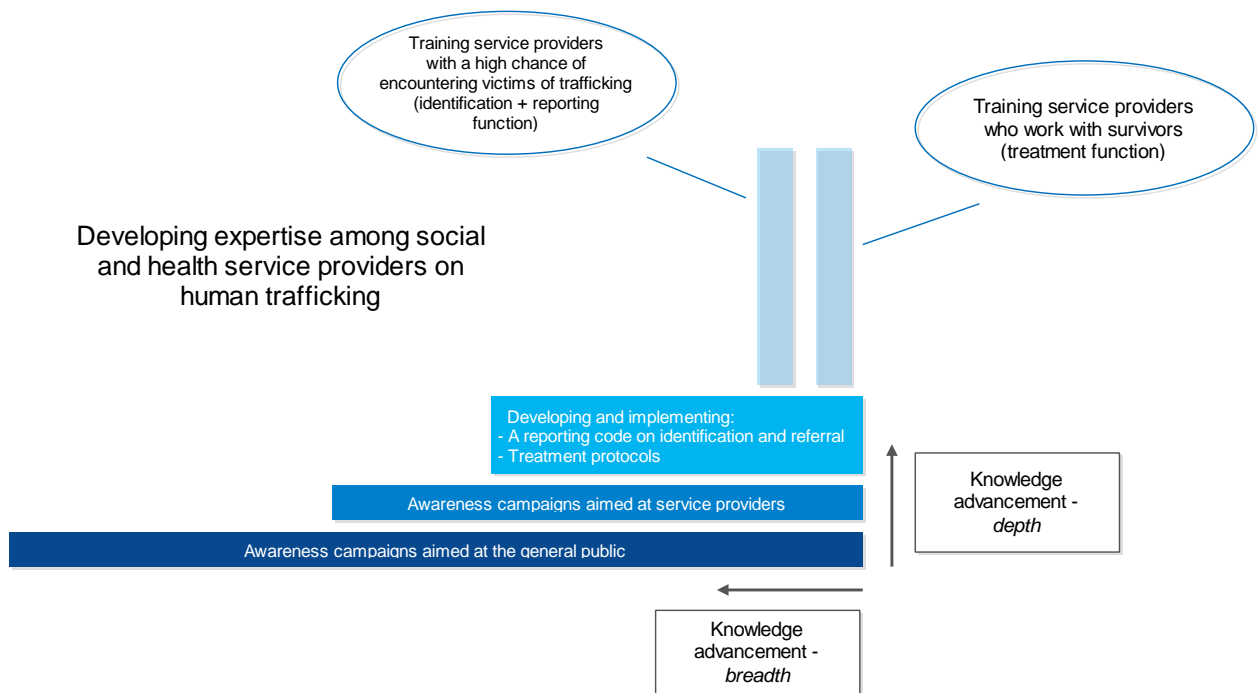


Figure 7.1. A model that I developed that outlines the strategies that are needed to enable adequate responses by social and health service providers to victims of human trafficking in the Netherlands

## **Chapter 8**

# **Monitoring social and health services for victims of human trafficking in the Netherlands**

## Summary

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### Introduction

A range of services is needed for victims of human trafficking in the Netherlands, including preventive programmes, outreach programmes, post-trafficking shelter, social services and medical care. This chapter explores how the Dutch government ensures that the services that are available for victims of human trafficking match the services that are needed by this group via public health monitoring programmes, implemented by the Dutch municipal health services (GGDs).

### Methods

A documentary analysis was undertaken. The websites of all 28 GGDs in the Netherlands were searched for documents on regional public health monitoring, i.e. that reported on the nature, size or service needs of vulnerable groups and/or provided insight into available social and health services for these groups. In addition, each GGD was approached via email with a request to provide such documents. My data analysis of these documents consisted of two components. First, in each document, I assessed whether information was presented about the social and health services available to victims of human trafficking and to other vulnerable groups. Second, I assessed if the information that monitoring documents provided was enough to be able to lead to suggestions for improvement of the existing services.

### Results

Victims of human trafficking were only mentioned by two of the 28 GGDs in their public health monitoring documents. To understand why monitoring for this group lagged behind monitoring for other populations, I assessed the frequency with which other groups were monitored to determine patterns in which groups were monitored and which groups were not. In total, the GGDs monitored 54 different vulnerable groups. Because of two *monitoring frames*, several vulnerable groups were monitored more frequently than other groups. More than 50% of the groups fell outside these two monitoring frames, including victims of human trafficking. Consequently, these groups and the services provided for them were monitored much less often by GGDs. Public health monitoring documents nearly always described the nature and size of monitored vulnerable groups, but in terms of the descriptions of these groups' service needs and the availability of social and health services in the region, there were large differences between different GGDs.

## **Discussion**

To safeguard the accessibility of the various social and health services needed for victims of human trafficking it is essential that the Dutch government monitors their availability. Yet, victims of human trafficking were only rarely included in regional public health monitors published by GGDs in the Netherlands. Moreover, the public health monitors often did not present enough information to allow for conclusions to be drawn about how services might be improved. There was substantial variation among the GGDs in terms of vulnerable groups monitored and the ability of monitoring documents to suggest improvements for existing services, showing that advances in the Dutch regional public health monitoring system are not only desirable, but also feasible.

## Introduction

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In Chapters 5 and 6, I explored service users' and service providers' experiences with the Categorical Care for Victims of Human Trafficking (COSM) programme in the Netherlands, to arrive at insights into victims' post-trafficking recovery processes and how these might be best facilitated as part of the COSM programme. However, the COSM programme is only one component of a broader spectrum of social and health services for victims of human trafficking in the Netherlands (see Chapter 1). When I first started thinking about my doctoral research, I wanted to devote one chapter to a more inclusive analysis of the Dutch system of service provision for this group. What social and health services were available to help victims of trafficking exit various exploitative situations? What about preventative programmes that aimed to prevent young people from being trafficked? What about the services that were available to people after they left the COSM shelters? And what about the people who never entered the COSM shelters?

Although these questions are interesting, I concluded quickly that their scope was too broad, and that it would not be feasible for me to study all the social and health services for this population in the Netherlands in detail as part of my doctoral research (particularly not on the basis of interviews with service users and providers). My initial plan to explore this broader set of services more inclusively, however, did raise another research question with me, that was of interest to the larger aim of my thesis and that could also be feasibly investigated. Instead of exploring service provision in these other service areas myself, I decided to explore how the broader set of social and health services for victims of human trafficking was monitored in the Netherlands by the Dutch government. That exploration has given rise to this chapter, which was published in a modified form in 2013 in the Dutch Journal of Health Sciences.<sup>345</sup>

## Background on public health monitoring in the Netherlands

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A wide range of social and health services is needed for victims of human trafficking in the Netherlands, ranging from outreach programmes, to preventive programmes, to post-trafficking shelter, social services and medical care. It is important that the availability of these services is monitored by the government to assess whether they match the service needs of this population.<sup>346</sup> This is called *public health monitoring*.

In the Netherlands, the social and health services for victims of trafficking are monitored in three ways: at the national level and at the regional level, where monitoring is split up into that conducted under the framework of the Dutch Social Support Act<sup>268</sup> and that conducted under the framework of the Dutch Public Health Law.<sup>346</sup>

At the national level, the monitoring function is mainly executed by the Dutch Coordinating Centre for Human Trafficking (CoMensha). CoMensha's reports provide information about the number of suspected victims and the number of victims who have received shelter in the previous year (see Chapter 1).<sup>347</sup>

At the regional level, there are two types of monitoring instruments through which the social and health services for victims of human trafficking might be monitored. First, social services are monitored at a regional level in the Netherlands under the framework of the Dutch Social Support Act.<sup>268</sup> This is primarily done as part of the Public Mental Health Care (OGGZ) monitors, serving to inform city councils' social support policy decisions.\* The second regional monitoring instrument through which the social and health services for victims of human trafficking might be monitored in the Netherlands are the regional public health monitors, which are conducted under the framework of the Dutch Public Health Law.<sup>346</sup> Conducted by the Dutch municipal health services (GGD), these serve to inform city councils' health policy decisions, by providing insight into the general health status of the population in the region, including youth, adults and the elderly and vulnerable groups within those populations.

Each of the abovementioned monitoring instruments fulfils different functions. At a national level, the numbers provided by CoMensha annually provide an important national overview of the number of potential victims of trafficking and the number of victims who have received shelter. Because of regional variations in the nature and size of the population of victims of human trafficking in the Netherlands, as well as in the availability of social and health services, the regional-level monitoring instruments are better suited to provide insight into whether the available services for victims of human trafficking match those needed regionally in the Netherlands. Since I was mainly interested in this latter aspect of monitoring, I focused on these regional instruments in this chapter.

My aim was to review the various reports of these two regional monitoring instruments to assess how often social and health services for victims of human trafficking were monitored and to explore

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\* The OGGZ target groups can be defined as people who are: not or insufficiently able to lead independent lives in society; who have simultaneous problems; who often do not receive the care they need; and whose health care demands often cannot be addressed by regular service providers.<sup>415</sup>

the quality of the monitoring, i.e. whether the information that the monitoring documents produced was enough to be able to suggest improvements for the regional social and health services for victims of human trafficking. However, I quickly learned that only a few regions in the Netherlands included victims of human trafficking in their monitoring efforts. Therefore, I decided to add a research question to my analysis, and to explore *why* there was a lack of monitoring for this group. Finally, as part of my preparatory work for this research, I identified a report by the Verwey-Jonker Institute and IVO, two research institutes in the Netherlands, that presented a joint analysis of all OGGZ monitors in the Netherlands (one type of regional monitoring), including a description of the populations that were monitored in these documents, and an analysis of the quality of the monitoring.<sup>348</sup> Therefore, I limited my primary data collection and analysis to the other type of regional monitors: the regional public health monitors (I discuss the Verwey-Jonker Institute and IVO's findings in the Discussion in conjunction with my own findings).

## Methods

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### Data collection

#### *Collection of public health monitoring documents*

In the Netherlands, public health monitoring is conducted by the GGDs. Therefore, I searched the websites of all 28 GGDs for published documents that reported on the nature, size or service needs of vulnerable populations and/or provided insight into available social or health services for vulnerable populations. I also approached each GGD via email with a request to provide any documents that complied with the description above. Eighteen out of 28 GGDs responded. Most referred to the publications sections of their websites. None of the responses led to the inclusion of new documents not already identified via my search of GGDs' websites.

#### *Types of regional public health monitors*

The regional public health monitors could be subdivided into two subtypes of monitors that GGDs published: the regional Health Monitors and the regional Public Health Future Explorations. The former constituted mainly periodical reports of the health status of the population in a region. The latter provided the same information, but also more frequently included an overview of the available social and health services in a region. To limit the scope of data collection, I included only general public health monitors and I excluded those specific to youth and the elderly.



## Data analysis

My documentary analysis consisted of three steps.

First, in each document, I assessed whether information was presented about the social and health services available to victims of human trafficking.

As stated earlier, the number of documents that described monitoring of social and health services for victims of trafficking turned out to be very small (see Results). Therefore, second, to investigate why victims of human trafficking were only rarely included, I took stock more broadly which vulnerable groups were being included in these documents and which groups were being excluded, after which I searched for commonalities between the groups that were included and excluded.

Third, for my assessment of the quality of the monitoring, i.e. whether the information that the monitoring documents produced was sufficient to be able to suggest improvements for the regional social and health services for victims of human trafficking, I was interested in the quality of monitoring for victims of human trafficking. However, given the small number of documents that included victims of human trafficking, such an analysis would not have resulted in useful findings. Therefore, I evaluated more generally whether the monitoring documents provided enough information to be able to suggest improvements in service provision for the vulnerable groups that they reported on. To do so, I assessed the degree to which the documents reported the nature, size and service needs of these groups, and if they reported how those needs matched with the available social and health services for these groups in the region. I assessed whether there were differences between GGDs in how often these elements were present. To do so, I described the presence of the abovementioned elements for each of the public health monitors. I then analysed these descriptions to discover common reasons for lacking information and I contrasted these descriptions between GGDs.

## Definition of vulnerability

Before I present my results, I need to explain how I defined ‘vulnerable groups’ in this chapter. The definition of vulnerability is dependent on the context in which the term is used. Within the context of public health, vulnerable groups can be defined as “those at risk at any particular point in time for unequal opportunity to achieve maximum possible health and quality of life”.<sup>71</sup> The “unequal opportunity” that may lead to vulnerability can be caused by an increased or different need for care, or because of decreased access to prevention or care for these populations.<sup>71–73</sup> This definition includes groups that are vulnerable because they have certain lifestyles (e.g. smoking), because they

have mental or physical impairments, or because the group shares a certain social characteristic that is associated with vulnerability. Examples of shared social characteristics that are associated with vulnerability include living in a certain location, having a certain educational level, having certain ethnic or cultural backgrounds, or having experienced certain life events that carry risks for one's health (e.g. having experienced violence).<sup>349,350</sup> Victims of human trafficking are a group that is vulnerable because of a shared social characteristic (having been trafficked). Therefore, for this chapter, I limited my investigation to groups that are vulnerable because of a shared social characteristic.

## Results

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### Types of documents

Ten GGDs published a regional Health Monitor, seven published a regional Public Health Future Exploration, and ten published both. One GGD had published neither.

### Monitoring of victims of human trafficking

Victims of human trafficking were only mentioned by two of the 28 GGDs in their regional public health monitoring documents (in the regional Health Monitors, the regional Public Health Future Explorations, or those two combined if the GGD produced both). One additional GGD included sex workers under the age of 18 years, which is a subpopulation of victims of human trafficking. Six additional GGDs, and the two GGDs that mentioned victims of human trafficking, also mentioned sex workers in their monitoring documents.

### Monitoring of other vulnerable groups

In total, 54 different vulnerable groups were monitored in the regional public health monitoring documents of the 28 GGDs combined (Figure 8.1). The median of the number of vulnerable groups that each GGD monitored was 12 (IQR 9-21). For the seventeen GGDs that published a Public Health Future Exploration the median was 17 (IQR 11-23). For the ten GGDs without a Public Health Future Explorations that produced only a regional Health Monitor the median was 10 (IQR 7-12).

Among the vulnerable groups that were monitored in regional public health monitors patterns could be distinguished (see Figure 8.1, columns on the right). An important component of public health monitoring in the Netherlands is the periodic health surveys, for which a sample of the population is

asked to answer questions about their health. All 27 GGDs for whom public health monitoring documents were found reported on the results of these health surveys. From these results, various vulnerable groups emerged, often owing to specific questions in the surveys about these groups. As a result, the vulnerable groups that followed from these surveys were mentioned most often in public health monitoring documents (see Figure 8.1, black column).

In the public health monitoring documents of thirteen GGDs (48%), few other vulnerable groups were mentioned besides the vulnerable groups that followed directly from the health questionnaires. With the fourteen other GGDs (52%), the monitoring documents also contained information on additional groups, often in the form of an additional section, chapter or report about vulnerable groups. For twelve of the seventeen GGDs who produced a regional Public Health Future Explorations and for two of the ten GGDs who produced a regional Health Monitor this was the case. With eight of these fourteen GGDs (57%) that provided information on additional groups, that information was limited to the OGGZ target groups (see Introduction). With the other six GGDs (43%) a broader stocktaking was conducted of which vulnerable groups were relevant for the region's public health monitoring function. That stocktaking was always inclusive of OGGZ target groups. As a result, these vulnerable groups were mentioned relatively frequently (see Figure 8.1, grey column).\*

Thus, there are two *monitoring frames* that guide GGDs in monitoring social and health services for vulnerable populations as part of the regional Health Monitors and Public Health Future Explorations (Figure 8.2): 1) the vulnerable groups that follow from the health surveys that a sample of the population is periodically asked to complete; 2) the OGGZ target groups. Of the 54 vulnerable groups that were monitored by at least one GGD, 29 fell outside these two monitoring frames, including victims of human trafficking. These vulnerable groups were monitored much less often than the groups that fell within the two monitoring frames (Figure 8.1).

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\* While information about the OGGZ target groups is collected as part of the OGGZ monitors, which I excluded from my data collection because they had been analysed in detail by the Verwey-Jonker institute and IVO, information was also provided about the OGGZ groups as part of the regional public health monitoring documents. See the Discussion for a note on this duplication of efforts.

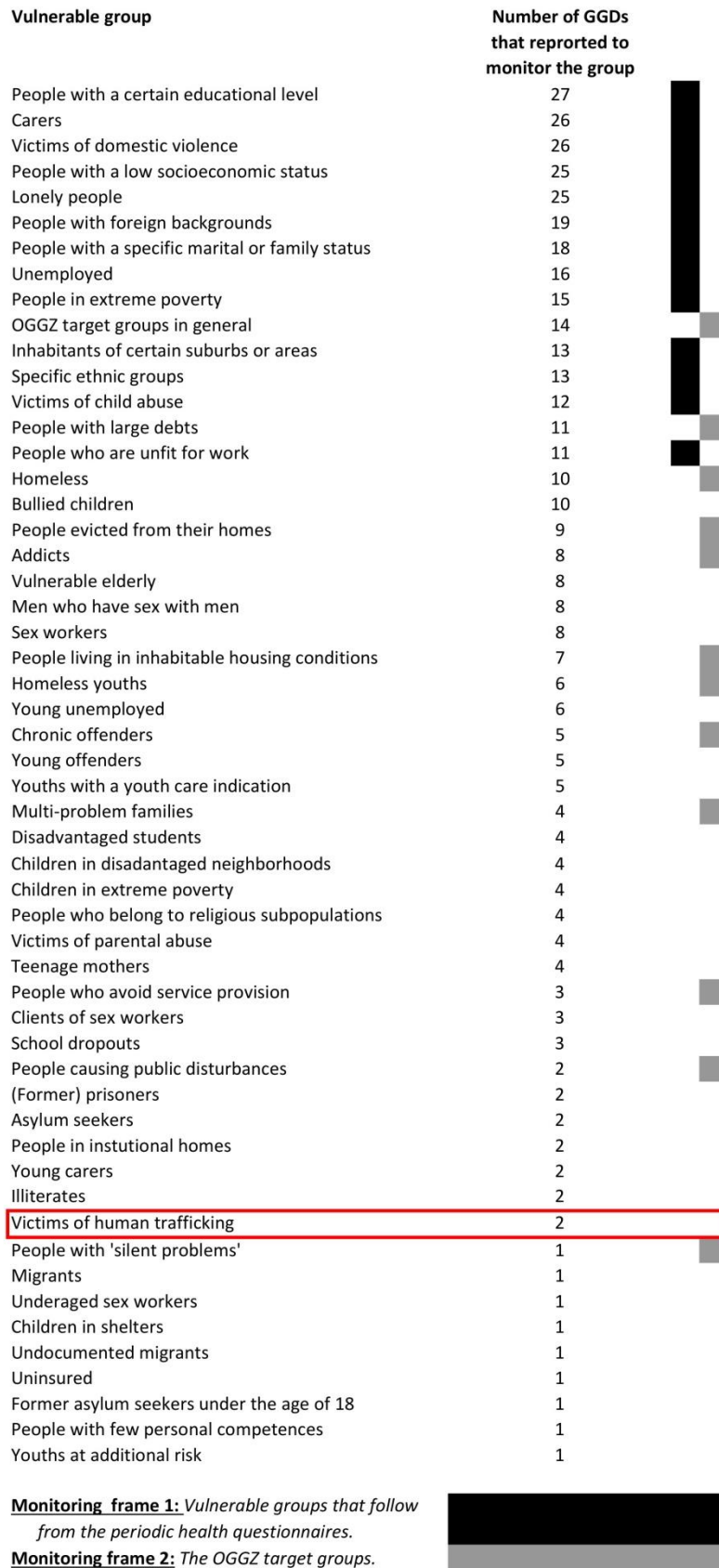
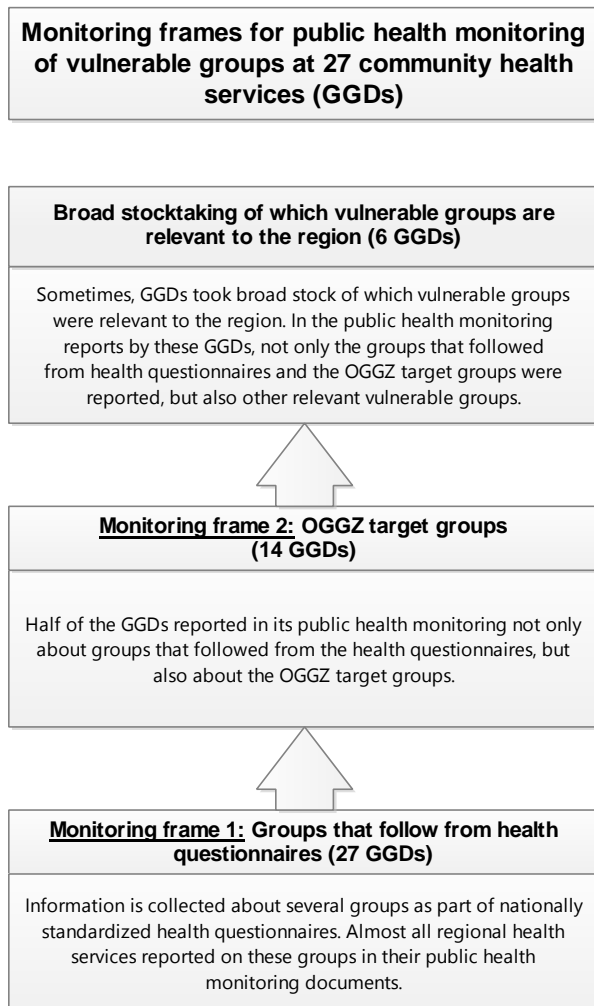


Figure 8.1. Vulnerable groups identified in the public health monitoring documents of 28 community health services (GGDs)



**Figure 8.2. Monitoring frames for public health monitoring of vulnerable groups in the public health monitoring documents of 27 community health services (GGDs)**

Two main monitoring frames were uncovered: the groups that follow from periodic health surveys and the OGGZ target groups. Only rarely do GGDs conduct a conscious, broader stocktaking of which vulnerable groups are relevant to the region and should be monitored. One GGD was excluded from this figure because it had published no regional public health monitoring documents.

## The quality of monitoring: information about service needs versus available services

In terms of the quality of monitoring, the regional public health monitors nearly always described the nature and size of monitored vulnerable groups. However, the documents' descriptions of these groups' service needs and the available social and health services for these groups in the region varied per GGD.

Several documents stood out, both negatively and positively. On the one hand, several public health monitors stood out negatively because they did not report the services that were available to address the social and health problems of these groups at all. On the other hand, the reports from several other GGDs stood out positively because they provided a structured overview of the nature and size of each vulnerable group, its service needs and the available services. As a direct result of this approach, these documents offered a good opportunity for assessing whether the available services for vulnerable groups matched the services that were needed. Some GGDs took the middle ground, and reported about service availability for some groups, but not for others. One reason for this might have been that these documents often adhered to a reporting model with separate chapters for discussion of the population's health, the determinants of health, preventive services and curative services; it regularly happened that vulnerable groups were identified in earlier chapters, but that the service needs or available services for these groups were not discussed in later chapters.

In total, there were five GGDs that produced structured overviews of the service needs and available services for each vulnerable group, allowing for the establishment of an integral understanding of the two. Four of these five GGDs were the same as the six aforementioned GGDs that conducted a broader stocktaking of which vulnerable groups required monitoring in the region (Figure 8.2), suggesting that specific attention for vulnerable groups led to positive results on both aspects of these GGDs' public health monitoring efforts.

## **Discussion**

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The nature and size of the group of victims of human trafficking differs per region in the Netherlands. For example, larger cities in the Netherlands are more likely to see trafficking for the purpose of exploitation in the sex work sector, while rural areas may see more labour exploitation. The social and health services available for victims of human trafficking are also different per region, partly in response to variations in the nature and size of the group, and partly because social care and public health interventions are largely decentralized in the Netherlands and thus regions' responses to vulnerable groups differ. To ensure that the service needs of victims of trafficking are met in each region of the Netherlands, it is important that this group is included in regional monitoring instruments, i.e. the regional OGGZ monitors and/or the regional public health monitors, and that monitoring is conducted in such a way that it produces information that can lead to suggestions for improvement of the available services.

Yet, only two of the 28 GGDs in the Netherlands included victims of human trafficking in their public health monitoring efforts (I will come back later in this Discussion on how often victims of human trafficking are included in OGGZ monitors). My broader analysis including other vulnerable groups made clear that victims of human trafficking are not the only vulnerable group that is rarely included in monitoring efforts and that GGDs frequently do not provide enough information in their monitoring documents to make suggestions for improvement of the available services.

Here, I discuss the reasons for these problems and suggest solutions. I first provide suggestions for how to address the problem of poor inclusivity, i.e. that many relevant vulnerable groups are currently not included in monitoring efforts. After this, I discuss two solutions for the absence of information that can lead to suggestions for improvements to existing services: standardization and the establishment of integral understanding of service needs and available services.

Finally, I also discuss the results of the Verwey-Jonker institute and IVO's assessment of the OGGZ monitors in this Discussion and compare their findings to my own assessment of the regional public health monitors.

## **Inclusivity**

The primary reason for the scarce inclusion of victims of human trafficking in regional public health monitors was that GGDs implicitly applied two monitoring frames to collect information on vulnerable groups. Both frames are nationally standardized frameworks that are useful in their own context, but are insufficient for guiding public health monitoring efforts.

Half of the GGDs presented only information on the vulnerable groups that followed from the nationally standardized health surveys in their public health monitoring documents. While this nationally standardized survey is useful for providing a broad overview of the health status of the population, it falls short of achieving an important other goal of public health monitoring: to monitor the health status of various vulnerable groups. The reason for this is that many vulnerable groups are unlikely to be included, unlikely to respond to the survey, or too small to be picked up on in survey that is undertaken in a sample of the general population.<sup>351</sup>

The other half of the GGDs did report information on additional vulnerable groups. However, half of these limited these monitoring efforts to the OGGZ target groups. It is a good development that these groups are receiving prioritized attention as part of GGDs' monitoring efforts. The OGGZ target groups consist of some of the most vulnerable people in the general population. However, the definition of the OGGZ target groups is specific (see Introduction); if these groups are used as a

monitoring frame for *all* vulnerable groups as part of public health monitoring efforts, a significant number of other vulnerable groups are excluded. This chapter demonstrates clearly the consequences of such a lack of inclusivity: more than half of the vulnerable groups identified by at least one GGD as a target group for monitoring did not belong to the two main monitoring frames and were only rarely monitored. Victims of human trafficking are one such group.

Several measures could be taken to improve the inclusivity of regional public health monitoring for vulnerable groups in the Netherlands. First, GGDs that publish regional Public Health Future Explorations monitor more vulnerable groups than those that publish Health Monitors. This may be because the more comprehensive nature of the former type of document leads to greater inclusion of various vulnerable groups. Thus, the development of Public Health Future Explorations by all GGDs may help to improve the inclusivity of regional public health monitoring. Second, GGDs that prepare a specific section, chapter or report on vulnerable groups as part of their public health monitoring do better in terms of inclusivity than their counterparts who do not. Thus, the development of a specific section, chapter or report on vulnerable groups may also help to improve the inclusivity of regional public health monitoring. Third, only a few GGDs reported having taken stock of the vulnerable groups for whom monitoring is *needed* at the beginning of their monitoring process. By letting go of monitoring frames that are inadequate for use as part of public health monitoring functions and by conducting a conscious stocktaking of the groups for which monitoring is needed at the start of the monitoring process, GGDs could greatly improve the inclusivity of their public health monitoring.

Since GGDs are used to applying national frameworks in their public health monitoring efforts, it may deserve recommendation to help GGDs develop such a conscious stocktaking of which vulnerable groups are relevant to the region. This could be done by developing a framework that the GGDs can use for this purpose. To do so, example might be taken from the guidance that is offered to GGDs by the 'Local and National Health Monitor' in the Netherlands, a nationally standardized database that provides possible indicators for measuring the general health of youth, adults and the elderly and forms the basis for, for example, the periodic health surveys that are conducted by GGDs.<sup>352</sup> By expanding this guidance database with a section on vulnerable groups that provides a list of all the vulnerable groups that might be relevant for regions' public health monitoring, GGDs could be provided with an inclusive framework that could function as a starting point for GGDs' monitoring efforts. Such a national-level list should expressly not be a *minimum* requirement for which groups to measure. On the contrary, it should consist of a list of *all* possible vulnerable groups,



to provide a starting point for GGDs to decide which vulnerable groups are relevant in their region and should be monitored.<sup>352</sup>

The results of this chapter form a first step towards developing such a standardized list of vulnerable groups, which currently does not exist.<sup>287</sup> However, this study has not included documents specific to youth or to the elderly and has only looked at groups that are vulnerable because of social factors, excluding vulnerability because of mental or physical impairments and because of lifestyle factors. A stocktaking of the relevant vulnerable groups within these categories is needed to proceed with developing such a list. Moreover, the list of 54 groups presented in this chapter consists of the groups that GGDs are currently including in their monitoring efforts. To establish a list of all vulnerable groups for whom public health monitoring might be relevant, a broader stocktaking is needed to assess whether there are groups that have remained completely outside the scope of current monitoring efforts.

## Monitoring approaches

Besides being hampered by lacking inclusivity, public health monitors often fall short of providing information that can be used to make suggestions for improvement of the existing services for vulnerable groups. I now discuss two possible reasons for this problem and possible solutions.

### *Standardization*

Besides offering standardized possibilities for indicators that can be used to measure the general health of youth, adults and the elderly in the Netherlands, the Local and National Health Monitor also provides standardization for how those indicators might be measured. It suggests standard questions for health questionnaires and standard data that can be collected from registration datasets.<sup>352,353</sup> Such standardization offers two important advantages: First, it makes possible comparison of regionally collected data at a national level.<sup>354</sup> Second, it makes the data collection process easier for GGDs that are often faced with limited human resource capacity, and thus increases the chances of data collection at a regional level and improves the quality of that data collection.<sup>353</sup>

For vulnerable groups, standardization of indicators and measurement methods is problematic. As compared to collecting information about the general health of youth, adults and the elderly, information about vulnerable groups often cannot be acquired through health surveys that are completed by a sample of the population.<sup>351</sup> Data can then only be acquired via registration data from specialized social and health care institutions or via targeted research aimed at these

groups.<sup>355,356</sup> Standardization of such data collection at a regional level is difficult, because of regional differences in the nature and size of vulnerable groups and in the available services for the groups.<sup>357</sup> As a result, for many of the groups in Figure 8.1, no standard indicators or methods of measurement have been developed yet. The most standardization has taken place for the OGGZ target groups, but even for these groups this has only been partially successful<sup>348,357,358</sup> (efforts are underway to increase standardization for the OGGZ target groups<sup>359–361</sup>).

Thus, more standardization of indicators and measurement methods for vulnerable groups in general is desirable, but poses a methodological challenge. It is precisely because of this increased level of difficulty in collecting such data that it is especially important to offer GGDs tools that can aid in such data collection, to maximize the chances of monitoring and the quality of monitoring at a regional level. Addition of standard indicators and potential measurement methods to the aforementioned list of all possible vulnerable groups for whom public health monitoring might be relevant in the region could greatly increase the chances that such groups are monitored and improve the richness and comparability of the information collected through monitoring.

To further advance the development of such indicators and measurement methods, lessons could be learned from specific vulnerable groups for whom standardized information collection has been more successful than for other groups, such as for drug users.<sup>362,363</sup> Similarly, progress for the OGGZ target groups has been greater than for other groups, perhaps in part due to the IT systems that have been developed in recent years to track OGGZ service users.<sup>364,365</sup> Finally, for some groups, international guidance is available to help GGDs set up such standardized data collection, such as the ‘Good practice guidelines for monitoring and measuring homelessness’ by the European Federation of National Organisations working with the Homeless (FEANTSA).<sup>366</sup>

### *Establishing an integral understanding of service needs and available services*

Besides having information about the size and nature of vulnerable groups that are relevant for the region, it is necessary to have information about the service needs of these groups, the possibilities for intervention,<sup>367–369</sup> and the existing social and health services (both preventive and curative) for the groups. This is important for two reasons: first, to promote access to services. Both service providers and service users should have access to a source of information about where services can be found. Second, by establishing such integral understanding, i.e. an overview of both service needs and available services and how these two compare, it becomes possible to make suggestions for how the available services for a particular group can be better matched to the service needs of that group.<sup>350</sup>

Only a few of the public health monitors reviewed for this chapter provided structured overviews of these various elements to establish an integral understanding of both service needs and available services. There were two reasons for the absence of such structured overviews. First, with several GGDs, the public health monitoring documents did not include any discussion about the services that were available to address the population's health problems, and thus also did not allow for developing an overview of how services matched needs. Second, other GGDs did describe the services available for some groups, but not for other groups. This was because of the reporting model that these GGDs adhered to, separating descriptions about health problems from those about preventive and curative services. As an additional disadvantage, this reporting format makes it difficult to develop of an integral understanding of both service needs and available services, even when both were described somewhere in the document.

Several things could be done to improve the establishment of an integral understanding of the service needs and available services for each vulnerable group that would assist improved matching of those services to each group's needs. The main thing to do, as a select few public health monitors demonstrate, is to give vulnerable groups a central place in public health monitoring efforts. Currently, this is often not the case. One reason for this may be that the national standards for such monitoring, the Local and National Health Monitor, only provide guidance on measuring the general health of youth, adults and the elderly. The development of a fourth category of indicators and measurement methods in the Local and National Health Monitor specifically for vulnerable groups, as proposed earlier in this Discussion, could encourage integral discussion and comparison of service needs and available services for these groups at a regional level. It is noteworthy that giving vulnerable groups a more central place in public health monitoring efforts, potentially through the creation of a national framework for doing so, emerges as a solution for all three problems discussed in this Discussion: it may improve inclusivity, standardization and the establishment of integral understanding of vulnerable groups' service needs and available services at a regional level.

Should increased integral understanding of vulnerable groups' service needs and available services be achieved in regional public health monitors, this might have several additional benefits. First, such structured overviews per vulnerable group of service needs and available services would not only allow for discussions about whether the current services are adequate, but would also shed light on information gaps, i.e. they would make clear for which groups and in which areas more information would need to be collected to enable discussions about the adequacy of services. The information that is currently available about vulnerable groups at the regional level is often insufficient<sup>370-372</sup> (as this chapter also makes clear). The lack of such information is one of the main

limitations in formulating effective social and health policies for these groups.<sup>373</sup> Second, giving vulnerable groups a central place in public health monitoring efforts could also help to stimulate networks of collaboration for each of these groups, in which questions about whether the available services adequately address the needs for those services, and whether there is sufficient information to answer those questions, could be discussed and answered jointly by all actors involved.<sup>374</sup>

## **The other type of regional monitoring of vulnerable groups: the OGGZ monitors**

As I noted in the Introduction, there is a second type of monitoring in the Netherlands that might provide valuable information about victims of human trafficking and other groups that are vulnerable because of a shared social characteristic: the OGGZ monitors. These monitors were assessed by the Verwey-Jonker institute and IVO.<sup>348</sup> In this section, I will discuss briefly the results of the Verwey-Jonker institute and IVO's study, to allow me to draw conclusions about the full spectrum of monitoring activities for victims of human trafficking in the Netherlands.

### ***Inclusivity***

In terms of inclusivity, monitoring for victims of human trafficking (and other vulnerable groups), is similarly absent from the OGGZ monitors as it is from the regional public health monitors described in this chapter. The study by the Verwey-Jonker Institute and IVO shows that OGGZ monitors monitored the following groups: the homeless (63%), victims of domestic violence (63%), addicts (63%), people with mental health problems (38%), chronic offenders (25%), lonely people (25%), people in extreme poverty (25%), people who have been evicted (25%), people with debts (25%), homeless youth (25%), undocumented migrants (25%), vulnerable elderly (25%), multiproblem families (25%), youth with problems (13%), victims of sexual violence (13%), sex workers (13%), and people living in inhabitable housing conditions (13%). As this listing shows, none of the OGGZ monitors included victims of human trafficking.

### ***Monitoring approaches***

I have discussed the current problems with the monitoring approaches of regional public health monitors in two separate sections in this Discussion. In the first I showed that there are issues around standardization. As I explained in that section, standardization is also a problem for the OGGZ groups, and so these issues are equally problematic for the OGGZ monitors. In the second section I showed that there are problems with the degree to which regional public health monitors provide insight into vulnerable groups' service needs, the availability of services and the degree to which these two match. As for the lack of inclusivity in the regional public health monitors, this

conclusion also applies to the OGGZ monitors. The Verwey-Jonker institute and IVO concluded that the OGGZ-monitors mainly provide insight into the size of various vulnerable groups; they only provide limited insight into the service needs of these populations and to what degree existing services address these needs.<sup>348</sup>

### *Integration of regional public health monitors and OGGZ monitors*

I should make a final note here about the overlap that exists between the OGGZ monitors and the regional public health monitors. The combination of social and health problems that victims of human trafficking and other vulnerable populations are faced with leads them to be relevant groups both within the framework of the Dutch Social Care law and the framework of the Dutch Public Health law.<sup>268,346</sup> Many authors have argued in the past for increased integration of policy development under these two laws for such populations.<sup>370,375–377</sup> Doing so as part of regional monitoring efforts, combining the regional public health monitors and OGGZ monitors to produce one ‘vulnerable groups monitor’ to inform policy development under both laws might be beneficial both in terms of preventing duplication and in terms of putting vulnerable groups central to GGDs’ monitoring efforts.

## **Conclusions**

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The goal of this study was to create more insight into how social and health service provision for victims of human trafficking is monitored in the Netherlands, with the goal of understanding better how the availability and quality of this service provision is assessed periodically and unmet need identified. Monitoring social and health service provision for this population takes place at two levels in the Netherlands: nationally and regionally. At the national level, monitoring provides mainly information on the number of identified victims of human trafficking each year and on the number of victims who have received shelter. Monitoring at this level is less suitable to assess whether existing services match the needs for those services. For that, monitoring of those service needs and the available services at a regional level is necessary. At that regional level, social and health service provision for victims of human trafficking might be monitored via the regional OGGZ monitors, which are conducted under the framework of the Dutch Social Support Act, and via the regional public health monitors, which are conducted under the framework of the Dutch Public Health Law. This chapter focused on investigating the latter.

I found that victims of human trafficking often remain outside the scope of these regional public health monitors. Moreover, even if victims of human trafficking are included, the approach used to

monitor the social and health services in these documents often does not result in enough information to be able to suggest improvements to existing service provision. Similar problems exist for the OGGZ monitors.

Together, these findings lead to the conclusion that there is currently not an adequate system for monitoring the availability of services for victims of human trafficking in the Netherlands. To redress this problem, improvements are desirable to Dutch system for regional public health monitoring of vulnerable groups in three areas: 1) inclusivity, 2) standardization and 3) the establishment of an integral understanding of service needs and available services to enable discussions about how those services might be improved. Further integration of regional public health monitors and OGGZ monitors might also be beneficial. Variations in the quality of monitoring across different GGDs suggest that improvements in these areas are not only desirable, but also feasible.

# Chapter 9

## Discussion

In the preceding five chapters, I have provided analyses of the social and health services for victims of human trafficking in the Netherlands from various angles. I explicated my dilemmas and practices in conducting interviews with this population (Chapter 4); I provided an exploration of how victims of trafficking view their own recovery process in the COSM shelters (Chapter 5); I assessed what challenges were encountered in establishing the COSM programme (Chapter 6); I took stock of what is needed to ensure adequate professional responses in identifying and referring victims of trafficking and providing care for survivors (Chapter 7); and I explored how the broader set of social and health services for this group in the Netherlands is monitored in the Dutch decentralized system for social and health service provision (Chapter 8).

In this chapter, I will discuss the theme that for me has recurrently emerged from all these chapters: the lag that exists between the development of service provision for this population and other vulnerable populations and how this lag was partly addressed over the course of my research.

## **A lag in service provision for victims of human trafficking**

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By ‘the lag’ I mean that service provision for victims of trafficking has been in arrears as compared with other populations both in terms of the outcomes of service provision and with respect to service provision processes. It is interesting how this lag became apparent in every aspect of my research: in my literature review, in my interviews with service users, in my interviews with service providers and in my explorations of the broader set of social and health services for victims of human trafficking in the Netherlands.

The first indication that I received of this lag was that the research that I have conducted for this thesis had not been conducted before in the Netherlands. This, in itself, provided a clue that social and health service provision for this population was in arrears as compared with service provision for other vulnerable populations in the Netherlands. More generally, my review in Chapter 2 showed that the social and health services research that has been conducted for victims of trafficking has been scarce, indicating an immature state of service development for this group.

In Chapters 5 to 8, which describe my explorations of the Dutch system of social and health service provision for victims of trafficking, further indications of this lag became apparent. In Chapter 5, I showed that there was incongruence between service users’ goals for their own recovery process and the services provided as part of the COSM programme. I argued that service provision approaches for other populations addressed better the needs of these populations and that service provision approaches for victims of trafficking could learn from those approaches. In Chapter 6, I



showed that a range of challenges in service provision for this population were encountered as part of establishing the COSM programme and that these challenges were being addressed quickly as the programme developed. It is interesting to note the wide scope of these challenges and particularly how these are mirrored by the wide scope of challenges encountered by service users. The underlying reason for this similarity is discussed in the next section (see “Why has there been a lag in social and health service development for victims of human trafficking?”). Furthermore, in Chapter 7 I showed that improvements were necessary in how adequate professional responses were ensured in the Netherlands with regards to identifying and referring victims of trafficking and providing care for survivors. I suggested that in doing so lessons could be learned from how professional responses are ensured for other populations, such as victims of domestic violence and victims of child abuse. Finally, in Chapter 8 I showed that the availability of social and health services for victims of human trafficking was frequently not monitored in the Netherlands, while the availability of these services was monitored for other more established populations.

The lag in service provision for victims of human trafficking that emerged in all these chapters has led me to ask three questions that I wish to discuss here. The first of these questions is: *Why has there been a lag in social and health service provision for victims of human trafficking in the Netherlands?*

## **Why has there been a lag in social and health service provision for victims of human trafficking?**

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To be able to answer this question, it is necessary to look beyond the health discourse on this topic and beyond the boundaries of the Netherlands. Human trafficking has not only been absent from health policy agendas for a long time, it was generally not a prominent issue on national and international policy agendas until the 1980s and 90s.<sup>378,379</sup>

There are several reasons why human trafficking may have become a problem of increasing severity around this time. These reasons include: population increases, economic globalization, increasing inequalities and economic disparities between developed and developing regions, corruption, and increased within-country and cross-border migration (made possible by increased permeability of borders).<sup>178,303,380,381</sup> Therefore, it is possible that an increase in the prevalence of the cross-border human trafficking in the second half of the 20<sup>th</sup> century has led to the emergence of this issue on national and international policy agendas. However, given the hidden nature of the problem, making estimates of the size of the human trafficking problem is renownedly difficult even today.<sup>382</sup> There is

a dearth of evidence on numbers of trafficked persons before the year 2000 and as a result it is impossible to make assertions about trends in the number of trafficked persons in the second half of the 20<sup>th</sup> century with certainty.

A more demonstrable reason for the emergence of human trafficking on national and international policy agendas in the 1980s and 90s is that the problem was increasingly recognized to exist. As the first *Trafficking in Persons* report by the US Department of State from 2001 reads: “The problem of trafficking in persons is not new – it is in many ways a modern-day form of slavery, which has persisted into the twenty-first century. Yet it is only in the past several years that the contemporary manifestation of this problem has captured international governmental attention, and that governments have begun to address it systematically”.<sup>31</sup> Various factors may have contributed to such increasing recognition, including: the growth of the international sex industry; the sex workers’ rights movement which commenced in the 1970s in Western Europe and Northern America; increased depiction of women engaging in sex work as victims instead of as criminals, in particular by feminist groups; changes in the profile of trafficked women to Western Europe and Northern America with the fall of the Soviet Union (as Stolz writes, “the closer resemblance of the women and girls trafficked in the 1990s to the wives and daughters of many policymakers may have been one factor in arousing attention to the trafficking issue”<sup>383</sup>); increased attention for human rights of women; the advent of HIV/AIDS; the globalization of crime; the link between trafficking, transnational crime, and government corruption in emerging democracies; the recognition that trafficking was a threat to the national security of countries in the Western Europe and Northern America; and the advancement of the welfare state, and concomitant developments in social policies, in the second half of the 20<sup>th</sup> century.<sup>58,378,383</sup> Both as a result of the increasing recognition and adding to the increasing recognition of human trafficking, scoping exercises of the size of the problem started being undertaken at the end of the 20<sup>th</sup> century. Bales famously kickstarted these exercises in 1999 by reporting that there were 27 million slaves in the world at that time – more than at any other point in human history.<sup>384</sup> From 2001 onwards, the US Department of State has produced yearly *Trafficking in Persons* reports, which describe estimated numbers of trafficked persons and report on the measures that countries are taking to combat trafficking.<sup>31</sup> Currently, estimates for the number of adults and children in forced labour, bonded labour, and forced prostitution around the world range from 21 million to 36 million, and estimates for the number of people who are trafficked each year into such conditions range from 1.2 million people to 3 million people.<sup>1-4</sup>

The increasing international recognition of human trafficking resulted in a UN convention on human trafficking in 2000, the *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Convention against Transnational Organized Crime (the Protocol)*,<sup>6</sup> and in changes to national laws regarding human trafficking. Key to the reformulation of the perception of trafficking in this transition period was the “shift in the characterization of the trafficked person from criminal to victim.”<sup>383</sup> The *Protocol* has a focus on protection (<sup>385</sup>,p486) and inspired legislative changes in many countries that reflected that focus, such as in the US, where the new legislation on trafficking in this period was aptly called *the Victims of Trafficking and Violence Protection Act of 2000*.<sup>386</sup>

The increasing recognition of human trafficking as an important human rights problem in the 1980s and 90s and the increasing focus on the protection of victims resulted in increasing attention for the health consequences of trafficking, which led to the first studies on the health problems of trafficked persons being conducted and published in the early 2000s.<sup>13,14</sup> Together, these developments led victims of human trafficking to be newly recognized as a target population for the social and health services in many Western European and Northern American countries. In the Netherlands, after several years of advocacy efforts to establish specialized shelter and care for victims of trafficking, the COSM programme was established in 2010 to provide such care for this newly recognized vulnerable group.

So why has there been a lag in social and health service development for victims of human trafficking? One key factor has been that the group was previously not recognized as a target population for countries’ social and health services, owing to its absence from countries’ general policy agendas. As a result, there were no specific provisions in national social and health care policies for victims of human trafficking<sup>48</sup> and specific programmes such as the COSM programme only emerged in the 2000s. Since these programmes have been established, there has been little time to gain experience with providing care for this group and for conducting research to provide input into social and health care programmes. As noted by Clawson: “Due to the fairly new development of anti-human trafficking activities and initiatives and the recent recognition of the phenomenon of human trafficking in the field of mental health, there is little evidence-based research on the treatment of victims of human trafficking.”<sup>162</sup> And as one of the service providers noted in my research: “Because [the COSM shelter] was established a short while ago, there has not been a place before yet where people could gain experience [with providing care to this population]. (...) It’s such a specific group. Yes, so no one could have predicted at an earlier stage what that would be like.” Because this newness of the population was relevant to all aspects of service provision for

this group, and because there are so many aspects to service provision for victims of human trafficking, a wide scope of challenges was experienced both by service users in moving forward and by service providers in providing care, as I noted in the previous section (see “A lag in service provision for victims of human trafficking”).

For the remainder of this Discussion, I will explore in more detail how the new emergence of victims of human trafficking as a target population for the Dutch social and health services resulted in a lag in service provision for this population. To do so, I will first discuss if there is a theoretical basis for this link, to explicate why the new emergence of a vulnerable group as a target population for countries’ social and health services can result in an immaturity of the social and health services provided. I provide this discussion in the next section, where I answer my second question of this chapter: *What was the process of introducing a new system of care for victims of human trafficking in the Netherlands?* After answering this question, I will explain why it is relevant to understand that process conceptually.

## **What was the process of introducing a new system of care for victims of human trafficking in the Netherlands?**

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Ideally, to be able to answer this question, a theoretical framework would be available that would outline the various characteristics of the process of introducing a new system of care for victims of human trafficking. However, I was not able to find such a framework. Therefore, I explored theories from several bodies of literature, which, when combined, are able to provide me with the answer to this question. The first body of literature I explored was the health systems literature.

### **The nuts and bolts of a health system: building blocks, levels and actors**

My first step in this exploration was to conceptualize the introduction of a system of care for victims of human trafficking as the introduction of an entirely new *health system*. This was a step for me, because previously I had predominantly considered health systems to be synonymous with health systems of countries. However, the World Health Organization (WHO) definition for a health system is “the sum total of all the organizations, institutions and resources whose primary purpose is to improve health”.<sup>387</sup> This definition applies to a country’s health system, but can equally apply to a

system of care that was established for one specific population within a country. Thus, the COSM programme can be conceptualized as a subsystem within the larger Dutch health system.

Considering it as such is helpful, because it allows for the deconstruction of the services for victims of human trafficking according to health system frameworks. This helps one to consider issues that may otherwise be overlooked. In Chapter 2, I described the best-known and most-used framework for health systems, the WHO Health Systems Framework,<sup>89</sup> which proposes that all health systems are composed of six 'building blocks': leadership / governance; financing; workforce; products and technologies; information and research; and service delivery. In my thesis, it became clear that these building blocks are useful for considering the process of introducing a new system of care for victims of human trafficking: in Chapter 6 I demonstrated that the challenges that were encountered in establishing the COSM programme occurred across various building blocks of a health system, ranging from governance and financing to human resources and service delivery; in Chapter 7 I explored further issues around a particular human resource challenge (expertise development); and in Chapter 8 I showed that there were issues with the health information system for the broader set of social and health services for this population in the Netherlands.

Another way to deconstruct a health system is by identifying different levels within it.<sup>87</sup> These too I reviewed in Chapter 2, calling them policy and governance, organizational and service delivery levels. In Chapter 6 they provided a useful categorization to help me consider the challenges in the COSM programme. They were also useful in making explicit the links that I showed to exist between decisions that are made at various levels in the COSM programme and the impact of those decisions on victims' recovery processes.

Finally, yet another way of deconstructing a health system is by focusing on the various actors that play a role in making the health system work and their interrelations.<sup>88</sup> There are many different actors that played a role in the social and health service provision of the COSM programme, and the recognition of this fact played a salient role in my own research right from the very beginning, when I planned which participants to include in my interviews (including service users from different shelters, different kinds of direct service providers, shelter managers, policymakers from different ministries, and members of NGOs). I also showed in this thesis that considering the interrelations between these actors is important in that they both interact and are interdependent. This became clear, for example, from the fact that I found network development to be a crucial factor (and challenge) in helping to establish a comprehensive range of services for the COSM programme.

In short, in considering the process of introducing a new system of care for victims of human trafficking (the COSM programme) and in understanding its complexity, it was helpful for me to consider the programme's building blocks, levels, actors, and their interrelations. It will become clear at the end of this section why this is important.

## Health system goals

There is another reason why it was helpful for me to consider this system of care as a health system in this thesis. The WHO framework, besides describing the six building blocks, also links these 'inputs' to the 'outcomes' of a health system: its goals. It defines these as health improvement (both in terms of overall health and health equity), responsiveness to users' expectations, and fairness in financial contribution. In this thesis, I have shown that operationalizing these goals for the population of victims of human trafficking is not straightforward. For example, while the literature and policy documents in the Netherlands commonly focus on redressing potential adverse mental health outcomes for victims of trafficking, I showed in Chapter 5 that victims themselves set quite different goals for their recovery process. They had a future-orientated view, exhibiting desires to find a life of autonomy, with a job, a family, and friends, and showed that they would go to great lengths to adapt to survive and achieve these goals. These findings provide insight into users' expectations of the COSM programme and into what its goals for health improvement should be.

Operationalizing the goals of this system of care was further complicated by the fact that the opinions of service providers about what those goals should be differed. For example, while direct service providers and employees of the Ministry of Public Health, Welfare and Sports often stressed a focus on facilitating victims' recovery, employees of the Ministry of Safety and Justice explained that achieving victims' compliance with law enforcement activities and achieving reliable witness statements was also a priority. Moreover, these views changed over time, as the introduction of new service modules (e.g. including mental health screening in the COSM programme) and new treatment approaches (e.g. with a strength-based focus) in the COSM shelters made clear.

The conclusion of all this is that when a new system of care for victims of human trafficking is introduced, that views on what the goals of that system are may differ depending on whom you ask and that consensus on what those goals are may change and develop over time. As a consequence, the definition of the goals of a new system of care for victims of human trafficking deserves careful, inclusive and repeated consideration.

## Adapting to survive: a process of developing services

While the WHO framework is useful for helping to understand some of the complexities involved with introducing a new system of care for victims of human trafficking in the Netherlands, it is less suitable for helping to understand that process itself. The main reason for this is that the framework does not describe any form of development or system change; it does not capture well the dynamic nature of health systems.<sup>388</sup> This poses a problem, because just as the lag in service development for victims of human trafficking was a key theme throughout this thesis, so were the adaptations that occurred to these services during my doctoral research.

In Chapter 6, particularly, I showed that the Dutch COSM programme developed to address the challenges that it faced. Moreover, I showed that the three COSM shelters developed their services at different rates for various aspects of service provision, indicating that such service evolution does not follow the same path everywhere. Chapters 5 and 7 also provided clues to the developing nature of this system of care. Some of their recommendations, such as the development of more future-orientated treatment approaches for victims of trafficking and the development of a signalling code for human trafficking, had been addressed toward the end of my research.<sup>267,304</sup> This makes clear a remarkable aspect of the changes that occurred in the COSM programme: the breadth and speed with which they took place. Chapter 6 showed as well that developments took place in a range of different areas and that large system changes, such as the inclusion of mental health screening in the programme, were implemented rapidly after the COSM programme's initial establishment.

The WHO health system framework is not able to account for these developments, nor for the speed with which they appeared to be occurring. Other health system frameworks highlight different characteristics of health systems, such as the actors in the system, funding flows between actors, the interrelationships between various functions of a health system, the different levels in a health system, the demand side, or the context within which health systems function.<sup>87,88</sup> However, the insights they provide about how new systems are introduced or develop are also limited. My views on my conceptual framework (see Chapter 2) have changed in this regard. While the framework was complete in describing the post-trafficking social and health services for victims of trafficking in the Netherlands, and the various factors that influence how those services are experienced by service users and service providers, it was a stagnant model, like the WHO health system framework, and lacked insights on how I expected those services to develop after their introduction.

Such insights into how social and health services can be expected to develop after they have been introduced can be derived from other subsets of the health systems literature. I have found the

implementation science literature especially useful for achieving more insight into the process of introducing a new system of care for victims of human trafficking in the Netherlands.<sup>389</sup> To assess this literature, I have looked at publications and reports focusing on complex interventions, because of the large number of interacting and interdependent actors, services, and organizational levels in the COSM programme.<sup>390</sup> When frameworks for the process of introducing and developing complex interventions are reviewed, most deconstruct this process by categorizing it in various phases.<sup>390,391</sup> The Medical Research Council (MRC) framework for developing and evaluating complex interventions is frequently used and comprises four phases: 1) synthesis of the existing evidence base and development of the intervention; 2) piloting of the intervention; 3) broader evaluation of the intervention; and 4) implementation of the intervention.<sup>390</sup>

Similar phases could be distinguished in the introduction of the COSM programme. The programme was first established as a pilot, after which it was formally implemented and continued to be evaluated in various ways (e.g. by periodic meetings between the COSM shelters and patient satisfaction questionnaires). Two important insights follow from applying frameworks for developing and evaluating complex interventions to the COSM programme's establishment.

First, the frameworks offer a theoretical grounding for the existence of a phase of development after the introduction of a new intervention (e.g. the COSM programme). It makes clear that that process of development should lead to adaptations in the intervention which will, over time, help it to better achieve its goals.

Second, when a population has newly emerged as a target population for a country's social or health services, such as victims of trafficking recently in the Netherlands, there is limited evidence to support the development of interventions for that population in that country. As a necessity, a process of knowledge translation is engaged in as part of the first step of intervention development, by which the content of the to-be-developed services is modelled after services delivered in other contexts, both in terms of population context and geographical context. As noted by Clawson (about population context): "Pending sufficient evidence-based research on the direct treatment of human trafficking victims and the treatment of mental health disorders experienced by these individuals, research conducted with similar populations can be examined to provide a foundation for the treatment of this population."<sup>162</sup>

The importance of geographical context in intervention development is exemplified by my review in Chapter 2, for which I assessed what could be learned about the service provision needs of victims of trafficking in the Netherlands by reviewing literature from countries with comparable social and



health care contexts. In that same chapter I drew upon needs frameworks for victims of domestic violence in the Netherlands (a different population), in order to be able to develop a framework of needed social and health services with relevance to the Dutch context (Table 2.1). Throughout this thesis, I have shown that a similar process of knowledge translation occurred in the initial development of the COSM programme. I showed that existing service practices within the COSM programme were often built from experience with such practices for other groups (e.g. the development of treatment guidelines or the personal professional experience of service providers). I also made clear that there was room for improvement in this area, and argued in several chapters that the social and health service practices for victims of trafficking in the Netherlands could and should have learned more from best practices among other vulnerable populations.

## The importance of context

Besides insights from implementation science, there are two other areas of health systems discourse that I consulted to further clarify what the process of introducing the COSM programme in the Netherlands entailed: discourse around health systems reform and discourse around health systems in crises.

The former, when confined to systems reform of services for *subpopulations*, shows great overlap conceptually with implementation science for complex interventions. Among the many articles that provide frameworks for systems reform<sup>88</sup> only a few are limited to subpopulations. Among these, I found the discourse around systems of care for children with mental health problems particularly useful,<sup>90,91</sup> as this population shares several important characteristics with victims of human trafficking: the service needs of children with mental health problems also consist of a broad range of social and health services, comparable to Table 2.1 in Chapter 2; authors stress that these needs are different but interdependent, as I also stressed for post-trafficking services in Chapter 2; and similar to the outcome of my literature review in Chapter 2, providers have not only defined various services that are needed, but also various best practices for how those services should be provided.<sup>90</sup>

From this body of literature similar lessons follow as from the health system frameworks and the implementation science literature, which has affirmed my belief in the salience of the insights that followed from these bodies of literature. Stroul in particular, in speaking about systems reform for children's mental health services and the introduction of such services in regions where they do not yet exist, notes several things that are in line with my considerations about introducing a new system of care in the previous paragraphs. For example, in her framework for systems reform, she

emphasizes the importance of formulating the core values and guiding principles, or goals, of a system of care. She also speaks about the process of development that follows the introduction of a system of care and notes that “it is (...) appropriate to define the level of development of a system of care” because “many communities in the nation have some elements of the system of care philosophy and services in place, even if they are not too far along the developmental pathway.”<sup>90</sup> She also highlights the complexity of that process of development by stating that “developing a system of care is a difficult and complex process with many challenges”.<sup>90</sup> Moreover, she explains that a key reason for that complexity is that the process of development is a multifaceted, multilevel process, which takes place on three levels: the policy and larger system level, the local system level, and the service delivery level.<sup>90</sup> And finally, she notes that a characteristic of systems reform for children’s mental health services is a process where many providers and service users have to collaborate to achieve their goals.

In the health systems in crises literature, I found similar confirmation of the insights described in the previous paragraphs. The guidance that exists for developing gender-based violence responses in humanitarian crises, for example, also emphasizes the importance of considering the presence of multiple actors, of multiple types of services and of multiple levels in the health system response.<sup>392</sup>

There is one additional consideration that follows from these two bodies of literature. The guidance for developing responses to gender-based violence in humanitarian crises particularly emphasizes the importance of context and ‘local knowledge’ in developing such responses. And for systems of care for children with mental health problems, it is stressed that these systems are highly variable depending on the context in which they are implemented, and that any guiding theory on what a system of care should comprise, is more a framework or a guide than a prescriptive format for how services should be arranged. In the words of Stroul: “Flexibility to implement the system of care concept and philosophy in a way that fits the particular state and community is inherent in the approach.”<sup>90</sup>

Context also emerged in this thesis as salient to the consideration of the introduction of the COSM system of care. In Chapter 6, for example, I showed that varying contexts can result in different trajectories of service development for different service institutions and in Chapter 8 I showed that there were large regional differences in how the broader set of services for victims of human trafficking was monitored.

## Developmental evaluation

Finally, the last body of literature that I have consulted in my search for clues about what the process of introducing a new social and health service for victims of human trafficking entailed was the evaluation science literature. I have found an area of discourse around a specific form of evaluation, developmental evaluation, to specifically provide additional insight in this regard.

Developmental evaluation is an emerging form of evaluation science that “supports program, project, product, personnel and/or organizational development”.<sup>393</sup> Preskill describes it as a type of evaluation that is particularly useful when a programme has just been established and puts it along a continuum with the more traditional forms of formative and summative evaluation (she notes: “Is the initiative innovating and in development? Try developmental evaluation. Is the initiative reforming and under refinement? Try formative evaluation. Is the initiative stabilizing and well-established? Try summative evaluation.”)<sup>394</sup>

Patton in particular has written a lot about this field of evaluation science that is based on the idea that systems that are newly established are different from systems that are well-established.<sup>393–395</sup> Patton and others describe that: 1) systems can be in various stages of development, ranging from just emerged and in development, to well-established and stabilized; 2) as compared with well-established systems, newly emerged systems are subject to a range of challenges that are specific to their recent establishment and can be considered to be in an immature state; there is less experience with what works, and hence there is “uncertainty about what will work, where, and with whom”<sup>394</sup>; and 3) as opposed to well-established systems, newly emerged systems find themselves in a state of dynamic change, which entails that programme strategies evolve rapidly as time progresses.<sup>394,395</sup>

Developmental evaluation is an area of evaluation that aims to tailor to this type of situation, for example when: exploring the creation of a new programme; when replicating a programme in a new context or population; in case of major systems change; in case of crisis situations that require rapid adaptation; and for programme contexts that are highly dynamic in which major changes are continuous.<sup>394,395</sup> An application of developmental evaluation in the health systems research field was recently described by LaFond, who notes that in this field “developmental data collection and evaluation approaches promote tailoring and adaptation of program models.”<sup>396</sup> Developmental evaluation was developed specifically to evaluate complex interventions and has a strong focus on collaboration between all actors in the system. One of its characteristics is that it is more flexible

than other forms of evaluation. In developmental evaluation, “program goals and strategies evolve”, and indeed, “the evaluation evolves”.<sup>393,395</sup>

These insights are useful for considering what the process was by which the COSM programme was introduced in the Netherlands. It provides a theoretical explanation for the lag in service development that existed for victims of human trafficking, linking the establishment of the new system to a range of challenges that were caused by the immaturity of the system. It also provides a theoretical grounding for the fact that a system of care can develop and evolve and is likely to do so particularly dynamically recently after its establishment.

## **The process of introducing a new system of care for victims of human trafficking in the Netherlands**

In conclusion, in order to conceptually describe the process of introduction of the COSM programme, a system of care for victims of human trafficking in the Netherlands, three types of theoretical frameworks need to be combined: 1) frameworks that provide insight into the nuts and bolts of health systems / complex interventions; 2) frameworks that shed light on the developmental nature of newly established systems / complex interventions; and 3) frameworks for social and health service provision for victims of human trafficking and for social and health service provision in the Netherlands (the population and geographical context). As I have described in the paragraphs above, all of these theories provide clues about what the process of introduction of the COSM programme in the Netherlands entailed. By combining these clues, a list of conceptual characteristics of this process can be described:

The process of introducing a new system of care for victims of human trafficking in the Netherlands

- was characterized by a set of goals, values and/or guiding principles that the services aimed to achieve, on which views differed, and which developed over time.
- took place across multiple, different, yet interdependent social and health services.
- took place across all the building blocks of a health system.
- took place on multiple levels (policy and governance, organizational and service delivery).
- was achieved through the actions of multiple interacting and interdependent types of actors.
- resulted in challenges for the services in achieving the goals of the system that were specific to the immaturity of the system, to the population context (for victims of human trafficking) and to the geographical context (in the Netherlands).

- was characterized by a process of development in the provision of services toward achieving the goals of the system, which was a complex process because
  - it took place across different yet interdependent social and health services,
  - because it took place across all the building blocks of the system,
  - because it took place on multiple levels,
  - because of the involvement of multiple interacting and interdependent types of actors,
  - and because it took different development trajectories depending on the context in which the services were introduced.

The list above creates more clarity on what the process of introducing a new system of care for victims of human trafficking in the Netherlands entailed. But why is it relevant to have this list? Or to explore the process of introducing a new system of care for victims of human trafficking in the Netherlands to begin with? The answer to these questions lies with the specific challenges that are associated with the establishment of those services. To understand the process of introducing a new system of care conceptually is a prerequisite for understanding what can be done to address the challenges that prevent services in a new system of care from achieving the goals of the system. This leads me to the third question that I will answer in this Discussion: *What can be done to support the introduction of a new system of care for victims of human trafficking in the future?*

## **What can be done to support the introduction of a new system of care for victims of human trafficking in the future?**

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To start to answer this question, I would like to go back to a paragraph in the previous section, in which I suggested that when a population has newly emerged as a target population for a country's social and health services, considerations around the content of the service will be based on experience with and evidence from other geographical contexts and other populations through a process of knowledge translation. Indeed, even in my own review of the service needs of victims of human trafficking in the Netherlands in Chapter 2, I developed a table (Table 2.1) outlining the various services needed by combining international frameworks of service needs for victims of trafficking with a Dutch framework of service needs for victims of domestic violence. In the chapters that followed, I concluded that much more could have been learned from other populations in developing the services for victims of trafficking in the Netherlands. Such knowledge translation is useful and is the only option for developing a new intervention programme when a group emerges

as a new target population for a country's social and health services, because evidence on interventions for that specific population is not available yet.

However, what the previous section in this Discussion shows, is that in establishing a new intervention programme for victims of human trafficking, besides thinking about the *content* of the new service, it is equally important to consider the *process* of introducing that new service. Stroul notes, for example, that "ongoing research and evaluation focusing on the process of implementing systems of care is essential to learn more about what we are doing and how we can do it better", as well as that "in addition to elucidating the system building process, increased emphasis on understanding the process of system development adds a much needed focus on internal evaluation".<sup>90</sup> Patton even notes about developmental evaluation that "the process is the outcome".<sup>395</sup>

Two questions, then, should be asked in the first phase of introducing a new system of care for victims of human trafficking: 1) what should be the *content* of the new service, and 2) how do we engender a *process* of service introduction that is conducive to evolution\* of the content of that service?

Two recommendations have followed from the literature reviewed above about how to answer the first question. First, as I described in the first paragraph of this section, in the absence of evidence to support the development of interventions for a new population, the content of the to-be-developed services needs to be modelled after services delivered in other contexts, both in terms of population context and geographical context. Second, the content of that service should be designed to be flexible, both because it is likely to change over time, and because the system will likely have to be implemented in different institutional contexts, which will require solutions tailored to those contexts.

The second question, however, is the main focus of this Discussion, and is the question that I will address in the remainder of this chapter. To understand what is necessary to be able to engender a process for the introduction of social and health services for victims of human trafficking that is conducive to evolution of the content of those services, it is first necessary to understand conceptually what such a process entails. Here, the usefulness of the previous section becomes clear, where I developed a list of the conceptual characteristics of that process on the basis of three types of theoretical frameworks (the nuts and bolts of a health system / complex intervention, the

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\* Definition of 'to evolve' = to change or develop slowly often into a better, more complex, or more advanced state.<sup>416</sup>

developmental nature of a newly established system / complex intervention, and the geographical and population context). Although in that section I explained the relevance of each of these characteristics to my own research, the list itself was developed on the basis of those three frameworks and bears relevance beyond the Netherlands.

In the following sections, I demonstrate the value of this list, by showing that for each of the conceptual characteristics on the list activities can be employed as part of the introduction process to engender evolution of the service content (Table 9.1). In these sections, I describe each of the activities listed in Table 9.1 in more detail. I also describe the sources for each activity (in part from my own research; in part from the theoretical frameworks described above).

## Define goals

Explicit recognition of the fact that a new system of care for victims of human trafficking aims to achieve certain goals and is subject to a set of values or guiding principles is helpful in developing a new programme. Several of the theories discussed above stress the importance of defining those goals, values and/or guiding principles in an inclusive manner, with all actors that are involved.<sup>90,393–395</sup> My own research (Chapter 5) stressed that care should be taken to include the viewpoints of service users in that process. Furthermore, in defining the services' goals, values and/or guiding principles, it should be recognized that a consequence of the complexity of the system of is that although “we all have the same ultimate goal — improving services and outcomes for [service users]”, we also “do not necessarily approach this from the same perspective.”<sup>90</sup> It is equally important, in accordance with the principles of developmental evaluation, that it is recognized that goals may change and will require reassessment.<sup>393,395</sup> Patton, for example, writes that the process of developing services includes making “adjustments based on dialogue about what’s possible and what’s desirable, though the criteria for what’s ‘desirable’ may be quite situational and always subject to change.”<sup>395</sup>

**Table 9.1. A conceptual framework for the characteristics of the process of introducing a new system of care for victims of human trafficking and the activities that can be employed to engender evolution of the system of care**

<b>Conceptual characteristics of the process of introducing a system of care for victims of human trafficking. That process ...</b>	<b>Recommended activities for introducing a new system of care for victims of human trafficking</b>
1. is characterized by a set of goals, values and/or guiding principles that the services aim to achieve, on which views differ, and which develop over time.	<p style="text-align: center;"><b>Define goals</b></p> <ul style="list-style-type: none"> <li>• Define the goals, values and/or guiding principles of the system of care jointly with all involved actors (including service users) before introducing the new service, allowing for the expression of different views.</li> <li>• Periodically reassess the goals, values and/or guiding principles.</li> </ul>
2. takes place across multiple, different, yet interdependent social and health services.	<p style="text-align: center;"><b>Map, collaborate and communicate</b></p> <ul style="list-style-type: none"> <li>• Map               <ul style="list-style-type: none"> <li>○ the social and health services that need to be provided;</li> <li>○ the programme areas / building blocks that are relevant to the new system of care;</li> <li>○ all types of actors in the system and at which levels they operate.</li> </ul> </li> <li>• Consider which aspects of service provision require collaboration and identify avenues for communication between the relevant actors, services, programme areas and levels.</li> </ul>
3. takes place across all the building blocks of a health system.	
4. takes place on multiple levels (policy and governance, organizational, service delivery).	
5. is achieved through the actions of multiple types of actors, whose decisions and actions influence and are influenced by actors and processes in other services, building blocks and levels.	
6. results in challenges for the services in achieving the goals of the system that are specific to the immaturity of the system, the population context (for victims of human trafficking) and the geographical context.	<p style="text-align: center;"><b>List challenges and potential solutions</b></p> <ul style="list-style-type: none"> <li>• Develop a list of challenges and potential solutions to introducing the social and health services that might be expected based on the experience with and evidence from the introduction of similar services in other geographical contexts and among other populations.</li> </ul>
7. is characterized by a process of development in the provision of services toward achieving the goals of the system, which is a complex process ...	<p style="text-align: center;"><b>Facilitate and evaluate</b></p> <ul style="list-style-type: none"> <li>• Develop a list of potential facilitators of service evolution based on the experience with and evidence from the introduction of services in other geographical contexts and among other populations.</li> <li>• Use an evaluation approach that takes into account the complexity and developing nature of the system of care, as well as the population and geographical context.</li> </ul>



## Map, collaborate and communicate

The multitude of different types of actors in the COSM programme, as well as the various services, programme areas and levels in which these actors operated, makes the COSM programme a complex intervention. The frameworks discussed above about systems reform, health systems in crises and about developmental evaluation all stressed the importance of strengthening collaboration between those actors in order to achieve system evolution.<sup>90,392,393,395</sup> To facilitate such collaboration, it is useful to map the various services that need to be provided, as I have done in Table 2.1 of Chapter 2. It is also useful list the programme areas that are relevant to the new service. The WHO building blocks, for example, could be used to make such an assessment. Questions such as “Will the new service be governed and financed separately or be included in existing governance and financing provisions?” and “Are the human resources needed available, or do we need to invest in training of health professionals?” are relevant to consider when introducing services for a population that has newly emerged as a target population for a country’s social and health services. Finally, mapping all the different types of actors in the new system of care and the levels at which they operate is necessary to identify service aspects that require collaboration as well as avenues for communication. Doing so deliberately upon introduction of the service may help to improve network development and collaboration between various actors in the young system.

## List challenges and potential solutions

The frameworks reviewed above that describe developmental situations for systems led me to conclude that there are specific challenges associated with introducing a new system of care for victims of human trafficking.<sup>90,395</sup> Arguably, being conscious of what service provision challenges may arise at the point of introduction of a service could help to mitigate some of the adverse effects of such challenges. This might be achieved by developing a list of challenges that might be expected. Chapter 6, for example, provided such a list for the introduction of the COSM programme in the Netherlands. However, the list in Chapter 6 was developed after introduction of the services, while such a list would be needed *before* the introduction of services. A list of this kind can clearly not be developed from experience when the services have not been introduced yet, but it can be developed based on the experience with and evidence from the introduction of similar services in other geographical contexts and among other populations. As a system of care develops, the list can be modified and adapted according to the experience gained with the programme itself. Besides making actors aware of what challenges can be expected, developing a list of potential challenges before the programme is introduced allows for a scoping of potential solutions to these challenges,

and provides a setting for discussing them as they arise, thus increasing the likelihood that they are identified and addressed.

## Facilitate and evaluate

In Chapter 6 I showed that besides developing a list of challenges to establishing a new system of care for victims of human trafficking, it is also possible to consider what factors facilitate (or impede) the evolution of that system. As for the abovementioned list of challenges that might be expected, and potential solutions to those challenges, it might be beneficial for governing actors in a nascent system of care for victims of human trafficking to be aware of those facilitating and impeding factors. As for the challenges, a real-time evaluation of what those facilitating factors are cannot be made before the introduction of such a programme, but valuable lessons might be learned from other geographical and population contexts.

One facilitator, evaluation, merits separate discussion here, particularly the type of evaluation that should be engaged in. Patton, who has written extensively on developmental evaluation, is also well-known for his theories on utilization-focused evaluation.<sup>393,395</sup> This approach to evaluation is not so much an evaluation method, like developmental evaluation, but more an overarching evaluation theory. In Patton's own words: "Utilization-focused evaluation does not advocate any particular evaluation content, model, method, theory, or even use. Rather, it is a process for helping primary intended users select the most appropriate content, model, methods, theory, and uses for their particular situation."<sup>395</sup> In other words, Patton argues that the evaluation approach should be adapted to match the context in which the evaluation takes places. The context of the introduction of a new system of care for victims of human trafficking requires that the evaluation approach takes into account the developmental and complex nature of that process of introduction, as well as the population and geographical context of the system of care. Practically, this means several things. First, to account for the system's development and complexity, it necessitates an evaluation approach that is: flexible, in that it allows for programme goals and strategies to change and for the evaluation approach to change; that specifically includes all relevant actors in the evaluation process; and that accounts for the complexity of the system by "questioning the assumptions, policies, practices, values, and system dynamics" that led to a particular problem.<sup>393-395</sup> Developmental evaluation is an example of an evaluation approach that incorporates these characteristics and that was developed specifically for evaluating complex systems in development. Second, as for any other evaluation, the evaluation approach should take into account salient socio-cultural norms in the country where the intervention is implemented. Third, the evaluation should

take into account the nature of the population. I have provided an example of how this might be done in Chapter 4, where I explicated my dilemmas and practices in interviewing victims of trafficking, and in Chapter 3, where I reviewed approaches for taking into account that my study population was a multilingual, multicultural and vulnerable group.<sup>17</sup>

## **Activities as part of the introduction of the COSM programme**

In conclusion, a number of things can be done to support the introduction of a new system of care for victims of human trafficking in the future. First, through a review of similar services in other population and geographical contexts, the content of the programme can be developed to be in line with the best available evidence. Second, several activities can be employed to facilitate a process of service introduction that is conducive to the evolution of the social and health services in the new system of care.

Several activities were employed upon introducing the COSM programme that were conducive to the evolution of its social and health services. The programme started with a pilot phase and an evaluation programme was commenced when the COSM pilot started. At a later stage, evaluations started to include the views of service users through a satisfaction questionnaire. There was also a periodic meeting between the governing ministries and the service providers of the three COSM shelters to discuss any challenges that arose. All provided the potential for acting on challenges that arose as the COSM programme was implemented.

However, several things could also have been done to improve the introduction of the COSM programme in the Netherlands. First, as I argued at several points in this thesis, more could have been learned from similar populations and from other geographical contexts in establishing the content of the COSM programme. Second, in developing the COSM programme, there appeared to be a focus on deliberating the content of the programme, while little attention was paid to the process by which the programme was going to be introduced. More attention could have been paid to the programme's developing nature and the process of its introduction. For example, more effort could have been made to acquire service users' views on the goals of the programme (as I did for Chapter 5). Moreover, as I argued in Chapter 6, there were several issues with the process of evaluation and with the feedback loops to the governing actors. Finally, there was little consideration of what challenges may have been expected (or potential solutions to those challenges from other contexts), nor was consideration given to what factors may have engendered evolution of the programme, such as the use of a developmental process of evaluation.

## **A lack of discourse on the introduction of new services for victims of trafficking**

This focus on the content of the COSM programme, rather than on the process of introducing it, is also seen in the descriptions of how services for victims of human trafficking were developed elsewhere. The health services literature on social and health service provision for victims of human trafficking that I reviewed in Chapter 2 displays a substantial focus on content and provides little guidance for how implementers should engender the evolution of those services after their introduction. This suggests that there is a need for a paradigm shift both among policymakers and researchers in considering the introduction of novel services for victims of human trafficking toward a greater focus on the process of that introduction. To achieve such a paradigm shift, there is a need for the development of a coherent discourse on the process of introducing new systems of care for victims of human trafficking.

In this thesis, I have tried to set a first step toward developing that discourse: I have established more clarity on service users' perspectives of what the goals of such a system of care should be (Chapter 5); I have investigated what some of the challenges are that may be encountered when introducing novel social and health services for victims of human trafficking and what factors might facilitate the evolution of those services (Chapter 6); I have explored what might be done to increase the likelihood of ensuring adequate professional responses to victims of human trafficking by service providers at a time when there is little experience with service provision for this population (Chapter 7); I have shown that when services for victims of human trafficking are introduced, specific attention needs to be paid to the inclusion of this population in a country's public health monitoring mechanisms, because they might otherwise be easily overlooked (Chapter 8); and I have provided a theoretical basis for the process of introducing a new system of care for victims of trafficking by unpacking how that process can be conceptualized and how that knowledge can be applied to support the introduction of systems of care for victims of trafficking in the future (this Chapter).

## Conclusions

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### The introduction of a system of care for victims of human trafficking

The sections above contain the three main conclusions that follow from my doctoral research:

1. The introduction of a new system of care for victims of human trafficking can benefit from a review of the *content* of similar services in other population and geographical contexts and from a *process* of service introduction that is specifically designed to help evolve the social and health services provided.
2. While several activities were implemented as part of the COSM programme that were conducive to the evolution of its social and health services, more could have been done to help the COSM programme achieve its goals.
3. More generally, there is a need for the development of a coherent discourse on the process of introducing new systems of care for victims of human trafficking.

In addition to these conclusions, I feel my research allows for drawing one additional conclusion, that is not limited to social and health services for victims of human trafficking, but bears broader relevance.

### The bigger picture: the introduction of systems of care for new vulnerable groups

As I have stressed throughout this thesis, lessons can be learned for the introduction of services for victims of human trafficking in the Netherlands both from other countries and from other populations with overlapping service needs. I have also consistently argued that the opposite is also true, and that my research findings might be transferable to other geographical and population contexts as well. This is particularly the case for my discussion around the process of introducing a new system of care for victims of human trafficking in the two sections above. The theoretical frameworks that I reviewed and used to develop Table 9.1 and the conceptual characteristics of that process that I listed at the end of the first section are not unique to victims of human trafficking in the Netherlands. In the previous section, I discussed the wider geographical relevance of this framework (not limited to the Netherlands). In this section, I will discuss the wider population-context relevance of this framework: its validity for any vulnerable population that requires a

coordinated set of social and health services and that has newly emerged as a target population for such services.

There are numerous recent examples of such populations in the Netherlands, besides victims of human trafficking. These are mainly *subpopulations* of already recognized vulnerable populations that are increasingly receiving specific attention, just like victims of human trafficking are a subpopulation of the larger group of victims of violence. Examples of such subpopulations within the larger group of homeless people are: homeless youths,<sup>397</sup> foreign homeless people,<sup>398</sup> undocumented homeless people<sup>399</sup> and homeless people with mental health problems. For all these groups there have been recent policy and service evaluations that have drawn attention to their specific service needs. Within the larger group of victims of violence, besides victims of human trafficking, there has been increasing attention for: victims of grooming (a subpopulation of victims of human trafficking),<sup>400</sup> victims of honour-based violence,<sup>27,270</sup> people at risk for forced marriages,<sup>331</sup> undocumented victims of violence,<sup>332,333</sup> male sex workers under the age of 18 years of age,<sup>175</sup> men who are victims of violence,<sup>334</sup> and more specifically male victims under the age of 18 years of age,<sup>270</sup> elderly victims of violence,<sup>335</sup> teenage mothers,<sup>270</sup> and parents who are victims of domestic violence by their children.<sup>336</sup> Besides the recent publication of policy and service evaluations about these groups specifically, for several of these populations, categorical shelter accommodations have been newly established in recent years, along with other subpopulation-specific social and health services, just like for victims of human trafficking.<sup>27,270,334</sup>

One might wonder why these groups have recently emerged as target populations for the Dutch social and health services. Well, some of these groups really did ‘emerge’ – they did not exist previously. Changes in migratory patterns to the Netherlands have likely resulted in an increase of honour-based violence in the Netherlands and grooming is also a relatively new phenomenon, at least at the scale at which it currently occurs. However, other groups have merely increasingly been recognized to exist, to be eligible for access to services, or to be in need of specifically tailored services. As one report explains about male victims of violence: “The policy document ‘Protected and Empowered’ [2007] was [a] major step forward. Unique globally, it laid the foundation for shelters for men.”<sup>334</sup> Finally, it is also possible that a group has existed for a long time, and was also recognized to exist, but for whom service provision recently underwent such significant reform that it resulted in an entirely new system of care. A recent example of such a group in the Netherlands has been rape victims. While these victims previously made use of dispersed health services, there are now specialized centres for sexual violence, where all related service provision takes place in one centre.<sup>173</sup>

Other developed countries have also seen the new emergence of vulnerable groups as target populations for their social and health services. Some examples are: the increasing numbers of undocumented migrants across the European Union and the increasing recognition of their right to access to health services;<sup>399,401</sup> the grooming of young women into the sex industry;<sup>9</sup> the growing problem of violence against elderly with disabilities;<sup>402</sup> increased attention for victims of honour-based violence;<sup>403,404</sup> a growing international literature on adults with mental disorders and multiple social and health problems;<sup>405</sup> and increasing recognition of male victims of violence.<sup>406</sup>

Also, vulnerable groups for whom social and health services are now commonplace in many developed countries, once newly emerged as target populations for those services. For example, shelters for victims of domestic violence did not exist before the second half of the 20<sup>th</sup> century in Europe and the US.<sup>407</sup> Developing countries often lag in their recognition of the need for shelters and care for such vulnerable populations that have long been recognized in developed nations.<sup>407,408</sup> As they develop economically, they are likely to see the new establishment of such services. Recent examples of this include China and India, where violence against women has become a prominent policy issue in the past decade.<sup>409,410</sup>

Despite the numerous recent examples of vulnerable groups emerging as new target populations for countries' social and health services, there is a dearth of literature discussing the processes of how those services were introduced. The notion of vulnerable groups newly arising as target populations for countries' social and health services is in itself newly emerging, or rather, has hardly emerged yet. In the Netherlands, I have found one policy document that draws parallels between such groups,<sup>270</sup> but there is no academic discourse that provides a theoretical grounding for this process. This is in contrast with the need for such a discourse: as for victims of human trafficking, the introduction of services for other vulnerable groups could benefit from the existence of a body of literature that describes that introduction process and provides recommendations for how it should be approached. Although these introduction processes will invariably vary by population and by geographical context, this chapter has made clear that there will also be commonalities in these processes, given that they share number of important characteristics: for all groups a coordinated set of social and health services needs to be in place; for all groups service provision will be complex as it spans various services, programme areas and levels; and for all groups services will need to be introduced and developed – a process that is characterized by specific challenges, potential solutions and facilitators of service evolution. Thus, besides there being value in the development of a coherent discourse on the process of introducing new social and health services for separate vulnerable groups such as victims of human trafficking, there is value in developing a consolidated

discourse on the process of introducing such services for vulnerable groups (who share the need for multiple social and health services) in general.

At this point, before formulating my final conclusion of this section, I feel it is important to make a note about language and concepts. First, because there has been little consolidated discussion about vulnerable groups that have newly emerged as target populations for countries' social and health services, there is no label yet for such groups. Because sometimes giving a name or a label to something can help a discourse around a phenomenon to develop, I propose to name these groups 'new vulnerable groups'. Second, I feel that in discussing service provision for these groups, lessons can be learned from what has been written about systems of care for children.<sup>90,92,411</sup> In Chapter 2, I proposed to use the term 'systems of care' for the social and health services for victims of trafficking because it captures well the coordinated, broad range of services that need to be available for this group, and because it has given a common language and coherence to the scientific debate in service provision for children with mental health problems. Along the same line of reasoning, because all new vulnerable groups that I have discussed in this chapter need a coordinated set of social and health services, I propose here to use the term 'system of care' when referring to the social and health services provided for any of these groups.

This allows me to formulate the fourth and broadest conclusion of my doctoral research as follows:

4. There is a need for the development of a consolidated, coherent discourse on the process of introducing systems of care for new vulnerable groups.

Several things could be done to achieve this. First, it is important that for individual new vulnerable groups evaluations are conducted of the process of introducing new services using a theoretical developmental perspective. This would provide insights into the similarities between the introduction processes of systems of care for different vulnerable populations and it would provide insights into the differences. In this thesis, I have explored the process that was associated with establishing a new system of care for one vulnerable population, victims of human trafficking, and have shed more light on the goals of that system, the challenges associated with establishing it, and the factors that facilitated and impeded its development. Another example of a group for which such discourse development has taken place is systems of care for children and youth.<sup>90,92,411</sup>

Second, if the lessons from these evaluations are consolidated into a generic framework, that framework could be used to guide the introduction of systems of care for new vulnerable populations in the future. Such a generic framework might have a similar format as Table 9.1. This table was developed as a framework for the process of introducing a new system of care for victims



of human trafficking, on the basis of the two main characteristics of that process: its developmental nature and that it concerned the introduction of a complex set of coordinated social and health services. I have argued above that victims of human trafficking share precisely these two characteristics with a range of other new vulnerable groups. Therefore, this table may prove useful for guiding the introduction of systems of care for any new vulnerable group. While its use for that purpose will need to be validated before it can be recommended for such application, it provides a starting point for discussion about how systems of care for new vulnerable groups can be introduced in such a way that will stimulate the evolution of those systems towards achieving their goal: optimal facilitation of service users' recovery.

## Strengths and limitations of the thesis

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Because I have provided a discussion of the strengths and limitations of my research in each of the chapters, I will limit myself in this section to discussing only the main overarching strengths and limitations of my thesis.

One strength of my thesis is the contribution it makes to the knowledge base about social and health service provision for victims of human trafficking and other populations. I explained earlier how the various chapters in this thesis contribute to the development of a more coherent discourse on the process of introducing new systems of care for victims of human trafficking. Not least, it has provided more clarity on what service users view the goals of such services to be. Moreover, it has established firmly the need for such a discourse given the scarce consideration the process of introducing new systems of care has received both in practice and in the literature. Finally, I have argued that such a discourse is not only needed to advance service provision for victims of human trafficking, but also for other new vulnerable populations, and I have made a case and a starting point for the development of a framework that might guide the introduction of systems of care for new vulnerable groups in the future. In Chapter 3 I wrote that I placed my research within the field of social and health services research, which seeks knowledge that will lead to improvements in the delivery of social and health care. Through these contributions, I hope to have achieved this goal.

Another strength of my thesis is the due attention that I have paid to developing the methods of my research, and in doing so the contributions that I have made to the methodological literature on conducting research among victims of human trafficking. In Chapter 3 I outlined my methods and the rationale for them and in Chapter 4 I described my dilemmas and practices in conducting my research. I demonstrated there that for developing methods that are ethical and result in rich data,

interview-based research among victims of human trafficking requires not a one-time effort to establish the methods in advance of the research, but rather a deliberate focus on further developing those methods as the research progresses. I presented a model for how to do this in this chapter, built on the combined and related practices of flexibility and reflexivity, and provided practical examples of tools that researchers can put in their 'methodological toolkit', such as the lifehacking list that I used to keep an overview of all the methodological aspects of my research (and the changes therein).

The main limitation of my thesis is the specific programmatic, social, medical and legal context in which most of my research has taken place. My research has focused on social and health service provision for victims of human trafficking in the Netherlands and within the Netherlands it has concentrated on investigating service provision as part of the COSM programme. This leads the main findings of this thesis to only bear direct relevance to this programme. However, at several places in my thesis I have transferred my findings to other geographical and population contexts. To justify this, I have always made clear why those themes were 'overarching themes' that might be transferrable to other contexts<sup>189</sup> and I have provided additional theoretical support for the themes that I transferred. In doing so, I hope to have produced findings that bear relevance to a broader context than that in which my study took place.

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# Appendices

This section lists the following Appendices to my thesis:

Appendix 1: Review of the health consequences of human trafficking

Appendix 2: Search terms for literature review

Appendix 3: 'Lifehacking list'

Appendix 4: Information sheets and consent forms

Appendix 5: Topic guides for the interviews

Appendix 6: Ethics approval letters

# **Appendix 1**

## **Review of the health consequences of human trafficking**



This section reviews the existing literature on the health consequences of human trafficking.

In this section, I will discuss the

- mental health,
- physical health, and
- social health consequences of trafficking.

In addition, I will discuss

- key influencing factors on the health of trafficking survivors, and
- what is known about the differences between short-term and long-term health consequences of trafficking.

In these discussions I will limit myself to health problems arising from trafficking for the purpose of sexual exploitation, since this is the population under study in my research.

## Mental health

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The consequences of trafficking for the mental health of victims are potentially substantial and severe. To adequately review the mental health problems that are associated with trafficking, I have drawn on several information sources:

- Firstly, several conceptual frameworks have been created in the past to describe possible mental health outcomes of victims of trafficking and influencing factors on mental health<sup>1-4</sup>.
- Secondly, several studies have focused specifically on researching the mental health of victims of trafficking<sup>3-6</sup>.
- Thirdly, research on trauma experiences in other groups has been used to create a broader frame of reference of the mental health consequences of trafficking.

The first overview of the mental health consequences of human trafficking was generated by Raymond and Hughes<sup>7</sup>. However, by far the most comprehensive and inclusive overview of mental health symptoms that trafficked women suffer from is provided in two studies by Zimmerman et al<sup>3,4</sup>. Although the latter two frameworks differ slightly, they are in essence the same. The framework of mental health symptoms from the *Stolen Smiles* study is the most recent<sup>3</sup>:

- Suicidal thoughts, self-harm, suicide
- Depression, frequent crying, withdrawal

- Chronic anxiety
- Sleep disturbances, frequent nightmares, chronic fatigue
- Post-traumatic stress disorder symptoms
- Acute stress disorder
- Hostility, irritability, outbursts, aggression
- Memory problems, dissociation, peri-traumatic dissociation
- Decreased cognitive functioning
- Somatic complaints (e.g., chronic headaches, stomach pain, trembling, heart palpitations)
- Immune suppression
- Substance misuse, addiction
- Loss of trust in others or self
- Identity and self-esteem problems, stigma, guilt, shame
- Difficulty developing and maintaining intimate relationships

A different framework for mental health symptoms of victims of human trafficking distinguishes between externalizing and internalizing behaviours <sup>1</sup>, a distinction that is commonly made in discussions on post-traumatic stress <sup>8</sup>. This distinction might have value, considering the different co-morbidity patterns of individuals with internalizing and externalizing behaviour, and the different necessary treatment interventions that follow from these differences in co-morbidity.

In most previous studies on the mental health of trafficked persons, four 'symptom domains' of mental health have been emphasised and predominantly researched <sup>3,4,6</sup>:

- depression
- anxiety
- anger or hostility
- post-traumatic stress symptoms

These four domains are in concurrence with the symptom domains frequently observed in victims of other types of traumatic experiences <sup>3,9-11</sup>. However, several other symptom domains could also be considered. Substance abuse or dependency among victims of trafficking is not uncommon, either forcedly or as a coping mechanism <sup>3,4</sup>. Studies on traumatic experiences in general confirm the relation between trauma and substance abuse / dependency <sup>12</sup>. Secondly, somatization is a well-known response to trauma <sup>4,13,14</sup>.

Very little is known about the prevalence of clinical diagnoses in the population of trafficked persons. The few studies that have researched the mental health of victims of human trafficking suggest a high prevalence of post-traumatic stress syndrome (PTSD), anxiety disorders and depressive disorders<sup>3-6,92</sup>. These symptoms are especially prevalent in the acute post-trafficking phase, but have also been shown to endure longer-term<sup>15</sup>.

More is known about the mental health effects of other types of trauma. Post-traumatic mental health morbidity has been reported to include post-traumatic stress disorder (PTSD), other anxiety disorders (especially generalised anxiety disorder (GAD) and agoraphobia), depressive disorders (especially major depressive disorder), substance abuse<sup>16</sup>, psychosomatic diseases<sup>13,17</sup>, disordered eating behaviours, and sexual dysfunction<sup>18</sup>, and even personality changes in the case of catastrophic traumatic experiences<sup>19</sup>.

PTSD is not necessarily likely to be the most prevalent psychological manifestation experienced by trafficked persons<sup>3</sup>. The chance of developing PTSD after exposure to a traumatic event differs greatly depending on the severity and length of exposure, and a range of influencing factors, such as sex and previous (childhood) traumatic experiences<sup>20,21</sup>. An important differential diagnosis of PTSD in victims of trauma is Acute Stress Disorder, which follows the same diagnostic criteria, but is distinguished by the fact that symptoms must start and end within four weeks of the traumatic event, and a fewer number of traumatic symptoms are required to make the diagnosis as compared to PTSD<sup>22</sup>.

There is also a large degree of psychiatric co-morbidity after exposure to traumatic events<sup>20,23</sup>. PTSD co-morbidity is reported to include anxiety disorders (GAD, panic disorder, specific phobia, social phobia, agoraphobia), mood disorders (major depressive disorder, dysthymia), dissociative disorders, substance abuse or dependence, and conduct disorder<sup>20,24</sup>. The overlap between different diagnoses after trauma exposure is shown most clearly in an article by Yehuda et al from 1998<sup>23</sup>.

Occurrence of a psychiatric disorder in the short term can even predict the occurrence of another in the longer term<sup>25</sup>.

Besides PTSD, depression, and anxiety, trauma resulting from trafficking has been found to lead to aggression or hostility in trafficked women and girls<sup>3,4</sup>. A study by Sibnath on this topic showed that there are high rates of aggression in trafficked girls, and that counselling results in improvements of symptoms<sup>26</sup>.

Finally, it is important to note that mental health problems in victims of trafficking are caused by chronic trauma, which has different health consequences than a single traumatic experience<sup>4,23,27</sup>. It has even been argued that with the severe and prolonged kinds of traumatic experiences that are common in trafficking situations, a variety of psychological responses should be viewed as a normal response, rather than as pathological<sup>1</sup>.

## Physical health

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Besides the possibility of mental health consequences, trafficking also has potential consequences for the physical health of victims. The first overview of the physical health consequences of human trafficking was generated by Raymond and Hughes<sup>7</sup>. Zimmerman, researching this in more detail, found a wide variety of physical symptoms in trafficking survivors in her 2003 study<sup>4</sup>:

*“Women reported broken bones, contusions, pain, loss of consciousness, headaches, high fevers, gastrointestinal problems, undiagnosed pelvic pain, complications from abortions, dermatological problems (e.g., rashes, scabies, and lice), unhealthy weight loss, and dental and oral health problems.”*

Zimmerman’s 2006 study *Stolen Smiles* confirmed the high prevalence of physical health complaints among trafficked women<sup>3</sup>:

*“The most prevalent and severe physical health symptoms included: headaches, fatigue, dizzy spells, back pain, stomach/abdominal pain and memory problems.”*

Additionally, given the nature of sexual exploitation, a lot of women suffer from sexual and reproductive health problems<sup>3,4,28–30</sup>.

From the scarce literature on the physical health consequences of trafficking, it follows that these may be categorized as follows:

1. Psychosomatic, trauma-related, physical health problems
2. Physical health problems that follow direct from the type of exploitation
3. Physical health problems that follow from health neglect

## Psychosomatic: trauma-related

*“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).”*

– From <sup>31</sup>

There are many different possible psychosomatic symptoms, but some of the most commonly occurring ones include asthma/obstructive symptoms, headache, abdominal symptoms, sleeping problems, chronic fatigue and backache <sup>32,33</sup>. Especially victims of sexual trauma are very prone to developing psychosomatic complaints <sup>34</sup>.

Many of the complaints identified by Zimmerman coincide with these physical health problems that can be a consequence of traumatic experiences, such as fatigue, headaches, dizzy spells, and stomach pain <sup>4</sup>.

## Exploitation related

Sex work is strongly associated with increased risk of sexually transmitted infections (STIs), including HIV. Forced sex, as is common in victims of trafficking, is known to be associated with even higher chances of gynaecological problems <sup>35</sup>. The chances of trafficked sex workers experiencing sexual violence upon initiation into sex work are higher than for other sex workers <sup>36</sup>. The lack of access to reproductive health counselling and the lack of bargaining power among trafficked victims may contribute to increased infection risks <sup>4</sup>. In certain regions, HIV prevalence among trafficking victims is extremely high, especially among those who were trafficked at a young age <sup>28-30</sup>. Furthermore, increased likelihood of pregnancy and unsafe abortion are also commonly seen in victims of trafficking <sup>4,31</sup>.

Besides the increased risk of sexual and reproductive health problems, victims of trafficking are also more likely to endure physical abuse <sup>36</sup>. This abuse can result in health problems, such as the broken bones and contusions that Zimmerman reports <sup>4</sup>.

## Health neglect

Zimmerman in her 2003 study shows very clearly the difficulties faced by trafficked women in accessing health services in the country of destination. This lack of access, Zimmerman explains, exists because of a number of reasons, including their multidimensional service needs, the difficulty

of gaining access to trafficked women, cultural and linguistic barriers, the need for gaining trust, and women's mobility <sup>4</sup>.

This lack of access to health care is problematic considering the elevated risks of mental, physical, and social health problems in this group. But also 'normal' health problems, such as cardiovascular disease, diabetes, high blood pressure, or dental problems, that would otherwise be treatable, could become more severe due to neglect and lack of treatment. Poor nutrition, malnutrition, and starvation can further negatively affect the health status of trafficked persons <sup>4</sup>.

For several physical health problems identified by Zimmerman, such as dermatological problems (e.g., rashes, scabies, and lice), unhealthy weight loss, and dental and oral health problems, health neglect is a plausible cause <sup>4</sup>.

## Social health

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Zimmerman et al identify three major social problems, with the potential to result in mental and physical health problems, all resulting in isolation of the victim during the destination stage (at which time their trafficker enforces this isolation) <sup>4</sup>:

- Restricted movement, time and activities
- Absence of social support
- Linguistic, cultural, and social barriers

Although restriction by the trafficker might be solved by rescue from a trafficking situation, the latter two problems might endure, as becomes obvious from similar problems that are prevalent among asylum seekers and refugees <sup>37</sup>.

Social problems may arise not only for those who stay in a foreign country, but also for those who return home. Social stigma is an enormous problem for returning survivors <sup>4</sup> regularly resulting in rejection or neglect by the trafficked person's own family <sup>38</sup>. Chatterjee et al, for this reason, emphasize the importance of counselling programs for families of returning survivors. Finally, guilt and shame are frequently encountered among surviving victims of trafficking <sup>4</sup>.

The risk of victims being re-trafficked <sup>39</sup>, which is aggravated by factors such as these, reminds us how incredibly important it is to have programmes in place in origin countries to help survivors acquire work or train/educate themselves, as is specifically called for in the *UN Palermo Protocol to prevent, suppress and punish trafficking in persons* <sup>40</sup>.

## Influencing factors

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*Women who have spent less time abroad tend to recover more quickly, as do women who experienced less abusive treatment and women who have support from their friends or families. Generally, the women who have the hardest time recovering are those who are diagnosed as HIV positive and those rejected by their families.*

– La Strada, Ukraine. From <sup>4</sup>.

This short comment from a treatment and care centre for victims of trafficking in Ukraine shows the enormous complexity of the health impact on this group, and the array of different factors that can influence the psychological and physical consequences of trafficking. In this one short comment, four influencing factors are mentioned: the duration of time in a trafficking situation, the degree of abuse, the degree of social support after having been rescued, and co-morbidity.

There is a broad range of factors that can influence the health of trafficked persons in a post-trafficking setting <sup>1–6,28–30,41,42</sup>. These factors can be subdivided into the following groups:

- Socio-demographic factors
- Pre-trafficking experiences
- Pre-trafficking health
- Experiences during travel, transit and destination stage <sup>\*</sup>
- Co-morbidity in post-trafficking stage

These factors will be discussed one by one here below. Given the importance of trauma and mental health problems for the population of trafficked people, I have focused this discussion on how these factors influence the mental health consequences of trafficking.

### Socio-demographic factors

There are several socio-demographic factors that can influence the health of a trafficked person.

Young *age* has been shown to be a risk factor for more severe health consequences of trafficking <sup>28,30</sup>. This may be in part due to the longer duration of forced sex work among young victims of trafficking <sup>28</sup>. Specifically with regards to mental health, there are indications that responses to

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<sup>\*</sup> Travel, transit and destination stage are defined by Zimmerman et al in the conceptual framework that describes the different stages of trafficking <sup>4</sup>.

trauma are different in children than in adults<sup>1,43-45</sup>. Additionally, the long term-effects of abuse at such a vulnerable state of development can have long lasting effects on health into adulthood<sup>46-49</sup>. Trauma reactions differ between children of different ages<sup>50,51</sup>.

Several reviews exist of the *gender* differences in reactions to trauma, and PTSD prevalence<sup>21,52</sup>. Many studies show that women have an elevated chance of developing post-traumatic stress symptoms after exposure to a traumatic event. The reason for this difference may lie both in exposure to different kinds of trauma, as well as in responses to trauma. Some studies have found no significant gender differences in trauma experience, suggesting that gender differences might disappear under circumstances of extreme trauma exposure<sup>21</sup>.

There are also significant *cultural differences* in the way individuals react to trauma. As for gender differences, these variations can originate from differences in exposure, as well as from differences in responses<sup>53,54</sup>. The DSM-IV-TR explicitly highlights the importance of cultural considerations in making psychiatric diagnoses<sup>22</sup>. It provides a handle for taking into account different cultures by including discussions on cultural variations in clinical presentation in the descriptions of disorders, by providing a list of culture-bound symptoms, and by providing a framework for cultural formulation to assist diagnosticians in systematically evaluating and reporting the individual's cultural context.

Furthermore, there are indications that *educational level* is a predictor of post-traumatic stress disorder<sup>55-57</sup>. However, findings are mixed; other studies show no influence of educational level<sup>58</sup>.

Lastly, *marital status* might be a predictor for the development of mental health symptoms after traumatic exposure. Findings again are mixed: some studies show that PTSD is less likely in married individuals, others show people with PTSD were more likely to be married<sup>58</sup>. For trafficked persons, information about marital status is especially important. If a victim still has a spouse in another country, this is important information for care providers; the spouse might be able to provide social support. It is also very important to know whether the spouse may have played a role in the trafficking of the person, in order to prevent re-trafficking<sup>59</sup>.

## Pre-trafficking experiences

It is important to have knowledge of certain pre-trafficking experiences of trafficked individuals in post-trafficking treatment settings. Research has shown that previous exposure to trauma may influence the emergence and severity of the symptoms of PTSD<sup>23,27,60-62</sup>. Previous (domestic) mental, physical or sexual abuse could therefore impact the health and recovery process of trafficked persons, as has been shown for example by Cwikel<sup>63</sup>. This is the case for previous abuse in



childhood or in adulthood; findings are mixed on whether the severity of psychological consequences of child abuse versus adult abuse differ<sup>9,18,64</sup>. Importantly, trafficking victims often have a history of violence and abuse<sup>4</sup>.

Female genital mutilation comprises a special kind of assault that deserves separate mentioning in this context. Female genital mutilation has been shown to be sufficiently stressful to cause PTSD<sup>65</sup> and is commonly seen among migrant populations in Europe<sup>66</sup>.

Lastly, it is important to know whether the victim has previously been admitted to a shelter or made use of outpatient social services<sup>67</sup>. This might impact the recovery process, but could also provide important clues about the risk of being re-trafficked.

## **Pre-trafficking health**

Similar to pre-trafficking experiences, there are pre-trafficking health conditions that might affect the health of trafficked persons in post-trafficking treatment settings. Pre-existing psychiatric disorders have been shown to be a risk factor for the development of PTSD<sup>60</sup>. It has also been shown that a family history of disorders is predisposing for the development of PTSD<sup>60</sup>. Persons with Mild Mental Retardation, who have been reported to be specifically targeted by traffickers<sup>68,69</sup>, might have a predisposition for PTSD and a different expression of post-traumatic stress symptoms<sup>70</sup>. Personality traits, such as neuroticism, and personality disorders, such as Borderline Personality Disorder or Paranoid Personality Disorder, can also predispose persons to experiencing PTSD after traumatic exposure<sup>55,71</sup>.

## **Experiences during travel, transit and destination stage**

The severity of trauma related psychiatric morbidity depends heavily on the severity and length of exposure<sup>20,21,23</sup>. Prolonged exposure in the form of torture has been reported to result in chronic PTSD in 50% of victims, while the rate of chronic PTSD developing in survivors of natural disasters is only 4%<sup>23</sup>. The duration of time spent in a trafficking situation has been shown by several studies to impact on the health, including the mental health, of victims<sup>5,28</sup>.

Considering the above, the purpose of trafficking is likely to have a significant influence on the mental health consequences of trafficking. Most studies to date on the health of trafficked people have focused on women and girls who were trafficked for the purpose of sex work<sup>2-6,28-30,41,72,73,92</sup>. Little is known about the health consequences of trafficking for other types of exploitation such as labour exploitation.

Physical, mental and sexual assault have been shown to be frequent in both the transit and travel stage, and the destination stage among sex-trafficked women<sup>4</sup>. The nature and degree of physical, mental and sexual assault influence health in a post-trafficking treatment setting. Previous research has shown that the victims of trafficking who experienced sexual violence were more likely to experience symptoms suggestive for PTSD<sup>5</sup>. Such a correlation did not exist for physical violence, although there was some association between physical violence and anxiety symptoms. Having experienced severe injuries was also correlated with mental health outcomes, as was mental assault in the form of threats, either against the individual or against family or loved ones.

Pregnancy and induced abortions are not uncommon among trafficked persons<sup>4</sup>. Although voluntary induced abortions have been shown to have no negative effects on the mental health of individuals, this might not be the case for those who are pressured into an abortion<sup>74</sup>.

Substance abuse is common among trafficked persons, either forcedly or by choice as a coping mechanism<sup>4</sup>. Substance abuse in the transit and travel and destination stage can lead to problems with substance dependency in the post-trafficking stage, or possibly withdrawal symptoms. Conversely, there is some indication that trafficking victims are able to cut down on substance abuse when leaving the trafficking situation<sup>31</sup>. Other studies have shown that substance abuse might only be a significant issue with domestic victims of trafficking<sup>75</sup>.

Confinement is common among victims of trafficking<sup>4</sup>. Social isolation<sup>76</sup> and confinement<sup>77</sup> have been shown to have implications for the mental health of individuals. Among trafficked persons specifically, restricted freedom of movement has been shown to have an effect on mental health symptoms<sup>5</sup>. A lack of social support due to this confinement might increase these mental health problems<sup>52</sup>, as might linguistic and cultural barriers that prevent access to health care<sup>78</sup>.

## Co-morbidity in post-trafficking stage

*Disease is somatic; the suffering from it, psychic.*

– Martin Henry Fischer

Physical morbidity, especially when chronic and severe, can influence the mental health of individuals<sup>79–81</sup>. There is a large variety of physical health symptoms that victims of trafficking can suffer from<sup>4</sup>. For example, HIV is well-known to have psychological consequences<sup>82,83</sup>. Zimmerman has reported that infertility may also be a consequence of trafficking for women<sup>4</sup>, which may also have mental health consequences<sup>84</sup>.

There are also several social health factors in the post-trafficking stage that can influence the mental health of trafficked persons. As mentioned earlier, linguistic and cultural barriers are known to prevent access to health care <sup>78</sup>, and can even diminish the relevance of certain clinical diagnoses such as PTSD <sup>85</sup>. Also, feelings of social isolation are common in post-trafficking stages, both during re-integration in the country of origin and integration in a new country <sup>4</sup>. Isolation is associated with increased risk of mental health problems <sup>76</sup>. Social support is known to ameliorate post-traumatic stress symptoms <sup>52</sup> and is recognised as a key response for victims of trafficking <sup>4</sup>. Isolation can be aggravated by feelings of guilt, and by stigma <sup>1</sup>. With integration in a new country, language and cultural barriers can aggravate isolation too. Finally, legal insecurity is a common psychological stressor among victims of trafficking, who are often insecure about their immigration status and legal rights <sup>4</sup>. Even when trafficked persons are recognised as such and receive temporary residency status as part of the reflection period <sup>86</sup>, the possibility of acquiring residency status is often dependent on their willingness to cooperate with law enforcement (with the exception of Italy), and on the eventual conviction of the trafficker <sup>87,88</sup>. \* Many of these social problems resemble problems faced by asylum seekers and refugees <sup>37</sup>. Within this population, research has shown that several socio-legal factors may influence psychiatric disorders, 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 <sup>31</sup>.

## Long term vs. short term health

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*Trust, freedom and hope*, is what Korsby found to be what trafficking victims strive for in the long-term in an anthropological study in a shelter for trafficked women <sup>89</sup>. What exactly are the health consequences of trafficking in the longer term? Several studies have shed light on this topic.

In 2006, Zimmerman found that mental health symptoms endure over several months in post-trafficking care <sup>3</sup>. Symptoms of PTSD and anxiety started to show reductions after three months, but remained above normal. Depression scores especially remained very high. A secondary analysis of these data showed that the amount of time that has elapsed since people are rescued from a

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\* The lack of a human rights based, victim centred approach to care for victims of trafficking, and the concomitant inferiority of the (health) care needs and protection of victims of trafficking as compared to the importance of the justicial process against traffickers is not in agreement with the victim assistance that is provided to other groups of victims of violence <sup>88</sup>.

trafficking situation influences the severity of experienced anxiety, depression and PTSD symptoms<sup>5</sup>. Ostrovschi et al took Zimmerman's research further and showed that mental health symptoms endure for long periods, recommending a treatment period of at least 12 months<sup>15</sup>. Care providers share the view that mental health consequences can be enduring, as becomes clear from a quote in an earlier study of Zimmerman:

*Most women are in crisis in the beginning. They are insecure, feel unsafe, and are afraid that the traffickers will find them again. They have problems eating and sleeping. After a few weeks, most of these things are resolved. However, often about one month after leaving the safe house - when women have work and a place to live so their basic needs are taken care of - most women start showing signs of more serious mental health problems. When everything is ok they "wake up" and start dealing with the past.*

– Payoke, Belgium. From<sup>4</sup>.

These findings are also in congruence with general literature on trauma. Post-traumatic health consequences are known to be able to persist for a long duration of time and it is known that symptoms can vary over time<sup>10,24,90</sup>.

Furthermore, trafficking can have physical consequences that may never heal. Severe forms of abuse sometimes leave survivors maimed for life<sup>91</sup>. In the words of Zimmerman: "Infertility and other resulting complications, including cervical cancer may be unalterable personal legacies of their nightmare"<sup>3</sup>.

Lastly, especially social problems can form a significant problem in the long-term. This is true for victims who acquire residency status in a new country, with all the concomitant challenges, but also for victims who return home. Feelings of guilt and shame can have profound impacts on the psyche of trafficked persons<sup>4</sup>. This is aggravated by the fact that social stigma prevents survivors from speaking about their experiences<sup>4</sup>. And when relatives do find out, family rejection is common, especially among trafficked children who return home<sup>38</sup>. All these factors, worryingly, increase the risk of victims being re-trafficked<sup>39</sup>.

## Conclusion

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Human trafficking is a crime that involves various forms of abuse and exploitation which can cause acute and chronic physical and psychological harm to victims<sup>3,4</sup>. The few studies that have researched the health of victims of human trafficking suggest a high prevalence of post-traumatic

stress syndrome (PTSD), anxiety disorders, and depressive disorders<sup>3,5,15,92</sup>. A large variety of physical health problems can be seen among victims of human trafficking attending post-trafficking treatment services. Care for this group is further complicated by pregnancy or care for children among some trafficked women<sup>75</sup>; by legal procedures against traffickers and immigration procedures for victims that can have negative consequences for the mental health of victims; by cultural and language barriers that can impede the provision of effective care<sup>67</sup>; and by other social challenges such as difficulties with finding work or education, a lack of social support, feelings of shame and guilt, and social stigma that may impede a successful return to independent living.<sup>4,75</sup>

Knowledge about health and human trafficking remains extremely limited, in particular since several groups have remained understudied, such as victims of labour trafficking and men,<sup>92,93</sup> since certain health problems have received relatively little attention, such as mental and social health problems,<sup>93</sup> and since health problems are likely to vary considerably between trafficked persons based on trafficking experiences, socio-demographic factors, pre-trafficking health and experiences, and the geographical context of both the origin and the destination country.<sup>94</sup>

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## **Appendix 2**

### **Search terms for literature review**

I used OvidSP to search five databases (Medline, Embase, Social Policy and Practice, Global Health and Psycinfo), using the following search terms (search terms for synonyms of human trafficking were identified from articles and reports that followed from my review of the health consequences of human trafficking (see Appendix 1)):

(Human trafficking or sex trafficking or sex trafficked or trafficking in persons or trafficking in men or trafficking in women or trafficking in children or trafficking in boys or trafficking in girls or trafficking of persons or trafficking of men or trafficking of women or trafficking of children or trafficking of boys or trafficking of girls or trafficked persons or trafficked women or trafficked men or trafficked children or trafficked boys or trafficked girls or victims of trafficking or trafficking experiences or posttrafficking services or persons who had been trafficked or women who had been trafficked or men who had been trafficked or children who had been trafficked or boys who had been trafficked or girls who had been trafficked or persons who have been trafficked or women who have been trafficked or men who have been trafficked or children who have been trafficked or boys who have been trafficked or girls who have been trafficked or persons who were trafficked or women who were trafficked or men who were trafficked or children who were trafficked or boys who were trafficked or girls who were trafficked or violence while trafficked or anti-trafficking protection or health impacts of trafficking).ti,ab. and (Service\* or needs or audit or satisfaction or satisfied or experience\* or quality).mp.

For grey literature, I searched Google, which allows less search terms. Therefore, I used the following search terms:

("Human trafficking" OR "sex trafficking" OR "trafficking in persons" OR "trafficking in men" OR "trafficking in women" OR "trafficked persons" OR "trafficked women" OR "trafficked men" OR "victims of trafficking" OR "trafficking experiences" OR "post-trafficking services") AND (Services OR needs OR audit OR experiences OR quality)

## **Appendix 3**

### **'Lifehacking list'**

## Carry with you every day:

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- Documents:
  - Lifehacking list (this one)
  - List of research participants and observed activities
  - Summaries of the COSM shelters
  - All blank consent forms and information sheets
  - A new topic guide for each interview
- Tools:
  - Dictation machine
  - backup batteries
  - A4 notepad + pen
- Laptop
- Tissues
- LSHTM business cards
- Sign saying 'interview in progress'
- Black notebook

## Things to keep in each shelter:

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- In a file folder in a locked cabinet in the shelter:
  - A list of interviewed participants, linked anonymous identification numbers, and dates of the interviews
  - All blank consent forms and information sheets
  - All completed consent forms
- Information sheets in the staff rooms and common rooms for service users

## When inviting service users for an interview:

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1. Ask the language he or she would prefer for the interview.
2. Ask if they have children in the shelter, and if so, whether it is OK to conduct the interview without them.
3. Put any interview agreement in the calendar of the service providers.



Exclusion criteria:

- a. Anyone who stayed in the shelter for less than 6 weeks
- b. Victims of trafficking for the purpose of labour exploitation
- c. Victims under the age of 18 years
- d. Victims of Dutch nationality

## Before every interview:

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- Make a new, updated topic guide
  - Check the 'topic guide update'-file for previous questions and remarks
  - With some service providers, incorporate information from 'preparation file' with information about the organization that the service provider works for

## Interview rules, guidelines and other things to remember:

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- Beginning interview
  - Brief the interpreter before you bring in the service user: Stress that because this is a research study, it is important that translation is as close to what the participant actually said, and that the interpreter does not make summaries, conclusions, or inferences about the meanings of what the participant has said.
  - Wait outside the interview room for the service user if he or she will meet you there.
- Surroundings
  - Close the door
  - Put 'interview in progress' sign on the door
  - Let service providers know the interview is taking place
  - Take a 90 degree angle in seating yourself with the participant, if possible
- Informed consent
  - Introduce briefly with simple words.
  - With service users ensure that they understand who I am and what the research aims to do. If possible, see if they can word this in their own words (but don't start with this – too threatening).
  - Make clear that I am not a service provider of the COSM programme.
  - Provide participant with the information sheet.

- With service users, explain the narrative reporting format.
- During the interview
  - Actively watch out for any feelings of discomfort
  - Keep in mind discussions about professional distance and rapport and carefully consider how to balance the two
  - Try to use words that the participants use in referring to, for example, the shelter or the service providers
  - Stress that time is flexible, and ask how much time the participant has for the interview.
- Content
  - Ask about the 'Why behind the why' - keep asking why!
  - In narrative keep an active eye out for positive and negative service experiences. When these are mentioned, ask more: What precisely? Why? Examples? In order to not disturb the narrative, good to keep a list of mentioned experiences, and come back to those later.
  - Actively try to not talk too much, to let the other talk
  - Actively try to not ask leading questions
  - Focus on people's stories – so that you can write those out in the end
- Analysis
  - Do not make changes to old participant files – once things are uploaded in NVIVO only make changes there
- End of the interview
  - Debrief the interpreter
  - Denote impressions from the interview and make memos more expansive

## **Observation rules, guidelines and other things to remember:**

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- Continuous consent:
  - Make clear:
    - Who I am
    - What the purpose of the research is
    - How data will be collected
    - What confidentiality entails (not telling others including care providers)
  - Don't forget to stress this also with service providers

- "I am here to listen, to learn what happens here in the shelter"

## **Fixed times for reflection:**

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1. After every interview write down what your impression of the interview was, both in terms of content and in terms of methods
2. After every day make your memos more expansive
3. Keep your observation memos in 'observation logs' per day that you observed and keep your memos and impressions of interviews in the interview files
4. Keep separate 'development of data collection' and 'development of data analysis' files where you make notes about how data collection and analysis develop over time
5. Write regularly in your research diary the things that you doubt about, what happened, etc.

## **Appendix 4**

### **Information sheets and consent forms**

This section contains:

1. General information sheet for the research that was provided to shelters to place in the service user common room and the staff room (only the English version).
2. Consent form for shelter managers to consent to the shelter's participation in the research. The general information sheet (point (1)) functions as the information sheet for this consent form (only the English translation).
3. The information sheet and consent form for service providers who were employed by the COSM shelters to consent to being interviewed (only the English translation).
4. The information sheet and consent form for service users to consent to being interviewed (only the English version).
5. The information sheet and consent form for service providers who were not employed by the COSM shelters to consent to being interviewed (only the English translation).

## Research project: Shelter and care after human trafficking

### Information sheet for service users and care providers

Date: 12 Feb 2012

Version: 1.2

A research project is currently planned to take place in this shelter. The aim of the research project is to explore the experiences of service users and care providers with services that are provided by this shelter and two other shelters that take part in the Categorical Care for Victims of Human Trafficking programme (Dutch acronym: COSM). This information form is intended to explain the purpose and details of the research project.

#### **Why is this research being conducted?**

To date, very little research has been conducted into what service users and care providers think about the shelter and care that is provided after human trafficking. More research on this issue is much needed. After all, the service users, that make use of the shelter and care, and the care providers, that are closely involved in the entire care process, know best what kind of help is needed! Via this research project we hope to learn about what service users and care providers feel is particularly good about the help that the shelter offers. We also hope to learn what service users and care providers think is not-so-good, so that we can make suggestions for improvements. Both are important, because shelters in the Netherlands and abroad could learn a lot from this information.

#### **Your participation in the research**

As part of the research project the principal investigator, Rik Viergever, will invite several service users and care providers to participate in one or several interviews. Participation in these interviews is completely voluntary. Besides that, Rik will visit the shelter several times to learn more about what a typical day looks like in the shelter. By making notes of all that happens during these days, and by talking to both service users and care providers about their experiences with the shelter and care provision, we hope to obtain an overview of how what kind of help the shelter offers, what is good about it, and where improvements may be possible. It is important to stress that any participation in the research is completely voluntary. Sometimes it can also be difficult when there is an extra person present in the shelter that you don't know. So when Rik visits the shelter and you

would rather not talk to him at all, that would be completely fine. If this is the case, it is important that you let him know!

### **Protection of privacy and anonymity**

If you are invited for an interview, and you agree to participate, then everything that you tell Rik during the interview is completely confidential. This means that he can tell nothing of what you tell him to other service users or care providers. Also, the data from the interviews will be completely anonymised. This means that any information that could identify you (such as your name and birth date) will be removed. This is a standard procedure to protect your privacy. When Rik makes notes of his visits to the shelters, all the notes will also be completely anonymised. Finally, we plan to publish the results of this research as one or more scientific articles. When we do so, we will likely include interesting things that people have said during the interviews. If that occurs, we will not use your name or say anything that might identify you. In addition, this will only be done when you indicate before the interview that you agree to being quoted anonymously.

This research project was approved by the London School of Hygiene and Tropical Medicine Ethics Committee and the Medisch Ethische Toetsingscommissie Slotervaartziekenhuis en Reade.

### **More information**

For questions before, after, or during the research, you can contact Rik Viergever of the London School of Hygiene and Tropical Medicine:

Email: roderik.viergever@lshtm.ac.uk

Telephone: +31 638743294 / +44 7514434456

Would you like independent advice on participation in this study? Such advice can be acquired from an independent physician. At all times you can contact Mr. E. Meesters, doctor of internal medicine at the Slotervaart hospital in Amsterdam. Mr. Meesters is not involved in conducting the research, but is fully informed of the contents of the research.

Telephone: 020-5124622 or 020-5129333 and then ask for 3769.

## Consent form for shelter managers for participation in the research

Date: 23 Dec 2011

Version: 1.0

Name of the researcher and contact details:

Rik Viergever

London School of Hygiene and Tropical Medicine

Adres: 15-17 Tavistock Place, London WC1H 9SH, England

Email: roderik.viergever@lshtm.ac.uk

Phone: +31 638743294 / +44 7514434456

**I have read all of the information on the information sheet. Any questions that I had about the research have been answered by Rik. I hereby consent to (please tick boxes of what you consent to):**

- Rik visiting the shelter on our invitation to learn more about what a typical day looks like in the shelter.**
- He will also be allowed to invite service users and care providers for one or more interviews and record these interviews if they consent to being recorded.**
- During any of his visits to the shelter, to participate in a day activity, to conduct an interview, or otherwise, he will also be allowed to make notes of his observations.**

**Manager:**

Name.....

Signature.....

Date.....

**Researcher:**

Name: Rik Viergever

Signature.....

Date.....

## **Research project: Shelter and care after human trafficking**

### **Information sheet for care providers for the interview**

Date: 19 Apr 2012

Version: 1.4

A research project is currently taking place in this shelter. Rik Viergever is the principal investigator of the research project and will conduct all interviews. The aim of the research project is to explore the experiences of service users and care providers with services that are provided by this shelter and two other shelters that take part in the Categorical Care for Victims of Human Trafficking programme (Dutch acronym: COSM). Before we go further with the interview, it is important to us that you understand why we are conducting this research and what the research will entail precisely. This information form is intended to explain those things to you.

#### **Why is this research being conducted?**

To date, very little research has been conducted into what service users and care providers think about the shelter and care that is provided after human trafficking. More research on this issue is much needed. After all, the service users, that make use of the shelter and care, and the care providers, that are closely involved in the entire care process, know best what kind of help is needed! Via this research project we hope to learn about what service users and care providers feel is particularly good about the help that the shelter offers. We also hope to learn what service users and care providers think is not-so-good, so that we can make suggestions for improvements. Both are important, because shelters in the Netherlands and abroad could learn a lot from this information.

#### **Your participation in the research**

Your participation will consist of an interview that is expected to last 2 hours, but if you want it to last shorter or longer that is also possible. Participation is completely voluntary. Even if you decide to take part in the research, you can decide to stop and leave the interview at any time without having to give a reason. You can also request a break at any time during the interview. If you decide to take part in the research, we would like to record the interview, to help us analyse the information. However, if you prefer that the conversation is not recorded, that is also possible, in which case we will make handwritten notes during the interview. We hope to conduct a short second interview



with you, to verify the data collected during the first interview. This will also give you opportunity to provide additional information.

This second interview can be conducted in person, via the telephone, or via email. Finally, it is possible that during our research issues come up that deserve further exploration. Therefore, we might request you to participate in a short follow-up interview on a specific area of interest at a later stage. Your participation in such a follow-up interview would again be completely voluntary.

### **Protection of privacy and anonymity**

If you agree to participate, then everything that you tell Rik during the interview is completely confidential. This means that he can tell nothing of what you tell him to other service users or care providers. The only exception to this rule concerns information that suggests that someone wants to harm oneself or wants to harm or has harmed someone else. In that case, he is ethically obliged to follow up on that information and to try to prevent future harm or report previously done harm. Furthermore, to protect your privacy, your identity will be completely anonymised as part of the research, meaning that we will remove any reference to your name or any other information that could identify you as part of the analysis of the interviews. Additionally, Rik will be the only person that will have access to the interview material and will also conduct all analysis of the data. It is possible that he will hire someone to help with transferring the audio recordings to written text and he may ask one of his co-investigators to help with the analysis process.

We plan to publish the results of this research as one or more scientific articles, a PhD thesis, or a book, and will likely include interesting things that people have said during the interviews. When we do so, we will not use your name or say anything that might identify you. In addition, this will only be done when you indicate before the interview that you agree to being quoted anonymously. If you would rather not be quoted at all, not even anonymously, you can indicate this, in which case we will only use the information you provide us with during the analysis process of the research without quoting from it.

This research project was approved by the London School of Hygiene and Tropical Medicine Ethics Committee and the Medisch Ethische Toetsingscommissie Slotervaartziekenhuis en Reade.

### **More information**

For questions before, after, or during the research, you can contact Rik Viergever of the London School of Hygiene and Tropical Medicine:

Email: [roderik.viergever@lshtm.ac.uk](mailto:roderik.viergever@lshtm.ac.uk)

Telephone: +31 638743294 / +44 7514434456

Would you like independent advice on participation in this study? Such advice can be acquired from an independent physician. At all times you can contact Mr. E. Meesters, doctor of internal medicine at the Slotervaart hospital in Amsterdam. Mr. Meesters is not involved in conducting the research, but is fully informed of the contents of the research.

Telephone: 020-5124622 or 020-5129333 and then ask for 3769.

## Consent form for care providers for participation in the interview

Date: 23 Dec 2011

Version: 1.0

### Name of the researcher and contact details:

Rik Viergever

London School of Hygiene and Tropical Medicine

Adres: 15-17 Tavistock Place, London WC1H 9SH, England

Email: roderik.viergever@lshtm.ac.uk

Phone: +31 638743294 / +44 7514434456

### To be filled out by the participant in the research (choose every time for option 1 or option 2 by setting a mark!):

1. I agree that material from my interviews may be quoted anonymously.

2. I do not agree that the material from my interviews may be quoted, not even anonymously, but the researchers can use information from my interviews to inform their analyses.

1. I agree that the interviews are recorded.

2. I do not agree that the interviews are recorded.

1. I agree to be asked to participate in a short follow-up interview to discuss a specific issue of interest in greater detail at a later stage or to discuss the findings of this interview.

2. I do not agree to be asked to participate in a short follow-up interview to discuss a specific issue of interest in greater detail at a later stage or to discuss the findings of this interview.

**I have read all of the information on the information sheet. I understand what is expected of me in the interview that I will participate in. Any questions that I had have been answered by Rik. It is clear to me that at any time I may stop the interview without having to give a reason. I understand that what I say will be treated confidentially in accordance with my preferences. I agree to be interviewed.**

**Participant:**

Name.....

Signature.....

Date.....

**Researcher:**

Name: Rik Viergever

Signature.....

Date.....

## **Research project: Shelter and care after human trafficking**

### **Information about the interview**

Date: 19 Apr 2012

Version: 1.4

You have been asked to participate in an interview as part of a research project. Rik Viergever is the main researcher and he will interview you. But before the interview starts, it is important to us that you understand why we are doing this research and how you can help us as part of the research. This form will explain those things to you.

#### **Why is this research being done?**

The aim of the research project is to research what you, the other people who live in the shelter, and the people who work in the shelter, think about the shelter and how the shelter helps people. We want to help others understand what it is like to live in a shelter like this and what kind of help you need. We hope that the research will help this shelter and other shelters (in the Netherlands and in other countries) give better help to other people like you in the future.

#### **Your participation in the research**

Taking part in the interview is completely voluntary. If you agree to take part, there will be two interviews that will each last 1,5 hours maximum, but if you want the interviews to last shorter that is possible. The first interview is today and at the end of the interview today Rik will plan the second interview with you on a day and time that is good for you. You can stop the interviews at any time. You can also have a break at any time.

We would like to record the interviews, because it helps us with the research. However, if you do not want this, then we will not record, and Rik will make notes during the interview. This is your choice.

Most often two interviews are enough. But sometimes we want to invite someone for a third interview. You can also choose whether you agree with being invited for a third interview.

Finally, we would like to ask your permission to read your dossier or file that is kept by the shelter staff in which they make notes of their meetings with you, because it would help us with our research. Again, this is your choice and you can choose whether Rik can read your dossier or file.

### **Protection of privacy and confidentiality**

Everything that you tell Rik during the interview is completely confidential. This means that he can tell nothing of what you tell him to other people who live or work in the shelter. (The only exception to this rule is when he thinks someone is in danger. Then he has to try to prevent that person from getting hurt.)

In addition, to protect your privacy, we will remove your name and other personal information about you as part of the research.

Finally, Rik is the only person that will have access to the interview recordings or notes. He may ask one of his co-researchers to help with the research. They will also keep all information confidential.

### **What will happen with the information that I give Rik?**

When the interviews are done we will write a book and several “scientific articles” (these are short reports that researchers write for each other in magazines for researchers to tell others about their research). In this book and articles we will repeat interesting things that people have said during the interviews – this is called “quoting”. This will only be done if you agree with this. (We will not use your name when we quote you or give other personal information about you.)

In one part of the book, we will tell the stories of some of the people we interviewed, to help others understand what it is like to live in a shelter like this (such a story about someone is called a “narrative”). This will only be done if you agree that the information from the interview and from your dossier or file is used to write a story about you and your experiences. If you agree with this, in the story about you, your name and other personal information about you will be changed.

This research project was approved by two committees that make sure that Rik and his co-researchers follow all the rules that exist for researchers. The committees are called the ‘London School of Hygiene and Tropical Medicine Ethics’-Committee and the ‘Slotervaart hospital Medical Ethical’-Committee.

### **More information**

If you have questions before, during, or after the research, you can contact Rik Viergever of the London School of Hygiene and Tropical Medicine (Rik’s university):

Email: roderik.viergever@lshtm.ac.uk

Telephone: +31 638743294 / +44 7514434456

Would you like independent advice on the research, so from someone other than Rik? Then you can contact Mr. E. Meesters, doctor of internal medicine at the Slotervaart hospital in Amsterdam. Mr. Meesters is independent and not a researcher in this research project, but he knows everything about the research, and you can ask him questions about the research.

Telephone: 020-5124622 or 020-5129333 and then ask for 3769.

## Consent form for the interview

Date: 19 Apr 2011

Version: 1.4

Name of the researcher and contact details:

Rik Viergever

University: London School of Hygiene and Tropical Medicine

Adres: 15-17 Tavistock Place, London WC1H 9SH, England

Email: roderik.viergever@lshtm.ac.uk

Phone: +31 638743294 / +44 7514434456

Here you can make several choices:

1. **I agree** that the interviews are recorded.

2. **I do not agree** that the interviews are recorded.

1. **I agree** to be asked to take part in a third interview if that is necessary.

2. **I do not agree** to be asked to take part in a third interview.

1. **I agree** that Rik can read my dossier or file that is kept by the shelter staff and that he can use that information for his research.

2. **I do not agree** that Rik can read my dossier or file that is kept by the shelter staff and use that information for his research.

1. **I agree** to be quoted. My name or other personal information about me will not be mentioned when I am quoted.

2. **I do not agree** to be quoted.



[ ] 1. **I agree** that the interviews and my dossier or file may be used to write a story about me and my experiences (“a narrative”). In this story about me, my name and other personal information about me will be changed.

[ ] 2. **I do not agree** that the interviews and my dossier or file may be used to write a story about me and my experiences.

**I have read all of the information on this form or the information has been read out to me. I understand what the interview will be about. Any questions that I had have been answered by Rik. It is clear to me that I can stop the interview at any time without having to give a reason. I understand that what I say will be treated confidentially respecting the choices I have made above. I agree to be interviewed.**

**Participant:**

Name.....

Signature.....

Date.....

**Researcher:**

Name: Rik Viergever

Signature.....

Date.....

## **Research project: Shelter and care after human trafficking**

### **Information sheet for experts**

Date: 19 Apr 2012

Version: 1.4

A research project has recently taken place in several shelters in the Netherlands that provide care after human trafficking. The aim of the research project was to explore the experiences of service users and care providers with services that have been provided by these shelters. This information form is intended to explain more about the research project that has already been conducted and about your intended contribution to the project.

#### **Why has this research been conducted?**

In June 2010 a new programme for specialised shelter and care for victims was initiated in the Netherlands: the Categorical Care for Victims of Human Trafficking (Dutch acronym: COSM) programme. In other countries similar shelter and care programmes have been established in recent years. However, to date, very little research has been conducted into what service users and care providers think about the shelter and care that is provided after human trafficking. More research on this issue is much needed. After all, the service users, that make use of the shelter and care, and the care providers, that are closely involved in the entire care process, know best what kind of help is needed! Via this research project we hope to learn about what service users and care providers feel is particularly good about the help that the shelter offers. We also hope to learn what service users and care providers think is not-so-good, so that we can make suggestions for improvements. Both are important, because shelters in the Netherlands and abroad could learn a lot from this information.

#### **Your participation in the research**

You have been invited by the principal investigator of the study, R.F. Viergever, to participate in the study. As part of the research we have planned to interview several experts in fields relevant to shelter and care provision after human trafficking, to shed more lights on issues emerging from the interviews with care providers and service users. We feel that your expert views would be of value to our study. Your participation can take the form of an interview, which can be conducted via the telephone or in person, or you might be asked to participate by commenting on the results of the project via email. Your participation is completely voluntary. Even if you decide to take part in the

research, you can decide to stop at any time without having to give a reason. If you decide to take part in the research, and if you will be participating via an interview, we would like to record the interview, to help us analyse the information. However, if you prefer that the conversation is not recorded, that is also possible, in which case we will make handwritten notes during the interview.

### **Protection of privacy and anonymity**

If you agree to participate, then everything that you tell Rik during the interview is completely confidential. The only exception to this rule concerns information that suggests that someone wants to harm oneself or wants to harm or has harmed someone else. In that case, he is ethically obliged to follow up on that information and to try to prevent future harm or report previously done harm. To protect your privacy, your identity will be completely anonymised as part of the research, meaning that we will remove any reference to your name or any other information that could identify you as part of the analysis of the interviews. Additionally, Rik will be the only person that will have access to the interview material and will also conduct all analysis of the data. It is possible that he will hire someone to help with transcribing the interviews and he may ask one of his co-investigators to help with the analysis process.

We plan to publish the results of this research as one or more scientific articles, a PhD thesis, or a book, and will likely quote participants. When we do so, we will not use your name or say anything that might identify you. In addition, this will only be done when you have indicated that you agree to being quoted anonymously. If you would rather not be quoted at all, not even anonymously, you can indicate this, in which case we will only use the information you provide us with during the analysis process of the research without quoting from it.

This research project was approved by the London School of Hygiene and Tropical Medicine Ethics Committee and the Medisch Ethische Toetsingscommissie Slotervaartziekenhuis en Reade.

### **More information**

For questions before, after, or during the research, you can contact Rik Viergever of the London School of Hygiene and Tropical Medicine:

Email:            roderik.viergever@lshtm.ac.uk

Telephone:      +31 638743294 / +44 7514434456

Would you like independent advice on participation in this study? Such advice can be acquired from an independent physician. At all times you can contact Mr. E. Meesters, doctor of internal medicine at the Slotervaart hospital in Amsterdam. Mr. Meesters is not involved in conducting the research, but is fully informed of the contents of the research.

Telephone: 020-5124622 or 020-5129333 and then ask for 3769.

## Consent form for experts for participation in the research

Date: 23 Dec 2011

Version: 1.0

Name of the researcher and contact details:

Rik Viergever

London School of Hygiene and Tropical Medicine

Adres: 15-17 Tavistock Place, London WC1H 9SH, England

Email: roderik.viergever@lshtm.ac.uk

Phone: +31 638743294 / +44 7514434456

To be filled out by the participant in the research (choose every time for option 1, option 2, or option 3 by setting a mark!):

1. I agree that material from this interview may be quoted anonymously.

2. I do not agree that the material from my interview may be quoted, not even anonymously, but the researchers can use information from my interview to inform their analyses.

1. I agree to be interviewed in person.

2. I agree to be interviewed via the telephone.

3. I agree to answer questions via email.

In case of an interview:

1. I agree that the interview is recorded.

2. I do not agree that the interview is recorded.

**I have read all of the information on the information sheet. I understand what is expected of me. Any questions that I had have been answered by Rik. It is clear to me that at any time I may**

**discontinue my participation in the research without having to give a reason. I understand that what I say will be treated confidentially in accordance with my preferences.**

**Participant:**

Name.....

Signature.....

Date.....

**Researcher:**

Name: Rik Viergever

Signature.....

Date.....

# **Appendix 5**

## **Topic guides**

## Topic guides for interviews with service users

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### Non-threatening conversation / getting to know each other

#### Acquiring informed consent and explanation of the research

- Explaining the purpose of the interview (especially during 1st interview; during 2nd interview check whether purpose is still clear)
- Explain who I am
- Explain interview schedule and times (2 x maximum 1,5 hours but flexible, can be shorter)
- Explain why there is a form to account for fear of forms. Let participant read consent form if their preferred language is Dutch or English, or read out the consent form if the preferred language is any other language and an interpreter has been arranged. Provide additional explanation where necessary. Ask if there are any questions. Participant can sign, mark, or provide verbal consent if he/she agrees to participate.

#### Socio-demographics

- What is your age?
- Where are you from, from which country?
- How long have you been in the Netherlands?
- How long have you resided in this shelter?
- Do you have any children?

#### Feelings about previous interview (only during second interview)

Possible probing questions:

- How do you feel about the previous interview?
- Did you discuss it with others?
- Have you thought about what we discussed during the previous interview?

#### Daily lives / personal story

Possible probing questions:



- Can you tell me a little bit about yourself?
- What does a typical day or week look like for you?
- What did you do yesterday?
- Can you tell me a little bit about what it's like being here in the shelter\*?
- How have things changed for you here since you arrived?
- What do you hope for, for the future? Are there also things that you worry about? How do you see your future?

### **Interaction with other service users**

Possible probing questions:

- Have you made friends here?
- How do service users interact with each other?
- In the shelter where you're staying there are a lot of service users from different countries. What is it like to live in such a varied group?

### **Perceived needs for social and health services**

Possible probing questions:

- Could you explain to me why you are here in the shelter?
- What kind of help do you need from the shelter?
- Why do you need that help?

### **Descriptions of service provision**

Possible probing questions:

- How does, or did, the shelter help you with these things?
- What else does the shelter help you with?

### **Experiences with services provision**

Possible probing questions:

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\* The shelter is called "the house" in Amsterdam, "Humanitas" in Rotterdam, and "Jade" in Emmen. Adjust to formulations used by service users as much as possible.

- Can you give me one or two examples of something that you found really good about the help that the shelter gives you? Why is that good for you?
- And one or two examples of something you found not-so-good? Why is that not-so-good for you? What do you think could be improved?
- If you were the boss of the shelter, what would you change?

### Final questions

- We discussed a lot of things today. Is there anything that was most important to you, something that I should really pay attention to as part of my research?
- What did you think of the interview(s)? How do you feel about being asked these questions?

### Rounding up

- Thank participant for his/her participation and for allowing future service users to benefit from this research!
- After the *first* interview, remind service user of the second interview. Ask if the participant would still be happy to take part in the second interview, and if so, if we can arrange a date and time for the next session.
- Also stress that the participant can contact me at any time to talk about what we have discussed today or when there are any questions about the research.
- Thank the interpreter for her/his participation.

## Topic guides for interviews with service providers

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### Non-threatening conversation / getting to know each other

#### Informed consent and explanation of the research

- Explaining the purpose of the interview
- Explain who I am
- Explain interview schedule and times
- Let participant read the consent form. The participant can sign if he/she agrees to being interviewed.

#### Socio-demographics

- Could you describe your profession to me?
- How long have you worked in the care sector for victims of trafficking?

#### Personal history with regards to study population

- Can you tell me a bit about how you have become involved in providing care for this population?

#### Perceived social and health service needs

Possible probing questions:

- Could you tell me what service users, in your view, need from the shelter and care provision?
- When they arrive, what do they need most? What kind of problems do they have?
- Does this change over time?
- What are the essential elements, the 'pillars', of social and health care provision for this group?

### **Differences between service users**

Possible probing questions:

- Have you noticed any individual differences between service users, in terms of health care needs and experiences?
- Have you ever provided care for male / female service users (*opposite of shelter where participant is currently employed*)? Do you feel there are differences?

### **Descriptions of service provision**

Possible probing questions:

- How does your organization address these needs? (that were mentioned in the previous question on Perceived social and health service needs)
- Have you tried to specialize in providing care for this population? If so, how? (for service providers outside the COSM shelters)

### **Experiences with service provision**

Possible probing questions:

- Can you give me one or two examples of something that you find really good about the help that is currently provided to service users? Why is that good for you?
- If someone were to establish a similar programme as the COSM in another country tomorrow, what should they really copy from the Dutch experience? Why?
- Can you give me one or two examples of something you find not-so-good about the help that is currently provided to service users? Why is that not-so-good for you? How could it be improved?

**Different questions were asked to participants from different disciplinary backgrounds and at different organizations. Questions were prepared before each interview.**

- Examples for social workers in the shelter:
  - What does "individually tailored care" mean for you precisely?
  - And "culturally appropriate care"?
  - How is continuity of care ensured after people leave the COSM shelter?
- Examples for policymakers at a Ministry:

- Why was a maximum shelter period of three months chosen for the COSM?
- Why was the COSM financed via a tender system?
- Three ministries work together in the COSM, why was this system chosen? Could you tell me a bit more about the collaboration between these ministries?
- Examples for mental health care providers:
  - How is treatment for this group of victims different than for other victims of traumatic experiences?
  - Why does your institution choose to provide group treatments rather than individual treatments for this population?
- Examples for general practitioners:
  - Can you tell me a little bit about your cooperation with <name shelter>?
  - If you suspect someone in your practice has been trafficked, would you know what kind of action to undertake?

### Final questions

- We discussed your views of the shelter and the care that the shelter provides today. Of what we discussed, what was most important to you?
- Is there something that we haven't spoken about yet that you really feel I should include in my research?
- What did you think of the interview(s)?

### Rounding up

- Thank participant for his/her participation!
- Stress that the participant can contact me at any time to talk about what we have discussed today or when there are any questions about the research.

# Appendix 6

## Ethics approval letters

This section contains four ethics approval letters:

1. Ethics approval from the London School of Hygiene and Tropical Medicine Ethics Committee
2. Renewed ethics approval from the London School of Hygiene and Tropical Medicine Ethics Committee after information sheets and consent forms were adapted.
3. Ethics approval from the Medisch Ethische Toetsingscommissie Slotervaartziekenhuis en Reade in the Netherlands.
4. Renewed ethics approval from the Medisch Ethische Toetsingscommissie Slotervaartziekenhuis en Reade in the Netherlands after information sheets and consent forms were adapted.



**OBSERVATIONAL/INTERVENTIONS RESEARCH ETHICS COMMITTEE**

30 January 2012

Roderik Floris Viergever

Dear Roderik

**Study Title:** Service users' and care providers' experiences of post-trafficking shelter and care services for adult victims of cross-border human trafficking to the Netherlands  
**LSHTM ethics ref:** 6112  
**Department:** Public Health and Policy  
**Head of Department:**

Thank you for your email of 27 January responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

**Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

**Conditions of the favourable opinion**

Approval is dependent on local ethical approval having been received, where relevant.

**Approved documents**

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date	
LSHTM ethics application	n/a		
Protocol	V2.0	30/01/12	
Information Sheet	V1.0	30/01/12	
Consent form	V1.0	30/01/12	

**After ethical review**

Any subsequent changes to the application must be submitted to the Committee via an E2 amendment form.

Yours sincerely,



**OBSERVATIONAL/INTERVENTIONS RESEARCH ETHICS COMMITTEE**

A handwritten signature in black ink, appearing to read "Andrew J Hall". The signature is written in a cursive style and is positioned above a horizontal line.

**Professor Andrew J Hall  
Chair**



London School of Hygiene & Tropical Medicine  
Keppel Street, London WC1E 7HT  
United Kingdom  
Switchboard: +44 (0)20 7636 8636  
www.lshtm.ac.uk



**Observational / Interventions Research Ethics Committee**

Dr RF Viergever  
Research Student  
HSRP/PHP  
LSHTM

28 May 2012

Dear Dr Viergever

**Study Title:** Service users' and care providers' experiences of post-trafficking shelter and care services for a dult victims of cross-border human trafficking to the Netherlands  
**LSHTM ethics ref:** 6112  
**LSHTM amend no:** A327

Thank you for your application of 24 April 2012 for the amendment above to the existing ethically approved study and submitting revised documentation.

The amendment application has been considered by the Committee

**Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above amendment to research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

**Conditions of the favourable opinion**

Approval is dependent on local ethical approval for the amendment having been received, where relevant.

**Approved documents**

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
LSHTM amendment application	n/a	
Information Sheet	V1.4	19/04/2012
Consent form	V1.4	19/04/2012

**After ethical review**

Any further changes to the application must be submitted to the Committee via an E2 amendment form.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Andrew J Hall', written over a horizontal line.

**Professor Andrew J Hall**  
Chair

# slotervaartziekenhuis

Telefoon: 020 - 512 4487

Datum: 30 januari 2012

Nummer: JJ/12.017/P1201

Drs. R.F. Viergever  
Palembangstraat 19 bis  
3531 EE Utrecht

**Medisch Ethische Toetsingscommissie**  
voor het Slotervaartziekenhuis  
en Reade

Secretariaat  
mw. P. Visser

tel. 020 - 512 4487  
e-mail: paula.visser@slz.nl  
2C kamer 12

Betreeft: Positive judgement NL39367.048.12

Dear drs. Viergever,

Hereby I send you the decision of the accredited Medical Research Ethics Committee of the Slotervaart hospital and Reade concerning the research protocol entitled "Service users' and care providers' experiences of post-trafficking shelter and care services for adult victims of cross-border human trafficking to the Netherlands" (national registration number: NL39367.048.12).

The Committee has reviewed the aforementioned research protocol and is of the opinion that this protocol adheres to all relevant sections of the Dutch Medical Research Involving Human Subjects Act (WMO). Therefore, the Committee has decided to approve the aforementioned protocol unconditionally.

Yours sincerely,  
on behalf of the accredited Medical Research Ethics Committee  
of the Slotervaart hospital and Reade

  
Drs. C.T.J. de Koning, chairman

# slotervaartziekenhuis

Telefoon: 020 - 512 4487

Datum: 26 april 2012

Nummer: U/12.050/P1201

Drs. R.F. Viergever  
Palembangstraat 19 bis  
3531 EE Utrecht

**Medisch Ethische Toetsingscommissie**  
voor het Slotervaartziekenhuis  
en Reade

Secretariaat  
m.v. P. Visser

tel. 020 - 512 4487  
e-mail: p.m.v.Visser@slz.nl  
2C kamer 12

Betreeft: **Positief nader oordeel NL39367.048.12, overige wijzigingen**


Geachte heer Viergever,

Hierbij zend ik u het nader besluit van de Medisch Ethische Toetsingscommissie van het Slotervaartziekenhuis en Reade inzake wijzigingen behorend bij het protocol getiteld 'De ervaringen van cliënten en zorgverleners met verleende zorg voor buitenlandse slachtoffers van mensenhandel in Nederland' (NL39367.048.12).

De METC verleent haar goedkeuring aan genoemde wijzigingen. Voor de overwegingen bij het besluit verwijs ik u naar het bijgevoegde oordeel.

Ik hoop u hiermee naar behoren te hebben geïnformeerd.

Hoogachtend,

  
Namens de METC van het Slotervaartziekenhuis en Reade  
Dr. C.T.J. de Kort, voorzitter

cc: CCMO (via ToetsingOnline)