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Access to, and experiences of, healthcare services by trafficked people:

findings from a mixed-methods study in England

Abstract

Background
Physical and psychological morbidity is high in trafficked people but little is known about their experiences of accessing and using healthcare services while, or after, being trafficked.

Aim
To explore trafficked people's access to, and use of, health care during and after trafficking.

Design and setting
A mixed-methods study — a cross-sectional survey comprising a structured interview schedule and open-ended questions — was undertaken in trafficked people's accommodation or support service offices 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
In total, 136 trafficked people (from 160 contacted) participated in the open-ended interviews of whom 91 (67%) were female and 45 (33%) male. Participants reported being trafficked for domestic servitude ($n = 40$; 29%), sexual exploitation ($n = 41$; 30%), and labour exploitation (for example, agriculture or factory work) ($n = 52$; 38%). Many responders reported that traffickers restricted access to services, accompanied them, or interpreted for them during consultations. Requirements to present identity documents to register for care, along with 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 people who have been trafficked.

Conclusion
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 these people can be supported to access care, especially if they lack official documentation.

Keywords
health services accessibility; immigration; minority groups; primary health care; qualitative; trafficking in human beings.

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 sectors such as agriculture, construction, and factories. In 2015, 2284 adult and 982 child potential victims of trafficking were referred for identification and support in the UK;[2] due to the hidden nature of human trafficking, however, the actual scale of the problem is unknown.

Studies with trafficked people who are in contact with Shelter — the housing and homelessness charity — and other support services in the post-trafficking period have found a high prevalence of physical, sexual, and mental health problems, as well as experiences of physical and sexual violence prior to, and during, trafficking.[3–7] However, little is known about trafficked people's experiences of accessing healthcare services or how health professionals meet their needs; in addition, there is scant evidence about their health problems or access to health care while in situations of exploitation.

Reports suggest that trafficked people have difficulty accessing services.[4,8–10] A qualitative study of 12 survivors of human trafficking in the US found that fear, shame, and language barriers can hinder disclosure and care.[11] The fact that studies have shown, however, that health professionals do come into contact with trafficked people suggests there are 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 having contact with a patient they knew to be, or suspected to have been, trafficked.[12] However, to date, little research has been conducted with trafficked people to learn about their access to, or experiences with, healthcare services. This study aimed to investigate these people's experiences of accessing and using English health services.

METHOD

Study design

This study used a mixed-methods approach: a cross-sectional survey comprising a structured interview schedule and open-ended questions was undertaken.

Participant recruitment

A two-stage recruitment strategy was employed. In the first stage, 19 voluntary-sector organisations, 10 healthcare organisations, and 15 social services departments were approached to recruit participants. In the second stage,

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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. Results from this study suggest that a minority of trafficked people are able to access health services, including primary care, while being trafficked. Findings also highlight a reliance on support workers to access and use healthcare services after escape from exploitation. Key barriers faced include restrictions from traffickers, poor access to interpreters, and requirements to provide identity documentation to register for care (although this is not strictly a legal requirement). Wherever possible, patients should be seen separately from those accompanying them and provided with independent interpreting services. GPs should consider how to assist those unable to provide proof of address or identity to access NHS care and have a coordinated system in place in GP practices to assist people in this situation.

organisations taking part approached a convenience sample of potential participants, provided basic study information, and worked with the study team to schedule research interviews. Participants of this study comprised trafficked people who were:

- aged ≥14 years; and
- 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 from the study if they were:

- still in the exploitation setting (exclusion was for ethical and safety reasons);
- 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. Potential participants were provided with an information sheet about the study in English or in their first language by workers in the organisation. Consent was discussed and agreed in writing at the start of the interview and provided in the participants' first language, and, where requested, interpreters assisted participants with understanding the consent forms. In total, 160 agreed to participate. 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

As part of the wider study, responders were asked structured survey questions about their:

- sociodemographic characteristics;
- trafficking experiences;
- medical history; and
- current health problems (including physical symptoms, symptoms of depression, anxiety, post-traumatic stress disorder, and suicidality).

A topic guide was used. This comprised the themes and lengths of the interviews. Themes were: access to and experiences of using health services during and after the trafficking period, including medical care received; being asked about trafficking by a health professional; being denied health care; and knowing how to access health care. The interviews lasted between 60–90 minutes). Participants were then 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. With their consent, their responses were digitally recorded and transcribed verbatim. Participants who did not consent to the recording of this part of the interview were asked to consent to the researcher making handwritten notes. Those responders not included declined to respond to the open-ended questions for several reasons: time pressures of the interviewee or the interpreter, and interviewee distress or fatigue.

Interviews were conducted with professionally qualified and independent interpreters as required; that is, the 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 with NVivo (version 10) using thematic analysis, in line with guidance from Braun and Clarke.[13] The initial coding frame was based on the open-ended questions

used during interviews. Analysis involved inductively coding keywords and phrases, then grouping them into sub-themes and synthesising them into meaningful thematic clusters.

Within the European context, participants aged ≤25 years would be considered to have been trafficked as a young person so responders were categorised as:

- 16–25 years; and
- ≥26 years.

RESULTS

Participants had been trafficked for a variety of reasons and from more than 30 countries. In total, 160 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 terminating the interview before completing the open-ended section included:

- participant distress;
- fatigue; or
- the participant or interpreter needing to attend another appointment.

Table 1 presents key sociodemographic characteristics of the sample, their trafficking experiences, and health problems at interview.

In line with the main emerging themes, findings were grouped as follows:

- trafficked people's ability (or inability) to negotiate access to healthcare services:
  - during the time they were being exploited ('trafficking period'); and
  - after escape ('post-trafficking period');
- the barriers to and facilitators of healthcare access and use; and
- experiences of care.

In order to maintain participant anonymity, quotations have been attributed using sex, exploitation type, and age group only.

Access to healthcare services during trafficking

One-fifth (*n* = 26, 19%) of the participants reported having access to healthcare services while being trafficked, most often via GP surgeries and walk-in centres. Box 1 summarises the key themes identified regarding access to, and experiences of, healthcare services during and after trafficking.

Almost one-fifth (*n* = 26, 19%) reported having access to healthcare services while being trafficked, most often via GP surgeries. A small number of others attended accident and emergency 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 health care, despite having health concerns they wished to have treated:

'*I thought I needed to see a doctor … they wouldn't take me.*' (Female, sexual exploitation, 18–25 years)

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 years)

Others reported self-treatment with their own non-prescription medicines or medication provided by traffickers.

Those permitted to access healthcare

Table 1. Participants' characteristics

	Women (*n* = 91)	Men (*n* = 45)
Country of origin, *n* (%)		
Albania	13 (14)	1 (2)
Nigeria	27 (30)	0 (0)
Poland	4 (4)	17 (38)
Other	47 (52)	27 (60)
Mean age, years (SD)	30 (9.1)	37 (11.7)
Age group, *n* (%)		
16–25 years	33 (36)	10 (22)
≥26 years	49 (54)	35 (78)
Unknown	9 (10)	–
Type of exploitation, *n* (%)		
Sexual	40 (44)	1 (2)
Domestic servitude	35 (38)	5 (11)
Labour exploitation	14 (15)	38 (84)
Median duration of exploitation, months (IQR)	12 (5–48)	4 (1–12)
Allowed to go out unaccompanied while trafficked, *n* (%)		
Always/often	8 (9)	14 (30)
Occasionally	10 (11)	5 (12)
Never	73 (80)	26 (58)
Median time since exploitation, months (IQR)	15 (3–43)	3 (1–6)
≥1 chronic health problem(s) at interview, *n* (%)	44 (48)	18 (40)
Physical health symptoms at interview, *n* (%)		
Headache	54 (59)	22 (49)
Fatigue	49 (54)	8 (18)
Memory problems	33 (36)	4 (9)
High levels of psychological symptoms in 2 weeks before interview, *n* (%)	74 (81)	19 (42)
Suicidal ideation in week before interview, *n* (%)	45 (49)	5 (11)

IQR = interquartile range. SD = standard deviation.

Box 1. Key themes regarding trafficked people's access to and use of healthcare services

Barriers to care	Experiences of care during and post-trafficking
During trafficking	• Being believed
• Controls imposed by traffickers	• Being accepted versus being judged
• Fear of repercussions	• Being provided with information
• Language problems	• Receiving continuity of care
• Lack of identity documents	• A lack of information
	• Delays in accessing health care
	• Not understanding information
During the post-trafficking period	
• Language problems	
• Lack of identification documents	
• Lack of familiarity with the system	

services reported close monitoring; this corresponded with participants' responses in the structured survey, in which 80% of women and 58% of men reported never being able to go out unaccompanied (Table 1). This surveillance meant private consultations were difficult or almost impossible:

'*I was taken to the GP to register … by my trafficker … he was there with me … I wasn't really comfortable to tell him* [GP] *stuff.*' (Female, domestic servitude, 18–25 years)

Other participants did not seek, or were unable to access, health care because they:

- lacked the necessary identity documents;
- lacked sufficient English-language skills;
- had no knowledge of local healthcare services; and/or
- had concerns about potential repercussions from traffickers, police, and/or immigration.

For some, friends and acquaintances were an important means of finding out where healthcare services were located and how to use them:

'*I explain to him* [friend/acquaintance] *that I'm pregnant and he took me to a nearby doctor.*' (Female, domestic servitude, ≥26 years)

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.

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 years)

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, labour exploitation — car washing, ≥26 years)

Participants reported that GPs and other health 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 years)

Access to healthcare services post-trafficking

Participants reported using a range of healthcare services after escaping from exploitation. Most commonly, these were:

- primary care;
- dentistry;
- sexual health services;
- maternity services;
- mental health services, including counselling and psychiatric services; and
- specialists for specific health conditions, such as cardiology and gynaecology.

Several participants were held in immigration detention after escaping exploitation and reported having limited access to healthcare services at that time.

For most participants, access to health care 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, sexual exploitation, 18–25 years)

'I was just worried because I have no legal paperwork or anything.' (Male, labour exploitation — cannabis farming, ≥26 years)

Support workers from post-trafficking support services played a key role in helping to negotiate with gatekeepers such as GP receptionists and organising the required documentation, but language difficulties continued to cause problems:

'... really my problem is that I can't speak English.' (Female, sexual exploitation, ≥26 years)

Among participants in this study, some were not able to speak English or to speak it fluently enough to communicate fully with health professionals; as an example, 57 (42%) of the 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 health 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 (the support worker) *went with me twice and then on a third occasion I had a Polish interpreter.'* (Female, domestic servitude, ≥26 years)

However, 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 mainly positive experiences, reporting that they:

- were given sufficient time to talk to their GP;
- felt that the practitioner listened to them, understood, and cared;
- had medical procedures clarified; and
- had regular contact with the same professional.

As one responder explained:

'Once a month she [health practitioner] *sees me. She will sit for at least half an hour talking to me. She encourages me.'* (Female, domestic servitude, ≥26 years)

However, other participants described health professionals as dismissive or insensitive, reporting that professionals' attitudes towards them changed once they were informed by support workers that the patient 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, sexual exploitation, 18–25 years)

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 years)

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 2 months. Nothing came from them.' (Female, labour exploitation — nail salon, 18–25 years)

DISCUSSION

Summary

This study indicated that trafficked people were unable to access healthcare services when they needed to for a variety of reasons. They 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 health care. They also feared harm from traffickers and experienced isolation, control, deprivation, and coercion while trafficked.

Responders showed that trafficked people may be detained after escaping exploitation (for example, for immigration or criminal offences) and reported inadequate provision of healthcare services during detention. For that reason, it appeared that detention was likely to have a deleterious effect on their physical and mental health, compounding experiences of isolation and

control. Many participants also reported having experienced difficulties registering with GPs, which caused treatment delays.

Once individuals achieved access to care, experiences were varied: some reported that services were generally very good, with practitioners being empathic and understanding, but others reported dismissive encounters, saying they received poor explanations about the purpose of the medical tests they underwent, and when and how they would receive the results.

Strengths and limitations

To the authors' knowledge, this is the largest study of trafficked people's access to, and experiences of, healthcare services conducted to date in a high-income country. Participants had been trafficked for a variety of reasons and from more than 30 countries.

However, the findings are limited to the experiences of trafficked people who were in contact with support services and it is not possible to comment on the experiences of trafficked people who are not in contact with these. In addition, as participants could not include people in the process of being trafficked, information regarding healthcare experiences is retrospective and, as such, recall bias cannot be ruled out.

Comparison with existing literature

Taken together the findings from the qualitative and quantitative data suggest that, in line with the inverse care law,[14] and despite a high prevalence of physical, mental, and sexual and reproductive health needs among trafficked people,[15] the utilisation of healthcare services in this group is low. In addition, the findings resonate with early work on how vulnerable people and marginalised groups access and interact with healthcare providers,[16] with less access to preventive services and reliance on emergency or walk-in services being apparent.

Previous research with asylum seekers and other migrant groups highlights that language difficulties and requirements to provide identity documents to register for healthcare services can act as barriers to care.[17–21] The findings of the study presented here support this and indicate that these barriers may be exacerbated for trafficked people because they fear harm from traffickers and experience isolation, control, deprivation, and coercion while trafficked.

Zimmerman and colleagues[22] conceptualised trafficking as a cycle of migration, across which health risks and opportunities to intervene accumulate; they highlighted that escape from exploitation is not necessarily accompanied by the cessation of health risks or access to healthcare services: again, these are points that were supported by the findings of the study presented here. The migration cycle framework also suggests that formerly trafficked people trying to integrate into community settings may struggle with restricted access to services; participants in the study presented here reported having such difficulties.

Implications for practice

GPs and other health professionals (for example, midwives and 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.[23] Improving these people's access and experiences of care requires mechanisms for them to be able 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 to register patients, in England they are not legally required to do so.[24] Therefore, practices could consider joining up their registration policies so as to encourage registration.

Trafficked people must also be offered opportunities to:

- be seen privately;
- access professional interpreting services; and
- be given 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, which can prove a challenge for GPs, who work under time pressures. Monitoring the availability and uptake of translation and interpretation services, and setting aside additional time when these services are requested by patients, is a constructive way to address the situation. When it is suspected that a person may be trafficked and they are accompanied by someone who speaks on their behalf or is present during the consultation, GPs may wish to try to book another appointment for when an independent interpreter can be arranged.

It is not uncommon for trafficked people to be unaware that they are victims of a crime or to be reluctant to disclose their experiences to officials, so health professionals who are able to talk to their patient alone should seek to gain a better

understanding of their situation through sensitive questioning (for example, *'Were you injured while working? Can you tell me about your work and how you were injured?'*).[23] Health professionals should also familiarise themselves with the local support services that are available for trafficked people and hold details of national helplines. Positive and accepting relationships with healthcare providers are known to facilitate disclosure of other forms of abuse, such as domestic violence, and to promote engagement with services.[25,26] In addition, giving these people a voice and a sense of personal control is likely to be important for their recovery.[25]

To improve access to care for trafficked people and other vulnerable migrants, GPs may consider offering walk-in clinics in partnership with other services for those who are awaiting identification documents or who wish to access care anonymously.

Although many people cannot access health care while being trafficked, a small proportion come into contact with providers and could be identified and referred. Controls imposed by traffickers are not the sole reason that these people do not seek services: insecure immigration status, difficulties providing the 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 on how trafficked people may:

- present;
- be identified;
- be provided with treatment; and
- be safely referred for further support, especially if official documentation is lacking.

In addition, these people would benefit from information on:

- how the NHS works;
- documentation necessary 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 information on health services. Most importantly, however, policies and attitudes must shift to ensure that people who have been trafficked gain access to the health services that are necessary for their safety and rehabilitation.

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Competing interests

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