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Mental health of female survivors of human trafficking in Nepal

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Abstract

Little is known about the mental health status of trafficked women, even though international conventions require that it be considered. This study, therefore, aims at exploring the mental health status, including anxiety, depression and post-traumatic stress disorder (PTSD), of female survivors of human trafficking who are currently supported by local non-governmental organizations (NGOs) in Katmandu, the capital of Nepal, through comparison between those who were forced to work as sex workers and those who worked in other areas such as domestic and circus work (non-sex workers group). The Hopkins Symptoms Checklist-25 (HSCL-25) was administered to assess anxiety and depression, and the PTSD Checklist Civilian Version (PCL-C) was used to evaluate PTSD. Both the sex workers' and the non-sex workers' groups had a high proportion of cases with anxiety, depression, and PTSD. The sex workers group tended to have more anxiety symptoms (97.7%) than the non-sex workers group (87.5%). Regarding depression, all the constituents of the sex workers group scored over the cut-off point (100%), and the group showed a significantly higher prevalence than the non-sex workers (80.8%). The proportion of those who are above the cut-off for PTSD was higher in the sex workers group (29.6%) than in the non-sex workers group (7.5%). There was a higher rate of HIV infection in the sex workers group (29.6%) than in the non-sex workers group (0%). The findings suggest that programs to address human trafficking should include interventions (such as psychosocial support) to improve survivors' mental health status, paying attention to the category of work performed during the trafficking period. In particular, the current efforts of the United Nations and various NGOs that help survivors of human trafficking need to more explicitly focus on mental health and psychosocial support.

Keywords: Human trafficking; Women; Nepal; Mental health; Sex work; Post-traumatic stress disorder (PTSD); Anxiety; Depression

Introduction

Human trafficking is the exploitation of human beings in ways that include sexual exploitation, other forms of forced labor, slavery, servitude, or the removal of human organs through the threat or use of force; coercion, abduction, fraud, deception, abuse of positions of power or abuse of positions of vulnerability

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(UN, 2001). Annually, about 600,000–800,000 people are trafficked across national borders worldwide, and 80% of them are women and girls (U.S. Department of State, 2006). The International Labour Organization (2005) reports that there are 2.45 million trafficking victims currently under exploitative conditions. According to one estimate, human trafficking generates about US$9.5 billion in revenue annually and is linked to other organized crime such as human smuggling, drug trafficking, and money laundering (U.S. Department of State, 2006). Another calculation estimated that the average profits generated from trafficked forced labor were as high as US$32 billion per year (International Labour Organization, 2005). Human trafficking is one of the most devastating violations of human rights, as stated in international conventions such as the Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography (United Nations, 2000); and the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Convention against Transnational Organized Crime (United Nations, 2001). These conventions have laid down intensive countermeasures for the issue in terms of prevention, constructing legal frameworks, and strengthening the International Criminal Court, among others. In addition to this, these conventions explicitly require the ratified states to provide survivors of human trafficking with psychological care and to assist with their psychological recovery while training the individuals who work with survivors (United Nations, 2000, 2001). However, psychological aspects are often more neglected than physical and social aspects despite the former's huge impact on personal quality of life (QOL) and on society.

The purpose of human trafficking can be divided into two categories: one is for sexual exploitation and the other includes non-sexual practices such as domestic work, although the majority of trafficked victims are forced into sexual exploitation (UNODC, 2006; U.S. Department of State, 2006). The physical risks of such trafficking have been previously understood. Previous studies on survivors of human trafficking documented sex workers' higher vulnerability to sexually transmitted infections (STIs) including Human Immunodeficiency Virus (HIV) and tuberculosis (Bal Kumar, Subedi, Gurung, & Adhikari, 2001; Beyrer, 2001; Silverman et al., 2006, 2007).

Regarding health problems among sex workers in general, another study on sex workers, although they were not survivors of human trafficking, revealed that sex work itself carried a high risk of STIs (Gossop, Powis, Griffiths, & Strang, 1995), and physical violence (Church, Henderson, Barnard, & Hart, 2001; Farley & Barkan, 1998; Harcourt, van Beek, Heslop, McMahon, & Donovan, 2001; Kurtz, Surratt, Inciardi, & Kiley, 2004).

Concerning the mental health problems of sex workers in general, who are not victims of human trafficking, a significantly higher rate of depressive symptoms was found, regardless of their HIV infection status (Alegria et al., 1994). A higher rate of post-traumatic stress disorder (PTSD) was also observed (Farley & Barkan, 1998; Roxburgh, Degenhardt, & Copeland, 2006). Female drug users with a lifetime involvement in prostitution had a significantly higher prevalence of lifetime suicidal attempts and depressive ideas than those without (Gilchrist, Gruer, & Atkinson, 2005). Another study observed drug dependence and poor mental health among female drug users who had engaged in sex work in the preceding 30 days (el-Bassel et al., 1997). These results indicate the profound impact of sex work in general on mental health.

Despite these findings, not enough attention has been paid to the psychological or mental health of victims and/or survivors of human trafficking. This may be even more relevant to women who have been trafficked for the purposes of sex work, given the involuntary nature of the work and the potential for being a victim of violence. To the best of our knowledge, while there has been no research on the mental health of victims and/or survivors of human trafficking who were forced to work as non-sexual laborers, there is one study investigating the mental health of victims of human trafficking who worked as sex workers. In Israel, about 17% of trafficked women (the majority of which were from Moldavia, Ukraine, Russia and the Central Asian Republics of the former Soviet Union), who had worked as sex workers, scored over the cut-off point of measurement for PTSD and 19% were over the cut-off on the depression scale (Chudakov, Ilan, Belmaker, & Cwikel, 2002). Nonetheless, there is still a lack of research on the mental health of female victims and survivors of human trafficking.

Therefore, we examined the mental health status, including anxiety, depression and PTSD, of female survivors of human trafficking in Nepal. An estimated 12,000 women and children per year are trafficked for sexual work beyond the national borders of Nepal (U.S. Department of State, 2006), where the gender-related development index ranks 106 out of 136 countries (UNDP, 2006). In this study, the design provided a comparison between trafficked survivors who were

forced to work as sex workers and those who were forced to work in other areas, predominantly in the circus as well as some in domestic labor.

Method

Study design

This study was cross-sectional in its design. A pilot study was conducted, and necessary revisions to the questionnaire were made. The main study was conducted during September and October 2005.

Respondents and data collection

We interviewed female survivors of human trafficking who had come back to Nepal from the destination of trafficking and who were at the time supported by governmentally-authorized local non-governmental organizations (NGOs) in Katmandu, the capital of Nepal. Survivors of human trafficking are defined as people who were previously victims of human trafficking but who were no longer under trafficking circumstances at the time of the interview. After the objectives and procedure of the study had been explained to them, interested participants gave consent prior to their participation in this study; 164 out of the total 200 survivors who had accessed the NGOs' services during the study period were willing to be involved in this study. The response rate was 82.0%. Trafficking survivors who had been forced to work as sex workers were categorized in the sex workers group and those who worked in different areas were categorized in the non-sex workers group.

Due to their low literacy rate and cultural distrust toward written contracts, all participants gave verbal consent rather than written consent, and answered a structured questionnaire through narrative interviews. Additionally, to secure and ensure the privacy of the participants, individual interviews were conducted in a private room by experienced female interviewers who had undergone a one-week training session. We also made sure to refer study participants for psychological care when they wanted or needed to receive it through the NGO. We followed the Declaration of Helsinki recommendations to address ethical issues (*World Medical Association Declaration of Helsinki. Recommendations guiding physicians in biomedical research involving human subjects*, 1997; *World Medical Association Declaration of Helsinki: ethical principles for medical research involving human subjects*, 2000).

Materials

Participants responded to a structured questionnaire contained items addressing the participants' human trafficking experiences, such as destinations they were taken to, age when trafficked, forced jobs, and duration, in addition to socio-demographic characteristics. The questionnaire also included the Hopkins Symptoms Checklist-25 (HSCL-25) (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974) to evaluate their anxiety and depression status. The HSCL-25 contains 10 items on anxiety and 15 on depression. All items had a 1–4 response set. The anxiety and depression scores are average scores of all items divided by the number of items within the respective subscale (10 on anxiety and 15 on depression), with higher scores indicating greater mental disturbance from anxiety and depression. The HSCL-25 has previously been used for the Nepali population (Shrestha et al., 1998; Thapa & Hauff, 2005) and validated (Thapa & Hauff, 2005). A dichotomized cut-off point of anxiety and depression was set at above-average scores of 1.75 or more for both subscales (Thapa & Hauff, 2005).

Furthermore, the PTSD Checklist Civilian Version (PCL-C) (Weathers, Huska, & Keane, 1991; Weathers, Litz, Herman, Huska, & Keane, 1993) was employed to screen for symptoms of PTSD occurring in the past month that corresponded with the *Diagnostic and statistical manual of mental disorders, fourth edition* (DSM-IV) (American Psychiatric Association, 1994). The PCL-C contains 17 items. Each item has a 1–5 response scale. In addition to higher scores indicating greater symptoms of PTSD, a dichotomized cut-off point was set at a total score of greater than 50, as validated in a previous study in Nepal (Thapa & Hauff, 2005).

These instruments were used with permission of translators of the Nepali version of the scales. The questionnaire also asked about their HIV infection status.

Statistical analysis

Continuous variables were analyzed between the sex workers group and the non-sex workers group with a *t*-test. The analysis of covariance (ANCOVA), putting age as a covariate, was performed when a significant difference in age between the groups was found. Categorical data and the case proportion of anxiety, depression, and PTSD, as assessed by cut-off points of the scales administered, were compared between the groups, using the chi-square test (two-tailed) with significance set at 0.05.

Results

Socio-demographic characteristics

The socio-demographic characteristics of the participants are shown in Table 1. The mean age of the sex workers group (range 11–38 years) was significantly higher than that of the non-sex workers group (range 15–44 years) ($p < 0.01$). There was a significant difference in the distribution of marital status between the groups, showing more people in the sex workers group as having married, compared with the non-sex workers group ($p < 0.01$). The proportion of women having had a child and the number of children were higher in the sex workers group than in the non-sex workers group ($p < 0.01$) even after controlling for age difference with ANCOVA. The sex workers group had fewer family members compared to the non-sex workers group ($p < 0.01$). The sex workers group had completed significantly less education and was less literate compared to the non-sex workers group ($p < 0.05$ and $p < 0.01$, respectively). The sex workers group perceived their social and economic status to be worse than did the non-sex workers group ($p < 0.01$), though the difference in their current employment status was not significant. The prevalence of HIV infection was higher in the sex workers group ($p < 0.01$); 13 out of 44 sex workers (29.6%) were infected compared to none in the non-sex workers group (0%). This is a notable finding, as it may have important public health implications.

Table 1
Socio-demographic information

	Sex workers ($n = 44$)	Non-sex workers ($n = 120$)	$t/\chi^2/F$
Continuous variables (*M*, SD or SE)			
Age	28.0 (7.2)	20.2 (4.5)	6.7**
Number of children	0.9 (0.1)	0.3 (0.1)	17.7**
Number of family members	4.6 (2.2)	6.2 (2.4)	4.1**
Categorical variables (frequency, %)			
Marital status			56.6**
Married	29 (65.9)	22 (18.3)	
Separated	2 (4.5)	3 (3.0)	
Divorced	5 (11.4)	0 (3.0)	
Never married	8 (18.2)	95 (62.8)	
Has children	14 (31.8)	20 (16.7)	40.3**
Education			3.8*
Above primary	11 (25.0)	50 (41.7)	
None	33 (75.0)	70 (58.3)	
Literacy			10.2**
Literate	18 (40.9)	82 (68.3)	
Illiterate	26 (59.1)	38 (31.7)	
Currently employed	38 (86.4)	111 (92.5)	0.2
Current perceived social status			21.5**
Average or above	25 (56.8)	107 (89.2)	
Below average	19 (43.2)	13 (10.8)	
Current perceived economic status			9.3**
Average or above	11 (25.0)	62 (51.7)	
Below average	33 (75.0)	58 (48.3)	
HIV			58.2**
Positive	13 (29.6)	0 (0.0)	
Negative	20 (45.5)	24 (20.0)	
Unknown	11 (25.0)	96 (80.0)	

Note: *t*-test was used with continuous variables and chi-square test with categorical variables.
*$p < 0.05$; **$p < 0.01$.

Human trafficking profile

As shown in Table 2, there was no significant difference between the two groups in the number of trafficking experiences, meaning how many times in their lifetime they had been trafficked and/or passed on from one trafficker to another. All the women in the sex workers group and all but two of the non-sex workers were taken to India as a trafficking destination. The sex workers women were trafficked at a significantly older age (mean ± SD: 16.64 ± 4.00) than the

Table 2
Human trafficking information

	Sex workers ($n = 44$)	Non-sex workers ($n = 120$)	*t* or χ^2
Continuous variables (means, SD)			
Number of trafficked experiences	1.1 (0.3)	1.1 (0.3)	0.1
Age when trafficked	16.6 (4.0)	11.73 (3.4)	7.2**
Duration of trafficking (months)	29.7 (24.4)	54.3 (36.7)	4.9**
Categorical variables (frequency, %)			
Country taken to			
India	44 (100)	118 (98.3)	0.7
Nepal	0 (0.0)	2 (1.7)	
Person who made trafficking contact			
Immediate family/relative	6 (13.6)	36 (30.0)	4.5*
Stranger/other	36 (81.8)	84 (70.0)	

Note: *t*-test was used with continuous variables and chi-square test with categorical variables.
*$p < 0.05$; **$p < 0.01$.
$N = 115$ in duration of the trafficking of the non-sex workers, due to missing data.

non-sex workers group (11.73 ± 3.40) ($p < 0.01$). Regarding the persons who initiated the trafficking by bringing the victims to a trafficker, about 13.6% in the sex workers group and 30.0% in the non-sex workers group were immediate family members or relatives ($p < 0.05$). The mean duration of being trafficked was 29.7 months (range 2–144 months) in the sex workers group and 54.3 months (range 1–168 months) in the non-sex workers group ($p < 0.01$).

Anxiety, depression and PTSD

There were no significant differences between proportions of sex workers and non-sex workers reporting anxiety over the cut-off points (see Table 3). As for depression, all women in the sex workers group were above the cut-off point, compared to 80.8% of the non-sex workers group ($p < 0.01$). A significantly higher proportion of the sex workers group (29.6%) screened positively for PTSD symptoms in the past month than the non-sex workers group (7.5%) ($p < 0.01$).

Discussion

The high rate of anxiety and depression in both groups was observed, while the sex workers group showed worse status than did the non-sex workers group. This is consistent with the results of a study showing the heavy burden of mental health problems found among non-trafficked sex workers (Alegria et al., 1994; el-Bassel et al., 1997; Farley & Barkan, 1998; Gilchrist et al., 2005; Roxburgh et al., 2006). While the rate of depression found through screening among non-trafficked former sex workers with HIV in Nepal was 3%, 18% complained of psychosomatic problems (Eller & Mahat, 2003). In addition to the mental health effects of performing sex work, trafficked women undoubtedly also experience trauma by the very nature of being trafficked, as well as possibly starting out by being raped and subjected to physical abuse.

Table 3
Distribution of anxiety, depression and PTSD

	Sex workers ($n = 44$) frequency (%)	Non-sex workers ($n = 120$) frequency (%)	χ^2
Anxiety	43 (97.7)	105 (87.5)	3.8†
Depression	44 (100)	97 (80.8)	9.8**
PTSD	13 (29.5)	9 (7.5)	13.5**

Anxiety and depression were assessed with Hopkins Symptoms Checklist-25 and PTSD Checklist Civilian Version. Cut-off score set above 1.75 for the anxiety and depression subscales of HSCL-25, respectively, and above 50 for PCL-C.
†$p < 0.1$; **$p < 0.01$.

The duration of the trafficking was shorter in the sex workers group than in the non-sex workers group. However, non-significant correlations were found between the duration and anxiety, depression and PTSD (data not shown). Additionally, there was no correlation found between age when trafficked and anxiety, depression and PTSD for both the sex workers' and the non-sex workers' groups (data not shown). The fact that they were trafficked and taken to a different country might have been reason enough for mental health problems to develop, regardless of the duration of the trafficking and their age at the time of trafficking.

The sex workers group experienced more difficult social situations than the non-sex workers group. They were more likely to be older, illiterate and have fewer family members with earning power. Thus reasons for their being trafficked for sex work may include poverty and being old enough; younger female children tend to be trafficked for non-sexual work such as domestic and manual labor, and circus work.

It is necessary to take the category of work performed during the trafficking period into consideration. The sex workers group showed a higher prevalence of anxiety and depression. Depression was much higher in both groups here compared to a study in Israel of trafficked survivors who had worked as sex workers (about 19%) (Chudakov et al., 2002). Comparing with the results of previous studies in Nepal demonstrating rates of 80.7% for anxiety and 80.3% for depression (90.3% and 88.5%, respectively, in females) of internally displaced persons during an armed conflict (Thapa & Hauff, 2005) and 25% and 43%, respectively, among tortured persons (mainly male) (Shrestha et al., 1998), this study showed slightly higher rates. Some reasons for the difference may be age of the women and the nature of the traumatic events. Regarding PTSD, the sex workers group had higher rates of PTSD than the non-sex workers group. The rate of PTSD in this study was clearly higher in both groups than among the trafficked survivors who had worked as sex workers in Israel (about 17%) (Chudakov et al., 2002). This compares with 53.4% of internally displaced persons (59.3% in females) who experienced PTSD (Thapa & Hauff, 2005) and 14% of tortured persons (mainly males) who had a diagnosis of PTSD (Shrestha et al., 1998). In comparison to internally displaced persons who were still undergoing traumatic experiences, the survivors of this study had been rescued by the NGOs and were no longer experiencing traumatic events nor were they forced workers. These findings imply that

female survivors of human trafficking are considerably more vulnerable to anxiety and depression but not to PTSD, compared to victims of other traumatic events. However, further replications are needed.

Additionally, approximately 30% of the constituents in the sex workers group were HIV-positive, while this rate was nil in the non-sex workers group. This is consistent with a previous study in Nepal demonstrating that 38% of rescued victims of human trafficking who had been forced to work as prostitutes had contracted HIV/AIDS (Bal Kumar, Subedi, Gurung, & Adhikari, 2001) and other STIs (Bal Kumar et al., 2001; Gossop et al., 1995). Silverman et al. (2006, 2007) reported that 22.9–38.0% of Nepalese females trafficked for forced sex work were HIV-positive; this implies that sex work carried out under trafficking conditions incurs a high risk of contracting HIV. Unlike non-trafficked sex workers, those who were trafficked may have been forced to have unprotected sexual intercourse with clients, leading to the high rate of HIV seropositivity.

The findings suggest that measures to address this situation should include interventions to improve survivors' mental health status, paying attention to the category of work performed during the trafficking period. It would also be an effective intervention to provide community/mass education on human rights, on the increasing risk of physical and mental disorders among the general public, and on how to prevent females from being trafficked.

The present study has some limitations. First of all, though the study revealed a very high rate of depression and anxiety, it did not indicate the need for active psychiatric treatment against depression and anxiety, since the scales employed did not give a clinical diagnosis. Many of them are probably in need of general psychosocial care and assistance while some of them may be in need of specialized health care. Next, there is the possibility that some of the non-sex workers group had performed sex work during the trafficking period, but hesitated to reveal this fact since prostitution (sex work) and other sexual matters are taboo and stigmatized in Nepal. Therefore, the number of those in the sex workers group may be underestimated. Additionally, the participants were recruited from recognized organizations that offer support to them; we did not include women outside the NGO network. The mental health status of non-rescued trafficked workers might be even more severe. Furthermore, the number of the participants seems to be relatively small compared with usual epidemiological studies. However, human trafficking is a very sensitive issue. In this regard, the present study is a first step toward documenting the problem. Lastly, it is possible that HIV infectious status was under-reported in this study since HIV testing was not done and the some participants reported that they did not know their status.

In conclusion, female survivors of human trafficking showed high rates of anxiety and depression, especially among those who were forced to work as sex workers. To help relieve this problem, the prevention of human trafficking itself is needed, which can be advanced though the implementation of government policies. The United Nations System and other international communities including the Association of Southeast Asian Countries (ASEAN) in Asia need to increase their action to prevent human trafficking, which is a human rights violation (Beyrer, 2001). In addition, response and protection programs for survivors of human trafficking are warranted. In this regard, the findings suggest that measures to address this should include interventions to improve their mental health status as well as psychosocial support, depending on the type of forced work.

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