

# Bringing it all back home



A research on the  
reintegration of  
survivors of trafficking  
in their families and  
communities

## Prologue

For Yasmin who asked...



Do you know how bad it feels to be scared to stay in any room which has bars on its windows...reminds me of the police station, the brothel, the shelter home and back in my home, in my village...all of them had iron bars... why do all window bars feel the same everywhere?

For Yasmin who said...

And 'you' can say sorry for what you did and I will most likely try to move on and forgive 'you'  
But 'you' cannot say sorry to that thirteen-year-old girl at her sister's house  
Because, as of today, that scared little girl no longer exists...



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**A SANJOG INITIATIVE**

## INTRODUCTION

With the Supreme Court of India passing directives to the Union and State Governments to develop policies and instruments for assistance to women in prostitution, it is an important time in India for the legislature to know what kind of policy will benefit the intended constituency. The State policy in India, on rehabilitation of trafficked persons, relies on rescue operations, rehabilitation services in shelter homes and returning children and women back home, to their communities. Service providers and stakeholders of this system are also aware of its challenges – the scarcity of experienced and skilled social workers and counsellors to implement rehabilitation services, the lack of sensitivity towards survivors in our law enforcement systems or inadequacy of health care services, the challenges in managing shelters, challenges in coordination and communication between states and countries for family identification and checking feasibility for returning survivors to their families for reintegration and so many more.

*Where Have All The Flowers Gone* (P. Banerjee, Sanjog, 2010) was an important research in this region that forced us to confront the poor impact of services in rehabilitation of the survivors. Debates and discussions, triggered by the stark findings of that research, also helped provoke the question – what is the location from which research examines its realities?

- Is it an extraspective location from where one can only accuse the system for its inefficiencies, or does it attempt to understand its stresses and pulls, the tensions within the system, and between the system and the context, as a phenomenon for diagnosis?
- Are we reflexive of our own interpretations, of the data we

generate, of what we see and hear, and mindful of our projections onto others, the system and the context?

This process of challenging ourselves, and clarifying our location and methodology was a serious part of the rigour in this research. For one, it tries to deconstruct what rehabilitation would mean for survivors of sex trafficking who return to their homes.

- Should rehabilitation mean a 'state of a person, free from all physical and psychological impact of having been trafficked, tortured and forced into physical and sexual bondage'? Or should it mean a 'state of a person wherein a survivor will have learnt to cope with the trauma of having been trafficked, and other consequences therefrom, without maladaptive behaviours'?
- If the tacit policy assumption on rehabilitation of victims of sex trafficking is that services in shelters post-rescue, and returning them back to their families, will have ensured recovery (from health impacts) and reintegration of survivors in their families and communities, how do we measure or determine the status of these outcomes with survivors?
- How should we study survivors' access to rehabilitation services, or lack of it therein (carrying a bias from earlier researches which claims the lack of rehabilitation services reaching survivors, post their return to their families)? Should we check only availability of services, or should we try to listen to survivors and service providers both, to understand the problems in service delivery? What questions may be useful to help service providers or duty bearers respond to questions without feeling judged or attacked?



We have been mindful and reflective in



asking ourselves these questions while designing the framework, methodology, tools and most importantly, while interpreting the data.

With each research, we learn a lot from the implementation of the research design and methodology.

- Using the assimilation and acculturation framework may be very useful to understand reintegration of survivors, discounting any expectation that survivors must or must not dissolve their distinctiveness of identity in order to assimilate with their families and communities. What has also been a ‘revelation of the obvious’ is that while we may have started out being mindful about the stress of survivors in assimilating within their families and communities being subject to stigma and discrimination, it is equally important to understand and accept that the family and community, with its own (patriarchal) values and norms around masculinity, femininity, body and sexuality, marriage and procreation, undergoes stress in having to resolve its own biases and prejudice that it must construct and protect to maintain the roles and boundaries of their order and systems – in families, communities and villages. Researches that study reintegration of survivors of human trafficking or other population may find it useful to develop on this framework.
- Like HIV AIDS, human trafficking has also forced rural India (and rural, agrarian communities of many other countries) to deal with critical issues around sexuality, particularly of girls and women. Child marriage has been a traditional way of protecting monogamy, patrilineality and patriarchy. But with the phenomenon of greater mobility and migration in girls and women, families and communities having to rely on women’s remittance as a necessary source of income, of having to deal with the incidence of sex trafficking where girls and women in prostitution return to their families, the known social order is under stress. This is resulting in increase of violence against girls and women, as a backlash of the patriarchal system.
- It has been a very useful idea to offer survivors clinical testing (mental and physical health) as a research method. For one, we found that research participants were much more keen and interested in these tests – wherein they found concrete benefit for themselves, know the reasons of their problems and pursue its treatment thereafter. On the other hand, they were much less interested to join in focus group discussions, where they felt that they had to repeat and relive narratives that they had said many times before to many different people, and that offered them nothing beyond a promise that the research would benefit them or people like them in a larger way.
- Studies on survivors of sex trafficking have utilized mental health tests but have usually assumed presence of trauma and have restricted mental health in terms of absence or presence of PTSD (Post-Traumatic Stress Disorder) only. This study made a departure by trying to understand the personality make-up of a survivor in order to unearth the conflicts and needs that shapes her responses. However, we had to drop results from the Bender Gestalt Test that was administered along with other tests; as such, results were expected to point towards an organic predisposition towards ‘risky behaviour’ for which we did not have any control group

for meaningful comparison. Absence of a control group could have been a limitation if the basic purpose of the mental health study was to make predictions. However, our purpose was to identify how this group of survivors may differ from the general population, in terms of their mental health status, and that did not necessitate a control group.

We thank all who have been instrumental in making this research possible. The research team including Dr Ishita Majumdar as the Principal investigator, Dr Chandrani Dasgupta as Editor, Indrani Chakraborty and Ruma Das as Research associates, Dr Soumitra Basu and Samita Das as Research consultants for health assessment, The PAT Network of community-based organisations in North 24 Parganas – BUP (*Barasat Unnayan Prostuti*), CLHS (*Charuigachchi Lighthouse Society*), GSS (*Gokulpur Seva Sadan*), KEYA (*Katakhal Empowerment and Youth Association*), MATE (*Malipota Association for*

*Transformation of Environment*), NSSS (*North 24 Parganas Shamyo Sromojibi Samiti*), SBMS (*Seth Bagaan Mahila Sangha*) and TISM (*Teghoria Institute of Social Movement*) as Research coordinators, Nisha Mehroon as Project manager, Smita Sen as Programme officer, Snehasish Sarkar as Financial manager and Nityananda Ghosh as Support and, last but in no means the least, our Research financers and supporters –The Anesvad Foundation in Spain.

And thanks and respect to all the survivors who participated and shared their stories with us – shared their experiences of feeling pushed, thwarted, coerced, shamed as girls and women. And then again, shared stories of surviving, hoping, dreaming again... of walking through this journey by themselves and together...



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# Bringing it all back home

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*Bringing It All Back Home* is a work of great perseverance and keen observation of the lives of girls who were reunited with their families after having been trafficked for sex work. The uniqueness of this study lies in what it doesn't study, as much as it lies in what it does. While reviewing literature on trafficking and women, a lot was found on the incidence of trafficking, the trafficking experience and anti-trafficking efforts, but very little information on in-depth and holistic understanding of experiences of survivors of trafficking who are reunited with their families, was found. This study fills this gap in knowledge by beginning the enquiry from the point at which the survivors are back in their families and communities post-rescue from sex work. There is very little, if any, mention of their sex work experience in this study. Instead, what the reader will find is an almost exclusive focus on life, post-reunification.

This study will interest people who are working in the broad area of human trafficking and will be most informative for someone working or interested in rehabilitation of survivors of sex trafficking. There is analysis and data in this report that can serve as strong lobbying points for people or organisations interested in persuading the State for better action for this group.

Sociologically, it presents the nature and consequence of interactions between the survivor and her family and community. It tries to explain the reason why families and communities react the way they do. In terms of health, the report presents disturbing data on the status of mental and physical health of the survivors, a very useful and scarcely available data, especially in the Indian context. In this report, one will also find an in-depth analysis of various State duty bearers' and service providers' knowledge and role towards survivors of sex





trafficking. It critically examines the machinery in place, identifies gaps and explains why these gaps exist. Hence, the report is not just a description of events or data but also an explanation of why things are, the way they are.

The first chapter introduces the problem statement and lays out the methodology. Here, one will find all the information pertaining to the rationale for this study, participants, methods, ethical considerations and limitations. This chapter is the foundation for the rest of the report.



The second chapter presents findings on the process of assimilation of a sex trafficking survivor into her family and community. It presents information and analysis on the nature of societal reactions and her own efforts at dealing with such interactions in order to fit into her role of a daughter, sister, mother, wife, friend, colleague, etc.

The third chapter presents the physical and mental health status of the survivors. This chapter is based on both, the survivors' account of health and a clinical study of her health. It presents a well-validated account of their health status and explains the implication of such consequences.

The fourth chapter presents an in-depth and layered analysis of various governmental systems represented by duty bearers and service providers who are responsible for protection and empowerment of the survivors. It offers a policy praxis analysis and presents barriers to service access and reasons for such barriers.

The final chapter presents a summary of the findings and leaves the reader with points of further enquiry, questions that emerged through this research but were beyond its scope.

## INTRODUCTION

*“Out of 552 returnees to West Bengal, only 18 (3%) received support towards relief and welfare; none of them towards livelihoods or vocations.”*

*“Ujjawala ineffective in meeting rehabilitation needs of survivors post-family reunification, does not use a case management strategy.”*

**Sanyukt Snapshots<sup>1</sup>**

*“In West Bengal, both, restored victims and their families, were found to be completely unaware of any role the State might play in terms of rehabilitation of the survivor.”*

**Where Have All The Flowers Gone?<sup>2</sup>**

*Where Have All the Flowers Gone* and *Sanyukt Snapshots*, and many other micro reports by anti-trafficking NGOs, have consistently observed that once survivors of sex trafficking return back to their families, they do not receive or benefit from any further rehabilitation or reintegration services. In *Where Have All The Flowers Gone*, researchers (Banerjee and Bandyopadhyay, 2010) observed that survivors of sex trafficking were often worse off than in their pre-trafficking condition, as they now had added burdens of shame and stigma, along with the poverty and deprivation that had made them vulnerable to trafficking in the first place.

Lack of reintegration support towards such survivors is suspected to force them into expulsion from their families and communities, and force them back into prostitution or other exploitative conditions. The reintegration process itself is complex and requires unraveling in order to understand why survivors of trafficking fail to benefit from welfare services of the State.

Studies in Nepal have suggested that reintegration of trafficked survivors is a problematic situation marred by stigma and shame, it is especially difficult for

survivors belonging to dysfunctional families or broken homes. However, in the same context, survivors identified economic independence as a solution to their problem of reintegration. Success of reintegration was also related to awareness built to reduce stigma by NGOs<sup>3/4</sup>.

Despite being reunited with their families, girls in Nepal encountered several challenges, such as gender-based violence, sexual exploitation, verbal abuses and inadequate sustainable income that hindered this process<sup>5</sup>.

Wickham (2009)<sup>6</sup> reports several political, economic and social challenges to successful reintegration. Lack of sensitivity to and understanding of sex trade is one among them. This refers to the oversimplification of the problems faced by people rescued from trafficking, and stereotyping them as naïve, stupid, dirty and immoral, by people who do not understand their complex circumstances. Wickham further explains that trafficked survivors are denied Governmental services at times, due to their own decisions, which are in reality taken under duress rather than willingly. Economic rehabilitation as a panacea is also criticised for overlooking the need to address physical, psychological and behavioural repercussions of violence and exploitation experienced both, before and during the sex trade.

Considering such findings and opinions, the present study aims to study the status of girls rescued from various parts of India and reunited with their families in North 24 Parganas in West Bengal. The problem identified is that of understanding challenges in reintegration after survivors were reunited with their families.

This research tries to answer three basic questions:

**(a) What are the service requirements by**



<sup>1</sup>Sanyukt – A case management regional project implemented in India, Bangladesh and Nepal; 2009-2012; Sanjog, The European Commission and Groupe Development

<sup>2</sup>Where have all the flowers gone? Research on Sex Trafficking in India, 2010; Sanjog

<sup>3</sup>Terre des homes. (2003). Child Trafficking in Nepal: An Assessment of the Present Situation: Terre des homes. Available at <http://www.reliefweb.int/library/documents/2003/tdh-nep-2jun.pdf> accessed on 12.12.13.

<sup>4</sup>Crawford, M and Kaufman, M.R. (2008). Sex Trafficking in Nepal: Survivor Characteristics and Long-term Outcomes. Violence Against Women: Sage Publication, Vol. 14, No.8. Available at <http://vaw.sagepub.com/content/14/8/905.full.pdf> accessed on 5.4.2011

<sup>5</sup>Adhikari, S. (2011). REINTEGRATION OF THE NEPALESE GIRLS TRAFFICKING RETURNNEES INTO SOCIETY- An Empirical Study of Reconstruction of the Self Identity: 'A Matter of Pride or Shame or Both?' Ph.D. Faculty of Social Sciences, University of Nordland, Norway.

<sup>6</sup>Wickham, L. (2009). *The rehabilitation and reintegration process for women and children recovering from sex trade.* Available at [http://www.ipg.vt.edu/papers/Wickham\\_Sex%20Trafficking%20Victims.pdf](http://www.ipg.vt.edu/papers/Wickham_Sex%20Trafficking%20Victims.pdf)

**survivors of sex trafficking towards assimilation in their families and communities?**

- (b) What is the degree of their access to health, welfare or other services that are necessary to sustain their restoration, recovery and rehabilitation?**
- (c) What are the barriers to access, if any, and what factors are responsible for these barriers?**

### Defining Trafficking

The 2010 study by Sanjog, *Where Have All the Flowers Gone*, adopted a definition of trafficking based on the SAARC convention<sup>7</sup> as this definition guides legal provisions within India.

The SAARC convention defines trafficking as 'moving, selling or buying of women and children for prostitution within and outside the country for monetary or other considerations with or without the consent of the person subjected to trafficking'. Though inherently flawed, as it defines trafficking with respect to prostitution only, this definition was adopted in the previous study because of its legal acceptance in the country. We shall thus treat this as our understanding of the term 'trafficking' keeping the girls who were rescued and returned as the focal point of all our analysis and debate.

Globally, it is estimated that human trafficking and forced labour affect around 20.9 million people. India is a source, transit and destination country for men, women and children who are subjected to forced labour and sex trafficking. Almost 90% of the trafficking though occurs within the national borders. Human trafficking is largely a hidden crime and only a small number of victims have access to justice<sup>8</sup>. A study such as this therefore, aims to work with a population that is largely invisible as far as records and numbers are concerned. There have been several

studies on trafficking in terms of the incidence and nature but very few have commented on the post-rescue reintegration process of a survivor, especially in the present setting.

Before introducing the problem statement in detail, a case study of a survivor will serve to highlight the process of trafficking as it happens.

*Nasima, eldest among her siblings, belonged to a joint family of ten members and was studying in class IX. Loved and admired, she was a typical daughter – obedient and of good conduct. She spent time chatting with friends, specially with one who was very close to her. She also helped her mother and aunt in sewing and stitching. They owned cattle and a small piece of cultivable land behind their house. All these together were the sources of income for their family.*



*Everything was normal, till Nasima's close friend confided in her about her boyfriend Kalam, and requested her to help her elope with him. Though reluctant initially, Nasima gave in to her friend's repeated requests and accompanied her to a station nearby called Machlandpur. Kalam was nowhere to be found. Instead, two unknown men approached them and said that as Kalam's family was against him, he was waiting in another place called Habra, and that he had sent them to take Nasima and her friend to Habra. They also told the girls that Kalam had sent a car for them and no one would notice where they were going.*

*Nasima refused to go any further. However, the sight of the car tempted her to have a ride as this was the first time in her life that she would be sitting in a car. The two strangers assured Nasima that she would not have to go to Habra and that they would drop her near her home on their way. As soon as Nasima and her friend got into car, the car drove off and took a different route. Nasima was about*

<sup>7</sup><http://www.saarc-sec.org/userfiles/conv-trafficking.pdf>

<sup>8</sup>Baseline study of UN women's anti-human trafficking programme. February 2013

*to scream out loud but she was threatened at gunpoint that any disobedience from them would lead to their death. Nobody outside got any hint as the car had tinted windows, which prevented visibility from the outside. After an all night journey, Nasima and her friend arrived in an unknown place, which in fact, was a brothel in Bihar. The brothel was run by a hijra (eunuch) who would take girls from the brothel to local dance bars of that place, where the girls danced and earned money for the hijra.*

*It so happened, that once the driver who regularly took the girls to the dance bar, got intimate with Nasima, who tactfully managed to get his cell phone and make a call to her father, describing to him in brief, the torture and pain they were undergoing. Nasima's father immediately contacted the local police station at Swarupnagar and gave them the driver's cellphone number (from which Nasima called him up). The Officer-in-Charge assured Nasima's father that they would rescue his daughter, if he agreed to accompany him. The OC established contact with the local police station of Bihar and tracked the place with the help of the cellphone number. West Bengal Police and Bihar Police together raided the brothel of the hijra and rescued Nasima and her friend, along with some other girls from the brothel and arrested the hijra.*

*Nasima knows that Kalam was sent behind bars for about three months and the case is going on. She expressed her gratitude to the police who rescued and rehabilitated her to her family. However, since returning home, Nasima finds her life has changed forever, as she lives a life of seclusion as no one in her village wants to associate with her. She is discriminated and despised at. Her school life is equally miserable, as even there she is stigmatised. However, her family members are supportive, as they know she is innocent.*

*Nasima does not want to come out of her house, as others don't seem to accept her lack of collusion in the whole matter.*

*Now, Nasima wants to be a nurse and dedicate her life for the well-being of others. She also wants to earn money and support her father financially. She does not want to marry, as she believes that no one would marry her and if they came to know about her past; they will forsake her. However, if at all she has to marry, she would marry someone who will accept her with the full knowledge of her past.*

#### **PROBLEM STATEMENT**



In India, reparation services for trafficked survivors are designed centrally through law enforcement, where the focus is almost entirely on punishment of traffickers or all associates of the trafficking process. The rehabilitation framework for trafficked survivors deals with the issue of 'health care and social protection need' for restored survivors in a very general manner.

The general hypothesis in post-rescue phase is that the healthcare counselling and vocational skill-building services received through institutional care at rescue-rehabilitation phase, would fulfill the critical protection need of the trafficked survivors. It is assumed that the survivors will access general health care and welfare services of the State as and when required, especially after they are returned to their families and communities. In the stated model, it is expected that the survivors, after their restoration within the family, would cope with upcoming situations and no difference in accessing care protection services by them is foreseen.

The overall focus for post-rescue services is laid on punishing traffickers and their associates, which does not take into

account–

- i) Restoration work in terms of health – both physical and mental, that takes the brunt of her trafficking experience;
- ii) The life skill need of the survivors to enable them to have a better option for social assimilation.

Till date, very little has been reported on how the rehabilitated survivors of trafficking get integrated into the context of their own family and community from where they were trafficked, or what sort of assistance and services the survivors require to lead their life normally. There is no published report on the impact of the release of Government funds through various welfare schemes on the life of rehabilitated survivors. Primary observation through intervention experience and anecdotal evidences envisage less participation by the survivors within different interactional contexts, including their family and community.

The one-way welfare approach of the State leaves no room to study compatibility, compliance and accessibility of these services. The option to bridge the gap for any identified mismatch is not available. Stigma and non-acceptance of the survivors of trafficking by family and society is posited to act as push factors to send these girls back to the places from where they were rescued. But any empirical evidence justifying this is yet to be published.

Keeping these factors in mind, the study was developed to focus on three aspects of a survivor's life, namely:

- Assimilation
- Health
- System access

## Specific questions within each focus area

### Assimilation

Assimilation, sometimes known as integration or incorporation, is the process by which the characteristics of members of immigrant groups and host societies come to resemble one another. That process, which has both economic and socio-cultural dimensions, begins with the immigrant generation and continues through the second generation and beyond. Assimilation might be incomplete because it is blocked outright, delayed or unfinished, but the type of incompleteness matters, because it has implication for theory and policy frameworks. The reintegration process of survivors is being studied as an assimilation process, though theoretically they do not represent a migrant group seeking to settle in a host community; however, there are similarities in terms of their struggle to fit in, as suggested by existing literature. The questions are:

- i) What is the quality of life of a woman rescued from trafficking and returned home?
- ii) What is the nature of their participation in a social-cultural domain?



### Health

According to a WHO report<sup>9</sup>, despite obvious implications of the health service needs of survivors has been understudied especially when compared to attention paid to law enforcement aspects of trafficking. Moreover, because research on health of trafficked survivors has been focused on sexual exploitation, the results have generally focused on sexual health needs such as HIV/AIDS and to a lesser degree on mental health or general physical health needs.

Hence, the present study focuses not just on physical but also on mental health

<sup>9</sup> Understanding and addressing violence against women: Human Trafficking. WHO and Pan American Health Organization. [http://who.int/reproductivehealth/topics/violence/vaw\\_series/en/index.html](http://who.int/reproductivehealth/topics/violence/vaw_series/en/index.html)

needs of survivors of trafficking. The questions are:

**i) What are the health (physical and psychological) needs of a survivor of trafficking?**

**ii) What healthcare (physical and mental) services are available in the district for the survivors of human trafficking and sexual exploitation, particularly to address health conditions resulting from the impact of human trafficking and sexual exploitation?**

**iii) What are the barriers or challenges in accessing health care services by survivors?**

#### System access

Findings of abysmal utilisation of services by trafficked survivors warrant a critical analysis of the system of implementation and utilisation of welfare services. With respect to the 18 cases that were identified to have utilised welfare schemes in West Bengal by the *Sanyukt Snapshots* report, the trigger seemed to have been successful lobbying and personal motivation of a duty bearer rather than institutional or policy responsiveness, hence vindicating the need to conduct a systemic analysis to identify challenges, gaps and best practices.

The questions are:

i) What is the status of implementation of the welfare schemes in North 24 Parganas and what is the nature of access to services by survivors of human trafficking and sexual exploitation?

ii) What are the allied welfare schemes that could benefit survivors of human trafficking and sexual exploitation and how well are they utilised in North 24 Parganas?

iii) What are the barriers in survivors'

accessing rehabilitation services under these welfare schemes?

#### Objectives of the study

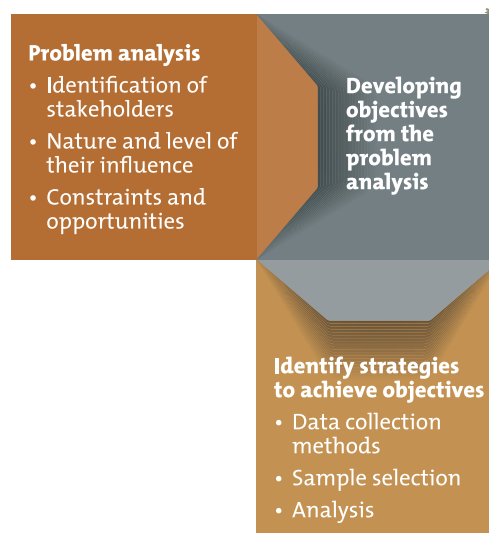
1) To study a survivor's reintegration status by understanding how well they assimilate in their societies and the challenges therein.

2) To study physical and mental health status, and thereby assess health service needs, if any.

3) Conduct systemic analysis to understand survivors' access to health and welfare services and barriers therein.

#### METHODOLOGY

Figure 1.1 Study Plan



A qualitative methodology was used to study the status of women rescued from trafficking and restored back to their families in North 24 Parganas, West Bengal. The methodology of the study was driven by the socio-cultural constraints impinging on participation of respondents whose identity as a sex trafficking survivor draws social ire and ridicule and who herself might be extremely hesitant in participating due to various reasons. Therefore, the

sample size for different qualitative techniques has varied as per availability of respondents, willingness to participate in the study and type of information targeted to collect from each category of respondents. The unit of analysis is the theme of assimilation, health and system access rather than the survivor herself. For the theme of health, apart from qualitative data collection, a clinic-based study was conducted using psychological assessment tools, laboratory tests to measure physical health indices and psychiatric evaluation by a psychiatrist working in the field for many years.

**Research Team**

Figure 1.2 Organisation of Research Team



Considering the context and intensity of the problem, Sanjog – a technical resource organisation, working in association with eight NGOs (henceforth called Partners Against Trafficking, PAT) of North 24 Parganas, West Bengal, India at the grass-root level with support from Anesvad, Spain adopted a time-bound agenda and began executing a capacity building project to enable communities and the State agencies on restorative practices to ensure

health and rehabilitation rights for survivors of human trafficking and sexual exploitation. For effective and result-based intervention, the project also conducted the present research to provide sufficient context specific data to answer gaps in the restoration framework.

**Why North 24 Parganas?**

North 24 Parganas is geographically located near India’s boundary with Bangladesh. This area has featured prominently and repeatedly in literature of trafficking, as a source and transit point for the last decade, because of which Sanjog and its partner organisations, PAT have been actively involved in prevention, protection and rehabilitation work in this area. The fact that social workers have been involved in lives of trafficking survivors over several years and in coordinating legal actions against traffickers makes North 24 Parganas a unique social laboratory.

This allows for continuity in engagement with lives of survivors after the research is completed and results disseminated. Therefore, a longitudinal approach through action, based on research is possible in North 24 Parganas, consolidating it as an ideal research location for the present issue.

The Blocks covered within this district were – Basirhat, Barasat, Hasnabad, Swarupnagar, Bongaon, Gaighata, Baduria, Bagda and Sandeshkhali. The survivors were rescued from various parts of the country, mainly Mumbai, Pune, Delhi, Bangalore and parts of Uttar Pradesh.

**Participants**

The survivor sample for this study came from an undefined universe. In such a situation, they were identified and invited to participate in the study by NGO partners involved in prevention,



protection, rescue and rehabilitation services with the study group over several years.

The selection of sample was entirely based on voluntary participation by women who responded to the invitation to participate in the study. There were several who declined to participate or who left mid-way. Probable reasons for such loss of sample could be

- i) Interruptions in survivor-social worker relationship
- ii) Migration due to marriage
- iii) Forced migration or expulsion from home
- iv) Fatigue effect from re-telling the same incident at various points in time

**Inclusion criteria**

- 1) Respondent should be a survivor

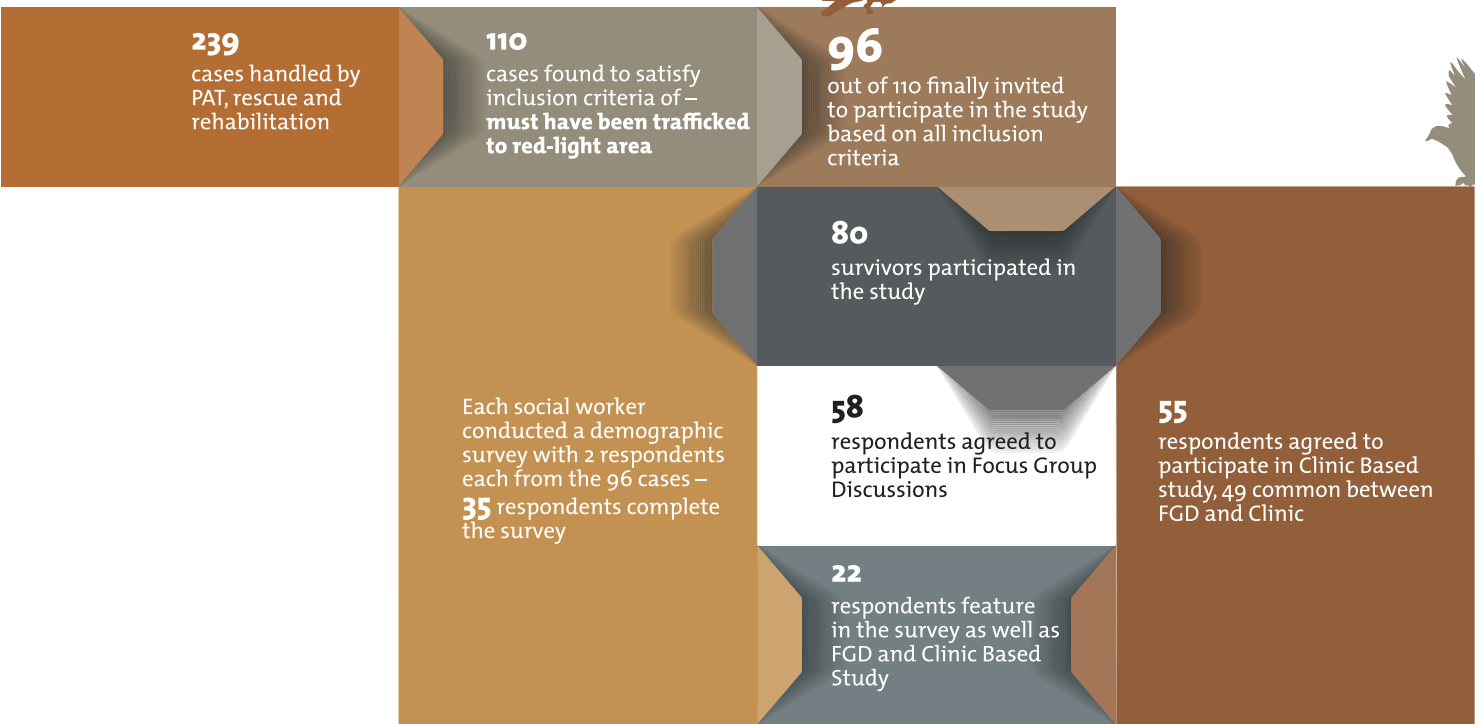
of trafficking (not rescued in-transit and must have been a victim of sexual exploitation in a red-light area) and above 12 years of age (at the time of being trafficked).

- 2) Rehabilitated in the working area of project implementation – Basirhat, Barasat, Swarupnagar, Hasnabad, Bongaon, Gaighati, Baduria, Bagdah and Sandeshkhali Blocks of North 24 Parganas.
- 3) Returned home not more than two years before participation in research.

These criteria guided the selection of the sample, though these were not exclusive. The group was hence an amalgamation of all these features.

Figure 1.3 shows the sample allocation in terms of various phases of research. The pool from which respondents were invited to be a part of the study consisted of girls rescued and rehabilitated with

Figure 1.3 Sample collection





the co-ordinated efforts of PAT and Sanjog in North 24 Parganas. The age of respondents ranged from 13 to 30, out of which around 31% were below 18 years of age and 57% were between 18 to 20 years, while 11% were above 20 years. The demographic detail of survivors is based on a survey that was possible with only 35 girls. Since only 22 out of 35 girls participated in the larger study, we shall not go into details of the survey data; only broad trends have been described next.

Most of the respondents were literate (94%) having been to schools, but 63% were school drop-outs. One-third had completed studies till Class 8, while 6% had passed Class 10. After being rescued, 28% had resumed school. Reasons for not starting school were: not interested (25%), economic constraints (25%) and fear of trafficker (7%).

Around 67% reported their per capita family monthly income was less than or equal to 1,000 INR, while 35% reported it as less than 500 INR. Most of the families

were landless labourers and almost all were from Below Poverty Line status. About 26% had cultivable land holdings. 76% of the families were under debt of village moneylenders.

With family sizes ranging from six and more (50% reported this), the economic burden on these survivors was quite evident. FGDs revealed that most of the survivors were elder in birth order, with multiple siblings. Around 68% of the survivors were Muslims. So our sample consisted of largely literate girls from Muslim households belonging to lower socio-economic groups.



Another important group of respondents constituted of people/officials who had a stake in the survivor's rehabilitation process. These respondents were part of the State welfare system and family and in their roles as protectors and duty bearers; their involvement in a survivor's life during her restoration and reintegration process was of great essence. Their details are given in *Table 1.1* below:

*Table 1.1 Stakeholder sample*

| Level  | Source (number of respondents in parentheses)   |
|--|---|
| District   | Superintendent of Police (SP,1), District Social Welfare Officer (DSWO, 1), Chief Medical Officer of Health (CMOH, 1)   |
| Block Administration                               | Block Development Officer (BDO, 3), Community Development Project Officer (CDPO, 2)   |
| Block health                                       | Auxiliary Nurse Midwives (ANM, 3), Accredited Social Health Activists (ASHA, 10), Anganwari Workers (AWW, 15), Block Medical Officer of Health (BMOH,3), Medical Officer (MO,1), Anwasha counsellor (2) |
| Local police station                               | Officer-in-Charge (OC, 2)   |
| Panchayat  | Panchayat pradhan (5), Panchayat member (5), Samiti representative (3), Samiti official (1)   |
| Family   | Family members and care givers (15)   |
| <b>Total Duty bearers, care giver participants</b> | <b>73</b>   |

### Methods and tools of data collection

#### 1) Secondary data review and analysis:

Project documents, policies and programmes, utilisation of different schemes for survivors at district level. This resulted into a stakeholder and policy mapping.

#### 2) Demographic survey of respondents:

The survey questionnaire focused on various socio-demographic aspects of a survivor's life.

#### 3) Focus group discussions on various themes<sup>10</sup>:

An innovative projective tool was used to initiate discussions in various sessions. This was a set of paintings depicting either a portrait of a girl/woman, a typical school scene, a government office scene, etc. (present in Annexure I). Made by a trained artist, the aim of using these paintings was to help participants overcome initial inhibitions by initiating discussions around the girl/s in the picture, rather than about themselves.

#### 4) Open-ended interviews with stakeholders and service providers:

The interview schedules are presented in the Annexure; there were different sets for different duty bearers, depending on their roles.

#### 5) Psychological assessment tools:

a. Thematic Apperception Test (TAT), a projective test, was selected as verbal responses would be more suitable for the sample to be studied, given their limited educational background. Nine cards were specifically selected from the original version of TAT which would do justice to the study group and draw as much information as possible to elicit the traits, anxieties, conflicts, needs and relationship patterns of the population at one sitting. Card nos: 1, 2, 3GF, 6GF, 8GF, 11, 13MF, 14, and 17 were shown. The qualitative analysis of responses was done in accordance with Bellack's norms.

b. Barratt Impulsiveness Scale (BIS II, Patton JH, Stanford MS, Barratt ES, Factor Structure of BIS, *Journal of Clinical Psychology*, 51, 67:768-774, Nov 1995). This test was conducted to study an overall impulsivity along with second order factors such as attentional, motor and non-planning dimensions of personality.

#### 6) Laboratory test of physical health included the following:

a. Routine Haemogram including Hemoglobin, Total and Differential Blood Count, ESR

b. Complete Liver Function Test

c. Thyroid Function

d. VDRL

e. Assessment of Pregnancy



7) **Psychiatric evaluation** by a practicing psychiatrist using Diagnostic and Statistical Manual, fourth edition (DSM IV) and International Classification of Disorders, 9th edition (ICD 9) guideline including a mental status examination (MSE).

### Procedure

For the Focus Group Discussions (FGD), participants were identified by PAT members and invited to participate in the study. In some instances, FGDs could not be conducted due to lack of participants. The lowest number of participants in FGD was 6, average number of participants was 8. Duty bearers were interviewed by taking prior appointments.

For the clinic-based study, participants were interviewed and tested away from their homes to ensure some degree of anonymity. Arrangements were made for comfortable transport to and fro the test venue. It was presumed that drop-outs could be high due to social stigma, hence both psychological and physical

tests were carried out on a single girl in a single day. As blood tests required a minimum of 4 hours on an empty stomach, care was taken to provide adequate and wholesome food to the respondents. The psychiatrist first interviewed the participants and later prescribed medications based on their psychological and physical health assessments.

### ETHICAL CONCERN FOR THE STUDY

To preserve the right of respondents, various ethical considerations were adhered to:

- Confidentiality was maintained by not using the real names of the survivors and family/care givers at any point of reporting.
- Voluntary participation and withdrawal from participation without any explanation was practised.
- Informed consent was taken and description of participant's rights was done, before data collection. For minor respondents, informed consent from parents was taken as well.
- During FGDs, there were times when the participants broke down crying. In such instances, the procedure was interrupted and participants were allowed to vent out their emotions, resuming the discussion only when they appeared to be comfortable again.

### STUDY LIMITATIONS

Social research is based on human responses and social contexts. Both these aspects are ever changing, making it extremely unwise to generalise results beyond the study context. However, one can generalise the findings of this study to other groups with similar demographic and socio-cultural profiles, with a caveat of research discretion.

The present study used a cross-sectional

sample, but since no groups were being compared, the disadvantages of cross-sectional sample over longitudinal sample diminish considerably. However, one must treat the findings with caution as they represent a range of responses obtained and analysed qualitatively. The issue of subjectivity remains present and appreciated as the study aims to understand lives of girls and women rescued from trafficking. It is an inductive study and hence the reader is encouraged to look at it as a field-based research, generating knowledge on a very poorly represented section of the society.



Apart from such methodological limitations, accessing survivors who agreed to participate in the study was very challenging. Due to various reasons, survivors did not participate and some left mid-way, leading to variance in sample size for various parts of the study.



*“After I was rescued, I came back home and even took admission in a local school. But I was isolated and given a separate seat in the class. The teachers told my parents that other girls in the school would have a similar fate if they remained friends with me. My classmates used to ask me many awkward, insulting and embarrassing questions. For these reasons, I quit school in the end” (17-year-old girl).*

Assimilation, sometimes known as integration or incorporation, is the process by which the characteristics of members of immigrant groups and host societies come to resemble one another. It is a concept through which one can study mainstreaming of a minority group. The present chapter explores the myriad ways in which girls who were reunited with their families, reintegrated into their homes and communities, though same, but changed, since they were trafficked, rescued and ‘restored’. The assumption here is that these girls share an identity of being victims/survivors of sex trafficking within their society. By the virtue of this new identity, trafficking survivors represent a minority group, marked by having been forced into sex work. Thus, returning from their absence in the community is not a simple process of reintegration, given the socio-cultural meanings impinging on their reason for absence – sex work. Thus, a parallel is being drawn between a migrant community finding its place in a host community and a trafficking survivor finding her identity in her host society.

By studying the process of assimilation, we intend to draw out the problems/challenges inherent in a linear model of rescue and rehabilitation. The survivor, who is a victim of trafficking, is taken back exactly to the place from where she was trafficked, with very little thought spared as to how she would be received by her family and community or how would she respond to the changed

dynamics. The study scrutinises this exact interplay between the survivor and her environment, comprising family, neighbours, friends, peers and service providers. Focus Group Discussions intending to capture a survivor’s assimilation process were conducted on the themes presented in *Figure 2.1* below and the findings are discussed beneath.

*Figure 2.1 FGD themes to study assimilation*

- Attitude towards life
- Incidents of violence, threats, etc. within the family and in society
- Events of exclusion
- Survivor’s response to reactions of family and society

### **‘THROUGH THE LOOKING GLASS...’**

Traumatic events can leave an indelible mark on a person’s life in terms of her life expectations and her general world-view. To study reintegration, it is imperative to analyse a survivor’s frame of reference in terms of meaning making. How she makes sense of her experience will impact on the way she understands herself and her world.

Psychologist Janoff-Bulman (1992)<sup>11</sup> has posited that traumatic experiences can challenge global belief systems, which include assumptions that the world is benevolent, the world is meaningful and the self is worthy. When events in life shatter these assumptions, the person may come to believe that the world is not a safe and predictable place, that bad things may befall good people or that she deserved the misfortune. To study whether similar changes had occurred in the survivors’ world-view, an innovative projective tool in the form of portraits of girls was introduced during FGDs to initiate discussions.

To initiate discussions, typically the girls were asked to look at the girl in each

<sup>11</sup> Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York: Free Press.

portrait and answer what their days would be like, or what the portraits made them think. Some responses to these portraits are given below, categorized as 'resilient image' and 'vulnerable image' depending on the nature of the response.

Table 2.1 *Projected self-image*

| Resilient image   | Vulnerable image  |
|---|---|
| <i>"She will wake up, clean the house, cook, help in household chores, will talk to friends, cousins and neighbours."</i> | <i>"She cannot share secrets with friends as they cannot be trusted."</i>   |
| <i>"Family is the real confidante."</i>   | <i>"Some people will like her, others will not."</i>  |
| <i>"Will learn embroidery, tailoring, bidi binding."</i>  | <i>"She cannot participate in weddings and functions."</i>  |
| <i>"She is playing."</i>  | <i>"She doesn't go to school. Works at home."</i>   |
| <i>"She goes to school, if not married."</i>  | <i>"She is a school dropout."</i>   |
|   | <i>"Will work as a domestic help, possibly in cities, people may let them stay there."</i>  |
|   | <i>"She has been attacked with acid. She is ill, feels bad."</i>  |
|   | <i>"She hasn't been to school because her economic condition is bad. People don't like her, that's why. Maybe she has a stepmother. Maybe she has done something bad and so people don't like her."</i> |
|   | <i>"She is tortured for dowry. Husband drinks and beats her occasionally."</i>  |

A range of emotions and desires get reflected through these responses. At one point is an ideal resilient image of a girl who wakes up, goes to school, helps in the house, watches TV, has friends and, at the other end, is a girl who cannot participate in community events, who is married off to rid her off the stigma of having been in prostitution and who is beaten by her husband when he comes to know about her trafficked past and who feels deceived and cheated. The survivor may have to discontinue her school, be attacked by acid and cannot trust her friends any more. These shared constructions revealed a mind behest with conflicts between what must have been an ideal for most of the girls and what must be the reality for most of them. Perceptions of an acid attack in a neutral portrait and suggesting that the character was leading a life of pain and distress appears to be a projection of their own fears and insecurities.

Most of their responses revolved around grim and sad outcomes describing their vulnerabilities. Borrowing Janoff-Bulman's terminology, their frame of reference consisting of a benevolent world and a worthy self appears contrasted with a fractured world and an unworthy self, which could be a depiction of what occurs in reality. Sentences like 'maybe she has done something bad and so people don't like her' reveal an internalisation of messages she is receiving from people around her, including her neighbours, relatives and immediate family members. Such beliefs underlie behaviour of withdrawal and fear. There is a recurring theme of experiencing discrimination in the school through peers and teachers. The survivors seem to perceive resuming school education as a measure of acceptance by peers, teachers and maybe the community. It is interesting to note that out of 35 respondents surveyed, 28% had resumed school education.



Those who did not go back to school were either older and had dropped out of formal education long before they had been trafficked as well as/ or those who did not want to return to school because they perceived risks in getting out of the house, travelling distances from home to school where traffickers may attack them, or risks of being stigmatised by their peers in school. As we explore other areas of their lives, the incongruence between what appears to be an ideal life and what actually occurs becomes more pronounced.

#### **“WHAT WILL PEOPLE SAY...”**

*“Everyone is rude towards me and the little food I get, I get it at the cost of my tears. The insult and humiliation are unbearable.”*

*“Ma always says, she is insulted. Many like us are thrown out of home. Married off to whoever they find, without thinking of consequences.”*

*“I was in Delhi. I was married off upon my return. Husband beats me, is suspicious, abuses me – and extorts me for dowry. My brothers have asked me to leave home.”*

*“I have spent 70,000 to 80,000 rupees to get her back.” (Parent of a survivor)*

*“Everyone is relieved that she is back.” (Parent of a survivor)*

*“For me, all five girls are same. Just because of this accident, we don’t neglect her. We don’t pressurize her to work or study.” (Parent of a survivor)*

*“Not all parents are as supportive as us.” (Parent of a survivor)*

The family’s role in a survivor’s assimilation process is best described as ambivalent. On one hand, they were relieved to get their daughter back but at the same time, there was a presence of bewilderment over her status in society and family. The dominant perception

among survivors was that though their families sheltered them after rescue, they were hardly treated as part of the family.

Consider the response of a girl who says whenever my family gets an opportunity they say, ‘the work done by you is bad’. This reflects an underlying sense of disappointment and a desire to hurt the survivor for maybe causing shame to the family.

The ambivalence becomes more accentuated in cases where the family was actively involved in finding the survivor but couldn’t accept her completely when she returned, as illustrated in the following excerpt:



*“Others say, ‘don’t mix with her’.*

*My mother went thrice to Bombay to look for me and get me back. Brother, sister, villagers don’t speak to me, I feel insulted.”*

It appears that the family, when alienated or disgraced by the community due to the survivor’s trafficking history, displaces their anger on her. Moreover, though they mention that they treat her like her other siblings, there is a presence of differential treatment in statements like, ‘we don’t pressurise her to work or study’. For the family, this could be their way of showing affection, but many times it has been noticed in trauma victims that treating them with extra caution and care reinforces their ‘condition’ and delays healing. In the ‘resilient image’ presented in the previous section ‘household chores and studying in school’ are most frequently mentioned, while the family/caregiver group seemed to be interpreting this in a different way and was keeping the girls from engaging completely in these activities. It is important to note that the parents and guardians who participated in the FGDs must be in some ways different from those who did not. They might be those who are willing to engage positively in the survivor’s

life, and support her. This strengthens the notion that not all families are unsupportive and that varying degrees of strength and vulnerabilities are present.

The community's role in retarding her assimilation process came across quite vehemently. Their behaviour towards survivors has been mostly described as hostile and insulting. For example, as one girl says, "*Neighbours say you are a bad girl and spit at me, they also turn their face away when they see me*". Such stigmatisation gains more strength if religious fundamentalists or community leaders issue social diktats of boycott and coerces the family of the survivor to remove the girl from their society by calling her defiled.

Apart from such direct stigmatisation, they also seem to be actively involved in breaking marriage alliances for survivors. The family considers marrying off their trafficked daughters as the best way of dealing with the shame and stigmatisation that follows on her return. In most cases, marriage is arranged by concealing her servitude in sex work to avoid further stigmatisation or abuse, an endeavour, which is usually foiled by neighbours. Abuse in marital home is also quite prevalent, especially when they come to know of her sex trafficking history, as it appears to alienate others in the family along with her, as depicted in the excerpt below:

*"In-laws knew about my history but were abusive. My husband said, 'For you I can't go out'. He beats me and doesn't let me go out. Wasn't allowing me to come here either. He doesn't take me out and I stay indoors all the time. I like reading but have no books."*

These findings are indicative of the way society treats a survivor. The question is 'what could be the reason for such reactions?'

In case of family's ambivalence towards their daughters, it appears to be a case of 'approach-avoidance' conflict – a situation in which their source of affection is also their source of affliction. The family appears unprepared to deal with the stigma associated with their daughter's sex trafficking history.

What is the source of this stigma? The agents are neighbours, schoolteachers, peer, family members, relatives, etc. but the source could be an underlying tension surrounding sexuality in a typical agrarian, conservative community. The norm of a girl's honour is usually tied to her sexual chastity, which in the case of a survivor is perceived to be compromised. A survivor, hence symbolises the 'forbidden fantasy' revolving around prostitution and sex. She is known to have been living a life without the usual restraint that ties the women and girls in their own families; often a life that is believed by the community to be that of a sexually liberated and uninhibited person. Such fantasies are at times acted out and take form of sexual abuse meted out to the survivor outside and within the house as reflected in the excerpt below:

*"When someone touches my body, I feel insulted. If someone touches my breasts or even the whole body, I feel insulted. This occurs inside, as well as outside the house."*

*Neighbourhood boys think, she has gone once, so there is no hesitation in touching me."*

As far as negative stereotype goes, the attribute that sets a survivor apart from the rest of the girls in her community is that of her sexuality, that is no more under the so-called control of the norms of society. The source of a community's anger is thus this deviance from the norm that sets a survivor of trafficking





apart from other girls or a *'bhalo meye'* (good daughter) of their own families.

However, amidst stigma and shame exists strength and support in their responses as seen in the following excerpts:

*"Husband got to know after one year of marriage. He doesn't say anything."*

*"I was trafficked to Bombay under the pretext of domestic help. I used to be beaten by a rod if I did not cooperate. My husband says he will try to punish the trafficker in the same way."*

*"I wake up at 6 am, before others, do household chores, cook. Mother-in-law has taught me to weave chattai and husk rice. They did not take any dowry. In-laws and neighbours know of my history but nobody says anything bad."*

Presence of such experiences point towards a positive assimilation process with better resolution of shame and stigma related to her trafficking history. An interesting point that emerges out of the second excerpt is about a sense of empathy with the experiences of the survivor. In that, the husband expresses anger towards her perpetrators and wants to inflict similar pain on them. This is perhaps because the survivor could share her experiences with her husband, a communication that most often doesn't occur in other cases.

Again, the fact that the source of support is usually from her husband points towards a resolution of her sexual deviance status. Marriage, in this sense, is a leveller, a socially sanctioned status that allows her to be a sexual being and when accepted by her husband, it also in some ways helps diminish the stigma as now she is a married woman, a *'barir bou'* (housewife). This status is most often elusive for survivors of sex trafficking, as seen in their responses but when

achieved, it can be restorative. Further in-depth studies of such cases of support can help in unravelling protective processes that might accentuate a survivor's resilience or her chances of successful assimilation.

### **"SHE'S A CHANGED PERSON..."**

The final section on assimilation deals with the survivor's role in the process of assimilation. How does she deal with the changed dynamics? What are her reactions or coping mechanisms?

### **Avoids going out**

*"I don't get out of home. When I can stand on my feet, I will show my face."*

*"I don't go anywhere else but school. I don't leave the house. I don't like to stay at home always; when I hear others in school go out, I too feel like going."*

*"Everybody likes going out. It is not safe to go out with friends. Parents or husband after marriage is safe. If you believe your friend, you might be cheated."*

*"Feel ashamed of going out."*

*"I go to work in the farm with my father, I can't go out alone, as I am very scared."*

Shame and stigma seems to lead to fear of going out or interacting with others. Negative reinforcements in the form of verbal abuse and alienation by neighbours, schoolteachers, peers and relatives seem to discourage her from going out. Staying indoors also seemed to be a way out of resolving the tension surrounding a survivor's sexuality. There is definitely a presence of disappointment with such confinement but what appears is an internalisation of shame as reflected in this excerpt – *"I am also not good any more."* She seems to have accepted that she is supposed to be ashamed of being a sex trafficking survivor. What does she do and how she resolves these issues is reflected in the





next two sections.

### Engage in some activity

*"I watch TV."*

*"I do Aarikaaj (embroidery) and sewing. Don't earn much, so how can I buy a machine?"*

*"I do household chores and sewing."*

*"I work as a nurse."*

*"I work in ICDS (pre-primary centres for children), school."*

*"I feel insulted when people discuss me in school and in my community. Not so much from family. I can change my circumstances. If I can study I will be better and will not remember my past."*

*"I wake up at 5 am and walk a herd of sheep. Amongst neighbours, one is friendly but rest say 'bad words'. Relatives are not good."*

*"I work in a small company. I have passed class ten (in school) and am trained in nursing. If one works, there is respect. I am respected at my workplace."*

What is apparent is that within the house, a survivor is mostly involved in household chores and sewing or embroidery. Some girls are also involved in outdoor activities. However, only one among all talks about 'respect at workplace' which points towards a possibility that her workplace consists of people who do not stigmatise her for her trafficking history or that her workplace is not in the community, so such information has remained concealed.

A supportive environment can therefore mean a lot to a survivor's sense of self, just as an unsupportive environment can be detrimental for her self-image. Such feelings of worthlessness or negative self-image can be internal barriers to successful assimilation. If the survivor herself feels she is below the others

around her, that she is deficient in ways that are beyond her control, economic rehabilitation or medical services will be less successful in truly reintegrating her in the society.

There is also a need to repress the whole incident as reflected in a statement – 'I will not remember my past.' These sentences give away her sense of self that needs to get rid of a very 'real' part of her life.

How she resolves such conflicts is reflected in the set of excerpts presented next.

### Resolution

*"I visited the hospital after coming back as I was pregnant. I confided in my mother."*

*"I told my mother I was pregnant, she asked me to go and die."*

*"If others find out that a girl is pregnant, she will never be able to marry; she might even think there is no meaning in staying alive, but if she wants to continue the pregnancy, there will be more problems."*

*"God will take care of my future."*

*"We are helpless and destined to live the rest of life this way."*

*"I feel like committing suicide. If I had any work, I would not need to socialise with them, others wouldn't be able to say anything."*

*"I keep quiet although I am always discriminated and abused verbally."*

*"If a boy approaches me, at first it feels good but later I am afraid, I don't trust him. Even when parents discuss my marriage, I don't agree."*

*"That I did not go by my own will is something nobody wants to believe."*

*"After 5-6 months, I was married off, but in-laws came to know of my trafficking history and I was sent back home."*



*Neighbours and villagers said bad words. My husband has married again. I have resumed my school. I wake up at 5 and study with my elder brother. Attend school from 10 to 4. Others point at me and say, 'she was once lost, but has come back.' We sit together in school but no one wants to talk to me. Relatives tell their children not to interact with me."*

*"I live in my mother's hotel. Am good. Friends ask me to forget the past. I don't pay much attention to what others have to say. I don't talk to anybody if they don't want to talk to me."*

The set of responses here reflect varying ways of dealing with issues that emerge once the survivor starts her life anew in her own home and community. "That I did not go by my own will is something nobody wants to believe" is a response replete with pain of not being accepted as a person without guilt. The society's response towards survivors of sex trafficking is thus a matter of stress and emerges as an adversity that she has to deal with on a daily basis.

In such a situation, being pregnant on return is a very sensitive issue, especially since the stigma attached to unwed mothers is so malicious. Being able to go to a hospital and confiding in one's mother appeared to be better options than being ashamed and guilt-ridden. Mother's reaction or support from family again played an important role in either improving the condition or as in the second and third excerpt, leading to an accumulation of stress for the survivor, even leading to suicidal tendencies and utter hopelessness as is reflected in sentences like – *'we are destined to live the rest of life this way'*.

However, providing variance in this section are the last two excerpts, which indicate some amount of agency and normalisation of the situation. The girl who returned from her in-laws because

they found out about her trafficking history and resumed her education, even being assisted by her elder brother, despite facing stigma in school and community, is a case worth delving into deeper. It highlights the distance a little support from family can take a survivor. That every family doesn't cower to pressure or stigma from community is also an implication that can be drawn from such cases.

The findings therefore paint a picture of a process of assimilation that is largely counterweighed by the presence of stigma and prejudice against a survivor of sex trafficking. If assimilation is the process of fitting into existing pattern of living in a society, these girls find their pathways of fitting in, mostly blocked.

The blocks are both internal as well as external. Survivors seem to be internalising shame and guilt, leading to a self-image that is vulnerable. Families of survivors appear to be ambivalent about their feelings towards their daughters who have returned from prostitution. Neighbours and other relatives appear mostly hostile and negative. In order to fit in or assimilate, the survivor appears to be on the following pathways:

- Early marriage by concealing victimisation into sex trade
- Avoid going out and interacting with others
- Involvement in household chores and home-based activities
- Resuming school education
- Employment outside the house
- Seeking support from family



These pathways are all aimed towards the goal of fitting in, however, some appear to be leading her away from that objective. For example, marriage by

concealing her sex work history, ends up adding to her stress when she has to live her life in constant fear of being exposed. When exposed, she suffers further stigma and abuse at her marital home. On the other hand, when marriage works out, it does lend some respite and augments her assimilation process. Being involved in household chores or income generation activities within the house appears to be less protective than being employed outside the house in an environment where she can uncloak herself of her identity of a victim of sex-trafficking and earn a better livelihood. Support from the family when received is definitely a protective factor, whereas lack of it might lead to further feelings of worthlessness and set her off-course. Therefore, there is a constant endeavour to find the correct balance that will allow her to function despite the ripples created by stigma and prejudice and negative self-image. What makes a survivor develop a resilient self-image, what differentiates a supportive family from an unsupportive one, what differentiates empathetic husbands from those who further victimise survivors, what differentiates neighbours who see her as a member of their clan from others who are hostile towards her, are questions this research did not set out to answer but are questions it presents for further analysis.

The trauma of being trafficked does not end with rehabilitation in terms of reuniting the girls with their families. Experiences of violence, abuse, discrimination and stigma follow the girls into their homes and community. The society is clearly not ready to accept the girls without coercing them to 'repent' for their 'sins' – of transgressing fundamental norms of that society. It appears that the girls are expected to embrace this new identity of a 'fallen woman' who deserves no respect and

sympathy. In such conditions, it is only natural that some girls are withdrawn, mistrustful, dejected and even suicidal.

The effect of such a 'homecoming' can be most telling on a survivor's health – both physical and psychological. Hence, the next chapter delves deeper into the consequences of sex trafficking and the post-reunification situation on their health.



To quote an oft-quoted definition of health by WHO, 'health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. Considering the nature of shame and stigma in their lives as discussed in the previous chapter, it might not be presumptuous to hypothesize that survivors belong to the lower spectrum of health as per the WHO definition.


The detrimental effects of prolonged captivity and serious threat to life which is often a method used to keep trafficked people from escaping are well-documented. The person's sense of self in relation to others is usually destroyed to achieve complete domination on her life and actions. This is done by isolating the person from any outside contact and information or material aid<sup>12</sup>. A study conducted on health consequences of trafficking on women and adolescents in Europe<sup>13</sup> asked the participants to rate symptoms experienced by them. They found that fatigue and weight loss were the most prevalent symptoms, followed by headaches, memory deficits, dizziness, gastrointestinal problems, back pains, skin problems, pelvic pain and vaginal discharge and gynecological infections. The psychological symptoms identified in that study were depression in the form of loneliness, worthlessness, hopelessness and having no interest, feeling tense, nervous, anxious, hostile and irritable. The study tested for presence of Post-Traumatic Stress Disorder (PTSD) and found 56% of the respondents reporting it in the initial stage of post-trafficking phase. Similar symptoms have been reported in several other studies<sup>14</sup>. These symptoms reflect the nature of trauma suffered by the girls. The hostility of their experience leaves no part of their bodies or minds unfettered.

<sup>12</sup> Herman, J. (1997). *Trauma and Recovery*, 74-79

<sup>13</sup> *Stolen Smiles: a summary report on the physical and mental health consequences of women and adolescents trafficked in Europe*. The London School of Hygiene and Tropical Medicines, 2006

<sup>14</sup> Devine, S. (2009). *Psychosocial and mental health service provision for survivors of trafficking: baseline research in the Greater Mekong sub-region and Indonesia*. International organization for migration, Regional office Bangkok, Thailand

Figure 3.1 *Most prevalent and severe symptoms as identified in Stolen Smiles, 2006*



| Most prevalent and severe symptoms over time |
|--|
| Headaches                                    |
| Fatigue                                      |
| Dizzy spells                                 |
| Back pain                                    |
| Stomach or abdominal pain                    |
| Difficulty remembering                       |

It is important to highlight the point that physical and psychological health symptoms impinge on a person's life and they also have the potential to negatively impact a woman's participation in administrative, legal and socio-cultural activities that require intellectual and emotional functioning.

For the present study, data was collected using two distinct methods. FGDs were conducted with survivors and their caregivers/parents to obtain qualitative assessment of health complaints and a clinic-based study was conducted to quantitatively assess their psychological and physical health indices. The results have been discussed by grouping symptoms together to give an idea of the type of conditions a survivor might suffer from.

### **ABDOMEN PAIN, WHITE DISCHARGE, WEAKNESS**

Abdomen pain was the most commonly reported symptom, that was mentioned in all the 3 health related FGDs, followed by white discharge and fatigue or extreme weakness. The reason for pain in abdomen can be many. In one case it was a result of extreme form of torture by husband as described in the following excerpt:

*“My husband forced me to swallow acid, my liver is 50% damaged.”*

In most of the other cases, the abdomen pain appeared to be related to a sexual health problem. For example, one respondent who was four months pregnant said she experienced pain while having intercourse with her husband, while some mentioned it occurred mainly during their menstrual cycles. White discharge was also mentioned by most in connection with their menstrual cycles.

Along with this weakness in the form of extreme fatigue, many also mentioned listlessness and inability to do household work. The weakness could be both physiological and psychological as implied by the following excerpt –

*“So much has happened with me, how can I not feel fatigued?”*

Pain in lower abdomen, white discharge and weakness could have been signs of Sexually Transmitted Diseases (STD), which was tested for in the Venereal Disease Research Laboratory Test (VDRL) as part of the clinic-based study. However, contrary to expectations generated from such reporting, only one case tested positive for STD out of 55 survivors tested. The high frequency of white discharge complaints has been explained in the ensuing section.

However, anemia was present in 70% of the sample and 59% had low resistance levels while 61% had disturbed liver function. Jaundice was also identified in 18% of the sample. The clinic-based study therefore revealed the poor and vulnerable physical conditions of the survivors. Most of them were unaware of their own conditions.

The high prevalence of anemia is also reflected in other parts of rural India. In fact NFHS 3 data shows that the percentage of anemia has increased from

51.8% in 1999 to 56.2% of married women in the age group 15-49 in 2006. Compared to the national average, anemia is more prevalent in the present sample. The impact of anemia is most noticeable in energy levels and cognitive functioning. A study by Sen and Kanani<sup>15</sup> noticed that even among girls with similar nourishment levels, anemia had an adverse effect on cognitive abilities. The comorbidity of low resistance level and poor liver functioning requires sustained treatment.

#### **DIZZINESS, HEADACHES, SLEEPLESSNESS, LACK OF APPETITE, NAUSEA**

The next set of symptoms mentioned by the survivors in their FGDs was related to general functioning. Many reported dizziness, feeling faint and headaches. These were probably effects of anemia and general weakness. One particular case of dizziness appeared to be related to epilepsy, but the explanation given by the survivor was interesting and gave an insight into cultural meanings of certain diseases. The excerpt is as follows –

*“I fainted around 13-14 times in the last 10 days. Three years ago, I had fallen down. I used to vomit even while sitting. When I have a fainting spell and my teeth get stuck, I feel I have been possessed by a ghost. I feel the need to call an Ojha during those times. My family is getting me treated by a Moulvi who has given me a maduli (amulet) and ‘jhere diye geche’ (exorcised me). My condition has improved a little. I can’t go to the hospital for ‘such a kind of problem.’”*

Being possessed by a ghost in case of unexplained fainting spells is an interesting and very local interpretation of a physical problem. Ojhas and religious leaders, some of whom, not all, offering such services are traditional healers who practise medicine and exorcism. Survivors reported their dependence on a *maduli* or amulet and seemed to have



<sup>15</sup> Sen, A. and Kanani, S.J. (2005). Deleterious functional impact of anemia on young adolescent school girls. Indian pediatrics, Vol 43.

faith in the power of traditional healing and in some cases reported having found relief. A *maduli* or amulet is supposed to have magical properties providing protection from evil eye and spirits, which are usually held responsible for all problems. The presence and impact of traditional healers have been studied in India by several researchers. Our findings corroborate previous observations that traditional healers are the most common alternative to formal medicine and usually the point of first contact for most people in a rural set-up. Only when religious and faith-based healing fails is psychiatric consultation sought, as noted by Campion and Bhugra (1997)<sup>16</sup>.

Some mentioned lack of sleep, which is known to be a stress reaction as is apparent in the following excerpt –

*“I live in a hostel at Bidhannagar. I cannot sleep. If someone talks nearby, I can hear everything. I want to get a little sleep. At times, I feel like I have lost my mind and feel very angry. Even pouring water on my head doesn’t bring me sleep. I can hear everything.”*

Inability to relax and hyper-vigilance are common post-traumatic reactions. Heightened sensitivity and flashbacks of trauma-related events cause such restless states. Lack of sleep is thus a common physical outcome of an underlying psychological process. Similarly, loss of appetite is also a common stress outcome, most often featuring in diagnostic criteria for depression.

### DYSTHYMIA, DEPRESSION

The clinic-based study included psychological assessment and psychiatric evaluation by a doctor to determine the consequences on a survivor’s mental health. Doctor’s evaluation and mental status examination reports show that all the survivors displayed a feeling of loneliness, hopelessness, rejection and social anxiety (100%). Similar assessment

also showed that 87.3% had dysthymia, while 12.7% were diagnosed with depression, which is quite high compared to general population. One population-based cohort study of 2,494 women, aged 18 to 50 years in India, reported a 12-month incidence rate of 1.8% (95% CI 1.3%-2.4%)<sup>17</sup>, which implies that for the present population, the rate of depression is on the higher level, though this will need further investigation.

Dysthymia is chronic state of depression, where the symptoms linger for around two years or more with episodes of major depression. Major life stressors, relationship problems and genetic factors can cause it. Such a person is usually sad, with low mood, experiences loss of enjoyment in activities which were once pleasurable, changes in weight, lack of appetite, changes in sleep, fatigue, restlessness, feelings of hopelessness, worthlessness, guilt and recurring thoughts of death and suicide. All these symptoms were mentioned by the survivors in the course of FGDs and are of serious concern. Here, it appears that if the survivors are suffering from dysthymia, it raises questions on whether PTSD was treated adequately post-rescue, whether post-rescue mental health services are currently adequate in destination points and whether survivors have sufficiently recovered from their trauma prior to returning home. Very often, psychological counselling is started in shelter homes, but it is interrupted when the girl is sent home. There are no State-sponsored programmes to extend psychological counseling services or continue their mental health therapies post-reunification with families.

As observed, there is a preponderance to rely upon traditional healers for mental health problems and studies have shown that psychiatric facilities are least preferred due to stigma (Mishra, *et al.*, 2011)<sup>18</sup> hence morbidity remains largely untreated and undiagnosed.



<sup>16</sup> Campion, J and Bhugra, D, 1997. Experiences of religious healing in psychiatric patients in South India. *Social psychiatry and psychiatric epidemiology*, May, 32(4)-215-221.

<sup>17</sup> Patel V, Kirkwood BR, Pednekar S, Weiss H, Mabey D. Risk factors for common mental disorders in women. Population-based longitudinal study. *Br J Psychiatry*. 2006 December; 189:547-55

<sup>18</sup> Mishra, N., Verma, S.S., Chadda, R.K. and Sood, M. 2011. Help seeking behavior of patients with mental health problems visiting a tertiary care center in north India. *Indian Journal of Psychiatry*, July-September, 53(3). 234-238

In an incidence study of common mental disorders, Patel *et al.* [ibid] reported that poverty (low income and having difficulty in making ends meet), being married as compared with being single, use of tobacco, experiencing abnormal vaginal discharge and reporting a chronic physical illness, were associated with risk of developing a common mental disorder. Studies have also reported that economic and interpersonal relationship difficulties, partner violence and sexual coercion by the partner as the common causal factors related to development of depression in general<sup>19/20</sup>. Such findings widen our understanding of a survivor's vulnerabilities to depression in the present socio-cultural context as many of these variables have featured in their responses too. The connection between vaginal discharge and depression is interesting as studies suggest that vaginal discharge, in cases which are non-infectious, could be a result of stress. Patel *et al.* (2005)<sup>21</sup> reported that psychosocial factors have strongest association with vaginal discharge. They have, therefore, stressed that beliefs about illness need to be targeted to treat such complaints of vaginal discharge. Thus, the psychological morbidity encountered in the present sample is an amalgamation of the trauma of their experiences and lack of sustained treatment.

### AGGRESSION AND IMPULSIVENESS

A person taking the Thematic Apperception Test (TAT) is asked to make a story about the pictures shown to them. These stories are then interpreted by using a guideline to identify underlying needs, motivations and conflicts that shape a personality. Following are the findings from TAT analysis:

i) Storylines showed conflict over the need for achievement, producing frustration, which often underlies

aggressive impulses.

ii) The stories also reflected a need for affection from contemporary male figure and parental figure which when not gratified, results into passive aggression (observed in 21.8%) or overt aggression (78.2%), sometimes getting directed towards male figures and sometimes towards self.

iii) Strong feeling of insecurity (98.2%) was noted in majority. The surrounding environment was perceived as non-supportive and contemporary male figure as dominating. Difficulty in maintaining adequate heterosexual relationship and guilt was also reflected.



The frustration-aggression hypothesis (Berkowitz, 1989)<sup>22</sup> and the reformulated version suggest that frustration is caused when expected gratifications are not met, and this leads to aggression. In the present sample, frustration could have been caused because their expectations from male members were not met and they were abused as a consequence of this breach of trust, as suggested by the TAT interpretations. The results imply that in order to work through this frustration-aggression, the girls would need to deal with the emotion causing frustration, rather than only participate in emotional catharsis to bring a change in their complexes surrounding heterosexual relationships. Recent research<sup>23</sup> indicates that developing a sense of control over one's life and forming co-operative relationships are important for getting over frustration and thereby, reducing aggression.

Results from Barratt Impulsiveness Scale (BIS), which measures impulsiveness as a personality trait, showed that more than one third of the respondents reported medium levels of impulsiveness, while 6% showed high impulsivity. Heightened sexuality, not related to bipolar disorder or schizophrenia, was observed in one

<sup>19</sup> Pereira B, Andrew G, Pednekar S. The explanatory models of depression in low income countries: Listening to women in India. *J Affect Disord.* 2007;102:209-18

<sup>20</sup> Verma D, Chandra PS, Thomas T, Carey MP. Intimate partner violence and sexual coercion among pregnant women in India: Relationship with depression and post-traumatic stress disorder. *J Affect Disord.* 2007;102:227-35

<sup>21</sup> Patel, V. 2005. Why do women complain of vaginal discharge? A population survey of infectious and psychosocial risk factors in a South Asian community. *International journal of epidemiology*, 34, 853-862.

<sup>22</sup> Berkowitz, L. 1989. Frustration-aggression hypothesis: examination and reformulation. *Psychological Bulletin*.

<sup>23</sup> Lewis, W. A. & Bucher, A. M. 1992. Anger, catharsis, the reformulated frustration-aggression hypothesis and health consequences. *Psychotherapy*, 29, (3), 385 - 392.

respondent by the psychiatrist, while three respondents displayed symptoms of extreme suspicion.

Impulsiveness is a personality feature that is related to risk-taking and inability to delay need-gratification<sup>24</sup>. A person with high impulsiveness is prone to anger and frustration as well. The scale used to measure impulsivity also measures cognitive, motor and non-planning features. People with high cognitive impulsivity would display inability to focus on their task, implying poor decision making ability. Non-planning factors measure ability of self-control and cognitive complexity, which implies that people with high scores would display anger and frustration without weighing consequences of such behaviour. Finally, motor impulsivity measures features such as acting on spur of moment and presence or absence of perseverance. High score on motor impulsivity reflects the behavioral aspects of poor-decision making, risk taking and low frustration tolerance levels. This implies that the 11 women, or 6% of our sample, may require therapeutic interventions to help them deal with their personality feature that might accentuate their vulnerability to re-trafficking.

Aggression, insecurity, impulsiveness and suspicion are features that can contribute to a sex trafficking survivor's difficulties in reintegration with her community and family. Very often, such complex emotional and behavioural patterns end up becoming counter-productive to a person's attempts at normalising her situation. For example, given the presence of stigma in the society, a girl riddled with frustration and impulsiveness, could end up having several angry outbursts. In the context of a conservative, agrarian community, and the added burden of history of prostitution, such angry outbursts might create more negativity for the survivor.

It might alienate her further, as people around her might never be able to understand her irritability. This situation has been further explained in the next section.

### FINDING THE SELF

According to the psychiatrist who conducted clinic-based assessments, all the survivors displayed a sense of fear, shame and social anxiety. Along with the nature of stigmatisation observed in the previous chapter, it suggests a change in sense of self. Fear, shame, guilt and social anxiety arise out of learning to expect the worst. When such expectations are reinforced by interactions with others or by a person's interpretations of interactions, it can only be strengthened as reflected in the following excerpt –

*“When I go out, if someone says bad words, I feel very bad.”*

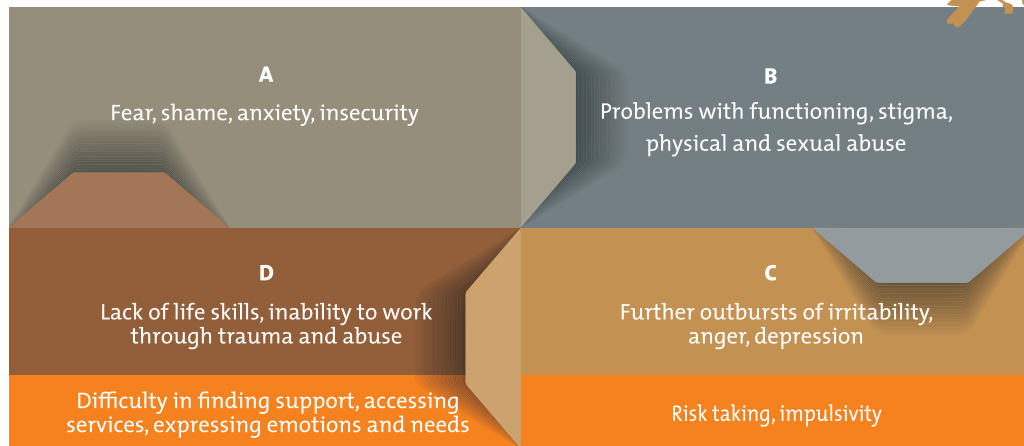
The experience of trafficking and prostitution and stigma on return can have a telling impact on a person's sense of self. Very often, this vulnerable self-identity dominated by fear, shame and anxiety is maintained as a result of a negative loop of functioning. *Figure 3.2* alongside illustrates such a loop.

*Figure 3.2* theorises that a survivor with feelings of fear, shame, anxiety and insecurity, may face problems with functioning of the self and at times, is met with stigma and physical and sexual abuse from the society. The arrow connecting A and B imply the connection between the psychological condition of a survivor and reactions of her self and society. Such reactions of self and society may lead to further outbursts of irritability, anger and/or depression. The arrow connecting B and C imply the consequence of reactions of self and society on the survivor's behaviour. Such consequences strengthen her vulnerable mental state in cases where she lacks skills to cope or work through the societal reactions and her own emotions.



<sup>24</sup> Arce, E. and Santisteban, C. (2006). Impulsivity: A review. *Psicotherma*, 18 (22), 213-220.



Figure 3.2 *Vulnerable Self-Image*

Arrows connecting C and D imply that behavioural reactions and societal abuse are left unresolved because of lack of skills and thus the arrow connecting D and A imply that it all reinforces a sense of self that is shame and fear driven. This reflects a very low self-esteem, a feeling that is usually reinforced by the society. The two orange bands contain possible consequences of their mental state. Risk taking and impulsivity are possible outcome of anger, irritability and depression caused by her current situation. The other possible outcome is inability to access services or support and difficulty in expressing needs and emotions. This consequence is reflected in the following excerpt –

*“When I was in Bombay, a Copper T was inserted inside me, forcibly. I still have it inside me. I am anxious every time my family talks about my marriage. I am too ashamed to confide in anyone. I haven’t been able to confide in the social workers either, as they are all men. They don’t have any girl in their office. I want to remove it.” (This participant requested to talk about her problem in private; she did not share this during FGD.)*

Thus, apart from the obvious debilitating effects, these psychological reactions also prolong a survivor’s vulnerable state by preventing them from accessing health care as noted in other studies on

trafficking survivors<sup>25</sup> as well. Secrecy or hiding one’s past and not opening up while seeking help, could be a coping mechanism to deal with shame and stigma, but it might act as a barrier to recovery.

For example, let us consider the case of the girl experiencing difficulties in sleeping and complaining of fatigue, tension and anger. Suppose she sees a doctor with her apparent problem of lack of sleep, and cannot share her history or underlying problems, her treatment will be restricted to sleep only and not cover the wider etiology of stress and trauma. In this sense, a survivor’s health needs also differs from the general population as their nature of symptom may be common but the etiology is not. Hence, treatment approach for an ordinary woman and a survivor of trafficking will need to be different. Thus, the health status of a survivor of trafficking or prostitution does appear to be at the lower end of the WHO definition. Such high levels of physical and psychological weaknesses imply a huge health risk in a young population. It is clear that they need health services that can address their problems. Are there provisions for such services? Do they access them?

The next chapter on system access answers these and several other service related questions.

<sup>25</sup> Clawson, H., Salamon, A. and Grace, L.G., () Treating the hidden wounds: trauma treatment and mental health recovery for victims of human trafficking.

So far, the study discusses problems faced by a survivor after return and thereby identifies her needs for protection against stigma and abuse, need for participation and recreation as against being alienated and kept indoors, need for education and respectable income generation opportunities, need for physical and mental health problems and need for assimilation in the society.

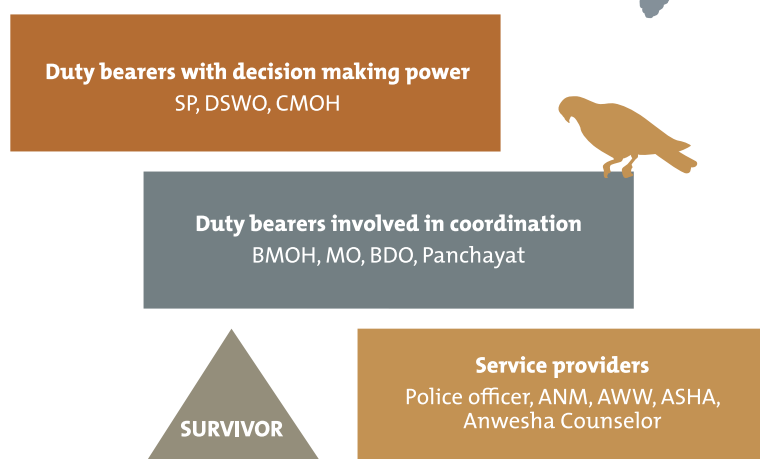
The present chapter aims to conduct a systemic analysis to identify gaps that inhibit a survivor who has welfare needs from accessing services. It aims to understand why such a gap exists. Assumptions are that either services don't exist that address her needs or survivors do not access existing relevant services. The methodology adopted here is a secondary analysis of policy documents and one-to-one interviews with duty bearers who hold key positions with respect to policy implementation, along with information obtained from survivors and their parents/caregivers through FGDs.

Figure 4.1 below delineates duty bearers and service providers who are part of the

Government and, as an incumbent, have certain stake in a survivor's life in terms of rehabilitation. It has been observed that there is a hierarchy in terms of decision-making power vested in certain roles. Clear demarcation of such roles can help in analysing the impact of their responses and thought processes on a survivor's rehabilitation.

The stratification alongside reflects that the survivor has a higher probability of interacting with service providers such as a police officer, ANM, AWW, etc. as compared to the SP or CMOH of the district. Similarly, the service providers such as AWW or ASHA routinely deliver their services but do not have the power to decide whether their services must be extended to survivors of sex trafficking in any special manner. At the second tier are duty bearers such as BDO, BMOH, Panchayat, etc. who are primarily responsible for coordination, direction for implementation of services and general management of their departments. Such duty bearers can interpret schemes and policies and give directives to service providers to use them in certain ways, however, they cannot take policy decisions. At the third tier are duty bearers with decision-making powers such as the SP, CMOH, DSWO, etc. who receive guidelines from the State and head departments at the district level.

Figure 4.1 Stakeholder stratification



### PANCHAYAT

The Panchayat featured most prominently in survivors and their parents'/caregivers' account with respect to service access. The survivor's perception of Panchayat had varying degrees to it, ranging from supportive to indifferent and unsupportive. The excerpts presented in Table 4.1 alongside gives a better idea of the range of their responses with respect to the Panchayat.

Table 4.1 Survivor's perception of Panchayat



| Perception of support and accessibility   | Perception of indifference and lack of support  |
|---|---|
| <i>"I have gone to Panchayat Pradhan for signature. I have gone for OBC certificate. I visited for pulse polio."</i> (Survivor, Swarupnagar)    | <i>"I have not gone to the Panchayat office; I will not get a sewing machine if I go there."</i> (Survivor, Hasnabad)   |
| <i>"I visited Panchayat member for ration card. I visited Panchayat office for tax bill and character certificate."</i> (Survivor, Swarupnagar) | <i>"Not many have been to the Panchayat. Those who have been, were not helped as they help only those who have been receiving help."</i> (Survivor, Hasnabad) |
| <i>"Panchayat was helpful, even the MP."</i> (Parent, Barasat)  | <i>"The Panchayat had some issues with me regarding employment, so they did not issue documents needed to rescue her."</i> (Mother, Barasat)                  |
| <i>"Only one out of six participants visited the Panchayat office for voting card."</i> (Bongaon)   | <i>"The Pradhan Panchayat is not good. He is from opposite political party and did not sign for my rescue."</i> (Survivor, Barasat)                           |
|   | <i>"As we are of X political party and the Panchayatis from Y political party, we did not get any help."</i> (Parent, Barasat)                                |
|   | <i>"Panchayat spoke rudely with us."</i> (Survivor, Barasat)  |

The above responses at the outset present a varied picture. In terms of accessibility, it appears that respondents have access to the Panchayat for various reasons. Reason for access and its resolution is the distinguishing feature. When Panchayat offices are visited for services such as tax bill, character certificate or OBC certificate, there seems to be a greater chance of successful service delivery as compared to issues related to signature needed for rescue or rehabilitation. Tensions around political affiliation and personal bias seem to be disabling factors. It appears that survivors and their families know of and may seek to receive support for employment under NREGA and related

schemes. It also follows that they approach the Panchayat for identity verification and certificates to prove they are residents of that village. Such identity documents are particularly useful for Muslim migrants who may be falsely detected or accused of being illegal migrants from Bangladesh and incarcerated in certain States in India. However, it is clear from their responses that they do not know if and whether the Panchayat has any resources, scope or obligation to support them in their recovery and rehabilitation process. To see what the Panchayat officials have to say about their role in rehabilitation of trafficking survivors we present the next table, *Table 4.2a*.



Table 4.2a Responses of Panchayat officials

|  | Risk factors  | Information  | Support to family   | Rehabilitation of survivor  | Role of Panchayat/ government schemes   |
|--|---|--|---|---|---|
| Saha Sabhapati, Panchayat                                | <i>"Social problem due to lack of money and education. In many situations, it is a girl's desire that pushes her to venture outside."</i>           | <i>"3-4 new cases in a year."<br/><br/>"We haven't come across any such case yet."</i>   | <i>"Can take parents to police for FIR. Samiti on its own contacts people in Mumbai and Pune and help is taken from police."</i>  | <i>"If we can find a good groom and get her married, otherwise we have to find employment."<br/><br/>"For physical problems government hospital can be approached for help. We help economically."<br/><br/>"We can get them involved in some economic activity."</i> | <i>"I am not very clear."<br/><br/>"I don't know."</i>  |
| Panchayat Pradhan and Zilla Parishad member, Swarupnagar | <i>"Our area is not vulnerable to trafficking."</i>   | <i>"This area doesn't have such a lot of incidence."<br/><br/>"I don't have any list of trafficked girls."<br/><br/>"We have record of families migrating outside for work."</i>   | <i>"If a family of a trafficked victim comes, we first do an FIR and if we have a mobile number, we arrange money and go there."</i>  | <i>"BDO Malikan Goswami is there, she will be able to say it better."</i>   | <i>"We do Gram Sabha and discuss this, 10% people attend it."</i>   |
| Panchayat Pradhan  | <i>"Trafficking doesn't occur here, girls go by their own wish, they love to get lost, they are at times lured to leave home."</i>                  | <i>"Trafficking is taking to Bombay and taking money."<br/><br/>"In case a girl approaches us before going to Bombay, we get her I Card and ration card made. The people taking her do not come to us so we do not have any records for them."</i>     | <i>"If they come we inform CBO, and will conduct a meeting with five people from the village."<br/><br/>"Neighbours will call her a bad girl."<br/><br/>"Can't help more than discussing this with members from the village."</i> | <i>"There is no provision or resources for this."</i>   | <i>"There is no such word as 'trafficking' in Panchayat books."<br/><br/>"Ujjawala is there but I don't know the details."</i>  |
| Panchayat member, Basirhat                               | <i>"Those who have big families cannot get all their children educated. They are more prone to send their children to Delhi for work and that's</i> | <i>"Before going out we arrange residence certificate for such migrants. But still it hasn't been possible to include everyone in this register..."<br/><br/>"Outsiders are traffickers, and there is a lot of trafficking incidents in our area."</i> | <i>"One girl had come to us for help, we extended administrative help and told her parents not to send her to Delhi or Mumbai but try and become self-sufficient within our GP."</i>  | <i>"To help her return from her bad path, we try to explain all members of the GP are encouraged to take proactive steps.<br/><br/>If the girls go to various officials they might face stigma as such officials are not very well educated</i>                       | <i>"SHG, ASHA, AWW and others are repeatedly informed so that they can create awareness in their areas.<br/><br/>Sewing, preparing jams and jelly, schemes to make them empowered."</i> |



Table 4.2a Responses of Panchayat officials...contd.

|  | Risk factors  | Information   | Support to family   | Rehabilitation of survivor   | Role of Panchayat/ government schemes  |
|--|---|---|---|--|--|
| Panchayat member, Basirhat (contd.)  | <p>where the danger lies.”</p> <p>Vulnerability is poverty and lack of education.</p>   |   |   | or aware.”   | <p>Nirmal Bharat Abhijat, Indira AwaasYojana.”</p> <p>(He mentioned an array of schemes that he will utilise for a survivor)</p>   |
| Zilla Parishad member but also acts on behalf of his wife who is the Panchayat Pradhan | <p>“From poor family, they are given false assurances of employment, if they come from poor family they go.”</p> <p>“There is a lack of employment opportunity here, so many times such girls are lured by promise of money and taken.”</p>   | <p>“It wasn’t so prevalent earlier but is now.”</p> | <p>“Parents come when girls get trafficked, and I have helped by contacting the police. However, no cases have approached me after return for help.”</p>  | <p>“If they come to the Panchayat, we can support them through the Panchayat fund. Like sewing machines can be bought or they can be helped to open small provision shops. It is necessary to help these girls stand on their feet.”</p> | <p>“There is no fund in Panchayat that is earmarked for such girls. If someone comes for help, it can be arranged through the development block or employment fund.</p> <p>Government might have some schemes but I don’t know of any.”</p>  |
| Samiti member, Basirhat  | <p>“Trafficker lures girls by promises of work and this is done in private. Police takes money and arrests innocent people while releasing the bad ones.”</p> <p>“When information reaches the police station it is not shared with the public. The police is in collusion with the pimps. If administration works well this can be curbed. At the Bangladesh border, trafficking takes place by bribing the police, BSF with Rs 1 lakh.”</p> | <p>Many victims.</p>                                | <p>“I inform the police station. Have been successful in rescue and reunification of around 10-12 girls.”</p> <p>“I go to the police station personally when a girl goes missing.”</p> <p>“I had gone to Bihar where a girl was trafficked and was being made to sing and dance.”</p> | <p>“ICDS helper roles can be for these girls. Class 8 pass is the requirement.”</p>  | <p>“I give 12 kg rice, tarpaulin for house, help furnish documents needed by BDO office, but no work gets done. Police has no proactive role.”</p> <p>“There is no interest in working on the schemes and policies in the department. Most people are worried about self-interest, there is no value of honesty even in your own Party.”</p> |

Table 4.2b Responses of Panchayat officials



| Themes   | Responses with high uniformity  |
|--|---|
| Reaction of community towards survivor                             | <p><i>"Society does not accept, parents or others view it negatively. Nobody in our society perceives it positively."</i></p> <p><i>"Neighbours will make fun, it will be difficult to marry such girls."</i></p> <p><i>"For those girls who return, stigma is a big problem. To help her return from her bad path, we try to explain. All members of the GP are encouraged to take proactive steps."</i></p> |
| Directives and training for rehabilitation of trafficking survivor | <p><i>"No directives."</i></p> <p><i>"No training."</i></p> <p><i>"Been to Bangladesh for training through NGO".</i></p>  |

- Construction of trafficking as a consequence of unscrupulous migration. The Panchayat seems to be of the opinion that trafficking is not a law and order issue but a social problem caused primarily by lack of education, large families, poverty and lack of employment. Some have also mentioned that 'girls go by their own wish.' The role of a trafficker is best described as a person who 'lures and makes false promises' while most of the responsibility is placed on the 'victim' and her family. Only one Panchayat member seems to be of the opinion that the police is in collusion with the traffickers and that there could be an active nexus to protect and even aid the perpetrators. What is interesting is the exact opposite way in which organisations at 'destination' points treat trafficking as only a law and order problem with very little attention to the economic compulsions that might have pushed the girl towards migration.
- The responses under the second column (Table 4.2a) indicate that though the officials are aware of trafficking, they are unaware of specific cases or data about girls who have been rescued and reunified with their families. Interestingly, the Panchayat members from Swarupnagar and Bongaon (compare it with responses in Table 4.1) seem unaware of any trafficking that occurs in their area, thereby corroborating the data from survivors. The Panchayat also seems responsive towards issuing OBC certificates necessary for affirmative services such as PDS and other welfare schemes.
- Some from the Panchayat appeared to be willing to help and intervene when families approach them with missing cases. They have mentioned instances of helping families file FIRs with police, arrange papers required for rescue and also establish contacts with NGOs for coordinating rescue of girls.
- Lack of identification seems to be thwarting any further intentions towards helping survivors. The Panchayat seems to be aware of the stigma a girl might face on her return but their role in rehabilitation is limited because survivors hardly seem to approach them after family reunification. This is clearly reflected



in this response, '*...however, no cases have approached me after return for help*'.

- In terms of ways in which they would help the girl, their responses range from supportive that mention livelihood generation, support through funds available to them and referring them to health service providers for health problems, to distant approach as reflected in a Panchayat Pradhan's response of '*can't help more than discussing this with members of the village...there is no provision or resource...*'. Though there is a uniform understanding of the nature of stigma that survivors might have to face as they return to the community, there were no suggestions for ways in which they might help resolve such issues for survivors.
- In terms of limitations, the Panchayat identified lack of funds, resources and provisions. There seems to be hardly any information about the Ujjawala scheme.

Triangulating data from survivors and Panchayat members, it appears there are barriers in place that prevent a survivor from utilising services that the Panchayat has to offer, or that keep the Panchayat from acknowledging survivors and fulfilling their needs.

### Barriers

**1. Onus and burden of trafficking on victim and family:** This is reflected in the attitude of the Panchayat members who feel that girls and families knowingly participate in trafficking for economic gains. Migration is considered to be a greedy and bad practice as reflected in the statement here, '*...told parents not to send her to Delhi or Mumbai, but try to become self-sufficient within our own GP*.' Though it appears

contextually viable, the tonality of this suggestion is disapproving. What appears to be implied here is that if this is the consequence of parents and girls themselves, then perhaps it absolves Panchayat from helping a survivor, or owning up to the responsibility for the survivor. Their attitude gets reflected when the survivor approaches the Panchayat for affirmative services revealing her identity.



**2. Invisibility of the survivor to the duty bearer:** This refers to the apparent lack of information about a survivor of trafficking who may have returned and who may be in need of rehabilitation services. Response of survivors show that they usually approach the Panchayat for general services such as OBC certificates, voters card, etc. Responses of Panchayat members show that since no one approaches them for rehabilitation help directly, they are unable to do anything to that effect. So there appears to be a barrier around identification of a survivor, as the Panchayat receives no information about a returnee survivor from the system.

Information flow seems to get confined to and restricted to the sending State and the receiving State NGOs. For an adult survivor, the court from the destination State directs the survivor to the custody of a NGO with a shelter, in Kolkata. In case of adults, the courts have 30 days to identify the families of the survivor and return the girl, otherwise it becomes illegal detention. So, it passes an order to return the survivor to a NGO in West Bengal that is running a shelter home. From this step onwards, the system gets totally bypassed, thus at the State, District or Panchayat level, no duty bearers have any information about the survivor returning to their families. The argument of confidentiality is usually used to justify this process. This seems to be no longer true because when the survivor returns to the village, and files

a case against the trafficker who was the procurer and transporter to the destination point but wasn't indicted, the incidence of trafficking becomes visible to the public in most ways.

**3. The blind spot:** Neither the Panchayat knows what a survivor might need, nor does the survivor seem to know what the Panchayat can do for them. This is well expressed by a Zilla Parishad member, who says, *"There is lack of awareness of what work the Panchayat does and how, so people do not come to ask for help. If they come, they can be helped through the block development fund. This is not well-known, so nobody comes. Awareness of how girls can get trafficked is campaigned through mikes and hoardings but there is no communication on what kind of help they can receive after they are rescued and reunited with their families."* The barrier is, therefore, an absence of communication between duty bearer and service recipient, lack of an interface that creates a blind spot.

**4. Lack of clear directives:** None of the Panchayat members mentioned getting any clear directives or training to deal with rehabilitation of trafficking survivors. It is obvious that such a group is not provided with clear guidelines or provisions. In fact, a Panchayat Pradhan says there is no mention of trafficking in any Panchayat book, which more or less sums up the situation at the Panchayat level. One of the policy gaps is that the National Plan of Action document of 1998 doesn't say anything about what the Panchayat can do; Ujjawala doesn't talk about the Panchayat role either. PNRD also hasn't given any clear directive to this effect. Support in terms of willingness to help if they are identified and they are directed to help, is however, present in most of their responses, showing that once directives are in place,

the Panchayat can be expected to extend support to survivors of sex trafficking.

### BLOCK AND DISTRICT LEVEL DUTY BEARERS

Since the survivors mentioned very few duty bearers from block and district level administrative unit during FGDs, this group has been considered together as a whole, to analyse gaps herein.

Table 4.3 Survivor's interaction with block and district level duty bearers

| Positive   | Negative   |
|--|--|
| <p>"I visited BDO office for OBC certificate."</p> <p>"I visited BDO office to collect the cycle I got from school."</p> <p>(Survivors, Swarupnagar)</p> | <p>"Behaviour at police station is not good. They want to be bribed. Only when Party people accompany, they help. They might or might not help in presence of NGO."</p> <p>(Survivor, Barasat)</p> |
| <p>"I was sent home through the police..."</p> <p>(Survivor, Bongaon)</p>  | <p>"...but not all policemen are good. For some such policemen, I couldn't return."</p> <p>(Survivor, Bongaon)</p>   |
| <p>"Bangalore police helped a lot."</p> <p>(Survivor, Hasnabad)</p>  | <p>"Ahmedabad police was not helpful."</p> <p>(Survivor, Hasnabad)</p>   |

While BDO office was visited for general services, their interaction with police has been more trafficking centric. References are not very positive and are reflective of corruption and maltreatment. Looking at the responses from duty bearers, specifically BDOs, DSWO and police officers including the SP (Table 4.4 & Table 4.5) will make our analysis richer.







Table 4.4 Responses of DSWO, BDO and CDPO

|      | Risk factors   | Information/identification   | Action   | Plans and Schemes   | Other departments/infrastructure  |
|------|--|--|--|---|---|
| DSWO | <i>"Don't know, I am new in this post, information will be available at Childline."</i>  |  | <i>"No follow-up of rehab cases."</i>  | <i>"Swavalamban, Swadhaar, Ujjawala schemes are used for such work."</i>  | <i>"ATU is present in district. Trying to reintegrate cases by obtaining data from police. Trains have to be checked to control trafficking."</i>   |
| BDO  | <i>"Main reason for trafficking is lack of education and poverty. Those families that cannot eat and live decently participate in trafficking. Apart from that, many 'bad' people work in this area who make up stories and trick girls and their family, take them out of this place and sell them. Apart from that, this place is very close to the border, thus migration from across the border is very easy and frequent, causing a lot of problems."</i> | <i>"Yes they are present. But I don't have any numbers, information."</i>          | <i>"WCD and Panchayat can arrange loan and training for the survivors. AWW can spread awareness about trafficking through their meetings. The Health Dept. can be roped in as well. This area is Muslim dominated, and each family has many children, because of which their resources are strained, poverty is created. If we want to stop this, we need health and family welfare dept's cooperation."<br/><br/><i>"We haven't analysed this, but if there is a demand or if someone comes with a demand, we can arrange something."</i></i> | <i>"Planning can be done according to their age and education levels, but it is best if such planning suggestions are made by them. Otherwise we might plan and start some training and projects for them which might not be of any use to them in future."<br/><br/><i>"I don't know much about Ujjawala, my office is not responsible for it."<br/><br/><i>"The activities of State department has no connection with the activities of local office. First, these two departments need to work in tandem, otherwise it is difficult to implement any action. Girls and their families also need to think practically about economic activities."</i></i></i> | <i>"There are no such lists, but if the case is sent to block welfare officers, something can be done. Mostly, the second officer in police stations is responsible for such cases."<br/><br/><i>"There is no other social worker."<br/><br/><i>"What kind of help is needed by the girl and her family will determine where I refer her. However, block welfare officer does all the work which is supposed to be done by some kind of social worker."</i></i></i> |
| BDO  | <i>"This area is very vulnerable."</i>   | <i>"If some organisation can identify such girls, then we can work with them."</i> | <i>"But in case we come to know of some girl in distress, we can do the following – Indira Awaas Yojana for house, 100 days work, etc. can be done. But since last year, I haven't heard of any such incident. 48% women are involved in 100 days work but am not sure whether any belong to a trafficking survivor group. We can give one month grain through GRE. But not everyone belongs to a poor family."</i>  | <i>"Economic schemes are given once in a year, like sewing, etc. when there is job guarantee for 5,000 to 10,000 rupees. Swadhaar or Swavalamban schemes are not there. Since we don't have welfare officer, I have to refer cases through DSWO. NABARD hasn't given any support for women's empowerment."</i>  | <i>"We have no anti-trafficking cell at the block level, and have no directive."</i>  |



Table 4.4 Responses of DSWO, BDO and CDPO...contd.

|      | Risk factors  | Information/identification  | Action   | Plans and Schemes   | Other departments/infrastructure  |
|------|---|---|--|---|---|
| CDPO | "Socio-economic condition, lack of education and family planning, father cannot feed them so daughter is being sent outside." | "I don't know of any in my area, but through AWW I have come to know that trafficking occurs in this area." | "Income generation opportunity is needed. With proper training a lot of these girls can be employed in canteens of government offices or call centres. NGOs can take a proactive role in this."<br><br>"If I get a survivors' list, I can raise the need for employment opportunities for such girls with the DM." | "There are no such packages."<br><br>"Training and employment doesn't have a connection in this area, so training is not proving to be successful."   | "AWW can prepare group awareness and opinion so they can be involved in anti-trafficking programmes. But AWW needs connection with police. They can give the right person information." |
| CDPO |   | "Have not received any written application for help. I don't know if any has arrived."                      | "Computer training is done for younger girls. GSS, NGO has made an application to start such training."  | "There is no separate facility for victims."<br><br>"But if a scheme has to be planned, it has to come through the BDO. Bottom to top communication channels are not available to us. So if these issues are taken to DM, DSW, it is better." | "WCD has sent letter, to raise awareness against trafficking in Mother's meeting. This happens regularly."<br><br>"There was a committee at block level."                               |

- Looking at the way administrative officials construct the process of trafficking, it seems that the onus lies entirely on the girls and their families. The role of a trafficker in the entire process does not feature in their understanding. The vulnerability factor is entirely dependent on the girl, her family, socio-economic condition and number of children in each family. The inherent prejudice against the survivor and her family is quite apparent.
- The lack of information on girls who may have been reunited with their families is also very apparent, even at the DSWO level. The reasons for such lack of information as mentioned by the DSWO could be lack of follow-ups, no written application for help from survivors and lack of an 'organisation' who can inform duty bearers about such cases.
- Since there exists no knowledge of survivors who might have returned, subsequently there exists very little knowledge of their needs, especially health needs. They mentioned they could help survivors in terms of livelihood options, but suggestions were generic, ranging from computer training to referrals to Health Department for family planning, because the reason for trafficking is 'more number of children'.
- There is an implicit expectation towards NGOs taking responsibility to identify survivors and taking a 'proactive' role in organising training in relation to market demands, like for call centre employment.
- Duty bearers in this group have also expressed a need for interdepartment connection and coordination, in order to fill in the gaps in information disclosure.





Table 4.5 Responses of SP, OC and sub-inspector

|                   | Risk factors  | Identification/ information  | Responding to complaint  | Role of police   | Activities   |
|-------------------|---|--|--|--|--|
| SP                | <p>“Reason for trafficking is poverty. It is because of the girl’s character and poverty of her family due to which girls leave home consciously or at times without being fully aware.</p> <p>Then girl sends home money and parents are not bothered whether she is fine or not, but when the money stops, parents come to the police station and seek help to find the girl.</p> <p>The girl returns back to her trafficked life because of poverty or abuse at home or because she is now used to living a more comfortable life unlike the one in her community and hence, she returns back by herself.”</p> | <p>“If there is a decision that police department has to give information on how many girls were rescued and sent to shelter home to their respective BDOs and Panchayat Pradhans, I can do that with pleasure.”</p> <p>“How many girls were returned from shelter home to their own homes, such information can be shared by the shelter home officials with local duty bearers.”</p> | <p>“Earlier, many police stations did not want to record FIR but that has improved now. No police station refuses FIR.”</p>  | <p>“The police department is responsible for the girl’s rescue, court procedures, and sending her to shelter home but after that the police is not responsible.”</p>   | <p>“There are no committees at block level to fill in this information gaps, there is committee in district level. The DM arranges a meeting of this committee every two months. DM, DSP, SP and DSWO are present, sometime block representatives also attend. This committee discusses – description of trafficking prone areas, number of trafficking cases, number of girls rescued, difficulties faced by rescued victims, etc.</p> <p>However, there has been no work in terms of passing data or information to lower officials or departments about such issues.”</p> <p>“Some posts have been lying vacant in this committee, hence discussions lack continuity.”</p> <p>“Awareness against trafficking should be improved further.”</p> |
| Officer-in-Charge | <p>“Trafficking occurs to get work done cheaply, cheap labour, earn money by selling girls, and gain illegally.”</p> <p>“Lack of education is responsible.”</p> <p>“During restoration, even if parents or husband agree to accept the girl, family and larger society does not accept. Hence, the girl is forced to leave home again.”</p>   | <p>“Every month there are two to three such cases.”</p> <p>“No police officials are present during restoration.”</p>   | <p>“When parents complain that their daughter is missing, we note a case under 363, 366, 363A, 366A, 372. 363 and 366B is for taking people under false pretext, 372 is for taking people with intention of selling in red light area, 373 or 366A is for taking minor with promise of marriage.”</p> <p>“Azad Hind express is used to take girls; Raju is a common trafficker name.”</p> <p>“If we get mobile number we track the mobile and rescue or we can send a police officer in search of the girl. But mostly, due to lack of funds we can’t send police. We contact other police stations and work on rescue.”</p> | <p>“After rescue, the investigating officer questions the girls, parents or husband who take the girl after furnishing a bond from the court.</p> <p>We speak, our female officers also question, but we do not have any counselor here. We normally ask the girl, where did she go, with whom did she go and why. Questions regarding nature of violence or sexual violence incidents are not asked because of lack of female officers. We don’t have provisions for keeping the girls overnight, there are no clean washrooms either.”</p> | <p>“We have done a rally on Women’s Day and there has been no problem.”</p> <p>“There are some people who are involved in trafficking from this area, they try to hinder us, but it is not possible to stop us.”</p>   |

Table 4.5 Responses of SP, OC and sub-inspector...contd.

|               | Risk factors   | Identification/ information                           | Responding to complaint   | Role of police  | Activities   |
|---------------|--|---|---|---|--|
| Sub-inspector | <p>"For sex work and cheap labour."</p> <p>"Lack of awareness &amp; education are responsible; in this case parents and girls are uneducated."</p> | <p>"Four cases per month."</p> <p>"No follow-up."</p> | <p>"In case of a missing person, we inform CID Bhawan with a photo. The victim and accused is caught for kidnapping."</p> <p>"If they let us know we can trace the trafficker. But nobody has complained that they have been harassed by the trafficker."</p> | <p>"Because of lack of funds, we can't go out and do something. There is no fund allocation for such operations."</p> <p>"It takes time to get funds sanctioned, at times we spend money from our own pockets and go for rescue missions."</p> <p>"We can't do much at this moment."</p> <p>"First the medical test is done, then the investigating officer tries to find out everything, how did it take place, who is responsible. There is a female officer present but we don't have any counsellor."</p> | <p>"If someone comes to us, we can spread awareness about trafficking, we can't do anything else."</p> <p>"We haven't faced any problems."</p> |

- Even at the law enforcement level, trafficking is perceived predominantly as a problem of the victim or the girl who is being trafficked. Trafficker's role in the entire operation is conspicuous by its absence. The issue is constructed as a social consequence of lack of education and livelihood options. It is also construed as a choice of a girl wanting to get rid of poverty, which may be true but the tonality of such an observation is that of disapproval and not of empathy.
- There appears to be a well-maintained database of missing reports but none of the girls after rescue and restoration, which is primarily because the police is not involved in this process. Usual practice of restoration follows that the destination NGO contacts a source NGO, who perform a home investigation, following which the girl is handed over to her family. There is no presence of any systemic duty bearer in the entire process. Role of police is perceived to be at the initial stages of rescue in order to record details of trafficking process. Lack of female officers, counsellors, social workers and funds are cited. Awareness generating activities are not well-defined or evaluated.

### Barriers

Considering these accounts, the barriers that emerge in terms of accessing

administrative services are as follows:

**1. Stigma and negative stereotype:** Same as that observed among Panchayat but still removed from reality in terms of traffickers' role. Girls, their families, their socio-economic deprivation and their efforts to earn a living by migrating are the common risk factors. There are beliefs about the girls' character and her vulnerability to be re-trafficked on account of not being able to adjust to her new life. This confirms that there is awareness among duty bearers about stigma and abuse faced by survivors in their families and communities upon return. Hence, both survivors and duty bearers are aware of the stigma but no affirmative action seems to have been taken. This could be because the stigma associated with a survivor of sex trafficking is accepted as a 'normal reaction to an abnormal situation,' something that is expected and even condoned, hence existing beyond any corrective action.

**2. Lack of synergy:** 'AWW might know but the CDPO doesn't, shelter homes know but we don't' is the kind of data that indicates that though there is identification, it is not shared or there is no mechanism of reporting and recording this information, leading to invisibility of survivor. A chain of information sharing between



all duty bearers who come in contact with survivors is missing, leading to loss of data. The SP identifies this gap very well when he says that it is the police's responsibility to place the girls in shelter homes, but they have no information when shelter homes restore girls back in the community. Overcoming this disjointed nature of effort might lead to better information flow.

**3. Missing policy praxis:** This occurs in two ways – one, where there are schemes but beneficiaries, in this case survivors of sex trafficking, are not identified. This lack of identification is caused by lack of data sharing and also because survivors don't seem to approach BDOs or CDPOs for rehabilitation-specific needs. At another level, there is a mismatch between existing training or skill development with market demands or livelihood options. For example, girls might be taught sewing but the returns from sewing, as a livelihood option, is quite low. This mismatch has been pointed out by a CDPO, who says, *'Training and employment doesn't have a connection in this area, so training is not proving to be successful.'*

**4. Lack of public-private partnerships:** Lack of identification is the underlying reason why administrative duty bearers fail to reach whatever existing schemes or services to survivors. There is an implicit expectation that the survivor would overcome stigma and shame and approach for help or an NGO will coordinate this service delivery access. Having a public-private partnership is therefore indicated by the duty bearers as a possible way of overcoming the issue of survivors of sex trafficking not getting their rights.

**5. Dysfunctional Anti-Trafficking Unit and other committees:** The presence of ATU at district level is mentioned but what emerges from the SP's account is that there is discontinuity of

discussions because of vacant posts and transfers and there is no mechanism of implementing decisions taken at such meetings. This is corroborated by a BDO who mentions not receiving any directives about anti-trafficking or rehabilitation of survivors.



**6. Unidirectional communication channels:** India's administrative set-up is a colonial legacy, hence bottom-up communication is almost non-existent. The data here suggests that though people working at grassroot levels might have more information and awareness of a survivors' needs, there is no mechanism to allow them to channelise their knowledge to higher up officials who frame policies. As mentioned by a CDPO, who says, *'...if a scheme has to be planned, it has to come through the BDO. We don't have bottom to top communication channels...so if these issues are taken to DM, DSW, it is better.'* The DSWO, on the other hand, appears far removed from any contact with real issues regarding survivors, as reflected in a statement such as this – *'...no follow-up of rehab cases...information is with Childline...trains have to be checked to control trafficking.'*

**7. Decision making and proximity to survivor:** Decisions on schemes and plans for survivors are clearly taken at a level of duty bearers far removed from the survivors. Their responses appear generic and devoid of the real issues that a survivor or her family might be facing. This barrier is endemic in any system but a BDO gives a significant insight into dealing with this problem. BDO, says, *'Planning can be done according to their age and education levels, but it is best if such planning suggestions are made by them. Otherwise, we might plan and start some training and projects for them which might not be of any use to them in future.'*

**8. Resistance within the system:** When a BDO says, *'the activities of State*

*department has no connection with the activities of local office. First, these two departments need to work in tandem, otherwise it is difficult to implement any action' or when another BDO says, 'Since we don't have a welfare officer, I have to refer cases through DSWO. NABARD hasn't given any support for women's empowerment', it implies that there are barriers within the system that cause resistance. Lack of resources, funds and lack of clear directives are also part of systemic resistance to bring trafficking survivors within the ambit of state welfare schemes.*

### Healthcare System

The analysis presented in the previous chapter shows that trafficking and assimilation does make a survivor vulnerable to various physical and mental disorders requiring sustained health services. Here, we shall first analyse the survivors' health seeking behaviour and then we shall present responses of health service providers with respect to survivors of trafficking.

#### Accessing healthcare

*"For fever or stomach upsets, we get medicines from local pharmacy. A lot of times this works."*

*"We don't have any good doctors here. They don't give any medicines in the hospitals, Just make us wait."*

*"I feel I have been possessed by a ghost. I feel the need to call an Ojha during those times. My family is getting me treated by a Moulvi who has given me a 'maduli' (amulet), 'jhere diye geche' (exorcism ritual). My condition has improved a little. I can't go to the hospital for such a problem."*

Findings on accessing healthcare, shows a preference towards traditional healers and private doctors against government doctors or government health care

services. To understand this attitude and behaviour, we need to look at the unique socio-cultural context of a survivor. A young Muslim female, in most cases, complains of mainly symptoms such as fainting, dizziness, pain in abdomen, white discharge. The general trend is to avoid going to Government hospitals for such complaints. The reasons are reflected in the following excerpts –

*"What do I say to a doctor about fatigue and aches in hands and legs? So much has happened with me, how can I not feel fatigued?"*

*"I don't go to the hospital directly. Only women who are married and those who are very ill visit the hospital. We are not suffering from a grave illness, what do I say? They are also rude."*

There are two types of factors that seem to be acting as barriers towards accessing designated healthcare services by the government. The first factor is socio-cultural concept of illness. Diseases with no apparent cause such as fainting, dizziness and aches and pains are most often defined as 'effects of an evil eye/spirit' that can only be treated by a traditional healer such as a Moulvi or Ojha. Treatment is usually through rituals and amulets and healing or perception of cure is mostly at a psychological placebo level. When situation deteriorates the person is taken to a government hospital, but not before losing precious time.

The second factor is systemic. Government hospitals have been perceived mainly as places that are time consuming, rude and better fit for grave illnesses. As reflected in the following experience of a parent of survivor –

*"Seven months since her return, she used to be quiet and withdrawn. We tried to give her love and affection but she did not eat, was feverish and nauseated. She*



*was transferred from Barasat to RG Kar hospital. She was diagnosed with kidney problem, she would vomit even if she took one glass of water after sundown. At RG Kar they said, 'marry her off.' Now after visiting the private clinic she is better. Doctor has asked us to consult a psychiatrist."*

Many survivors mentioned the problem of cases being transferred to RG Kar hospital in Kolkata, and the fear of the long drawn process and hassle made many avoid government health units in their district. These problems are not specific to trafficking survivors only. All residents of these areas face such difficulties but what sets them apart is the added disadvantage of shame and stigma acting as an internal deterrent from accessing whatever is available in their district level health units.

The excerpt above which says that only married women go to a government hospital for sexual and reproductive health problem is reflective of how shame and stigma acts as a barrier to accessing government health care services. This raises serious concern about how pregnancies are dealt with when they occur outside marriage. These were responses to such a point during discussion –

*"I told my mother I was pregnant and my mother said I must go and die."*

*"In another case a girl committed suicide."*

*"Those who are well off can abort by using pills."*

*"I visit private doctor for gynaecological problems."*

So what appears is that the barrier of shame and guilt within the survivor that is fostered by reactions of people around her can cause grave harm if not changed, especially in terms of healthcare.

Traditional healers, private doctors, RMPs

(rural medical practitioners – quacks who pass themselves as medical practitioners with no degree), chemists and compounders, and others seem to fill the gap that exists between present health needs of the survivors and health service accessed. In fact, studies have shown that traditional healers often represent first source of any therapeutic intervention.

Such sources of healing score over government facilities because they are trusted, easily accessible, recommended by significant others and work in favour of people with strong belief in supernatural causation of illnesses. So why does the health mission fail to reach out to survivors of sex trafficking? Responses from interviews with health service providers are analysed next, to answer this question.

### Healthcare system analysis

Several officials who are part of the National Rural Health Mission are expected to play an important role in a trafficking survivor's life with respect to providing formal healthcare services. An Auxiliary Nurse Midwife (ANM) is expected to identify cases of ill-health, make referrals, serve as the first contact person between a care seeker and medical care provider. They train and are assisted by female Accredited Social Health Activist (ASHA) and by Anganwari Workers (AWW). Together, their main focus is usually maternal and child health but they are expected to conduct out-reach programmes and health camps to develop general awareness of health and encourage safe and proper treatment of medical illnesses. Another important factor in the rural health scheme is an Anvesha Counsellor and finally a Block Medical Health Officer (BMOH). An Anvesha Clinic, which is unique to West Bengal Government's health programme operates at block level and provides primary healthcare services along with counselling and psychosocial



support and performs outreach work for adolescents in middle school. A BMOH is responsible for providing services and monitoring and supervising primary healthcare centres and implementation of health programmes.

These service providers were interviewed to understand their opinion about the health situation of women who have been rescued from trafficking and rehabilitated back in their homes. These responses are presented in Table 4.6 below.

The BMOHs interviewed held parents, girls and their general lifestyle responsible for pushing them towards trafficking just like other duty bearers. The negative stereotype with respect to a girl willing to migrate and a family willing to let their daughters go out is conspicuously present in their account. Though their knowledge about the health consequence of sex trafficking is very accurate, they too seem bound by the lack of identification or information

about survivors.

It appears from their responses that there is no insight into why girls don't access government health services for abortion or other reproductive problems. Family members are seen to act as deterrents but they refrain from going beyond it and understanding that it is fear of stigma and lack of privacy that motivates a family to prevent their daughters from accessing hospitals for abortions. Comparing data from survivors and medical officers, it looks like there is no outreach worker present in the society who can identify cases and help them access proper healthcare service from a reliable source. So we present findings from outreach workers – ANMs during FGDs.

*"Don't know of any such girl in our area."*

*"Will refer them to BMOH/MO."*

*"In case of mental problem, there is a Anwasha counsellor."*



Table 4.6 Responses of BMOH and MO

|                        | Risk factors   | Information   | Common health symptoms   | Role   | Challenges  |
|------------------------|--|---|--|--|---|
| BMOH/<br>MO<br>various | <p><i>"Poor economic condition and ignorance are the main contributing factors of trafficking."</i></p> <p><i>"Promise of a good job and well-settled life prompt them to be trafficked."</i></p> <p><i>"Girls often get married at the age of 14-15 years and give birth to a baby at the age of 16-17 years."</i></p> <p><i>"Parents also do not hesitate in shrugging off their responsibilities by sending them to far away places for work."</i></p> <p><i>"Sometimes, if husbands marry for the second time in the presence of the first wife, then also the possibility of being trafficked rises. All these happen due to sheer negligence on the part of the parents, husbands and also the in-laws."</i></p> | <p><i>"Officially, I do not have any information on any case of girl-trafficking in my working area."</i></p> <p><i>"This BPHC serves the border villages and I know trafficking is one of the major problems in this area. I am working here for quite a long period. But none of my patients reported to me that she is a victim of trafficking."</i></p> | <p><i>"Injuries in various parts of the body including vaginal injury."</i></p> <p><i>"Problem of STD, RTI and HIV."</i></p> <p><i>"Pregnancy, internal injury and UTI etc."</i></p> <p><i>Depression</i></p> <p><i>Anxiety</i></p> <p><i>Schizophrenia</i></p> <p><i>Amnesia etc.</i></p> | <p><i>"If any one comes to us with any health problem, we serve that individual. She may or may not be a trafficked survivor. It does not matter for service access."</i></p> <p><i>"But definitely, if we come to know about the background of the girl, at the time of history taking, we will pay special attention and try our level best to link other services for her."</i></p> | <p><i>"There is no problem to access the government service, but the family members don't allow the girls to get it."</i></p> <p><i>"There lies no problem at the end of service provider, but the girls who need to abort prefer to get the services from the non-government agencies. If the girls are below 18 years, they need their guardian for abortion, but many of them do not want it."</i></p> |



The problem here is that the medical understanding of 'sexual and reproductive health' that an ANM deals with is within the social ambit of marriage. Survivors suffering from such problems would hesitate from revealing their condition to the ANM and the duty bearer would not go about looking for such problems in such groups, because they are not married. Similarly, the Anwasha counsellors interviewed had no knowledge of any survivors seeking help. It is possible that some might have been referred to her, but since their history remains concealed, the counsellor too appears ignorant and whatever counselling takes place is low on efficacy because the underlying history remains untapped. Interestingly, AWWs are the only group who appear to be cognizant of the presence of survivors in their area. As reflected in the following excerpt –

*"I heard in a mother's meeting that one of the girls of this village left her home without informing her family members and got married to a person whom she had met in her relative's house. Later, that person sold her to a brothel. A few months later, the girl somehow managed to run away from the brothel and return to her home. The family has accepted the girl but none of the villagers interact with her. If I have any option to support her, I will definitely do that. I have sometimes felt that I need to inform the police. But I do not know how I should I go about it. We require official instructions to work with the police for such victims..."*

This response sums up the situation at the village level. AWWs are aware but do not have any directives to help such girls.

### Barriers

The systemic barriers therefore identified with respect to health, are as follows:

**1. Socio-cultural meaning of illness and health:** Defining mental illnesses and some symptoms as possession by

spirits seem to act as a barrier towards accessing healthcare services at the survivors' level. At another level, the same problem with meaning prevents service providers from including or being sensitive to cases of unwed mothers or unwed young girls with sexual and reproductive problems. The whole issue surrounding the norm of sexuality appears to be working at a meaning-making level, when it comes to defining sexual and reproductive health in this situation.



**2. Internalisation of shame and stigma:**

On one hand, the survivor is prevented from accessing sexual and reproductive healthcare due to her internalised shame and stigma and on the other, there seems to be a prejudice against girls who are trafficked, as reflected in the first column of the responses by BMOH/MO in *Table 4.6*. As noticed among other duty-bearers, this group also appears to blame the family and girl for willing to take the risk of migration for better employment opportunity. The accounts of survivors about rude behaviour in government hospitals must be true for other patients visiting the hospital as well. However, the survivor in her vulnerable mental state (marked by dysthymia, social anxiety and depression) is more susceptible to perceive it as an insinuation to her sex-trafficking history/identity.

**3. Record book invisibility:** No record of survivors and no outreach that includes them in the medical health programme seems to be acting as a major reason for losing girls to non-governmental and, at times, dubious medical practitioners. AWWs are aware of such cases but this information falls through the gap created by lack of any directive to include survivors in some form of recording mechanism.

It is not that the survivors do not access healthcare, nor is it that health infrastructure is absent, but the problem lies in the complexities within the

survivor, within duty bearers and within the system that requires some transformations to make the health system more responsive to a trafficking survivor's health needs. It has been often observed that people largely depend on traditional healers for a certain category of diseases; even WHO studies of *Pathways to Care* showed native faith healers to be an important source of care for people who ultimately attend psychiatric services. However, this significant section of health service providers has been left out of any State Health System. They are neither banned nor are they integrated. In a rural set-up where mental health service providers are rare and often restricted to a psychiatrist in a Government hospital, presence of such traditional healers also serve the purpose of medical pluralism, or a greater availability of distinct forms of therapy that might suit individual needs. Is closer collaboration necessary? Do we need a mutual development of practical guidelines for care, exchange of information and referral of appropriate patients between traditional and medical services? These are the questions that emerged from this study, which will require further discussion and efficacy tests. If such fine-tuning is achieved, issues surrounding mental health problems that require sustained attention in this group can be resolved well. It is a loss of human capital to ignore a group with such high levels of dysthymia and depression such as this. As compared to the administrative system, the health system has well-defined services but the main problem is to scale the above-mentioned barriers and make the presence of such a system relevant for survivors of trafficking.

### POLICY FRAMEWORK ANALYSIS

The lack of directives at block levels is quite apparent and troubling. In order to complete the systemic analysis, it is important to look at what exists at the

policy level. The Constitution of India discusses provisions on trafficking at two levels – one, at the level of Fundamental Rights, which are available to all, irrespective of caste, creed, sex, place of birth, etc. and two, at the level of Directive Principles of State Policy. Fundamental Rights are justiciable and directly enforced by a Court of Law, whereas Directive Principles are non-justiciable and cannot be enforced by a Court of Law. However, Directive Principles play a major role in shaping the policy of the State and may sometimes be the basis that legislation is built upon. As a Fundamental Right in Article 23, trafficking in human beings is prohibited, as are all forms of forced labour. According to Directive Principles of State Policy in Articles 39(e) and (f), the health and strength of a worker should not be abused. It prohibits all forms of labour that is exploitative and unsuitable. It especially protects children and youth against exploitation of any kind. While the Directive Principles do not mention trafficking, it mentions exploitation, which is a key element of trafficking<sup>28</sup>. The Immoral Trafficking Act, 1956, is the only legislation specifically addressing the issue of trafficking, though as mentioned in Chapter One, does not demarcate issues of trafficking and prostitution. However, several Acts and provisions that have an impact on trafficking directly or indirectly are listed in *Figure 4.2* alongside, along with various Ministries and Departments involved and finally, the working of Ministry of Women and Child Development has been elaborated alongside and in the next page, to give an idea of the policy framework within which trafficking is dealt with in India.



<sup>28</sup> Responses to Human Trafficking in Bangladesh, India, Nepal and Sri Lanka: legal and policy review. UNODC, 2011, New Delhi.

Figure 4.2 Acts and provisions

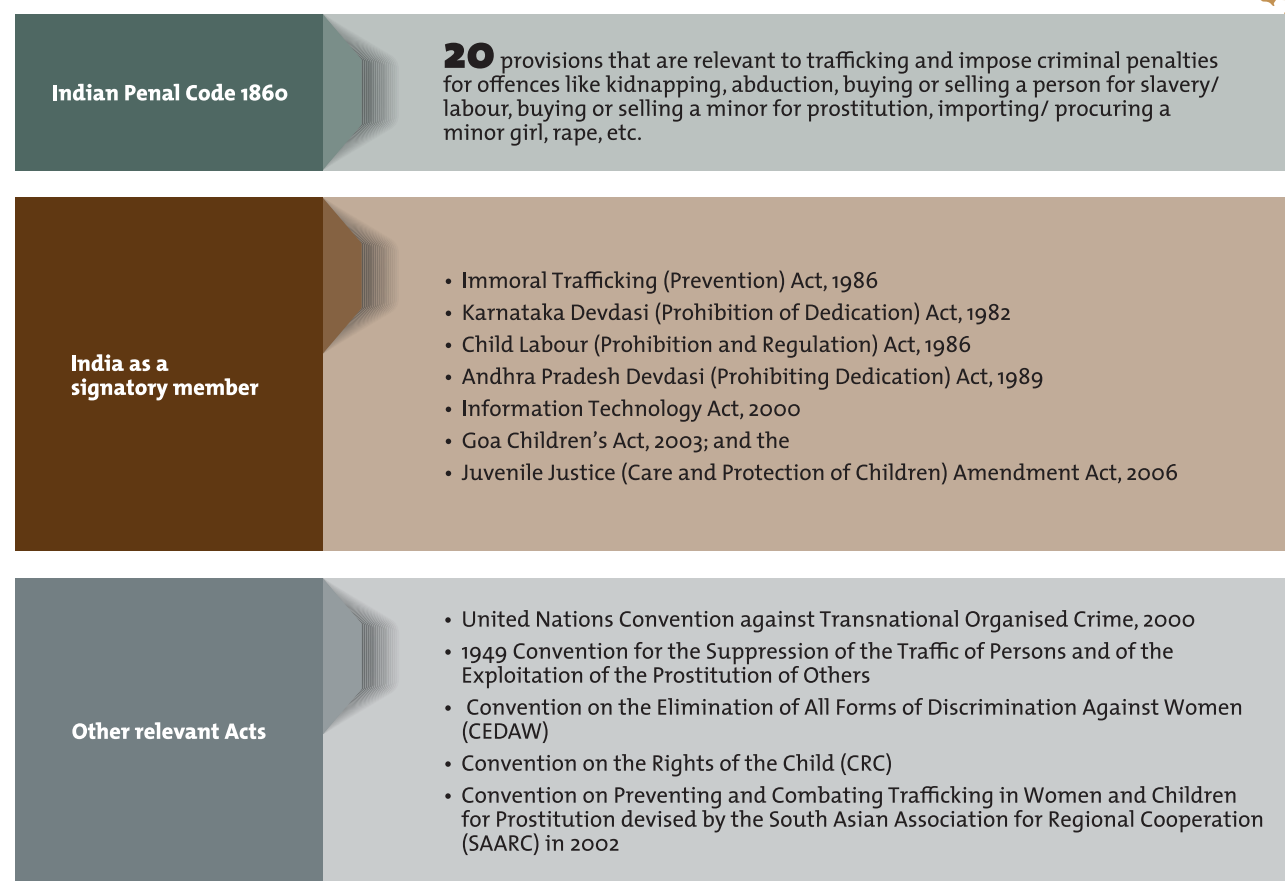


Figure 4.2 presents all the relevant legal acts and international conventions binding on India's response to the issue to trafficking. The Immoral Trafficking Prevention Act 1986 is the chief amongst all its legal provisions towards combating trafficking. Originally known as the Suppression of Immoral Trafficking Act 1956, it mirrored the UN convention of 1949.

Ministries and Departments are assigned precise and well-defined roles to prevent and combat trafficking in India such as –

- Identification of a Nodal Ministry *i.e.*, MWCD at Centre and Directors Social Welfare in States to deal with the concerned issues.
- Setting up a functional cell on trafficking in Ministry of Home Affairs.

- Formation and activation of Unified Monitoring Committee (UMC) to oversee and coordinate the issue of human trafficking at state level. Under the UMC, there should be one Anti-Trafficking Unit, (ATU) at the state level and one at the district level under the DC/SP. Anti-trafficking cells at state and district level should be set up and they should work in proper coordination.

The Ministry of Women and Child Development, the Nodal Ministry in the Government of India, dealing with issues concerning women and children including trafficking, drew up a National Plan of Action to Combat Trafficking and Commercial Sexual Exploitation of Women and Children in the year 1998.



This action plan considers the Report of the Central Advisory Committee on Child Prostitution, the recommendations of the National Commission for Women, the directions of the Supreme Court of India as well as the experiences of various non-governmental organisations working in this area. A Central Advisory Committee, under the chairpersonship of Secretary, Ministry of Women and Child Development, has also been constituted with members from Central Ministries like the Ministry of Home Affairs, Ministry of External Affairs, Ministry of Tourism, Ministry of Health, Ministry of Social Justice & Empowerment, Ministry of Information Technology and Ministry of Law and Justice, to combat trafficking in women and children and their commercial sexual exploitation, as well as to rehabilitate victims of trafficking and commercial sexual exploitation and improve legal and law enforcement systems. A State Advisory Committee has also been constituted under the 1998 National Plan of Action to monitor initiatives undertaken in the state with regard to prevention, rescue, rehabilitation, reintegration and repatriation of victims of trafficking.

The Ministry of Women and Child Development has also undertaken a study in collaboration with UNICEF on Rescue and Rehabilitation of Child Victims Trafficked for Commercial Sexual Exploitation. The Ministry of Women and Child Development, in 2005, also formulated a Protocol for Pre-Rescue, Rescue and Post-Rescue Operations of Child Victims of Trafficking for Commercial Sexual Exploitation. This Protocol contains guidelines for State Governments and a strategy for Rescue Team Members for pre-rescue, rescue and post-rescue operations concerning children who are victims of trafficking and were sexually exploited for commercial reasons.

The Ministry of Women and Child

Development, in collaboration with UNICEF and various other organisations, has developed three training manuals – the ‘Manual for Judicial Workers on Combating Trafficking of Women and Children for Commercial Sexual Exploitation’, ‘Manual for Medical Officers for Dealing with Child Victims of Trafficking and Commercial Sexual Exploitation’, and ‘Manual for Social Workers Dealing with Child Victims of Trafficking and Commercial Sexual Exploitation’. Manual for Medical Officers was developed by the Ministry of Women and Child Development in collaboration with the Indian Medical Association and the Manual for the Judiciary was developed in collaboration with the National Human Rights Commission.

The Ministry also developed, in collaboration with UNICEF, several communication creatives in the form of posters, games, newspaper advertisements, films for video parlours, television spots in several regional languages for prevention of trafficking of girls.



### Schemes and Provisions

The constitutional framework and administrative system of India reflect the commitments in its various laws/ legislations and policy documents to forbid trafficking in human beings. Economic compulsions have featured as a push factor in trafficking, though Government of India has been committed to empower the vulnerable sections living in remote corners of the country by extending to them various welfare, development and anti-poverty schemes. The schemes such as Swadhaar, Swayamsiddha, Swashakti, Swawlamban, Balika Samriddhi Yojana, Support to Training and Employment Programme for Women (STEP), Kishori Shakti Yojana, etc. are expected to provide ample economic opportunities for women and other traditionally disadvantaged

groups. But these are general provisions that are not planned for a survivor of trafficking, *per se*. These schemes are more at the preventive level rather than at rehabilitation level.

Another effort of the government aimed towards empowerment is the ICPS (Integrated Child Protection Scheme, 2009) through which, it aims to improve children's access to schools and increase their school attendance, especially of those affected or dependents, including girl children, in remote and backward parts of the country. Effort is also made to incorporate sex education and gender sensitive concerns in the school curriculum, both at the primary and secondary levels. This initiative is expected to reduce vulnerable context to trafficking indirectly and thereby reduce its incidence.

The only scheme that exists for prevention of trafficking and rescue, rehabilitation and reintegration of victims is Ujjawala scheme under the MWCD. This scheme, however, stops short of any plans for survivors who have been restored back to their families. The tacit assumption is that having been in the shelter home before being placed back in her society, sufficiently rehabilitates her. There is no provision for any needs that the survivor might have after being reunited with her family. However, interviews with duty bearers clearly show complete absence of knowledge of this scheme, which is essentially a trafficking prevention plan. This only raises questions about its relevance and degree of implementation.

'*Trafficking in Persons Report*' (19th June, 2012) published by United States Department of State<sup>29</sup> continues to retain India's status in Tier 2 and defines this territory as a source, a destination and a transit country for men, women and children, subject to forced labour and sex trafficking. It also recognises that 90%

of trafficking in India is internal, and those from India's most disadvantaged social strata, including the lower castes. Women and girls are trafficked within the country for the purpose of forced prostitution. Establishments of sex trafficking are moving from more traditional locations – such as brothels – to locations that are harder to find, and are also shifting from urban to rural areas where probability of detection is very low.



The report points out that Government of India does not fully comply with the minimum standards for the elimination of trafficking, though it commends the following steps taken in the desirable direction:

- The Ministry of Home Affairs (MHA) continues to establish Anti-Human Trafficking Units (AHTUs) responsible for combining law enforcement and rehabilitation efforts.
- The Central Bureau of Investigation launched an anti-trafficking unit and gave investigation authority to all its police officers under trafficking-related laws.
- Penalties for sex trafficking under the Immoral Traffic Prevention Act (ITPA) and the IPC, ranging from three years to life imprisonment, are sufficiently stringent and commensurate with those prescribed for other serious crimes, such as rape.
- Introduction of scorecards for its AHTUs in June 2011 to improve the availability of real-time data.
- Continuation of government funds to support 100 NGO-run hotlines that assist vulnerable people, including trafficked victims.
- The 2009 directive of MHA (Ministry of Home Affairs) that advised State government officials to use standard

<sup>29</sup> (<http://www.unhcr.org/refworld/docid/4fe30cc1c.html>)

operating procedures developed in partnership with UNODC to proactively identify trafficked victims and refer them to protection services.

- Allocation of \$118 million for 2011-12 to the Ministry of Women and Child Development (MWCD) to fund 153 projects in 17 states under Ujjawala programme and 58 new Swadhaar projects – which help female victims of violence, including sex trafficking.

At the same time, the report criticises the options of acceptance of trafficking act as bailable offences, which in some cases result in the accused absconding after receiving bail. In addition to this as a challenge for government, the report cites the NGOs' voices which question the official complicity of the execution of these laws due to corrupt law enforcement. A trend, corroborated by Sanjog's study (2010) that reported around 74% of traffickers in the study area of Andhra Pradesh and West Bengal, had a nexus with police personnel as expressed via a range of incidents. In the same study, it was also observed that the state's role in victim assistance and reparation was conspicuous by its absence. In West Bengal, the restored victims and their families were found to be oblivious of any role the state might play in terms of rehabilitation of survivors. This implies that there is a discrepancy between what exists in terms of acts and policies on paper and what occurs in reality.

### **ANALYSING THE CORRECT FIT – POLICY PRACTICE**

In order to look at system access from the point of view of a survivor of trafficking, in need for systemic rehabilitation, it is important to understand the rescue and restoration protocols present in theory. The aim is to see how well the commitments made on paper hold true

as they percolate down to the beneficiary. The rescue and restoration protocols were designed by UNODC, which were approved by the Ministry of Women and Child Development (MWCD) and mandated to be followed during rescue and restoration of a traffic victim. These along with the Integrated Plan of Action formulated in 1998, list down specific steps which are listed in *Figure 4.3* and discussed next.

The policy analysis has been done by taking points from the Integrated Plan of Action, 1998 and measuring them against data from the field. The aim is to compare what the policy says and what actually takes place in North 24 Parganas, West Bengal. *Figure 4.3* lists the main points in the Integrated Plan of Action, 1998 and *Table 4.7* compares the policy with the practice as observed during data collection.

*Figure 4.3 Salient features of Integrated Plan of Action, 1998*

- Human rights approach
- Assigning nodal officers
- Maintaining a robust database of traffickers and those complicit in trafficking and how trafficking is carried out
- Synergy amongst stakeholders
- Directory of services
- Legal representation of the traffic victims

#### **Post-Rescue phase**

- Immediate responsibility
- Avoid further victimisation
- Services of sensitised counsellors
- Detailed interview
- Medical care and attention
- Legal counselling
- Media briefing





Table 4.7 Policy-praxis

| Policy directive   | Praxis  | Data source   |
|--|---|---|
| <p>As per the advice of the National Human Rights Commission and the Government of India, the State Governments are supposed to assign two Nodal Officers on Anti-Human Trafficking, one representing the Police Department (PNO) and the other, representing the Departments of Women and Child/Welfare/Labour (GNO). PNO will be the key contact person for all inter-state rescue activities and GNO for all post-rescue activities.</p>                  | <p>No information on 'nodal officers' who are meant to be the 'key person of influence' in rescue and post-rescue activities.</p>   | <p>Local police stations.</p>                           |
| <p>Maintaining a robust database on trafficking and synergy among various groups. One of the major challenges in Interstate activities on preventing and combating trafficking, is the lack of database of traffickers and victims. Local police, despite having intelligence, are unable/do not share it with their counterparts in other states. The database should be updated at least on a monthly basis and disseminated among all concerned PNOs.</p> | <p>As noted in the earlier sections, there is no database or synergy. For various reasons.</p> <p>District level ATU present. However, shortage of officials restricted the expected outcome of their services.</p> <p>Passing over the responsibility to various departments, Childline was the most referred to organisation for any trafficking related activity.</p>  | <p>Police stations, block offices.</p>                  |
| <p>Directory of services and list of legal representatives must be available for handling cases of survivors.</p>  | <p>None available.</p>  | <p>Offices of DSW and SP.<br/>Local police station.</p> |
| <p>Immediate responsibility and protecting rights of the survivors. The rehabilitation and reintegration of trafficked victims being a long process, it needs to take into account the short and long term needs of the individual trafficked survivor. Effort must be non-punitive and it should be aimed at protecting the rights of trafficked victims.</p>   | <p>Field data indicated that rescue operations are disjointed and hardly follow any protocol.</p> <p><b>Case I:</b> A trafficked person was found outside her source State. She was rescued and kept under police custody for a few hours. She was transferred to a local shelter home from where her court formalities were carried out. At the completion of the court formalities, she was handed over to her family at the source area. NGO provided the restorative care to the victim. She received some short-term skill-building training at shelter home or after rehabilitation with family. However, she did not have access to or awareness of any government scheme nor did she receive any individual skill-building training, based on her own skill assessment.</p> <p><b>Case II:</b> In another case study, a trafficked person was rescued from the destination state. She was handed over to her family and the court formalities were met at the source area of the trafficking incident. This time, however, the survivor only received livelihood support from NGO.</p> <p><b>Case III:</b> In the third case, the trafficked person with her own effort and intellect, succeeded in escaping from the brothel she was handed over to. She came back to her own family and after that, her court formalities were carried out with the help of the local police and NGO. She also got her livelihood support from NGO.</p> | <p>Trafficking survivors, police officers, NGOs.</p>    |



Table 4.7 Policy-praxis...contd.

| Policy directive   | Praxis   | Data source  |
|--|--|--|
| Avoid further victimisation of the survivor.   | Findings of this study suggest presence of stigma and discrimination at all points.  | Survivors of trafficking, parents, care-givers, service providers. |
| Provide sensitised counselling.  | Anwasha counsellor is present but she is not aware whether any survivor has benefitted from her service as none identified themselves as such.   | Anwasha counsellor.  |
| Detailed interview.  | Police officers interviewed mentioned conducting detailed interviews. However, a detailed interview, as mandated in the protocol, was rare due to paucity of women police officers and counsellors at police stations to facilitate interrogation on sexual harassment.  | Police officers.   |
| Provision for medical services for trafficked survivors and categorically mentions special attention for HIV positive cases. | Health services were made specifically available to the trafficked victims while they were in shelter homes. However, the status of accessing healthcare after reintegration was poor.   | Survivors, health service providers such as AWW, ANM, BMOH.        |
| Providing gender sensitive market driven vocational training to trafficked survivors.  | Shelter homes provided vocational or skill-building exercises to rescued trafficked victims. However, trainings were hardly conducive to income generation opportunities for the survivor later. Findings implicate that just income generation would not lead to empowerment in the true sense of the word. Rather, employment opportunities in low stigma, high acceptability groups would be more effective in rehabilitation of survivors. | Block level officers, survivors, Panchayat officials and members.  |

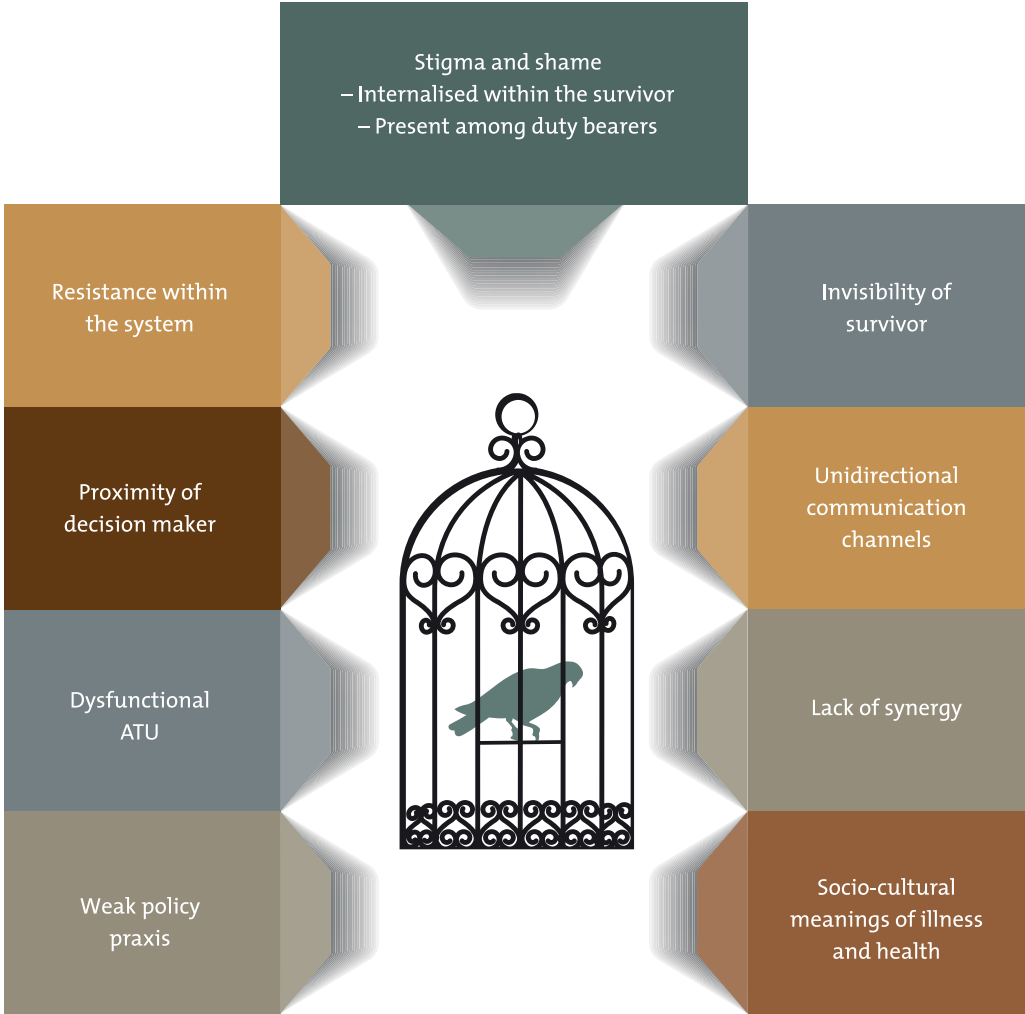
Table 4.7 is self-explanatory and leaves no doubt about the huge gap between policy and praxis.

A summary of barriers identified through this elaborate system analysis is presented in Figure 4.4 alongside.



The main barriers identified through this elaborate analysis are as follows:

Figure 4.4 *Barriers preventing access of services*



## Chapter Five Questions

*Bringing it All Back Home: A Research on Reintegration of Survivors of Sex Trafficking* was aimed towards answering primarily what are a survivor's reintegration needs and, if services are available, why doesn't she access them, what are the possible barriers. However, the end of the study went beyond its research question and presented a holistic picture of a sex trafficking survivor's status, post-family reunification and the systemic response to her presence. The findings from various points of enquiry have been summarised and listed below, just for a quick reference. This chapter also lists questions that emerged during analysis of data that went beyond the scope of this study and could serve as starting points for future research.

### Summary of findings

1. Shaming and blaming emerges to be the strongest inhibitor of recovery and assimilation of sex trafficking survivor.
2. Families who are also victims of shame are ambivalent towards the survivor.
3. Marriage becomes a strategy for families and survivors to deal with stigma and shame.
4. Jobs, not home-based income-generating labour, seems to offer dignity and respect to survivors.
5. Vulnerable psychological health marked by dysthymia, depression, social anxiety, insecurity, aggression, impulsivity and other signs of stress such as excessive vaginal discharge.
6. Weak physical condition, marked by anemia, low resistance, poor liver function and jaundice.
7. Dependence on faith-based healers to treat psychological problems.
8. No information flow from destination to source areas on returning survivors results in lack of preparedness in duty bearers and service providers.
9. Shame and stigma prevents survivors from accessing services.
10. Lack of outreach-based services leads to disconnect between survivors and service providers.
11. Absence of policy implementation leads to poor systematic response.

### Emerging questions for further research

1. What motivates families and community members, who are supportive and willing, to eschew the typical reactions of stigma and shame?
2. While change of attitudes and values is a long-term agenda and a very slow process, what could be some of the shorter term immediate methods to protect survivors of sex trafficking from shaming?
3. What are those factors that protect a survivor from shame and stigma and enhance her resilience?
4. How can traditional and faith-based healers be integrated into a public health system?
5. What kind of mental health policy can be useful for increasing correct and timely referrals and continuation of consultation or treatment?
6. What kind of policy framework changes is needed to continue rehabilitation of survivors of sex trafficking even after they are reunited with their families?
7. How to improve information flow between various organisations involved in rescue, rehabilitation and reunification on one hand and duty

bearers and service providers on the other hand?

8. What kind of directives and training are needed at various levels to sensitise duty bearers about the needs of a survivor of sex trafficking?

There is still a lot that needs to be done to have a positive impact on the lives of survivors of sex trafficking. Many questions need to be answered through research and discussions. The process has begun and though a lot still remains unknown, there is sufficient knowledge to build a case for immediate and sustained attention towards survivors of sex trafficking living amidst us.





The research on reintegration of survivors of sex trafficking covered three main aspects – assimilation, health status and systemic gaps. The present chapter lays out the main findings and follows it up with recommendations from NGOs, CBOs, individuals working with survivors of sex trafficking and government officials from Maharashtra and West Bengal. There were 27 participants from NGOs and 15 participants from government departments (13 from West Bengal<sup>1</sup> and 2 from Maharashtra). The recommendations were collected through a questionnaire designed specifically for this purpose and this chapter presents a synthesis of those responses.

### 1. DEFENCE AGAINST SHAMING AND SHAME

One of the starkest findings of the research is the uniform shaming and stigma by the community onto the family and the survivor and the ambivalence of the family towards the survivor. For example, families have all received survivors back; many of them have struggled and fought to rescue their daughters back. Yet, the shame of having a daughter, who has been in prostitution, is a common struggle amongst all families and they are subject to shaming by the community.

In an agrarian community with strong patriarchal values governing sexuality, the stress of assimilation of survivors works both ways – it is the stress of the survivor, and of the community and the family. There is no law or policy against stigma emanating from such values that may be enforced through governance or law enforcement. The stigma and prejudice is not restricted to communities alone, it extends to systemic duty bearers across sectors, from Panchayats, to law enforcement, to administrative and health sectors and service providers. Interestingly, it

is also a finding that survivors of sex trafficking internalise shame of being in prostitution, which indicates that their internalisation may not have been challenged in the post-rescue shelter home counselling services.

The burden and onus of trafficking seems to be placed on the survivor and the family for wanting to migrate and there is not enough burden on the trafficker, who mostly belongs to the same community. As a survivor states, “*they don’t accept that I was forced into prostitution.*” Within this overall context of shame and prejudice, many survivors have reported having also found support and protection from men and women in their families and communities, be they be mothers, fathers, brothers, husbands, uncles, sisters, etc.

Keeping this context in mind, recommendations were sought for methods and qualities to protect the survivors from shaming.



#### 1.1 Recommendations for short-term immediate methods to protect survivors of sex trafficking from shaming

##### Survivor-centric methods

Psychosocial counselling was the most frequently (almost 90%) mentioned method to build resilience in a survivor to deal with stigma and shaming. The aim of such counselling could be – ‘constructive coping strategies to deal with their immediate and long term life stresses’, ‘realise it is not her fault’, ‘to reduce self-stigma’, ‘capacity building, develop self-confidence, life skills, communication for advocacy of rights’ and ‘remove negative attitude and motivation.’

Support group of survivors was the next most frequently mentioned method to develop a feeling of togetherness. The aim of a support group or ‘survivors collective’ could be – ‘to introduce her to

others who have had a similar fate [sic], to make her realise she is not alone', 'to adopt constructive coping strategies', 'to talk freely', 'a self-help group' and 'develop leadership skills'.

Economic rehabilitation and skills training was also mentioned by some. This would be aimed at – 'getting back confidence and leading a dignified life', 'something to cling on to, something which she would love doing, find a new self', 'jobs in cities away from her community where she can live an anonymous life' and 'economic independence.'

It is interesting to note that almost all community-based caregivers/workers mentioned that the main goal of counselling would be to remove a feeling of guilt that the survivor was responsible for her trafficking. This indicates that perhaps according to community-based workers, this is the main factor hindering a survivor's ability to deal with shaming.

One social welfare officer from West Bengal expressed that he did not agree with the criticism of the government with regards to action for survivors of sex trafficking since the administration was trying to do as much as possible.

### Family and community-centric methods

Counselling the family was a commonly mentioned method. The aims of counselling a survivor's family would be – 'to prepare the family for the protection of the survivor', 'accept that it is not the survivor's fault', 'develop friend-like relations with the survivor' and 'learn effective coping methods to deal with stigma'.

Organise family and community-based support groups, identify stakeholders from community who have empathy and involve them in protection of survivors, motivate some positive people from the survivor's society to spend some

time with the survivor while she is in a shelter home, create a sense of disgust and shame towards trafficking in the community by making them realise that it is not a personal problem but a failure of the community as a whole. All this can be done through community dialogues. The point of identifying role models from the community and spreading awareness and using them to ostracise the trafficker and their group were common responses from government officials of West Bengal.

### 1.2 Qualities that would help a survivor deal with shaming

All the respondents mentioned **self-confidence** as an essential quality to deal with shaming. Clusters of other qualities were:

**Self** Esteem, identity, analysis, awareness, belief, as part of a collective

**Attitude** Positive, positive towards sexuality

**Skills** Leadership, economic, communicate own needs, communicate assertively fight for rights, emerge as role model, think rationally, and learn new things

**Personality** Trust, courageous, challenge norms, accepting, patient, free of guilt

**Knowledge** Of her rights, of gender and sexuality, issue of trafficking, of others who have experienced the same

### 1.3 Contextualising the recommendations

A survivor of sex trafficking is housed in a shelter home after being rescued. This is where she is supposed to undergo psychosocial counselling to help her deal with the trauma of her experiences. Simultaneously, legal procedures are conducted to send her back to her family. Once she returns to her family, it is assumed that she would no longer need



counselling or further rehabilitation measures.

The recommendations given above stress the importance of 'psychosocial counselling' which is a very broad and poorly understood term. As a recommendation, it is repeating what is already in practice at shelter homes. However, that it has been recommended again, points to the fact that maybe the type and duration of counselling received by survivors at a shelter home is not enough. In that case, there is a need to develop skills of counsellors present at shelter homes and to make counsellors available at the community level to ensure continuity of counselling. Moreover, the aim of counselling needs to change between shelter home and community. At the former, it can be more group counselling, while at the community level, it can be individual and family counselling with community level work as well.

While training counsellors to meet the needs of survivors, it is important to include specific techniques aimed at behavioural patterns arising out of sexual and physical abuse, guilt arising out of complex emotional responses and internalisation of shame. The basic aim of training counsellors must be to sensitise them to the fact that survivors also belong to the same community that eventually shames them. This means that survivors also at some level may endorse the norms governing sexuality and thus, might end up blaming themselves. Developing the skill, to be aware of such contextual features and incorporating them while counselling a survivor of sex trafficking, is imminent.

Finally, the recommendations seem to point towards the 'resilience framework' of 'I am, I have and I can.' Personal resources in terms of emotional, cognitive, behavioural and social skills have been recommended, which is aimed

at developing a survivor's self or the 'I am'. Recommendations of developing support groups that can act as social support and resources to fall back on, family counselling and community development seem to be aimed at developing survivor's 'I have' aspects. Support groups at shelter homes and after returning to the community, would be a good way of developing social skills and social support. When they return to their communities, such groups can offer some succour from the alienation and isolation. Recommendations for interpersonal and intrapersonal skills (assertiveness, leadership, vocational) are aimed at developing her 'I can' virtues. It, therefore, appears that utilising the 'resilience framework' might be most valuable for truly rehabilitating survivors of sex trafficking.

## **2. RELEVANCE OF UJJAWALA SCHEME IN ITS PRESENT FORM AND BEYOND**

The Ujjawala scheme does not have any provisions for rehabilitation services post family reunification. The policy assumes that survivors would have recovered from their trauma and health impacts during institutional care and their health conditions would not be dissimilar to the general population, and subsequent health needs would be met through public health and welfare services. It also assumes that their rehabilitation needs will be met by existing policies applicable for the rest of the community.

However, the research indicates the prevalence of high levels of depression and social anxiety amongst survivors, and possible psychosomatic or physical health problems that are distinctive from the general population. The shame and fear of being further stigmatised prevents survivors from disclosing sexual and reproductive health problems or sharing their history of sexual exploitation and violence even with health service providers.



The community's propensity towards traditional healers and their lack of accessing mainstream psychological health services, largely due to ignorance of mental disorders and their faith in traditional healers, has been observed.

### 2.1 Making Ujjawala more relevant

The unanimous recommendation to make Ujjawala more relevant was to modify it and include physical and mental health rehabilitation along with economic rehabilitation even after a survivor is reunited with her family.

Specific recommendations supporting modification were: development of open-shelters and half-way homes, improving accessibility of health services, including survivors in government schemes for adolescent and maternal health programmes, more emphasis on case management of survivors, a comprehensive survivor assistance programme that combines psychosocial and economic support along with wage-earning-oriented skills development, special attention by outreach workers in terms of health needs, as these become more acute after reunification with family and community and more process-oriented rather than stage-wise intervention. One of the respondents also mentioned the need to include legal assistance for punishing the trafficker as part of Ujjawala.

Very few concrete recommendations with respect to making Ujjawala more effective came forth from the government officials of West Bengal. Overall, this category of respondents felt that the survivors need to be assessed to identify their interest and skill levels before planning training for them. None of the government officials from the Health Department had any knowledge of this scheme, while one of the Block Welfare officers wrote that he had not worked with this scheme, so had no

recommendations.

The recommendations point towards the fact that a survivor's need for assistance from the state doesn't end, rather continues after family reunification, which is not present in the current form of Ujjawala.

### 2.2 Awareness generation for mental health

Mostly, all believe that the health department must be responsible for generating awareness about mental health. Many recommended that various departments can coordinate in order to create an awareness and responsiveness towards mental health, for example, Childline, NGOs, Panchayat, department of family welfare and block level administrative offices. The awareness can be generated via outreach workers such as ANM, ASHA, AWW and through television advertisements.

Unfortunately, the recommendations for this issue were not very clear, giving no specific direction as to who would be responsible for generating awareness for mental health.

### 2.3 Status of traditional healers

There was a divided opinion on whether traditional healers must be integrated in some capacity or whether the community must be motivated to seek mainstream health services.

One group of participants recommended that traditional healers could be integrated into the system by proper training and capacity building so that they could perform timely identification and referral of disease. This was recommended because traditional healers were trusted, accessible and comfortable with the community. Mainly, they recommended that traditional healers must be integrated not as 'healers' but as first point of contact that would help in referrals.



One participant mentioned that remuneration must be included in expecting this service from traditional healers.

On the other hand, a group of participants felt strongly against integration of traditional healers on the account of their dubious and counter-productive healing techniques. This ideology is based on the belief that traditional healers would need an overhaul in their way of thinking to help health officials, that they would not be motivated to help health department as that would mean a loss of their own occupation and area of expertise and that survivors of sex trafficking represent an extremely vulnerable group that cannot be exposed to further risk involved in methods used by traditional healers. This group recommended that the community as a whole and survivors specifically must be encouraged to utilise mainstream health options and that outreach workers of health department such as ANM, ASHA and AWW must be responsible for identification and referrals of such cases. It is interesting to note that all the government officials felt strongly against any integration of traditional healers. The common response in this category was to develop awareness in society so that people avail proper treatment from medical staff. However, a medical officer felt some sort of dialogue could be initiated with traditional healers and specific cases also could be discussed in such forums, maintaining the confidentiality of the person.

#### **2.4 Extending the role of the Anwasha counsellor**

Except for government officials from Maharashtra who were not aware of the role of an Anwasha counsellor, all participants, that also included an Anwasha counsellor, felt that Anwasha counsellors must be trained to deal with

mental health issues of survivors. The recommendation was to build their capacity to be sensitive and prepare them to deal with issues that are specific to survivors of sex trafficking.

#### **2.5 Extending the role of ASHA for outreach, identification, referral, awareness generation**

About 19% (8 out of 42 participants) felt that extending the role of ASHA would not be a good idea as they were burdened with their present roles and it might lead to further stigma as they were from the same communities. It did not appear as a feasible option to them.

However, the rest, that is 80% of the participants, felt that this could be tried out with extra remuneration and robust training to ensure confidentiality of a survivor's identity and perform the functions of identification and information delivery of existing programmes. Interestingly, almost all government officials from West Bengal felt that ASHA workers were capable of doing this task and that it would not add to their workload.

#### **2.6 Contextualising the recommendations**

This section presents recommendations to improve the impact of the Ujjawala scheme and improve a survivor's access to health services by building awareness, utilising available services and enhancing outreach. Since it is well-established that survivors need rehabilitation services post family reunification and no such provision is present in the present form of Ujjawala, there is an urgent need to modify the scheme. There is no preparedness to deal with survivors of sex trafficking once they are reunited with their families.

Given the nature of stigma and shaming in the community, coupled with health needs of survivors, the recommendations





point towards something beyond just modifying Ujjawala. Rather, a 'rehabilitation policy' is needed that covers all domains of a survivor's life even after family reunification. Such a policy would aim at actual 'reintegration' and 'assimilation' of the survivor while clarifying the roles of duty bearers and service providers and capacity building of those agencies and offices. Since every survivor has a unique situation, a case management approach, which is used by CBOs, must be made mandatory under such a policy. Ujjawala can be modified to have a section on community reintegration programmes and resources can be allocated for public-private partnership where NGOs would provide services and the State would monitor it.

With respect to health needs, the issue of integrating traditional healers remains unclear, as opinion was divided about their usefulness. What comes across is a complete lack of awareness of what traditional healers actually do, leaving a lot of room for interpretations, either positive or negative. Since these healers are part of the community and culture, it would be worthwhile to study their techniques and procedure before making any decisions about integrating them. Globally, there is a growing awareness of their impact in areas where very little formal mental health service provision exists.

### 3. IDENTIFICATION OF SURVIVOR – A GAP IN SYSTEMIC RESPONSE

One of the main reasons for lack of systemic response towards survivors of sex trafficking seems to be lack of information/identification. Survivors, returning from destination states to North 24 Parganas, seem to come through NGOs and the state and district administration and other stakeholders are bypassed. As a result, service providers and duty bearers neither have information about returning survivors,

nor is there any systemic responsibility towards them. This has uniformly been reported by Panchayats, health department, law enforcement agencies and administrative bodies.

#### 3.1 Coordination between sending states and receiving states

The recommendations for issue of sharing information between the sending state and received state were:

- a. District Social Welfare Office must be informed.
- b. For minor girls, the CWC and DCPO must be informed and they must share information with the DSWO.
- c. Some mentioned the WCD must be informed but information must be shared with the DSWO.
- d. Majority feel that the nodal office must be the DSWO; one participant felt a separate duty bearer must be created.
- e. There was no pattern in the response from government officials. The responses ranged from Panchayat Pradhan to the police department to the CMOH and the court inspector. What was interesting is that none of the Government of West Bengal officials felt that DSWO or CWC had any pivotal role to play.



Overall, the recommendation suggests that departments responsible for welfare, women and children must be informed and that the DSWO must take the lead in acting as a nodal office for information related to survivors being sent from outer states.

#### 3.2 Role of NGOs in return of survivors

The recommendations to deal with delays arising out of bureaucratic hassles that might prevent early return of the victims causing longer gestation periods in shelters and the issue of making

NGOs who manage the return of victims more accountable, so that information is shared with district level offices were:

- a. The return must be coordinated through a public-private partnership, where NGOs are involved in the return process but must inform district level offices.
- b. NGOs need to be monitored and in case there is non-compliance on information-sharing, such NGOs must be held responsible.
- c. An official list of NGOs must be prepared and shared by all district level offices of destination as well as receiving states.
- d. NGOs would have to be registered with the DSWO and would have to follow standard guidelines.
- e. There should be a shared format for recording information, use of e-governance for easy file transfer.

The general recommendation seems to be that of a public-private partnership with monitoring the compliance of NGOs in sharing information with district level offices and strict reprehension of non-compliance.

### 3.3 Supportive recommendations

Other recommendations to bridge the systemic gap of lack of information sharing were:

- a. Dissemination of the present research findings to attract attention of policy makers and political parties.
- b. Social audits of existing schemes, using RTI effectively, PIL in case of non-performance.
- c. Survivor-led advocacy groups.
- d. Software, system, MIS to track or record information that can be used

by various stakeholders.

- e. Coordination and convergence between various departments, appointing a liaison officer to administer the coordination.
- f. Making AHTUs functional through public reporting system.
- g. Panchayat, AWW and ASHA must be included in reporting cases identified.



### 3.4 Contextualising the recommendations

The National Plan of Action instated in 1998 was found to be non-functional in West Bengal, with no role clarification and poorly coordinated anti-trafficking units. According to the recommendations therefore, nodal offices need to be reinstated. Such nodal offices need to coordinate between sending states and receiving states. A rehabilitation policy mentioned earlier would clarify such responsibilities of nodal offices. It is possible for governments of Maharashtra and West Bengal to initial MOUs defining roles and responsibilities of stakeholders. One such MOU is in the process of being formulated.

The idea is to avoid bottleneck situations that arise out of only one department being completely responsible for the entire process. The coordination must be between corresponding departments of sending and destination states. For example, CWC of Maharashtra must coordinate with West Bengal CWC of a particular district. The information being shared between these respective CWCs must be shared with the state level departments of Social Welfare, thus moving towards a more synergistic way of functioning. Apart from coordination, there is need for training and monitoring as well.

As far as the NGO's role is concerned, they are playing a pivotal role in the

rescue, rehabilitation and restoration of survivors. However, there is a lack of accountability and information sharing between NGOs and government departments, leading to gaps that affect a survivor's chances of availing existing welfare schemes. Fostering a mutually dependent public-private partnership, officiated by including it in a rehabilitation policy seems to be a necessary measure. Individual case management approach needs to be part of the policy directive, which would also make resource allocation by considering the survivor as a unit of analysis rather than a particular service, for example, shelter homes.

#### 4. CREATING CONVERGENCES OF STAKEHOLDERS

The systemic analysis shows that there is lack of convergence and coordination between the departments in the district. For example: the Block Development Office (BDO) reports that while it has the responsibility and authority to implement existing and running welfare schemes, the Block Welfare Officers (BWO) are responsible for welfare of survivors of sex trafficking. The District Social Welfare Office (DSWO) relegates the responsibility and knowledge of survivors of trafficking to Childline, but Childline has no involvement in the return and rehabilitation of survivors of sex trafficking, most of whom may have been trafficked as children but rescued as adults.

The Superintendent of Police (SP) reports that he has information about survivors only in shelter homes but does not get information about them returning home or post-family reunification challenges. He also adds that the anti-trafficking units in the district level is dysfunctional due to transfers and vacancies of posts, which suggests a lapse in coordination. The National Plan of Action to Combat Trafficking in Women and Children, 1998 which is the last policy document on the

issue, directed formation and functioning of the ATUs in each district.

#### 4.1 Strengthening coordination between departments and improving functioning of ATUs

The recommendations for achieving the above were:

- a. The role of facilitation of the convergence bodies, ATUs at the district and block levels to be entrusted to the District Social Welfare Office which is supported in the process by NGOs.

All 42 participants agreed to this recommendation. An additional recommendation was made to make the DSWO accountable for which it must be incorporated in their reporting system. This reporting system for DSWO must be developed in consultation with various district, block and Panchayat level officials and NGOs and integrated in the official protocol. This would mean that non-reporting would have consequences on the officer's career and remuneration.

- b. The role-taking to be improved by preceding training of various stakeholders, informing them about their systemic role as per the NPA.



Again, all 42 participants agreed to this recommendation. Additionally, it was felt that the training be consistent with NPA guidelines, that various stakeholders be brought under one umbrella in order to create real convergence and a feeling of working as a whole. The trainings should also be combined with direct interactions between stakeholders and survivors to facilitate attitudinal change and real awareness of survivor issues.

#### 4.2 Role of NGOs in creating convergence

In the matter of NGOs performing a facilitative role in the above process

of convergence between various departments, the recommendations were as follows:

- a. About 30% participants felt NGOs must not be involved in the process. Some of these participants felt that the facilitation should be done by the ADM supervising the DSWO. Reasons for wanting the state to be responsible for convergence and functioning of the ATUs were constitutional-directed and therefore, offered a more sustainable option.
- b. 6 out of 13 government officials from West Bengal felt that NGOs must facilitate the Government. Reasons supporting such collaboration were the speed at which the NGOs got work done and a belief that if proper infrastructure was provided, NGOs could be asked to assist at different levels.

#### 4.3 Additional recommendations

On the matter of an anti-trafficking unit and its functioning, some additional recommendations were:

- a. More effort should be given on prevention. Therefore, coordination with labour and law enforcement departments to ensure regulation of labour agents and registration of individuals migrating out of their villages for work is required.
- b. Awareness programme should be organised about the need for migrating with registered labour agents, entitlements, social security schemes, labour rights and self-defence mechanisms. Information should also be provided on anti-trafficking units.
- c. Training should be given in PRI systems to local law enforcement bodies on the implementation of labour laws and monitoring the trafficking situation.

- d. A close coordination between source and destination district/state labour department.

#### 4.4 Contextualising the recommendations

At present, very little convergence exists between departments expected to play a role as per the NPA, 1998. This condition could be a result of non-implementation of the Act itself and a better option would be to have a rehabilitation policy which will clarify roles, have provision for training and also clarify NGO roles, responsibility and accountability.

#### 5. EMPATHY AND INTERFACE

Duty bearers report that they do not know enough about what will help survivors. This lack of understanding and empathy is a result of lack of direct interface and dialogue between survivors of sex trafficking and these duty bearers. This lack of interface or dialogue also results in prejudice, assumptions and inappropriate policies and services.

For example:

- Many duty bearers, particularly who are more distanced from survivors, feel that victims of trafficking do get trafficked on their own accord and their parents participate in trafficking. There is a lack of distinction between the intent of the victim (*migration*) and the consequence (*trafficking*). The onus and burden of trafficking, in their minds, lies on survivors and their families, and not on traffickers, who also belong to the district.
- Training programmes for survivors very often do not result in employment or poverty alleviation.

#### 5.1 Creating empathy among duty bearers

- a. Direct interfaces and dialogue to be



created between survivors of sex trafficking and duty bearers.

However, such interface can occur only after sensitisation of duty bearers to prepare them to 'listen' and not judge and be empathetic. Also, such interfaces must be in a survivor's voice instead of NGOs coaching or putting words into their mouths, which will require adequate preparedness amongst survivors as well.

- b. NGOs to create sensitisation programmes with duty bearers.
- c. One Social Welfare Officer felt that officials who were responsible for interacting with survivors were sensitive enough and that direct communication between such officers and survivors would benefit both.
- d. One Panchayat Samiti member felt that it was important to be aware of the official's level of sensitivity or such direct interface could lead to ridicule.
- e. One sub-inspector clarified that his help would be extended only to survivors who were trafficked and placed into prostitution and not for the girls who were sent by their families to earn money or who left home to marry.

### 5.2 Contextualising the recommendations

Responses showed that there was a lack of communication though it was deemed to be a very useful development. Interestingly, findings of police apathy were corroborated by the response of the SI who reiterated a general lack of empathy towards a negative outcome of migration for work or marriage. This strengthens the need for sensitisation and awareness among the administrative ranks even more.

## 6. TRAINING AND DIRECTIVES

Lack of directives and training is what

is reported by all service providers uniformly. While grassroot workers (ASHA, AWW) know about survivors, and are also open to playing a role in service delivery, they feel bound by lack of a policy directive and are largely non-agentic. Panchayats do not use their existing funds or resources towards assistance of such survivors in rehabilitation, and do not know about the Ujjawala scheme. The Anwasha counsellors have reported lack of any understanding or experience of having worked with survivors of sex trafficking.

### 6.1 Training for information dissemination on NPA, existing provisions including Ujjawala, to these stakeholders

- a. The most common (65%) recommendation for 'who' should conduct such training is the state and its various duty bearers such as DM, Social Welfare Department, district level administration, administrative training unit, WCD, BDO, Panchayat, etc.
- b. Others felt the training could be done by both state and NGO as a partnership.



### 6.2 Contextualising the recommendations

As many Panchayat members expressed, there is almost a dearth of training for government officials to introduce rehabilitation of survivors of sex trafficking as part of their roles and responsibility. Recommendations clearly point towards such training and sensitisation to build empathy as part of any policy development in future. However, given the piecemeal nature of training, success of such training would depend on how grounded and culturally feasible its tenets are. Thus, training programmes need to be built on research and collation of what works and what fails to produce desired change.

### THE WAY FORWARD...

The ways forward are two key steps to bring about a sustainable systemic change in ensuring rehabilitation of survivors of human trafficking:

1. A scheme on rehabilitation of survivors of sex trafficking and building capacities for policy implementation
2. Management and monitoring of policy implementation, outputs and outcomes of inputs



#### 1. THE REHABILITATION POLICY FOR SURVIVORS OF HUMAN TRAFFICKING

The rehabilitation policy should include:

- a. Definitions and clarification of nomenclature: A definition of what rehabilitation of survivors of human trafficking means and encompasses its various dimensions, and how it may be assessed or measured with survivors of human trafficking.
- b. Entitlements of survivors of human trafficking: the policy should define what services survivors should be entitled to in the course of rehabilitation, and minimum standards therein.
- c. Role clarification of various duty bearers and service providers, and their obligations in meeting entitlements of survivors.

This policy should be developed with participation from policy implementors and service providers from across verticals (health, local governance or PRIs), and in consultation with link departments of those verticals, to ensure that the policy takes into account risks and checks assumptions of strategy and

implementation.

#### 2. DEVELOPING A SCHEME AND BUILDING CAPACITIES FOR POLICY IMPLEMENTATION

While this scheme may become a key instrument to ensure direct rehabilitation of survivors of sex trafficking, and ensure specific allocation of resources, the central focus of the scheme should be to remove barriers of access to services by survivors of sex trafficking rather than create separate services for survivors. The overall systemic response seems to indicate that there are three primary barriers that prevent survivors access to services – stigma, lack of information and awareness amongst the target group and lack of information, awareness and skills amongst service providers. Therefore, the following are the recommended steps for policy implementation:

- a. Development of a scheme for implementation of the policy on rehabilitation of survivors of sex trafficking.
- b. Training and skills-building for service providers, focusing on



knowledge-building of duty bearers (on impact of trafficking on survivors, on trauma management and recovery programming, on psychosocial programming). For example: the trainings with Anwasha counsellors may focus on skill-building, whereas the training with PRI members or district administration may require to focus on information, attitudes and knowledge, than on skills.

- c. There is a need to develop, or collate what is existing, training resources for this human resource development (HRD).

### **3. DEVELOP MANAGEMENT SYSTEMS AND PROCESSES FOR PLANNING, IMPLEMENTATION AND MONITORING OF THE POLICY**

Given that this policy may be developed by each state individually, there is a need to consider that the case management process needs to take into account that much of the human trafficking in West Bengal (and many other states in India) is interstate. Therefore, tools for case management and monitoring implementation of policies should be useful. For example:

- a. Given that most duty bearers and service providers in the public services system have spoken about lack of information on returning survivors of trafficking, it is necessary to consider how information may reach duty bearers without posing risks and threats to survivors (or breaching confidentiality). Tools for data management and flow of information between sending states and social welfare offices of the concerned district should be useful in helping streamlining this data flow.
- b. The district and block level anti-(human) trafficking units need

to be revived and made functional, and made responsible for monitoring of policy and scheme implementation, and conducting social audits to check outcome and impact of the policy implementation. This monitoring data and feedback should flow back to district and state head offices, for reporting and policy monitoring.

- c. Building on the monitoring tools on case management for Ujjawala shelter homes: While the MWCD has initiated a process for all service providers who run Ujjawala homes to report on their case management plans and progress to district social welfare authorities, and for the district social welfare authorities tools for reporting and monitoring of standards of care and outcome of services, this should be extended to community-based interventions (reintegration – post-family reunification).





### FGD GUIDELINES FOR SURVIVORS, FAMILY & CAREGIVERS

| Type of Respondent              | Themes explored   | No. of groups and number of sessions                                    |
|---------------------------------|---|---|
| Survivors                       | The context of physical discomfort  | 3 groups with 10 members in each // 3 sessions // Total 30 participants |
|                                 | Disease-specific treatment access trend   |   |
|                                 | Non-availability of services  |   |
|                                 | Denial to extend services due to stigma   |   |
|                                 | Self-stigma of survivors  |   |
| Survivors                       | Misconception of survivors  | 3 groups with 10 members in each // 3 sessions // Total 30 participants |
|                                 | Incident of violence and threats within family and community before she is being trafficked   |   |
|                                 | Mapping of vulnerable factors within family that may act as push factors for vulnerable and unsafe migration or trafficking   |   |
|                                 | Perception and attitude of the girls on different vulnerable context within the family, like poor diet options, domestic violence, addictive or irresponsible parents, lack of safety |   |
| Survivors                       | Incident of violence, threats of violence or assaults within family, community, service set up  | 3 groups with 10 members in each // 3 sessions // Total 30 participants |
|                                 | Involvement of the girls in domestic chores and income generating activities (home-based)   |   |
| Survivors                       | Events of exclusion from family or community and its impact on girls' behaviour   | 4 groups with 10 members in each // 4 sessions // Total 40 participants |
|                                 | Involvement of the girls in community-based events  |   |
| Home-based caregivers / parents | Knowledge, perception and attitude of service providers on care and needs of survivors  | 2 groups with 10 members in each // 2 sessions // Total 20 participants |
|                                 | Misconception of survivors on health issues   |   |
|                                 | Involvement of the girls in community-based events  |   |
|                                 | Events of exclusion   |   |

### INTERVIEW GUIDELINES FOR PANCHAYAT MEMBERS

1. Have you ever heard the words 'human trafficking'? Yes/No. If yes, then where did you hear about it?
2. What is your viewpoint about the

occurrence of human trafficking?

3. Have you ever heard about incidents of trafficking in your area?
4. What do you think are the vulnerable factors that lead to trafficking in your area?



5. What role do you think the Panchayat can undertake to resist or prevent incidents of trafficking?
6. In case a girl is trafficked, and her family members seek help from the Panchayat, what according to you should be the steps taken up by the Panchayat?
7. When a girl wants to return home after being rescued from prostitution, what according to you are the problems that she might face?
8. What kind of support should a trafficked victim receive? How can the Panchayat help in this aspect?
9. What are the government schemes available for victims of trafficking?
10. How do you think the the victims of trafficking can avail the different government schemes?
11. How do you think the different offices at the government level can benefit the victims of trafficking?
12. Are there any victims of trafficking in your area? If yes, how many are there and how has the Panchayat supported?
13. In your area, which are the organisations working on issues of rescue and rehabilitation of trafficked survivors?
14. Did you receive any training by the Government on issues of human trafficking?
15. Did you receive any directives from the Government on issues of human trafficking? If yes, from which office? Can you please mention it?
2. Have you ever heard about incidents of trafficking in your area?
3. What do you think are the vulnerable factors that lead to trafficking in your area?
4. In your area, which are the organisations working on issues of rescue and rehabilitation of trafficked survivors?
5. In the present scenario, the rescued girls are supported by which departments? What kind of help are they receiving?
6. What types of schemes are being introduced by Government to help these girls? What types of schemes do you think would help these girls?
7. What kind of support should a trafficked victim receive? What are the Government schemes available for victims of trafficking?
8. Do you have the contact details of the various departments and organisations that provide service to the rescued girls?
9. Which schemes are applicable for the rescued victims considering their educational level and skills ?
10. For financial rehabilitation of the rescued victims, what kind of work or job opportunity is available in your area ?
11. Do you have a block level or village level ATU (Anti-Trafficking unit)? If yes, how do they function?
12. Where do you refer the rescued survivors or their families?
13. How does the Ujjawala scheme function in your area? What do you think should be done for better utilisation of the scheme?

### **INTERVIEW GUIDELINES FOR BDO AND OTHER ADMINISTRATIVE OFFICIALS**

#### **Block Development Officer (BDO)**

1. What are your views regarding human trafficking?
4. In your area, how much do you think the schemes like SGSY, KSY, Swavalamban and Sahaday have worked?





### **Anwasha counsellors**

1. Have you ever heard the words 'human trafficking'? Yes/No. If yes, then where did you hear about it?
2. If any victim of sex trafficking comes to you, what kind of issues would you like to learn from her?
3. Have you ever handled any such cases? If yes, please share the experiences.
4. What kind of physical health problems do you think a victim of trafficking may have?
5. What kind of mental health problems do you think a victim of trafficking may have?
6. While providing service to victims of sex trafficking, which areas will you focus on?
7. Where do you think such cases can be referred to?

### **Auxiliary Nurse Midwife (ANM)**

1. Have you ever heard the words 'human trafficking'? Yes/No. If yes, then where did you hear about it?
2. Have you ever heard about incidents of trafficking in your area? If yes, please share the incidents.
3. What are your views regarding human trafficking?
4. If any victims of sex trafficking have come to you, what kind of health problems have you noticed among them? Please share your experiences.
5. When a girl returns home after being rescued, what according to you are the problems that she may face? What kind of support should a trafficked victim receive?
6. What do you think are the barriers for receiving health services for trafficked

victims?

7. Where would you refer cases of rescued victims in your area?

### **Aganwadi workers (AWW)**

1. Have you ever heard the words 'human trafficking'? Yes/No. If yes, then where did you hear about it?
2. What are your views regarding human trafficking?
3. Have you ever heard about incidents of trafficking in your area? If yes, please share her physical, mental and social health issues that you have experienced while handling her case.
4. How many girls who have been rescued from trafficking are presently in your working area? Do you have any database of the same?
5. What role does the women and child department play to stop trafficking and help the rescued victim? Do you have any idea about it?

6. In your working area, what are the schemes available for the adolescent girls? How do you think the rescued and returned survivors can be integrated in these schemes?

7. If any of the rescued victims or their family comes to your centre for receiving services, where would you refer them?

8. Do you have any database of rescued survivors? If yes, how do you get it?

### **INTERVIEW GUIDELINES FOR DISTRICT SOCIAL WELFARE OFFICER (DSWO)**

1. To what extent is the North 24 Parganas district prone to the problem of women trafficking? Answer in yes or no. Mention the reasons for both answers.

2. In the previous two years, how many trafficking cases have been recorded?

3. In the last three years, exactly how many girls have been successfully reintegrated in the society? Is there any such record?
4. How does the AHTU exactly work in this district?
5.
  - a. Exactly, in what ways are the girls, who are rescued from being trafficked, being reintegrated back into the society?
  - b. In order to reintegrate the trafficked girls into society, what kind of economic programmes has the social welfare department taken up? What are the applications of those programmes in these districts?
6. Besides the social welfare department, which other departments are working for the welfare of these girls?
7. According to you, which governmental bodies should work along with social welfare department for the betterment of these girls? Are there any plans for this work?
8. What kind of plans is the Panchayat Infrastructure taking up for the welfare of these rescued girls?

9. Does the district of North 24 Parganas have the complete infrastructure required for carrying out the processes of rescue-rehabilitation and reintegration? If it has a lacking point, what is it?

10. After the reintegration, at what time period are they followed up?

#### **INTERVIEW GUIDELINES FOR SUPERINTENDENT OF POLICE (SP)**

1. To what degree is the district of North 24 Parganas prone to women trafficking? Answer in yes or no? For both cases, what are the reasons?
2. How many trafficking cases have been

filed in the last two years? Generally, in which sections of the law are these cases registered?

3. How many girls have been re-integrated in the past two years? Are there any records?

4. In what ways does the AHTU operate in this district?

5. During the process of reintegration, exactly which departments are informed by AHTU?

6. In what ways and time span, are the reintegrated girls followed up? During follow-up, what problems are kept in mind? Does any kind of monitoring team exist for these follow-ups?

7. In order to bring back the trafficked girls into main society, what kind of programmes have been taken up presently?

8. Will it be better if certain modifications are carried out regarding the provisions for service of these girls? What are your comments regarding this?

#### **INTERVIEW GUIDELINES FOR POLICE OFFICERS**

1.
  - a) Name of the police station:
  - b) Name of the respondent:
  - c) Designation of the respondent:
2. If any 'Missing case' is registered in your police station, what kind of steps do you usually take?
3. In the past three years, number of 'Missing cases' registered in the police station?
4. In the past three years, number of 'trafficking-related cases' registered in the police station and your interventions?
5. In your experiences, what were the purposes of trafficking?



6. What is your role during rescue?

7. During post-rescue, who generally interacts with the girls (probe whether there is any option for a lady police officer and counsellor) and what is generally enquired?

8. Do you have any role during restoration?

9. If yes, which officials remain present during restoration?

10. Do you find your role important in a survivor's life after restoration? If yes, in what way?

11. After restoration, if the survivor feels threatened from the trafficker which hinders her regular life, what would be your role?

12. Who do you think is responsible in the cases related to trafficking?

13. Have you ever taken any step(s) to prevent trafficking? Yes/No.

14. If yes, what are the steps? Mention the problems faced (if any) during implementation.

15. State the problems faced (if any) during handling a case of trafficking.

#### **INTERVIEW GUIDELINES FOR BLOCK MEDICAL HEALTH OFFICER/ MEDICAL OFFICER (BMOH/MO)**

1. What are your views regarding human trafficking? To what extent do you feel that this district is prone to human trafficking?

2. Do you think that a girl who has been saved from being trafficked would face problems? What health-related problems could she face? Do you think the infrastructure required to deal with these

problems is present in your district?

3. Do you think that the infrastructure required to deal with the psychological problems of these girls are present in your district? What kind of initiatives can be taken?

4. In the present scenario, what kind of development in the infrastructure or health departments would help them to get better treatment?

#### **INTERVIEW GUIDELINES FOR DM/ADM**

1. To what extent do you think your district is prone to women trafficking?

2. Is there any record of the trafficking that might have taken place in your district in the last three years?

3. In order to solve these kinds of problems, what type of obstacles do you have to face on administrative level? Who do you think, is responsible for this?

4. Rescuing a trafficked girl and bringing her back in to the social mainstream, do you have enough infrastructure, monetary funding and human resources to execute this procedure? What do you feel should be done if the resources are lacking?

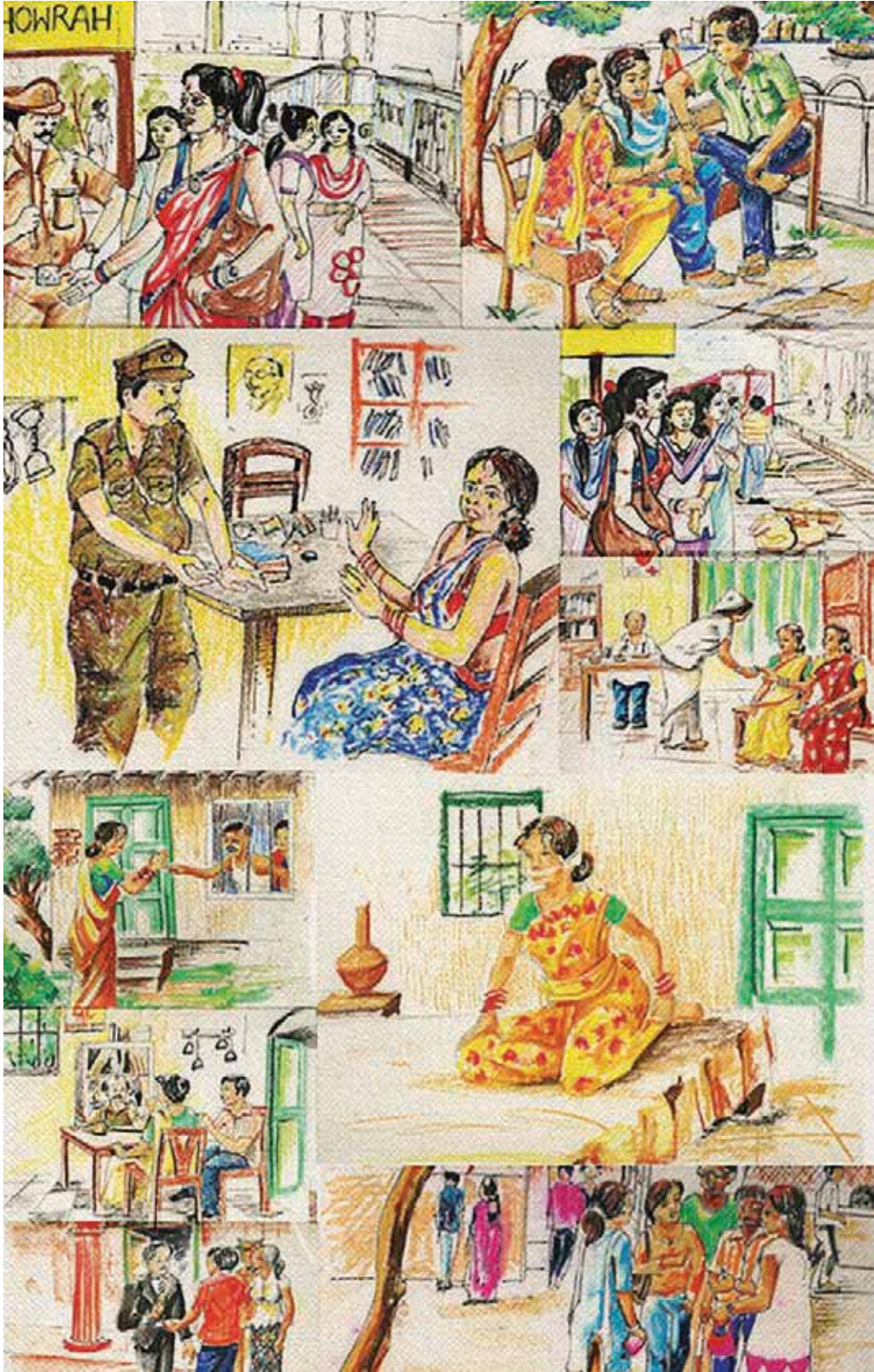
5. In the present scenario, the rescued girls are supported by which departments? What kind of help are they receiving?

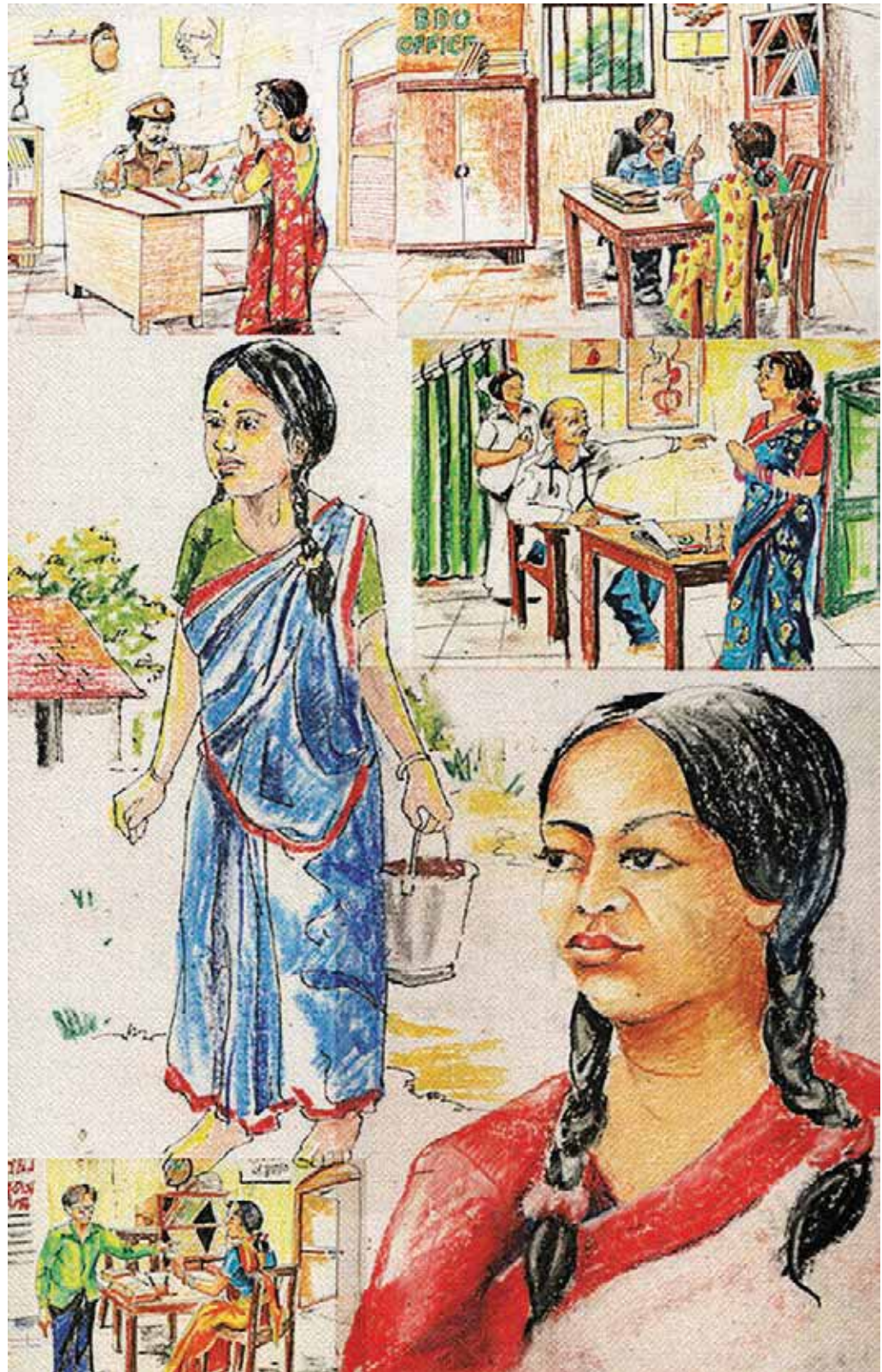
6. What are the type of schemes being introduced by the Government to help these girls? What types of schemes do you think would help these girls?

7. What are the kinds of extra measures do you think would help them to become independent?

8. How do you think the menace of trafficking should be dealt with?







## QUESTIONNAIRE FOR RECOMMENDATIONS



1. One of the starkest findings of the research is the uniform shaming and stigma by the community onto the family and the survivor and the ambivalence of the family towards the survivor. For example, families have all received survivors back; many of them have struggled and fought to rescue their daughters back. Yet, the shame of having a daughter who has been in prostitution is a common struggle amongst all families and they are subject to shaming by the community.

In an agrarian community, with strong patriarchal values governing sexuality, the stress of assimilation of survivors works both ways – it is the stress of the survivor and of the community and the family. There is no law or policy against stigma that may be enforced through governance or law enforcement. The stigma and prejudice is not restricted to communities alone; it extends to systemic duty bearers across sectors, from Panchayats, to law enforcement, to administrative and health sectors and service providers.

Interestingly, it has also been found that survivors of sex trafficking internalise shame of being in prostitution, which indicates that their internalisation may not have been challenged in the post-rescue shelter home counselling services. The burden and onus of trafficking seems to be placed on the survivor and the family for wanting to migrate and there is not enough burden on the trafficker, who mostly belong to the same community. As a survivor states, ‘they don’t accept that I was forced into prostitution.’

Within this overall context of shame and prejudice, many survivors have reported having also found support and protection from men and women in their families

and communities, be they be mothers, fathers, brothers, husbands, uncles, sisters, etc.

- a. While change of attitudes and values is a long-term agenda and a very slow process, what could be some of the short-term, immediate methods to protect survivors of sex trafficking from shaming?
- b. What qualities do you think would help a survivor deal with this shaming?

2. The Ujjawala scheme does not have any provisions for rehabilitation services post family reunification. The policy assumes that survivors would have recovered from their trauma and health impacts during institutional care and their health conditions would not be dissimilar to the general population, and subsequent health needs would be met through public health and welfare services. However, the research indicates the prevalence of high levels of depression and social anxiety amongst survivors, and possible psychosomatic or physical health problems that are distinctive from the general population. The shame and fear of being further stigmatised prevents survivors from disclosing sexual and reproductive health problems or sharing their history of sexual exploitation and violence even with health service providers. Community’s propensity towards traditional healers and their lack of accessing mainstream psychological health services, largely due to ignorance of mental disorders and their faith in traditional healers, has been observed.



- a. Would you suggest modification of Ujjawala scheme or do you feel reintegration service can be part of the current Ujjawala scheme even without modification or amendment of the scheme? Please justify your answer.
- b. Who or which department must



be responsible for generation of awareness about mental health in the community?

- c. Do you think, traditional healers should be included in some capacity, to both sensitise them about trafficked victims so that they can make referrals or should the community be influenced and encouraged to access mainstream mental health services? If yes or no, why?
- d. Do you agree that Anwasha counsellors should be trained in appropriate counselling techniques specifically for survivors of sex trafficking? Yes/No.
- e. Do you agree that ASHA workers should be trained in outreach, identification of survivors and information delivery of existing services? Or do you feel this will be counter-productive leading to more stigma? Do you think this would be stretching their capacity? Yes/No.

3. One of the main reasons for lack of systemic response towards survivors of sex trafficking seems to be lack of information/ identification. Survivors, returning from destination states to North 24 Parganas, seem to come through NGOs and the state, the district administration and other stakeholders are bypassed. As a result, service providers and duty bearers neither have information about returning survivors, nor is there any systemic responsibility towards them. This has uniformly been reported by Panchayats, health department, law enforcement agencies and administrative bodies.

What would you recommend to address this problem?

- a. Sending states must mandatorily inform the receiving state duty bearers, particularly the District Social Welfare Office, about survivors returning to their homes.

If yes to the above, who should be the nodal office?

- b. If you feel that 'a' will result in bureaucratic delay and prevent early return of victims causing longer gestation periods in shelters, and that the transfer should happen through NGOs, what accountability measure should be set in place to ensure that NGOs will report the information to district level duty bearers and service providers?
- c. What other recommendations do you propose to address this systemic gap?

4. The systemic analysis shows that there is lack of convergence and coordination between the departments in the district. For example: the Block Development Office (BDO) reports that while it has the responsibility and authority to implement existing and running welfare schemes, the Block Welfare Officers (BWOs) are responsible for welfare of survivors of sex trafficking. The District Social Welfare Office (DSWO) relegates the responsibility and knowledge of survivors of trafficking to Childline but Childline has no involvement in return and rehabilitation of survivors of sex trafficking, most of whom may have been trafficked as children but rescued as adults. The Superintendent of Police (SP) reports that he has information about survivors only in shelter homes but does not get information about them returning home, or post-family reunification challenges. He also adds that the anti-trafficking units in the district level is dysfunctional due to transfers and vacancies of posts, which suggests a lapse in coordination. The National Plan of Action to Combat Trafficking in Women and Children, 1998 which is the last policy document on the issue, directed formation and functioning of the ATUs in each district.

What would you suggest to strengthen



and enforce coordination between departments and offices at district, block and village level and improved functioning of ATUs?

a. The role of facilitation of the convergence bodies: ATUs, at district and block levels, to be entrusted to the District Social Welfare Office which is supported in the process by NGOs. Yes/No.

b. The role-taking to be improved by prior training of various stakeholders, informing them about their systemic role, as per the NPA. Yes/No.

c. Instead of 'a', the role of facilitation to be entrusted to a third party (an NGO or other). NGO/Any other

.....

d. Any other recommendation you may have?

5. Duty bearers report that they do not know enough about what will help the survivors. This lack of understanding and empathy is a result of lack of direct interface and dialogue between survivors of sex trafficking and these duty bearers. This lack of interface or dialogue also results in prejudice, assumptions and inappropriate policies and services. For example:

a. Many duty bearers, particularly who are more distanced from survivors, feel that victims of trafficking get trafficked on their own accord and their parents participate in trafficking. There is lack of distinction between the intent of the victim (migration) and the consequence (trafficking). The onus and burden of trafficking, in their minds, lies on survivors and their families, and not on traffickers, who also belong to the district.

b. Training programmes for survivors that do not result in employment or poverty alleviation.

What would you recommend should be done to create empathy among duty bearers for survivors of sex trafficking?

(1) Direct interface and dialogue to be created between survivors of sex trafficking and duty bearers. Yes/No.

(2) NGOs to create sensitisation programmes with duty bearers. Yes/No.

(3) Any other?

6. Lack of directives and training is what is reported by all service providers uniformly. While grassroots health workers (ASHA, AWW) know about survivors, and are also open to playing a role in service delivery, they feel bound by lack of a policy directive and are largely non-agentic. Panchayats do not use their existing funds or resources towards assistance of such survivors in rehabilitation, and do not know about the Ujjawala scheme. The Anwasha counsellors have reported lack of any understanding or experience of having worked with survivors of sex trafficking. The question, therefore, is:

a. Who should take the responsibility for organising training (information dissemination on NPA, existing provisions including Ujjawala) to these stakeholders?

b. If it is the responsibility of the State, which department do you think should take the responsibility?

*Thank you for your comments and suggestions, they are highly appreciated and valued.*



## Acronyms

|              |  |               |  |
|--------------|--|---------------|--|
| <b>AHTU</b>  | Anti-Human Trafficking Units   | <b>SAARC</b>  | South Asian Association for Regional Cooperation       |
| <b>ANM</b>   | Auxiliary Nurse Midwives   | <b>SITA</b>   | Suppression of Immoral Traffic in Women and Girls Act  |
| <b>ASHA</b>  | Accredited Social Health Activists   | <b>SP</b>     | Superintendent of Police                               |
| <b>ATU</b>   | Anti Traffic Unit  | <b>STD</b>    | Sexually Transmitted Disease                           |
| <b>AWW</b>   | Anganwadi Workers  | <b>UMC</b>    | Unified Monitoring Committee                           |
| <b>BLSA</b>  | Bonded Labour (System) Abolition Act                                       | <b>UNICEF</b> | United Nations International Children's Emergency Fund |
| <b>BMOH</b>  | Block Medical Officer of Health  | <b>UNODC</b>  | United Nations Office on Drugs and Crime               |
| <b>BPHC</b>  | Block Public Health Centre   | <b>UTI</b>    | Urinary Tract Infection                                |
| <b>CAC</b>   | Central Advisory Committee   | <b>VDRL</b>   | Venereal Disease Research Laboratory test              |
| <b>CBI</b>   | Central Bureau of Investigation  |               |  |
| <b>CBO</b>   | Community-Based Organisation   |               |  |
| <b>CEDAW</b> | Convention on the Elimination of All Forms of Discrimination Against Women |               |  |
| <b>CRC</b>   | Convention on the Rights of the Child                                      |               |  |
| <b>DCP</b>   | Deputy Commissioner of Police  |               |  |
| <b>DMHP</b>  | District Mental Health Programme   |               |  |
| <b>FGD</b>   | Focus Group Discussion   |               |  |
| <b>FIR</b>   | First Information Report   |               |  |
| <b>HIV</b>   | Human Immuno-deficiency Virus  |               |  |
| <b>ITPA</b>  | Immoral Traffic (Prevention) Act   |               |  |
| <b>MHA</b>   | Ministry of Home Affairs   |               |  |
| <b>MO</b>    | Medical Officer  |               |  |
| <b>MWCD</b>  | Ministry of Women and Child Development                                    |               |  |
| <b>NGO</b>   | Non-Government Organisation  |               |  |
| <b>NPA</b>   | National Plan of Action  |               |  |
| <b>PHC</b>   | Public Health Centre   |               |  |
| <b>RMP</b>   | Rural Medical Practitioners  |               |  |
| <b>RTI</b>   | Reproductive Tract Infection   |               |  |



## Epilogue

The journey is very painful.  
It is not possible to stay with all this pain,  
But I have many responsibilities now.



Nobody knows about my past here,  
I used to worry what others may think of me,  
I spent a year this way,  
What do I say to people?  
It is, perhaps, better not to talk about it.



A girl must not be broken by negative comments  
of others...  
She needs to find out what makes her happy  
and comfortable.

There are many, with worse misfortunes than mine,  
who have moved ahead,  
Then why should I end my journey here?



These are extracts from statements we have heard  
from survivors of sex trafficking who participated in  
this research. The voices are of lament, sorrow, fear  
and confusion, and also of resolution, determination,  
hope and a commitment to negotiate with life.

We thank all the girls and young women who made  
this research possible. We hope that their call for change  
will be heard and respected by all of us who may want to  
join them in their struggle for change.



Anesvad is an independent, development NGO operating in 19 different countries across Asia, Africa and Latin America. Their goal is to contribute to promoting health as a fundamental human right.

Anesvad believes that Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. This can be achieved by acting on political, social, economic and cultural aspects and by promoting partnerships with actors from the South as the protagonists of their own development.



Sanjog, a technical resource organisation, develops resource programmes for NGOs to build gender equality and social justice. It is committed to strengthening civil society initiatives that work on childhood and adolescence, to build their capabilities in psychosocial programming. It promotes convergence of resources and building multi-stakeholder alliances for greater impact.

The organisation has emerged as a response to sectoral needs and gaps in psychosocial programming to address abuse, violence and exploitation of children.

