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The Role of Healthcare Professionals in Detecting and Referring Victims of Human Trafficking

AN EXPLORATORY STUDY

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Abbreviations

ANES National Agency for Equal Opportunities for Women and Men

ANITP National Agency Against Trafficking in Persons

ASSMB Bucharest Hospitals and Medical Services Administration

BCCO Organized Crime Brigade

CNAS National Health Insurance Agency

DAS Social Assistance Directorate

DGASPC General Directorate for Assistance and Child Protection

DIICOT Directorate for Investigating Organized Crime and Terrorism

DSU Department for Emergency Situations

HCP_PR - healthcare professional - participant [no. 1-6 to the interviews]

HCPs Healthcare Professionals

HT Human Trafficking

IGI General Inspectorate for Immigration
INML National Institute of Forensic Medicine

MoH Ministry of Health

NGO non-governmental organisation

NIRM The National Mechanism for the Identification and Referral of Victims of Trafficking in Persons

OAMGMAMR The Order of General Medical Assistants, Midwives and Nurses in Romania

UN United Nations

UNODC United Nations Office on Drugs and Crime

VOTs Victims of Trafficking

WHO World Health Organisation

1. Introduction

According to EU statistics for the past five years (2019-2023), Romania has been one of the top source-country for victims of human trafficking (VOTs), particularly for sexual exploitation within the EU[1]. Furthermore, data published by the National Agency Against Trafficking in Persons (ANITP)[2] for the period 2019–2023 indicates that sexual exploitation remains the most prevalent form of human trafficking in Romania. According to these findings, 71% of all VOTs were subjected to sexual exploitation[3], highlighting its persistent and dominant nature within trafficking cases. To put it in more concrete terms, roughly three out of every four victims fall into this category. Since HT is a gendered phenomenon, with males being usually exploited for physical labour[4] and women for sexual services, most of the victims identified in this category were females, accounting for 89% of cases. Trafficking for sexual purposes, whether transnational or domestic, affects especially young women. The latest statistics paint concerning pictures regarding sex trafficking in Romania, as the share of minor victims exceeds that of adult victims. In the period under analysis, almost 48% of all identified victims of forced prostitution and pornography were under 18[5]. Women from both urban and rural areas, with a precarious financial situation, low levels of education, poor housing situations, without family support, and, in some cases, suffering from physical or mental issues, are more prone to be coerced into exploitative sexual situations. In most cases, the abuser was someone known to the victim, most frequently the life partner, a close friend, or a relative. The promise of a stable and prosperous relationship, also known as the 'loverboy' recruitment strategy, is still the preferred way of convincing these young girls to engage in exploitative relations.

The situation at the European level is strikingly similar to the one Romania faces. With females representing 63% of all VOTs and 75% of child victims, most of them being sexually exploited, sex trafficking and exploitation remain a challenge on the EU agenda.[6] The most recent data released by Eurostat shows the grim reality of Romania in comparison with the other EU countries. Our country ranks number one at the European level in terms of registered VOTs in human beings in 2022. If we take a closer look and correlate the number of victims with the overall country population, the situation looks more favourable. Nonetheless, with 26 victims per one million inhabitants, Romania is still in the top tier of EU states dealing with large-scale HT, with sexual exploitation being the prevalent form of exploitation.

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[1] See the Progress Reports published by the EU concerning the progress made in the fight against human trafficking in the EU. The five reports can be accessed here: link (A/N).

[2] The statistical data in this section is sourced from the annual reports and annual analyses for 2019-2023 published by ANITP. The report can be accessed here: link (A/N).

[3] Between 2019 and 2023, a total of 2,750 victims were identified, of whom 1,951 were subjected to sexual exploitation (A/N).

[4] Although the most recent data shows an increase in the number of males being sexually exploited, according to ANITP report for 2023 (A/N).

[5] Between 2019 and 2023, a total of 1,319 minor victims were identified (A/N).

[6] More information on human trafficking statistics can be found on the Eurostat page: link (A/N).

Far from illustrating the complete picture of sex trafficking, the above-presented data points to the amplitude, complexity, and intricacies of this phenomenon in Romania. Sexual exploitation and trafficking are both a national and a transnational problem, often involving interconnected, overlapping, and mutually exacerbating risk factors, starting from structural aspects, such as poverty or patriarchal norms, to more relational or individual causes, such as family trauma or disability status.

Poor health is also a vulnerability factor, as defined by the Convention on Action against Trafficking in Human Beings[7], that places VOTs in a position where they may be more susceptible to exploitation. Health is not only a risk factor that leads victims into sexually exploitative situations but also a crucial element that sustains their involvement in forced prostitution. Health problems can represent, for some victims, a tipping point that encourages them to act and escape from the abusive situation. Because there is a high correlation between sexual exploitation and health-related problems, most individuals who have experienced sex trafficking seek medical attention during their exploitation.

Thus, healthcare systems play a crucial role in both early identification of sex trafficking and addressing the physical and mental health consequences faced by victims of sexual exploitation and trafficking. Despite the importance of this issue, there has been little to no research in Romania on the health needs of trafficked individuals, the impact of trafficking on their physical and mental well-being, or the barriers they face in accessing healthcare. Concrete data is lacking on the specific medical issues victims encounter and the types of care services they require. Additionally, there is insufficient information on how well HCPs are equipped to recognize victims of sex trafficking and exploitation.

The research which underpins this report started from the need to address this knowledge vacuum. We wanted to provide an evidence base on the intersection between healthcare and HT in Romania to design more data-driven policies and services that focus on the victim's well-being. More precisely, on the one hand, we sought to examine the experiences of sex trafficking survivors in accessing care and the ways they engage with the different healthcare systems. On the other hand, we tried to grasp the perceptions and realities of the healthcare professionals (HCPs) interacting with the VOTs and to assess how well prepared they are to identify the victims of sexual exploitation and to provide them with the appropriate support, resources, and services.

Since the topic had not been researched in a systematic way before and all the available information was largely anecdotic, our main aim was to conduct an **exploratory, qualitative study** with the hope of laying the groundwork for a more extensive research journey on this subject. Thus, we focused more on elucidating rather than explaining, more on informing and illustrating rather than giving definitive answers. We broke down our research plan into five research objectives, as detailed below:

- Identify the barriers and facilitators that affect access to quality medical services for VOTs.
- Explore the experiences and perceptions of VOTs when seeking medical services.

[7] Council of Europe, *Convention on Action against Trafficking in Human Beings*, Warsaw, 16 May 2005, *Council of Europe Treaty Series - No. 197*. Available at: https://rm.coe.int/168008371d.

- Investigate how HCPs respond in different situations involving suspected or confirmed cases of HT.
- Describe successful strategies and best practices for facilitating interaction between VOTs and the medical system.
- Inform intervention programs, particularly training initiatives for HCPs, regarding the needs of VOTs and the appropriate moral, legal, and social responses.

Methodologically speaking, we conducted twelve semi-structured, in-depth interviews with purposively selected participants. Half of these interviews involved sex trafficking survivors who attended different aftercare programs managed by specialised non-profit organisations. The other six interviews were conducted with HCPs, mostly emergency medicine physicians, who either identified victims during their medical practice or had strong medical and behavioural evidence that pointed to cases of sex trafficking. It was crucial for our team to include in the research, first and foremost, the voices of the sex trafficking survivors and to centre our scope and methodology on their immediate and long-term well-being. It is our conviction that any practice, protocol, and policy relevant to sex trafficking must include survivor participation and feedback in order to ensure appropriate trauma-informed services, as recommended by the World Health Organization.[8]

Beyond the above-expressed need for this study, this report provides evidence that supports Romania in its efforts to implement recently adopted strategies and action plans, namely The National Strategy Against Trafficking in Persons for 2024-2028, at the national level, and The Council of Europe Convention on Action against Trafficking in Human Beings, at European level. As an EU member state and a major country of origin for the victims of sex trafficking, Romania has acknowledged its responsibility to prevent and respond to sexual exploitation and trafficking. Yet, to keep its commitments, all policy considerations and intervention programs must be grounded primarily in knowledge drawn from the reality of trafficking in Romania.

We hope our initiative opens the space for more research on this topic.

The ultimate purpose of this research and our complementary actions is to use the collected data to design specific procedures and measures to early identify and report cases of trafficking and better assist the victims who access healthcare. We also expect that different policymakers, hospital managers, HCPs, NGOs active in this area, or various public servants working on sex trafficking would leverage this evidence to improve the healthcare system's responses to trafficked people and survivors of trafficking.

By the end of this report, we hope to persuade the reader to view healthcare systems in general, and HCPs in particular, as playing crucial roles in preventing the recurrence of sex trafficking. First, we want to make sure that their current practices, attitudes, or procedures do not exacerbate or contribute to existing vulnerabilities in sex trafficking and exploitation. Their second role in prevention goes even further as HCPs are in the unique position to meet trafficked individuals while they are being trafficked. This implies that they can directly influence their life trajectory by gaining access to justice and effective remedies. Thus, the healthcare system has the opportunity and an important role in promoting and protecting the

[8] For more information on the World Health Organization's approach to human trafficking, refer to their 2023 report titled *Addressing Human Trafficking Through Health Systems: A Scoping Review*. The report can be accessed here: link.

health and other rights of individuals who have been trafficked, while contributing to their identification and supporting their transition from trafficking to safety.

At the same time, putting too much responsibility and, thus, pressure on HCPs would be both unreasonable and unethical. Sex trafficking is a complex and structural phenomenon, and only a multidisciplinary approach can lead to the success of removing the victims from their exploitative situation. Comprehensive needs assessments[9], interdisciplinary teams, and co-location of services[10] have proven, in some cases, the most effective facilitators of care for trafficking survivors in other countries. Even more, every targeted measure to fight sex trafficking should be integrated into a larger social approach that addresses the socioeconomic underpinnings of vulnerability to trafficking. Sadly, Romania has the largest poverty rate of all the countries in the European Union, with 34,4% of its total population being at risk of poverty or social exclusion.[11] Women and children are particularly affected by severe material and social deprivation, making them easy targets for sex trafficking networks.

Romania has made progress in addressing sexual exploitation through legislative and law enforcement efforts. However, sex trafficking and exploitation can only be eradicated by tackling its structural root causes. These include poverty, the lack of social programs for vulnerable citizens, inadequate housing conditions, a patriarchal culture that objectifies women, and the absence of protection programs for youth exiting the child protection system, as highlighted by our research findings.

This report sheds some light on an essential element in this social architecture, the healthcare system. It encourages decision-makers to adopt a proactive public health approach to trafficking as a key strategy for intervening in trafficking and supporting harm-reduction efforts for trafficked individuals.

The report is structured as follows: in the first Section, we lay the conceptual and methodological ground that guided our research. Then, in Section 2, we introduce a brief analysis of the existing legislative, policy, and practical measures on the prevention of HT and the protection of the rights of VOTs. Special attention was paid to the role of medical systems and HCPs in anti-trafficking activities. We later move on in Section 3 to the most important part of this report, our research findings, where we present the empirical data we gathered on the interaction of the victims with the healthcare systems. Based on the study results, we conclude with Section 4, in which we make policy recommendations designed to help relevant institutions and organizations improve healthcare system responses to trafficked people and survivors of trafficking.

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[9] Hemmings, S., Jakobowitz, S., Abas, M., Bick, D., Howard, L. M., Stanley, N., Zimmerman, C., & Oram, S. (2016). Responding to the Health Needs of Survivors of Human Trafficking: A Systematic Review. *BMC Health Services Research, 16*, 320. https://doi.org/10.1186/s12913-016-1538-8.

[10] Jain J, Bennett M, Bailey MD, Liaou D, Kaltiso SO, Greenbaum J, Williams K, Gordon MR, Torres MIM, Nguyen PT, Coverdale JH, Williams V, Hari C, Rodriguez S, Salami T, Potter JE. Creating a Collaborative Trauma-Informed Interdisciplinary Citywide Victim Services Model Focused on Health Care for Survivors of Human Trafficking. Public Health Rep. 2022 Jul-Aug;137(1_suppl):30S-37S. doi: 10.1177/00333549211059833. PMID: 35775914; PMCID: PMC9257486

[11] This information is based on data on people at risk of poverty or social exclusion, published by Eurostat. The data can be accessed here: link (accessed January 2025).

2. Context and Justification

Since 2016, the eLiberare Association has actively engaged survivors of human trafficking in policy development, program design, and resource co-creation through structured consultations. In January 2022, this commitment was further reinforced by integrating a survivor[12] into the organizational team. Her lived experience has provided valuable insights into the critical role of healthcare professionals (HCPs), who frequently serve as the first point of contact for victims seeking medical assistance—often while still under the control of their traffickers.

This study emerged directly from her input, which underscored a significant gap in victim identification. Despite multiple interactions with HCPs during her trafficking experience, she was never recognized as a victim. This finding suggests that healthcare providers could serve as a crucial intervention point, provided they possess the necessary knowledge and skills to identify trafficking indicators.

Moreover, the study is also built upon the counsel and recommendations of a Survivor Leader from the UK, Jane Lasonder, who is a member of the International Survivors of Trafficking Advisory Council from ODIHR/OSCE and a founding member of the Red Alert Task Force[13], a multi-disciplinary task force designed to raise awareness of modern slavery and HT[14]. As a survivor of child trafficking, Jane shares her expertise as a consultant with organizations and groups who are interested in increasing their knowledge of modern slavery and HT, including school-age children, teens, and medical students. She has contributed to the work of the European Parliament, the UN, OSCE/ODIHR, the WHO, and various media outlets regarding HT.

A Review of Research and Advocacy Efforts

In 2021, the government established a working group focused on improving the identification and quality of medical assistance for VOTs. This group, composed of both public and private healthcare providers alongside Ministry of Health (MoH) officials, developed an action plan to offer tailored medical services to VOTs and to train healthcare providers in victim identification. The Working Group ceased operations in early 2022, and the Action Plan was not implemented.

To further explore this issue, eLiberare conducted a brief summary in 2022 titled *"Perspectives of Human Trafficking Survivors on Community Actors"*,[15] which concluded that the most frequent reasons VOTs end up in a hospital are either for emergency interventions due to violence (beatings inflicted by traffickers or clients) or for medical issues resulting from exploitation (gynecological conditions, forced or voluntary pregnancy terminations, or psychological disorders). A second conclusion was that emergency interventions are predominant in cases of extreme violence, while scheduled interventions, such as treatments

[12] Her name is anonymised for safety concerns (A/N).

[13] Red Alert Task Force.

[14] She is also the author of her autobiography *Jane* and her second book *Red Alert: the inside story of prostitution and human trafficking* (A/N).

[15] eLiberare Association, *Perspectives of Human Trafficking Survivors on Community Actors*, 2022.

for chronic or gynecological conditions, often take place in private clinics. Survivors mentioned either a preference for a specific doctor or, conversely, a repeated change in the location of interventions.[16]

In this context, at the beginning of 2023, eLiberare signed a protocol with the Department for Vulnerable Populations within the Government, as well as with the Department for Emergency Situations, which oversees the country's emergency services, including qualified first aid and emergency medical assistance within emergency reception units and departments (UPU/CPU). This collaboration aims to train HCPs in proactively identifying VOTs and ensuring their proper referral to the relevant authorities.

Building on these first steps of exploring victims' interactions with HCPs, in September 2023, eLiberare Association launched a project funded by the British Embassy, titled *Addressing Human Trafficking within the Romanian healthcare system.*[17] The project was part of the bilateral partnership between Romania and the UK to address modern slavery and HT. This initiative aimed to strengthen Romania's healthcare system in tackling HT by improving early victim identification, establishing clear referral pathways, and fostering a more victim-centred response. Central to this effort was the integration of the expertise and lived experiences of both Romanian survivors and British survivor leader - Jane Lasonder, ensuring that those most affected have a voice in shaping better support systems.

The project set out to achieve a range of objectives, including capacity building and the creation of specialised tools, such as a user-friendly guide for HCPs and a focused social media campaign, as well as an analysis of how victims interact with the healthcare system.

a) Capacity Building Efforts

In collaboration with the relevant authorities, nine in-person and two online training sessions were conducted[18], equipping a total of **406 HCPs**[19] with the knowledge and skills necessary to identify and refer trafficking cases at an early stage. Participants included professionals from the Department for Emergency Situations (DSU), the Social Assistance Directorate (DAS), the Bucharest Hospitals and Medical Services Administration (ASSMB), and those attending the SARTISS National Medicine Conference. These training sessions were held across various locations in Romania, with a particular focus on Brașov, Sibiu, Oradea, and Bucharest. The training programme emphasised a victim-centred approach and promoted the National Mechanism for the Identification and Referral of Victims of Trafficking in Persons (NIRM)[20].

b) Learnings from Trainings

According to the feedback received, 81% of participants had not previously attended any training on HT. However, following the sessions, 94% reported an improved understanding of

[16] *Ibidem*, pp. 5-6.

[17] eLiberare Association, *Modern Slavery Fund Romania Project Proposal*, unpublished concept note for the project *Addressing Human Trafficking within the Romanian healthcare system*, funded by the British Embassy in Romania.

[18] During 2024 and beginning of 2025 (A/N).

[19] Up to date, February 2025 (A/N).

[20] ANITP, *Mecanismul Național din 31 ianuarie 2023 de identificare și referire a victimelor traficului de persoane*.

HT, while 92% noted enhanced communication skills when interacting with patients exhibiting potential indicators of trafficking. Furthermore, participants expressed their intention to apply the professional skills and techniques acquired during the training to their daily work. Notably, 90% reported an increased ability to recognise trafficking indicators and respond appropriately, demonstrating greater overall competence and confidence in handling such cases.

Another critical finding from training evaluations highlighted that, while doctors and nurses identified key indicators, they lacked effective reporting mechanisms and were discouraged from reporting potential cases. For instance, some HCPs shared that, despite their efforts to report potential cases to 112 (emergency telephone number), there were instances where no response was received while the patient was still in the emergency room - on some occasions, the police did not arrive at all. Following the training, medical staff began reaching out directly to the eLiberare team when such situations arose, underscoring the urgent need for multiple reporting channels specifically designated for HCPs. Notably, within a week of the training session with emergency medical staff in Brașov, two potential cases were reported to eLiberare Association.[21]

eLiberare's hypothesis - that HCPs play a crucial role in identifying VOTs and require specialised training - has thus been validated. Since the project's inception, **a total of eight doctors** have sought support from the organisation in identifying potential HT cases. As a result, they **successfully identified six VOTs**, including four cases of sexual exploitation and two of labour exploitation, along with one victim of sexual abuse. Among these victims, **two were minors**. All identified victims were referred to the ANITP and provided with the necessary services and support.

c) Resources Developed to Equip Healthcare Professionals

In collaboration with the ANITP, ASSMB and DSU, eLiberare also developed materials specifically designed to support HCPs in identifying and responding to HT cases more effectively.

These tools are all available on a dedicated landing page[22], which was designed as an open-access resource hub featuring informative videos with expert-by-experience Jane Lasonder, a simplified and user-friendly version[23] of the NIRM, offering clear, actionable procedures aligned with current legislation, a detailed curriculum[24] for HCPs, a poster[25] to be displayed in consultation rooms and an indicators sheet[26]. Another particularly impactful initiative was the introduction of the **"Sunt pregătit să ajut"** ("I am ready to help") badge, conceived by HCPs themselves. The badge serves as a visible declaration of their commitment to assisting VOTs.

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[21] Information based on the groundwork experience of eLiberare Association.

[22] eLiberare Association, *Detectarea și notificarea cazurilor de trafic de persoane. Resurse pentru personalul medical*.

[23] eLiberare Association, *Ghid practic de identificare și sesizare a cazurilor de trafic de persoane pentru personalul medical*, January 2024.

[24] eLiberare Association, *Curriculum pentru detectarea și notificarea cazurilor de trafic de persoane pentru personalul medical*.

[25] eLiberare Association, *Este pacientul tău o victimă a traficului de persoane?*.

[26] eLiberare Association, *Indicatori specifici ai traficului de persoane în context medical*.

eLiberare also distributed printed versions of these materials, including **2,300** guides, **700** badges, and **700** posters, across **143** school medical offices, eight hospitals, and multiple private clinics. These resources were provided to all trained professionals and shared through the organisation's broader collaborative network, including ASSMB and DSU, further strengthening the healthcare sector's ability to identify and support VOTs effectively.

The National Strategy Against Trafficking in Persons for 2024-2028 and the Working Group on Healthcare Professionals

In 2024, Romania's National Strategy Against Trafficking in Persons for 2024-2028 was adopted, which opened new opportunities for the anti-trafficking movement. The strategy includes specific objectives for the medical field, such as training for HCPs, including forensic specialists, to better interact with VOTs and conduct gender-sensitive victim identification.

The Governmental Inter-Ministerial Strategic Coordinating Committee for the Fight Against Trafficking in Persons issued Decision No. 1 on 17 September 2024, officially approving the formation of several working groups, including the one on "*Healthcare Professionals – Victim Identification, Referral, and Assistance*. It brought together key representatives from Romania's healthcare system, including the CNAS, National Institute of Forensic Medicine (INML), MoH, ASSMB, and the National Agency for Equal Opportunities for Women and Men (ANES).

The discussions focused on two main objectives: 1) Increase the rate of identification of victims by medical personnel; 2) Clarify issues related to medical services provided to VOTs. These endeavours have led to the conclusion that public-health-based prevention efforts need to attend to the root causes of trafficking, including all forms of social, economic and cultural marginalisation, and to trigger a protective protocol any time a patient shows indicators of HT.

3. Methodology

For a more comprehensive picture of the interaction between the victims and survivors of sex trafficking and the medical system, we used a qualitative, multimethod research design that includes document analysis and semi-structured individual interviews.

3.1. Document Analysis

Through documentary analysis, the laws and regulations that constitute the national legislative framework regarding the fight against HT and the protection of victims, as well as other relevant national and international documents in this field were studied and analysed. The list of selected documents included strategy policies, legislative policies, administrative policies (*e.g.*, government decisions, ministerial orders, etc.), and regulatory policies at the level of specialized structures (*e.g.*, intervention protocols). The analysis heavily relied on the data included in The National Strategy Against Trafficking in Persons for 2024-2028, as it is the most comprehensive and recent plan undertaken by the Romanian government to guide action and the allocation of resources on the subject of HT. For each policy paper we examined, we used the following conceptual grid: context, policy framework, policy text, and policy implementation. Each mentioned category came with its own set of questions, as exemplified below.

Context	What is the social, political, and economic context? What critical junctures can be identified? What is the political and public debate around sex trafficking and exploitation?
Policy framework	What are the definitions, assumptions and hypotheses with which the policy operates? What are the target populations and what are the characteristics of these populations?
Policy text	What exactly does the policy provide? What are the stated objectives? Who is responsible for implementation and monitoring? How is it funded?
Policy implementation	Through what mechanisms was the policy implemented? How was it monitored? What were the implementing agencies?

3.2. Individual Interviews

Because the research topic has not been previously studied in depth in Romania, we opted for an exploratory design based on individual, semi-structured interviews. Due to its flexible and open-ended nature, an interpretative approach has the advantage of determining future research priorities on the interaction of VOTs and survivors with the healthcare system and opens the avenue for quantitative studies on the topic. We conducted twelve semi-structured, in-depth interviews with purposively selected participants. The study population was

comprised of sex trafficking survivors and HCPs. With each category under study, we conducted an even number of interviews.

Participant Selection and Recruitment

Both categories of research participants were selected using purposive sampling.

The first group consisted of individuals identified by Romanian authorities as victims and survivors of sex trafficking. We collaborated with NGOs in the Bucharest area that provide reintegration assistance to VOTs, asking them to inform survivors about the study. Those who expressed interest in participating and had at least one interaction with the healthcare system during or after their exploitation were included in the study. Eligibility criteria also included individuals who had experienced sex trafficking in the past ten years, were aged 18 or older at the time of the interview selection, and were able to provide informed consent.

The final sample of participants included young women of Romanian ethnicity with varying levels of education (ranging from compulsory education to university degrees). Most were from working-class families and came from both urban and rural areas. It is important to note that two victims had interactions with the medical system only after the trafficking period ended, but were included in the sample because they had knowledge about the subject.

The second group of participants consisted of HCPs working in the public sector. We compiled a list of medical units and locations most likely to encounter cases of sex trafficking and exploitation, such as hospital emergency departments and gynecological clinics, and informed them about the study. We also reached out to previous participants from eLiberare's training programs on HT, as we wanted to include the perspectives of HCPs who had successfully identified and reported cases of sex trafficking after receiving training on the topic.

The selected HCPs were primarily emergency medicine physicians working in public hospitals in Bucharest and Sibiu. Gender representation in the sample included two female and four male interviewees.

All study participants signed a consent form after reviewing the research information sheet and discussing it with the field operator.

Data Collection

We conducted individual, semi-structured, in-depth, in-person, and online interviews between September and November 2024. The interviews lasted between a minimum of one hour and a maximum of three hours. All the interviews with the victims were conducted in person, in a safe, private, enclosed location of their choice. The following section outlines the ethical considerations. The interviews were audio recorded and later transcribed by our team members. With both categories of participants, we used an interview guide that touched upon the following subjects: perceptions and lived experiences on the encounter between the VOTs and HCPs/medical system at large; health-related problems faced by victims of sex trafficking; barriers and facilitators in accessing healthcare; solutions to improve medical services for VOTs. Although we had a predetermined set of questions, we tried to leave as much space as possible for an open discussion, and thus prompted the participants to offer their input and explore the themes they found relevant in more detail.

Data Analysis

The interview transcripts were coded using two qualitative software programs, MAXQDA and NVivo. To ensure both validity and reliability, each researcher independently conducted an initial analysis of the data. Descriptive labels were applied to the data, which were subsequently organized into themes and broader concepts grounded in the theoretical framework. Following this, the two researchers compared and contrasted their individual analyses. Finally, the findings were refined and subjected to review by both internal and external experts in the field of sex trafficking, ensuring the accuracy and depth of interpretation.

Methodological Limitations

The most important research limitation is determined by the characteristics of the research participants and how they were selected. In the case of VOTs, all of the respondents have benefited from assistance programs offered by specialised organizations. In the case of HCPs, three of them were previously trained within the capacity building program conducted by eLiberare. Therefore, the responses we collected, and thus the research results, might be influenced by social desirability effects stemming from the relation the respondents have with the organization. Another methodological limitation related to the study population is sample size and sample uniformity. Among the victims of sexual exploitation, all the respondents were adult females of Romanian ethnicity and heterosexual. Previously collected data show that individuals of different genders, ages and ethnicities are frequently victims of sex trafficking and exploitation. Thus, the research population does not constitute a nationally representative sample. Another limitation of the research comes from the fact that it refers exclusively to interactions with medical institutions from the urban environment. As a result, the research does not provide a full picture of the interaction of the victims with specialists from the entire medical system. Finally, it is important to emphasize that **this study is a pilot, exploratory research.** Due to its limited scale, the findings cannot be generalized to the broader population of VOTs in Romania. While the study provides valuable insights into sex trafficking and exploitation, its conclusions should be further examined and validated through additional research on this topic.

Ethical Considerations

Due to the sensitive nature of the research, supplementary ethical aspects were taken into consideration. Throughout the research process, we strived to apply the principles of trauma-informed practice, such as:

- The researchers were trained in trauma-informed interviewing techniques and in managing participant distress.
- Prior to the interviews, informed consent was obtained from each participant.
- All participants were fully informed of their right to discontinue the interview, refuse to answer questions or withdraw their participation at any time without facing any negative consequences.
- Anonymity was maintained by coding all collected data on records, transcripts, and associated documents.

- Access to a specialist therapist was provided both during and after the interview for support.

Additional safeguards were taken concerning survivors interviewed. To ensure ethical integrity and the well-being of participants, interviews were conducted exclusively with individuals who were no longer in exploitative situations, had access to comprehensive support services, and were receiving appropriate emotional and psychological assistance.

The interviews were carried out in a safe and confidential setting, allowing participants to share their experiences without fear of repercussions. The interviewer was a trained and trauma-informed professional with expertise in working with trafficking survivors. Specialised interview techniques were employed to minimise the risk of retraumatization, including a survivor-centred approach that prioritised autonomy, informed consent, and emotional safety. The structure of the interviews was flexible, allowing participants to guide the discussion based on their comfort level, while also ensuring that key thematic areas were systematically explored.

4. Analysis of Policies

Romania is bound by both national and international legislation to provide medical services to VOTs and to report any suspicions of trafficking cases.

Law no. 211/2004[27] affirms that the state is obliged to provide free or subsidized medical services[28] for victims of crime (which includes VOTs), and to compensate them financially for "hospitalization and other categories of medical expenses incurred by the victim for the restoration of physical or mental health, affected as a result of the criminal act committed against him/her, including the cost of investigations, analyses and medical consultations".[29]

However, the **U.S. Department of State TIP Reports from 2020-2024** state that "the quality of government-provided assistance was overall inadequate, especially medical services (...)" and that Romania did not "finance medical care costs. Moreover, access to medical care and social services required Romanian victims to return to their home districts to receive care; the process presented safety, logistical, and financial hurdles for many VOTs".[30]

GRETA's third report on Romania (2021) highlights the need for systematic training for medical staff to enable them to proactively identify victims[31] and underscores that victims' right to compensation includes the costs of medical treatment.[32] Also, "when compensation is not fully available from other sources, the State shall contribute to compensate those who have sustained serious bodily injury or impairment of health directly attributable to an intentional crime of violence, as well as the dependents of persons who have died as a result of such crime, even if the offender cannot be prosecuted or punished".[33]

Despite these shortcomings, Romania has also made significant progress in recent years in the fight against trafficking in human beings, which directly intersects with the needs identified above. Some of these are listed below:

- **Recent legislative changes** now mandate that every citizen who becomes aware of a potential case of trafficking or exploitation of vulnerable individuals, especially those who may encounter VOTs due to the nature of their work, report it.[34]
- **The National Mechanism for the Identification and Referral of Victims of Trafficking in Persons (NIRM)**, approved by Government Decision no. 88 of January 31, 2023,[35] defines the process of detecting and reporting potential trafficking cases

[27] Law no. 211/2004 on certain measures to ensure information, support and protection of victims of crime, with subsequent additions and amendments.

[28] *Ibidem*, Article 7(1), (3) and 4(g).

[29] *Ibidem,* Article 27(1), para. a(1).

[30] US Department of State, *2024 Trafficking in Persons Report: Romania; 2023 Trafficking in Persons Report: Romania; 2022 Trafficking in Persons Report: Romania; 2021 Trafficking in Persons Report: Romania; 2020 Trafficking in Persons Report for Romania*.

[31] GRETA (Council of Europe), *Evaluation Report Romania. Third evaluation round. Access to justice and effective remedies for victims of trafficking in human beings*, 3 June 2021, p. 5.

[32] *Ibidem*, para. 69, 74 and 81.

[33] *Ibidem*, para. 69.

[34] Article 266 para. 1^1 and Article 267 of the Romanian Criminal Code, in force since 2021.

[35] *The National Mechanism for the Identification and Referral of Victims of Trafficking in Persons* (NIRM), in Romanian.

and outlines the responsibilities of various actors, especially professional categories who, by the nature of their work, are likely to encounter potential victims. In collaboration with the ANITP, DSU and ASSMB, eLiberare Association developed a user-friendly guide for HCPs based on the NIRM.[36]

- **The National Strategy Against Trafficking in Persons for 2024-2028**,[37] highlights the lack of a flexible framework for VOTs to access health insurance and emphasizes that medical assistance is among the most accessed services by victims,[38] alongside psychological counselling, financial and material support, and shelter.[39] The related **National Action Plan (NAP)** sets out Specific Objective 3.3, which calls for the establishment of a national measure for providing medical services to victims.[40] Objective 3.2.2 also targets medical staff for training on proactively identifying victims, considering the gender perspective.[41] The SNITP also includes the MoH among the responsible institutions for organizing and participating in training activities related to proactive identification of VOTs and other vulnerable groups. The MoH, through its subordinate bodies, such as the CNAS, also regulates the provision of free medical services to VOTs.[42]

- **The establishment of the Working Group on Healthcare Professionals – Victim Identification, Referral, and Assistance** – for victims within the Assistance and Protection Working Group set up by the Government Decision no. 1 of 17.09.2024 of the Governmental Inter-Ministerial Strategic Coordinating Committee for the Fight Against Trafficking in Persons, to implement the objectives of the NAP 2024-2026. The stated objectives of this subgroup are: 1) increasing the rate of identification of victims by medical staff, and 2) clarifying issues related to the medical services provided to VOTs.

These efforts reflect Romania's increasing recognition of the critical role HCPs can play in identifying and supporting victims. In addition to national progress, Romania is a signatory to several EU and international legislative and policy instruments that impose obligations and responsibilities, particularly in the area of medical services for VOTs. Some of the most significant include:

- **The United Nations' Palermo Protocol** (2000) includes medical assistance among the measures that states must implement to ensure the physical, psychological, and social recovery of VOTs.[43] This obligation is further reiterated in the United Nations

[36] eLiberare Association, ANITP, DSU, ASSMB, *Practical Guide for Healthcare Professionals for Identifying and Reporting Human Trafficking Cases*, January 2024. In Romanian. Other materials dedicated to healthcare professionals developed by eLiberare: *Curriculum for Detecting and Reporting Human Trafficking Cases for Healthcare Professionals*, a poster to be used in medical units and a dedicated website.

[37] *The National Strategy Against Trafficking in Persons for 2024–2028* (SNITP), in Romanian.

[38] *Ibidem*, pp. 18-19.

[39] *Ibidem*, pp. 16.

[40] *Ibidem*, pp. 23-24.

[41] *Ibidem*, p. 48.

[42] *Ibidem*, p. 28.

[43] United Nations, *Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime*, Article 6 para. (3)c.

Global Plan of Action to Combat Trafficking in Persons,[44] which highlights the need for specialised medical services, such as for "HIV and AIDS and other blood-borne and communicable diseases for those VOTs that have been sexually exploited" and in the UNODC Global Report on Trafficking in Persons 2020.[45] According to a UN study with 85 interviewed practitioners, medical services rank first in top five services most needed by VOTs,[46] including mental health services.[47]

- **The Council of Europe's Convention on Action against Trafficking in Human Beings** (2005) lists emergency medical care among the minimum measures that states are required to adopt in order to assist victims in their physical, psychological, and social rehabilitation.[48]

- **The EU Anti-Trafficking Strategy 2021-2025**[49] calls on member states to "promote awareness-raising activities targeting frontline professionals in high-risk sectors and high-risk environments where VOTs are exploited; (...) improve the functioning of National Referral Mechanisms; provide training to HCPs on diversity management and the needs of VOTs who are migrants, under the EU health programmes";[50] "promote activities such as gender-sensitive and child-rights based training for professionals likely to come into contact with victims [such as (...) HCPs], developing guidelines, toolkits and exchanging best practices among practitioners (...)".[51]

- **The revised EU Anti-Trafficking Directive** (2024), which requires states to ensure medical treatment for VOTs[52] and mandates the provision of "regular and specialised training for professionals likely to come into contact with victims or potential VOTs, including (...) HCPs, aimed at enabling them to prevent and combat trafficking in human beings and to avoid secondary victimisation, and to detect, identify, assist, support and protect the victims".[53]

Regarding Romania's responsibility to ensure training, GRETA recommends that "training on [HT] should be integrated into the regular training curricula of relevant professional groups, including (...) health-care staff",[54] and regarding proactive identification in vulnerable communities, states that Romanian authorities "should provide additional resources to Roma health mediators to enable them to identify potential and actual VOTs within the Roma

[44] United Nations, *United Nations Global Plan of Action to Combat Trafficking in Persons*, Sixty-fourth session of the United Nations General Assembly, 12 August 2010. New York; 2010 (A/RES/64/293), para. 36.
[45] United Nations, *Global Report on Trafficking in Persons 2024*, December 2024.
[46] *Ibidem*, pp. 99, 102.
[47] *Ibidem*, p. 93.
[48] Council of Europe, *Council of Europe Convention on Action against Trafficking in Human Being*, Article 12, para 1b).
[49] European Commission, *Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on the EU Strategy on Combating Trafficking in Human Beings 2021-2025*.
[50] *Ibidem*, pp. 16-17.
[51] *Ibidem*, p. 14.
[52] European Parliament and the Council of the EU, *Directive (EU) 2024/1712 of the European Parliament and of the Council of 13 June 2024*, Article 11 b) para. (5).
[53] *Ibidem*, Article 18 b) para. (1).
[54] GRETA, *Evaluation Report Romania. Third evaluation round*, p. 5.

communities".[55] GRETA also notes that "many victims do not have health insurance and therefore can only receive short-term emergency medical assistance. NGOs try to fill this gap by paying for medical assistance to the best of their abilities. The government does not finance medical care costs of victims of [HT]".[56]

Given Romania's international obligations and recent progress in legislation and public policy documents, we observe a momentum that can be leveraged to **develop a national protocol within the healthcare system** regarding interactions between HCPs and potential VOTs. This proposal is supported by the World Health Organisation's recommendation in a recent study, according to which Member States should aid in the implementation of "standardized, system-wide protocols, along with screening and reporting systems that can be activated when trafficking indicators are identified".[57]

[55] *Ibidem*, para. 187 and 191.

[56] *Ibidem*, para. 212.

[57] World Health Organisation, *Addressing Human Trafficking through health systems. A Scoping Review*, 2023, p. VI.

5. Findings

5.1. Analysis of Interviews with Survivors

Participants Overview

This analysis draws on interviews with six survivors of human trafficking, all of whom are no longer in exploitative situations and have access to comprehensive support services. Some have successfully reintegrated into society and are living independently. Their ages range from 26 to 34 years old. Of the six participants, three were trafficked within Romania, while the other three were exploited abroad. The interviews were conducted to assess the effectiveness of the healthcare system in identifying victims while they were still being trafficked, highlighting both its strengths and critical gaps in early detection and intervention.

5.1.1. Social and Individual Determinants of Trafficking and Health-related Problems during Trafficking

A) Social Vulnerabilities

Sex trafficking and exploitation have wide-ranging negative effects on the lives and health of the victims. Sex trafficking results from a multidimensional state of vulnerability of the victims, represented by a combination of factors operating at macro and micro levels, such as lack of material resources, lack of housing, lack of adequate family support, lack of education, history of mental illness, limited fundamental life experience related of the young age of the victims, etc. Understanding the impact of sex trafficking on women's health, before, during, and after exploitation, is crucial. Root causes, coupled with social systems and cultural norms, affect victims' health, healthcare access, and treatment quality. Health is therefore central to effective, victim-centred prevention, response, and mitigation strategies.

Therefore, understanding the health consequences arising from sex trafficking and exploitation, as well as using healthcare systems for prevention or harm reduction, should be based on identifying a range of risk factors at the individual, family, and societal levels associated with trafficking. The World Health Organization (WHO) also recommends a socio-ecological approach as the most comprehensive anti-trafficking strategy to reduce individual vulnerability and reform the structural elements perpetuating exploitation. This means taking a more proactive and thorough approach that looks at the individuals and their decisions in their social, cultural, and economic contexts[58].

As the ultimate purpose of this research is to design more data-driven policies and services for VOTs, we hope that this first section can offer professionals involved in healthcare systems an insight into the potential indicators for trafficking when screening at-risk patients. For all these reasons, before delving into the specific health-related aspects of sex trafficking, we describe some of the risk factors associated with sex trafficking in Romania as they resulted from the interviews we conducted.

[58] World Health Organization. (2023). *Addressing Human Trafficking through Health Systems*.

Our findings align with previous research in understanding vulnerability to HT as subjected to various intersectional factors. More precisely, sex trafficking, as a specific form of exploitation, is the result of multiple forms of structural violence, the most prevalent being gender-based and economic. These forms of violence are linked to the profitability of the sex trade industry and facilitated by institutional obstacles, such as bureaucracy, discriminatory policies, and corruption. All these aspects are briefly discussed below.

While this report identifies common patterns, it's crucial to recognise that victims of sex trafficking are not a homogenous group. They experience a spectrum of exploitation, all involving force, fraud, or coercion, come from diverse backgrounds, and are subjected to vastly different circumstances.

Gender inequality. From a gender perspective, in a male-dominated society, such as the Romanian one, women are often perceived not only as having an inferior status but also as being objects at men's disposal. Sex trafficking, the ultimate commodification of women, is rooted in social practices and norms that dehumanize women and normalize violence and exploitation. Romania ranks last in the EU on the Gender Equality Index,[59] and cases of various forms of violence directed at women are widespread. These gender power imbalances contribute to intimate partner violence, sexual coercion, and risky sexual behaviour, all of which are intensified in sex trafficking, with severe health consequences. For example, a study conducted in 2014 at the EU level showed that 30% of women in Romania had experienced physical and/or sexual violence, but only 23% reported the most serious incident to the police.[60]

Our research sheds light on the intersection between physical and sexual abuse and how they play out in the case of trafficking. The testimonies we gathered show the gradual process of being subjected to domination and different forms of violence. Sex trafficking is the most extreme form of abuse but one that derives from a long history of misconduct and exploitation endured by these women. Most of the survivors we interviewed have had previous experiences of sexual assault, neglect, and physical or emotional abuse, most often the perpetrators being men from their social circle. If they resisted and sought justice, either by calling the police or publicly denouncing the abuse, they were met with a lack of institutional support and empathy, often facing judgment and are sometimes even blamed for their own exploitation. This lack of support, particularly in earlier, less severe instances of abuse, erodes their trust in authorities, making them reluctant to seek help once they are trafficked.

"And the thing was, they didn't believe you. They believed him. No matter what you said, you weren't trusted. You were just a product that made them money. A little box that had to make money, money, and more money. And as for protection from the authorities—back then, there was no such thing." (survivor, 34)

Furthermore, fear of social judgment helped perpetuate the exploitation as victims did not feel safe to expose their abusers for fear of being stigmatized, judged harshly, or blamed for their circumstances, even by their family or friends.

[59] The Gender Equality Index is a synthetic indicator, a tool to measure the progress of gender equality in the EU. Romania currently has 56,1 score, out of 100 the maximum score possible. More details here.
[60] More information regarding violence against women in Romania can be found here.

Despite enduring physical, emotional, and financial abuse, victims were often wholly or partially blamed for the harm they suffered, rather than the perpetrators being held accountable. One survivor we interviewed recounts her first encounter with the police after finally escaping her trafficking situation:

"They called the police, and the officers from the nearest station to where that man was staying came. There was something about the police that really didn't sit right with me. They took my statement, I told them everything that had happened, and at the end… I told them that I was... I told them everything. And then they said, 'You know that if you're lying, that's a very serious offense, and you could go to prison for it...' Maybe they just wanted to make sure I knew the law, but at that moment, in the state I was in, having someone basically tell me they didn't believe me… I needed understanding, a lot of it. I don't know, at that point, I was at rock bottom, I was in withdrawal. [...] Somehow, it really felt like they didn't believe me." (survivor, 33)

Economic precarity. From an economic perspective, traffickers exploit women's economic vulnerabilities to push them into forced commercial sex, either in the domestic sex industry or abroad. All the females we interviewed came from socially and/or economically disadvantaged backgrounds, lacking proper guidance, financial support, or opportunities for education and employment. The lack of financial security meant they were more prone to being targeted by criminals who promised quick cash and a higher social status. Poverty and social marginalisation are often accompanied by lack of education and weak social support networks. The link between poverty, lack of education, and vulnerability to sexual exploitation was highlighted in most of our victims' answers. For the victims, prostitution is not at all lucrative, but in some cases it offers a way out from even more dire circumstances, as the following account suggests:

"We're talking about vulnerability. Just imagine a girl who grew up in the countryside, who never even had proper shoes, who's never seen much of anything. [...] And of course, when she suddenly finds herself in that kind of life… I get chills just thinking about it. But that life where—look—I have what I need to wash myself, I have shampoo..." (survivor, 34)

"Let's understand the fact that the vast majority of girls who end up in trafficking come from disadvantaged backgrounds. They usually enter [a trafficking situation] for financial reasons—they're looking for some kind of financial support. Most of the time, they've never had any to begin with. When they are trapped in this thing, they actually believe they're going to make money. That's what they're focused on—money. But think about it… yes, they're making that money, but it's not theirs." (survivor, 27)

Because the victims didn't have access to quality education and didn't acquire the necessary skills and knowledge to find decent employment, they were more prone to accept deceiving job offers. At the time of their recruitment, most of them were either unemployed or working low-wage jobs. Yet, many of them have had a formal employment history, as the testimony below exemplifies.

"He lied in court, saying that he met me there [in Germany]. I'd never even been to another country before that. I mean, it's easy to check—I worked in Romania, I had a work contract, I've got all the documents from the places I worked at. I was handing out flyers from the age of 16..." (survivor, 30)

Compared to the general population, youth leaving state care systems are disproportionately vulnerable to sex trafficking, as highlighted by previous research.[61] While our research sample was small—limiting the ability to draw broad conclusions—our findings reinforce the concern that children who 'age out' of state protection are particularly vulnerable to trafficking. Two of the victims we interviewed came from families experiencing extreme poverty and were removed from the custody of their parents due to child neglect or abuse at an early age. They were forced into prostitution after leaving the child protection system when faced with the total lack of institutional support to integrate into society. They faced many obstacles to independent living without family support, education, or stable employment. The lack of family models or the absence of a father figure skewed the perception of romantic relationships and parental responsibilities. They entered quickly into romantic relationships when exiting the child protection system as a survival strategy and ended in trafficking situations. A victim recalls how she had to move into an acquaintance's house who forced her into prostitution in exchange for lodging and food after transitioning out of institutional care and exchanging various residences:

"I was supposed to stay there [in the orphanage] from the age of 9 until I turned 18. Yeah, so I decided to go to my grandfather's [after leaving the care system]. From there, I ended up back in [...], falling in with a really bad crowd [...] Some friends. After I left that place, I went to stay with an aunt—she was related to my ex-boyfriend. This woman already had four kids, and with me, it was five in front of her, because I was basically just a kid myself. She decided to send me to one of her own aunts [...] I mean, she had been involved in prostitution for a very long time. And then, one morning, both she and her husband told me, 'If you want to keep staying here, you do what we say.' [...] And at that point, I had no choice." (survivor, 25)

"I was working in [...], and I had been living in an orphanage dormitory until I was about 18, maybe a little older. And when I left, I just left—I was on my own. No one helped me find a place to stay, no one helped me look for a job. It was tough. I ended up at my mum's place in [...], but I had to stay with one of her neighbours. She didn't want me in her house." (survivor, 26)

As it becomes clear from the excerpts above, housing plays a pivotal role in maintaining or breaking the cycle of trafficking. It serves as a tool for traffickers to recruit and later control their victims. More victims described moving between temporary accommodations, such as staying with a schoolmate, a distant relative, or a known contact before entering trafficking. Yet these arrangements were short-lived. In fact, not having stable and safe housing conditions was the common denominator and one of the main risk factors for their sexual exploitation. Homelessness is a dangerous entry into criminal circles, which can lead to forced prostitution. In the most extreme situations, trafficking is a housing solution, as the victims share the same accommodation with their trafficker, and thus, they avoid homelessness.

Oftentimes, the traffickers exploited the victims' desire to emigrate in order to recruit them or to gain their initial cooperation. Ever since Romania joined the EU community, migration has been the preferred strategy of young individuals to secure financial resources and improve the

[61] More information about the links between children's institutions and human trafficking can be found in the following Lumos report.

quality of their lives.[62] Therefore, most of the victims that were trafficked externally left the country having the aspiration to access lifestyles prevalent in Western industrialized nations by engaging in formal work. In some of the cases, they were in a romantic relationship with the trafficker for extended periods, and the rationale behind emigrating was to save money to start a family life together. Some of the survivors explicitly articulates this:

"Well, I had already been in a relationship with the pimp for a year. We were a couple. That's how it works—they make you trust them, so you'll leave the country. I left the country, in my mind, with my boyfriend, my future husband, to work and save money—just like anyone else who goes abroad—to build a future together back in Romania. Well… things changed. The moment I left the country, everything changed." (survivor, 34)

"I didn't realise he was some kind of loverboy. I just thought he was a normal guy, someone I could build a family with. And it's not like it happened straight away after we got together. Two years went by before we left for England. That's when he made the first proposal [for her to engage in prostitution]. After two years. He waited a really long time." (survivor, 26)

Traveling or migration also comes with a symbolic charge for a lot of young people, as it can signal the transition from youth to adulthood and independent living. Some victims recall the initial context of their departure and how it symbolically marked a separation from the authority of the adults in their lives while simultaneously offering them the possibility of grasping a better future in an alternative space. As the testimony below shows, for some of the victims coming from disadvantaged environments, it was their first time exiting the country. Thus, it was perceived as an exciting opportunity:

"And he started telling me, 'Look, if you want to come with me to Germany for two or three weeks, I've got some car deals to sort out, I need to pick up some cars.' That's what got me last time. I was 19 years old at the time. And I said ok. I say to myself: 'I've never been abroad…'" (survivor, 30)

When talking about economic deprivation and housing instability, it is important to mention the state of vulnerability the victims face after leaving the trafficker. Oftentimes, they leave their exploitative situation in a rush, either identified by the police or they run from the traffickers, with no plan and no money saved. This becomes an obstacle to their autonomy and impedes their access to medical services that they badly need. This is particularly worrisome if, during their trafficking period, they were infected with a sexually transmitted disease (the most commonly mentioned was the HPV virus) or if they were chronically ill. A respondent, after seven years of being sexually exploited in Romania and several other European countries, describes how hard it was for her to start over with no financial savings or external support:

"I had nothing. Nothing. Zero. So I got out of this whole phase with nothing." (survivor, 34)

In conclusion, economic pressures and social stigmas compound the difficulties faced by the victims we interviewed, leading them to enter and remain in exploitative conditions. The testimonies we gathered point to the fact that VOTs were forced into situations they would not choose otherwise due to desperation or circumstance, most often linked to poverty.

[62] According to the World Bank, Romania ranks one among EU countries in terms of emigration stock increase since 1990. More details regarding migration to and from Romania can be found here.

Profitability of commercial sex. Sex trafficking has reached such a vast scale in Romania because of its high profits and low risks for the traffickers. According to the testimonies shared by our respondents, external forced prostitution usually occurs in clubs and brothels, while in Romania, street and 'on location' prostitution (rented apartments) are more prevalent. Some parts are more marketable than others and often involve using specific platforms or websites. The price of sexual services is determined by several factors, including the level of income of the country where the transaction takes place and the country's legal regime. The most often mentioned countries for external trafficking were Germany, the United Kingdom, The Netherlands, Spain and France, while in Romania, larger cities are preferred, such as Bucharest or Cluj-Napoca. Recalling her experience of sex trafficking in London, a survivor talks about the large amounts of money often sent to Romania in ways that wouldn't raise the suspicion of the authorities.

"You can make a lot of money from prostitution, a lot [...] When I reported everything, it was clear how much money I was sending. You could see I was blocked at MoneyGram because of the amount I was sending. I'd send part of it [via MoneyGram], then they'd come and I'd send the rest in cash because I couldn't send 10,000 at once. So we're talking about big amounts, really big amounts, not just a thousand or two in lei [RON]. We're talking tens of thousands of euros." (survivor, 34)

Institutional causes. Finally, when addressing the social causes of sex trafficking, it is important to mention the role played by institutions. The stories shared by our respondents clearly indicate a lack of trust in state institutions and their ability to protect them. The most often mentioned causes are fear of stigma and authorities siding with the abuser, corruption, and inefficiency due to lack of resources. For example, the role of corrupt officials as a facilitator of organized crime groups is clearly articulated in the following excerpt:

"Somehow, in Romania, I know the authorities don't do anything. That person won't be locked up because they have money, they have power everywhere. It's even worse if I report them, because then he'll just come after me again, and who knows what he'll do to me." (survivor, 33)

The testimonies shared with us reveal that, when victims come forward about their abuse, too often the response from institution officials is to disbelieve, suppress, criticize, or ignore. This is particularly worrisome information given the fact that trust in justice institutions is correlated with higher levels of disclosed violence. Law enforcement and even HCPs often failed to adequately protect the victims, with testimonies highlighting neglect, lack of understanding, or outright mistreatment. Their narratives frequently underline the importance of external support systems, such as NGOs, intervening on their behalf when engaging with the state systems.

B) Individual Vulnerabilities

All the trafficked women we interviewed have an element of personal trauma in their biographies, including a history of foster care or child protective services involvement, sexual assault, neglect, emotional or physical abuse, mental health issues, or drug use. The following section tries to capture aspects related to the individual vulnerabilities present in most of the victims of sex trafficking we interviewed (traumas, family and emotional problems, youth, etc.) while highlighting aspects related to health before and during exploitation.

Young age. Our research shows that, except for gender and socio-economic status, the most critical characteristic that correlates with the heightened risk for sex trafficking is age. At the time of recruitment, the majority of our respondents were between 19 and 20 years old. One respondent, a victim, was 28 years old. Yet, her story is particular because she was abducted, and the nature and the conditions of trafficking were horrendous. Our findings reinforce the general concern that minors are increasingly represented among the victims of sex trafficking in Romania. For example, ANITP reported that, in 2023, 7 out of 10 girl victims were in the 14-17 age group.[63] At the same time, most of the traffickers are of adult age, most likely engaged in formal relations and raising children. Thus, often, the gender and economic imbalance of power is aggravated by the big age gap between the trafficker and their victims. Age is significant in trafficking because it is associated with a lack of life experience, which affects the victims' ability to perceive risk or make informed decisions.

"Now it's different. They marry you, take you home, the same dreams sold, same old things. They even marry them. […] It's very hard to get them out of that situation. And now they're not focusing on adult women, they focus on minors […] The younger you get them, from 17 onwards, the more they absorb everything, like a sponge. Like a child. And it's going to be much harder when they reach a certain age and are identified by the police, taken and saved, and so on. I [as a victim] would have said: 'No, nobody forced me. I wanted it.' It's just very hard." (*survivor*, 34)

The preference for younger victims is also driven by the dynamics of sexual services(supply & demand). Trafficked women are subject to a perceived decline in social value, largely determined by physical attributes such as looks, age, and health. Traffickers exploit societal pressures related to beauty standards. For example, one victim was pressured to undergo cosmetic surgery to enhance her appeal to clients.

Adverse childhood experiences. Traumatic events that occurred either in childhood or in the early youth age were everyday experiences among the research respondents. These experiences included losing one or both parents, enduring violence, sexual abuse, or neglect, and going through periods of instability due to parental separation. Some survivors describe growing up with absent or emotionally neglectful parents. For example, one survivor recounts living with a narcissistic father and a mother who refused to support her for fear of retaliation from her husband. Another victim describes their mother refusing to house her when she was vulnerable.

Dysfunctional family dynamics often perpetuate cycles of abuse and neglect, leaving children and young adults vulnerable to exploitation. The lack of positive family support systems led traffickers to manipulate victims. It also implies dependence on the traffickers once entering trafficking, as a survivor explains:

"I don't even know what else to explain or how to explain it. There are thoughts that just eat away at you. If you're on your own, with no parents and no one to turn to, it's much harder. I don't know how girls with parents deal with it. [...] But I literally had no one to turn to, so I had to depend on them [the traffickers]." (survivor, 26)

[63] More details about the distribution of VOTs by age can be found in the Annual Report on the Evolution of Trafficking in Persons in Romania in 2023, which can be accessed here.

Positive family interventions, although rare, played a crucial role in the survivors' attempts to regain stability. In some cases, family members insisted on medical care or fought to remove the survivor from abusive situations.

Substance abuse is the riskiest behaviour related to health that the trafficking survivors mentioned. Alcohol, tobacco, marijuana, synthetic drugs, and prescription medications were the most commonly used substances. In some cases, substance use was initiated in adolescence, before their trafficking started, often as a result of peer pressure and entourage, as the extracts below show:

"In the meantime [after the death of her parents and grandmother], I met a guy who didn't have very orthodox habits, in the sense that he used drugs. He told me that, to get rid of the pain, I should start using drugs too. So, I started taking drugs. He then broke up with me. Later on, he broke into my apartment. He caused me nothing but trouble in that apartment... [...] The thing is, I ended up with a drug addiction." (survivor, 33)

Yet, in most cases, drugs were used as a coping mechanism during the period when they were sexually exploited, often provided by their traffickers. Cocaine and methamphetamine were most often used drugs for their immediate effects on mood and productivity. The psychological effects of these stimulants, including a heightened sense of well-being, euphoria, excitement, and alertness, implied that the victims could attend to more clients and engage in riskier behaviours. As a result, the financial gains were increasing. However, our interviews revealed that dealing and consuming drugs is often a more complicated story, with some of the victims engaging in consumption without the trafficker's initial knowledge or, in one case, the victim even selling substances to her clients.

"Of course, in the Netherlands, drugs are everywhere. You have the freedom to get them wherever you want, and you can find them on every corner. He drugged me to calm me down because I was really panicked and didn't want to do it [engage in prostitution]." (survivor, 34)

"They started talking to me after about two or three weeks, I think [the staff from a sex club in Germany]. And she told me he liked the way I behaved, that I was very civilised, not like the others I was with. And she said: 'Come on, I'll give you something good so you can...' So I went with her into a room. We locked ourselves in there, and she brought out cocaine for the first time. And she said: 'Look, snort this and see how you feel.' I did. Then she said: 'You need to mix it with alcohol.' So I mixed it with alcohol. And I noticed I could handle it [engaging in prostitution] better, and I didn't have the same bad thoughts anymore. And that's how I kept using it. I would get it from the bartender. I'd give her the money, she'd buy it, and then give it to me. And later on, they [the traffickers] found out what I was doing. But they couldn't say no, because they saw it was making them money." (survivor, 26)

Regarding health outcomes, stimulants increase heart rate, blood pressure, and respiratory rate. With the repeated use of stimulants and other drugs, some victims experienced paranoia or psychosis. In other cases, victims reported being at risk for overdose and attempting suicide.

5.1.2. Health Consequences of Trafficking

Sex trafficking has several health consequences that include injury, chronic pain, sexually transmitted diseases, depression, and post-traumatic stress disorder, just to name a few. Women face threats, violence, and control mechanisms, such as dependency on traffickers for basic needs, which leave lasting psychological marks.

A) Mental Health Consequences

The victims we interviewed report lasting trauma, including anxiety, depression, paranoia, and post-traumatic stress associated with being sexually trafficked. Overwhelmingly, the emotions they used to describe their period of trafficking are deep sadness, emptiness or hopelessness, anxiety, and restlessness, as well as intense feelings of worthlessness or guilt. In some cases, these feelings were severe and led to development of serious mental health conditions, such as clinical depression, bipolar disorder, or psychosis, for which some of them were hospitalized. In other cases, poor mental health came out as unexplained physical problems, such as stomach pain, back pain, or headaches. A particularly worrisome fact that our respondents shared is that almost all of them had frequent or recurrent thoughts of death, suicidal thoughts, or even suicide attempts.

"I'd reached the point where I was criticising myself, asking why I was doing this. [I'd say to myself] 'This isn't good for you, you're destroying yourself, can't you see what state you're in?' So, I got to the point where I was really hard on myself, losing my mind, feeling like I wanted to throw myself in front of a car, to commit suicide in that way." (survivor, 25)

Some survivors of sex trafficking accessed mental healthcare during the period they were trafficked, primarily through emergency departments. Except for one victim who disclosed her situation, they were not identified as trafficked by HCPs.

Psychological control and manipulation. Most victims described that they were forced into prostitution through a combination of emotional manipulation coupled with threats and physical violence. The only exception was a case where the victim was held in confinement, deprived of basic human needs, such as food, sleep or toilet facilities. A recurrent theme is the transition from initial deceit (such as the promise of a relationship or a higher social status) to more direct forms of control, such as financial dependence or outright violence. The controlling behaviour included not allowing the victim to go outside the home, room, or accommodation facility; checking or interfering with their email, phone, or social media; restricting their access to financial resources; asking to know their every action, etc. The victims describe how they were forced to comply with the exploitation, losing their autonomy and even their capacity for independent thinking.

Even in cases where there was no physical injury, the psychological scars were deep because of the ambivalent nature of the relationship the victims had with their traffickers, who were their intimate partners, acquaintances, or friends. Many had to grasp paradoxical and contradictory feelings towards their trafficker, as a victim might still be in love with her trafficker (Stockholm Syndrome) and believe his promises of a stable, successful relationship, and simultaneously be frightened for her life or the safety of her loved ones. Many expressed their frustration and

the desire to escape, on the one hand, and hope and desire to be loved and cared for, on the other, which indicate their intense internal struggle while being trafficked. This tension caused them to question the reality of their abuse and prevented them from seeking a way out. These inconsistent and complicated relationships also led to behaviors that may appear perplexing to an outsider. For example, even after escaping trafficking, two victims chose to return to the trafficker or abuser, while others minimized their exploitation.

Social isolation. Seclusion and disconnection are recurrent topics in the histories shared by our respondents. In all cases, the traffickers aimed to cut off the victims from their old life, family, friends, or community networks. In some situations, social isolation implied imposing physical distance (especially prevalent in cases of external trafficking). Still, in most cases, it meant controlling all the relationships the victim had with people outside the circle of influence controlled by the trafficker. In other cases, the social abuse meant threats or even attempts to ruin the victim's reputation in her original reference group. Social isolation meant not only removing the victim from systems of social support, but it was also a profound disconnection from usual social experiences and everyday joys, such as going for a walk in the forest, talking about the weather with strangers, or asking for advice from your friends about a new shampoo brand. Although everybody experiences reality differently, the victims don't have much choice but to know it through the narratives and definitions given by their abuser, as the excerpt below demonstrates:

"All traffickers find a naive victim, who usually comes from a broken family, and they take advantage of her weaknesses. Being naive, she believes everything he says. He pushes the people around her away to distort her reality, so that no one can step in and say, 'Look at what he's doing, it's not right.' They isolate the victim from the start." (survivor, 27)

Cohabitation is an added risk factor in terms of mental health. During interviews, the survivors outline a claustrophobic context in which they felt trapped due to sharing the same house with the trafficker and his extended family. Our findings also suggest that traffickers usually operate in small groups based on family ties that are connected to other such trafficking operating groups, forming a network. These housing arrangements allowed the traffickers to control the victims' movements, ensuring they remained dependent. One survivor described being allowed only limited visits to their mother under strict surveillance, reflecting the lack of autonomy and constant monitoring. Attempts to leave the cycle of trafficking are met with obstacles, threats, and retaliation.

Shame and social stigma. The emotional abuse included destroying the victim's self-worth, making them feel helpless and alone. Yet, the ones who took advantage of the victims, pimps, 'friends' or drug dealers, relied very much on general societal attitudes that devalue women in general and are particularly harsh and discriminative towards those who are sexually exploited: *"You are very lonely and often you feel worthless. The people around you make you feel that way." (survivor, 34)*

Societal judgment amplified the victim's emotional suffering. Fear of judgment keeps the victims silent, even in front of their families. If they speak, they fear they won't be believed or that the response they receive would be harmful. Survivors often discussed family environments where maintaining appearances or adhering to societal norms was prioritized. Growing up in households where societal judgment was feared discourages openness about struggles or abuse. In some cases, family members were complicit in or sided with the

abusers. For example, one survivor mentioned having family members who supported the trafficker even after the abuse was exposed:

"Some family members are still on his side, even now. [A few years back] I joined a programme for the protection of victims of trafficking, with a protected address. And can you realize that from [then] till nowadays, I still have family members who are on his side?" (survivor, 34)

Coping mechanisms. Alcohol and drugs are the most mentioned coping mechanisms, which can make existing abuse worse or be a reason for the victims to stay in the exploitative relationship or even to be complicit with the trafficker because of developing addictions or fear of prosecution from the authorities. Drugs are both a deliberate instrument to control the victims and a coping mechanism for victims to survive in a profoundly harmful situation.

Some victims used compartmentalization and dissociation to cope, such as creating alternate personas when forced into sexual activities to endure exploitation. Others who dealt with feelings of hopelessness and lacking the confidence to act were shutting down and numbing out, especially when extremely negative emotions were arising. Yet, dissociation or numbing was never a long-term solution, and the recurrent negative, sometimes suicidal thoughts are a strong indicator in this sense.

One respondent evoked an acute sense of longing for ordinary life and mundane conversations, indicating a profound disconnection from usual social experiences: *"I really missed normal life so much […] just chatting about how nice it rained yesterday..." (survivor, 34)*. In this case, escapism into memories or imaginative projections of a mundane world helped her cope with the exploitation, but also fuelled her desire to free herself.

After trafficking. The period of trafficking leaves a mark on their mental health as all the victims report chronic anxiety and stress, including having flashbacks or nightmares, hypervigilance in public spaces, experiencing panic from various triggers such as specific perfumes or bodily odours, avoiding situations, places and other things related to the traumatic event, difficulties in sustaining romantic relationships or trusting men in general.

B) The physical impact of human trafficking on victims

The testimonies provided by our respondents point to some of the most common medical problems that victims encounter during and after being sexually trafficked. Episodes of physical abuse, health issues, and medical neglect inhabit their narratives. The most mentioned effects on health are injuries and diseases related to sexual exploitation, reproductive health issues, bodily harm, substance abuse and overdose, chronic pain, and dental problems. All these conditions are detailed below.

Physical injuries. Since traffickers often used sexual violence and severe beatings as a means of control and punishment, most of the victims had long-term injuries, such as fractured ribs, head trauma, and other internal organ damage. The physical abuse involved hitting, grabbing, slapping, hair-pulling, and even biting. Those who tried to resist were subjected to intensified abuse. After the abuse, the traffickers are reluctant to access care, so oftentimes, the victims were denied medical assistance. Because of the nature of the work, which most of the time involves nudity, the traffickers were often careful not to cause too visible damage, such as large bruises. In one extreme case, the victim was drugged, forced to engage in violent sexual activities, threatened, and hit repeatedly with an axe, which left her with life-

lasting scars. When she finally managed to escape and seek help, her bruises were so large that the state authorities had technical problems measuring the bruises:

"They took my statement and left; they were coming the next day to take me to INML [National Institute of Forensic Medicine]. At INML, the ruler wasn't enough for them [INML professionals]. Their ruler wasn't enough to measure the bruises I had." (survivor, 33)

In another case, one victim describes how she developed an abscess in her kidney due to beatings endured after the trafficker discovered that she refused to enter the private rooms with various clients in a brothel in Germany:

"And that's when the beating started, with the broomstick, I remember, and with the leather belt. He hit me on my hands, legs, and back. It hurt so bad. He even displaced my kidneys." (survivor, 30)

Although these are the most severe cases of bodily harm, based on the stories shared by the survivors, physical punishments are common in sex trafficking. In some cases, sexual violence was used as a complementary method to intimidate and humiliate the victims, such as coercing sexual contact with the trafficker or pressure to have more sexual contact with clients. In one extreme case, where intense physical constraints were used, the victim describes enduring extreme pain during sexual contact with the trafficker because of penile implants.

Regarding **reproductive health**, the most common gynaecological issues mentioned are various infections caused by bacteria, fungi, or viruses. Candida infections, HPV infections, and urinary tract infections were the most frequently recalled. The possibility of getting a sexually transmitted disease is correlated to the duration of the trafficking, with victims who were forced into prostitution for longer periods of time being more at risk of having sexually transmitted infections (STI) or other health problems. None of our participants was diagnosed with an STI at the moment of joining the NGO assistance and protection program for trafficking survivors. Youth is a protective health factor, as young people typically possess stronger immune systems, making them more resilient to infectious diseases. At the same time, many STIs have no noticeable symptoms. So, the STI test results don't exclude the possibility of a virus infection (such as HPV) and developing specific symptoms later in life when the immune system is weakened.

Nonetheless, it becomes clear from the stories the victims shared that sexual infections are common among those sexually exploited, especially among those who are forced into street prostitution.

Sex trafficking survivors have also indicated that their engagement with health systems was, in many cases, determined by the availability of testing for sexually transmitted infections and reproductive health services. They mainly chose to visit private clinics in these situations. Yet, searching for medical professional help was not always an option. Therefore, in some cases, untreated infections and a lack of preventive care led to worsening health outcomes, as it becomes apparent from the quote below:

"I've always dealt with Candida. Of course, with all the trauma to my genital area, I've ended up with ongoing sensitivity. It's really bad. I mean, I have to be careful all the time when I use the toilet – where I go, how I sit, and what I do – because of the sensitivity I still have. […] And

urinary infections are frequent. [...] So a la long, let's put it this way, the trafficking period still haunts me to this day […] I honestly don't know how it will be if I ever decide to have a child." (survivor, 34)

Often, the trafficker also encouraged the victims to treat their health conditions at home, using over-the-counter medication. There are two reasons behind this behaviour. On one hand, since most of the victims were not insured, a visit to the hospital or a clinic implied significant financial costs, especially if they were abroad. On the other hand, a medical visit came with the risk that the victim would speak up and reveal their state of exploitation. Therefore, unless the condition was severe and the pain acute, oftentimes at home treatment was the preferred choice to deal with medical problems. Denying medical care is considered by the UN as a form of physical abuse.

Except for denial of medical care, another aggravating factor related to reproductive health was that the trafficker forbade the victims to talk to each other when experiencing symptoms of sickness or disease. This was an especially risky behaviour in case of sexually transmitted diseases, when different exploited women were sharing the same spaces, such as bathrooms or dorms. This situation created a heightened state of anxiety for some of the victims who constantly worried about their health status, as it is clearly articulated in the following fragment:

"They looked a certain way, like they were somewhat healthy, but I never really knew about their health [the other victims]. Because, of course, if I saw one of them sick, I didn't want to stay in the same house as her or share the same toilet. These things weren't talked about. Naturally, you were always on high alert and had to take care of yourself." (survivor, 34)

Pregnancies and subsequent miscarriages, and abortions were frequently recounted by the survivors. Although it is impossible to tell with certainty, the stories shared by the victims point to their trafficker as the one responsible for their impregnation. Reproductive coercion didn't result from the desire of the trafficker to have a child with the victim (most of the traffickers already had children from official relationships), but it was another form of domination, in which they stripped the victim from the ability to control their own reproductive system.

"I had three pregnancies with him [the trafficker]. From which only one was an abortion. The rest were miscarriages." (survivor, 34)

Yet, a pregnancy, although unexpected, can also be a motivator for the victims to manage their addictions and seek a way out of exploitation, as was revealed by one case we analysed. In another case, the victim found out about the pregnancy only when doing the medical tests requested after entering the NGO assistance program for VOTs, as revealed in the testimony below:

"After the trafficking period, when I got here, a few days later, I had all the tests done, everything. Everything was fine. Along with the tests, they did a pregnancy test, and it came back positive, with two lines... [...] I was in the early stages, about four months and a bit." (survivor, 25)

Abortions and miscarriages can come with lasting emotional repercussions, especially when lacking a social support system. A victim recalls the moment during her trafficking period when

she had a miscarriage at home and she had to rush to the hospital, but was reliant on her trafficker and his family to understand what has happened to her:

"I felt so, so sick, I just couldn't take it anymore. I said, 'I'm really sick, I can't take it anymore.' [...] I had a miscarriage. I woke up, told him. I had already miscarried at home, but I felt really sick. He saw how pale I looked [...] He came, took me, we went to the hospital, they did the check-up, and they told me I'd lost the pregnancy. I didn't speak much because I didn't speak [to the doctors] because I didn't speak French." (survivor, 34)

Many victims are forced to take **drugs**, either to endure their suffering or to increase their compliance to sexual exploitation or are voluntarily choosing to do so as a coping mechanism. In some cases the victims described instances when they experienced increased heart rate and respiration which could be related to the use of stimulant drugs, along with the adrenaline and state of euphoria. Drug use can develop into addiction, which can lead to long-term health problems and damage to internal organs. In one case we analysed, drug use lead to psychosis:

"I started screaming: 'I'm going numb, I can't feel my hands.' It was something really shocking for me. They [the ambulance staff] had probably seen this kind of thing before. I hadn't experienced it up until that point. [...] It was one of the first times for me. I've had more episodes like that." (survivor, 27)

In the most extreme cases, it can also cause death by overdose. One victim reported experiencing a near-fatal overdose while in prostitution in Spain and was treated poorly at the hospital because she was assumed to be a drug addict. Drug use and unprotected oral sex can also lead to serious oral health problems including generalized dental caries, periodontal diseases, and tooth loss.

C) Proactive health measures

Some victims had a proactive approach to health prevention, being acutely aware of the challenging and high-risk environments they were activating in. In two cases, the victims emphasized taking control of their health by securing necessary medications and treatments in anticipation of potential issues or having regular tests and medical check-ups. What sets these two cases apart from the rest is the higher level of education, which translates into heightened alertness regarding their health. These respondents mention consistent health screenings out of concern for potential infections or illnesses. The medical check-ups included recurrent gynecological examinations, as described below:

"There's the possibility of getting Candida. There's also the chance of getting HIV. Because before I came here, I was getting tests done regularly, every six months, because I was really scared." (survivor, 27)

Some other health prevention measures mentioned by the victims included hygiene practices, preventive medication, protective measures during sexual encounters, and managing their mental health.

In terms of hygiene practices, some of our respondents recalled being careful to disinfect shared spaces, like bathrooms, to minimize risks of transmitting infections. Use of personal hygiene routines, including bathing after every encounter and changing bed linens were also mentioned, especially in the case of brothels.

Preventive medication included the use of contraceptives like birth control pills to avoid unwanted pregnancies or self-administration of anti-inflammatory medications and other treatments as precautionary measures.

One of the most positive pieces of information that our respondents shared during interviews is the importance of protective measures during sexual encounters. Except for the sexual contact with their trafficker, which is usually unprotected, as it results from the interviews, all the victims insisted on the fact that they used condoms during their encounters with the clients to prevent sexually transmitted infections or unwanted pregnancies. For instance, one of the survivors recalls the measures taken by the sex clubs in Germany which had a strict condom-use policy that was often broken, at the clients' requests:

"Normally, the club had a strict rule about using condoms. Those who didn't use them did it for extra money, you know? If they found out at the club, they'd throw them out. Pretty much everyone did that, except me. Yeah, I was scared of that [of not using condoms]. God forbid. What if someone [client] comes... What should I do? So I made sure to be careful. And I didn't go with just anyone [selecting clients]." (survivor, 26)

Finally in order to manage the mental burden, some victims recall engaging in relaxing activities to cope with stress and maintain psychological well-being, like listening to calming music or temporarily dissociating through character role-play.

5.1.3. Experiences of Victims of Trafficking Interacting with Healthcare Systems

The trafficking survivors we interviewed sought medical assistance in a variety of healthcare settings, both within Romania and abroad. While experiencing sexual exploitation in foreign locations, most respondents reported primarily accessing emergency units in the cities where they were situated. The frequency of their visits, the severity of their conditions, and the diversity of health issues they faced highlight the profoundly detrimental impact that sex trafficking has on victims' health. Despite this, during interviews survivors hinted at a level of presumptive distrust in healthcare systems and HCPs, which meant that only in crisis situations did they seek professional care. Their lack of trust was partly conditioned by their trafficker who encouraged them not to trust any authorities. Yet, oftentimes it was largely determined by their previous negative experiences with the medical systems and limited knowledge of their rights or how to navigate healthcare settings. When trafficking took place externally, this situation was aggravated, as both language and cultural barriers prevented victims from seeking medical treatment or imposed significant barriers to consent and privacy. Since medical settings didn't represent safety, trust, or assistance for the victims, the victims were less likely to disclose their exploitative situation to the HCPs they met. In fact, one of the most critical research findings is that, in most cases we analysed, the survivors didn't explicitly mention being exploited and abused. The more sad reality shared by our respondents is that,

with only one exception, no medical professional had enquired them about this, despite the visible bruises, signs of distress or the presence of a controlling accompanying person. Furthermore, according to victim testimonies, the HCPs did not recognize signs of abuse or coercion, with some ignoring indicators of trafficking or domestic violence and failing to provide assistance.

The interviews also revealed that VOTs interact selectively with different domains of healthcare practice. The most used medical services were part of secondary care, where specialist treatment and support is needed. The victims recall accessing a wide range of healthcare facilities including gynaecology clinics, emergency units, specialized hospitals, psychiatric units, or family doctors. Yet, it is interesting to notice that private clinics and services were preferred in case of preventive care, while state hospitals and emergency rooms were the default option in case of reactive care. For example, private clinics, such as Sanador or Synevo, were mentioned for regular gynaecological checks, tests and screenings, including consultations related to pregnancies and reproductive health.

Meanwhile, the public medical infrastructure was most often used for addressing health issues and medical conditions after they have already occurred, including treating injuries and surgery. Referrals to specialty services came from emergency health departments (either ambulance or hospital emergency reception units), including voluntary or compulsory psychiatric hospital admissions. Dental services were noted as relevant in cases of sex trafficking, as dental problems are often linked to drug use or physical violence. However, except for one case, no trafficking survivor we interviewed mentioned visiting a dental clinic during or after being trafficked.

It is worth considering that victims rarely mentioned their family doctor, which is typically the first level of primary care and the first contact with the healthcare system for the general population.[64] This situation is probably resulting from the increased spatial mobility of the VOTs, with some victims spending long periods abroad, while others are moving from place to place due to unstable housing conditions, which makes them less likely to be anchored in a specific place and community, and thus have regular visits to a general practitioner. In the single case where family doctors were mentioned, they were described as points of continuity for care. However, the interview also highlighted the family doctor's lack of empathy and interest. This is sadly a double-missed opportunity. On the one hand, family doctors were vital to delivering personal, comprehensive, and continuous healthcare to patients. This is particularly important in case of victims of sex trafficking. Having a complete account of a patient's medical history can increase the doctor's awareness when specific symptoms and conditions associated with trafficking appear, such as losing weight or unexplained bruises.

On the other hand, previous research has shown that survivors of trafficking may be less reluctant to disclose their experiences of trafficking if they trust the HCPs[65]. Yet, trust is hard to gain, especially in criminal environments, and it usually comes from repeated interactions and developing relationships over long periods. In the current configuration of our healthcare

[64] The INS statistics for 2021 show that 51.1% of the population had visited their family doctor or general practitioner at least once in the last 12 months.

[65] Lorvinsky J, Pringle J, Filion F, Gagnon AJ (2023) *Sex trafficking survivors' experiences with the healthcare system during exploitation: A qualitative study*. PLoS ONE 18(8): e0290067. https://doi.org/10.1371/journal.pone.0290067

system, the family doctor has that unique opportunity to build trust with their patients and encourage them to reach out for support when needed. Thus, they should be a central part of any prevention plan including preventing trafficking from occurring, preventing the negative impacts of trafficking and preventing re-trafficking.

Since a lot of VOTs end up reaching out for healthcare when in emergency situations, it is worth briefly describing how the national system of emergency medical assistance is organized in Romania. According to Ministry Order no. 1706/2007, the emergency reception unit (UPU) or emergency room (CPU) is available to all patients who seek emergency medical assistance for acute symptoms, whether they are new or arise from pre-existing chronic conditions. They are open 24 hours a day and free of charge, regardless of the quality of the patient's insurance.[66] Every emergency unit has social assistance available in charge of managing the social cases requiring medical care, including cases of child abandonment, domestic abuse, people faced with homelessness, etc. Upon arrival in the UPU or CPU, the patients are assessed and classified by a competent person (physician or paramedic), taking into account their clinical condition and a series of other factors (age, the stability of vital functions, the potential for worsening of their condition, etc.). The doctors on duty will decide the necessary investigations and will refer the patients to various specialist doctors and, based on the results of these preliminary interventions, decide the longer term care plan. The patient has the right to be informed about the state of their health, the proposed medical interventions, the potential risks of each procedure, the existing alternatives to the proposed methods, including the non-treatment and non-compliance with medical recommendations, and information about the diagnosis and prognosis. In emergency medical interventions, written consent is no longer necessary. The patient's relatives and friends can be informed about the progress of investigations, diagnosis and treatment, but only with the patient's consent. The patient can expressly ask not to be informed and to choose another person to be told in their place. Yet, most interviews revealed that hospital policies regarding consent and patient confidentiality were often breached, especially in emergency rooms.

Confidentiality, consent and safety. According to interviews with survivors, HCPs did not always verify the identity of the accompanying person, allowing situations where the patient was subjected to medical examinations without privacy. Many of the testimonies suggest that the victims were not allowed to speak for themselves during medical consultations. Instead, traffickers or their family members spoke on their behalf, sometimes making medical decisions without their direct consent. In some cases, the trafficker pretended to be the husband of the victim, without anybody checking that information.

Oftentimes, the abuser remained present even during gynaecological consultations, making it impossible for the patient to speak freely. Doctors and nurses did not communicate diagnosis or treatment plans directly to the patient in several instances. Instead, they relayed information through the accompanying individual, reinforcing the patient's lack of control over their

[66] N.B.: While people generally have free access to emergency medical care at UPUs or CPUs, there are some differences between insured and uninsured individuals in the national health system. Individuals without insurance are entitled to a minimum package of basic services free of charge: medical-surgical emergencies, diseases with epidemic potential, and childbirth. There is an exhaustive list of diagnoses and procedures included in this package. The list can be found in the Methodological Norms for the application of GD no. 521/2023 for the approval of service packages and the Framework Contract that regulates the conditions for providing medical assistance, medications, and medical devices within the social health insurance system, from May 30, 2023. If an uninsured person faces a situation outside of the list, they will have to pay for the medical services.

healthcare. Some patients experienced intimidation through non-verbal threats, such as being stared at by their abuser in a way that conveyed the message '*I will hurt you if you speak*.' A victim clearly articulates this lack of autonomy and breach of confidentiality during her medical encounters and how it made her feel invisible:

"I mean, I can't say I come from a high social class, but I did know how to talk, how to say what hurt [...] and I understood what the doctor was saying to me. But as long as he [the trafficker] was talking, I... I basically didn't exist." (survivor, 34)

Intimacy and confidentiality were most often associated in the victims' narratives with the need to feel secure in medical environments. Most survivors declared they would have preferred medical enquiries be made in privacy, confidentiality, without judgement and in a calm environment. Many expressed a desire for HCPs to show interest, empathy, and concern. There was no precise data that would point to the fact that female victims prefer female HCPs. Lack of education and fear of judgement further contributed to the uneasiness that many victims felt about discussing their health concerns with the doctors or undergoing specific medical procedures.

Furthermore**,** patients were not always asked to sign forms for medical procedures or were pressured into consenting without fully understanding the medical implications. Other times, doctors provided minimal or no explanations about diagnoses or treatments. For example, in one case, a patient was nearly injected with medication in Germany without a proper diagnosis or clear explanation.

"They told me they were going to give me an injection, to dissolve whatever was in my stomach. But they hadn't done an MRI, just an ultrasound and some scans of my back and abdomen. Then E. [the trafficker's main partner] came to see me after four days [in the hospital]. She came in and said, 'Look, they have to give you an injection in your stomach, and you need to sign a consent form for it.' And I was like, 'I'm not signing any consent for an injection, because I don't even know what's wrong with me.'" (survivor, 30)

At the same time, more respondents emphasized victim agency and respecting boundaries, even when HCPs have clear suspicion indicating trafficking. This is especially important when considering reporting trafficking to law enforcement agencies. According to our respondents, the best approach for the medical professional would be to present various options to the victim, to inform them on their rights and to report to authorities only with the patient's consent. The below testimony points to the delicate line between help and harm when dealing with a trafficking situation:

"If she doesn't want to from the start, she doesn't want to [leave a trafficking situation]. End of story. You don't push it, because if you try to convince her, you're actually the one becoming the aggressor." (survivor, 34)

It becomes clear that survivors did not disclose their trafficking experiences for a wide variety of reasons, including restrictions imposed by traffickers, acute pain and stress, lack of trust in authorities, inadequate interpreter services, etc. However, it is important to note that, while some survivors did not disclose their situation, our findings suggest that most want HCPs to enquire about their situation.

"If a doctor had come to me [during a medical emergency in a hospital in Germany] and said, 'Come with me to the office, I want to talk to you privately,' and the doctor started asking questions without the pimp being there or waiting outside [...] I would have spoken up [about the trafficking situation] if they [the HCPs] had taken me to a private room to share my story. Whether it was in Romania or Germany, I would have tried using Google Translate. Ok, I don't speak English, but at least they could have said, 'Look, I can tell something's happened to you. What happened? Can I help you with anything?' Maybe then, I would have opened up, back then in Germany." (survivor, 30)

The interviews revealed that many HCPs failed to protect vulnerable patients. The interviews indicate that, except for systemic causes, discussed below, their lack of action may be due to a lack of awareness about sex trafficking and its diverse typologies. To address this, sex trafficking indicators can help strengthen HCPs' ability to identify and support at-risk patients. However, a list with indicators is just one of many tools available for assisting victims. Notably, victims frequently emphasize that the most effective screening approach involves compassionate and ethical discussions about their situation.

Attitudes of the HCPs. Findings indicated that perceived behaviour and approach of HCPs were determining factors in health outcomes for this patient population. Survivors emphasized that a considerate and compassionate approach from HCPs significantly supported their recovery. They highlighted the positive impact of nurses who calmly enquired about their situation and provided emotional support, social assistance officers who actively engaged (*e.g.*, recommending group therapy or other support services), regular check-ups in hospitals, and empathetic HCPs in general. These supportive interactions not only improved their mental well-being, but also had positive effects on their physical health.

"The empathy [of the medical staff] helped me, but I went willingly [to the hospital]. I mean, I went willingly to tell my story, to let it be known, to move on, to do everything I had to do to lock that guy up and never hear from him again." (survivor, 33)

However, despite these few instances of supportive care, the prevalent attitudes of HCPs, as described by trafficking survivors, consist of a pattern of indifference, judgment, and lack of empathy, as the excerpt below illustrates:

"Maybe I was a little paranoid, or I was... psychotic or... that was just my impression. But yes, lack of empathy. […] But not everyone. But I also felt this: 'She's just another patient. She wanted to end up there [to commercial sex]. It's her fault.' Somehow, this mentality is quite widespread in this country. 'Even if he raped her, she [most probably] was playing the whore, somehow'. That you are to blame somehow and that you deserve your fate. That attitude comes from both women and men alike." (survivor, 33)

Many survivors reported being treated harshly or as if they were at fault for their medical conditions. Medical staff bias interfered with appropriate service delivery to VOTs who suffer from mental illness or drug addiction. As their attention was focused on diagnosis and recommendations on mental illness and drug recovery, they overlooked the signs of trafficking despite indicators of physical abuse being present. One victim described feeling like '*the last piece of trash*' when seeking care after a semi-overdose:

"I was in Spain, for example, and I had a semi-overdose. I got sick and I had to go to the hospital and they treated me like a drug addict. I felt like the last piece of garbage." (survivor, 34)

One survivor mentioned that, when she was in severe pain, a doctor threatened to send her to a psychiatric facility if she didn't '*calm down.*' In another case, a woman was denied proper examination and told she was fine, leading to further abuse at home. This case is particularly relevant to our research as it highlights the strong connection between emotional and physical health. The victim initially sought medical care for stomach aches and migraines; however, diagnostic tests revealed no underlying medical condition. Upon reflection, the victim recognized these symptoms as somatization – a physical manifestation of emotional distress. Such distress can present as various physical symptoms, including headaches, joint pain, stomach aches, nausea, vomiting, fatigue, memory issues, body weakness, and difficulty breathing. It is crucial to recognize that doctors may overlook the impact of stress from exploitation, making these unexplained symptoms an important red flag for identifying potential VOTs.

"I was really internalising everything, a lot. Yeah, because it was like... It was the psychological side of things, I just couldn't deal with it. He [the trafficker] was stressing me out because I didn't want to do it anymore. And he needed money right now, but I didn't have any to give him. So, of course, I ended up at A&E. He took me there, and then I started feeling nauseous and throwing up. I explained to the doctor what [symptoms] I had. The doctor was really mean to me, no empathy at all. [She asked the trafficker] 'Sir, why did you even bring her? She's fine, there's nothing wrong with her.' And when the doctor said there was nothing wrong with me, I got in the car and got beaten up [by the trafficker]." (victim, 34)

Failure to Identify Signs of Trafficking. HCPs often failed to ask basic safety questions, such as whether the patient felt safe or needed help. In some cases, visible signs of abuse, such as bruises or malnourishment, were ignored. In others, doctors and nurses suspected something was wrong, but did not intervene or report concerns.

"I ended up at the hospital [in Brașov]. The people there were really rude. It was all so cold. You can't go up to them and tell them [about the abuse]. When they asked you what had happened, you felt like... I don't know, like you'd stolen something. I just felt like there was no way out, honestly, like I was trapped." (survivor, 27)

Cases of Compassionate Care. A few HCPs demonstrated genuine care and concern, especially those with prior experience working with vulnerable populations. Some survivors were eventually referred to support groups or social workers, which helped them break free from their situations. For instance, one survivor noted that a single caring nurse who offered comfort and conversation helped her regain trust in medical care.

"I became friends with this woman, a nurse there [at the psychiatric hospital]. She told me she'd worked at a hospital for three years dealing with drug addicts, and she said she'd never seen anything like the kind of poisoning I had. She was really kind and helped me a lot." (survivor, 27)

Overall, the accounts highlight systemic failures in recognizing and addressing the needs of VOTs, with apathy and judgment being common experiences. However, they also suggest that small acts of empathy from HCPs can make a significant difference in helping survivors seek safety. The Romanian medical system was described as unprepared to identify and address complex cases, including HT and related exploitation.

5.1.4. Barriers and Facilitators in Accessing Healthcare

These barriers highlight how personal fears, social stigmas, and systemic issues intertwine to restrict access to healthcare. A survivor clearly articulates the interplay between structural aspects such as poverty and individual obstacles, like lack of knowledge when accessing healthcare.

A) Systemic Constraints

A recent analysis by the European Commission reveals that, despite an increase in health expenditures in Romania over the past decade, the country still ranks second to last in the EU in both health spending as a percentage of GDP and per capita.[67] Workforce shortages in the health sector, bureaucratic inefficiencies, corruption, and inadequate healthcare infrastructure were mentioned as significant barriers to accessing care.

Yet, by far, trafficking survivors most often talked about the **lack of health insurance** and the implicit financial constraints as one of the most significant barriers to accessing care. According to the law, VOTs receive free medical services through the CNAS. Yet, these measures apply only to the identified victims, leaving at risk the women who are currently in a situation of sexual exploitation.

"One of the obstacles was definitely the insurance. Because before I worked and had insurance, I was paying for my own meds. And if you don't have the money, especially if you're just out of trafficking or don't have any support, like no NGO [to support you]... If you've just come out or escaped, or something like that and you're trying to rebuild your life but need to take treatments, whether it's for HIV, hepatitis, or whatever […] and you don't have insurance because you haven't worked or you've been doing this [prostitution] for years because it was easier or for other reasons – and you can't get your meds for free to be treated – well, you're not gonna make it and things are just gonna get worse." (survivor, 33)

Medical costs caused financial difficulties for the VOTs. Without the state to provide adequate financial protection, victims struggled to pay for the health services they needed. Without health insurance, some victims opted for private medical services. The lack of personal financial means and minimum state support was remedied by the efforts of non-governmental organisations, who covered the medical consultations and tests needed by the victims, after exiting trafficking.

[67] More information on this topic can be found in the European Commission's report. *România. Profilul de țară din 2021 în ceea ce privește sănătatea,* https://health.ec.europa.eu/system/files/2022-01/2021_chp_romania_romanian.pdf

"Besides the psychiatric hospital, I went to the dentist and so on. Everything was out of my own pocket. Gynaecologist – absolutely everything. I went to a private clinic. Let's understand the fact that most of the girls who end up trafficked come from disadvantaged backgrounds. [...] They don't have insurance, they can't... Basically, you're tied up, you know? It's like being unemployed. And no one's there to help you. I mean, if you get pregnant, that's even worse." (survivor, 27)

Therefore, the lack of economic security can reduce access to healthcare, undermine health, increase poverty and exacerbate medical and socioeconomic inequalities.

Inadequate healthcare infrastructure contributed to limited access to care and a transactional approach to care of the health professionals. Several survivors mentioned that doctors seemed to prioritize money over care, especially in private settings. Medical consultations often felt rushed, as if patients were just '*another case to get rid of.*' During crises, such as the one determined by COVID-19, the prioritization of virus-related cases led to delays and neglect of other urgent healthcare needs.

"I think there's also a lack of staff. And I don't entirely blame them, because I've never been in their situation. I'm just telling you things from the patient's point of view. But I've never put myself in their shoes, because I get that there are really serious cases. People having heart attacks, people with metastasis, people in horrible pain, with cancer. I understand them too. But it just feels like they don't... they don't have a plan." (survivor, 27)

Medical system corruption. The stories shared by our respondents revealed that corruption continues to weigh on the Romanian healthcare system. The main forms are bribery and influencing the HCPs by the use of private social networks. Some victims recall needing to pay under the table to obtain the services from doctors and nurses:

"I went straight into the hospital hall, through an acquaintance. I knew there was a doctor, a female gynaecologist, who was really good at the time. […] I simply stepped to the nurse who was an acquaintance of the gynaecologist, and slipped her 50 lei. She went, spoke to the doctor who was there, and, of course, the consultation went ahead." (survivor, 34)

In conclusion, the interviews revealed that medical costs, the quality of medical services and the attitudes of HCPs can either facilitate or hinder a survivor's willingness to seek healthcare assistance. They indicate that a lack of empathy, burnout, or dismissiveness among healthcare providers created additional barriers to care in case of the VOTs who sought medical assistance. Fear of social judgment, victim-blaming and fear of retaliation from the trafficker further discouraged survivors from reaching out for help. Stigmatizing attitudes can have severe consequences, exacerbating mental distress. Ensuring a compassionate and nonjudgmental healthcare environment is crucial in addressing these barriers and improving access to care for trafficking survivors.

B) Individual Barriers

Based on the accounts shared by our respondents, we identified several individual barriers to accessing healthcare, including fear and trauma, shame and stigma, lack of support, educational barriers and reluctance to seek help.

Fear of judgment or being labelled (*e.g.*, as "*a loose woman*" or responsible for their situation) by healthcare providers or society coupled with internalized feelings of unworthiness or guilt discouraged victims from seeking care. Many victims felt like they were treated like burdens, unwelcomed, and felt like HCPs were quick to label, victim-blame, and pathologize them.

In some cases, the reluctance to seek professional medical help was projective, but in a lot of cases it came from previous negative interactions with the medical system, as described before. As a result, some victims recalled a 'misplaced independence', *i.e.* a hope or illusion that they can manage their health alone, without specialised intervention.

Fear of retaliation or harm from traffickers and abusers constitutes further barriers that prohibited and prevented trafficked women from accessing and engaging with healthcare systems in Romania and abroad. In some cases, the anxiety that the trafficker can cause harm extends to their family members and even to HCPs, as the quote below demonstrates. One interview also revealed concerns about losing custody of children or facing other family related repercussions if they disclose their circumstances.

"They don't want to get involved because they're scared. Usually, traffickers can hurt you, they can hurt your family, and no one wants to complicate their own life for someone else's, even if they are doctors." (survivor, 27)

Educational barriers. A lack of knowledge about navigating the healthcare system or seeking appropriate care prevented some VOTs from accessing services. Challenges like knowing which doctor to visit, long waits, and limited resources further hindered access. These barriers were often coupled with practical difficulties, such as no access to transport, which further limited the survivors' ability to visit healthcare providers.

Lack of support. VOTs often face severe social isolation, imposed by their traffickers, which limits their access to family or social support networks when seeking healthcare. In some cases, victims themselves delayed informing their families about health issues due to feelings of shame and fear of exposing their situation. Additionally, traffickers actively discouraged cooperation and friendships among victims, further preventing mutual support. As a result, survivors lacked both individual and community support systems that could have contributed to their physical and mental well-being, leaving them entirely dependent on their abusers or traffickers for managing health concerns.

C) Facilitators in Accessing Healthcare

The victims mention the following facilitators to accessing healthcare:

Support from organizations: Assistance from NGOs or foundations that provided moral and logistical support in accessing medical services. Involvement of external institutions (*e.g.*, through legal or social processes) to facilitate healthcare access.

Emergency medical services: Availability of round-the-clock services in emergency rooms ensures care during critical situations.

Empathy from healthcare providers: Instances where compassionate HCPs showed understanding and provided necessary care. Providing compassionate and non-judgmental care led them to develop trusting relationships that strengthened health-seeking behaviours.

Social networks: Support from family members or trusted individuals who assisted with medical appointments, covered costs, or offered emotional support.

Personal determination. Victims' self-motivation to seek help despite challenges, often driven by a desire to recover or protect loved ones.

5.2 Analysis of Interviews with Healthcare Professionals

Participants Overview

The HCPs who took part in this research included a primary care physician, two resident emergency physicians (A&E), and three specialist emergency care providers, all with experience in primary emergency care during initial encounters with VOTs and potential victims. Three participants worked at Sibiu Clinical Emergency Hospital, two at Elias University Emergency Hospital, and one at Bucharest University Emergency Hospital UPU. Among the six participants, only three had received training on HT prevention, and one had received training in managing sexual abuse and assault victims.

5.2.1. Recognising Potential Victims of Human Trafficking

A) Awareness of Human Trafficking and Spotting the Signs

Participants who attended anti-trafficking training had a better understanding of the issue and felt more confident in identifying and referring potential cases. For example, one participant (HCP_PR3) successfully identified and referred a trafficking case, despite facing challenges within the system. They later shared their experience with colleagues in meetings, which sparked significant interest and proved valuable in improving their approach to such cases. However, this was not consistent across the sector. While those with knowledge felt confident in handling such cases, they noted that many colleagues lacked the necessary skills. Some participants also felt inadequately informed and emphasized the need for a clear protocol and proper training (HCP_PR4). Another aspect involved the possible VOTs. Participants emphasised that some might not be aware of their own victimhood and discussed the fine line between victimisation and perceived normalcy for VOTs (HCP_PR2).

Signs of trafficking and possible exploitation. Apart from the medical cases involving physical and genital trauma, the non-verbal and body language of victims and especially the involvement of carers, family members or others (*i.e.* those accompanying the possible victims to the hospital) could raise red flags for medical staff. Apart from that, much of the information that is collected through the medical history and linked to the medical emergency at hand helps practitioners identify signs of exploitation, which could be later referred to the competent authorities. Suspicious and questionable signs that participants noted were: hiding signs of physical or genital trauma (HCP_PR4); strange tattoos with names of people and dates (HCP_PR3); others trying to control the narrative and information and/or exercise control over an adult patient (HCP_PR5); cases presented as being sexually abused by boyfriends which happens as often as once a month or once every two months (HCP_PR5); non-verbal communication from the patient, especially if they are accompanied by others (potentially the trafficker or perpetrator) (HCP_PR6).

All the cases where the patients/victims are accompanied by someone create suspicion, especially if the participants noted changes in the behaviour of the patients, their stories or simply the way in which the accompanying person behaves. As mentioned in previous sections, patients accompanied by others – such as potential traffickers or perpetrators – who attempted to intimidate them or the hospital staff were seen as clear signs of possible exploitation. Participants were able to follow up with these patients and collaborate with colleagues to respond appropriately to such situations. Moreover, participants suggested that, especially with the underage patients who are viewed in a different emergency unit, the risks of exploitation could be significantly higher and should be investigated.

Labour exploitation and slavery – 'slugoi' – represented yet another example of signs that suggested exploitation. One participant identified such a case, presented below, and talked at length about the context of children and young people who could end up in exploitative situations in rural and underdeveloped areas of the country. This specific case referred to a young boy – possibly a minor at the time of exploitation – who was uneducated, isolated, subjected to forced labour under extremely precarious conditions on a farm (could also be as a shepherd, or helper of a shepherd). Both the physical examination and conversations with the boy led the participant to seek support and refer this case to social services as possible labour exploitation:

"I had an 18-year-old patient, illiterate, who came to the emergency room beaten and bruised. When I asked him what was wrong with him, you could see the fear in his eyes, you could see he was terrified, extremely withdrawn, and visibly panicked. At one point, a colleague snapped a glove, and he didn't know where to hide. It was clear that something had happened to him… I asked where he would go from here [after leaving the hospital] and he said he didn't know. Then I asked him if anybody knew he was here [emergency room], and he said, 'I hope they don't find out'. At that moment, I called the social worker and started the whole procedure." (HCP_PR2)

Trafficking versus domestic violence (DV) and sexual violence. Given the complex and hidden nature of HT, participants highlighted challenges in identification, particularly due to its overlap and conflation with sexual violence, assault, and domestic violence. Participants discussed cases in their practice where it was unclear whether the situation involved HT or solely sexual assaults and domestic violence. The lack of cooperation and engagement from

victims further reduced efforts to act. Such examples also included cases of women being intoxicated with drugs or alcohol (HCP_PR6), or involving nightlife:

"There have been situations where the patient had a torn perineum and other things, and needed to be taken to the operating room. I repeat, I don't know if they were victims of human trafficking, or had simply been raped. So I've had situations where young girls went to a club the night before, got drunk, and the next day came in claiming they had been raped by a man who had brought them home." (HCP_PR5)

Domestic and sexual violence. Participants considered domestic violence cases to be common and noted that '*many times domestic violence and trafficking intersect'* (HCP_PR1). They described situations where a wife was involved in prostitution to provide for her family, highlighting the difficulty in distinguishing cases where domestic abuse is intertwined with sexual and psychological abuse.

"From my point of view, there is a very fine line between domestic violence and – not necessarily sexual exploitation, but psychological exploitation, because this is where it seems to be the most complicated to me… It seems to me that it is very difficult to distinguish between these cases." (HCP_PR2)

"Similarly, a 21-year-old girl, beaten by her husband – they had been married for 24 hours. She had been severely beaten, with bruises all over her body… When I saw her, I asked her if she had called the police or filed a complaint. [She said] 'No, I wouldn't even think of that. He's my husband, I love him.' She didn't even wait to be examined – she just left. I think she was heading towards a trafficking case, because she had a certain look… a little weird… I don't know how to say, slightly naked. And I think it was out of love for him. At some point, that's where it all leads [i.e., to trafficking]." (HCP_PR3)

Due to the often complex nature of these situations, participants regularly consult colleagues and seek guidance when assessing potential trafficking or exploitation cases for referral.

B) Consultations and Collaboration in Handling Potential Human Trafficking Cases

Consultation and collaboration. Participants consistently discuss suspected exploitation cases with their supervisors, team members, colleagues from other departments or social workers. They seek guidance on referral steps, identifying available resources, expediting the referral process, and ensuring the potential victim's safety within the hospital. Given the absence of a protocol in dealing with potential cases of HT and exploitation, they work to identify solutions:

"If you raise a question mark like that [i.e., possible exploitation case], I like to respect the hierarchy. And then, when I identify something like that, I go to the shift manager all the time. There's a shift manager on every shift… if they don't understand, then I consult with other doctors who are more experienced or senior, and we see what decision is to be made in this case. However, I don't have any problem with bypassing the hierarchy. I try not to do it, I try not to break the normal chain of command, but if I have to, I don't have a problem." (HCP_PR2)

"I contacted the head doctor on duty in the gynaecology department that evening. It was a kind of blind luck, because I understood that this doctor had previously dealt with similar issues and had the phone number of an association that works on the protection of sexually exploited individuals and human trafficking. He put us in touch with someone from this agency who was able to come and offer help to the person." (HCP_PR5)

Police cooperation and involvement. A step forward often requires the involvement of police in dealing with potential trafficking cases. Depending on the urgency (apart from sexual assault, which needs to be referred either way), they call 112 or use contacts they or their colleagues have of specific departments dealing with trafficking [*e.g.*, Organised Crime Brigade (BCCO) or Directorate for Investigating Organised Crime and Terrorism (DIICOT), ANITP or different NGOs]. The police were considered '*close colleagues, since we often work with them'.* (HCP_PR2)

Collaborations with others involve social workers, psychologists within the wider team in the hospital or other departments such as social services (*e.g.*, DGASPC) or immigration services. These collaborations are essential in cases of high vulnerability and/or possible exploitation. So far, some participants considered that these collaborations exist, but there are limitations within the emergency department regarding the existence of well-established teams (*e.g.*, social worker and psychologists) who should follow up with these cases and further refer them to the appropriate entities for support. This element was missing, thus adding more pressure on the HCPs in dealing with such cases, as the following examples suggest:

"[It would be good to] know that you have access to a prepared team, other than the police and the social worker. A complex team that you can call at any time. So, information and access – that is, the leverage. Ok, it's useless to have information if you can't use it correctly. So I think these two are the most important… I do my part medically, and the others do theirs." (HCP_PR1)

"If I have a phone number that can be called at any time to have them come and handle the situation, letting them take care of it and do their own thing, I have no problem. But think about it — in the Emergency Room, as a doctor, I have 10-15 other patients, for example, at that moment. And if I have a case like this, I am blocked. I can't care for the other 10 patients because I will have to handle all the administrative work related to this case [trafficking]. But if you have contacts that you know you can call and they take care of everything, it lifts a big burden off your shoulders." (HCP_PR5)

Therefore, collaboration and procedural efficiency should be enhanced through proper protocols, enabling HCPs to focus on their duties while ensuring that potential victims are appropriately referred and cared for by the relevant departments. This will be further examined in the Recommendations Section.

5.2.2. Interactions with Victims and/or Potential Victims of Human Trafficking

A) Initial Stages of Medical Contact with Victims of Trafficking

Arrival at the medical unit. Given the study's context and within the three settings where data was collected from, most victims or potential victims arrive in the emergency room by ambulance, alone, or accompanied by others. Upon arrival, common symptoms and medical

issues include abdominal pain, bleeding, gynaecological concerns, and broken limbs. After initial assessments, medical history review, and registration, patients are referred to appropriate departments based on their medical needs. Most of the cases are seen in the emergency room or, in some cases, at a special centre for sexual assault at the hospital outpatient clinic (HCP_PR6).

Encountering patients who use false information/identity. Participants highlighted challenges in identifying individuals who use false identities. Hospitals rely on ID numbers, but cannot verify their authenticity or track medical histories. Such practices were acknowledged as common. Some participants also noted collaborating with the police in these cases to address similar situations (HCP_PR1). However, in the first instance and for providing emergency care, the identity was not considered relevant, as for later referring possible victims and keeping track of exploitation or medical history.

Accompanied by the trafficker and/or others at the hospital. It was not uncommon for victims to be accompanied by others (*e.g.*, mother, husband, partner), including traffickers in confirmed cases of trafficking. While conscious adults do not require accompaniment during consultations, participants reported instances where perpetrators remained present, displayed aggression, and exhibited behaviours that raised suspicion of exploitation or abuse. One case included an abuser who was a police officer, and the participant emphasised the great level of intimidation and control that went beyond the victim themselves (HCP_PR1). Some participants described witnessing victims' fear, hesitation, and ambivalence in disclosing information, changing their statements or just avoiding sharing any information. Such cases were often marked by a lack of cooperation, due to external pressure, control and coercion, as reflected in the following excerpts:

"She said she was afraid to give more details because he was outside the hospital, waiting for her with other people, including one individual who was trying to ask for information about her from outside. They refused to give him any details. He tried to approach the Emergency Room and the triage nurses to ask for information about the patient, but I simply wouldn't give it to him. He was pretending to be a family member. I told him that I personally provide information to patients, and as long as they are conscious [awake/aware], I have no right to share any details with anyone other than the patient about their diagnosis and medical condition." (HCP_PR5)

"*I understood that she was accompanied to the hospital yard by the person who was assaulting her. Usually, they tried to maintain control as much as they could."* (HCP_PR1)

The level of control and coercion puts the victim at risk even in the hospital, as hospital staff lack the knowledge and resources to effectively deal with traffickers, as illustrated by the following example:

"… if the trafficker knows how to talk to the nurses. He's the kind of guy who, let's be honest, can slip a little money in their pockets and could come in at any time. I think it's important to intervene quickly. That nurse, who is 60 years old and nearing retirement, might not understand. She wouldn't understand what human trafficking means, and that no one is allowed to come in to see that patient." (HCP_PR6)

B) Observations on Encounters with Victims of Human Trafficking

Some participants had encountered at least two confirmed trafficking cases in their careers, along with other suspected but unconfirmed cases. They detailed the victims' stories, the disclosure process, medical issues, and referral steps to specialized services. References to 'gaining trust', 'showing care', 'empathy', and 'professionalism' were made. However, they also mentioned the challenges they face, such as a lack of time, a high volume of cases and difficulties in spotting the signs or acting when there is no cooperation from the victim.

"She was young with abdominal pain… And I took her in. I started to consult her and talk to her, and when I began to undress her to see what was going on, I saw that she was covered in bruises. Then, I noticed that she had some suspicious tattoos – one on each hand, with a man's name and a date. And that was the moment when she raised my greatest suspicion, and I started to ask her questions. Eventually, she told me that she was practicing prostitution, that she supported the man in question, that he beat her regularly, and that she had been tied to a tree for about two days. I also found out that she had recently given birth, about two or three months prior. She was breastfeeding and had a little baby. And I started the investigations. She had a 20-centimeter liver hematoma, in addition to several broken ribs in various stages of healing. She had been beaten badly! I asked her if this was the first time [this had happened]. I reported it, and then asked if she agreed to file a complaint. That was basically the only thing I was focused on – if she wanted to file a complaint... Because, while I was legally and morally obligated to report it, I felt it was more of a moral obligation." (HCP_PR3)

Other cases were less straightforward; for example, participants described situations where patients disclosed inconsistent or dubious stories, which were later attributed to mental health issues and no further action was taken (HCP_PR5). Similarly, there were instances where a woman engaged in prostitution initially reported sexual assault, but ultimately, she admitted that her claim was a form of revenge against her pimp (HCP_PR6). As medical priorities are complex and often shift away from the social aspects of cases, such stories and disclosures are frequently not followed up on. A participant discussed the medical duty and priorities of their work:

"Healthcare professionals are trained to prioritise the medical situation, regardless of any suspicions or external factors. Focusing on medical care is essential, as distractions – whether due to a patient's mental condition or other circumstances – can lead to critical oversights, for which they remain accountable." (HCP_PR1)

Observations on the profile of victims. All the cases included young females where Roma ethnicity was frequently noted, linked with instances of domestic abuse and violence (HCP_PR1; HCP_PR3; HCP_PR5).

"[Roma ethnicity] that's what it seemed to me. Later I understood that she had been practicing prostitution since she was 13. But over the years the trafficker changed." (HCP_PR3)

"She was a girl of about 20 years old; she was young, thin, of Roma ethnicity." (HCP_PR5)

Another common characteristic was represented by motherhood. In most of the cases encountered, victims and potential victims had children.

C) Engaging with Victims of Human Trafficking: Disclosure and Confidentiality

Direct disclosure cases are rare, as participants noted: '*Nobody would ever come to tell us that they are trafficked*' (HCP_PR3). However, in some cases, it was noted that victims sought ***medical assistance as an escape opportunity.*** For instance, HCP_PR5 presented a similar case, in which the victim planned her escape in this way:

"She also had a child and managed to leave him with her sister. Once she had gotten herself out of that situation, so to speak, and removed the child from harm, she called an ambulance to run away from there. I mean, she couldn't have done that before because of her child, for fear that something would happen to the child if she reported that person. I don't even know how much of it was a medical case, so to speak [...] She had come solely to get out of that house, to escape from that individual." (HCP_PR5)

The reasons for disclosure include an inability to endure the violence or exploitation, finding the right time and place, or encountering individuals whom the victim can trust. However, when victims do disclose, they often express concerns about their safety and the safety of their family, seeking assurances of protection. Beyond safety, factors such as shame, blame, discrimination, and the normalization of violence are perceived as barriers to disclosure and engagement. Participants stressed the ***importance of effective communication***, asking the right questions when exploitation is suspected, and ensuring that potential victims feel safe and heard. The following examples present questions asked in cases where the medical staff suspected trafficking and victims later confirmed they had been trafficked:

"Are you unwell? What is causing you discomfort? What are you anxious about? Ok, let's talk.' I told her directly that a team would come and take care of everything. 'Are you being mistreated? We can't deal with anxieties ourselves. I don't know [how to do this] personally, but there are much more qualified people that I can refer you to." (HCP_PR1)

"The first question [I asked] was, 'Who is hurting you?', because I wanted to know whether it was a partner, a husband, or a parent – because that happens too. She then told me it was her partner, and I think she wanted to talk to someone. It seemed like she had reached the end of her tether, after enduring so many beatings in the last few days. She said it had gotten worse over the last week and that she had been tied to a tree, and I think she wanted to escape." (HCP_PR3)

Issues with ***confidentiality in medical settings*** were also raised by participants***.*** Emergency rooms are typically overcrowded, resulting in low levels of confidentiality in interactions between medical staff and patients. All participants agreed that, due to the high volume of cases and limited time per patient, individuals often feel embarrassed to share personal details in such environments.

"I think confidentiality is extremely important, but it is a bit difficult to ensure. If the patient confesses [that she is a victim], we do have a room, for example, where we can take her. We identified an examination room that we share with pregnant women receiving a certain type of treatment. This room has its own bathroom, it has everything it needs so that, at least in the case, as we see now, of sexual assaults, patients feel as comfortable as possible. They are not exposed to the gaze of others, of other patients, and can speak freely and there is a practical flow just for her. But what about others? Until they disclose their situation, we have

no way of taking them all there [in that room] and open up discussions. In addition to that, we also need to have time to spare. In that sexual assault case, even though it seemed straightforward, it took me over two hours to handle, yes, over two hours. There is still a lot to explain." (HCP_PR6)

Consequently, disclosure of HT is also limited by the lack of confidentiality within the medical context, as suggested by some participants.

D) Pathways and Referrals for Support: Police and Support Services

Medical referrals are common according to the medical needs of the patients. Cases of sexual abuse are also referred to INML for further forensic investigations and examinations. Moreover, when sexual abuse or any type of aggression is suspected, HCPs are obliged by law to inform the police: '*I told her that it was my obligation to inform the police, and it was her choice whether or not to file a complaint'* (HCP_PR4). Thus, by admitting victims to the hospital for treatment and further investigations, they provide time for reflection on whether they want to get in touch with the police or other relevant entities, such as ANITP:

"In the meantime, I managed to admit her to the surgery ward so that she wouldn't have to leave the hospital that day. It made things easier; the ANITP team was also able to come during the week, and things went really well. After some time, I was interested in finding out what had happened to the girl, and I learned that she had ended up in a centre, that she had brought the girl from the man they had arrested." (HCP_PR3)

"Initially, she was afraid to contact the police. I explained to her that, in principle, this is how it should be done, and I asked her why she was afraid, that, after all, she was in a hospital, we had security, and from there, the police could take her and offer protection. She said she had a child and that, because of the child, she couldn't report him [the perpetrator], let something happen to the child. Later, I also contacted the head of the department and the gynaecologist. They came, and we talked to the patient. She later refused to call the police." (HCP_PR5)

Consent challenges. Apart from the standard medical procedures for collecting data and medical samplings, which require patient consent, one HCP discussed the challenges involved in notifying the competent authorities. For instance, although the majority suggested that they would be obliged to inform the police, one participant also pointed out the necessity of obtaining patient consent, as the following example suggests:

"Yes, so I think we automatically notify the police once the person agrees. That is, until they give their consent, there is nothing I can do. That is, I could be wrong. Until proven otherwise, I could be wrong. And if I call the police on my own initiative and they vehemently deny it, saying: 'No sir, I was not assaulted, it was someone in the family…', I would feel stupid for having called the police for nothing. So the patient must automatically agree. The victim's consent is the most important factor. The longer we delay this, the longer it takes to call the police." (HCP_PR5)

Another issue of consent arises when individuals attempt to ***obtain information on behalf of the patient*** (or potential victim). Participants recalled instances where others sought information on the patient's behalf but appeared suspicious, resulting in no information being disclosed. For example, in one case, an individual claimed to be the patient's uncle, but did

not even know her name, which led to a refusal to share any details (HCP_PR5). In another instance, an individual accompanying the patient was not permitted to remain in the consultation area. Later, it was discovered that he had falsely presented himself as a patient to stay close to the potential victim.

Offers of support. Participants described collaborating with hospital social workers, where available, to assess victims' needs and refer them for support when necessary (HCP_PR6). They emphasized the importance of establishing clear protocols and procedures to ensure that the information provided to victims and potential victims is accurate and consistent, while also avoiding false promises about available support:

"You must avoid making promises. Don't make promises that you can't keep. Secondly, you can't give her concrete data. You can tell her that there is an option available, but ultimately let her decide what she wants to do with her life in the short term or the long term. [She should know] that she can choose to leave at any time, if that's realistic. If she doesn't think it's okay, it's very important that she knows she can go back to what she wants. That she won't be confined, that she won't be forced to follow any particular course. No one is forcing her to do anything but what she wants; she's simply being given the opportunity to do what she wants and not what others want for her." (HCP_PR1)

Victims refuse support. All participants dealt with cases where victims refused any type of support or referral, even when there were clear signs of exploitation. Such findings resonate with the wider literature on rejecting support. Moreover, some participants noted that *'9 out of 10 cases would not accept support'* (HCP_PR1), while others recalled specific cases where *'practically it all stopped there… I thought she would accept that phone number, but she didn't even want that'* (HCP_PR6). As mentioned in earlier sections, participants observed that in certain cases where signs of constraint were evident, although victims initially disclosed and engaged with the medical staff, they later refused any type of support and referral. This was attributed to the perceived benefits of support and security being limited and insufficient to meet victims' needs:

"Here she presented the situation as such, after which, as with all cases, I think, of this kind, there are a lot of fears related not only to personal safety, but also to the safety of the family. What followed probably didn't give her the security she needed, and so she gave up on taking the next steps, even though we tried to offer her some sense of security. We made an effort, both myself and the competent authorities, to explain to her what could be done to ensure both her safety and that of her family." (HCP_PR01)

Consequently, VOTs often refuse support, even when clear signs of exploitation are evident. Despite initial engagement with HCPs, many victims later withdraw from seeking further help due to deep fears for their own safety and that of their families. Additionally, participants suggested that possibly the support offered often fails to meet their needs or provide the level of security they require, leading them to abandon any efforts to pursue further assistance.

E) The Risks and Role of Healthcare Professionals in Preventing Human Trafficking

One of the main risks identified by participants in medical settings was the ***physical safety of HCPs***, due to a lack of proper security on hospital premises and the generally risky situations

they deal with. They mentioned that, in general, security personnel were not physically fit for the task. The following excerpt captures the widely shared perception about security in hospitals:

"Yes, let's say, just in writing, if you ask me. I mean, I don't want to create problems for others in the hospital, but I can say that I trust the stretcher bearers on the team more than the security, sometimes. I mean, if there's a bigger guy on guard, I have no problem, but when you see an old man who's 70 or 60 years old, I still think we need much better security." (HCP_PR5)

Encounters with recalcitrant or intoxicated patients were common, and participants described incidents of violence, including physical assaults on colleagues. One participant recounted stories where patients and their families arrived at the emergency room armed with '*knives and swords*' (HCP_PR4). Similarly, another participant described a violent episode and emphasized that the workplace can become a hostile environment:

"It happened to my colleagues a month ago, when a guy, just because he was drunk, got up from his chair, slapped a pregnant colleague, broke her lip, ripped another colleague's shirt off, and kicked another colleague in the legs. It's hard to stay focused. If you lose sight of a patient or one of these drunk people for a second, you have a very high chance of getting into trouble, and it becomes super stressful. It becomes a very hostile environment. You can't stay calm anymore, you can't do your job properly." (HCP_PR2)

Risks connected to trafficking. Nevertheless, participants acknowledged the inherent risks in their work and the broader limitations of the medical system. Regarding HT, one participant noted that some HCPs may fear perpetrators, although this was not a concern for her (HCP_PR3). She recalled informing a colleague about a case, where she was advised to be cautious, yet she felt secure in the emergency room due to its controlled environment. While she did not personally feel threatened, she believed most HCPs likely experience fear in such situations. Only HCP_PR1 was directly impacted by a trafficking case, in which the perpetrator was a police officer. During the consultation, he accompanied the victim and attempted to intimidate the HCPs by leveraging his position. However, the participant managed the situation by adhering to protocols and preventing him from approaching the patient. The case was later confirmed as trafficking and the trafficker was imprisoned. Subsequently, the participant was informed that the trafficker had followed his car for some time.

"I was informed that the person followed my car for about two weeks and they told me, 'We'll be behind you too. So don't panic. If it's not him, it's us anyway.' Him being a police officer made everything more difficult. After that, I did indeed give a statement at the trial. The statement was anonymous, although I understand that he found out my name and everything, which could later represent a risk factor. I guess... I know that he knew who I was and where I worked. I don't know if he knew where I lived, but being from the police… It was quite difficult. I didn't keep in touch with those who dealt with it, precisely for safety reasons… Anyway, I think cases like this are terrible. He, on the other hand, didn't interact directly with me, such as to send me any direct threats. He probably knew that doing this could expose him much more easily. But indirectly, I told you that I also found out from the Organized Crime people, that yes, he followed my car for a few days, and so on." (HCP_PR1)

One participant highlighted the risk of ***legal action*** against doctors, a concern not raised by the others participants. Lawsuits are often filed for reasons such as malpractice or

dissatisfaction with medical procedures. However, in cases involving HT – particularly in identifying and referring victims – the participant suggested that the potential legal implications might deter HCPs from getting involved, due to fears of facing legal consequences.

"It's very true and it seems very okay to me, but it comes with the fear of courts and lawsuits, which is growing in Romania. I don't think there is a doctor who hasn't had at least one lawsuit. There's no way to combat that, because everyone does their job the way they know best." (HCP_PR1)

Incentives for trafficking cases. Participants indicated that there were no incentives for identifying trafficking cases, nor should there be. They agreed that referring cases is both a medical and ethical responsibility, driven by their professional conscience (HCP_PR2).

"There are no such incentives, but there shouldn't be, because what happens in this field should really just be part of the job, regardless of whether you're a family doctor or have another specialisation." (HCP_PR6)

Some also noted that they derive pride from resolving cases both medically and non-medically (HCP_PR1). One participant emphasized that, despite the challenges of working in the medical unit, motivation and passion should drive their work, thus being prepared to deal with the risks and any challenges brought by the context (HCP_PR2). Consequently, as it will be discussed later, incentives could be translated into clear guidelines for practice and sufficient resources within hospitals to ensure that they have the capacity to deal with trafficking cases, including referral mechanisms.

Finally, the ***role of healthcare professionals in preventing, identifying, and responding to HT*** was generally viewed as a *'human responsibility'* (HCP_PR3) extending beyond their medical duties, particularly with respect to ensuring proper referral procedures. However, a clear referral process must be established. While participants acknowledged their role in recognising signs of exploitation, they did not see it as solely their responsibility, but rather a shared duty, relying on a specialised team to handle such cases (HCP_PR1). As the following example suggests:

"Since it raises a question, they must call and deal with it further until another entity reaches the trafficked person, so that she can have a chance to move on. If you identify her, you call 112." (HCP_PR3)

One participant highlighted factors that may hinder referrals and actions by HCPs, including a lack of knowledge, potential risks and repercussions for those making referrals, and work-related pressures.

"First of all, fear – the fear of *repercussions on you as an individual. Then, preparation. Lack of preparation, basically. Like many other major system deficiencies that we have at the moment, that would be one of them. First, everything starts with preparation… Have you identified it? You have to do this, this, this, this, this, and then pass it on. Goodbye! Nobody knows about you anymore, nobody knows that you identified it, nobody knows that you passed it on. And here, it is also about data and information security."* (HCP_PR2)

Finally, prevention efforts should be integrated at all levels of the medical system, including family doctors, school doctors, and nurses. Clear referral pathways must be established, ensuring anonymity for those making referrals and minimizing any associated risks.

5.2.3. Migrants as Potential Victims of Human Trafficking

Given the current migration context in Romania, migrants represent a newly emerging group requiring further attention. Participants discussed the challenges of working with these patients and identifying potential signs of exploitation. As a demographic, the participants reported cases from Ukraine, Asia (*e.g.*, India, Pakistan, Bangladesh, Nepal, Sri Lanka, China), and the Middle East, all involving migrant workers in various industries.

Medical issues. Migrants are seen on a daily basis, with cases occurring regularly: '*we have migrants daily, 4 to 5 per shift*' (HCP_PR3). The primary medical concern reported was digestive issues, while other conditions included work-related injuries, back pain, cuts, alcohol-related problems, colds, the flu, and chest infections. Participants did not observe severe signs of abuse or exploitation, apart from digestive problems, which they attributed to environmental changes and the precarious living conditions migrants experience, as the following example suggests:

"… which indeed, some of them live in miserable conditions or are not properly fed, leading to a lot of intestinal problems – gastroenterocolitis, enterocolitis, gastritis, ulcers, and so on. We come across these very frequently." (HCP_PR2)

Medical staff faced significant challenges due to ***communication and language barriers***, which often hindered their ability to engage effectively with patients. While English was commonly used, they occasionally relied on colleagues who spoke other languages, such as Arabic. However, it was widely agreed that Google Translate was the primary tool used to overcome these difficulties, but that did not accurately solve the problems:

"… they don't even know English, it's zero. Zero medical history. We understand each other through signs. He puts his hand where it hurts. Unfortunately, even with Google Translate, there is a language barrier and unfortunately, information is lost." (HCP_PR5)

Signs of possible abuse or exploitation were not often present or noticeable in the overall caseload. However, participants did notice that while the individuals '*did not seem overworked or exhausted*' (HCP_PR3), there were concerns regarding their wellbeing, with one participant questioning whether *'they are given proper food and accommodation'* (HCP_PR3). Another case raised suspicions of potential exploitation, prompting intervention from immigration services:

"We have had situations of Indians and Pakistanis who came to the country for work and were later assaulted by their employers. They were brought to the Emergency Room because they had nowhere to stay, they were isolated in Romania." (HCP_PR5)

These ***immigration issues*** were typically resolved quickly, as participants had direct contacts within immigration and social services who responded promptly to assist those in need*: 'we call a social worker from social services who comes and takes them to a social centre'* (HCP_PR5). However, as some of these incidents occurred at night, the patients (migrants)

had to spend the night in the emergency room until immigration officials arrived the following day. One participant considered this a relatively new issue that is escalating quickly.

Only one case raised suspicions of potential female exploitation. It involved a young woman of Middle Eastern origin who arrived at the emergency room with her husband. The husband's insistence on translating, refusal to leave her alone, and her avoidance of eye contact raised red flags for the HCP (HCP_PR6). However, as she chose not to engage or disclose any concerns, no further action was taken.

5.2.4. The Health of Victims and Survivors of Human Trafficking

As the interviewees had limited engagement with trafficking cases, their knowledge and observations regarding the general health and wellbeing of victims were restricted to instances of physical injuries resulting from severe beatings (*e.g.*, broken ribs, head, chest, or limb trauma) and gynaecological issues. Once victims receive primary care in the emergency unit, they are either referred for hospitalisation or discharged. Emergency care and up to three days of hospitalisation are provided free of charge. However, participants were unaware of whether victims or potential victims had medical insurance, though this did not impact their practice.

Medical staff in the receiving emergency unit do not follow up on cases long-term and are therefore unable to provide clear accounts of victims' long-term health. This was reflected in the following examples:

“The police don't come back to give us feedback on what happens in these situations”. (HCP_PR5)

“Some had anal problems, vaginal problems, other things broke much more easily, but other than that, I can't say in the long term. First of all, the patients have to come back for re-evaluation. Most of them come back through the outpatient clinic, or they should come back through the outpatient clinic, not through the Emergency Room. But for these kinds of problems, I don't really interact with them anymore.” (HCP_PR5)

HCPs from emergency units rarely are aware of the victim's journey after initial encounters. Yet, depending on the context, some were able to learn about short-term outcomes. One participant recalled: '*I think about two weeks later, the head nurse in the surgery department told me that they had seen her [the victim], and she looked completely different. She was well-dressed, well-groomed, and wearing makeup'* (HCP_PR3). Another participant learned that the case he supported '*was successful on all counts because she has regained her own life'* (HCP_PR1).

The long-term impact remains unclear from these interviews. Participants noted that, beyond addressing medical issues, psychological support and long-term care from specialised services are crucial to ensuring the recovery and well-being of VOTs:

“Medically speaking, their medical pathology must be resolved. But their main problem is their psychological pathology. That's where they need to work, and not necessarily with a psychiatrist, but more often with a psychologist. These people need support and a kind word more than a psychiatrist who will give them antidepressant pills. (HCP_PR3)

"If a complex, long-term support team is not created, they will eventually return to the same environment. But immediate success does not necessarily mean long-term success. That's why a comprehensive network of teams must be established to provide both stability and, later, reintegration. Even if it sounds harsh, reintegration should be a gradual process that helps them see and experience its benefits." (HCP_PR1)

HCPs working in emergency rooms have limited involvement in the long-term well-being of VOTs, as they primarily treat immediate physical or gynaecological injuries. While emergency care, including short-term hospitalisation, is free, staff are often unaware of victims' medical insurance status. Long-term recovery remains unclear, as follow-up is rare. Participants emphasised the need for a holistic approach, including specialised psychological support and social reintegration, to ensure lasting recovery.

5.2.5. Perceptions and Observations on Trust

The lack of trust among VOTs is a common theme in the literature and prevents engagement with authorities, acceptance of support and generally exiting the exploitation situations. This was reflected in this study as well, as participants discussed the general impression they get from victims: '*they have been conned and abused too many times; it's normal that they don't trust anyone'* (HCP_PR3); '*they don't even trust themselves'* (HCP_PR1). However, within this study, participants discussed the lack of trust in the medical system and the barriers they believed victims and potential victims face when attempting to engage with healthcare services.

The barriers and explanations for this lack of trust were commonly agreed upon as stemming from a ***lack of education*** or ***distorted information*** regarding the medical establishment. These issues were attributed to the ***popular negative media*** portrayals of malpractice cases, which are often generalised to the entire medical profession, further negatively impacting public perceptions and undermining trust in the Romanian medical system (HCP_PR2; HCP_PR4; HCP_PR6). Similarly, a recent example mentioned by a participant was the COVID-19 pandemic, during which misinformation and '*fake news'* aggravated the public's perception of and trust in the medical establishment and practice (HCP_PR2). The participant suggested that a comprehensive solution would require both a bottom-up and a top-down approach. ***Education*** and accurate information would help the public develop a better understanding of public health, while the medical establishment must also improve its attitudes toward patients, regardless of their role within the healthcare system (HCP_PR2).

Superiority attitudes among HCPs, particularly those from older generations, were considered another factor contributing to barriers, as the following example suggests:

"Unfortunately, getting older doctors to change their approach is very difficult. They can't change. When they graduated from college, they were taught that being a doctor meant being a god – and that's how they behave." (HCP_PR3)

A ***lack of empathy*** toward patients and, at times, ***possible discrimination and stigma*** – particularly against those involved in prostitution – reduce patient cooperation. Additionally, communication issues among HCPs hinder effective listening. In the emergency room, HCPs handle numerous cases under constant time pressure, often lacking the time or '*patience to*

engage with each patient calmly' (HCP_PR6). However, all participants agreed that a key limitation is the constant pressure on emergency unit staff, who handle high caseloads, making it nearly impossible to establish trust. One participant emphasized the importance of staying objective and focusing solely on the medical issue to gain trust, with a proper referral pathway in place to support this (HCP_PR5). It was commonly agreed that HCPs need to have the proper knowledge regarding available support and acknowledge their limitations in addressing trafficking: '*not to make promises that you cannot keep regarding available support*' (HCP_PR1).

Finally, participants also encountered issues with patients' attitudes regarding medical priorities and general health and wellbeing (HCP_PR1; HCP_PR2), as well as cases that are difficult to engage with and gain trust due to a lack of understanding and literacy:

"There's also this thing when it comes to victims of sexual abuse and human trafficking. There are many people who have a fairly low IQ and no matter how much you explain that you're trying to help them – that you're calling the police, that you're supporting them – it's like talking to a wall." (HCP_PR5)

Key findings from Interviews with HCPs revealed that a lack of trust in the medical system is a major barrier for VOTs seeking medical support. This distrust stems from several factors, including negative media portrayals, misinformation (worsened by events like the COVID-19 pandemic), perceived superiority among some medical staff, and potential discrimination against vulnerable populations, such as individuals involved in prostitution. Furthermore, high pressure emergency room environments and gaps in staff knowledge about trafficking hinder patient engagement and effective support. Addressing this requires improved public education about healthcare and systemic changes in HCPs' attitudes and patient communication.

5.2.6. Resources and Barriers in Medical Settings (Emergency Units)

Staff (social worker, psychologist) availability. Participants highlighted the shortage of social workers in emergency settings, noting that, even when available, they typically work limited hours – '*Monday–Friday, 8 AM–3 PM*' (HCP_PR3). A key concern was that HCPs are unable to manage cases of vulnerability or potential exploitation beyond their medical responsibilities. Additionally, overcrowded emergency rooms and high patient intake make it difficult to identify and assist potential victims. Psychologists are also not consistently available across all hospitals and rarely provide 24/7 coverage (HCP_PR6). A common recommendation was to enhance both the quality and quantity of staff, including social workers and psychologists, and ensure their round-the-clock availability in emergency rooms.

"The social worker has a strictly theoretical, so to speak, or administrative role. He can come, say, once a week to discuss with decision-makers what can be done legislatively, what funds can be allocated, and what training or professional re-education is needed… "(HCP_PR1)

"More or less, I know that we have a hospital psychologist, but I'm not sure. I haven't seen one. I've been working in the Emergency Department for 9 years. I've never seen a psychologist come to the emergency room." (HCP_PR4)

"From my point of view, a social worker should be available 24/7. So, if we had social workers available at all hours, like they do in Târgu Mureș, for example, because I know they have a permanent social worker, with a team of social workers working in shifts, just like assistants, one per shift, the management would be completely different. From my point of view, they are the key element. Ok, I have identified the patient as a victim, but from then on, the social worker handles practically everything related to alerting, referring and so on. This seems to me to be the key point in identifying and reporting cases of trafficking, domestic violence, and so on." (HCP_PR2)

The integration of qualified and experienced social workers collaborating closely with medical staff was seen as essential for improving victim identification and enhancing outcomes for potential victims in medical settings.

Materials available and needed. Infrastructure and working conditions vary significantly across the country. While some participants work in well-developed facilities, smaller hospitals often face greater challenges. A key concern was the lack of privacy and confidentiality in emergency units due to insufficient space, including the absence of dedicated confidential rooms. Participants emphasized the importance of having designated spaces – such as a welcoming room with a comfortable atmosphere (*e.g.*, having flowers, armchairs, calming decorations) for private discussions (HCP_PR2; HCP_PR3). Others noted that, in the absence of such facilities, they make efforts to identify suitable areas within hospitals for confidential conversations and consultations (HCP_PR6). Finally, regarding information, some hospitals display posters about abuse and HT, including helpline numbers. However, it remains unclear whether this practice is consistently implemented across all hospitals.

Overall barriers for HCPs in dealing with HT. Barriers to addressing trafficking cases include overburdened HCPs, confidentiality challenges, a lack of knowledge about HT and referral pathways, lack of a protocol, a lack of interpreters for migrants, and limited referral options – particularly at night. Additional obstacles include a shortage of specialized staff such as social workers, inadequate hospital security to ensure victim safety, and legal complexities previously discussed which can affect HCPs and increase their reluctance to act. Additionally, time constraints and case overload faced by HCPs reduces opportunities for communication and victim disclosure:

"I think it took about an hour and a half – the part that directly involved me… I also took advantage of the manager's request to take special care of it [the case], even though I was the head of the shift for that case. But, realistically speaking, if a more serious medical situation arises, you don't have the time allocated to take care of something like that, because there's no excuse for it." (HCP_PR1)

Considering these challenges and barriers, participants proposed solutions and recommendations aimed at improving their ability to identify victims and refer them to appropriate support services, presented in the section below.

6. Conclusions

Characteristics of VOTs: While sex trafficking can affect anyone, our research highlights that certain groups are more vulnerable to exploitation. Key risk factors include gender, poverty, unemployment, unstable housing conditions, young age, a history of personal trauma, and substance abuse. Victims often experience multiple overlapping vulnerabilities, increasing their susceptibility to trafficking. Children exiting state protection systems are particularly at risk. Ethnicity also plays a role in trafficking dynamics, though perceptions differ between victims and HCPs. Victims emphasized the significance of Romanian ethnicity in cases of external trafficking, particularly when individuals lack citizenship, residency, language proficiency, cultural familiarity, or access to essential services in the host country. HCPs, however, primarily identified victims of sex trafficking and domestic abuse as Romanian nationals of Roma ethnicity. Additionally, they noted that Ukrainian and South Asian migrants represent an emerging at-risk group for trafficking and pose challenges to the medical staff due to communication and language barriers. Given the complex and hidden nature of HT, the doctors emphasized challenges in identification, particularly due to its overlap and conflation with sexual violence, assault, and domestic violence.

Health consequences of sex trafficking: Sex trafficking has severe and long-lasting effects on both physical and mental health. In regards to the ***physical impact*** of sex trafficking, the most commonly reported physical health consequences include injuries, sexually transmitted infections, reproductive health issues, substance abuse, and chronic pain. VOTs mention suffering from bacterial, fungal, or viral infections affecting reproductive health. Many endured long-term injuries such as fractured ribs, head trauma, and internal organ damage. Physically abused women were more likely to seek medical attention. Survivors also recounted pregnancies, miscarriages, and abortions as common occurrences. Abortions and miscarriages can come with lasting emotional repercussions, especially when lacking a social support system. HCPs who treated suspected VOTs observed similar conditions, *i.e.* severe physical injuries resulting from beatings and a high prevalence of gynaecological complications. From a ***psychological perspective***, victims often endure emotional manipulation, social isolation, threats, violence, and coercive control, including forced dependency on traffickers for basic needs. These experiences leave deep psychological scars. Survivors reported persistent trauma, including anxiety, depression, paranoia, and post-traumatic stress disorder (PTSD). In some cases, prolonged exploitation contributed to the development of severe mental health conditions such as clinical depression, bipolar disorder, or psychosis, leading to hospitalization. Many victims also disclosed experiencing recurrent thoughts of death, suicidal ideation, or suicide attempts during their exploitation period.

Preventive actions and self-administered remedies: Despite experiencing symptoms of medical conditions, many victims were unable to seek professional healthcare and instead relied on at-home treatments. Several factors contributed to this, including isolation or seclusion by traffickers, high medical costs, distrust of authorities, and a lack of knowledge on how to navigate the healthcare system. In these cases, victims resorted to over-the-counter medications and home remedies, often leading to untreated infections and worsening health conditions due to the lack of proper medical care. Some victims, aware of the high-risk environments they were exposed to, took a proactive approach to health prevention. They sought to maintain control over their well-being by securing necessary medications in

advance, undergoing regular medical check-ups when possible, and taking preventive measures. This included the use of contraceptives to prevent unwanted pregnancies, as well as the self-administration of anti-inflammatory drugs and other treatments as precautionary measures.

Barriers to healthcare access: VOTs face numerous obstacles when seeking medical care, including lack of health insurance, financial constraints, and fear of retaliation from traffickers. While survivors frequently cited the absence of health insurance and financial limitations as major barriers, HCPs were often unaware of their patients' insurance status and stated that it did not influence their daily practice. Both groups highlighted that stigmatization by healthcare providers discourages victims from seeking medical help. At a systemic level, victims identified workforce shortages, bureaucratic inefficiencies, corruption, bribery, and inadequate healthcare infrastructure as significant barriers to care. Similarly, doctors acknowledged the impact of staff shortages, particularly in limiting their time with patients and managing heavy caseloads. Overcrowding in emergency rooms also made it difficult to maintain doctor-patient confidentiality. Several survivors reported that doctors in private clinics appeared to prioritize money over patient care. They also recalled instances where bribery or clientelism facilitated their access to public healthcare services. A commonly recognized barrier was lack of education. HCPs attributed misconceptions about medical practices to negative media portrayals, while survivors emphasized their limited knowledge of how to navigate the healthcare system or seek appropriate care.

Healthcare settings: Trafficking survivors sought medical assistance in various healthcare settings, including gynaecology clinics, emergency departments, specialized hospitals, psychiatric units, and dental clinics. The most frequently used medical services fell under secondary care, where specialized treatment and support were required, often accessed through emergency departments. For preventive care, survivors generally preferred private clinics and services, while state hospitals and emergency rooms were the primary choices for urgent or reactive medical needs. Notably, family doctors – typically the first point of primary care – were not a significant resource for victims. Dental services were identified as relevant in cases of sex trafficking, but they were not frequently accessed.

Confidentiality and consent: It was common for VOTs to be accompanied by others during medical visits, often including their traffickers. Both survivors and HCPs reported instances where perpetrators or their family members remained present, sometimes exhibiting controlling behaviour or aggression. Victims noted that HCPs did not always verify the identity of accompanying individuals. HCPs, on the other hand, highlighted the challenges of identifying individuals using false identities, as hospitals rely on ID numbers, but lack the means to verify their authenticity. Survivors recalled situations where they underwent medical examinations without privacy and were not allowed to speak for themselves during consultations. In some cases, traffickers or their family members spoke on their behalf, made medical decisions without their direct consent, or even falsely posed as the victim's spouse without verification. Additionally, some doctors and nurses failed to communicate diagnoses or treatment plans directly to the patient, further stripping them of autonomy. This lack of confidentiality and personal agency left victims feeling invisible and neglected. HCPs also acknowledged confidentiality issues, but attributed them largely to systemic problems, such as overcrowded emergency rooms. All participants agreed that a lack of privacy in medical settings often makes individuals hesitant or embarrassed to share personal details.

Disclosure of the trafficking situation: Victims were unlikely to disclose their trafficking situation to HCPs. They rarely mentioned their exploitation or abuse explicitly. HCPs confirmed that direct disclosures were exceptionally rare, and when they did occur, it was often because the victim saw seeking medical assistance as an opportunity to escape. Victims' reluctance to speak up was primarily driven by distrust of authorities and fear of judgment. Other contributing factors included restrictions imposed by traffickers, acute pain and stress related to their medical condition, and inadequate interpreter services. Although survivors often refrained from disclosing their situation, many expressed a desire for HCPs to show interest and concern. However, medical staff were generally hesitant to enquire about personal circumstances or further investigate at-risk patients, even when visible bruises, signs of distress, or a controlling accompanying person were present. Both survivors and HCPs emphasized the importance of effective communication – asking the right questions when exploitation is suspected and ensuring that potential victims feel safe and heard. Strengthening these practices could lead to more cases of trafficking being identified.

HCPs' attitudes: The quality of medical services and the attitudes of HCPs play a critical role in either encouraging or discouraging survivors from seeking medical assistance. Trafficking survivors frequently described encountering indifference, judgment, and a lack of empathy from healthcare providers. Their experiences highlight systemic failures in recognizing and addressing the specific needs of VOTs, with apathy and stigmatization being common challenges. However, survivors also emphasized that even small acts of empathy from HCPs can make a significant difference in their willingness to seek help and safety. HCPs acknowledged that time pressures negatively impact their ability to properly assess and respond to at-risk situations. They also pointed to a culture of superiority among some HCPs, particularly those from older generations, as well as a lack of empathy and occasional discrimination, all of which contribute to lower-quality care. Stigmatizing attitudes can have serious consequences, exacerbating the mental distress of VOTs and further discouraging them from seeking help. Creating a compassionate and nonjudgmental healthcare environment is essential to breaking down these barriers and improving access to care for survivors.

Institutional cooperation: Both survivors and HCPs emphasized the importance of collaboration between institutions such as law enforcement, healthcare providers, and social services. However, their perspectives on reporting sex trafficking and intimate partner violence differed. Victims were generally reluctant to recommend reporting such cases to the police without their prior consent, fearing potential repercussions. In contrast, HCPs tended to contact law enforcement agencies regardless of the victim's approval, as they are legally required to report suspected cases of sexual abuse or violence. HCPs described working with hospital social workers to assess victims' needs and refer them for support when necessary. However, they noted that victims frequently refused assistance or referrals, even in cases with clear signs of exploitation. Survivors, on the other hand, highlighted the lack of essential hospital services, such as psychological support and social assistance, as a significant barrier to receiving help.

Risks connected to trafficking: Both survivors and HCPs recognized the risks associated with assisting VOTs, as well as the broader limitations of the medical system in ensuring safety. One of the primary concerns identified was the physical safety of medical staff. HCPs highlighted the lack of proper security measures within hospital premises, making them

vulnerable in potentially dangerous situations. Survivors, on the other hand, emphasized the influence and power of traffickers, noting their ability to inflict harm – even on medical personnel – if they perceived healthcare intervention as a threat.

Training and capacity building: Both survivors and HCPs identified systemic failures in the healthcare system's response to sex trafficking, including a lack of awareness among medical staff, inadequate training, and poor recognition of trafficking indicators. Both groups acknowledged that the role of HCPs in preventing, identifying, and responding to HT extends beyond their medical duties. Survivors called for a more proactive approach, emphasizing the importance of monitoring for signs of abuse and implementing clear protocols for reporting suspicions. While HCPs recognized the need for such measures, many admitted they had not received formal training and did not feel confident in their ability to identify or respond to trafficking cases effectively. HCPs often overlooked trafficking indicators, particularly when treating individuals with mental illness or substance use disorders. In cases where signs of abuse were noticed but attributed solely to mental health issues, no further action was taken. This underscores the urgent need for a clear and structured referral process to ensure that potential victims receive the support they need. Long-term psychological rehabilitation, including counselling services and reintegration programs, was highlighted as essential for survivors' recovery and long-term well-being.

7. Policy Recommendations

In the final section of this report, we offer recommendations that can serve as a foundation to address human trafficking and modern slavery within the healthcare system.

Participants emphasized the need for clear **protocols** to guide HCPs in handling potential trafficking cases. The primary focus should remain on the medical aspects, ensuring that patients receive appropriate care without endangering their lives. In addition to addressing immediate health concerns, establishing communication should maintain a professional approach to building trust. HCPs highlighted that protocols should be simple, clearly outlining identification procedures and necessary actions. A standardized approach and structured guidelines would help ensure consistency in handling cases. One participant mentioned that there are protocols for referrals for other areas (e.g., drug usage, suicide attempt) and HCPs are obliged to fill forms and refer these cases to other departments (HCP_PR2), thus suggesting a similar approach for trafficking. While all HCPs acknowledged that their primary focus is on their medical role, one participant emphasized that maintaining professionalism is essential for effective communication and building trust.

"I think some protocols need to be put in place. You try to isolate the situation. Here, I don't deal with anything else. It's not about being indifferent to the person in front of me at first, but I'm not interested in the fact that you've come here beaten… What concerns me is the medical side of things. You must stick strictly to your role. That is, as I said, a very simple protocol. Identification as such, and then ensuring the next steps are extremely easy. Focusing on the professional aspect is, I believe, the most important thing in establishing initial communication. If they see you're preoccupied with anything else, including their emotional state, you won't gain their trust." (HCP_PR1)

Among the key recommendations for the protocol, participants suggested the following: establishing a clear, concise, and straightforward set of procedures; creating a dedicated helpline through 112; ensuring that referral points are staffed by well-trained professionals; fostering strong collaborations; and developing accessible materials to raise awareness of HT within medical settings.

The protocol and additional forms. Participants emphasized the need for a simple and straightforward referral form with minimal questions. They highlighted the risks associated with lengthy and complex forms, noting that such documents may discourage engagement and potentially cause further harm, as the following examples suggest:

"Make it as simple and logical as possible. You tick three boxes—OK, job done, you pass the case on, and it's no longer your business. That's how I see it. I mean, I don't see it as a long list with 20 indicators or however many there are in total. No one is going to sit there filling in thousands of boxes, 20 lines, and 30 bullet points. There's just not enough time for that, and you'd be overloading people. In the end, they'd just give up and do nothing at all." (HCP_PR3)

"All you need is an A4 page, with a few key points to guide you [...] Let's have some steps in which we can identify the victim with some helpful questions. And from there, it should effectively be like an algorithm. If we strongly suspect that she is a victim, let's notify all the competent staff." (HCP_PR4)

Therefore, a national protocol for the healthcare system in Romania addressing HT should provide clear, standardised guidelines for HCPs who may encounter victims in their practice. The protocol should include the following key components:

7.1. Identification and Screening Instructions

Integration of screening tools into routine assessments would equip HCPs to identify potential victims. This proactive approach is crucial, requiring HCPs and other frontline workers to stay alert to signs of abuse.

A short, clear, and structured screening tool. Such a tool should highlight key indicators and warning signs, encompassing both physical and psychological symptoms[68] that may indicate exploitation. The optimal way to use this tool would be to integrate it into routine patient assessments in a non-intrusive manner. For example, standardised health checklists can include discreet prompts for HCPs to observe behavioural cues, inconsistencies in medical history, or the presence of a controlling companion. By embedding these indicators within routine medical evaluations – such as emergency room admissions, maternity care, or mental health consultations – HCPs can increase the likelihood of identifying victims without making them feel targeted or exposed.

Trauma-informed communication. In addition to providing guidance on recognising these signs, the protocol should include trauma-informed questioning techniques,[69] ensuring that victims feel safe and supported rather than interrogated. HCPs should be trained to create a non-threatening environment, using open-ended questions and avoiding confrontational or overly direct approaches that might cause distress or deter disclosure.

Trauma-informed care. The majority of interviewees emphasized the essential role of empathy in healthcare settings. "However, a victim-centred protocol should extend beyond empathy and specifically integrate trauma-informed care principles. This ensures that healthcare practices acknowledge and address the impact of trauma on victims. Key components include fostering a safe, non-judgmental environment, respecting the patient's autonomy, and empowering them to make informed decisions, all while minimising the risk of re-traumatisation." (Jane Lasonder, Survivor Leader).

[68] A comprehensive list of trafficking indicators, both general, specific and in the medical context can be found in: eLiberare Association, ANITP, DSU, ASSMB, *Practical Guide for Healthcare Professionals for Identifying and Reporting Human Trafficking Cases*, January 2024, pp. 9-19.

[69] *Ibidem*, p. 20. See recommendations on trauma-sensitive communication for HCPs who might encounter potential VOTs in their practice.

7.2. Ensuring Confidentiality and Private Consultations

As a primary concern, the national protocol should include the requirement that HCPs must always conduct medical consultations with the patient alone, ensuring that any accompanying individual is respectfully removed from the room. VOTs are often closely monitored by their traffickers, who may insist on speaking on their behalf or refuse to leave the consultation. This behaviour should be treated as a strong indicator of control. Unless the patient has a diagnosed cognitive impairment that prevents them from communicating independently, no third party should be allowed to interfere with the medical assessment.

Private interview spaces. Therefore, healthcare units should ensure private, safe rooms where HCPs can conduct confidential conversations with potential VOTs. These spaces should allow for uninterrupted discussions, ensuring that individuals feel secure when disclosing sensitive information.

Alternative solutions in emergency settings. If an accompanying person insists on being present or answering questions on behalf of the patient, healthcare providers should find a way to separate them – such as requesting a routine examination in a different room (*e.g.*, for an X-ray or another medical procedure requiring privacy). Ensuring private consultations allows victims to speak freely and enables HCPs to assess the situation discreetly, without raising suspicion.

> *"Best practice policy should mandate that all patients suspected of being VOTs are interviewed alone, without the presence of any accompanying individuals, including family members or those claiming to be caregivers." (Jane Lasonder, Survivor Leader)*

This recommendation is particularly important in emergency rooms, where the flow of patients is extremely high – often 150 to 200 patients per 24-hour shift – while the number of healthcare staff ranges from just 6 to a maximum of 12 (HCP_PR2 and HCP_PR5). Due to limited space, doctors may have to treat patients in hospital corridors, but in cases where a nurse or doctor notices any signs of trafficking, it is crucial to take the patient aside for a private consultation. Otherwise, due to fear or shame, the victim may never open up about their situation.

Maintaining patient confidentiality and trust. In healthcare settings, safeguarding patient confidentiality is paramount, particularly when dealing with suspected VOTs. HCPs must be trained to navigate the delicate balance between respecting patient confidentiality within legal and ethical boundaries and fulfilling their duty to report trafficking suspicions.[70] VOTs may fear retaliation or further harm if they feel that their situation is being exposed or mishandled. Thus, healthcare providers must be sensitive to these concerns and take appropriate steps to protect patient privacy during the reporting process.

[70] Especially in the context of Article 266 para. 1^1 of Romania's Criminal Code: "A person who is aware of the commission of a criminal act involving trafficking, exploitation of vulnerable persons, or offenses against sexual freedom and integrity committed against a minor and fails to immediately notify the authorities is punishable by imprisonment for a term of 6 months to 2 years." (A/N).

Guidelines on mandatory reporting versus voluntary disclosure. It is vital to educate staff on when reporting is legally required and when a victim may choose to disclose their situation voluntarily, but doesn't want to cooperate with law enforcement.

7.3. Referral and Reporting Procedures

Another key component of a national protocol for the healthcare system is the reporting phase, aligned with the NIRM framework. Many HCPs lack awareness of proper reporting mechanisms, highlighting the need for better instructions. To address this, training should be offered to all HCPs, covering trafficking awareness, victim identification, response protocols, and step-by-step guidance on using available tools.

Dedicated hotline. Participants highlighted the need for a dedicated hotline or a structured protocol within the emergency dispatch system to facilitate the reporting of HT cases. They emphasized that simply calling 112 is insufficient, as it does not ensure direct connection to the appropriate authorities. Instead, dispatchers should be trained to recognise and properly redirect trafficking-related calls to specialised entities, such as BCCO or DIICOT, rather than general law enforcement. Given the existing GPS-based regional dispatch system, participants suggested integrating trafficking referrals into this framework to streamline communication and improve response efficiency.

"A list of these [relevant phone numbers] or a hotline would be a useful option. The moment you suspect something, you notify the dispatcher. [...]Once you've made the notification, they know what to do next." (HCP_PR2)

Clear referral pathways and access to support services. We also recommend that each healthcare facility establishes a clear internal referral pathway, with designated contact points and a set of procedures tailored to their specific environment. This ensures that once a HCP identifies a potential VOT, there is a clear, standardised process in place to connect them with the appropriate specialised support services both inside and outside the healthcare unit. Moreover, the referral pathway should be backed up by **regular meetings with the hospital healthcare team** and case reviews, bringing these cases to the attention of relevant staff to enhance coordination and improve response effectiveness.

Tailored procedures for different healthcare settings. To ensure better results, referral and reporting procedures should be adapted to the specific needs of various healthcare settings. These include family doctor practices, children's hospitals, school medicine services, gynaecological wards, emergency rooms and others. For example, an emergency department doctor has significantly less time to spend with each patient compared to a family doctor or a gynecologist, as confirmed by the interviewed doctors. In this context, procedures should be adapted to reflect the specific demands and constraints of each department.

7.4. Multi-Agency Collaboration Framework

A national protocol for the detection and referral of potential VOTs in healthcare settings must be built on a strong multi-agency collaboration framework between institutions and organisations.

Formalised partnerships and protocols. Collaboration agreements should be established between healthcare facilities, law enforcement, and victim support organisations. This includes secure information-sharing protocols that respect patient confidentiality while enabling rapid intervention when necessary. They should also outline roles, responsibilities, and referral procedures and should be regularly updated based on emerging trends in trafficking and lessons learned from case reviews.

Multidisciplinary response teams. Hospitals should have direct access to specialised response teams consisting of trained HCPs, law enforcement officers, social workers, and NGO representatives who can coordinate victim assistance from the moment a case is identified.

Joint training and awareness programs. HCPs should receive regular training alongside law enforcement, social workers, and NGO staff to ensure a shared understanding of trafficking indicators, victim-centred approaches, and legal responsibilities. Cross-sector training fosters trust and ensures all actors involved are equipped to handle cases effectively.

Follow-up and long-term support. A multi-agency approach should also focus on long-term assistance, including medical care, psychological support, legal aid, and reintegration services. Regular case reviews and feedback loops between agencies can help refine response mechanisms and improve victim outcomes.

7.5. Training and Capacity Building for Healthcare Professionals

Participants unanimously agreed that education and awareness of HT are essential in preventing and dealing with trafficking cases. They emphasized that when HCPs and other professionals, such as police and social workers, are well-informed, they can more effectively work together, identify signs of trafficking, and refer cases to the appropriate entities. Awareness was seen as best achieved through training – either integrated into school and university curricula for future HCPs or provided through continuous professional development for HCPs. The following examples illustrate the common perspectives shared by participants:

"Yes, education is power. Knowledge is power. Information is power. [...] From my point of view, if I hadn't had that connection, I would have been at zero. [...] It's clear that it has to start in schools, but specifically in medical schools. For example, [...] in training sessions on malpractice, the organisers recommended that someone from each ward attend. If you manage to capture the attention of one person, the next time, the room will be full." (HCP_PR1)

"That's why I was talking about education. This is the problem. The problem is with training sessions – people need to know what it's all about. They need to know that these cases exist because that is the reality. If you haven't encountered them yourself or if there hasn't been this kind of awareness until now, it's hard to know that such cases exist and that someone has come across them." (HCP_PR2)

Participants suggested various locations for training, including university seminars, presentations, and the annual congress of emergency medicine. While not all staff may receive direct training, key individuals could be trained to later share their knowledge with

colleagues (HCP_PR3). Some participants emphasized the need for more training in children's hospitals, highlighting the increased vulnerability of children to manipulation and grooming. Additionally, HCP_PR6 and HCP_PR3 discussed challenges they encountered in collaborating with the police and social workers on trafficking interventions, suggesting the need for these professional groups to receive more comprehensive training on HT.

"…unfortunately, we've had experience with both the police and social services, who either did not know or did not want to acknowledge this protocol [human trafficking interventions/referrals]. So, we had to remind them of it, and the case was resolved very quickly." (HCP_PR6)

Expert-by-experience Jane Lasonder also emphasises the importance of a trauma-informed, victim-centred approach to interviewing, highlighting the need for police and first responders to be trained in effective communication with victims, particularly during the initial contact.

Participants who attended training or awareness sessions on HT noted that the information was difficult to forget and made them feel more equipped to handle potential cases. Additionally, one participant conducted two presentations for colleagues, drawing from real cases they had encountered (HCP_PR3). These sessions were met with significant interest and engagement from her colleagues.

Based on the participants' responses and on our expertise in the field, we recommend that a national training programme for HCPs should include the following key elements:

Integration of training into medical education and professional development. A dedicated module on HT identification and response should be introduced in medical faculties and residency programs. This module should be aligned with national legislation, including an amendment to Law no. 46/2003, to formalise its inclusion in medical curricula. Another recommendation is that training programs be implemented through the National Institute of Health Services Management and Training Centres for Emergency Medicine Nurses, ensuring frontline healthcare workers receive targeted instruction. Additionally, forensic medicine specialists should undergo training via postgraduate courses for medical and pharmacy students, as well as through The Order of General Medical Assistants, Midwives and Nurses in Romania (OAMGMAMR) for nurses in forensic institutions.

In all cases, we highlight that a well-structured and mandatory training programme for HCPs should include the following key components:

a) recognising trafficking indicators,
b) understanding trauma-informed care principles and
c) knowing the legal obligations and referral procedures.

Ongoing education and best practices. One-off training sessions are insufficient; ongoing education is crucial. Regular refresher courses should be provided to update HCPs on emerging trends in trafficking, evolving best practices, and available resources. We

recommend that training be directly linked to a national protocol, ensuring that knowledge is consistently applied in practice.

Practical application and specialised interview techniques. To ensure practical application, training should incorporate role-play exercises, case studies, and specialised modules on victim-sensitive interviewing techniques. HCPs must be able to communicate effectively with victims of trafficking, slavery, domestic abuse, and sexual violence without causing further harm. Furthermore, all HCPs should be thoroughly familiar with referral mechanisms and reporting procedures to facilitate timely and effective interventions.

Posters and visual aids. Participants highlighted also the effectiveness and practicality of using posters and visual aids to guide HCPs in handling trafficking cases. They suggested that a simple, step-by-step algorithm displayed in emergency rooms and consultation areas could serve as an accessible reference, reinforcing awareness over time (HCP_PR4, HCP_PR6). Additionally, they emphasized the value of brief training videos – such as animations – designed specifically for medical staff. These videos would focus solely on the steps HCPs need to take, ensuring a clear and actionable referral process based on the victim's needs (HCP_PR6).

Avoiding misidentification. HCPs should be trained to distinguish VOTs from victims of crimes like rape, sexual abuse, or domestic violence, as these can overlap. The protocol must provide clear indicators to prevent misidentification and ensure victims receive appropriate support.

Support for HCPs. Finally, given the emotional toll of working with VOTs, HCPs should have access to support systems that help them manage vicarious trauma and maintain their well-being.

7.6. Addressing the Needs of Migrants in Healthcare Settings

Participants noted a significant increase in the number of patients from third countries, particularly in emergency rooms. Given this, a national protocol should include a section on identifying and referring potential victims from foreign countries, with a particular focus on labour trafficking.

Ensuring safety and trust. Migrants who are potential VOTs must be reassured that seeking medical help will not influence their residency status in Romania, even in cases of irregular stay.[71] Fear of legal repercussions often prevents victims from disclosing their situation, making it essential for HCPs to prioritise their safety and build trust.

Overcoming language barriers. Healthcare facilities should ensure the availability of professional interpreters and improve the use of translation apps to facilitate clear and

[71] In Romania, at the moment, when VOTs are identified and found to be residing illegally, they may be granted a temporary right to stay or tolerated status by the prosecutor, the court, or the General Inspectorate for Immigration (IGI) (A/N).

confidential conversations. HCPs should never rely on a patient's accompanying person for translation, as they could be the abuser.

> *"Professional, independent translation services must be utilised. Under no circumstances should the accompanying person act as a translator. If a professional translator is unavailable, a reliable translation application may be used as a last resort, but never the person accompanying the potential victim. Even if the patient and HCP share a common language (e.g., Romanian), a protocol should be in place to ensure a private consultation without any third-party present." (Jane Lasonder, Survivor Leader)*

Cultural sensitivity training. Foreign VOTs come from diverse cultural backgrounds, which can influence how they communicate, their perception of medical care, and their willingness to seek help. HCPs in Romania should receive training on cultural nuances, including beliefs about healthcare, gender roles, and social stigma. This knowledge will help them recognise victims who may not openly disclose their situation and provide care that is both effective and respectful.

7.7. Ensuring Accountability and Continuous Improvement

A final cross-cutting element of a national protocol for detecting VOTs in healthcare settings should be the establishment of mechanisms for **data collection, evaluation, and adaptation**.

Standardised data collection. A unified data collection system should be implemented to track potential trafficking cases while ensuring patient confidentiality. This data can provide valuable insights into trafficking trends, regional vulnerabilities, and the effectiveness of intervention strategies. Aggregated, anonymised data should be used to inform policy decisions, improve training programs, and enhance victim support services.

Regular evaluation and adaptation. The protocol should include **periodic assessments** to measure its effectiveness, identify challenges, and refine procedures. This may involve reviewing reported cases, gathering feedback from HCPs, and conducting inter-agency evaluations to ensure coordinated efforts between hospitals, police, social services, and NGOs.

Consult experts in creating the protocol. Finally, one participant suggested that apart from the advice shared through this study, further consultations with experts in the field would be required to decrease the risks of failure:

"We need to ask as many people as possible. That would seem to me the most important thing. I mean, get in touch with, I don't know, five people from the Emergency Department or five people from Bucharest, Cluj, Timișoara, etc., the big counties, the counties that have an impact and see from there. Plus university professors [...] and so on, the people who created the emergency system in Romania. That's where we must start [...] and from there, you need to figure out exactly how to implement it as simply as possible, to avoid creating a negative impact. Because if it's done poorly, the consequences could be terrible." (HCP_PR3)

7.8. Improving Access to Medical Services for Victims of Human Trafficking

To ensure uniform access to medical care for victims of trafficking (VOTs) across the country, CNAS should implement a standardised intervention framework in all counties. The medical services package for trafficking victims should explicitly cover gynaecological care and treatment for sexually transmitted infections, ensuring comprehensive and specialised medical support.

By embedding these recommendations within the national protocol, we consider that Romania can ensure a more effective, responsive, and victim-centred approach to addressing HT in healthcare settings.

Bibliography

1. ANITP, *Mecanism național din 31 ianuarie 2023 de identificare și referire a victimelor traficului de persoane*, https://anitp.mai.gov.ro/ro/docs/legislatie/MECANISM%20NAŢIONAL%20din%2031%20ianuarie%202023.pdf.

2. ANITP, *Rapoarte* (2019-2023), https://anitp.mai.gov.ro/subiectele/cercetare/rapoarte-anuale/.

3. ANITP, *Strategia Națională Împotriva Traficului de Persoane pentru perioada 2024–2028, mai 2024*, https://anitp.mai.gov.ro/ro/docs/Despre%20Noi/Anexe/Strategia%20Nationala%20Impotriva%20Traficului%20de%20Persoane%202024-2028%20RO.pdf.

4. Council of Europe, *Convention on Action against Trafficking in Human Beings, Warsaw, 16 May 2005*, Council of Europe Treaty Series - No. 197, https://rm.coe.int/168008371d.

5. Council of Europe, *Explanatory report to the Council of Europe convention on action against trafficking in human beings*, 2005, https://rm.coe.int/16800d3812.

6. Elena Mihaela Iagăr (coord.), *Starea de Sănătate a Populației din România, Institutul Național de Statistică*, https://insse.ro/cms/sites/default/files/field/publicatii/starea_de_sanatate_a_populatiei_din_romania_2019.pdf.

7. eLiberare Association, ANITP, DSU, ASSMB, *Ghid practic de identificare și sesizare a cazurilor de trafic de persoane pentru personalul medical*, ianuarie 2024, https://eliberare.com/personalmedical/wp-content/uploads/2024/04/04-30_MNIR_personal-medical_2024_eLiberare.pdf.

8. eLiberare Association, *Curriculum pentru detectarea și notificarea cazurilor de trafic de persoane pentru personalul medical*, https://www.eliberare.com/wp-content/uploads/2024/04/Curriculum_Personal-Medical.pdf.

9. eLiberare Association, *Curriculum pentru detectarea și notificarea cazurilor de trafic de persoane pentru personalul medical*, https://eliberare.com/personalmedical/wp-content/uploads/2024/03/Curriculum_Medici_final_compressed-3.pdf.

10. eLiberare Association, *Detectarea și notificarea cazurilor de trafic de persoane. Resurse pentru personalul medical*, https://eliberare.com/personalmedical/.

11. eLiberare Association, *Este pacientul tău o victimă a traficului de persoane?*, https://eliberare.com/personalmedical/wp-content/uploads/2024/04/04-30_poster-MNIR-A35mm-bleed.pdf.

12. eLiberare Association, *Indicatori specifici ai traficului de persoane în context medical*, https://eliberare.com/personalmedical/wp-content/uploads/2024/03/Indicatori-specifici-ai-tdp-in-contextul-medical_updaded-2.pdf.

13. eLiberare Association, *Modern Slavery Fund Romania Project Proposal, unpublished concept note for the project Addressing Human Trafficking within the Romanian healthcare system*, funded by the British Embassy in Romania.

14. eLiberare Association, *Perspectivele supraviețuitorilor traficului de ființe umane asupra actorilor comunitari*, 2022, https://www.eliberare.com/analize-si-studii/.

15. European Commission, *Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on the EU Strategy on Combating Trafficking in Human Beings 2021-2025*, https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52021DC0171.

16. European Commission, *România. Profilul de țară din 2021 în ceea ce privește sănătatea*, https://health.ec.europa.eu/system/files/2022-01/2021_chp_romania_romanian.pdf.

17. European Parliament and the Council of the EU, *Directive (EU) 2024/1712 of the European Parliament and of the Council of 13 June 2024*, https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=OJ:L_202401712.

18. European Union, *EU Progress Reports on the fight agaist human trafficking*, https://home-affairs.ec.europa.eu/policies/internal-security/organised-crime-and-human-trafficking/together-against-trafficking-human-beings/publications_en.

19. Eurostat, *People at risk of poverty or social exclusion in 2022*, 14 June 2023, https://ec.europa.eu/eurostat/web/products-eurostat-news/w/ddn-20230614-1.

20. Eurostat, *Trafficking in human beings statistics*, 3 January 2025, https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Trafficking_in_human_beings_statistics.

21. Hemmings, S., Jakobowitz, S., Abas, M., Bick, D., Howard, L. M., Stanley, N., Zimmerman, C., & Oram, S., „Responding to the Health Needs of Survivors of Human Trafficking: A Systematic Review", în: BMC Health Services Research, 2016, 16, Article 320, https://doi.org/10.1186/s12913-016-1538-8.

22. Institutul European pentru Egalitatea de Șanse între Femei și Bărbați, *Combating violence against women in Romania*, https://eige.europa.eu/sites/default/files/documents/2016.5491_mh0416665enn_pdfweb_20170215100610.pdf.

23. Institutul Național de Statistică, *Starea de sănătate a populației din România*, 2021, https://insse.ro/cms/ro/content/starea-de-s%C4%83n%C4%83tate-popula%C8%9Biei-din-rom%C3%A2nia-1.

24. Jain J, Bennett M, Bailey MD, Liaou D, Kaltiso SO, Greenbaum J, Williams K, Gordon MR, Torres MIM, Nguyen PT, Coverdale JH, Williams V, Hari C, Rodriguez S, Salami T, Potter JE. *Creating a Collaborative Trauma-Informed Interdisciplinary Citywide Victim Services Model Focused on Health Care for Survivors of Human Trafficking*. Public Health Rep. 2022 Jul-Aug;137(1_suppl):30S-37S. Doi: 10.1177/00333549211059833. PMID: 35775914; PMCID: PMC9257486

25. Law no. 211/2004 on certain measures to ensure information, support and protection of victims of crime, with subsequent additions and amendments.

26. Lorvinsky J, Pringle J, Filion F, Gagnon AJ (2023) *Sex trafficking survivors' experiences with the healthcare system during exploitation: A qualitative study*. PLoS ONE 18(8): e0290067. https://doi.org/10.1371/journal.pone.0290067

27. Lumos, *Cycles of Exploitation: The Links Between Children's Institutions And Human Trafficking*, 2021, https://www.wearelumos.org/resources/cycles-of-exploitation/.

28. OCDE, „România: Profilul de țară din 2021 în ceea ce privește sănătatea", în: OECD Publishing/European Observatory on Health Systems and Policies, 2021, https://health.ec.europa.eu/system/files/2022-01/2021_chp_romania_romanian.pdf.

29. Romanian Criminal Code.

30. The World Bank, *Romania systematic country diagnostic: Migration*, 2018, https://documents1.worldbank.org/curated/en/210481530907970911/pdf/128064-SCD-PUBLIC-P160439-RomaniaSCDBackgroundNoteMigration.pdf.

31. United Nations, *Global Report on Trafficking in Persons 2024*, December 2024, https://www.unodc.org/documents/data-and-analysis/glotip/2024/GLOTIP2024_BOOK.pdf.

32. United Nations, *Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime*, 2000, https://www.ohchr.org/en/instruments-mechanisms/instruments/protocol-prevent-suppress-and-punish-trafficking-persons.

33. United Nations, *United Nations Global Plan of Action to Combat Trafficking in Persons, Sixty-fourth session of the General Assembly of the United Nations*, 12 August 2010, New York; 2010 (A/RES/64/293), https://www.unodc.org/documents/human-trafficking/United_Nations_Global_Plan_of_Action_to_Combat_Trafficking_in_Persons.pdf.

34. US Department of State, *2020 TIP Report Romania*, https://ro.usembassy.gov/2020-trafficking-in-persons-report-for-romania/.

35. US Department of State, *2021 TIP Report Romania*, https://www.state.gov/reports/2021-trafficking-in-persons-report/romania/#:~:text=Prosecutors%20indicted%20234%20alleged%20traffickers,2019%20and%20130%20in%202018.

36. US Department of State, *2022 TIP Report Romania*, https://www.state.gov/reports/2022-trafficking-in-persons-report/romania/.

37. US Department of State, *2023 TIP Report Romania*, https://www.state.gov/reports/2023-trafficking-in-persons-report/romania/

38. US Department of State, *2024 TIP Report Romania*, https://www.state.gov/reports/2024-trafficking-in-persons-report/romania/.

39. World Health Organisation, *Addressing Human Trafficking through Health Systems*, 2023, https://iris.who.int/bitstream/handle/10665/366280/9789289058827-eng.pdf.

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