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Human Trafficking in Areas of Conflict: Health Care Professionals' Duty to Act

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Abstract

Given the significant global burden of human trafficking, the ability of clinicians to identify and provide treatment for trafficked persons is critical. Particularly in conflict settings, health care facilities often serve as the first and sometimes only point of contact for trafficked persons. As such, medical practitioners have a unique opportunity and an ethical imperative to intervene, even in nonclinical roles. With proper training, medical practitioners can assist trafficked persons by documenting human trafficking cases, thereby placing pressure on key stakeholders to enforce legal protections, and by providing adequate services to those trafficked.

Introduction

The United Nations (UN) Office on Drugs and Crime defines trafficking as

> the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the 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 payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs [1].

Across the globe, approximately 21 million people are victimized by human trafficking [2]. All types of trafficking affect all genders. Women and girls are more often identified as trafficked in the sex industry and as domestic servants; males are less often identified as victims of trafficking and, when they are, it is often for other forms of labor, like agricultural, factory, and construction work [3]. Vulnerability to exploitation increases substantially in times of conflict. During war, the erosion of the rule of law, corruption of legal and political authorities, and evolution of criminal networks can all contribute to an environment ripe for trafficking [4, 5]. Even the presence of humanitarian aid workers,

who have more liquid assets than local beneficiaries, can increase demand for sexual services or goods made through exploitative labor, leading to an increase in or the development of trafficking.

In 2000, the UN's Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children [1] provided an international definition of the crime of human trafficking (more comprehensive than its 1921 predecessor, which was drafted under the auspices of the League of Nations [6]) and established guidelines for UN states for the prevention and combatting of human trafficking [1, 7]. In 2004, the UN Commission on Human Rights appointed a special rapporteur to focus on the human rights aspects of trafficking in persons [8]. These developments have led to discussion within the UN Security Council about whether trafficking during conflict may constitute a war crime [7], but, at the time of this writing, the UN has yet to make this determination. Despite these developments and discussions, the number of prosecutions remains relatively low [5]. This is the result of multiple factors, but a major contributor is the lack of documentation or evidence. Trafficking in persons is often not identified and properly investigated in the field in real time, particularly in crisis situations when clinical and forensic resources are scarce and the context poses great challenges [5]. But without apt documentation of trafficking, which enumerates and describes those affected, resources will remain in short supply.

In this paper, we will explore the role of clinicians outside of their purely clinical duties. Specifically, this paper discusses the ethical imperative of clinicians—when relevant—to forensically document evidence of trafficking among populations served during conflict. We argue that acting outside of a solely clinical function, in or outside of conflict settings, is not a novel concept for clinicians and, further, that practitioners' nonclinical actions also benefit patients.

Trafficking During Conflict

The primary role of health care practitioners during conflict is to provide medical and mental health services to populations in need, both civilians and noncombatants. Health care facilities have been recognized as safe havens, providing care to people suffering from routine afflictions such as exacerbations of chronic disease [9] as well as injuries and illnesses specifically related to the conflict. As a conflict wages on, large groups of people can be displaced, fleeing for safety. During this phase, communities often experience decreased access to safe water, medications, food, and proper shelter, which can increase rates of infectious disease and malnutrition, making people more vulnerable to exploitation [9]. Some noncombatants move in with kin in other areas or even stay in their homes. Regardless of setting—and even outside of the directly involved conflict areas—noncombatants are frequently unable to safely earn a living in the positions they held before the conflict. In addition to the factors previously listed, the desperation of noncombatants to support their families can make them vulnerable to being trafficked

[10], and the crisis itself dampens the state's ability to intervene and respond to the crime of trafficking of persons [4].

In fact, there is ample evidence of human trafficking during conflict: most recently, International Organization of Migration (IOM) data from 2014 and 2015 confirms that, as part of the Iraqi conflict, Yazidi women and children were abducted by the Islamic State for domestic and sexual exploitation; migrant workers have been held by militia groups for forced labor; armed opposition groups have forcibly recruited children to fight in the Iraqi conflict; and human organs have been collected and sold [5]. In the Syrian conflict, some families have sold young daughters into marriage to "protect" them from sexual assault and provide financial support. Another "protective" measure called "temporary marriage" or mutah, which unites a man and woman as husband and wife for an agreed upon period of time [11] and largely affects internally displaced persons and refugees, has increased [5]. Additionally, in a common form of labor trafficking, Syrian refugee children have been seen begging and selling small items on the street [5]. Furthermore, as frequently occurs in conflict, many children are unaccompanied or separated from their usual caregivers. It is common practice for unrelated adults to take them in [12], but not all of these adults are well intentioned and some of these children end up trafficked in a multitude of ways [13].

The Ethical Imperative of Clinicians in Conflict Areas

Because trafficking does not require harboring of persons, trafficked persons may present for health care for a variety of reasons, including primary care and interventions during acute illness or injury caused by their trafficking situation [14, 15]. There is evidence that clinicians, when appropriately trained, can effectively identify patients with a trafficking experience [16, 17], and several guidelines exist to help clinicians develop appropriate techniques for interviewing and examining patients who may be trafficked [18-20]. But screening in conflict settings involves special difficulties that may not pertain to stable environments, such as an increased physical danger to both the patient and practitioner given the general context of conflict and the lack of accountability of and protection by state and international legal systems [21]. Still, even without governmental support, clinicians have the opportunity to practice a form of transitional justice—aimed at redressing the legacies of massive human rights abuses [22]—by providing medical and psychological care to trafficked persons and properly documenting evidence of human trafficking [23].

Health care practitioners have served in nontherapeutic capacities in conflict zones for decades, although not always in ways consistent with their noble calling. Physicians have participated in torture interrogations [24] and performed medical experiments without consent on captives taken during conflict [25, 26]. But practitioners have also specifically documented physical and mental injuries of noncombatants, and these medical records and documents, considered impartial and trustworthy because of their authorship, have

been used as evidence of war crimes committed [27]. Physicians for Human Rights trains and supports local clinicians on appropriate methods of forensic documentation for just this purpose [27]. Forensic documentation involves gathering information about the medical history, collecting and documenting evidence from the patient's body, and recording pertinent physical exam findings for the purpose of criminal investigation and documentation. This information may be used in court, if needed, and the health care worker may be asked to testify as well [28]. Because it is not directly crucial to the provision of medical or mental health care, it is not considered a clinical activity, but forensic documentation is within the scope of practice of trained clinicians in conflict settings.

Although some may argue that clinicians should only provide clinical care, receipt of a forensic exam may contribute to improved mental health because trafficked patients have told their story to someone with the power to be heard. In fact, some nurses, physician assistants, and physicians already serve in a strictly forensic capacity, performing sexual assault forensic examinations (SAFE) for survivors of sexual assault. Acting in this capacity, the SAFE examiner only performs the exam for the purpose of evidence collection, in a setting where the survivor can also receive medical and psychological care. However, the exam itself can be empowering to someone recently victimized: by choosing the exam, the survivor exerts autonomy—with the right to refuse any part of the history taking or physical exam—and is believed.

Conclusion

The significant global burden of human trafficking will require multiple actors in varying sectors, including the health, legal, and political arenas to adequately combat its devastating effects. Clinicians are in the unique position of serving as the first and sometimes only point of contact for trafficked persons and, as such, have an ethical duty to act on their behalf. Providing services for and documenting those who are trafficked in conflict zones is challenging, but, with proper training and purposeful efforts, health practitioners can have an important, positive impact in the lives of trafficked persons and survivors.

References

1. United Nations. Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime. http://www.osce.org/odihr/19223?download=true. Adopted 2000. Accessed August 20, 2016.
2. International Labour Organization. Forced labour, human trafficking and slavery. http://www.ilo.org/global/topics/forced-labour/lang--en/index.htm. Accessed August 15, 2016.

3. World Health Organization. Understanding and addressing violence against women: human trafficking. http://apps.who.int/iris/bitstream/10665/77394/1/WHO_RHR_12.42_eng.pdf?ua=1. Published 2012. Accessed August 20, 2016.
4. Craggs S, Lungarotti L, Macchiavello M, Tillinac A; International Organization for Migration. Responding to human trafficking and exploitation in times of crisis: reducing the vulnerabilities of migrants in preparedness, response and recovery efforts. Migrants in Countries in Crisis Initiative. https://micicinitiative.iom.int/sites/default/files/brief/Trafficking%20Issue%20Brief%20final.pdf. Published January 2016. Accessed September 1, 2016.
5. International Organization for Migration. Addressing human trafficking and exploitation in times of crisis: evidence and recommendations for further action to protect vulnerable and mobile populations. https://www.iom.int/sites/default/files/press_release/file/CT_in_Crisis_FINAL.pdf. Published July 2015. Accessed September 1, 2016.
6. International Convention for the Suppression of the Traffic in Women and Children. https://ec.europa.eu/anti-trafficking/sites/antitrafficking/files/1921_international_convention_en_1.pdf. Amended November 12, 1947. Accessed November 10, 2016.
7. Security Council presidential statement says human trafficking might constitute war crimes, as members consider issue for first time [news release]. New York, NY: United Nations. December 15, 2015. http://www.un.org/press/en/2015/sc12165.doc.htm. Accessed August 20, 2016.
8. United Nations Office of the High Commissioner for Human Rights. Special rapporteur on trafficking in persons, especially in women and children. http://www.ohchr.org/EN/issues/Trafficking/Pages/Traffickingindex.aspx. Accessed September 9, 2016.
9. Health care in war zones and countries affected by conflict. Global Research. January 23, 2010. http://www.globalresearch.ca/health-care-in-war-zones-and-countries-affected-by-conflict/17159. Accessed August 20, 2016.
10. Lungarotti L, Craggs S, Tillinac A. Human trafficking in crises: a neglected protection concern. Humanitarian Practice Network. October 2015. http://odihpn.org/magazine/human-trafficking-in-crises-a-neglected-protection-concern/. Accessed August 15, 2016.
11. Koundinya S. The concept of mutah marriage: is it a social evil? *SSRN Electron J*. 2010. doi:10.2139/ssrn.1666848.
12. Stark L, Rubenstein BL, Mansourian H, Spencer C, Noble E, Chisolm-Straker M. Estimating child separation in emergencies: results from North Kivu. *Child Abuse Negl*. 2016;52:38-46.
13. Child Protection Working Group. *Minimum Standards for Child Protection in Humanitarian Action*. Geneva, Switzerland: Child Protection Working Group; 2016.

http://www.unicef.org/iran/Minimum_standards_for_child_protection_in_humanitarian_action.pdf. Accessed August 15, 2016.
14. CdeBaca L, Sigmon JN. Combating trafficking in persons: a call to action for global health professionals. *Glob Health Sci Pract*. 2014;2(3):261-267.
15. Baldwin SB, Eisenman DP, Sayles JN, Ryan G, Chuang KS. Identification of human trafficking victims in health care settings. *Health Hum Rights*. 2011;13(1):e36-e49.
16. Grace AM, Ahn R, Macias-Konstantopoulos W. Integrating curricula on human trafficking into medical education and residency training. *JAMA Pediatr*. 2014;168(9):793-794.
17. Macias-Konstantopoulos W. Human trafficking: the role of medicine in interrupting the cycle of abuse and violence [published online ahead of print August 9, 2016]. *Ann Intern Med*. doi:10.7326/M16-0094.
18. Alpert EJ, Ahn R, Albright E, Purcell G, Burke TF, Macias-Konstantopoulos W. Human trafficking: guidebook on identification, assessment, and response in the health care setting. Massachusetts General Hospital; Massachusetts Medical Society; 2014. www.massmed.org/Patient-Care/Health-Topics/Violence-Prevention-and-Intervention/Human-Trafficking-(pdf)/. Accessed August 20, 2016.
19. International Organization for Migration. *The IOM Handbook on Direct Assistance for Victims of Trafficking*. Geneva, Switzerland: International Organization for Migration; 2007. http://publications.iom.int/system/files/pdf/iom_handbook_assistance.pdf. Accessed August 2, 2016.
20. Shandro J, Chisolm-Straker M, Duber HC, et al. Human trafficking: a guide to identification and approach for the emergency physician [published online ahead of print April 26, 2016]. *Ann Emerg Med*. doi:10.1016/j.annemergmed.2016.03.049.
21. Wŏlte S. Armed conflict and trafficking in women. Deutsche Gesellschaft für Technische Zusammenarbeit. Eschborn, Germany; 2004. http://www.ungift.org/doc/knowledgehub/resource-centre/NGO_GTZ_Armed_conflict_and_trafficking_in_women.pdf. Accessed August 2, 2016.
22. International Center for Transitional Justice (ICTJ). What is transitional justice? https://www.ictj.org/about/transitional-justice. Accessed October 19, 2016.
23. Ryken, K. The role of physicians in transitional justice: combatting the aftermath of mass rape in Bosnia-Herzegovina. *Proc Obstet Gynecol*. 2015;5(3)1-11.
24. Church AT. ISFT final report 2005. Executive summary (unclassified). Medical issues related to interrogation. http://hrlibrary.umn.edu/OathBetrayed/Church%20Report.pdf. Accessed June 16, 2016.

25. Weindling P, von Villiez A, Loewenau A, Farron N. The victims of unethical human experiments and coerced research under National Socialism. *Endeavour*. 2016;40(1):1-6.
26. Devolder K.US complicity and Japan's wartime medical atrocities: time for a response. *Am J Bioeth*. 2015;15(6):40-49.
27. Physicians for Human Rights. *Forensic Documentation of Torture and Ill Treatment in Mexico: An Assessment of the Implementation Process of the Istanbul Protocol Standards*. http://tbinternet.ohchr.org/Treaties/CAT/Shared%20Documents/MEX/INT_CAT_NGO_MEX_12973_E.pdf. Published 2008. Accessed September 2, 2016.
28. US Department of Justice Office on Violence Against Women. A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents. 2nd ed. https://www.ncjrs.gov/pdffiles1/ovw/241903.pdf. Published April 2013. Accessed November 22, 2016.

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