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SEX TRAFFICKING AND HEALTH CARE IN METRO MANILA: IDENTIFYING SOCIAL DETERMINANTS TO INFORM AN EFFECTIVE HEALTH SYSTEM RESPONSE

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ABSTRACT

This social science case study examines the sex trafficking of women and girls in Metro Manila through a public health lens. Through key informant interviews with 51 health care and anti-trafficking stakeholders in Metro Manila, this study reports on observations about sex trafficking in Metro Manila that provide insight into understanding of risk factors for sex trafficking at multiple levels of the social environment: individual (for example, childhood abuse), socio-cultural (for example, gender inequality and a "culture of migration"), and macro (for example, profound poverty caused, inter alia*, by environmental degradation disrupting traditional forms of labor). It describes how local health systems currently assist sex-trafficking victims, and provides a series of recommendations, ranging from prevention to policy, for how health care might play a larger role in promoting the health and human rights of this vulnerable population.*

INTRODUCTION

Trafficking of women and girls for the purposes of commercial sexual exploitation is a major human rights concern.[1] According to the International Labour Organization, at least 1.39 million people are victims of sex trafficking.[2] The United Nations' definition of sex trafficking, as outlined in its Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children, describes the "exploitation of the prostitution of others or other forms of sexual exploitation" by the use of force, fraud, and/or coercion.[3] Sex trafficking victims have been linked to a wide range of negative health consequences and, coupled with the large scale of the problem, represent a serious global health and human rights concern.[4]

The potential role of local health systems in addressing sex trafficking in affected areas requires elucidation. For example, providing health services to victims represents one obvious role for local health systems, but what more can health systems potentially contribute to the movement to eradicate sex trafficking altogether? To address this question, we completed in-depth, theory-driven case studies of eight major cities in five countries. The aims of our study were to examine the local contexts within which sex trafficking of women and girls takes place, identify salient trafficking determinants in these cities, describe current local efforts to combat trafficking, and propose opportunities for local health system engagement in future anti-trafficking work.[5] Our approach to studying sex trafficking mirrors the expansive, "holistic" approach of the World Health Organization (WHO) Commission on Social Determinants of Health.[6] In other words, we sought to identify

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underlying social factors — at multiple levels — that facilitate trafficking. This article focuses on our case study of Manila, Philippines.

In 2009, the Philippines was downgraded by the US State Department to a "Tier 2 Watch-List country," with Metro Manila being a major source, destination, and transit area for girls and women.[7] It is considered by UNICEF to have one of the world's worst child trafficking problems.[8] Accurate prevalence figures on sex trafficking are extremely challenging to generate due to the underground nature of human trafficking, but child trafficking estimates for the country hover around 100,000 annually.[9]

The present examination of sex trafficking in Manila is guided by the notion that sex trafficking is a serious and widespread violation of human rights in the Philippines. Analyzing the problem through a public health lens allows us to offer health system interventions that address trafficking at multiple levels of the problem and to inform subsequent human rights analyses of the issue.[10]

METHODS

Key informant interviews provided the primary data for this study. A list of potential key informants in Metro Manila was generated by contacting local service providers, doctors, social scientists, and anti-trafficking advocates, who subsequently referred us to additional individuals knowledgeable about sex trafficking and/or health care.[11] Fieldwork took place over a two-week period in June 2009 until theoretical saturation of our study questions was reached. All study protocol received approval by the Institutional Review Board of Partners Healthcare (Boston). Verbal consent was obtained by study subjects prior to the commencement of interviews. Audio-recorded interviews lasted between 45 and 90 minutes in length.

Fieldwork in Metro Manila and surrounding communities yielded a total of 24 individual and group interviews with 51 key informants, ranging from physicians, lawyers, and government officials to social service providers and anti-trafficking advocates at international and community-based nongovernmental organizations.[12]

RESULTS

Characterization of sex trafficking in Metro Manila: How trafficking occurs

Collectively, our interview respondents reported that the mechanism by which girls enter sex trafficking in Metro Manila often involves elements of force, deception, economic desperation, and psychological manipulation. Trafficked girls often do not realize they are entering prostitution and are deceived by promises of jobs (for example, domestic help or restaurant work). The literature on trafficking in the Philippines corroborates this finding.[13] The literature also describes how children may be trafficked at first for forced labor but are later transferred or sold into commercial sexual exploitation.[14] The major-

ity of girls and women were thought by respondents to be trafficked as minors.[15] Girls trafficked to Metro Manila were reported to come from rural regions of the Philippines, including Samar, Cebu, and Mindanao, as well as several areas within Visayas. Metro Manila reportedly serves both as a source and a transit area from which girls are sent to Japan and Singapore. Several respondents in Metro Manila also reported treating "rescued" girls and young women who had been trafficked through the province of Mindanao, to Malaysia, although it was unclear how many of these girls had originated from Manila.[16]

Two respondents characterized Metro Manila as a transit area where girls receive "training" before becoming dancers or entertainers elsewhere. As one anti-trafficking advocate noted, "They get recruited in the rural areas and then train in Manila. And once they [have completed] training preparation, they are ready for international exposure."

Traffickers who lure girls from their home communities often were described as "middle men," "headhunters," "canvassers," or "recruiters." Some traffickers were thought to operate via large networks while others described traffickers as solo operators that recruited and transported two or three girls at a time. Victims are frequently moved through seaports or international airports, passing through security checkpoints with forged or stolen birth certificates or ostensibly legal documents.

One NGO respondent who works to identify and intercept trafficking victims in transit areas described features of a typical trafficking case in a port area:

> [Y]ou could detect a group of very young women . . . the average age of those that are being trafficked . . . is from 12 to 23 years old. If you look at that age range and you see a group of women emerging, it should already raise a red flag to start thinking about it. [The] [s]econd thing that you need to look [for] is that there is always some kind of a mother hen who holds all of the documents; she has the tickets; she has the personal documents . . . [T]hird these young women are usually constrained in their movements. Once inside the ship, they are not allowed to talk to any other passengers, they are not allowed to talk with the crew, even the crew of the boat, and if you ask them where they are going, some of them have no idea, most of them really have no idea what will be their jobs.

Upon arrival in Metro Manila, girls are promptly sold to a brothel, bar, or "casa." In particular, casas and brothels were reportedly the most hidden, restrictive, and heavily guarded destinations for sex-trafficking victims.

Upon rescue, the reintegration process in the Philippines was characterized as being, as one policy advocate described, "quite questionable." However, the lack of established systems and services to integrate trafficking victims back into their communities of origin was perceived to create conditions that could lead to re-trafficking. "She might just be re-victimized again, or worse, encourage other children to be," reflected one social worker.

Sex trafficking: Key determinants

Our interviews paint a complex picture of sex trafficking determinants in Metro Manila.[17] Respondents described a wide range of individual, familial, cultural, and societal-level factors that affect a girl's vulnerability to trafficking and exploitation.

Individual-level determinants: Many respondents identified a girl's prior history of sexual abuse as a major risk factor for sex trafficking. Abuse reportedly occurs by a family member or someone close to the family. One doctor who treats victims of child abuse said, "I always say, especially if you have a history of abuse at home, you know, you're thinking 'anything else would be better. It cannot be worse than this.'"

Other trafficking determinants include neglect, emotional abuse, physical abuse, and poor self esteem. Also cited as a determinant was being a prior victim of trafficking, as well as being at a critical stage of socio-emotional development. As one respondent who treats trafficking victims described, a vulnerable girl has "a brain of [a] teenager that's not yet fully developed and is mainly emotion-based," which heightens her vulnerability to peer pressure.

Familial/Cultural-level determinants: A girl being raised in a large and/or dysfunctional family was identified as a risk factor for sex trafficking. Parents of trafficked

girls may be uneducated, work far from the city, have psychiatric problems, or have a history of prostitution themselves. Some families were also characterized by respondents as playing a complicit role in trafficking by pressuring their daughters, nieces, or neighbors to seek work in Metro Manila in order to support the family. Two respondents noted how family members may literally force girls to go with a local recruiter or trafficker. In return, family members reportedly receive cash advances and other gifts from traffickers and recruiters.

Several respondents described impoverished families in remote rural areas as operating in "survival mode." As one doctor reflected, "So there are girls who say 'What's wrong with that [prostitution] if we can fill up our stomachs?'" One NGO respondent described how such dire circumstances open the door to traffickers:

> [T]he very force of poverty and lack of choices [means] you don't even have to whip them; you don't even have to tie them down in the brothels so that they'll keep coming back to you. Because they will, because they don't have anything to go back to.

A "culture of migration" was reported to exist among families and communities in the Philippines. Particularly in source areas, cultural pressure for girls to support the family by moving to urban areas (or overseas for work) was perceived to lead to victimization.

Families in rural areas may also lack knowledge or awareness about the realities of sex trafficking in their communities. Lack of access to education was cited as a factor that leads to girls being trafficked. School fees are often prohibitive, and educational and financial resources are disproportionately allocated to boys.[18] Furthermore, a social worker who treats victims in a residential facility reported observing an influx of trafficking cases during the summer months when children are out of school, noting, "It's vacation time, so children have nothing to do. They are very easy to encourage."

Societal-level determinants: Consistent with recent trafficking literature, poverty and economic desperation in rural areas were cited by respondents as major risk factors for trafficking.[19] Economic circumstances in some areas were believed to be so dire that families would give up a daughter in order to survive. "The people, the families in the rural areas are just wanting to survive, and out of desperate measures, lend their young," noted one policy advocate.

Maintaining a sustainable livelihood through traditional forms of labor (for example, agriculture or fishing) was believed to be increasingly difficult, due to environmental degradation leading to decreased crop yields and declining fish harvests. In addition, recent agricultural policies and practices reportedly contribute to forced displacement and subsequent migration to urban centers. "We're having difficulties with so much pesticides dumped, you know, in the farms. The yield for each hectare of land is now reduced because they have destroyed the . . . fertility of the soil," noted one respondent. Mountainous regions of the Philippines are vulnerable to typhoons and landslides, increasing the likelihood of migration of people to urban areas to pursue viable livelihood options. As one social worker noted,

> A lot of them are from Samar province or that region, and it's because that region is very poor, very low, almost no infrastructure development in that region. It's typhoon-stricken, educational levels are low, the dropout rates, the school participation rates are low, and even the irrigation levels are low.

An increased likelihood for re-trafficking occurs when rescued girls are returned to their home villages, only to discover that extreme poverty remains. One respondent who works with an NGO remarked:

> My fear is that once they go back into their hometown . . . the whole situation that pushed her into that situation, into the trafficking scenario in the first place, is . . . [still] present [in] their hometown. You could imagine waking up early and seeing nothing has changed from when you left three or four years ago. It's kind of depressing and sometimes it even deteriorates the situation.

Another major theme of our interviews was the corruption, complicity, and denial of the extent of sex trafficking by local government officials, which

allows sex trafficking in Metro Manila to persist.[20] In the words of a policy advocate we interviewed,

> [I]f only we could get local governments to sign up and agree that they have to fix the problem [of sex trafficking], encourage local governors, mayors, whoever, just to be less corrupt, skim off a little less money off each thing, let some more money trickle through these places, you could actually make some incremental improvements in all sorts of governance or social issues.

Finally, the high demand for young girls in Metro Manila was described as an important trafficking determinant. Two respondents, who provide treatment for trafficking victims, observed that many customers are foreign businessmen, some of whom seek out virgins. Demand for virgins is reportedly so high that, when girls are first brought to Metro Manila, they are taken to a private doctor to verify their virginity. Regardless of the results of the "inspection," traffickers increase their profit by tricking customers into believing they are receiving the "services" of a virgin.

EXISTING RESPONSES TO SEX TRAFFICKING IN METRO MANILA

Health consequences

Victims of sex trafficking reportedly suffer from a number of health-related problems. Unwanted pregnancies and subsequent medical complications resulting from forced and often unsafe abortions were described by a number of respondents.[21] Physical and sexual abuse of trafficked girls was also reported in our interviews. As a senior government official noted, "Some would not be fed, some would be raped, and some would be asked to work from dawn until night . . . and I suppose these will have some effect on how they will be able to cope." While documentation of the health status of trafficking victims remains severely limited, several respondents believed that a high prevalence of sexually transmitted diseases and a vulnerability to HIV/AIDS exists among trafficking victims in Metro Manila.

Traumatic and post-traumatic stress were frequently cited as mental health problems among girls rescued from trafficking situations. One NGO representative described this problem using the example of devout Catholic women being forced to have abortions. Other issues include tobacco smoking, alcohol abuse, illegal drug use, and anger and mistrust, among other behavioral and emotional problems.

Health services for trafficked victims

Citing the illegality of sex trafficking and prostitution, trafficked girls in casas and brothels were reported by service providers and advocates alike to have extremely limited access to health care of any kind. One policy advocate recounted an interaction she had with a rescued girl on her life in a casa:

> [She] was really confined . . . she can't go out . . . and right there and then, the first night she had I think eight men. She was not treated. She had a severe STD with fever and shivers. And according to her, actually she was asked to take antibiotics on her own without seeing a doctor. And then they used a stick into her vagina to get a specimen of her then put it in a slide . . . it was brought to outside, but she was never allowed to go to see a doctor.

The only access trafficked girls had to medical attention was reportedly limited to private clinics favored by the pimp or bar owner. Given that abortion is illegal in the Philippines, terminations were thought to be carried out by private, unlicensed, and often poorly-trained abortionists.[22]

Alternatively, some girls were believed to be given herbal or pharmaceutical medications to induce abortion. A social services provider, for example, reported that

> [t]here are rescued victims who shared their story that [the trafficked victim's] employer will give them some kind of medicines to prevent them from getting pregnant or to abort their baby so that they will continue working as sex workers, and this information is based on the cases documented and testimonies of those rescued already.

Immediately following rescue, trafficking victims are reportedly sent to a forensic examiner in a government facility for age verification.[23] If the individual is

declared both underage and a trafficking victim, she is sent back to her family or placed in a rehabilitation home. This process was described as "critical" by one landmark report on child trafficking, "since [it] may spell the difference between the child overcoming the initial trauma and developing into a healthy adult or [instead] going back into the cycle of victimization and abuse."[24]

According to our interviews, the Department of Social Welfare and Development (DSWD) is responsible for the coordination of policies and services for trafficked girls who have been rescued. Resource allocations for the Philippine Government's anti-trafficking efforts reportedly focus largely on the prosecution of traffickers; as a result, the government looks to NGOs to coordinate health care and mental health support for victims.

Government and nongovernment respondents pointed to the active presence of NGOs as critical stakeholders in the delivery of health care services to victims. Government-run residential facilities for survivors of rape, abuse, domestic violence, and trafficking were described as having been established to rehabilitate and reintegrate the girls back into their communities of origin. NGO-run residential services were also said to have been established in and around Metro Manila. Most respondents noted that NGOs provide more sensitive and less discriminatory services than their government counterparts, and indicated that NGOs often made referrals to private hospitals that offer appropriate, "child-friendly" services. One NGO respondent who coordinates aftercare services for rescued victims noted:

> [A]nd for the government, because of budgetary constraints, their least priority is the medical checkup . . . of the kids, so we come as an NGO helping these kids. So we are the ones responsible for bringing . . . them to a private hospital . . . and the government cannot afford that.

The interviews also revealed the existence of collaborations among providers, advocates, and governments related to service delivery for victims. One frequently mentioned collaboration was the Child Protection Unit Network (CPU), thought to be the country's major service provider on issues related to child trauma and abuse.[25] The CPU reportedly receives the majority of its resources for services through private foundations, but is also endorsed and supported through a partnership with the Department of Health. The CPU was said to have evaluated and treated more than 7,000 abused children through 28 CPU facilities across the Philippines in 2008. Several respondents described how anti-trafficking organizations, in addition to providing services for child abuse and trafficking victims in Metro Manila, also link with CPUs in rural source areas for medical expertise and for abuse and trafficking prevention activities.

Efforts to involve health care service providers and related professionals in anti-trafficking training exist in some source areas.[26] In addition to providing anti-trafficking awareness and education in *barangays*, respondents reported working with local leaders to assure that service providers, community educators, and social workers are aware of available resources regarding child protection and trafficking prevention, including how to make referrals.[27] "If you start doing community education, you'll get [trafficking] cases; you have to know where to go," observed one respondent. Another anti-trafficking expert and community educator reflected:

> [We] ask [local service providers] to . . . link up with the local Child Protection Unit if it exists in that area because . . . we don't have expertise as medical professionals, so we have to learn how to link up locally as well. And some of our greatest advocates are actually medical practitioners, you know, medical municipal health officers for example, who take on the issue of trafficking in addition to what they're already doing.

Barangay health workers were reported to provide community outreach and education on issues of local importance to the community, such as child abuse, HIV/AIDS, and, in some cases, trafficking. "They know that trafficking is an issue, and is a reality in the areas they work in," commented one advocate. An NGO service provider explained how the system is structured:

> [*Barangay* health workers] used to be mothers who were not doing anything, so they just decided to volunteer for a commune. So, it is a pool of people engaged in the health care system who

> could be of help, and they're the ones who are usually trusted, because in every *barangay*, there is usually . . . one registered nurse, then they have this doctor who goes there once a week, full moon; yeah, so it's not really that much, but they're the ones that are trusted by the people and by the health professional himself or herself.

Barriers to health-system response to trafficking

Overall, respondents suggested that combating sex trafficking is not a health priority for the government. As reported above, the Philippine Government's coordination for anti-trafficking initiatives occurs through the Inter-Agency Council Against Trafficking (IACAT), chaired and co-chaired by representatives from the Department of Justice and the Department of Social Welfare and Development, respectively. IACAT's priorities have been interpreted as mainly prosecution-focused rather than victim-centered. "The [anti-trafficking] law was passed . . . without any appropriation for its implementation," noted one anti-trafficking policy expert. Consequently, members of IACAT are responsible for allocating funds from their own budgets to carry out IACAT-related activities. As a result, the government reportedly defers administration of most public health and some social welfare services for sex trafficking victims to NGOs.

Respondents specifically pointed to the fact that IACAT lacks representation on the Department of Health (DOH). Observed one advocate active in anti-trafficking policy, the DOH "hasn't even figured into any discussions that I've had over the past year on trafficking." As possible reasons for DOH's lack of involvement, respondents suggested DOH not wanting to add responsibility, given its current budget limitations, or the government's lack of recognition of trafficking as a health issue.

Public health care was not reported to be a high priority for the local or national government. Existing health and mental health services reportedly suffer from chronic funding shortages. Two respondents thought that such shortfalls are used to justify the public health system's lack of involvement on issues such as child abuse prevention or trafficking. While NGOs attempt to address this gap by offering their services to marginalized and vulnerable people in Metro Manila, one NGO respondent cautioned that NGO-run services are susceptible to funding cuts and shifting priorities, saying, "I mean we're really depending on grant to grant. What happens if the world 'flavor of the month' changes?"

Respondents described existing public health facilities as lacking materials and human capacity, and thus unable to deliver effective medical treatment on a population-wide level. The "brain drain" phenomenon was thought to be pronounced in the medical professions. In addition, the number of social workers and mental health professionals able to provide care was reportedly insufficient. As one psychiatrist observed,

> Some [hospitals] don't have mental health services for children. . . . Some of them try to encourage volunteers, so if they get volunteers, that's the only time that the children get mental health services. So if they don't have volunteers . . . they don't offer the services.

While the Department of Social Welfare and Development is responsible for ensuring that rescued girls receive health care and social services, respondents reported serious deficiencies in DSWD's response to the health care needs of victims. When newly rescued girls are taken to a government hospital, they are described as often being traumatized and upset, yet treatment was perceived as judgmental — and often not child-friendly. Clinical care for women at government facilities in Metro Manila was described as insensitive and "emotionally distant." Two respondents posited that the high number of patients waiting for treatment overwhelms government hospital staff, which, in turn, develop insensitive treatment routines as a protective mechanism. "They've developed numbness for this. And then they shout, they shout at these women, 'Oh you're here again!'" said one respondent. A social worker expanded on this sentiment, noting, "Sometimes they are being labeled as willing victims; that they came willingly and they should accept the fact that they have been victimized there, because they consented."

When NGOs are not present following a police-only rescue of a trafficked girl, there is reportedly an increased likelihood that a victim's health care needs are neglected. Two respondents attributed this to a lack of knowledge and priority among police. "Sometimes the police don't even record the case,

especially if it is something they can't solve," noted one respondent.

Another respondent engaged in advocacy work described an interaction with a law enforcement representative who was managing the case of a newly rescued trafficked girl:

> The NBI [National Bureau of Investigation] agent who was handling the case was complaining that he didn't have money to pay for the health tests that this girl needed. Basically he said that, "You know we have to do HIV, pregnancy, etcetera, etcetera, so many tests," but [the NBI agent] said "I don't have any budget for, you know to help the girl undergo all these other tests that are necessary, not just the medical, legal examinations."

Health care services to girls in residential rehabilitation facilities were described as being extremely expensive. Noted one social worker, "You have to pay for it, so that the girl will have access to it. Even the check, the HIV test, the HIV/AIDS testing, we have to pay for that. So it's not for free."

Rehabilitation services offered at government rescue homes (also known as government crisis centers) are reportedly intended to help survivors of child abuse, domestic violence, and trafficking. Yet many respondents indicated that workers at these centers lack the required technical skills and training to effectively respond to the health and mental health challenges of victims. One physician told us,

> It also depends on when you rescued them, you know. When you rescued them on the way to being trafficked, they've not yet been trafficked, it's just en route . . . so they have not yet experienced being raped. [The victims tell us,] "You're in the way, you're not being helpful; what can you offer us, you know, because we're being promised a job and a livelihood. What can you offer us . . . because you're preventing us from . . . helping our families."

Similarly, a major barrier identified by respondents is the lack of awareness among doctors, psychologists, and nurses regarding the particular needs facing trafficking victims, and how these needs differ from abuse survivors. An advocacy worker emphasized that

> [h]andling trafficking victims is somehow more challenging compared to handling victims of child sexual abuse or interfamilial abuse . . . how [forensic doctors] interview or how they draw out the situation of child sexual abuse . . . is very different from getting information about the trafficking incident . . . so, I think it's not yet as, it's not within the awareness, even of child trafficking practitioners or even child protection practitioners to really get more involvement of the medical profession.

Among our respondents, two senior level health care administrators thought that curricular materials about trafficking do not exist in schools of nursing, public health, or medicine in the Philippines.

OPPORTUNITIES FOR LOCAL HEALTH SYSTEM RESPONSE TO SEX TRAFFICKING

Policy actions

Collectively, interview respondents called for coordinated anti-trafficking efforts at local and national levels of government that explicitly involve a health care component. DOH representation on IACAT was seen as an essential and practical step that could begin to integrate public health perspectives into national policies and services. As one doctor who treats survivors of abuse and trafficking at a government hospital reported:

> The way that the Department of Health is acting is that they really look at child trafficking, child abuse, as not a health problem. . . . They really look at it as a problem mainly belonging to the hands of either the Department of Social Welfare or the Department of Justice. I think we were lucky . . . when we decided that [our child abuse center] was going to be hospital-based, because it more or less forced . . . the hand of [the Department of H]ealth to look at it as, to take ownership, that it is a

> health problem, too. That it's not just social welfare and . . . justice.

Many respondents believed that an effective public health response to trafficking could be achieved through improved utilization of existing resources. For example, one respondent thought the government could provide tax incentives for hospitals that demonstrate competency in treating trafficking survivors and victims of violence or abuse. The respondent also advocated for a coordinated effort for service delivery:

> [T]he social welfare offices should really devote the resources, not entirely in coming up with their own programs, but in mapping programs that are already in the community and finding links and helping them improve those programs. Because . . . we have community health centers that are available and that we utilize as some kind of focal point for stability for the social workers . . . they should have more rational process of allocating funds. There are a lot of actions, so, we have funds for livelihood programs but usually the livelihood programs that could be accessed by trafficked victims and their families are usually given to municipalities or to *barangays* that are politically connected with [for example] . . . the decision maker from that agency.

Mental health services for trafficking victims

Respondents also called for survivor-centered, rights-based psychosocial systems of care and support immediately following the rescue of victims. One NGO respondent who works with rescued children thought that many existing barriers to service delivery in Metro Manila could be lowered by offering a "one-stop shop" for victims, post-rescue:

> You go there, you don't have to be transferred from one agency to another; you get your initial medical exam; you get dental aging there . . . that's where they could also meet psychologists and social workers who can help out in counseling.

The Philippine Government's current policy of subsuming rescued trafficked victims under existing services and infrastructure for survivors of other forms of abuse was viewed by many as ineffective, because it fails to account for the complexities specific to victims of sex trafficking.

Respondents also called for curriculum development to train doctors, nurses, forensics specialists, mental health professionals, and social workers on the specific health needs of trafficking victims. As a recent International Labour Organization report on child trafficking in the Philippines notes, "Most medical curricula [in the Philippines] often capacitate medical professionals to diagnose the biomedical aspects of illness but lack child- and gender-friendly protocols."[28]

Respondents emphasized, in particular, how the needs of sex trafficking survivors may differ from the needs of survivors of other forms of abuse. As one advocate observed, "I think doctors may know about trafficking, but responding to a trafficking victim is different from responding to a child sexual abuse victim." Several respondents suggested the possibility of integrating sex trafficking into medical or nursing schools through existing social medicine modules covering child abuse, domestic violence, or sexual assault.

Prevention and community education

Another recommendation from respondents was for the health community to engage in primary prevention of trafficking by piggybacking onto existing community-based health projects in source areas of trafficking. For example, respondents recognized that the service needs of sex trafficking victims differ from those of other survivors of abuse. However, since childhood abuse was identified as a key trafficking determinant, respondents suggested linking local *barangay* health workers' ongoing efforts to identify and prevent child abuse with trafficking prevention activities. As one policy advocate observed,

> We're finding that a lot of the trafficking victims have already been victims of abuse within the home or in their community before they are trafficked, so if we can find ways to assist them at an early stage, you know when the family is not protecting enough, you know, to

> put in the protective mechanisms early enough then maybe we can prevent trafficking in the long run.

Another respondent, a service provider, noted:

> I also would like to see trafficking, migration, and violence against women and children's issue integrated with the training that's being provided . . . we have *barangay* health workers. These are volunteer health workers, so they should also at least receive information about this; they should be able to detect, because they're at the community levels, so we could detect whether a house is being used as a prostitution den or suspected recruitment or trafficking situation that's being initiated, so they should be part also of the solution.

CONCLUSIONS

This case study underscores how and why sex trafficking has become a health and human rights concern in Metropolitan Manila. For instance, the mere presence of child trafficking in Manila undermines core tenets of the UN Convention on the Rights of the Child. Our study illustrates the complexity of the sex trafficking trade and the myriad factors at multiple levels that underpin its existence and perpetuation. The interviews extend our understanding of the risk factors for sex trafficking at multiple levels, and their important interactions; factors include individual (such as childhood abuse), socio-cultural (for example, gender inequality and a "culture of migration"), and macro (such as profound poverty caused, *inter alia*, by environmental degradation disrupting traditional forms of labor). The case also underscores the severe health problems trafficking victims suffer across their life course, that is, prior to, during, and after their enslavement.

We have also presented evidence of the purported failure of the Manila health system to both recognize and intervene effectively on behalf of trafficking victims. Promoting health equity requires an integrated response that considers the complex and contextual realities facing this vulnerable population. However, mental health services in the city are insufficient to meet the needs of many trafficking victims. At a policy level, the Department of Health lacks representation and visibility on IACAT, the country's leading initiative related to trafficking. At present, trafficking prevention does not appear to be even remotely a priority of the local health system. The participation and leadership of the Department of Health on IACAT is one example of a pragmatic step that the government could take toward creating an integrated response for sex trafficking prevention and treatment in Metro Manila.

Furthermore, it is worth exploring how anti-trafficking initiatives could be integrated into existing health care and social services offered to communities, particularly in known source areas of trafficking. For example, despite the several important differences in service needs for survivors of sex trafficking and those of child abuse, child abuse was identified as a key determinant of sex trafficking. For this reason, respondents recommended an alliance between anti-trafficking programs and existing child abuse health care services at the *barangay* level to help prevent sex trafficking. In a similar vein, upon reintegration, *barangay* level health systems could be strengthened and engaged to integrate a victim girl back into her community and provide appropriate follow-up health and mental services.

At the same time, many respondents expressed frustration that the current government rehabilitation services for trafficking victims are often packaged into existing services for survivors of other forms of abuse without considering the wide range of health issues specific to sex trafficking victims, particularly around mental health. Sex trafficking victims warrant care and support by mental health professionals who are trained to address the particular circumstances victims face. Schools of medicine, nursing, or social work should consider incorporating a trafficking component into existing modules that discuss child abuse, domestic violence, or sexual assault.

Anti-trafficking strategies must be mindful of the multiple levels at which trafficking determinants occur. They must recognize the complex social factors that drive girls into sex trafficking and create the high demand for commercial sex. Many parallels can be drawn between strategies to address sex trafficking and those designed to eliminate health inequities. Interestingly, the major strategies proposed by the WHO Commission on Social Determinants of Health to reduce health inequities — "improve daily living conditions," "tackle the inequitable distribution of power, money, and resources," and "measure

and understand the problem and assess the impact of action" — would also likely disrupt sex trafficking and mitigate its harmful impacts.[29] For example, the Commission on Social Determinants of Health emphasized a need to redress "gender inequities" because of the hypothesized pathways through which these inequities translate into adverse health outcomes for women. Specifically, the Commission calls for "policies and programmes that close gaps in education and skills, and that support female economic participation."[30] Such action, if specifically applied within the anti-trafficking field, would also blunt some of the major drivers of trafficking.

We recognize that our study had several inherent limitations. For example, we limited our focus to women and children without examining exploitation and trafficking of men and boys. Furthermore, this case study is intended to represent a first phase of research toward the eventual development and refinement of theories on sex trafficking that will contribute to evidence-based theory-grounded intervention. While we spoke with a wide range of service providers who work directly with trafficking victims, we did not speak directly to sex trafficking victims. Hearing the perspectives of trafficking victims would strengthen the findings of the present study.

Ultimately, societies in which sex trafficking and severe health inequities continue to persist cannot be viewed as "healthy" in any sense. The underlying conditions that contribute to their existence must end if strides are to be made to improve population health. As one Manila interview respondent noted about strategies to address sex trafficking, "Livelihood, transport, housing, clean water . . . and all that. I mean that's a holistic view to address the problem."

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2. US Department of State, *Trafficking in persons report, June 2009* (Washington, DC: US Department of State, 2009). Available at http://www.state.gov/documents/organization/123357.pdf.

3. United Nations (see note 1).

4. The health consequences of sex trafficking have been well documented. See, for example, C. Zimmerman, M. Hossain, K. Yun, et al., "The health of trafficked women: A survey of women entering posttrafficking services in Europe," *American Journal of Public Health* 98/1 (2008), pp. 55–59; and J. G. Silverman, M. R. Decker, J. Gupta, et al., "HIV prevalence and predictors of infection in sex-trafficked Nepalese girls and women," *Journal of the American Medical Association* 298/5 (2007), pp. 536–542. This and a number of other studies in South and Southeast Asia report how sex-trafficked women and girls suffer disproportionately from myriad health problems such as HIV/AIDS. Silverman et al. (2007), who examined HIV prevalence in 287 repatriated Nepalese girls trafficked to Mumbai, found that 38% tested positive for HIV, and that those trafficked prior to age 15 were found to be at heightened risk for acquiring HIV. See also J. G. Silverman, M. R. Decker, J. Gupta, et al., "HIV prevalence and predictors among rescued sex-trafficked women and girls in Mumbai, India," *Journal of Acquired Immune Deficiency Syndromes* 43/5 (1999), pp. 588–593. On tuberculosis, see A. S. Dharmadhikari, J. Gupta, M. R. Decker, et al., "Tuberculosis and HIV: A global menace exacerbated via sex trafficking," *International Journal of Infectious Diseases* 13/5 (2009), pp. 543–546. On depression and anxiety, see A. Tsutsumi, T. Izutsu, A. K. Poudyal, et al., "Mental health of female survivors of human trafficking in Nepal," *Social Science and Medicine* 66/8 (2008), pp. 1841–1847. On exposure to violence, see M. R. Decker, H. L. McCauley, D. Phuengsamran, et

al., "Sex trafficking, sexual risk, sexually transmitted infection and reproductive health among female sex workers in Thailand," *Journal of Epidemiology and Community Health* 64/6 (2010), doi:10.1136/jech.2009.096834; H. L. McCauley, M. R. Decker, and J. G. Silverman, "Trafficking experiences and violence victimization of sex-trafficked young women in Cambodia," *International Journal of Gynaecology and Obstetrics* 110/3 (2010), pp. 266–267, doi:10.1016/j.ijgo.2010.04.016; and K. Sarkar, B. Bal, R. Mukherjee, et al., "Sex-trafficking, violence, negotiating skill, and HIV infection in brothel-based sex workers of eastern India, adjoining Nepal, Bhutan, and Bangladesh," *Journal of Health, Population, and Nutrition* 26/2 (2008), pp. 223–231.

5. Our case studies were guided by the social ecological model of U. Bronfenbrenner, *The ecology of human development: Experiments by nature and design* (Cambridge, MA: Harvard University Press, 1981). Bronfenbrenner's model was used as a framework for organizing and examining the interplay of myriad risk factors that operate in an interrelated fashion at the individual, relational, community, and societal levels to affect developmental outcomes. The eight cities and five countries were: Manila, Philippines; Kolkata and Mumbai, India; Los Angeles and New York, US; London, UK; and Rio de Janeiro and Salvador, Brazil.

6. Commission on Social Determinants of Health, *Closing the gap in a generation: Health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health* (Geneva: World Health Organization, 2008). Available at http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf.

7. Tier 2 Watch: US Department of State (see note 2). On the population of the Manila metropolitan area, "Metro Manila," at 11.5 million, see Republic of the Philippines National Statistics Office, *Total population and annual population growth rates by region: Population censuses 1995, 2000, and 2007* (Manila: National Statistics Office, 2007). Available at http://www.census.gov.ph/data/census2007/index.html. "Metro Manila" is a highly urbanized and densely populated area that encompasses 16 cities, including Manila, the capital of the Republic of the Philippines. It is an emerging hub of global commerce and a known "tourist and entertainment hotspot." See, for example, Tsutsumi et al. (see ref. 4); see also R. Ricardo, *Child trafficking in the Philippines: A situational analysis* (Manila: International Labour Organization, 2007). Its role as a transit area for girls and women is documented in US Department of State, *Trafficking in persons report, 10th Edition, June 2010* (Washington, DC: US Department of State, 2010). Available at http://www.state.gov/documents/organization/142979.pdf.

8. See, for example, UNICEF, *Reversing the trend: Child trafficking in East and South-East Asia* (Bangkok: UNICEF East Asia and Pacific Regional Office, 2009).

9. Child trafficking estimates in the Philippines hover around 100,000 annually, and the country's Department of Social Welfare and Development (DSWD) reported entry of over 3,000 children into prostitution each year; see Ricardo (see note 7). Documentation from one anti-trafficking service provider in the Philippines indicated that, since 2001, it had intercepted approximately 10,000 incipient trafficking victims at major seaports and airports en route to situations of forced labor and prostitution. M. Macapagal, C. Atienza, G. Jamon, et al., *Rights-based approach in protecting victims and organizing responsive task forces against trafficking (RBA-PORT) project: Final evaluation report* (Makati City: Plan Philippines, 2009). The Philippines is a member of the Association of Southeast Asian Nations (ASEAN), which adopted the *Declaration against trafficking in persons particularly women and children* in 2003; see Association of Southeast Asian Nations, *Declaration against trafficking in persons particularly women and children* (Jakarta, Indonesia: ASEAN Secretariat, 2003). Available at http://www.aseansec.org/16793.htm. Also in 2003, the Philippines passed its own Anti-Trafficking in Persons Act (No. 9208), out of which emerged the Inter-Agency Council Against Trafficking (IACAT). Comprising heads of government agencies as well as selected representatives of nongovernmental organizations (NGOs), IACAT is tasked with the coordination and implementation of the Philippines anti-trafficking law. Further information is available at http://www.doj.gov.ph/index.php?id1=4&id2=7.

10. The anti-trafficking field is filled with various, sometimes competing definitions of trafficking. We used the United Nations Palermo Protocol definition of trafficking in our case studies, and reported on activities that fell under the Palermo Protocol definition. The specific UN definition can be found on the Office of the United Nations High Commissioner for Human Rights website. Available

at http://www2.ohchr.org/english/law/protocoltraffic.htm. In our multi-city case studies project, we documented separately those instances in which interview respondents noted alternative definitions or descriptions of trafficking and related phenomena (for example, "survival sex").

11. In addition to speaking with health care workers, we also interviewed people outside the formal health sector, including, for example, government officials, anti-trafficking advocates, law enforcement officers, and program directors of shelters that assist trafficking victims. By interviewing people beyond the health care sector, we attempted to increase the internal validity of our findings by working across disciplines to corroborate and refute evidence. See P. R. Carlile and C. M. Christensen, *The cycles of theory building in management research*, Harvard University/Harvard Business School Working Paper 05–057 (Cambridge, MA: Harvard University/Harvard Business School Publishing, 2004). While the "Results" section of our paper, above, presents major thematic findings across all key informant interviews, we have included a range of quotations throughout the narrative that effectively capture the salient points of each theme.

12. Our sample included two interviews with five individuals in neighboring Subic Bay who could speak to the issue of sex trafficking in Metro Manila.

13. M. Ralston and E. Keeble, *Reluctant bedfellows: Feminism, activism, and prostitution in the Philippines* (Sterling, VA: Kumarian Press, 2009).

14. Ricardo (see note 7); see also Asian Development Bank, Canadian International Development Agency, European Commission, et al., *Paradox and promise in the Philippines: A joint country gender assessment* (Manila: co-published by the Asian Development Bank, Canadian International Development Agency, European Commission, National Commission on the Role of Filipino Women, United Nations Children's Fund, United Nations Development Fund for Women, and United Nations Population Fund, 2008).

15. While sex trafficking in Metro Manila was also thought to extend to women over age 18, we reflect language used by most of our respondents, who more frequently referenced sex trafficking as a problem facing girls.

16. "Rescue" refers to the removal of a woman or girl from the trafficking situation. Three primary mechanisms were reported for the identification and rescue of sex trafficking victims: 1) NGOs working with seaport and airport authorities to identify and intercept victims en route; 2) NGOs working undercover in bars and brothels; and 3) local law enforcement conducting rescues on their own.

17. Throughout the interviews, respondents did not differentiate between domestic trafficking and those trafficked out of the country.

18. Ricardo (see note 7).

19. Ibid. See also UNICEF (see note 8).

20. Many of our nongovernmental respondents perceived endemic corruption on all levels of civil society — a perception corroborated in the 2009 *Trafficking in persons* report by the US State Department (see note 2).

21. While abortion is illegal in the Philippines, the estimated abortion rate in Metro Manila is 52 per 1,000 women, including nearly 30,000 women hospitalized with abortion complications in the year 2000; F. Juarez, J. Cabigon, S. Singh, and R. Hussain, "The incidence of induced abortion in the Philippines: Current level and recent trends," *International Family Planning Perspectives* 31/3 (2005), pp. 140–149.

22. Ibid.

23. On rescue methods, see note 16.

24. Ricardo (see note 7), p. 7.

25. Child Protection Unit Network, *Annual Report 2008: Serving abused children, children at risk and their families* (Manila: Child Protection Unit Network, 2008).

26. A detailed description of trafficking and local services response in source areas is in Ricardo (see note 7).

27. *Barangays* are the smallest unit of administrative government in the Philippines. There are 1,695 *barangays* in Metro Manila; see Philippine National Statistical Coordination Board (NSCB), *Provincial summary: Number of provinces, cities, municipalities and barangays, by region* (Makati City: NSCB, 2006).

28. Ricardo (see note 7).

29. CDSH (see note 6), p. 2.

30. Ibid., p. 16.