Title: Access to and experiences of healthcare services by trafficked people: findings from a mixed methods study in England

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Abstract:

Background

Trafficked people experience high levels of physical and psychological morbidity, but little is known about trafficked people's experiences of accessing and using healthcare services during or after their trafficking experiences.

Aim

To explore trafficked people's access to and use of healthcare during and after trafficking

Design

Mixed methods study (cross-sectional survey comprising of a structured interview schedule and open-ended questions).

Setting

Trafficked people's accommodation or support service offices in locations across England.

Method

Participants were asked open-ended questions regarding their use of healthcare services during and after trafficking. Interviews were conducted with professionally qualified interpreters where required. Thematic analysis was used to analyse the data.

Results

136 trafficked people participated, 91 (67%) female and 45 (33%) male. Participants reported being trafficked for domestic servitude (n=40; 30%) sexual exploitation (n=41; 31%) and labour exploitation (e.g., agriculture, factor work) 52 (39%). One-fifth (n=26, 19%) reported access to health care services while trafficked, most often general practitioners (GPs) surgeries and walk-in-centres. Many reported that traffickers restricted access to services, accompanied them or interpreted for them during consultations. Requirements to present identity documents to register for care and poor access to interpreters were barriers to care during and after trafficking. Advocacy

and assistance from support workers were critical to health service access for trafficked people.

Conclusions

Trafficked people access health services during and after the time they are exploited, but encounter significant barriers. GPs and other practitioners would benefit from guidance on how trafficked people can be supported to access care, especially where they lack official documentation.

Keywords

Trafficking, access to health services, primary care, immigration status, qualitative, minority populations.

How this fits in

Little is known about trafficked people's access to and use of healthcare services either during or after their trafficking experiences. Findings from interviews with 136 trafficked people in England suggest that a minority of trafficked people are able to access health services – including primary care – while trafficked. Findings also highlight a reliance on support workers to access to and use of healthcare services after escape from exploitation. Key barriers include restrictions from traffickers, poor access to interpreters, and requirements to provide identity documentation to register for care. Wherever possible patients should be seen separately from people accompanying them and provided with independent interpreting services. GPs should consider how to assist those who cannot provide proof of address or identity to access NHS care.

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Introduction

Human trafficking is the recruitment or movement of people, by the use of threat, force, fraud, or the abuse of vulnerability, for exploitation (1). Exploitation includes sexual exploitation, domestic servitude, and forced labour in settings such as agriculture, construction, and factories labour. In 2015, 2,284 adult and 982 child potential victims of trafficking were referred for identification and support in the UK (2), however due to the hidden nature of human trafficking the actual scale of the problem is unknown.

Studies with trafficked people in contact with shelter and other support services in the post-trafficking period have found a high prevalence of physical, sexual, and mental health problems and experiences of physical and sexual violence prior to and during trafficking (3-7). Yet, little is known about trafficked people's experiences of accessing health services or how healthcare professionals meet their needs and scant evidence on their health problems, or access to healthcare while in situations of exploitation.

Reports suggest that trafficked people have difficulty accessing services (8-11). A qualitative study of twelve survivors of human trafficking in the USA, found that fear, shame and language barriers can hinder disclosure and care (12). Studies also show healthcare professionals come into contact with trafficked people, suggesting opportunities for practitioners to identify and provide care. A survey of NHS professionals working in areas where police had detected cases of trafficking, found that 13% of healthcare providers reported contact with a patient they knew or suspected to have been trafficked (13). However, to date, little research has been conducted with trafficked people to learn about their access to or experiences with healthcare services. In this study, we aimed to investigate trafficked people's experiences of accessing and using UK health services

Methods

Study design: Mixed methods study (cross-sectional survey comprising of a structured interview schedule and open-ended questions).

Participant recruitment: We included trafficked people who were aged 14 years and over in contact with voluntary sector services providing specialist support, to formerly

trafficked people (referred to hereafter as post-trafficking support services), healthcare services, or local authority social services in England between June 2013 and December 2014. People were excluded if they were still in the exploitation setting, were too unwell or distressed to participate, or unable to provide informed consent. No restrictions were placed on language, country of origin, type of exploitation, or time since exploitation. Participating organisations approached a convenience sample of potentially eligible service users with information about the study and worked with the research team to schedule interviews. Travel and childcare expenses were reimbursed, and participants were given a £20 shopping voucher to thank them for their time. Further details of recruitment procedures are provided elsewhere (7).

Data collection: Using a topic guide, participants were asked open-ended questions about their experiences of accessing and using health services during the time they were trafficked and after their escape from exploitation. Their responses were digitally recorded with consent and transcribed verbatim. Participants who did not consent to the recording of this part of the interview were asked for consent for the researcher to make handwritten notes. As part of the wider study, respondents were also asked structured survey questions about their socio-demographic characteristics, trafficking experiences, medical history, and current health problems (including physical symptoms, symptoms of depression, anxiety, post-traumatic stress disorder and suicidality), the results are summarised below and reported in full elsewhere (7). Interviews were conducted with professionally qualified and independent interpreters as required (i.e. support workers did not provide interpreter services).

Data analysis: Analysis focused on responses to the open-ended questions at the end of the survey interviews. Transcripts were analysed in NVIVO (10) using thematic analysis (14). The initial coding frame was based on the open-ended questions used during interviews. Analysis involved inductively coding key words and phrases, with codes then grouped into sub-themes and synthesised into meaningful thematic clusters. In line with the major themes emerging from the analysis, we report on trafficked people's ability – or inability – to negotiate access to healthcare services during the time they were being exploited (the "trafficking period") and after escape

(the “post-trafficking period”), the barriers and facilitators of healthcare access and use, and their experiences of care.

In order to maintain participant anonymity, quotes are attributed using gender, type of trafficking, and age-group only. Age-group is defined as 16-25 years and 26 years and older: within the European context participants aged 25 years and younger would be considered to have been trafficked as a young person.

Results: One hundred and sixty trafficked people participated in the research, of whom 136 (85%) responded to the open-ended questions at the end of the survey interview; reasons for not participating in this part of the interview included early termination of the interview due to participant distress, fatigue, or the participant or interpreter needing to attend another appointment. Table 1 presents the key socio-demographic characteristics of the sample, their trafficking experiences, and health problems at interview.

Table 1: Participant characteristics

Participants’ access to and experiences of healthcare services while trafficked and during the post trafficking period

Findings are presented firstly with regards to trafficked people’s access to and use of healthcare services while trafficked, and then with regards to their access to and use of healthcare services during the post-trafficking period. Also described are the types of services that trafficked people accessed while trafficked and after escape. Table 2 summarises the key themes.

Table 2: Key themes regarding trafficked people’s access to and use of healthcare services

Access to health services while trafficked

Approximately one-fifth of participants reported being able to register with local GP services while trafficked; a small number of others attended A&E departments and

walk-in-centres, providing a means of accessing urgent care anonymously, others reported being unable to access care. A minority reported that traffickers prevented them from seeking healthcare, despite having health concerns they wished to have treated: *I thought I needed to see a doctor. …they wouldn't take me* (Female, sex work, 18-25). For some, the first contact with health services was in an emergency: *I was found unconscious in the street when I was heavily pregnant … I was taken to the hospital by ambulance* (Female, domestic servitude, 26+). Others reported self-treatment with their own non-prescription medicines or provided by traffickers.

Those permitted to access healthcare services reported close monitoring; corresponding with participants responses in the structured survey, where 80% of women and 58% of men reported never being able to go out unaccompanied (Table 1). This surveillance meant private consultations were difficult: *I was taken to the GP to register …by my trafficker…I wasn't really comfortable to tell him [GP] stuff* (Female, domestic servitude, 18-25).

Other participants did not seek – or were unable to access - healthcare because they lacked identity documents, language skills, knowledge of local healthcare services, and/or concerns about potential repercussions from traffickers. For some trafficked people, friends and acquaintances were an important means of finding out where healthcare services were located and how to use them. One participant explained, being unable to register with a GP practice because she lacked photographic identification. Access to care was eventually enabled by a friend who knew of another practice that considered proof of address to be sufficient for registration. *I explain to him that I'm pregnant and he took me to a nearby doctor"* (Female, domestic servitude 26+).

Lack of language skills provided traffickers with additional means to control healthcare encounters, often acting as unofficial interpreters: *She (trafficker) spoke for me, I was learning English at the time* (Female, domestic servitude, 18-25). These control mechanisms meant traffickers could conceal abuse: *he told staff that I can't speak any English … he will interpret for me and he told them some story…the doctor asked me directly as well … I didn't want to say it was this person because he was there with me* (Male, car washing, 26+). Participants reported that GPs and other healthcare

professionals did not necessarily try to communicate directly with them, but relied on the person acting as the interpreter. A lack of appropriate interpretation also meant trafficked people were unable to fully understand the information provided to them: *I had no interpreter and so I couldn't understand what happen to me, what happen to my health* (Male, domestic servitude, 18-25).

Access to health services in the post-trafficking period

Participants reported using a range of healthcare services after escaping from exploitation, most commonly primary care, dentistry, sexual health services, maternity services, mental health services, including counselling and psychiatric services and specialists for specific health conditions such as a cardiology and gynaecology. Several were held in immigration detention after escaping exploitation, reporting limited access to healthcare services.

For most participants, access to healthcare in the post-trafficking period depended on having the required documentation for GP registration: *The GP wouldn't register me without any papers from the Home Office* (female, sex work, 18-25). *I was just worried because I have no legal paperwork or anything* (male, cannabis farming, 26+). Support workers (i.e. from post-trafficking support services) played a key role in helping to negotiate with gatekeepers such as GP receptionists and organising the required documentation.

Language difficulties also continued to cause problems: *really my problem is that I can't speak English* (Female, forced marriage, 26+). Among participants in this study, some were not able to speak English, or could not speak it well enough to fully communicate with health care professionals (e.g. 57 (42%) of participants required an interpreter to take part in the research interview). Access to interpretation was crucial to register with services, book appointments, and understand medical tests, physical examinations, and prescriptions. Participants reported that healthcare professionals used telephone interpretation services, and, in some cases, unofficial interpreters such as healthcare staff, medical students, or support workers from post-trafficking services: *She went with me twice and then on a third occasion I had a Polish interpreter*

(Female, domestic servitude, 26+). Some reported that they preferred not to reveal their health problems in front of, or with assistance from support workers.

Experiences of care

Participants noted positive experiences, reporting that they were given sufficient time to talk to their GP and felt that the practitioner listened to them, understood and cared, had medical procedures clarified and regular contact with the same professional: *Once a month she sees me. She will sit for at least half an hour talking to me. She encourages me* (Female, domestic servitude 26+).

However, other participants described healthcare professionals as dismissive or insensitive, reporting that professionals' attitudes towards them changed once informed by support workers that they had experienced trafficking: *I was really worried about how affected I am from abortion and how fertile I am...and then Support Worker told her that I was human trafficking victim and she somehow changed attitude* (female, sex work, 18-25). Others reported that they did not receive sufficient information about medical procedures or test results, experienced delays in finding out results, or did not understand the information provided. One participant, for example, was not told the X-ray results for a suspected broken rib: *it still hasn't been explained by the doctor what happened to me* (male, domestic servitude, 18-25). In another case, a participant described not receiving the results of an ultrasound test for abdominal pain: *when the doctor there finished she told me everything is fine... 'I will send the result to your GP'. And it's more than two months. Nothing came from them* (female, nail salon, 18-25).

Discussion

Findings suggest that – as predicted by the "inverse care law" (15)- despite a high prevalence of physical, mental, and sexual and reproductive health needs among trafficked people, (16) their utilisation of healthcare services is low. Our findings resonate with early work (17) on how vulnerable people and marginalised groups access and interact with healthcare providers, with less access to preventative services and overreliance on emergency services apparent. Trafficked people were

often denied access to healthcare services when trafficked, encountered administrative barriers to access during the post-trafficking period, and lacked the personal resources needed to navigate pathways to healthcare.

Previous research with asylum seekers and other migrant groups highlights language difficulties and requirements to provide identity documents to register for healthcare services can act as barriers to care (18-22). Our findings suggest these barriers are exacerbated for trafficked people because they fear harm from traffickers and experience isolation, control, deprivation, and coercion while trafficked.

Zimmerman *et al.* (23) conceptualise trafficking as a cycle of migration across which health risks and opportunities to intervene accumulate, and highlight that escape from exploitation is not necessarily accompanied by the cessation of health risks or access to healthcare services. As was found in this study, trafficked people may be detained after escaping exploitation (e.g. for immigration or criminal offences). Participants reported inadequate provision of healthcare services while detained and detention being likely to have a deleterious effect on the physical and mental health of trafficked people, compounding experiences of isolation and control. The migration cycle framework also suggests that formerly trafficked people trying to integrate into community settings may struggle with restricted access to services. Many trafficked people participating in this study reported having experienced difficulties registering with GPs, causing treatment delays.

Importantly, once individuals achieved access to care, they reported that services were generally very good, providers being empathic and understanding. Positive and accepting relationships with healthcare providers are known to facilitate disclosure of other forms of abuse, such as domestic violence, and promote engagement with services (24, 25). However, some interviewees reported dismissive encounters, receiving poor explanations about the purpose of the medical tests they underwent and when and how they would receive the results. Giving trafficked people a voice and a sense of personal control is likely to be important for their recovery (24).

Implications for practice

GPs and other healthcare professionals (e.g. midwives, practice nurses) have an important role to play in the identification, referral, and provision of care to trafficked people who come into contact with services either during the time they are trafficked or after their escape (26). Improving trafficked people's access to and experiences of care requires mechanisms for people to access medical treatment even when they are unable to provide proof of identity and legal status. Although many GP practices request proof of identity or address in order to register patients, in England they are not legally required to do so (27). Trafficked people must also be offered opportunities to be seen privately, access professional interpreting services, and clear information, in their own language about the medical tests and treatments they receive. Treating trafficked people often requires extra time because of language limitations a challenge for GPs, who work under time pressures.

Where it is suspected that a person is being trafficked and they are accompanied by someone who speaks on their behalf or is present during the consultation, GPs may wish to try to arrange a next appointment when they can organise independent interpreting. It is not uncommon for trafficked people to be unaware that they are a victim of a crime, or to be reluctant to disclose their experiences to officials; healthcare professionals who are able to talk to their patient alone should seek to gain a better understanding of their situation through sensitive questioning (e.g. "Were you injured while working? Can you tell me about your work and how you were injured?") (26). Healthcare professionals should also familiarise themselves with local support services available for trafficked people and details of national helplines. To improve access to care for trafficked people and other vulnerable migrants, GPs might consider offering walk-in clinics in partnership with other services for people who are awaiting identification documents or who wish to access care anonymously.

Strengths and limitations

To our knowledge, this is the largest study of trafficked people's access to and experiences of healthcare services conducted to date. Participants had been trafficked for a range of reasons and from over thirty countries. The findings are limited to the experiences of trafficked people who were in contact with support services; we are not able to comment on experiences of trafficked people who are not in contact with

services. For ethical and safety reasons, only trafficked people who had escaped exploitation were eligible to participate. Information regarding healthcare experiences while trafficked is therefore retrospective, and recall bias cannot be ruled out.

Conclusions

Although many trafficked people cannot access healthcare while trafficked, a proportion come into contact with providers and could be identified and referred. Controls imposed by traffickers are not the sole reason that trafficked people do not seek services. Insecure immigration status, difficulties providing required documentation, and poor access to appropriate interpreters also inhibit such contact.. To improve access, GP surgeries and other healthcare services should be provided with guidance about how trafficked people may present and how they can be identified, provided with treatment, and safely referred for further support, especially where people lack official documentation. Additionally, trafficked people would benefit from information about how the NHS works, information on documentation for registration, waiting times for appointments, tests they can expect, access to interpreters, and who can accompany them to appointments. As trafficked people may learn about health services through word of mouth, cultural and social focal points and networks should not be neglected when distributing health services information. Most importantly, however, policies and attitudes must shift to ensure that people who have been trafficked gain access to health services that are necessary for their safety and rehabilitation.

Ethics: The study was approved by the National Research Ethics Service Committee South East Coast–Kent.

References

1. United Nations (2000). Optional Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Convention against Transnational Organized Crime, United Nations, NewYork, (2000) Available at

http://untreaty.un.org/English/TreatyEvent2003/Texts/treaty2E.pdfUnited Nations

2.National Crime Agency: National Referral Mechanism Statistics (2015). http://www.nationalcrimeagency.gov.uk/publications/676-national-referral-mechanism-statistics-end-of-year-summary-2015/file

3. Oram S, Stoeckl H, Busza J, et al. .Prevalence and risk of violence and the physical, mental and sexual health problems associated with human trafficking: systematic review. PL o S Medicine. (2012) May 29;9(5). e1001224. Available from: 10.1371/journal.pmed.1001224

4. Abas, M., Ostrovschi, N.V. Prince, M. et al. Risk factors for mental disorders in women survivors of human trafficking: a historical cohort study BMC Psychiatry (2013), 13:204

5. Turner-Moss E, Zimmerman C, Howard L. M, et al. Labour Exploitation and Health: A Case Series of Men and Women Seeking Post-Trafficking Services. J Immigr Minor Health. (2014) 16 (3):473-480

6. Kiss L, Pocock N S, Naisanguansrid, V. et al. Health of men, women, and children in post-trafficking services in Cambodia, Thailand, and Vietnam: an observational cross-sectional study. Lancet Glob Health 3, (3), (2015), e154–e161

7. Oram S, Abas M, Bick D. et al. Human trafficking and health: a Survey of male and female survivors in England. Am J Public Health (2016) 106 (6) 1073-1078

8. Brennan D. Methodological challenges in research with trafficked persons: tales from the field. Int Migr (2005);43(1-2):35-54.

9.Goodey J. Human trafficking: sketchy data and policy responses. Criminol Crim Justice.(2008);8(4):421-42.

10.Laczko F. Data and research on human trafficking. Int Migr. (2005);43(1-2):5-16.

11.Tyldum G. Limitations in research on human trafficking. Int Migr. (2010) 48(5):1-

12. Baldwin S, Eisenman D.P, Sayles J.N, et al. Identification of human trafficking victims in healthcare settings. Health Hum Rights. (2011);14:e36-49.

13. Ross C, Dimitrova S, Howard L.M., et al. A cross-sectional survey of NHS professionals' contact with victims of human trafficking. BMJ Open (2015);5:e008682,

14. Braun V. and Clarke V. Using thematic analysis in psychology. Qual Res Psychol (2006) 3:2 77:101 doi:10.1191/1478088706qp063oa

15.Tudor Hart, J. The Inverse Care Law. The Lancet (1971), 27 : 297, 7696 405:412

16. Ottisova L, Hemmings S, Howard LM, Zimmerman C, Oram S. Prevalence and risk of violence and the mental, physical and sexual health problems associated with human trafficking: an updated systematic review. Epidemiol Psychiatr Sci. (2016) 12;1-25. doi:10.1017/S2045796016000135

17. Dixon-Woods M. Cavers D. Agarwal S. et al. Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups BMC Med Res Methodol (2006) 6:35 doi:10.1186/1471-2288-6-35

18. Campbell, R., Klei, A.G., Hodges, B.D.et al. A Comparison of Health Access Between Permanent Residents, Undocumented Immigrants and Refugee Claimants in Toronto, Canada. J Immigr Minor Health. (2014) 16: 1, 165-176

19. O'Donnell, A., Higgins, M., Chauhan, R., et al. "They think we're OK and we know we're not". A qualitative study of asylum seekers' access, knowledge and views to health care in the UK. BMC Health Serv Res (2007) 7:75. doi:10.1186/1472-6963-7-75

20. Asgary, R., and Segar. N. Barriers to Health Care Access among Refugee Asylum Seekers. J Health Care Poor Underserved (2011) 22 : 2 pp.506-522 http://muse.jhu.edu/journals/journal_of_health_care_for_the_poor_and_underserved/toc/hpu.22.2.html

21. Sinnerbrink, I., Silove, D.M., Manicavasagar, V.L. et al. Asylum seekers: general health status and problems with access to health care. Med J Aust (1996) 165 (11-12):634-637

22. Bhatia, R. and Wallace, P. Experiences of refugees and asylum seekers in general practice: A qualitative study. BMC Fam Pract (2007) 9: Article No. 48

23. Zimmerman C1, Hossain M, Watts C. Human trafficking and health: a conceptual model to inform policy, intervention and research.Soc Sci Med. (2011) 73 2:327-35. doi: 10.1016/j.socscimed.2011.05.028..

24. Feder , G. , Hutson , M. , Ramsay , J. et al. Women exposed to intimate partner violence. Expectations and experiences when they encounter health-care professionals: A meta-analysis of qualitative studies . Ann Intern Med (2006) 166, 22 – 37 .

25. Trvillion, K., Hughes, B., Feder, G., et al. Disclosure of domestic violence in mental health settings. Int Rev Psychiatry (2014) Vol. 26 Issue 4, pp 430-444 http://dx.doi.org/10.3109/09540261.2014.924095

26. Internation Organisation for Migration (2009) Caring for Trafficked Persons: Guidance for Health Providers. http://publications.iom.int/bookstore/free/CT_Handbook.pdf

27. NHS England/Commissioning Operations/Primary Care Commissioning.NHS Patient Registration Standard Operating Principles for Primary Medical Care (General Practice).(2015) https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/11/pat-reg-sop-pmc-gp.pdf

Additional information

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