Migration, Sexual Exploitation, and Women’s Health

A Case Report From a Community Health Center

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An estimated 50,000 women and children are annually trafficked into the United States, resulting in complex health and social consequences and significant risk for violence. This article presents a case of a trafficked woman identified in the U.S. health system and describes the vulnerabilities to forced prostitution as a result of trafficking and the challenges in providing an effective and comprehensive response to meet safety and health care needs. Health care providers are in a unique position to identify and support U.S. sex trafficking victims; thus, education and training for health care professionals on trafficking is needed.

**Keywords:** health care; human trafficking; violence against women

The trafficking of humans is a growing human rights concern both globally and within the United States; although difficult to accurately quantify because of the underground nature of trafficking networks and practices, it is conservatively estimated that between 600,000 and 800,000 people are annually trafficked across international borders, with 80% of these being women and girls (U.S. Department of State, 2005). Human trafficking is defined by the United Nations (UN, 2000) as

the recruitment, transportation, transfer, harboring or receipt of persons by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power, or of a position of vulnerability or of the giving or receiving of

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payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. (p. PLS PROVIDE PAGE NUMBER)

Trafficking for the purposes of sexual exploitation (e.g., forced prostitution and sexual slavery), also known as sex trafficking, is a form of human trafficking affecting hundreds of thousands of women and girls globally each year (U.S. Department of State, 2005). Once considered a more general form of economic and community violence, the UN Special Rapporteur on Violence Against Women has underlined sex trafficking as a critical aspect of human rights violations related to violence against women worldwide (UN, 2000). Sex trafficking poses significant challenges for advocates of women and immigrant health, law enforcement, immigration officials, policy makers, and health care providers, with multiple difficulties with case identification and development of victim-responsive interventions. The purpose of this article is to present a case example of a trafficked woman identified in the U.S. health care system and to explore the vulnerabilities of this woman to forced prostitution in the United States and the challenges encountered in providing an effective response to address her safety and health care needs.

Women and Girls’ Vulnerability for International Trafficking to the United States

Although sex trafficking of women within the United States has long been known, international trafficking of women to the United States has gained greater recognition in recent years, with specific concerns related to contextual and legal vulnerabilities of immigrant women within the United States. An estimated 50,000 women and children are trafficked into the United States across international borders annually, the majority of them from Asia, Latin America, and Central and Eastern Europe (O’Neill Richard, 1999; Raymond, Hughes, & Gomez, 2001). Unlike the sex trafficking industries of Europe and Asia, which have typically more been part of large-scale organized crime, sex traffickers to the United States historically were composed of small criminal groups or gangs. However, more recently, organized crime appears to be securing greater footing within the U.S. sex trafficking industry (O’Neill Richard, 1999; Raymond et al., 2001). Those trafficked to the United States are often young adult women, typically around age 20, although sex trafficking cases of girls in their early teens have been reported (O’Neill Richard, 1999). Multiple factors including war, displacement, economic and social inequalities, and demand for sex work contribute to trafficking of women and girls (Long, 2004; Raymond et al., 2001; Watts & Zimmerman, 2002), with gender-based abuse and violence primary components of women’s vulnerability to traffickers (United States Agency for International Development, 2003). As in many other parts of the world, those trafficked to the United States tend to be the most vulnerable women and girls, coming from poor, often agricultural, families, with less education.
and limited resources (Raymond et al., 2001). Although the levels of organization, the involvement of organized crime and local law enforcement, and the modes for passage across borders vary from country to country, most commonly recruiters seduce young women in their countries of origin with promises of economic or employment opportunities, such as waitressing, acting, working in a factory, or housecleaning (O’Neill Richard, 1999). Thus, many trafficked women may travel of their own volition, but often with limited understanding or knowledge of the actual circumstances awaiting them. On arrival, trafficked women often find themselves in debt bondage, expected to pay their transporters or traffickers for bringing them to the receiving country (O’Neill Richard, 1999; Raymond et al., 2001). In some instances, trafficked girls and women are immediately locked up and forced into prostitution as sex slaves. In other cases, women are expected to pay the traffickers for the falsified documents provided to enter the country; when unable to pay, they may become involved in sex work or be sold into sexual slavery (Miller, 2002; O’Neill Richard, 1999; Watts & Zimmerman, 2002). Although women who have been sex trafficked often want to leave, and many attempt to do so, they are stopped by violence or the threat of violence against them, their families, and their children (O’Neill Richard, 1999; Raymond et al., 2001). Linguistic and social isolation, and fear of immigration officials and the police, further impede their ability to escape sexual servitude (O’Neill Richard, 1999; Raymond et al., 2001). Mechanisms of the U.S. sex industry further reinforce this social isolation, where internal networks keep women moving to different venues across the country; women are constantly moved to keep fresh faces at sex work venues and also to inhibit women’s ability to gain social support within or recognition of an area and to reduce their access to assistance (O’Neill Richard, 1999; Raymond et al., 2001). The lack of basic services available (e.g., health care, substance abuse treatment) is also cited by women as a barrier to their ability to escape their position as sex workers (Farley et al., 2001; Raymond et al., 2001).

The Health Consequences of Sex Trafficking

The health effects of sex trafficking are multifocal, with extensive and profound consequences for psychological and physical health and well-being, effects that appear to be largely attributable to the violence experienced during trafficking and sex work (Zimmerman et al., 2003). A cross-national study of sex-trafficked victims in Europe demonstrates multiple examples of abuse, including direct physical and sexual assault, psychological abuse, forced or coerced use of drugs and alcohol, restrictions on movement and social isolation, economic exploitation and debt bondage, legal insecurity (including undocumented status), abusive working and living conditions, and a range of risks associated with being a migrant and/or marginalized (Zimmerman et al., 2003). Sexual assault, in particular, appears to be universal for victims of sex trafficking, with all participants of this European study reporting some form of rape (e.g., forced oral or anal sex, gang rape, forced unprotected sex) in the context of being
trafficked (Zimmerman et al., 2003). Victims of sex trafficking and immigrant sex workers in the United States similarly report extensive psychological, physical, and sexual violence from traffickers, clients, nonpaying intimate partners, and sometimes police (Church, Henderson, Barnard, & Hart, 2001; Dalla, Xia, & Kennedy, 2003; Dumont & McGregor, 2004; El-Bassel, Witte, Wada, Gilbert, & Wallace, 2001; Farley et al., 2001; Miller & Schwartz, 1995; O’Neill Richard, 1999; Raymond et al., 2001; Romero-Daza, Weeks, & Singer, 2003; Silbert & Pines, 1982; Watts & Zimmerman, 2002). These abuses, combined with the constraints of limited access to health and other social services and diminished economic and social resources, affect these women’s and girls’ mental and physical health well-being (Zimmerman et al., 2003).

Substance abuse and mental health concerns among sex-trafficked women and girls have been well documented in the United States and abroad (Farley et al., 2001; O’Neill Richard, 1999; Raymond et al., 2001; Zimmerman et al., 2003). Although substance abuse and addiction are common concerns for sex-trafficked women (Raymond et al., 2001; Zimmerman et al., 2003), the nexus of substance use and sex work is complex and includes addiction and exchanging sex for drugs. However, in studies with victims of sex trafficking and sex workers, many women report that their substance use began or escalated subsequent to their involvement with sex work, sometimes as a way of coping with and numbing themselves to the violence experienced (El-Bassel et al., 2001; Farley et al., 2001; Raymond et al., 2001; Romero-Daza et al., 2003; Silbert & Pines, 1982). In addition to substance abuse concerns, high rates of posttraumatic stress disorder, depression, and anxiety and suicidal ideation and attempts have also been documented among sex-trafficked women (Zimmerman et al., 2003) and women involved in sex work (Cwikel, Ilan, & Chudakov, 2003; El-Bassel et al., 1997; Farley et al., 2001). As with substance abuse, experiences of violence, including direct violence and threats, intimidation, and emotional manipulation from traffickers and pimps, have been cited as leading to mental health concerns among this population. Notably, much of the research on sex-trafficked women and sex workers is cross-sectional, so it may be the case that women and girls with substance abuse and mental health concerns may be more vulnerable to trafficking and sex work involvement. Alternatively, experiences of trafficking and sex work involvement may increase risk for substance abuse and mental health concerns.

In addition to poor emotional and psychological health reported by trafficked women and sex workers, physical health appears to be poorer in this population as well. In particular, when women have limited access to services and difficulty preventing unprotected sex because of the control and coercion described above, sex work increases risk for sexual health concerns, including sexually transmitted infections (All India Institute of Hygiene and Public Health, 1992; Cohan et al., 2005; Desai et al., 2003; El-Bassel et al., 2001; Weiner, 1996) and HIV (Dandona et al., 2005; Indian Health Organisation, 1996), and reproductive health issues, such as unintended pregnancy and abortion and vaginal pain (Cwikel et al., 2003; Farley et al., 2001; Pal, Raut, & Das, 2003; Ward, Pallecaros, Green, & Day, 2000). Research
with this population to date has disproportionately focused on sexually transmitted diseases to the exclusion of a comprehensive investigation of chronic and acute health risk associated with sex trafficking and sex work (Farley & Kelly, 2000; Raymond et al., 2001). Despite this, a number of other physical health problems, many of which have been linked to gender-based violence (Heise & Ellsberg, 1999), have also been reported by sex-trafficked women and women engaged in sex work. These include fractures, contusions, chronic pain, headaches, pelvic pain, unhealthy weight loss, gastrointestinal difficulties, and oral health problems (Cwikel et al., 2003; Farley et al., 2001; Jeal & Salisbury, 2003; Raymond et al., 2001; Zimmerman et al., 2003) and increased mortality rates (Potterat et al., 2004). These health concerns appear to include acute problems and chronic health concerns that persist years beyond escape from trafficking; disproportionate risk for these acute and chronic health concerns of sex-trafficked women and girls in the United States may represent an important opportunity for health providers to interface with this largely invisible population.

**Background for the Case Report**

Health care settings are often not geared to inquiring about trafficking experiences, and health professionals receive little training on the particular health and social vulnerabilities experienced by new immigrants, in particular those who may be undocumented and may have been trafficked. The following case report describes the story of a patient who sought care at a community health center affiliated with a large teaching hospital.

The community health center is located in Chelsea, a small, diverse community with many new immigrant and refugee families (with more than 60% of the population from Latin America, with at least 10 different countries represented). Chelsea has the lowest per capita income of any city in the commonwealth; Chelsea’s population is just more than 35,000, with a poverty rate of 18% and unemployment rates that are higher than the state average. Many of Chelsea’s immigrant population have fled war and violence, political struggles, and uprisings. Chelsea’s teen birth rate is well more than 3 times the state average. Chelsea has the 5th highest HIV infection rate in the commonwealth, with AIDS and HIV-related deaths 3 times the state rate. One fourth of the Chelsea residents are younger than 18, and 11% of students report that they are involved in gangs. A total of 42% of youth are living below the poverty level. The health center itself houses an extensive community outreach team with multiple innovative community health programs, including a home visitation program for new immigrant mothers of small children, a refugee and new immigrant outreach program, domestic violence advocacy, a teen clinic located in a youth agency, and a violence prevention and intervention program in collaboration with local child protective services and the police.

This particular case raised multiple questions and concerns about trafficking for the providers at the health center (physicians, nurses, social workers, counselors,
domestic violence advocates, and outreach workers) about how to best support this woman and her baby, about safety concerns among health center staff, about culturally and socially appropriate interventions, and about larger concerns about legal advocacy. The case illustrates some of the common health consequences associated with trafficking and the vulnerabilities of women seeking migration to becoming involved in nonvolitional sex and prostitution.

Case Report

A 27-year-old, Spanish-speaking woman, accompanied by her English-speaking sister-in-law, presented to the obstetrics clinic for her first prenatal appointment at 16 weeks. She was losing weight. She reported arriving from Guatemala about 6 months earlier. Several weeks prior to this clinic visit, she had presented to the hospital’s emergency room for pelvic pain and weakness and was found to be 3 months pregnant. During that emergency visit, when notified of the pregnancy, the patient broke down in tears, stating she wanted to kill herself. A psychiatrist evaluated her and hospitalized her for several days. She then began seeing a bilingual counselor once a week and was referred for follow-up care at a local community health center.

A careful history taken by the immigrant health outreach worker at the health center revealed the following narrative. Her husband and three children remained in Guatemala, one child with serious health problems. She left home to find a job, coming to Boston because this is where her brother and sister-in-law lived. She began working as a house cleaner for more than 15 hours a day, making less than $100 a day. She owed more than $10,000 to a group of coyotes who helped her get to the United States, including providing her with falsified documents. Gang members would call her brother’s house, repeatedly threatening injury to her or her children if she failed to pay.

Desperate to pay back these loans, she became involved in a prostitution ring. She believed the primary pimp was the father of her pregnancy. This pimp was involved in trafficking women for prostitution, and when he learned of her pregnancy, he assured her that he would take care of her as long as she moved with him to Baltimore and continued to sell sex on the streets. She reported being unable to tell her brother or sister-in-law, worried about being isolated even more. In fact, she had been trying not to eat (sticking to crackers and water), as she did not want the pregnancy to show. When her brother learned of the pregnancy after the emergency room visit, he insisted she terminate the pregnancy, but she felt she could not as she was too far along. She was diagnosed with chlamydia cervicitis; her HIV test was negative. She continued to have significant sleep disturbances, depressed mood, and suicidal ideation.

The pimp, and presumed father of the baby, had suddenly disappeared at the time she presented to the community health center for her first prenatal visit, and she did not know his whereabouts. Her brother continued to work and borrow money from friends to try to pay off the coyotes, while gang members continued to call the house,
threatening to hurt her family back home. Her brother’s family was planning to sell their home to raise enough money to stop the threats.

**Discussion**

This case illustrates the layered complexities of interpersonal violence and trafficking and the particular heightened vulnerabilities for physical and sexual violence among new immigrant women. Although not a “classic” case of sex trafficking and sexual slavery in that she was not trafficked with the sole purpose of working in the sex industry as a sex slave, the constraints associated with being trafficked and the potential for significant exploitation underscore the ways in which violence against women is intimately connected with a clustering of vulnerabilities associated with poverty, migration experience, and systems of trafficking. Furthermore, this is an illustrative case of trafficking from Latin America. An estimated 100,000 women are trafficked from Latin America each year (International Organization for Migration, 2001), with a substantial proportion (10% or greater) of these coming to the United States (O’Neill Richard, 1999). Those from Latin America, as in this case study, more commonly come to the United States via coyotes—a complex network of individuals who smuggle humans and sometimes drugs to the United States (O’Neill Richard, 1999). The illegal nature of coyote work is intertwined with organized crime, gangs, and trafficking.

**Implications for Identifying and Intervening in Trafficking in the Clinical Setting**

This case demonstrates some of the complexities and realities of interpersonal violence in the context of migration and trafficking. In contrast to the general training health care providers receive on screening for intimate partner violence that focuses on the intimate relationship itself (utilizing more traditional domestic violence paradigms), the health care providers involved in this case confronted multiple and unexpected layers of violence, power, and control. Not only was the pimp’s power and control a critical part of the story, but the woman’s family’s response, the desire to hide the prostitution and pregnancy from her brother and extended family, the fear of the coyotes and the threats to her family in Guatemala, and the geopolitical realities of being an undocumented worker in this country all contributed to novel discussions at the health center about how profound inequities and constraints of poverty shape the experiences of interpersonal violence. This case also underscored for providers that a patient experiencing violence may have multiple community expectations and constraints including financial, social, and familial pressures that prevent the acceptance of safety options. In addition, many discussions ensued about safety in general: how to ensure the safety of this woman and her unborn baby, the
safety of her family (both in Boston and Guatemala), and the safety of the providers involved in her care. Providers sought to establish protocols within the health center for identifying trafficking among patients and calling on security to provide some safety measures for patients when receiving care at the health center.

**Medical and Psychological Consequences of Trafficking**

The case illustrates some of the common physical, sexual, and mental health problems associated with trafficking. She experienced weight loss, anorexia, unintended pregnancy, sexually transmitted infection, depression, anxiety, and suicidality. The health effects of trafficking, described in the background, significantly overlap with the health risks experienced by migrant women in general, survivors of interpersonal violence and sexual assault, and sex workers. Migrant women workers may experience a range of vulnerabilities that contribute to poor health, specifically associated with being a migrant. Linguistic barriers and cultural expectations, limited education, low literacy and limited health literacy, lack of knowledge about symptoms (including mental and reproductive health), lack of financial resources, uninsured or underinsured status, and social isolation all contribute to limited access to care, care seeking, and poor adherence to medical care (Betancourt, 2003; Carrillo, Green, & Betancourt, 1999; Green, Betancourt, & Carrillo, 2002; Liebschutz, Frayne, & Saxon, 2003; Smedley, Stith, & Nelson, 2003). Fear associated with being an undocumented migrant adds to the potential for others (e.g., traffickers, employers, and intimate partners) to exert power and control, with the constant threat of being turned over to the authorities (Liebschutz et al., 2003). Undocumented status also prevents people from seeking care even when they recognize the need based on fear of inability to pay, being turned over to the authorities, and being tracked by abusers from whom they may be trying to escape (Dutton, Orloff, & Hass, 2000; Raj & Silverman, 2002).

Added to the experience of being an undocumented migrant are the complexities associated with gender inequality in education and work trajectories, the gendered dimensions of trafficking (where more girls and women are caught in webs of sexual exploitation), and the limited work options available to women constrained by limited resources. As discussed above, enslavement in the sex industry may be the direct goal of some trafficking networks, whereas other migrant workers may be coerced into sex work as part of paying back their debts to their traffickers (as in this case), and others may find that sex work is one of the few options available to them as undocumented workers. The physical, sexual, and mental health problems associated with sex work outlined in the background are further complicated by limited access to and knowledge of health care services, stigma of sex work (Rushing, Watts, & Rushing, 2005; Weiner, 1996), and lack of control over health care seeking because of pimp or brothel involvement (Cwikel et al., 2003), often the case for sex-trade involved and trafficked women. In addition, pimp control of sex work may confer additional complexities as it increases vulnerability to violence (Norton-Hawk, 2004) and a level of
control so great that physical protection from pimps is required to safely escape sex work (Farley et al., 2001). It is critical to underscore that sex work has multiple manifestations and encompasses a range of financial and social relationships that constrain social agency depending on the resources and options available to sex workers in any particular setting. Trafficked women engaging in sex work tend to have far fewer resources, limited options, and increased vulnerability to violence and abuse compared to women who have not been trafficked. These vulnerabilities are evident from even before they leave their countries of origin where poverty, limited education, and lack of viable options for work and survival may lead them into trafficking networks, all contributing to heightened experiences of control and isolation and severe forms of physical, emotional, and sexual abuse (Zimmerman et al., 2003).

**Challenges for a Health Care System Response**

This particular case raised many questions and concerns among health center staff. Many providers at this health center have been intimately involved in community health outreach, care for the underserved, violence prevention and intervention programs, and refugee health assessments, yet this story of trafficking, sex work, and the related physical and mental health consequences presented new challenges on multiple levels. Particularly notable was that this woman actually sought care, found a way to access health and social service resources, and ultimately was able to maintain the support of her extended family. Even with this degree of resilience, staff faced the realities of how to protect this undocumented woman from the potential reappearance of the pimp and ongoing threats from the coyotes. Staff wondered how many other women in this small community had experienced trafficking and similar health consequences, perhaps with even fewer social supports, and had not come to the attention of health care providers as survivors of trafficking experiences.

Zimmerman et al.’s (2003) summary of the health consequences of trafficking calls for health care providers who care for immigrant women to incorporate training on the realities and health consequences of trafficking and share this knowledge with other relevant care providers such as policy makers, educators, public health workers, law enforcement, and agencies involved in providing services for new immigrants. Developing client-responsive, culturally appropriate, and sensitive screening strategies for health care providers to identify interpersonal violence and trafficking experiences remains an important role for existing programs focused on violence against women, such as hospital- or clinic-based sexual assault and domestic violence advocacy programs.

In outlining a comprehensive strategy to address the needs of women affected by trafficking, Zimmerman et al. (2003) identified five challenges to service provision: meeting women’s multidimensional service needs, providing access for women in safe and appropriate ways, addressing language and cultural barriers, gaining trust and offering support, and developing strategies for addressing the lack of security and
frequent mobility for many of these women. Although trafficking is clearly a health issue with multiple profound consequences for women’s health and well-being, simply medicalizing this form of violence against women runs the risk of focusing on treating individual survivors and shifting the lens away from the gross global inequities, human rights violations, and systems that penalize victims of trafficking as “undocumented aliens.” In summary, addressing trafficking as a health issue will require a multimodal response, including advocacy for trafficked people’s rights that includes provision of holistic health care, legal assistance, and social services.

A critically important legacy of domestic violence advocacy within the health care system has been emphasizing the importance of creating safe spaces for patients experiencing interpersonal violence, of screening for violence with thoughtfulness and respect, and of reinforcing a link to resources and safety options. As trafficking is increasingly recognized as a health concern, clinical providers will need to embrace their role in extending safe spaces to new immigrant women who may have been trafficked while enlisting the support of community outreach workers, legal advocates, domestic violence and child protection advocates, resettlement agencies, and other community partners to ensure meaningful and safe case identification and potential interventions.

References


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