

How is Human Trafficking Understood within Health Care?

A Discursive Analysis of British Columbia Health Stakeholders' Understandings
of Human Trafficking and Health Care Implications for Persons who are Trafficked

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BSW, University of Victoria, 2009
BA, Memorial University of Newfoundland, 1994

A Thesis Submitted in Partial Fulfillment
of the Requirements for the Degree of

MASTER OF SOCIAL WORK

in the School of Social Work

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Abstract

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In this thesis, I examine how health stakeholders in British Columbia think and talk about human trafficking. I interrogate the health stakeholders' speech as a site where broad societal discourses associated with human trafficking manifest. Using critical race theory, interlocking analysis, and a Foucauldian discourse analysis approach, I critically deconstruct health stakeholders' understandings of human trafficking and persons who are trafficked. I pay particular attention to the discursive strategies the health stakeholders employ to construct the subjectivities of both persons who are trafficked and themselves in human trafficking discourse. I argue that these meaning-making processes and the uncritical reproduction of dominant human trafficking discourse in the health sector at least, in part, account for the lack of development and implementation of provincial human trafficking-specific policy and services to date. Given this absence, this thesis encourages health stakeholders to create evidence-based initiatives to address human trafficking and the health needs of persons who are trafficked.

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Chapter One: Introduction

While living in Vietnam in the mid-2000s and working with the International Organization for Migration, I became aware of human trafficking. I came to understand human trafficking as referring to three elements: a set of actions which involve recruiting or moving a person (recruitment, transportation, transfer, or harbouring); these actions are undertaken through various means (coercion, force, fraud or deception) and for an end purpose (forms of exploitation such as forced labour or servitude) (United Nations, 2000).

In 2009, I co-founded the Trafficking Education and Response Initiative (TERI) to address the absence of a health perspective in anti-trafficking dialogues and responses in British Columbia. TERI was a group of health professionals who engaged in curriculum development, education and training, policy advocacy and project management related to human trafficking. TERI maintained that health care should become an integral part of human trafficking prevention and response, but we observed that health care providers were not overly engaged in the issue. For example, TERI developed and was set to deliver a human trafficking training curriculum on health care strategies in intervention and prevention for front-line health care providers at a professional development workshop offered by UBC Continuing Studies in Vancouver in June 2011. The workshop was cancelled due to poor enrolment. At a health conference at BC Women's Hospital later that same year, a TERI colleague and I presented a paper on the question of whether health policies and practices were meeting the diverse needs of women who have been trafficked in both the transnational and domestic context. The presentation was poorly attended and the topic did not generate much interest among conference participants. Because of TERI's unsuccessful attempts to call attention to the health implications of human trafficking, I set out to determine why British Columbia health policymakers and front-line health care

providers (hereafter health stakeholders) seem to be disengaged from this issue, and are conspicuously absent from provincial and national forums on human trafficking. Health researchers, such as Zimmerman, Hossain and Watts (2011), have noted a similar trend, asserting that globally, the health sector's engagement in trafficking dialogues has been limited and that published literature on human trafficking from a health perspective remains scant.

Statement of the Problem

Given some of the processes involved in human trafficking, including coercive or deceptive recruitment practices and situations of forced labour and servitude, the health needs of persons who are trafficked¹ have been identified in Canada and elsewhere as a priority after immediate safety needs have been addressed (Oxman-Martinez, Lacroix & Hanley, 2005; U.S. Department of Health and Human Services, 2009). British researchers have further indicated that the complex health needs of persons trafficked transnationally may be similar to those found in other vulnerable populations such as survivors of torture, low-wage labourers, irregular migrants and refugees (Zimmerman, Hossain & Watts, 2011). Women trafficked for the purpose of sexual exploitation can have health needs that are the same or similar to those of sex workers and survivors of intimate partner violence or sexual assault (Zimmerman et al., 2003; Zimmerman, Hossain & Watts, 2011). However, addressing the health needs of persons who are trafficked is significantly more challenging and poses unique diagnostic and treatment problems when one takes into account the cumulative harms associated with the different stages of the human trafficking process, inaccessibility to health services and case management requirements specific to human trafficking. Zimmerman, Oram, Borland and Watts (2009) note that providing health services to persons who are trafficked transnationally also pose various ethical, safety and

¹ I use 'persons who are trafficked' instead of 'trafficked persons' in this study. The politically loaded, all-encompassing descriptor 'trafficked' reduces a person's individuality to a sameness that can be generalized, and can potentially create and reinforce trafficking stereotypes.

medical challenges. These challenges may include situations in which the individual is at risk of retribution, complex physical and psychological symptoms, language and cultural barriers as well as unique legal circumstances such as precarious immigration status or participation in a criminal trial.

The right to health, including the right to necessary care and treatment, is a fundamental human right for all persons including those who are trafficked (Family Violence Prevention Fund, 2005; United Nations, n.d.; Zimmerman et al., 2003). The *Budapest Declaration on Public Health and Trafficking in Human Beings* (2003) states that more attention should be dedicated to the health and public health concerns related to trafficking. It recommends that persons who are trafficked should receive “comprehensive, sustained, gender, age and culturally appropriate health care [...] by trained professionals in a secure and caring environment” (para. 2). To this end, “minimum standards should be established for the health care that is provided to trafficked victims” (para. 2). The International Organization for Migration (2004) followed this recommendation and developed a set of minimum standards for health care. *The Mental Health Aspects of Trafficking in Human Beings: a Set of Minimum Standards* provides guidance to health care providers in implementing comprehensive and coordinated psychosocial care. Further to this, the International Organization for Migration, the London School for Hygiene and Tropical Medicine and the United Nations Global Initiative to Fight Trafficking in Persons (2009) published *Caring for Trafficked Persons: Guidance for Health Provider*, a practical, non-clinical guide that outlines safe and appropriate standards for providing health care for persons who are trafficked. Both sets of guidelines can be applied to transnational or domestic trafficked persons.

Canada, a state party to the United Nations (2000) *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Convention against Transnational Organized Crime* (commonly known as the Palermo Protocol), has been criticized by non-governmental organizations (NGOs), policy analysts and researchers for not following through on international recommendations to provide adequate protective services especially for transnational trafficked persons which include health care (Future Group, 2006; Gajic-Veljanoski & Stewart, 2007; Oxman-Martinez, Hanley & Gomez, 2005). The language used in Article 6 (3) of the Palermo Protocol is weak in stating that state parties “shall consider implementing” or “shall endeavor to” provide protections and assistance which includes appropriate medical care (United Nations, as cited in Lepp, 2002, p. 93). Although health care is available for transnational trafficked persons who are granted a Temporary Residents Permit (TRP) under the Interim Federal Health Program, critics have argued that law enforcement and immigration officials, in collaboration with NGOs, tend to secure ad hoc medical services as needed (Future Group, 2006; Gajic-Veljanoski & Stewart, 2007; Oxman-Martinez et al., 2005). Furthermore, unless health stakeholders are aware of and understand the complex situations and health needs of trafficked persons, healthcare services could be inadequate.

An examination of how British Columbia health stakeholders understand human trafficking, and its implications for the health care of persons who are trafficked is particularly important and timely. In June 2012, the federal government prioritized human trafficking with the release of Canada’s first National Action Plan to Combat Human Trafficking. In it, the then Minister of Public Safety, Vic Toews, stated that “victims will be given the help they need” which presumably includes health care (Public Safety Canada, 2012, p. 2). However, the health needs

of persons who are trafficked do not figure prominently in the National Action Plan. Addressing the health needs of persons who are trafficked is also not a priority in British Columbia's Action Plan to Combat Human Trafficking 2013-2016 (Ministry of Justice, 2013). The question, then, is why have so few British Columbia health stakeholders not advocated for the inclusion of appropriate health services for persons who are trafficked as a necessary part of a comprehensive provincial strategy to address human trafficking?

Research Question

The reasons why British Columbia health stakeholders have not been actively engaged in the development of anti-trafficking policies and service provision regimes at the provincial level may be rooted in the ways in which human trafficking is understood in the health sector. With this in mind, my research question is: *How is human trafficking understood among health stakeholders in British Columbia and what are the implications for creating specific health services for persons who have been trafficked?*

Research Synopsis

To answer the research question, I interviewed 10 health stakeholders from across British Columbia. My analysis of the interview data is informed by post-structuralist discourse analysis influenced by the work of Michel Foucault, critical race theory and interlocking analysis. My principal aim is to consider the meaning-making processes health stakeholders employ to produce representations of persons who are trafficked and also of themselves, and how these representations enable *truths* about human trafficking which, I argue, have contributed to their disengagement from this issue. The conceptualization of truth that guides my analysis is informed by Foucault (1980):

Each society has its regime of truth, its 'general politics' of truth: that is, the types of discourse which it accepts and makes function as true; mechanisms and instances which enable one to distinguish true and false statements, the

mean by which each is sanctified; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true (p. 131, emphasis in original).

Finally, I assess the implications these *truths* have for the creation and provision of health care services for persons who are trafficked in the British Columbia context.

Although Foucauldian discourse analysis has been used to examine human trafficking (Carson & Edwards, 2011; Spanger, 2011), my literature review indicates that this approach, especially when combined with critical race theory and interlocking analysis, is virtually absent in examinations of human trafficking that use health as the entry point. In employing this analytical approach, my intent is not to suggest that the health stakeholders interviewed *rightly* or *wrongly* conceptualize human trafficking. Rather, I interrogate the origins, purposes and effects of the knowledge about human trafficking these health stakeholders articulate to demonstrate the need for critical health care approaches and evidence-based initiatives.

In investigating how something becomes known as *truth* to health stakeholders that, in turn, enables or prevents actions in the health care system, I am interested in exploring how some information about human trafficking comes to have greater currency and legitimacy than other information and the subsequent effects of hierarchical knowledge production (Foucault, 1981). That is to say, this is a study about how discourse functions to permit or disallow certain ways of speaking about human trafficking. I argue that the ways in which human trafficking and, more specifically persons who are trafficked, are currently understood among British Columbia health stakeholders do not allow the issue of human trafficking to be prioritized within the provincial health sector and for a fulsome health response to emerge at this time.

Organization of the Thesis

In Chapter Two, I review the relevant human trafficking literature and locate this study within it. I focus on definitional debates and the main discursive framings as they pertain to human trafficking. After categorizing the extensive human trafficking literature into five frameworks (migration, prostitution², human rights, transnational organized crime and modern-day slavery), I situate and review human trafficking-related health literature with reference to those frameworks. In so doing, I interrogate how the health literature produces or reproduces dominant human trafficking discourse. I also discuss how this study, which is an examination of how knowledge about human trafficking is produced in the context of health, contributes to a field of study that urgently requires critical analysis.

In Chapter Three, I outline the methodology employed in this study which is located in a post-structuralist paradigm. I describe the theoretical framework which includes critical race theory and interlocking analysis. I weave these theoretical perspectives together with Foucauldian understandings of discourse, power/knowledge, truth, subjectivity and biopower. I also consider data collection, research ethics, evaluative criteria and reflexivity when laying out my ‘theoretical decision trail’. Finally, I provide a rationale for using a Foucauldian discourse analysis approach as the method and discuss its limitations.

In Chapters Four and Five, I analyze the data and present the findings. The key finding is that the health stakeholders interviewed conceptualize human trafficking according to two discursive frameworks: migration and prostitution. The racialization of trafficked bodies is a theme that runs throughout these two conceptualizations, but since the analysis of the meaning-

² While I use the term sex work to refer to commercial sex (except when referring to the legal context, i.e. Canada’s prostitution laws), prostitution is used in this study when this term best reflects the intended meaning of the health stakeholders and/or the literature.

making process is considerably different for each, I discuss the transnational context and migration in Chapter Four, and prostitution, both transnational and domestic, in Chapter Five.

In Chapter Six, I analyze a counter discourse that emerged in the data. Rather than calling into question my findings in Chapters Four and Five, the counter discourse strengthens my argument about how meaning is or is not ascribed to racialized bodies in the context of human trafficking. I then discuss implications for human trafficking-specific health policy and services. I conclude by examining the importance of ethical decision-making in human trafficking-related health initiatives and outline what this might look like in practice.

Chapter Two: Literature Review

To situate this critical inquiry of human trafficking, which uses health as its entry point, I begin this chapter by providing a general overview of the human trafficking literature and do so by presenting five conceptual frameworks which, I argue, shape dominant human trafficking discourse and present-day debates about human trafficking. Given that human trafficking and what it entails has been the focus of significant debate globally and nationally, I identify the significance and relevance of these debates over meaning to this study. Following this discussion, I locate human trafficking-related health literature within the wider body of human trafficking literature, using the following questions as a guide. How is human trafficking discursively framed in the health literature? Are health scholars' conceptualizations of human trafficking consistent with or different from the aforementioned dominant frameworks? How does the health literature potentially shape health stakeholders' understandings of this issue? I then outline the gaps in the literature and discuss the contributions this study could make to the field.

Overview of Human Trafficking Literature

At the international level, contemporary discussions of and activism around human trafficking emerged in the 1980s (Doezema, 2010). However, it was not until the mid-1990s that human trafficking entered the public lexicon and anti-trafficking identified activities and related research began to take off (Agustin, 2007). Since that time, a large body of literature on human trafficking has been produced.

One feature that distinguishes studies of human trafficking is the extent to which they are or are not grounded in empirical evidence. Critical human trafficking scholars, such as Agustin (2007), Doezema (2010), Kempadoo (2005), Sanghera (2005) and Weitzer (2012), who analyze

human trafficking using broad-based perspectives on migration, human rights, race, gender and class, have argued that sensational publications, based on shoddy research, anecdotal information and opinion-based commentary, have gained wide circulation and popularity. This trend can also be found in the human trafficking-related health literature. For example, one of the most egregious examples of sensationalism is a much-cited U.S.-based journal article on the role of nurses in combating human trafficking which begins as follows:

Mimi could feel the blood start to run through her hair and down the side of her face. Her head ached where her customer had grabbed a handful of her hair and pounded her face into the gravel-strewn alley, where they'd gone so no one could see them. Now Mimi wished she hadn't chosen such a private spot. She told herself she'd be more careful next time—if she lived through this time. As she lay on the ground, her assailant kicked her several times in the stomach, then took all the money she'd made that night and ran off. Scared that she'd been badly hurt, Mimi struggled to her feet and made her way toward the street, where another man was waiting for her. In the light of a streetlamp, he could see that she needed medical attention (Sabella, 2011, p. 29).

Critical human trafficking scholars have also questioned the statistical estimates as to the scope of trafficking in persons that are in circulation globally. For example, one journal article that discusses how American emergency department health care providers can address human trafficking stated that “at least 27 million and perhaps as many as 200 million people are estimated to be enslaved on our planet in 2008” (Leof & Sanghera, as cited in Patel, Anh & Burke, 2010, p. 402). Such unsubstantiated statistical estimates with differences of 173 million people would likely not be acceptable in other areas of study; in fact, Salt argues that “much of the human trafficking research does not live up to academic standards common in other fields of research” (as cited in Tyldum, 2010, p. 2). Gozdziaik and Bump (2008) concur that “relatively little systematic, empirically grounded, and based on solid theoretical underpinnings research has been done on this issue” (p. 9). As a result, as Sanghera (2005) succinctly points out, the highly

influential “dominant anti-trafficking discourse is not evidence-based but grounded in the construction of particular mythology of trafficking” (p. 4).

There is, however, a small body of empirical literature on human trafficking. Gozdzia and Bump (2008) compiled a bibliography of research-based human trafficking studies, and of the 218 research-based journal articles included, only 39 drew on empirical research and three of these were not peer-reviewed. My review of human trafficking-related health publications, including reports and monographs, supports Gozdzia and Bump’s assertion that only a small percentage of the literature in this field is empirically-based.

As this thesis explores the production of knowledge and dominant human trafficking discourse, I reviewed both empirical and non-empirical literature. This included articles published in peer and non-peer-reviewed journals; reports from international organizations such as the United Nations, the International Organization for Migration, the Coalition Against Trafficking in Women (CATW) and the Global Alliance Against Traffic in Women (GAATW); documents found on Government of Canada and politicians’ websites; monographs and edited collections; and online and print media. I categorized this literature into five conceptual frameworks.

Conceptual Frameworks

Kempadoo (2005) points out that the discourse on human trafficking shifts in accordance with the understandings of human trafficking among feminists, researchers, anti-trafficking activists and community workers at any given time. I am cognizant of the fact that how I make sense of my own perspectives is also located within contemporary human trafficking discourse and that I am also creating discourse through this study. The five frameworks that currently inform my

own and general understandings of human trafficking include migration, prostitution, human rights, transnational organized crime and modern-day slavery.

Migration. The migration framework acknowledges that globally, there are millions of people on the move in search of better lives. The need to move, as precipitated by such push and pull factors as poverty, war, the desire to access greater opportunities in safer and healthier environments and restrictions on legal avenues of migration are some of the conditions that make migrants vulnerable to traffickers (Kapur, 2005; Marshall & Thatun, 2005; Wijers, 1998). However, among those who view human trafficking as a migration issue, there is much debate over strategies to address it.

The Canadian government, for example, maintains that implementing increasingly stringent immigration policies will curb human trafficking. More specifically, the government purports that Bill C-4 will prevent ‘irregular migrants’ from entering Canada under a law that claims to curb human trafficking and/or human smuggling (*Preventing Human Smugglers from Abusing Canada's Immigration System Act*, 2011). The logic is that stiffer penalties and the detention of ‘irregular arrivals’ will discourage people from leaving their home countries and deter traffickers and smugglers.

Some scholars argue that tight immigration policies play a key role in actually *increasing* human trafficking since the laws do not stop migration, but drive migration further underground. Andrijasevic states that “governments fail to realize that the strengthening of the borders to Europe and North America actually causes more migrants to use illegal methods to immigrate into developed countries” (as cited in Dorfman, 2011, p. 17). In rendering migration invisible, increasingly stringent immigration laws create environments where vulnerable persons can be more easily exploited, people are compelled to rely on third parties including smugglers and

traffickers as a means to migrate and the profitability of smuggling and trafficking increases (Dorfman, 2011; Kapur, 2005). Kapur (2005) argues that the law and order anti-trafficking framework, which is supported by most nation states and is used as a justification to tighten border controls, is an ineffective mechanism to address the realities of cross-border migration and to combat human trafficking.

Prostitution. Arguably among all conceptual frameworks, the prostitution framework has been the site of the fiercest human trafficking debates. Radical feminists, who advocate for the eradication of the sex industry, view prostitution as sexual slavery. According to Barry (1995), sex in prostitution reduces women to a body and to a sexual function as prostitution is inherently exploitative. Given that no woman can consent to engaging in prostitution, all women in the sex industry are “trafficking victims” (Barry, 1979; Coalition Against Trafficking in Women, 2000; Hughes, 2000; Jeffreys, 1997). Godziak and Bump (2008) assert that adherents of this perspective believe there is a direct causal link between prostitution and sex trafficking.

Critical human trafficking scholars argue that the prohibitionist viewpoint, which draws on Christian beliefs and moral values, has defined the international discourse on prostitution for 100 years. Historically, trafficking in women has meant prostitution in international law, national law and popular discourse (Ditmore, 2005; Doezema, 1998, 2010; Kempadoo, 2004). In the last two decades, the radical feminist perspective on prostitution has also become highly influential in shaping conceptualizations of human trafficking. Hence, I would argue that combined, the prohibitionist and radical feminists’ positions on prostitution have become the ‘commonsense’ understanding of human trafficking. In my experience working in the field, the people I encounter often invoke the prostitution-as-human trafficking perspective. They focus principally on the victimization of female sex workers (male and transgender sex workers are excluded in

such discussions) and the need to end male demand, often without considering the broader political, social, and economic context in which prostitution and human trafficking operate (Outshoorn, 2005).

Conversely, while not denying that human trafficking occurs, sex worker advocates differentiate between human trafficking for the purpose of sexual exploitation and sex work. They view commercial sex as labour and focus on the human and labour rights of sex workers. They also acknowledge and respect the agency of women, in particular racialized women, to engage in sex work and maintain that prohibitionists use both transnational and domestic anti-trafficking initiatives as vehicles to further their agenda of abolishing prostitution (Anderson, 2007; Doezeema, 2010; Sanghera, 2005).

Weitzer (2007) argues that, both conceptually and empirically, it is inappropriate to fuse prostitution and sex trafficking since “there is no evidence that ‘most’ or even the majority of prostitutes have been trafficked” (p. 455, emphasis in original). Gozdziaik and Bump (2008) concur in stating that the “causal link between legal prostitution and sex trafficking has not been empirically established” (p. 44). These critical insights resonate with me in the context of my current front-line work with racialized women engaged in indoor sex work, a population that is often misrepresented as trafficked. Since 2009, I have provided outreach to these sex workers and co-ordinated outreach teams that visit up to 50 indoor sex work sites per month throughout the BC Lower Mainland. Despite popular rhetoric to the contrary, our experience has shown that human trafficking at these sites is very rare.

Human Rights. This framework draws on international human rights standards and principles and considers human trafficking primarily as a violation of individual human rights. Adherents of this approach have, since the 1990s, argued for state recognition, in countries of

origin and destination, of the following individual rights for persons who are trafficked: temporary or permanent rights to remain in a country; assistance that is not conditional upon agreement to cooperate with law enforcement officials; readily available information about the possibilities of getting assistance once individuals return to their home countries; and the right for migrant workers to exercise freedom of association and to join or form trade unions (GAATW, 2007). Adherents also recommend that all legislation and regulations which allow for the detention of people who have been trafficked be repealed, and that there should be no obstacles to trafficked persons applying for asylum (GAATW, 2007). The United Nations Office of the High Commissioner for Human Rights (2010) further emphasizes that the human rights framework must be placed at the centre of any efforts to address human trafficking through the use of regional and international human rights mechanisms.

Critics of the human rights framework maintain that it has not resulted in a significant and meaningful reduction of human trafficking (Shamir, 2012), and cite several reasons why this is the case. Some scholars raise concerns about the reliance on regional and international mechanisms to ensure human rights are upheld. In the context of human trafficking, Waisman (2010) states that, “[r]egional and international schemes to date have failed to develop an enforcement scheme to hold individual states accountable” (p. 418). Also recognizing the difficulties associated with enforcing human rights norms and principles, Obokata (2006) maintains that the human rights framework is not even “being widely promoted or implemented, at the national, regional, or international level” (p. 404). Shamir (2012) goes even farther and states that the human rights approach may in fact be harmful since it creates the illusion that the international community is taking action.

Other scholars critique the framework from a different angle and question the type of human rights being upheld. Kapoor argues that “transnational elites in western countries or west-allied countries do not promote ‘universal’ rights but rather a model firmly entrenched in a western, capitalist, and neoliberal legal tradition” (as cited in McGowan, 2012, p. 55, emphasis in original). This model includes rights that are centered on the individual and the individual assertion of rights, and does not take into account group decision-making processes, duties or responsibilities common in some Asian or African societies (Tharoor, 1999). Further to this and speaking more broadly, Schick (2006) offers a critique of human rights discourse in that “[i]nternational liberalism celebrates the advent of human rights whilst failing to confront the deeper structural dilemmas that the international political economic system generates” (p. 321). One could argue, then, that addressing poverty and gender inequality in sending countries and the demand for cheap migrant labour and the imposition of restrictive immigration policies in countries of destination should be centred as primary state obligations in combating human trafficking (Pati, 2011). The critique that resonates with my professional experience is that the ‘human rights framework’ has become a popular catchphrase for many anti-trafficking initiatives. However, as Todres (2013) points out, the

mere mention of, or even attention to, the rights of trafficking victims does not mean one is taking a human rights approach or adopting a human rights framework. Even those measures aimed at forging a victim-centered approach are frequently rooted in the prevailing rescue narrative and not situated in a human rights framework (p. 151).

Transnational Organized Crime. As a supplement to the *UN Convention on Transnational Organized Crime*, the *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children* frames human trafficking within the context of transnational organized crime and mandates a strong law enforcement response (Global Network of Sex Work

Projects, 2011). Adherents of the criminal justice approach maintain that the enactment of stiff legal penalties and enhanced border control measures particularly in countries of destination will deter traffickers and curb human trafficking, as outlined in Articles (5) “criminalization,” (11), “border measures” and (12) “security and control of documents” of the Trafficking Protocol (United Nations, 2000).

Critics of this approach have challenged the notion that human trafficking is carried out by large transnational networks of organized criminals. Agustin (2005) reports that the United Nations Center for International Crime Prevention’s own report “found little proof of such activity” (p. 101). Furthermore, Kevin Bales, who is considered an authoritative voice on human trafficking in some circles, recently identified himself as the creator of the ‘human trafficking - the third largest organized crime after drugs and arms’ theory. Bales asserted that remarks he made in a United Nations meeting were misconstrued and became the basis of the theory that organized crime operations are responsible for most sex trafficking (cited in Weitzer, 2013). According to critical human trafficking scholars, traffickers are often current, former or potential migrants or intermediaries who may include family members or friends, that work together to meet particular migrant needs at a given time (Agustin, 2007; Busza, Castle & Diarra, 2004).

Salt asserts that, despite a lack of evidence-based data to support the claim that human trafficking and organized crime are closely related, this assumed link remains unchallenged (as cited in Gozdziaik & Bump, 2008). This can partly be explained by the fact that government delegates negotiated the UN Trafficking Protocol in conjunction with *the Convention on Transnational Organized Crime* which has lent legitimacy to the link between organized crime and human trafficking.

Modern-Day Slavery. This framework draws parallels between present-day human trafficking and the historical transatlantic slave trade with an emphasis on the denial of dignity and human rights and conditions of exploitation. Relying on an international law definition of slavery as “the status or condition of a person over whom any or all of the powers attaching to the right of ownership are exercised” (Perrin, 2010, p. 6), ‘new slavery’ or ‘modern-day slaves’ have been portrayed in much the same light as their historical counterparts (Musto, 2009). Bales (mentioned above as a myth maker) estimates that there are 27 million people around the world who fall into the category of slave, with a slave defined in his work as “a person held by violence or the threat of violence for economic exploitation” (as cited in Musto, 2009. p. 28); his research, however, does not provide the empirical basis of this statistical claim.

The language of ‘modern-day slavery’ has gained wide currency. It is used liberally by United Nations agencies, national governments including the Bush and Obama administrations, human rights organizations, powerful media figures such as Oprah Winfrey, *New York Times* journalist Nicholas Kristof who writes extensively on human trafficking and Hollywood celebrities such as Ashton Kutcher and Mira Sorvino, all of whom have considerable power and influence to produce discourse (Hoyle, Bosworth, & Dempsey, 2011; Musto, 2009). For the most part, the inaccurate use of slavery rhetoric conjures up images that incite moral indignation from the general populace. Musto (2009) has further pointed out that concerned individuals are asked and encouraged to donate funds to faith-based NGOs, who are fighting slavery through individualistic and charity-based campaigns. As a consequence, according to Musto, international economic policies as well as national immigration policies and prostitution laws that arguably play a role in exacerbating human trafficking go unchallenged and remain intact.

Doezema (2010) contests the notion of ‘modern-day slavery’ through an examination of what she identifies as the historical roots of contemporary anti-trafficking discourse as it pertains to prostitution: namely, the ‘white slavery’ narratives of the nineteenth and early twentieth centuries. She, like various historians, questions the extent of the ‘white slave trade’ as there is scant historical evidence to support the nineteenth- and early twentieth-century ‘moral panic’ over innocent, young, white girls being coerced into prostitution. Bernstein (2010) concurs that empirical investigations reveal that there is little historical evidence of ‘white slavery’ at the turn of the twentieth century, and draws links between the historical ‘white slavery’ panic and the contemporary moral panic over sex trafficking. In highlighting similar connections, Doezeema calls for an understanding of sex trafficking “not a matter of ‘fact’ but largely a sensationalized myth whose prevalence has been socially constructed by discourses of race, gender and sexuality” (as cited in Parreñas, Hwang & Lee, 2012, p. 1019, emphasis in original).

The five conceptual human trafficking frameworks discussed above are not mutually exclusive. Oftentimes, stakeholders adopt two or more discourses from different frameworks to further their political agendas. Talja (1999) maintains that there are simultaneously several, more or less conflicting discourses existing in a particular field of knowledge at a certain point in time. Alternative or new interpretations emerge as corrections to existing discourses. Or conversely discourses are used to complement each other as we see with the popular discourses of prostitution and ‘modern-day slavery’.

Together, these five conceptual frameworks have emerged as the most common ways of thinking and speaking about human trafficking in the contemporary period. What this accomplishes is that cumulatively, they create a dominant discourse about human trafficking and produce fixed subjectivities within the discourse. For example, the familiar victim subjectivity

of the trafficked woman casts her as naïve, duped and passive and is found in all five frameworks albeit to different degrees. Consequently, the discourse has little space for certain subjects (such as self-determined migrants, especially racialized women who engage in sex work) who knowingly migrate to engage in work of their choice, but find themselves in a trafficking situation.

Also worth noting is that the five frameworks do not have equal currency. In Canada, the organized crime, migration and prostitution frameworks, with ‘modern-day slavery’ weaved throughout, are the discursive framings that are most widely reproduced and re-circulated (Bruckert & Parent, 2004; Perrin, 2010; Public Safety Canada, 2010). All stakeholders identify human trafficking as a problem for different reasons and all have different political agendas tied to their definitions (Anderson, 2007; O’Connell Davidson, 2006). For example, the federal government discursively frames human trafficking as a criminal justice and border security issue. This approach is evident in the federal government’s 2012 National Action Plan to Combat Human Trafficking; of the \$6 million annual budget dedicated to combating human trafficking in 2012-2013, \$ 5.4 million was earmarked for RCMP and Canadian Border Services Agency anti-trafficking initiatives. An analysis of how framing human trafficking as a criminal justice and border security issue serves the federal government’s interests is outside the scope of this thesis. However, what is relevant to this study is how dominant discourses contribute to the establishment of strategic priorities in government or health authorities, for example, and inform policy frameworks.

Human Trafficking-Related Health Literature

To provide insight into my research question “How is human trafficking understood among health stakeholders in British Columbia,” I reviewed the health literature on human trafficking.

How do health scholars conceptualize human trafficking? Does the health literature offer a distinct perspective or does it reproduce some or all of the five conceptual frameworks discussed above? Using a keyword search that included one or a combination of the terms ‘human trafficking’, ‘human trafficking Canada’, ‘health’ and ‘public health’, I searched the following databases: JSTOR, MEDLINE/PubMed, EBSCOhost and Google Scholar. I uncovered approximately 50 publications all of which were produced between 2000 and 2013 in North America and Europe.

A close reading of the health literature reveals that health scholars understand human trafficking according to the same five conceptual frameworks discussed above. In fact, I found all five conceptual frameworks represented in the health literature. For example, Dovydaitis (2010), writing about the role of health care providers in the context of transnational trafficking, states that “human trafficking is the third largest source of income for organized crime, and there are twice as many people enslaved today as during the African slave trade” (p. 462). Barrows and Finger (2008), who also focus on the role of health care providers in addressing transnational trafficking, make the following claims:

Despite the legislation passed in the 19th century outlawing human slavery, it is more widespread today than at the conclusion of the civil war. Modern human slavery, termed human trafficking, comes in several forms. The most common type of human trafficking is sex trafficking, the sale of women and children into prostitution (p. 521).

According to Wong, Hong, Leung, Yin and Stewart (2011), who research Canadian medical students’ general awareness and attitudes about human trafficking, it “is a human rights violation prevalent globally” (p. 1).

Health scholars also reproduce the same subjectivities located in the five conceptual frameworks. The classed, gendered and racialized victim who is without agency or self-

determination is represented; for example, Miller et al. (2007), who present a transnational trafficking case study in order to examine the role of the U.S. health care providers, state that “those trafficked to the United States tend to be the most vulnerable women and girls, coming from poor, often agricultural, families, with less education and limited resources” (Raymond et al., as cited in Miller, Decker, Silverman & Raj, 2007, p. 487). Dovydaitis (2010), mentioned above, writes about the domestic child sex trafficking victim and maintains that, “[i]n the United States alone, [...] there approximately 400,000 domestic minors involved in trafficking” (p. 462). Gushulak and MacPherson (2000), whose work focuses on the health issues associated with the smuggling and trafficking of persons in the global context, discuss migrants and state that the “clandestine movement of humanity, by unofficial and often illegal means, is referred to as ‘trafficking in migrants’”(p. 68, emphasis in original).

Because of the reproduction and recirculation of dominant human trafficking discourse and the reinforcement of popular representations of trafficked persons (modern-day slaves, prostituted women and girls and duped migrants among others), I found the health literature to be quite superficial. Most of the publications focus on one or two themes: the health effects of human trafficking based on no original data; and/or the role of health care providers in addressing human trafficking. Most articles cover the who, what and why of human trafficking; provide wildly divergent statistics on the prevalence of human trafficking; do not employ any particular methodology; and are opinion-based commentaries rather than research-based studies. While I felt as if I was repeatedly reading the same article, one pattern did begin to emerge.

With an emphasis on defining the role of the health care provider in anti-trafficking work, a wide range of health care providers have taken up the cause and have carved out subject-positions for themselves in the discourse. Whereas earlier articles were written by doctors and

discussed their role in treating both transnational and domestic trafficked persons (Beyrer, 2004; Gushulak & MacPherson, 2000), more recent articles have been written by various health care providers and attempt to situate themselves in the discourse. For example, O'Callaghan (2012a), who represents American dentists, wrote:

[c]olleagues in many medical disciplines, such as psychiatry, gynecology, infectious disease, public health, midwifery and nursing, have reported on this topic. Dentistry's voice, however, has not been heard on the issue of human trafficking, at least not in the professional dental literature. A PubMed search of the English-language literature through May 2011 yielded no articles meeting the criteria 'dentistry' and 'human trafficking prostitution' or 'slavery' or "trafficking in persons". My objective is to inform the dental community about this topic, as well as to present information about how to identify possible trafficking victims and how to respond (p. 498, emphasis in original).

O' Callaghan (2012b) expands beyond the health professionals' role in identification and response within the health care system, and carves out the subject-position of the American health care provider. In an article entitled "The Health Care Professional as a Modern Abolitionist," O'Callaghan calls on health care providers not only to provide care for persons who are trafficked, but also to "combat the scourge of human trafficking by becoming modern abolitionists" (p. 67).

Social workers have also sought to define their subject-position. Struhsaker Schatz and Furman stated, in 2002, that globally, social work literature featured little discussion on human trafficking and that the absence of a strong voice from the profession on the issue was a "curious omission" (as cited in Okech, Morreau & Benson, 2012, p. 497). However, by 2013, social workers worldwide had positioned themselves in the discourse. As with dentists, the preoccupation with delineating the role of the social worker in relation to persons who are trafficked was evident in such journal titles as "Human trafficking: Improving victim identification and service provision" (Okech, Morreau & Benson, 2012); in this case, social

service provision in the U.S. involved defining the victim, and then delineating the social worker's role based on how the person who is trafficked is represented.

Forensic nurses in North America have also taken up the issue and defined their subject-position in the discourse. Focusing on the role of advanced practice forensic nurses in the U.S. in relation to transnational and domestic human trafficking, Cole (2009) states that, "[t]he forensic nurse in the generalist role can provide education in health care settings by educating colleagues regarding HT and assessment skills to identify [trafficked persons] and by problem solving within communities regarding how to provide service and safe refuge" (p. 466). What is not clear in this article is how nurses are informed about this issue and what discourse they reproduce when they educate. How aware are they of their role in the production of knowledge about human trafficking?

First and second year medical students in Canada have also weighed in. A study conducted at the University of Toronto medical school found that 93.9% of students either had no knowledge or some knowledge of human trafficking (Wong, Hong, Leung, Yin and Stewart, 2011). The study also indicated that none of the students surveyed had learned about human trafficking in the medical curriculum which suggests that they obtained their information elsewhere, such as from colleagues in the medical field. If in the future, health care providers are to become an integral part of a comprehensive response and are tasked with helping to care "for trafficked persons as they are rescued and must make difficult legal and immigration-related decisions" (Zimmerman et al., as cited in Wong, Hong, Leung, Yin and Stewart, 2011, p. 5), then a critical analysis of the broad discourses health care providers draw on to understand human trafficking is important.

My overall assessment of the health literature on human trafficking is twofold. First, the emphasis on identifying the role of the health care provider is a discursive strategy in which the authors produce subjects who are *subjected to* the discourse (Hall, 1997). That is to say, “they – we – must locate themselves/ourselves in the position from which the discourse makes the most sense, and thus become its ‘subjects’ by ‘subjecting’ ourselves to its meanings, power and regulation” (p. 80, emphasis in original). To put it another way, the authors first produce the ‘trafficked victim’ who is almost always female and then relationally speaking, produce the well-intentioned, benevolent health care provider whose role is to treat, save or rescue her. In many of the articles reviewed, the authors suggest that the health care provider’s investment in the issue is borne out of moral indignation and/or faith-based and prohibitionist understandings of human trafficking. For example, O’Callaghan, the dentist cited above, is a member of the Christian Medical and Dental Association (CMDA). The CDMA has a human trafficking webpage which offers information about its “[u]pcoming 2013 trips to minister to the victims of human trafficking,” including several Asian countries (Christian Medical and Dental Association, 2012).

Second, the health literature reviewed contains very little critical analysis. The same information is repeated, including statistics on the scope of human trafficking and representations of trafficked persons, and authors uncritically draw on each other’s work. What is missing is an analysis of how this knowledge is produced and the implications this has for the provision of health services for persons who are trafficked. This study attempts to fill this gap.

Human Trafficking as a Health Issue

There is one significant exception in the health literature. A small body of original research proposes a new public health discourse on human trafficking. Cathy Zimmerman and her fellow

researchers at the London School of Hygiene and Tropical Medicine have built on their 2003 landmark study, *The Health Risks and Consequences of Trafficking in Women and Adolescents: Findings from a European Study*, and have developed a comprehensive framework that conceptualizes human trafficking as a health issue. Rather than reproducing ‘commonsense’ understandings of persons who are trafficked, constructing the health care provider’s role in relation to these understandings, and focusing only on intervention after the ‘exploitation stage’, Zimmerman, Hossain and Watts (2011) propose a different conceptual framework and take a critical approach to how it should inform policy, intervention and research. They argue that human trafficking should be seen as a multi-staged process of cumulative harm during which health issues may arise. More specifically, their model “highlights the migratory and exploitative nature of a multi-staged trafficking process, which includes: ‘recruitment’, travel-transit’, ‘exploitation’, ‘integration’ or ‘reintegration’, and for some persons who are trafficked, ‘detention’ and ‘re-trafficking’ stages” (p. 1). Zimmerman, Hossain and Watts discuss the forms of abuse and risk, and potential health outcomes at each stage.

In addition to advocating an approach that is health informed and does not draw on sensational or popular understandings of human trafficking, research produced by the London School of Hygiene and Tropical Medicine with Zimmerman as lead researcher has several other strengths. Zimmerman, Hossain and Watts (2011) critique widely adopted approaches and conceptual frameworks such as the 4 Ps approach - prevention, protection, prosecution and partnerships – which constitutes the basis of many anti-trafficking initiatives. They state that the 4 Ps approach minimizes the health sector role; the health effects of trafficking and the provision of health services is not a discussion that has been given much discursive space in this approach. Zimmerman, Hossain and Watts also highlight exclusions or silences in dominant human

trafficking discourse. For example, they state that, “[t]o date, labour trafficking and men who are trafficked have been seriously under-represented in policy-making and service allocation” (p. 1). In a systematic review of the global evidence on the health consequences of transnational and domestic trafficking, Oram, Stöckl, Busza, Howard and Zimmerman (2012) reiterate that there continue to be gaps in the literature, which include the health of men who are trafficked, persons trafficked for other forms of exploitation, and effective health intervention approaches. Further to this critique, Oram, Zimmerman, Adams and Busza (2011), in discussing the UK’s national policy responses to the health needs of persons who are trafficked, note that despite the sometimes extreme harm involved in human trafficking, harm has not been incorporated in the Palermo Protocol’s definition of human trafficking or in the UK’s health policies on human trafficking. In these critiques, the researchers do not suggest that a health framework is *the* new truth, but argue that a collaborative approach to addressing human trafficking involves not only immigration and law enforcement measures, but also labor, social and *health* services.

While Zimmerman’s original 2003 study on the health effects of human trafficking is often cited, I have found no evidence that the studies produced by the research team at the London School of Hygiene and Tropical Medicine, which promote human trafficking as a health issue, are mentioned by other scholars. Is it possible that this research which presents evidence-based health analyses disrupts healthcare providers’ understandings of persons who are trafficked and of themselves relationally speaking? That is to say, are the subject-positions in the dominant discourse disrupted when the focus is on the health effects of human trafficking and less on the role of the health care provider in relation to the person who is trafficked?

Zimmerman, Hossain and Watts (2011) state that the “public health sector has not yet incorporated human trafficking as a health concern” and that “the inclusion of human trafficking

as a public health concern is in [its] nascent stages” (pp. 1, 8). If an increasing number of health providers have taken up human trafficking in recent years, why is this still the case? What is it about the way human trafficking is understood that results in it not being taken up in health policy? My data analysis which outlines the power relations involved in producing knowledge about human trafficking will attempt to answer this question.

The human trafficking-related health discourse established by Zimmerman and her team of researchers highlights the ways in which persons who are trafficked are represented in the general health literature on human trafficking. The health discourse disrupts dominant ‘commonsense’ knowledge about human trafficking and problematizes hegemonic ways of thinking and talking about human trafficking. That is to say, if the dominant conceptual frameworks claim to operate in the best interest of persons who are trafficked, whether in terms of prevention, protection, prosecution or partnerships, why do these frameworks rarely, if ever, mention the health needs of persons who are trafficked? For instance, if a criminal justice-based approach is employed, how can a person who has been trafficked testify at a criminal trial if he/she is not healthy enough to do so? If a prohibitionist-based anti-trafficking initiative is employed that does not accept sex work as an employment option, how can a person who has been trafficked find alternate employment if health issues render that person unemployable in a mainstream work environment? In effect, centring the health concerns and needs of trafficked persons problematizes the five anti-trafficking frameworks.

Chapter Summary

In this literature review, I discussed the conceptual frameworks, popular discourses and subject-positions that are used to conceptualize human trafficking. I also examined the health literature on human trafficking and determined that these same conceptual frameworks and

subject-positions are used by health scholars. That said, I did identify a public health discourse that presents an alternative way to discursively frame human trafficking. The public health discourse, however, has not been integrated into the corpus of what is known as legitimate human trafficking knowledge.

What I have come to understand through the literature review is that health stakeholders' understandings of human trafficking are very much informed by broader discourses in society such as immigration, organized crime and prostitution. In the next chapter, I present the methodology I employed to analyze the discourses that my health stakeholder participants used to think and talk about human trafficking and the subjectivities they produce for themselves and persons who are trafficked. This process enables human trafficking discourse to cohere, and in turn permit or disallow certain actions within the health care system and in health policy.

Chapter Three: Methodology

To answer the research question “How is human trafficking understood among health stakeholders?,” I analyzed the meaning-making process that the BC health stakeholders interviewed employ to comprehend human trafficking. Key elements of the meaning-making process are the discourses health stakeholders draw on and the subjectivities they construct within the human trafficking discourse. To analyze these subjectivities and the discourses that inform them, I conducted a discourse analysis of the interview data. Situated within a post-structuralist paradigm, the discourse analysis draws on Foucauldian theoretical concepts, in particular discourse, power/knowledge, truth, subjectivity and bio-power. To complete the theoretical framework, I also employed critical race and interlocking analytical perspectives to deepen my interrogation of the discourses health stakeholders draw on to produce knowledge about human trafficking.

Theoretical Framework

To begin, it is necessary to outline my ontological and epistemological framework. Ontology refers to one’s worldview and understanding of what the world consists of, how the world works and why (Strega, 2005). Defined narrowly, epistemology is “a philosophy of what counts as knowledge and truth; it is a strategy by which beliefs are justified” (Strega, 2005, p. 201). This study is situated within a post-structuralist paradigm and centers on the production of knowledge and how something becomes known as *truth*.

Post-structuralism

Post-structuralism is a movement of social, political and philosophical thought developed by French thinkers such as Jean François Lyotard, Julia Kristeva, Jacques Derrida, Gilles Deleuze,

Roland Barthes and Michel Foucault beginning in the 1960s (Harris, 2001; Peters & Burbules, 2004; Williams, 2005). Williams (2005) describes post-structuralism as a

thorough disruption of our secure sense of meaning and reference in language, of our understanding of identity, of our sense of history and of its role in the present, and of our understanding of language as something free of the work of the unconscious (p. 3).

I take the position that what we know about human trafficking has been discursively produced and is not *truth* but rather interpretation. Using a post-structuralist approach, I problematize widely-held *truths* by conducting a Foucauldian-informed discourse analysis. I draw specifically on the Foucauldian theoretical concepts of discourse, power/knowledge, truth, subjectivity and bio-power.

Foucauldian Theoretical Concepts

Discourse

From a Foucauldian perspective, discourses are linguistic structures that police and influence what is possible to know (Foucault, 1979). Discourses are “not just communicative exchanges, but a complex entity that extends into the realm of ideology, strategy, language and practice, and is shaped by the relations between power and knowledge” (Sharp & Richardson, as cited in Macias, 2010, p. 59). That is to say, discourse is much more than how we communicate and much more than language. Dei, Karumanchery and Karumanchery-Luik (2004) state that, “discursive relations [...] function as far more than a natural conveyer of ideas; rather, they shape ideas and work to constitute our social reality” (p. 74). A discursive approach to examining our social world highlights its formative nature in constructing the world around us which is contingent on power relations that determine who can access and produce discourse (Lynn & Lea, 2003). To put it another way, Chambon (1999) posits that “[m]ore than ways of naming, discourses are systems of thought and systematic ways of carving out reality” (p. 57).

Over time, discourses come to be regarded as ‘commonsense’ understandings because “ways of thinking and behaving are transmitted through social institutions, cultural traditions and day-to-day interactions” and become a part of our internalized thought and social practice (Lynn & Lea, 2003, p. 42). In order for this to occur, a particular discourse coheres at a specific time in history because it draws on the ‘extra discursive’.

Foucault distinguishes between the discursive and ‘extra discursive’ in asserting that the rules as to how a discourse forms must be articulated alongside its extra discursive conditions, because “extra discursive events transform the mode of existence by modifying its conditions of emergence, insertion and functioning of discourse” (as cited in Boucher, 2008, p. 95). Hook (2001) contends that a Foucauldian analysis of discourse “occurs fundamentally ‘through the extra-discursive’,” defined here as history, materiality and conditions of possibility (p. 538, emphasis in original).

To summarize, discourse is both an instrument and effect of power (Hook, 2001). A discussion of the Foucauldian concepts of power, knowledge and truth lends a fuller understanding of what discourse is and how it functions.

Power, Knowledge and Truth

Traditional juridico-discursive understandings of power assume that “power is a possession, that power flows downward from a centralized position, and that power’s primary function is repressive” (Dei, Karumanchery & Karumanchery-Luik, 2004, p. 60). Foucault (1978), however, conceives of power as productive, omnipresent and relational; “it is produced from one moment to the next, at every point, or rather in every relation from one point to another. Power is everywhere; not because it embraces everything, but because it comes from everywhere” (p. 93).

According to Foucault (1979, 1980), power and knowledge are inseparable and reciprocal; where there is knowledge, there is power. In speaking of the formation of a ‘power/knowledge nexus’, Foucault (1979) stated:

power produces knowledge [...]; that power and knowledge directly imply one another, there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time, power relations (p. 27).

If power is considered to be an intricate web of relations instead of a top down entity, one begins to understand how power enables certain knowledge to be validated as *truth* or fact depending on the privileged status of particular authoritative speakers and the resulting wide circulation of some discourses. For example, knowledge produced in the fields of medicine or law is considered legitimate knowledge and becomes *truth*. Conversely, power disregards other knowledge by excluding or silencing some discourses and subjugated speakers. Typically, knowledge produced by clients, patients or victims does not gain circulation and does not become *truth* due to its subordinate status.

According to Enlightenment thinkers, there is one true path to knowledge through scientific inquiry whereby knowledge, in a hierarchal sense, can be proved to be true or false through rigorous scientific methodology (Strega, 2005). In the positivist paradigm, knowledge, or what is deemed to be *truth*, is considered objective, impartial and neutrally discovered (p. 204). These facts constitute a society’s “‘regime of truth’, that is the type of statements that can be made by authorized people and accepted by society as a whole” (Mills, 2003, p. 74, emphasis in original). Mills (2004), building on Foucault’s work, defines truth as “something which societies have to work to produce, rather than something that appears in a transcendental way” (p. 16). For example, the production and circulation of ‘anti-slavery’ rhetoric is the basis of some present-day anti-trafficking initiatives both nationally and globally and is a discourse that is

widely accepted as *truth* and increasingly difficult to think outside of in the context of human trafficking.

The ‘will to truth’, a set of exclusionary practices that differentiate what is true and what is false in terms of the production of knowledge, determines the discourses that fall outside of accepted conceptualizations, those that are rejected and why it is “virtually impossible to think outside them. To think outside them is by definition, to be mad, to be beyond comprehension and therefore reason” (Foucault, 1981, p. 48). As I argue in subsequent chapters, the human trafficking public health discourse is an example of the rejected discourse Foucault speaks of here; human trafficking is rarely discussed from a health perspective even though health concerns are probable for persons who are trafficked at some point in the trafficking process.

Examining exclusionary mechanisms whereby lesser known discourses such as health and associated subjectivities have been excluded, or even silenced, is particularly useful to my research. I can “search for the scarcity of meaning, with what cannot be said, with what is impossible or unreasonable within certain discursive locations” (Hook, 2001, p. 10). By examining the power struggles within the production of knowledge and *truth* in human trafficking discourse, I explore how human trafficking and persons who are trafficked are produced as something that is not about health, but rather as other forms of dominant knowledge/truth. To understand to a greater extent how discourse functions to produce and perpetuate a hierarchy of knowledge, it is necessary to discuss subjectivity and the hierarchical relations of subjects within discourse.

Subjectivity

Foucault (1979) asserted that discourse gives rise to subjects. Rejecting the notion of the Cartesian subject who is autonomous, rational, and self-ruling, Foucault conceived of the subject

as an effect of discourse. Discourse produces subjects and sets the available subjectivities and subject-positions through two processes (Hall, 1997). First, discourse produces the subject which personifies the attributes of a particular discursive regime of a specific historical period. For example, discourse produced the ‘trafficking victim’ in the 1990s who is characterized as a passive, weak, ill-informed, vulnerable woman in need of rescue. Second, discourse produces a subject who is *subjected to* the discourse.³ Not all individuals fall into this category, for at any given time in history, not all become such subjects or bearers of power/knowledge; according to Hall, “for them – us – to do so, they – we – must locate themselves/ourselves in the position from which the discourse makes the most sense, and thus become its ‘subjects’ by ‘subjecting’ ourselves to its meanings, power and regulation” (p. 80, emphasis in original). For example, discourse produces the subjectivity of the benevolent helper who saves or rescues the ‘trafficking victim’.

The production of subjectivities occurs through power relations whereby subjects “are constructed as aspects of difference only connected in relation to their definition of opposites” (Dei, Karumanchery & Karumanchery-Luik, 2004, p. 73). Hence, I examine the possibilities of subjectivities within human trafficking discourse as determined by opposites constructed through the dimensions of race, class, gender, sexuality, age and nationhood. Critical race theory and an interlocking analysis offer important analytical approaches to interrogate this relational subject-making that enables the production of particular types of knowledge as *truth*.

Bio-power

According to Foucault (1980), ‘bio-power’ or ‘bio-politics’ is the administration and management of human life. As “[a] conceptual tool that makes it possible to analyse historically

³Given the scope of this thesis, I do not examine how the person who is trafficked understands his/her subjectivity. I limited the study to the production of knowledge and who the speaker understands both him/herself and the person who is trafficked to be.

how power has to come to work in relation to the human body,” Chambon and Wang (1999) describe the Foucauldian concept of bio-power as “the mechanism that takes the body and life as objects of intervention” (p. 270). The concept of bio-power is important in my analysis. Human trafficking discourse is biopolitical; oftentimes, how persons who are trafficked are represented in the discourse captures human life and constructs it in particular ways by allowing some to live (in this context, by providing access to health care), and letting Others die (by denying access to health care). Those who are excluded from the category of life (and health care) are not just anyone. Critical race and interlocking perspectives enabled me to analyze the subjectivities within human trafficking discourse whose race, class and gender location determine their in/accessibility to health services.

Critical Race Theory

Critical race theory (CRT) has engaged explicitly with post-structuralist concepts of discourse, power, knowledge, truth, subjectivity and bio-power. Both perspectives reject the existence of meta-narratives and universal truths, and emphasize multiple truths and realities; they assert that power relations determine dominant and subjugated knowledge, what becomes known as truth and consequently, that which informs our actions and speech; and they maintain that subjectivity is socially constructed through discourse (Marx, 2008; Ortiz & Jani, 2010; Strega, 2005).

CRT offers the necessary theoretical framework to interrogate human trafficking discourse as a racialized discourse, and the subjectivities produced within it. CRT’s main tenets are: 1) race is a social construction. Discourse produces race and material consequences, but race is not an absolute *truth*; 2) race-based ideology is threaded throughout society and race permeates all aspects of life. Race is ingrained and embedded permanently in our judicial, educational and

political systems; 3) CRT employs concepts of intersectionality and recognizes race alone does not account for disempowerment; 4) first-person narratives of persons of color figure predominately as a means to centre stories that have been dismissed and/or ignored by the dominant group in society; and 5) CRT advances a social justice framework that is action-oriented to redress social inequality (Delgado & Stefancic, 2001; Hill Collins, 2007; Marx, 2008; Ortiz & Jani, 2010; UCLA School of Public Affairs, 2007).

I employ CRT by putting race at the center of my critical analysis of the discourses the BC health stakeholder participants draw on to understand human trafficking and the subjectivities they produce within human trafficking discourse. Factors that exacerbate the vulnerability of racialized persons and increase their susceptibility to a variety of harms associated with human trafficking include a globalized economy in which the global North exploits the land and resources of the global South; a colonial context in the global North and global South in which Indigenous peoples continue to be robbed of their right to self-determination and control over their lands and resources; mass displacement and mass labour migration; the emergence of a global culture and an integrated socio-political world (Sanghera, 2005; Winant, 2000). Winant (2000) considers these factors “all deeply racialized issues” (p. 172). These everyday colonial encounters, both internationally and in Canada, produce and reinforce a dominant, white subjectivity in discourses that inform ‘commonsense’ understandings of human trafficking. Ergo, human trafficking discourse confirms whiteness, defined here as a “signifier for global racial supremacy” (Carr & Lund, 2007, p. 9), and the “status quo in which white identity is performed as dominant” (Schick, 1998, p. 20). Relationally speaking, then, persons who are trafficked must be predominantly conceptualized as persons of color in order for the discourse to cohere. CRT offers the theoretical tools to explore the significance of race in human

trafficking discourse and links the “micro- and macro-aspects of racial signification and a racialized social structure” (Winant, 2000, p. 181).

Although race is placed at the center of CRT, it recognizes that race works with and through other oppressions and systems of power such as gender, class and nationhood (Hill Collins, 2007). Because human trafficking is a multidimensional issue that is talked about using implicit and explicit assumptions about not only race, but also class, gender, sexuality, nationhood and age, an interlocking theoretical framework that enables an integrated analysis of all these categories of marginalization is necessary.

Interlocking Analysis

Hill Collins (1990) considers distinctive systems of oppression such as race, class and gender as being part of one overarching structure of domination which she names a “matrix of domination” (p. 222). This theoretical perspective posits that categories of oppression are dependent on each other for meaning; each operates in and through the other (Dei, Karumanchery & Karumanchery-Luik, 2004; Razack, 1998). Interlocked, one system upholds the other/s. The intertwining nature of oppressions gives meaning to each system and to the experiences of those in both privileged and subordinate positions.

An interlocking analysis builds on intersectionality theory (Crenshaw, 1989). Informed by Black feminist thought, intersectionality theory challenges a single-axis framework which proposes a mutually exclusive analysis of race and gender as separate identities (Crenshaw, 1989). This theoretical framework holds that multiple forms of oppression intersect simultaneously to generate and maintain the disadvantages of groups located at these intersections (Patel, 2001). Crenshaw (1989) uses a traffic analogy to outline how intersectionality works and to point out the limitations of a one dimensional analysis.

Discrimination, like traffic approaching an intersection, may flow in any number of directions. However, when an accident occurs, the investigation must take into account the traffic that flowed from all possible directions to the very point of the accident scene itself. Much like a one dimensional analysis, an accurate conclusion cannot be drawn about the accident if the traffic from each direction is investigated separately.

While intersectionality theory has made significant contributions to feminist and anti-racist literature, the interlocking concept of oppressions expands on the theory. Re-conceptualizing multiple forms of oppression, Hill Collins (1990) rejects any additive model, arguing that “additive models of oppression are firmly rooted in the either/or dichotomous thinking of Eurocentric, masculinist thought” (p. 222). Understanding systemic oppression in this way may result in the ranking of either/or categories and measuring oppression according to the number of categories of difference (Champeau & Shaw, 2003; Hill Collins, 1990).

Hill Collins (1990) speaks to how an interlocking analysis deepens one’s understanding of multiple forms of oppression:

Replacing additive models of oppression with interlocking ones creates possibilities for new paradigms. The significance of seeing race, class and gender as interlocking systems of oppression is that such an approach fosters a paradigmatic shift of thinking inclusively about other oppressions, such as age, sexual orientation, religion and ethnicity (p. 3).

Thus, an issue as multifaceted as human trafficking requires an analytical framework that can accommodate such a ‘paradigmatic shift’. For example, one of the most recent subjectivities produced in Canadian human trafficking discourse is the ‘girl next door’ (Dwyer-Joyce, 2012; Perrin, 2010; Smith, 2011). The girl next door is white, middle-class and from a good family. To interrogate the girl next door subjectivity, one needs to examine race, class, age, gender and sexuality to unpack how these interlocking dimensions function to construct meaning.

Race, class, gender, sexuality and age interlock to produce a young victim-subject who “is ‘innocent yet immoral’, who ‘deviates from white, middle-class standards of appropriate female behavior’” and “who can be acted upon by the helper-subject” (Abrams & Curran, 2000, p. 59, emphasis in original).⁴ To render the discourse comprehensible to the speaker, the discourse produces in relation to the girl next door a white, middle to upper class, benevolent helper-subject who by virtue of privilege is *qualified* to assume the role of rescuer. What may not be apparent is how the discourse functions here. The subjectivity of the girl next door creates fear by producing discourse that everyone’s daughter is at risk of being trafficked (Perrin, 2010). The discourse then dictates societal norms of girls’ sexuality. Furthermore, many of the helper-subjects believe abolishing prostitution is the only way young women and children can be protected from human trafficking.

Razack (1998) pursues the strengths of an interlocking approach further and discusses the tools required for this type of analysis. Because systems of oppression operate in and through one another, the analytical tools must enable the researcher to determine how these systems not only shape the experiences of the person who is trafficked, but also help those of us in positions of privilege realize our complicity in relations of power that contribute to the underlying causes of a problem. Martha Minow states that,

we fundamentally preserve the pattern of relationships in which some people enjoy the power and position from which to consider - as a gift or act of benevolence - the needs of others without having to encounter their own implication in the social patterns that assign the problems to those others (as cited in Razack, 1998, p. 138).

⁴ While I do not dispute that youth sexual exploitation occurs, this particular discursive construction is troubling due to the actions it renders possible. For example, the implementation of mandatory minimum sentences for child traffickers in Canada makes it appear as if the roots of human trafficking are being addressed, while the systemic causes that create an environment in which child and youth sexual exploitation occur remain intact. Furthermore, the spectre of child and youth sex trafficking as a central concern and trope among prohibitionists “push[es] the discussion of a complex topic to its extreme edge [i.e. child trafficking], to the case we can all deplore” and uncritically oppose (Agustin, 2012, n.p.).

To avoid examining our own complicity, Razack states that we “build critical consciousness about how we, as subjects, position ourselves as innocent through the use of such markers of identity as the good activist” (p. 18). In the case of human trafficking, there are ample opportunities for helper-subjects to participate in anti-trafficking initiatives that make them feel good about themselves. In actuality, oftentimes these initiatives do nothing to affect change in regard to the root causes of human trafficking. An interlocking analysis serves a dual purpose of examining how both white, privileged and racialized, oppressed subjectivities are produced in the discourse, and the material effects produced by these relations of power. In doing so, the interlocking analytical perspective, along with critical race theory, complement Foucauldian theoretical concepts outlined above.

Method

Discourse Analysis

Potter and Wetherell (1987) posit that discourse analysis “is a broad theoretical framework concerning the nature of discourse and its role in social life, along with suggestions about how discourse can best be studied” (p. 175). The underlying assumption of this approach is that “language is a medium oriented towards action and function in that people use language intentionally to construct accounts, or versions, of the social world” (Elliot, as cited in Bondarouk & Ruël, 2004, p. 5). Durrheim explains that,

[r]ather than describing and explaining the world and making truth claims, discourse analysis aims to account for how particular conceptions of the world become fixed and pass as truth; [...] it is a critical enterprise, a reflexive process, a form of ideology critique (as cited in Zeeman, Poggenpoel, Myburgh & Van der Linde, 2002, p. 99).

A researcher’s ontological perspectives along with the study’s aims determine the type and design of the approach to be employed. Since I draw on Foucauldian theoretical concepts such

as power/knowledge, truth and subjectivity to inform my understanding of discourse and consequently, how discourse informs what we say and do through power relations, I employ a Foucauldian-informed discourse analysis approach as the method.

Discourse Analysis Informed by Foucault

Instead of scrutinizing discourse to determine whether it is true or false, Foucault suggested an examination of the function of discourse through the power and the processes involved in the struggle for meaning whereby some statements become more valid and gain wider circulation as *truth* than others. A Foucauldian discourse analysis approach focuses on “discursive practices [which] work in both inhibiting and productive ways, implying a play of prescriptions that designate both exclusions and choices” (Foucault, as cited in Hook, 2001, p. 523). For instance, according to the human trafficking discourse the BC health stakeholders interviewed produced, who can be the person who is trafficked? Who is excluded from this category and why? A Foucauldian discourse analysis approach enabled me to investigate the discursive strategies the speakers employed to construct subjectivities that allow or disallow actions in the context of health service provision for persons who are trafficked.

To analyze the data, I am guided by the central foci of this study: how human trafficking is understood by BC health stakeholders, who BC health stakeholders understand themselves and persons who are trafficked to be, and how these understandings enable or prevent health stakeholders from developing and/or delivering health care to persons who are trafficked. Borrowing from Carla Willig’s (2008) summary of Foucauldian discourse analysis, I carried out several comprehensive readings to code and analyze the data.

First, I determined how human trafficking is conceptualized by the BC health stakeholder interview participants. Is human trafficking understood according to any or all of the six

frameworks (migration, prostitution, human rights, transnational organized crime, modern-day slavery and health) I outlined in the literature review or is it understood according to some other framework? Which discursive framing emerges as dominant? Having identified the framework within which human trafficking is understood, I situated the discursive framing/s in wider societal discourses. Foucault (1972) argued that statements have meaning dependent on the discursive context in which they appear. Otherwise, statements are discursively meaningless. What discourses do the speakers draw on in order for their representations of themselves and persons who are trafficked to make sense? Do the discourses overlap, complement or contradict each other? Here I identified power at work in a struggle for meaning. Next, I read to determine how the dimensions of race, class, gender, sexuality and nationhood interlock to produce subjectivity. What subjectivities are made possible? What subjectivities are excluded in the discourse? What meaning is made when the speaker assumes a particular position in relation to other subjects? After I established the subjectivities, I examined how discourse informs action. What practices are informed by these understandings? What actions are rendered possible? What actions are rendered impossible? In unraveling how the discourses function, I examined what is achieved when human trafficking is represented in particular ways. Finally, I discuss bio-power and explore the implications for the health care and life of persons who are trafficked when human trafficking is conceptualized in these ways.

In summary, Morris (2010) provides a metaphor that describes the Foucauldian discourse analysis approach I undertook to analyze the data:

I use the metaphor of visiting the optometrist. The intellectual resources outlined in Chapter 2, Theoretical Framework, can be likened to the lenses used by the optometrist to check eyesight - with an important caveat that the purpose of my analysis is not to arrive at a prescription. Rather, I use the lens offered by the questions in the analytical strategy every time I completed a close read of the transcripts. Sometimes I would read through the transcript

with just one lens, whilst at other times I would use several in an attempt to explore the interplay and synergy between each of these analytical nodes. Extending the metaphor, the lenses at times proved to be both clarifying and blurring when reading across the layers of data corpus (p. 64).

Data

The decision to conduct interviews to collect data was based on everyday conversations I engaged in with health stakeholders when I was a social worker in the health care system.

Hearing various representations of persons who are trafficked caused me to question how health stakeholders understand human trafficking, the assumptions that underlie the perceptions and the implications for the health care of persons who are trafficked.

Research participants included front-line health care providers, program managers and policymakers. I chose 10 health stakeholders who work in the province of British Columbia from the following categories:

- Group 1: Health policymakers such as provincial policy analysts and hospital administrators (3 participants)
- Group 2: Health program managers in fields such as sexual assault, forensic nursing and at-risk youth (3 participants)
- Group 3: Front-line health care providers such as nurses and outreach workers (4 participants)

More specifically, I selected participants from the fields of emergency nursing, outreach street nursing, forensic nursing, sexual assault, women's health policy, provincial health policy, health education, hospital administration and women's outpatient services. I chose participants who work with marginalized populations who may be at greater risk of human trafficking including un/documented migrant workers, at-risk youth, Indigenous persons, sex workers and street-involved persons. I recruited participants from government, health authority and community

organizations' websites or staff directories, and also used snowball sampling. Although unintentional, the participants were predominately white (two were visible minorities, indicated in their professional bios) and middle to upper class (determined by job status). The Invitation to Participate is attached as Appendix A.

The Invitation to Participate indicated my professional qualifications as a social worker. Therefore, participants in Groups 1 and 2 (provincial health policy analyst, hospital administrator and program manager) likely viewed me as a younger professional in the health field. Participants in Group 3 (nurses, outreach workers) likely viewed me an equal in the helping professions. A power over relationship did not exist between the researcher and participants. I characterized the dynamics between me and all participants as professional and cordial.

To protect the participants' anonymity, I provided the option to be identified by name and/or agency or by a pseudonym. Four participants requested pseudonyms and that I not identify their agencies. For consistency, I chose not to identify anyone by name or agency as I did not feel this was necessary in my analysis. Instead, I used a general occupational descriptor such as hospital administrator or emergency department nurse. The Participant Consent Form is attached as Appendix B.

Participants were not required to have worked on a case of human trafficking as a prerequisite to participation in the study. If participants had worked on cases of human trafficking, they were not asked to divulge details of any particular case. Rather, participants were asked to discuss their understandings of human trafficking in a broad sense and where they acquired knowledge about human trafficking. The Interview Questions are attached as Appendix G.

Data Collection

I conducted an audio-recorded, semi-structured interview at the participant's workplace or other mutually agreed upon location. The interviews each took 20-40 minutes. I recorded a total of approximately four hours of interviews. The interviews were then transcribed and I made the transcripts available to the participants if they wished to check for accuracy. I deleted fillers such as "ah," "uh," and "um" to make the transcripts easier to read. I did not use data analysis software to analyze the data. However, to provide guidance in analyzing the data, I looked to scholars who have employed a Foucauldian discourse analysis approach to discern how I could frame the questions that guided the analytical strategy (Bacchi, 2009; Willig, 2008).

The confidentiality of the data was preserved by downloading the audio files of the interviews onto my computer which is password protected and by deleting the files from the digital recorder. Electronic files of the typed transcripts were password protected. Hard copies of the transcripts were stored in a locked cabinet at my home office where I am the lone occupant. I will shred the consent forms and hard copies, and erase electronic copies of audio recordings and transcripts stored on my computer data five years after publication.

Ethics

I began the research after receiving full ethics approval from the University of Victoria Human Research Ethics Board. However, in the case of participants employed at health authorities, I needed to obtain additional institutional ethics approval before I could contact and interview these health professionals. In the end, Fraser Health Authority and UBC/BC Women's Hospital granted ethics approval. These institutions required their own Invitation to Participate and Participant Consent Forms. These are attached as Appendices C and D (UBC/ BC Women's

Hospital), and Appendices E and F (Fraser Health Authority). This complicated and lengthy process took months to complete.

I had to drop Vancouver Coastal Health Authority from the study because I found their ethics application process too time-consuming and cumbersome, and the proposed study was not well-received by this particular agency. It is unfortunate that the Vancouver Coastal Health Authority, which provides health services to the large, densely populated area of Vancouver, Richmond, North and West Vancouver, and along the Sea-to-Sky Highway, Sunshine Coast and BC's Central Coast, did not grant me permission to recruit research participants within the agency. In my view, this constituted a missed opportunity for Vancouver Coastal Health's health care providers to reflect on their work in regard to health service provision for at-risk or potentially trafficked persons.

Methodological Rationale

Discourse analysts do not necessarily need to work with vast amounts of text or speech in order to produce an analysis. A single piece of data can highlight how discourse functions to render actions im/possible. Because discourse analysis is very labour intensive, I chose to carry out a thorough analysis of 10 interviews which is within the scope of a Master's thesis.

Not intended to be exhaustive, this study does not aim to draw conclusions about how all or a majority of health stakeholders conceptualize trafficking. The purpose of a discourse analysis differs from a positivist study that might make generalizations or infer universal applicability about the phenomenon of human trafficking using statistics such as who is being trafficked, who traffickers are, the trafficking process and so on. Speaking to the critique that discourse analysis does not produce findings that are generalizable, Cheek (2008) asserts that generalizability in itself can be viewed as "a discursive construct that draws on particular meanings of what it

means to generalize,” a notion largely drawn from mathematics and science discourses which is incongruent with the post-structuralist rubric in which this study is situated (p. 358). Talja (1999) defines generalizability in post-structuralist studies in this way: “the research results are not generalizable of descriptions of how things are, but as how a phenomenon can be seen or interpreted” (p. 472). For instance, Doezeema (2010) posits that, as valuable as research is that establishes *facts* about human trafficking, such research “leaves unanswered how these ‘facts’ will be interpreted and which interpretations will come to be accepted as legitimate knowledge” (p. 10, emphasis in original).

Inevitably, some readers will not agree with the interpretations or findings of this study because they do not cohere with ‘commonsense’ understandings of human trafficking. Rather than describing *the* reality of ways BC health stakeholders conceptualize human trafficking, the findings are but one of a number of interpretations that can be produced. Cheek (2004) answers critics by stating that producing only one interpretation may, in fact, be in conflict with the very tenets of the methodology employed in this study. To this end, Bondarouk and Ruël (2004) suggest that, like a reader whose responsibility it is to understand the text, the responsibility falls on the critic to reach an understanding of the interpretations. Bondarouk and Ruël maintain that the “validity of discourse analysis is developed through a dialectical process of using a circle of evidence to create the social reality, and through the openness for other interpretations and critiques” (p. 12). Furthermore, they suggest that, the critic who does not understand or does not want to should “change yourself” (p. 12). If the critic still does not agree, s/he could suggest improvements which would add to the reliability or validity of the study. This study is transparent about its political aims and the partial and situated knowledge it produces as discussed in final section of this chapter. How then does a study that problematizes the notion of

a single, objective, verifiable truth that can be *proven* meet the academic requirements of a Master's thesis?

Evaluative Criteria

When employing a post-structuralist approach, Strega (2005) argues that it is necessary to discard standard measures of rigour and validity aptly suited to the positivist paradigm. Among other reasons, such standards draw on the definition of valid as “supported by objective truth or generally accepted authority” (p. 228). Because this study disputes that very premise and carrying out an *objective* study is not my intent, I look to evaluative criteria befitting a post-structuralist approach. I identify three criteria that reconceptualise rigour against which this study can be evaluated.

First, the study's interpretations and explanations must be comprehensive and understandable. Referring to a Foucauldian discourse analysis approach, Cheek (2004) emphasizes the importance of being forthcoming about the theoretical ‘decision trail’. Being explicit about theoretical understandings of discourse and discourse analysis, the conceptual framework underpinning the study as well as how the data was chosen and collected is essential. The entire research process must be able to withstand scrutiny.

The findings must also be understandable and accessible to the group being studied (Strega, 2005). Conveying the findings of a Foucauldian-informed discourse analysis approach in a clear way to health stakeholders can be challenging, but not impossible. For guidance, I look to scholars who have used this methodology and published their findings in journals and other print sources that are accessed by readers outside their fields of expertise.

Second, the findings must have “social justice validity” (Deyhle & Swisher, as cited in Strega, 2005, p. 229). Consideration must be given to the political usefulness of the findings for

decision-making, action and/or policy change. My social justice contribution will be the interrogation of how dominant human trafficking discourse forms; with this knowledge, space can be created for subjugated discourses which challenge dominant discourses that uphold the systemic marginalization of persons who are trafficked.

Finally, reflexivity – the process of laying out my assumptions and their effects on the research, as well as my own complicity in systems of domination and subordination – must be addressed (Strega, 2005). Since this is a study concerned with power relations, my look inward examines the multiple power relations involved in this research (herising, 2005). My process of reflexivity covers three areas of critical self-reflection: my social position, ideological bias and political stance.

Reflexivity

Social Position

My social location is that of a white, middle-class, able-bodied, heterosexual female. Social work pedagogy encourages me to be conscious of social location when working across difference to dismantle racial, class, gender, heterosexual and ableist systems and structures of oppression and in carrying out research within the discipline. However, Heron (2005) asserts that self-reflection that stops at the acknowledgement of social location leaves a researcher in a “place of double comfort: the comfort of demonstrating that one is critically aware and the comfort of not needing to act to undo privilege” (p. 344).

Critical social work pedagogy prompts me to take the self-reflexivity of social location one step further and to recognize the potential harms of my work (Heron, 2004). In order to accomplish this aim, my data analysis includes a detailed examination of the power relations that exist between the subjects this research may ultimately affect (persons who are trafficked if the

findings inform health services or policy) and me (as a helper-subject). Additionally, in regard to my social location, I did not perceive, as noted above, a power imbalance between me, the researcher, and the health stakeholder participants.

Ideological Bias

As a post-structuralist researcher, I acknowledge my ideological position and the effect it has on how I interpret the research (Strega, 2005, p. 204). I am the co-ordinator of the GAATW affiliate in Vancouver, Supporting Women's Alternatives Network (SWAN). SWAN is a group of culturally diverse women who provide culturally appropriate and language-specific support, education, research, advocacy and outreach to newcomer, migrant and immigrant women who engage in sex work. I am also a community developer with Living in Community, a Vancouver-wide initiative whose goal is to balance perspectives on sex work and to develop an integrated approach to sex work-related issues. I employ a harm reduction and human rights-based perspective that respects the rights and choices of women who engage in sex work to live their lives as they choose.

I am influenced by the work of Laura Agustin, Jo Doezema, Kamala Kempadoo, and Jyoti Sanghera, among others, who conduct research through critical race and feminist post-structuralist frameworks. These scholars write extensively on migration, sex workers' rights and human trafficking. Much of their work critically analyzes mainstream discourses on human trafficking.

I also follow and participate in the activities of No One Is Illegal – Vancouver Coast Salish Territories (NOII), a grassroots anti-colonial migrant justice group with leadership from members of migrant and/or racialized groups. NOII is a movement for self-determination that challenges the ideology of immigration controls, addresses detention and deportation, the

national security apparatus and the exploitative working conditions that migrants experience (NOII, 2007). NOII advocates for immigrant, migrant and refugee rights and as such, challenges federal policy that discriminates against these groups under the guise of anti-smuggling and anti-trafficking legislation. NOII's principles and community work are congruent with my own values and beliefs.

Political Stance

The political intent of this research is to challenge dominant constructions of human trafficking that mitigate the possibility of human trafficking being understood from a health perspective. My hope is that dominant human trafficking discourse could expand to include subjugated knowledges such as a health discourse. In regard to the health stakeholders, my hope is that a growing number will become collaborative community partners in addressing human trafficking. I would like to see health professionals become more critically informed about human trafficking and learn evidence-based clinical skills and approaches to respond appropriately to persons who are trafficked. I would also like health stakeholders, as part of the larger community, to realize their complicity in maintaining power relations that produce and maintain the oppressive economic and social conditions that make human trafficking possible.

It has long been a critique of anti-human trafficking initiatives that they mute the voices of those who are already considered to have limited agency – the persons who are trafficked (Kelly, 2005). Critical research maintains that agency is further removed by researchers who inadvertently de-center persons who are trafficked and push them even further to the margins. By explicitly choosing a Foucauldian discourse analysis approach, acknowledging my position and power as researcher and sharing my socio-political position, I hope that I have achieved an acceptable level of integrity and accountability in the research process.

Chapter Summary

In this chapter, I laid out the theoretical framework employed in this thesis: a post-structuralist conceptual framework that weaves together critical race, interlocking and Foucauldian theoretical concepts with a focus on the study of power relations. I also described my chosen method, a Foucauldian-informed discourse analysis approach. This theoretical framework and method allows me to critically analyze how hegemonic power relations manifest in the discourses under examination and how the material effects of power emerge in health policies or practices.

Chapter Four: Data Analysis

Of the six conceptual frameworks I presented in Chapter Two (migration, prostitution, human rights, transnational organized crime, modern-day slavery and health), only two frameworks figure prominently in the interview data: migration and prostitution. Using excerpts from the interviews to examine migration in this chapter and prostitution in Chapter Five, I analyze how the health stakeholders re/produce knowledge about human trafficking. Interrogating the origins, purposes and effects of these two representations, I unpack the layers of meaning-making that are located within ‘commonsense’ understandings of human trafficking. I analyze how the speakers exercise discourse to perform power relations in the representations of themselves and persons who are trafficked. I discuss how through these representations health stakeholders construct, impose and perform subjectivities that draw on various societal discourses in order for the issue of human trafficking to make sense. My intention is to expose the functional role of discourse because, as Weedon (1997) states, “[i]t is only by looking at a discourse in operation, in a specific historical context, that it is possible to see whose interests it serves at a particular moment” (p. 108). Finally, I discuss what the speakers accomplish in terms of the actions that can or cannot be taken from their subject-positions; that is to say, the actions that are rendered unlikely in the context of a health response to persons who are trafficked.

Human Trafficking as Migration

When asked what comes to mind when hearing the term human trafficking, several speakers responded with answers that fall within the migration framework. One nurse responded as follows:

I guess people coming from other countries by force or by bribery or without choice but oftentimes they may be thinking they are coming to another country because they want to help their families or they think they might get

some money. So I think it's people that come from a position of really great disadvantage (personal communication⁵, May 16, 2012).

Another nurse indicated that, "I think of people exporting people from Third World countries, you know to Canada and trying to get them to pay their way here" (personal communication, June 27, 2012). A Deputy Provincial Health Officer stated that, "often [people] from other cultures come here, you know, are brought here and are exploited. Very common in developed nations including Canada." These speakers conceptualize the person who is trafficked as the racialized migrant 'Other'.⁶

The Smuggled Other Subjectivity

Interestingly, however, the subjectivity that some health stakeholders produced was not just any racialized migrant Other, but a particular figure: the migrant Other who is smuggled to Canada by boat. When asked the same question as above, several speakers referred to persons who are trafficked in this manner. A sexual assault education coordinator stated that, "I think [of] human smuggling where people are coming in ships and it's obviously illegal and the people are very exploited and they're you know, hiding in the boat to try and get here for a better life usually" (personal communication, July 13, 2012). Others spoke of "some of the boats, the shiploads of people that have come into Vancouver or the port" (outreach nurse, personal communication, May 16, 2012), "the media reporting on the boatloads of people coming" (provincial health policy analyst, personal communication, May 9, 2012) and "that whole Sri Lankan boat thing. I'm sure - I don't follow the news very often, but I know that something there had to do with trafficking of probably women and children" (emergency room nurse, personal communication, June 27, 2012).

⁵ 'Personal communication' indicates quotes from research interviews.

⁶ Edward Said's (1978) concept of Orientalism defines the Other as "any individual or group perceived as weak or inferior to the dominant individual culture or society; the latter exercises power over the Other to exclude or subordinate them" (as cited in Dorfman, 2011, p. 7).

According to a Foucauldian theoretical approach, the cogent point is not whether health stakeholders discursively produce an accurate representation of persons who are trafficked. Instead, the question is how is it that the health stakeholders interviewed have come to understand persons who are trafficked as migrant Others who are smuggled by boat? Why is it that the health stakeholders do not conceptualize persons who are trafficked as migrant Others who arrive by air or land, for example? And referring to the purpose of this study, what are the implications for health care provision for persons who are trafficked if they are understood to be migrant Others smuggled by boat?

To produce this particular representation, the speakers employed the discursive strategy of ‘dividing practices’. Chambon (1999), drawing on the work of Foucault, states that dividing practices “constitute polarities between Self and Other, good and bad, normal and pathological. They create classes of features and categories of people” (p. 67). Chambon further asserts that, “these divisions expand into elaborate classification systems with internal graduations. They locate individuals within series and assign them a relational rank. They define degrees of development and hierarchies of deviance” (p. 67). Unlike human trafficking, human smuggling involves consent whereby a migrant pays an agent to facilitate his/her entry into a country. Migrants who pay third parties to board a ship destined for Canada fall into this category. Consequently, the migrant Other is understood by some to be deviant and to have malicious intent. This latter representation is reinforced by current immigration discourse that assumes that smuggled migrants “are guilty—of wanting to abuse the system at best, and of being actively engaged in criminality at worst—until they prove themselves innocent, and therefore deserving of the Canadian generosity that would allow them to enter the country” (Thobani, 2001, p. 25).

Benevolent Self Subjectivity

Relationally speaking, the production of the smuggled others' subjectivity produces the speakers' own subjectivity of innocence and benevolence. That is to say, by producing the Other, the speaker produces the Self. For example, one hospital administrator made the following observation:

I think we have a view that we're a very welcoming country to immigrants, really supportive, that we have a lot of social supports, and so I think we feel that we're a kind and supportive society and government. That we don't have by comparison to the States, you know, we are just not as rigorous, or [have] some of the policies, border policies and things (personal communication, May, 11, 2012).

According to Thobani (2007), the 'deployment of exaltation', observed by the speaker above, is a technique of power Euro-Canadians use to discuss their perceived benevolent treatment of immigrants:

Exaltation delineates the specific human characteristics said to distinguish the nation from others, marking out its unique nationality. As such, it invokes a particular subject-position that can only be inhabited by the nation's insiders, or those who seek inclusion – and are allowed to do so – by effacing their differences from this position (Thobani, 2007, p. 20).

However, to convey a nationalist narrative of compassion, altruism, goodwill and generosity requires much more than the production of binary subjectivities. All the speakers cited above draw on the 'extra-discursive', that is broader discourses associated with human trafficking through which the speakers understand and locate themselves in the discourse. These discourses include nationhood and the 'securitization of migration', the latter defined as a modern racist discourse that views all illegal - smuggled or undocumented - migrants as a security threat to the nation (Ibrahim, 2005). Through these discourses, race and class interlock to produce the trafficked person as smuggled other and the speaker as the benevolent Self; this meaning-making process enables human trafficking discourse to be understood.

The Extra-discursive: Nationhood

Considering the elements that create nationhood and a sense of belonging, Thobani (2007) asks, “[w]hat specific characteristics does the Canadian nation imagine itself to embody” (p. 5)? In the excerpt cited above, the speaker discusses the racialized discourse of nationhood that constructs Euro-Canadians as the ideal citizens - benevolent, kind and supportive of immigrants and migrants. In this way, Euro-Canadians can perform themselves as *the* national subjects. Thobani asserts that, “the figure of the national subject is a much venerated one, exalted above all others as the embodiment of the quintessential characteristics of the nation and the personification of its values, ethics, and civilizational mores” (p.3). This national subject is undeniably white, constructed positively in relation to the racialized migrant or immigrant:

From Confederation until the 1960s and 1970s, immigration and naturalization legislation distinguished first British and then French, and later, other Europeans as the ‘preferred races’ for integration into the nation. This exaltation positioned Europeans as the ‘true subjects’ of the nation. For over a century after Confederation, the state therefore organized and solidified white racial identity as *political* (citizen) identity. The nation’s racial identity, as well as its legal citizenship, thus became fused as white (Thobani, 2007, p. 75, emphasis in original).

In the relational process of nation-making, the speakers quoted above reaffirm whiteness and superiority and construct the inferiority of the racialized Other as demonstrated in descriptions of disadvantage and destitution. Such nationalist discourse would “fall apart if there were not Others against whom the nation could be defined” (Hage, as cited in Sharma, 2006, p.13).

Smuggled Others also generate anxiety and hostility as ‘commonsense’ thinking has it that they pay to come to Canada to take or get what Canadian nationals have. The sexual assault education coordinator stated that, “you know [they’re] hiding in the boat to try and get here for a better life usually. I think usually that’s what the perception is of their goal to come here” (personal communication, July 13, 2012). Thobani (2007) explains that,

[t]he outsider, on the other hand, cast in the trope of the stranger who ‘wants’ what nationals have is a figure of concern. Popularly devoid of the qualities and the values of the nation – as being quite alien to these- the stranger provokes anxiety, if not outright hostility (p. 4).

Such anxiety and hostility draws on ‘the securitization of migration’ discourse for the ideal national subject “requires the existence of a ‘threat’ to create a secure sense of Self” (Hage, as cited in Sharma, 2006, p. 13, emphasis in original).

The Extra Discursive: The Securitization of Migration

In 1999, four boats carrying 599 Chinese migrants arrived off the coast of British Columbia (Ibrahim, 2005). Canada was regarded as a nation ‘under siege’. How could so few migrants have generated such fear? The migrants were thought to threaten the security of the nation for various reasons including the spread of infectious diseases such as HIV and tuberculosis, participation in criminal activities and support for insurgencies and potentially causing the collapse of the welfare state (Hier & Greenberg, 2002; Ibrahim, 2005). The government’s response to the arrival of the Chinese migrant boats (among other factors between 1999 and 2007) was to create the BC Office to Combat *Trafficking* in Persons in 2007 (emphasis added).

In 2009-2010, two ships carrying 568 migrant Tamils arrived off the coast of British Columbia (Dhillon, 2012). Then Minister of Public Safety Vic Toews constructed the Tamil migrants as a security threat for many of the same reasons the Chinese migrants were perceived as a threat a decade earlier (Robson, 2010). Toews stated that the Tamil arrivals included “human smugglers and terrorists,” conjuring up the spectre of criminality and a nation under siege (Blaze Carlson, 2010, n.p.). The arrival of the Tamil ships generated media coverage in which the terms human trafficking and human smuggling were used interchangeably (Baziuk, 2011; Postmedia News, 2010). In 2012, the government’s response was Bill C-31, a bill designed to deter human smuggling. The Bill allows arbitrary designation of ‘irregular arrivals’

and their mandatory incarceration for up to a year, as well as restrictions on applying for permanent residency for five years (*Protecting Canada's Immigration System Act*, 2012).

Speaking with authority, the federal government has the capacity to influence and shape ‘commonsense’ thinking about national security issues among the general population. Ibrahim (2005) points out that the representation of the migrant as a national threat has become understood as fact or *truth*, not social construction. Buzan, Waever, and de Wilde (1998) concur. With regard to the ‘migrant-as-a-threat’ narrative, they state that, “the total effect is a national crisis so well structured and encompassing that it leaves little room for oppositional views” (p. 7). Within this discursive context, some of the BC health stakeholders associated the arrival of migrant ships over the past two decades with human trafficking, even though no one on these boats was ever charged with or convicted of human trafficking. What relevance does this representation of the trafficked person as the smuggled Other have for the health care of persons who are trafficked?

The Smuggled Other and Implications for Health Care for Persons Who are Trafficked

The absence of health policy and protocols for persons who are trafficked appears to disrupt the subjectivity some health stakeholders produce for themselves as benevolent, caring Canadians and health providers. Eight out of the ten health stakeholders stated that they believed human trafficking to be prevalent or very prevalent in their health region; one would think this belief would prompt concern and/or action. However, the same number maintained that human trafficking was not something that they themselves or their colleagues discuss at their workplace. However, if the person who is trafficked is understood by some to be the smuggled Other, criminality rather than victimhood is implied and the implications for health care become apparent; as in the case of illegal undocumented migrants, no health services need to be

provided. An outreach worker who advocates for migrant health care addressed this point with respect to one undocumented female migrant:

And the perception of health authorities is ‘why do we have to’? I had this experience yesterday. I was in a meeting advocating for health services for undocumented pregnant women, mostly from Mexico and then what I hear, usually from the health authorities is, ‘oh, why do we have to provide services for them if they are deciding to stay here illegally’ and they continually use the word illegals and then I get very mad (personal communication, May 31, 2012).

The discourse circulated by this health authority is informed by racist and classist understandings, particularly of illegal migrants who may be smuggled or undocumented, and manifests in our health care system to exclude Others not only from the space of the nation, but also from claims to the entitlements associated with membership in it (Sharma, 2006). Grit, den Otter and Spreij (2012) argue that, “many Western countries have adopted policies that exclude undocumented migrants from publicly funded health care, with the exception of life-threatening situations or, in some countries, if the situation poses a risk to public health” (p. 38). The hospital administrator indicated that “the kind of services that an undocumented person would seek are probably more emergency services I would think right. Because otherwise, you know, they’re not going to get elective things, necessarily it would be more emergent” (personal communication, May 11, 2012). This point is supported by Wolff et al. (2008) who state that undocumented migrants, whether smuggled or otherwise, encounter major problems in accessing prevention and health care. I argue the inaccessibility to health care services occurs because the ‘illegal’ undocumented and/or smuggled Other does not fit neatly into the subjectivity of the deserving migrant or the victimhood of the person who is trafficked. The outreach worker who advocates for migrant health care indicated that,

an undocumented person, an undocumented pregnant woman is not going to receive pre-natal care and delivery. Delivery will cost \$14 000-15 000 at the Women's Hospital. Some of them might get service if they answer the question on the assessment and they explain that they have a violent situation at home, and then they will be accepted probably, but most likely that a woman will not express this to a health provider right away (personal communication, May 31, 2012).

In effect, 'illegal' migrants (undocumented or smuggled) will potentially only receive health services if they assume a subjectivity that the discourse recognizes. Razack (1998) states, in regard to refugee hearings, that female migrants from the Third World are seen as "deserving asylum [and hence health care] only when they could present themselves as victims of unusually patriarchal, hence culturally inferior, states and communities" (p.131). This logic could also apply to persons, especially women, who are trafficked.

Health care for transnational persons who are trafficked is covered by the Temporary Resident's Permit (TRP). Between May 2006, when Citizenship and Immigration Canada began issuing TRPs and the end of September 2011, 126 TRPs were issued to 69 foreign nationals – 51 females, 15 males and 3 minor dependents of the adults (N. Hopkins, personal communication, February 2, 2012). Women and children who fit neatly into the racialized and gendered subjectivity of the 'trafficking victim' and whom the human trafficking discourse recognizes may be deemed deserving and entitled to a TRP and health benefits. Because ongoing changes to immigration laws and policies shift representations of immigrants and migrants into deserving and undeserving categories in relation to health access and services, understanding the intersection of immigration and health discourses in the context of human trafficking is essential - as is how health care stakeholders conceptualize persons who are trafficked. For example, sex workers who knowingly migrate to do sex work and subsequently find themselves in a trafficking situation may not be able to or want to perform the subjectivity of 'trafficked victim'

and may be categorized as undeserving of TRPs and access to health care. Here the interlocking dimensions of race, class and gender produce subjectivity and reinforce the marginalization of female migrants in the context of health care depending on how they are conceptualized.

Chapter Summary

If there is evidence to suggest that some health stakeholders interviewed understand persons who are trafficked to be illegally smuggled or undocumented Others, the health stakeholders' subject-position does not allow them to provide health care services to persons who are trafficked. Providing health services to smuggled Others would violate the Canada Health Act and provincial health care legislation and regulations and disrupt power relations. Disruption would mean health stakeholders would have to acknowledge complicity in oppressive legal systems and social structures that allow certain designated groups within the national state to exercise the full privileges of citizenship and that marginalize Others, including illegal (undocumented and smuggled) migrants.

Chapter Five: Data Analysis

In this chapter, I lay out how the BC health stakeholders interviewed came to understand human trafficking as prostitution, the predominant conceptual framework the health stakeholders employed when talking about human trafficking. I argue that the health stakeholders draw on a number of discourses to produce the racialized prostitute as trafficked woman and perform a particular subjectivity in relation to this figure. The way in which the health stakeholders produce this knowledge and their resultant understandings of human trafficking have profound implications for the health care for persons who are trafficked.

Human Trafficking as Prostitution

When asked to define human trafficking, a Deputy Provincial Health Officer responded by stating:

[w]ell I'd use some very broad terms around human trafficking that includes the degradation of women for profit. Usually it means the sexual exploitation of women and very often includes survival sex work, not necessarily just sex for profit but sex for survival. Do I use any other words? Prostitution, survival sex, sexual exploitation. I don't know where sexual abuse fits in (personal communication, May 14, 2012).

In another example, when asked if she had heard human trafficking referred to by any other phrase or term, an emergency room nurse answered that, “[o]ther than calling them you know your basic prostitutes or escort services, no I haven’t” (personal communication, June 27, 2012). Another emergency room nurse, when asked if she ever worked on a case of human trafficking, explicitly imposed the prostitute as trafficked woman subjectivity upon the patient:

Possibly one, one girl who presented here to emerg. Just the way that she was telling her story to me sounded like somebody was selling her on the streets and that somebody owned her and that they were basically getting money from her for doing prostitution activities, but it was in a way that she wouldn't form it in those exact words (personal communication, June 13, 2012).

As stated in an earlier chapter, my purpose is not to unpack what is or what is not human trafficking or to assess whether my participants accurately represent human trafficking in, for example, the commercial sex sector. Rather, my aim is to analyze the meaning-making processes the health stakeholders employ to produce the prostitute as the dominant representation of the person who is trafficked and to explore its implications for health services.

Racialized Prostitute Subjectivity

Similar to how some health stakeholders produced the smuggled Other as a particular type of migrant, some health stakeholders produced a particular type of prostitute in order for the discourse to cohere. Supporting my earlier assertion that human trafficking discourse is a racialized discourse, the prostitute invoked here as the trafficked woman could *only* be conceptualized as a racialized woman. For example, the Deputy Provincial Health Officer stated:

[m]any developed nations have exploited sex workers [...], often from other cultures come here, you know are brought here and are exploited. Very common in developed nations including Canada [...] And because we have Aboriginal women who are marginalized. Many Aboriginal women who are marginalized, they then become fodder for the flesh mill. So by all of those, we have a lot of human trafficking (personal communication, May 14, 2012).

A sexual assault education co-ordinator described persons who are trafficked as follows:

Usually the women we have seen where we think that's an issue, it is prostitution related. They're either a local issue, they're being moved from northern BC to southern BC and they're kind of being forced into prostitution or it's someone from overseas who usually has very limited language skills and then they are often working as an escort, or in a massage parlour (personal communication, July 13, 2012).

The speaker implies Indigenous women when speaking of women moved from northern BC to southern BC as this process has been widely publicized as the domestic trafficking of Indigenous women (Native Women's Association of Canada, 2013; Perrin, 2010; Sethi, 2007).

The hospital administrator also made the link between human trafficking and young Indigenous

women: “I think about human trafficking now in terms of even young Aboriginal women being exploited and moved from certain communities to work in the sex trade in urban areas” (personal communication, May 11, 2012).

In regard to the other racialized representation, ‘Asian’ women were also linked to human trafficking. The sexual assault education co-ordinator spoke of massage parlours and invoked “the quintessential ‘trafficking victim’ [...] a ‘young Asian woman’ [...] sold into ‘sexual slavery’ ” (Lepp, 2002, p. 95, emphasis in original). A forensic nursing coordinator similarly stated that, “[f]irst what I would say, my sort of understanding of the idea of trafficking is particularly Asian women from foreign countries” (personal communication, June 6, 2012).

These statements contain a number of implicit and explicit references that discursively produce and impose the subjectivity of the racialized prostitute as the trafficked woman. To do so, the speakers employ the discursive strategy of ‘dividing practices’, a term Foucault (1965) defined as a mode of objectification whereby the subject is divided from the speaker and objectified in order to be acted upon. Sharma (2006) explains that,

[p]eople who are different are so identified because of the ways they are seen as standing apart from those with power to define them. Their difference is organized by the ways they have been negatively racialized, gendered, classed, sexualized and so on (p. 27).

Specifically in regard to the racialized prostitute, Kempadoo (1998) explains that the representation is based on ideologies of racial and ethnic difference:

The brown or black woman is regarded as a desirable, tantalizing, erotic subject, suitable for temporary or non-marital sexual intercourse-the ideal ‘outside’ woman- and rarely seen as a candidate for a long-term commitment, an equal partner or as a future mother (p. 10, emphasis in original).

The prostitute is defined as Other in relation to the racial or ethnic origin of the speakers and more broadly speaking, as Kempadoo goes on to argue, in relation to “[w]hiteness [which]

continues to represent the hegemonic ideal of physical and sexual attractiveness and desirability (p.11, emphasis in original).

Thus, dividing practices define the self-subjectivity of the speakers. Self is defined relationally by what it is *not*; Indigenous women in Canada and women from the global South can *only* be understood to be vulnerable, naïve, uneducated and backwards, assumptions that are racially based and are embedded in colonial and imperial discourses (Doezema, 2001; Mohanty, 1988; Smith, 2005). Therefore, racialized prostitutes become ideal subjects for educated, autonomous, White, middle-class helping professionals to exercise bio-power and act upon.

Also key to this process is a lack of awareness of complicity, as health stakeholders tend to see themselves as moral and innocent (Heron, 1999). Health stakeholders, the majority of whom are White, middle to upper class women in this study, have a preventive, curative, and/ or rehabilitative role. Oftentimes, the care such health professionals provide lacks an anti-racist lens and an awareness of the inadvertent harms such care can cause.

The Extra-Discursive

The speakers also draw on the ‘extra-discursive’. In this case, this consists of broad discourses of race, gender, class, morality, sexuality and victimization. To interrogate the subjectivities the speakers produce for the trafficked woman and also for themselves, I locate their understandings of the woman who is trafficked within the extra-discursive and pay attention to how the discourses interlock and reinforce one another.

With regard to gender, the health stakeholders may draw on the international trafficking frameworks. For example, the UN Trafficking Protocol is titled ‘*Optional Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children*’, whereas the *Protocol against the Smuggling of Migrants by Land, Sea and Air* does not specify gender and

therefore implies men are agents not victims; men are smuggled, women (and children) are trafficked. The prostitute the health stakeholders produce is only conceptualized as a woman; male or transgender prostitutes were not mentioned in the interviews. Gender-informed assumptions about the racialized prostitute include a lack of agency and self-determination. As the sexual assault education co-ordinator maintained, “[they are] often working as an escort or in a massage parlour and it doesn’t seem that they have a lot of control over that environment or their choices when they’re leaving the hospital” (personal communication, July 13, 2012).

The racialized prostitute subjectivity draws on victimizing discourse which occludes all notions of self-determination, agency and ambition, or an acknowledgement of the number of decisions that are involved when racialized women actively pursue better lives for themselves. Often employed in human trafficking talk, the victimizing discourse does not differentiate between sex work, prostitution, sexual exploitation and human trafficking, and therefore assumes the majority of those involved in the sex trade have no agency and must be trafficked. When asked if she ever worked on a case of human trafficking, an outreach nurse answered that, “[a]gain, I don’t know. I mean when we have gone into parlors. It’s a question we don’t ask and women don’t tend to reveal a whole lot of information about themselves. So there’s a possibility, probably a strong possibility” (personal communication, May 16, 2012). In the absence of information from the women themselves, the nurse defaults to the conclusion that there is a “strong possibility” of human trafficking.

Doezema (1998) states that emotive words such as duped, tricked and lured evoke the image of women who do not know what was happening to them. What drawing on the victimizing discourse as a discursive maneuver accomplishes is it completely excludes racialized woman who knowingly migrate for economic betterment in sex work from the dialogue. Vance (2012)

states that there is no room for the “victims’ complicity, that is, their sexual knowledge or experience, or even their active efforts to leave home or earn more money” (p. 206). The speakers did not allow discursive space for this woman to exist, as this figure would disrupt power relations. How would the speaker define Self in relation to an empowered, capable racialized woman who does not perform the subjectivity imposed upon her? Doezema (2010) states such exclusion is the “ultimate exercise of power: to deny sex workers their very existence, to insist they cannot be” (p. 137).

Pursuing the interlocking nature of these discourses further, some health stakeholders produce the racialized prostitute’s subjectivity based moral judgments associated with societal norms of women’s sexuality. An emergency room nurse stated that, “they need a reason to not be in that profession” (personal communication, June 27, 2012). An outreach nurse similarly maintained that, “I think most women who are working on the street - my gut feeling is they don’t really want to be there” (personal communication, May 16, 2012). In regard to the moral campaign that underlies much anti-trafficking work, Doezema (1998) succinctly argues that, “a number of today’s campaigns against trafficking have become a platform for reactionary and paternalistic voices that advocate a rigid sexual morality under the guise of protecting women” (p. 45).

Foucault’s (1978) analysis of sexuality provides further clarity into the meaning-making process and the production of the racialized prostitute’s subjectivity. In the *History of Sexuality*, Foucault argued that the nineteenth century saw the emergence of the ‘science of sexuality’, whereby sexuality became an issue to be socially regulated, categorized and organized (Cabezas, 1998). The imposition of heterosexual sexual norms within the confines of marriage meant other types of sexual relations including prostitution were vilified. Cabezas (1998) argues that, “sex

became a nexus of power and knowledge through religious and ideological discourses in which the collective understanding of sexuality was exercised” (p. 80).

The health stakeholders achieved much more than producing the racialized prostitute’s subjectivity as indicted in the excerpts cited above. They also produced their own subjectivity in relation to her.

Helper Subjectivity

Without the relational subjectivity the speakers produce for themselves, human trafficking discourse would fail to cohere. By producing the subjectivity of the racialized prostitute as the woman who is trafficked, this meaning-making process creates a personal investment and the need to do something about her. Thus, as helping professionals, the speakers justify their need to exist (Agustin, 2007). I first discussed this process in the literature review of the human trafficking-related health literature which focused on defining the role of the health care provider.

To interrogate the meaning-making process that produces the helper, I employ critical race theory. Critical race theory is useful here as it highlights the selective unmarking and invisibility of whiteness as a discursive practice and the simultaneous excessive marking of the racialized body that is trafficked (Neunke, 2004). Human trafficking is a racialized discourse that produces white subjectivity. To produce white subjectivity, the speakers employ “discursive moves of superiority such as pity and racial othering” (Razack, 1998, p. 132). I examine pity as the “emotional response to vulnerability” that solidifies the hierarchical position of the helper in relation to the racialized prostitute (p. 132).

When asked if resources should be allocated to meet the health needs of persons who are trafficked, an emergency room nurse responded,

[y]es I think so because they need help, they need support, they need a reason to not be in that profession and they need health care because they could be carrying sexually transmitted infections that they don't know about. They need contraceptives or whatever. So yeah we do definitely need to care for these people but we have to find them first (personal communications, June 27, 2012).

Pity is implied through the imposition of inferior subjectivity, victimhood and vulnerability, and the assumed “need” of help and support. Spanger (2011) states that, “the notion of ‘female victims of human trafficking’ simultaneously produce a legitimization of the social rescue efforts that leaves the racialized premise of the rescue efforts unquestioned and easily place the female migrants selling sex in an inferior position” (p. 535, emphasis in original). The nurse reinforces inferiority by drawing on the historical ‘vectors of disease’ representation of prostitutes; she highlights sexual health issues above all other health concerns.

In another example, a nurse coordinator of a youth clinic emphasizes her desire to help when I ask what comes to mind when she hears the term human trafficking:

Wanting to help. I think that that is something cause I'm really thinking - I'm reading a book on a woman who started a program about human trafficking and I read her story and I'm just so taken. How can I help? What can I do? (personal communication, June 28, 2012)

When I ask what specifically makes her want to help, she replied:

The hopelessness sometimes or the naivety and I think education. I'm thinking of a particular girl I heard a story about [...] You know and it's just, oh my goodness, and I think to educate people, to make people aware that this is there. Personally, I'm really looking at what this will be when I retire. I'm looking at this world. It's important to me but I don't know exactly where I would fit (personal communication, June 28, 2012)

The nurse coordinator struggles to define her subject-position in the discourse, but she is leaning towards education, a recurring theme in human trafficking rhetoric. What qualifies the speaker to be an educator or authority on human trafficking is unclear. Could it be that she is an educated, white, middle-class woman with the time and means to become a self-identified human

trafficking *expert* who has no apparent expertise apart from her privilege as so many before her? Agustin's (2007) question in reference to anti-trafficking work is revelatory: "Are they so caught up in their projects that they do not stop to measure the effects on the people they want to help" (p. 7)? In the two excerpts cited above, the speakers do not indicate a sense of awareness of their sense of entitlement to women who are trafficked and to engage in anti-trafficking interventions (Heron, 2004). White, middle-class helpers have had a historical relationship of domination with racialized women who engage in sex work. History has shown that white women have always had an investment in this work that goes beyond simple altruism (Abrams & Curran, 2000; Agustin, 2007; Doezema, 2001; Heron, 2004). Feminist historians of Victorian prostitution, such as Antoinette Burton, establish that British imperial feminists, for example, used the denigrated prostitute in Britain and India to advocate for the political enfranchisement of British women (as cited in Doezema, 2001). Historical research has also shown that disciplining sex workers' sexuality dates back two centuries with the aim of carving out of an employment sphere for white, middle-class women and for the purpose of saving and controlling immoral women (Abrams & Curran, 2000; Agustin, 2007; Doezema, 2010). Such an agenda is tied to morality, and the social control and regulation of women's sexuality. This agenda also seeks to obscure power relations based on race.

Fellows and Razack (1998) name the injustice done to all women in the obscuring of race relations as the 'race to innocence'. This refers to competing marginalities whereby feminists focus exclusively on gender oppression and in doing so, refute how they themselves are complicit in the subordination of other women through race and class (p. 335). Dominant human trafficking discourse, which does not often employ a race and/or class lens, allows the helpers to avoid recognizing and acknowledging complicity in relations of power that contribute to the

underlying root causes of human trafficking. To avoid examining complicity, Razack states that, we “build critical consciousness about how we, as subjects, position ourselves as innocent through the use of such markers of identity as the good activist” or in the case of this study, the good health care provider (p. 18). An implied theme running throughout the data is the need to care for racialized women who cannot help themselves. By not critically examining one’s social location and one’s work, the health care provider is likely to satisfy Self, thinking s/he has always done a good job *helping*.

If the racialized prostitute is understood to be the woman who is trafficked, what implications does this have for the creation of human trafficking-related health care policy and the provision of specific health care services for persons who are trafficked?

The Racialized Prostitute and Implications for the Health Care of Persons Who are Trafficked

Since the racialized prostitute-as-trafficked woman evokes feelings of pity and paternalism, it follows that the health stakeholders would create and provide specialized health services for these women. However, this has not been the case. There are several factors that help to explain the absence of health policy and protocol in regard to the person who is trafficked when that person is understood to be the racialized prostitute.

First, those working in the sex industry do not have equitable access to health care. Recent research from Vancouver provides some of the first empirical evidence of the independent relationship between occupational sex work stigma and barriers to accessing health care (Lazarus et al., 2012). Sex workers face immense discrimination and prejudice in the health care system because of the stigma attached to the work they do. Stigma can result in the denial of services or

most certainly in inadequate health service provision. In addition to Lazurus et al., this assertion is based on my years of experience supporting sex workers in accessing health care.

A Deputy Provincial Health Officer offers further clarification:

It is puzzling to me why so little is done to help those who are sexually exploited. It must have something to do with blaming the victims. It must have something to do with the general sexual mores and sexophobia of the dominant culture. It's very puzzling how we can treat, how we can give our consent to treat a certain segment of the population like human garbage. Like people are allowed to do with those people whatever they darn well please (personal communication, May 14, 2012).

A general lack of awareness how societal stereotypes about sex workers, and one's own beliefs and values about sex inform our understandings of sex work result in paradoxically creating and blaming the victim. All of these ideas contribute to a 'discourse of disposal' - a discourse dominated by demands to get rid of sex workers (Lowman, 2000). As we never live outside of discourse, the lack of health services for those who are deemed undeserving and disposable such as sex workers sadly begins to cohere.

As if that were not enough, race interlocks with occupational stigma to occlude health care from being provided to racialized sex workers. If the women are understood to be domestic trafficking victims, most likely Indigenous women in the BC context, research indicates that Indigenous women face considerable barriers to health care (Halseth, 2013). Health inequity for Indigenous women is deeply connected to a history of colonization and is re-entrenched through the contemporary colonization Indigenous women face.

If the trafficked woman is understood to be non-Indigenous racialized woman, race overrides pity when it becomes a question of health resource allocation as these women are considered undeserving largely based on the discursive strategy of Othering. The fact that she may be a

victim of violence or sexual exploitation is completely subordinate to the fact that she is a racialized Other. I see evidence of this in my current work with racialized sex workers.

Regardless of length of time in Canada or citizenship, which includes being Canadian-born, the subjectivity imposed on these women is informed through a racial lens; the women are only conceptualized as newcomers, migrants or immigrants - not deserving *Canadians*. The image can at times conjure up the 'bogus asylum seeker' or the immigrant who takes advantage of Canadians' generosity and drains the system (Weekes, 2013). Physicians for Human Rights, in a study that focused on the complex causes of inequities in health and health care in the U.S., suggest that racism in institutional practices, as well as caregiver bias and stereotyping are significant factors (as cited in Nestel, 2012). Although the nature of racial inequities in Canada and the U.S. are different, there has been a call in the Canadian health literature to push the boundaries of the social determinants of health model to address processes of racialization through an interlocking analysis as I have attempted in this study (Anderson, as cited in Nestel, 2012).

All of these factors combined seem to result in a lack of motivation, interest and push to create health services for racialized women who are trafficked beyond expressing a need that does not translate into action. These factors help to explain the disengagement on the part of health stakeholders in regard to this issue.

Chapter Summary

In this chapter, I laid out how the health stakeholders produce the subjectivities of the racialized prostitute and helper through hegemonic power relations. Hegemonic power relations manifest in the human trafficking discourse the health stakeholders reproduce and re-circulate. The material effects of power are evident in the absence of health policy and protocol for persons

who are trafficked. Furthermore, the discursive moves discussed in this chapter sustain and legitimate the health stakeholders' positions of power and dominance in relation to that of the racialized prostitute and in doing so, allow the health stakeholder to avoid acknowledging their complicity in factors that create the economic and social conditions in which human trafficking occurs.

Chapter Six: Discussion and Conclusion

In Chapters Four and Five, I analyzed how the health stakeholders make meaning about persons who are trafficked. I determined that in present day discourse in the British Columbia context, the health stakeholders interviewed understand persons who are trafficked to be predominately smuggled migrants and/or racialized prostitutes. I argued key to these understandings is who the speakers understand themselves to be and their role in relation to the person who is trafficked.

In this chapter, I build on these arguments. I present a counter discourse that emerged in the interview I conducted with one of the stakeholders which warrants separate discussion. The counter discourse illustrates ways to rethink commonly accepted understandings of what constitutes human trafficking and demonstrates how key one's understanding of Self is in this process. Furthermore, in examining how we are individually and collectively implicated and complicit in dominant human trafficking discourse, I examine how meaning is, or is not, ascribed to racialized bodies in the context of human trafficking and what the implications are for the health care of persons who are trafficked. I conclude by discussing the importance of ethical decision-making in human trafficking-related health initiatives and outline what this could look like in practice.

Counter Discourse

One health stakeholder occupied a very different subject-position in the discourse compared to the other health stakeholders- that of a racialized migrant worker. As an immigrant to Canada who now provides outreach health care to racialized populations, he has personal and professional experience with migration, Canadian immigration policy, the challenges faced by newcomers in the Canadian labour market and access to health care for those with precarious

immigration status. Therefore, his vantage point and relational position to persons who are trafficked is very different from all the other health stakeholders interviewed for this study. He challenged dominant human trafficking discourse in regard to scope, who trafficked persons are and the need for specialized health care services. For example, when asked how prevalent he thought human trafficking was in the health region he serves, he stated:

The case I will be directly talking about are young guys from Honduras that came a few years ago and they were immediately sent to Hastings to sell drugs. And it was a mix of factors there. Many of them were related to each other; one cousin brought the other cousin and put them to work in the Downtown Eastside. There was a network of people here as well who participated in crossing these young guys, helping them to cross the border and things like that. Then do we call this human trafficking or not? It was hard to define because these young guys made lots of money and the town that they came from was a poor, poor town. Now it's the opposite. It's a very developed town with lots of resources south of the border. They were sending money home. They were paying for the person who brought them but they had enough money to send money home. Was that human trafficking? (laughs) (personal communication, May 31, 2012).

While the Vancouver Police Department was quick to label the situation of the Honduran youth in Vancouver as “essentially an issue of slavery”⁷ (“Honduran Kids Sell Drugs Here”, 1998), the speaker does not impose victim subjectivity on the “young guys”; in fact, he emphasizes that they benefitted from the situation by sending money home. Furthermore, he does not impose villain subjectivity on the *traffickers* who included family members and others who facilitated migration. As a consequence, the outreach health worker has difficulty conceptualizing this situation as human trafficking. Because he is a community activist and is politicized around issues of migration, he is able to understand the complex realities of economic migration and considers contextual information that is often excluded in simplified accounts of trafficking.

⁷Other trafficking terminology had not yet entered the lexicon and would not for another year until the arrival of the Chinese migrant ships off the coast of BC in 1999.

In a second example, the outreach health worker complicates understandings of human trafficking further:

At this time I feel that probably human trafficking is limiting - the definition is limiting. If I said that before the Olympics, between 4000 and 5000 Mexicans were living here in Vancouver and working and building the Olympic Village and then half of them stayed here after the end of the Olympics because there was a new criteria for Mexicans to have a visa. They decided to stay here because there was a need for a visa; they were not going to be able to come anymore. Then, I don't know if this is human trafficking or not? But this is an undocumented population, 2000 people or more, that go probably through the same situation as probably a human who has had trafficking experiences (personal communication, May 31, 2012).

Labour exploitation of Latin American workers occurred during the building of Olympic infrastructure, but the general public did not speak of it in those terms or voice outrage. A number of Latin American workers reported working two months in a row non-stop every day for a wage that worked out to be less than five dollars per hour⁸ (Canadian Labour Congress, 2010; Clancy, 2012). In 2008, a BC Human Rights Tribunal ruled the Latin American workers were discriminated against in wages, accommodation, meals and expenses. The workers were finally paid the salary owed to them in 2013, which worked out to be tens-of-thousands-of-dollars each in addition to \$10 000 each for injury to their dignity (Drews, 2013).

The health outreach worker, who works closely with immigrant and migrant populations, is aware that immigration law establishes particular categories of migrants – temporary foreign workers, undocumented, smuggled, refugees, trafficked - all with differing access to health services. Given his focus on addressing health needs regardless of federal immigration categories, this outreach health worker's practice differs from the other health stakeholder research participants. In his day-to-day work, he actively challenges these categories. When asked to whom he provides health services, he responded,

⁸ Workers from Europe were paid \$6 500 US per month and were provided luxury condominium accommodations and a meal allowance (Canadian Labour Congress, 2010).

if they don't have MSP, that's fine. If they want to use another name, that's fine. We don't care. What we care is that they access health care, right? Maybe if a victim of human trafficking comes to us without MSP and they want to use a different name to access healthcare that we provide, they are welcome cause we won't base our services on their status (personal communication, May 31, 2012) .

What frustrated the outreach health worker was how meaning is inscribed to racialized bodies and based on this, how the determination of trafficking is made or not. What was not lost on the outreach health worker, however, are the pull factors that bring so many migrant labourers to Canada and how for some, the outcome may be exploitation. He stated that, "come on, after exploiting them to build the Olympic village, paying the low wages or not even minimum wage, and then during the next two or three years, disposal – we don't want you anymore" (personal communication, May 31, 2012). Unfortunately, such are the realities of the global labour market system for many migrant workers.

We live in a market-driven consumer society. Organized around consumption, a global marketplace exists to feed our insatiable appetite for goods, services, technology and information. Brown (2005) states that "the market is the organizing and regulative principle of the state and society" (p. 41) and that First World nations' neo-liberal economic policies "increase the vulnerability of poor nations to the vicissitudes of globalization" (p. 38). To sustain global economic systems and international trade, there is an increasing demand for low-wage labour from the global South to satisfy our market needs. Middle-class Canadians reap the benefits of low-wage migrant labour and it secures our privileged position in society. The Canada Line, for example, built by Latin American migrant labourers, ensures that we carry out our daily activities with greater ease and comfort. In terms of the benefits reaped from the sexual and domestic labour of women trafficked transnationally, Thobani (2001) explains:

[t]rafficking in women is a highly profitable enterprise and serves the Canadian economy and Canadian society. Women who are trafficked, whether entering the country legally or otherwise, are engaged in entertainment and sex industries, as well as in domestic work. These women serve the interests of the employers who hire them, as well as the interests of individual Canadian men and women, by their sexual and domestic labour (p. 31).

For the most part, we go about our lives avoiding a sense of responsibility in the perpetuation of these global economic systems that bring migrant workers to Canada. As I pointed out in Chapters Four and Five, most of the health stakeholders interviewed are implicated in this process.

When race and class interlock to produce both privilege and oppression, health stakeholders can remove themselves by maintaining the normative structure of whiteness (Yancy, 2008) that directly contributes to the root causes of human trafficking. Razack (1999) states that “these constructs help the dominant group to tell a story of innocence, of non-involvement in the economic and political interventions of the North into the South that produce refugees and immigrants and bring them to our borders” (p. 161). By not acknowledging white privilege and how this is upheld by migrant labour, the health stakeholders are able to unmark their own identities to allow whiteness to go unnamed and for it to be reproduced and solidified. At the same time, the health stakeholders mark racialized bodies and name their experiences; in some cases these experiences are identified as trafficking and in some cases, something else depending on whether the marking disrupts or reinforces power relations. Depending on how the bodies are marked, they can be disciplined and acted upon. This is bio-power.

Implications for Health Care for Persons Who Are Trafficked

When migrants and racialized sex workers are conceptualized in the ways I have laid out in this study, there are a number of implications for specialized health care services for persons who

are trafficked. I have asserted that human trafficking-related health policy and protocol is unlikely to be created or implemented at this time because these actions are rendered virtually impossible from the subject-positions of the health stakeholders in the discourse. However, this assertion is at odds with how the health stakeholders assess the current need for health care services for persons who are trafficked.

When asked if resources should be allocated for these services, an overwhelming majority of the stakeholders answered in the affirmative. Responses included “definitely,” “without a doubt” and that “there is an extraordinary need.” At the same time, the same health stakeholders stated human trafficking is not something that is talked about at work. How can this difference be explained? The dissonance can partly be explained by witness subjectivity. Jacobsen and Stenvoll (2010) state that the ‘witness subject’ reproduces anecdotes and often sensational images as *truth* and calls upon those in power to intervene. However, the ‘witness subject’ does not go so far as to demand those in power critically reflect on the issue. In the case of human trafficking, this would necessitate an examination of complicity in maintaining power relations and structures that contribute to the underlying root causes of human trafficking and for some, this would cause an inexplicable rupture in the discourse. Therefore, we see a call for services, but no real outcry when services are not provided.

Or could the absence of an outcry be because human trafficking is simply not as big of a problem as dominant discourse would have us believe? Based on current statistics, there are no clear indicators just how prevalent human trafficking is and it is not the purpose of this study to delve into that debate. Though what became apparent in my research is that from within the health sector, it is extremely difficult, if not impossible, to get a sense of how prevalent human trafficking is because of the way the information has been organized. If little distinction is made

among economic migrants, undocumented workers, refugees, racialized sex workers and persons who are trafficked, the number of trafficked persons is likely to be perceived to be much higher than it actually is. Furthermore, if the perceived magnitude of human trafficking is based on what the stakeholders have learned from uncritical dominant discourse rather than from what they have seen themselves, the number is likely to be inflated.

A Way Forward

Shifts in discourse do occur and at some point, human trafficking may be considered a health issue and persons who are trafficked may be recognized as individuals with specialized health needs. If human trafficking-related health policy and services are to be developed, I propose a number of guiding principles that will help to ensure that these services are genuinely useful and helpful to persons who are trafficked.

First, health stakeholders must take an evidence-based approach. With the exception of Zimmerman and her colleagues' research, there were few, if any, evidence-based initiatives discussed in the health-related human trafficking literature. Instead, health care providers reproduce dominant discourse; they do not challenge, question or interrogate human trafficking knowledge and propose health services and a role for themselves based on this knowledge. I implore health stakeholders to critically examine the information that is used to inform the development of health care services. What is the source of the information? What government or organizational agendas are tied to this information? What opinions are disguised as *facts*? How does power work through the presentation of *facts*? Are statistics uncritically re-circulated? Those in the health sector who position themselves as self-identified human trafficking experts have a responsibility to examine the production of human trafficking knowledge before reproducing it.

While not denying that human trafficking does occur and that it is an abhorrent crime, it is pertinent that health stakeholders listen with the head and not the heart. Images of women and girls who are trafficked undoubtedly pull at heart strings and cause many health professionals to want to do something about this issue. What has become the new and sexy social justice issue in recent years attracts a broad range of helpers, including healthcare providers. Oftentimes, those who become involved in anti-trafficking campaigns in the realm of health prevention and intervention engage in initiatives that make them feel good as a person and as a professional who is caring and selfless, but in actuality do little to effectively address the health needs of trafficked persons and the root causes of human trafficking. Furthermore, there is little to no insight into how anti-trafficking initiatives can sometimes do more harm than good, something I can attest to in my daily observations of the interactions between health and social service providers and migrant sex workers; I spend a great deal of my time addressing the collateral damage caused by anti-trafficking activists. Health stakeholders who have taken up the trafficking cause should encourage those they work with to critically examine popular human trafficking discourse which is often based on myth-making, fear mongering and sensationalized storytelling. While the body of empirical evidence on health and human trafficking is small, it does exist and I encourage health stakeholders to separate evidence-based research from sensationalized anecdotal accounts of human trafficking when informing others.

Second, health stakeholders must be cognizant of how racialized bodies are situated in human trafficking discourse. This practice involves an awareness of one's own understandings of racialized persons and also the intersections of race, human trafficking and health care. Canadian health care providers often believe they are immune from racial bias and prejudice; unlike their counterparts in the United States, Canadian health practitioners believe they offer

‘culture free’ medicine (Nestel, 2012). Moreover, Beagan and Kumas-Tan, in research conducted with Canadian family doctors, found that nearly half of study participants claimed that race, along with class, sexual orientation and other socio-cultural differences, raised no tensions in their practices (as cited in Nestel, 2012). Health care providers must become aware of ‘color blind’ health care and how it perpetuates racism within health care system which results in some health services being inaccessible to racialized persons as I discussed in Chapters Four and Five. A colorblind health care approach has the added effect of producing the health care provider as fair and well-intentioned, and as engaging in best practice regardless of race. To provide health care that is accessible and appropriate, health services that are created for persons who are trafficked must be informed by critical race analyses.

Third, health stakeholders must consider ethics and the ethical implications of their work. If health policy and services are created based on the understandings of persons who are trafficked I have highlighted in this study, the services are likely to be paternalistic and ineffective as they would be “generated solely by the sensibility of the rescuer” and thus would “unlikely be genuinely helpful or empowering” (Vance, 2012, p. 211). To illustrate, I come full circle and critique the health-related human trafficking training curriculum I myself developed and delivered which I referred to at the beginning of this study.

In the training curriculum, I compartmentalized women who are trafficked and placed them into categorical boxes. I created a check list of what human trafficking is, who the trafficked woman is, what her health concerns are, how her body and mind should be treated and what the expected outcomes are when all of this knowledge is put into practice. I now realize the uncritical approach I employed focused solely on knowledge dissemination and this approach is

harmful. I discuss what happens when health stakeholders, such as myself, conceptualize persons who are trafficked through our own knowledge, assumptions and beliefs.

Persons who are trafficked become an extension of the theories we use to define them. A process of totalizing, it reduces what can be taught and what can be said in an attempt to explain persons who are trafficked and make sense of them (Rossiter, 2011). We reduce the trafficked person's singularity as an individual with a unique history and experience to something which we ourselves can make sense of. Diminishing the trafficked person's lived experience to a sameness that can be measured and generalized helps to create and reinforce stereotypes of who the trafficked person is. In this way, we add to and perpetuate a dominant discourse in that the trafficked person cannot be anything outside that which we have named. We portray the trafficked person as a solid, static, easily definable entity (Chambon, 1998) which does harm since this representation of the trafficked person is inadequate. One can never capture all that the trafficked person is. Something always overflows and escapes our knowledge, comprehension and conceptualization. We inflict violence on that which we fail to comprehend and that which we discard. We fail to acknowledge infinity, that is the inexhaustible, irreducible, singularity of the trafficked person (Rossiter, 2011). Trafficked persons' experiences are more than we can ever know and certainly more than we can ever *teach*.

What is even more problematic about teaching others about human trafficking interventions is that it assumes such competence can be taught, learned, trained and attained. An approach that focuses solely on knowledge dissemination erases the significance of the power relations and interdependence between the person who is trafficked and the helper (Ben-Ari & Strier, 2010). The training objectifies the person who is trafficked because the knowledge of him/her reduces the person to something we possess, something we have acquired and ultimately something we

will use (Gottlieb, as cited in Rossiter, 2011). We construct ourselves as *experts* who are competent with a substantive knowledge base on the issue; we produce ourselves as knowing what is best for persons who are trafficked and what is for their own good (Heron, 2004).

Uncritical human trafficking-related health policy and services reveal the threat knowledge poses to ethics (Rossiter, 2011). The training curriculum I developed epitomizes how knowledge is a *trespass* on the trafficked person. Orlie defines trespass as “the harm brought to others by our participation in the governing ways of envisioning and making the world” (as cited in Rossiter, 2001, p. 3). We impose and prescribe ways of intervening in the lives of persons who are trafficked contingent on our construction of them and of ourselves, and also on our investment in this work.

Furthermore, we do harm when our work excludes the agency and presence of persons who are trafficked in the conception, development and delivery of the training curriculum. We claim to make visible the issue of human trafficking but in actual fact, we make persons who are trafficked more invisible and push them further to the margins when we exclude them completely from the process. Whose story appears in the curriculum and whose story does not? *Our* stories appear in these representations. Not only do we define who trafficked persons are, we also define their needs and speak on their behalf without consent. Without having carried out research with persons who are trafficked, when we *teach* other health care providers what the health needs of trafficked persons are, it “exerts a kind of violence in that it robs people of the possibility of naming and framing their concerns in their own terms” (Heron, 2004, p. 125). We realize how unethical the work is when the trafficked person’s presence is not needed. Initiatives, such as my own, claim to be person and rights-centered, but they are not. How can an initiative be person-centered when the person is nowhere to be found? Dominant human

trafficking discourse constructs persons who are trafficked to be invisible and inaccessible due to the clandestine nature of human trafficking. Post-structuralism has made me aware of the social construction of knowledge and has taught me to interrogate common and usual ways of thinking and doing. Thus, I ask: why do persons who are trafficked come out of the shadows to receive our interventions, but are nowhere to be found when developing these same interventions? We must challenge the ‘common sense’ ways this work is normally carried out. We need to practice differently. We need to practice ethically.

Ethical Practice

Returning to Reflexivity

This study has uncovered in the health literature and in conversation with a selection of BC health stakeholders that there is little to no consideration of the ethical implications of anti-trafficking work in the health sector. Hugman (2005) regards the conscious reflection and engagement with ethics as the responsibility of every member of the helping professions. In order to practice ethically, health stakeholders collectively need to change the “knowledge before ethics” approach (Ben-Ari & Strier, 2010, p. 2159).

An ethical practice begins with redefined subjectivity for both the person who is trafficked and for the health stakeholder. Through the process of making transparent the power relations in human trafficking discourse and laying out complicity in re-inscribing power in relation to persons who are trafficked, we begin to realize the interconnectedness between the trafficked person and ourselves. To practice justly, we need to reconstruct ourselves in an “ethical relationship wherein we are responsible for the person who is trafficked” (Goodman, Walling & Ghali, 2009, p. 589). In other words, our subjectivities should be redefined by the ethical demands made upon us by the person who is trafficked. Goodman et al. (2009) state that only in

a dyadic relationship contingent on an ethical interchange can socially just work be carried out. That is to say, “the ethical relationship is the precursor to justice” (p. 590).

What does this theoretical perspective look like in practice? We have to let go of the belief that we can fully know the person who is trafficked. This is never possible because s/he is “infinitely unknowable” (Ben-Ari & Strier, 2010, p. 2163). We must disrupt the assumption that the more we know about the trafficked person, the better we are able to respond (Ben-Ari & Strier, 2010, p. 2163). What this introspection about my training curriculum has exemplified is that *knowing* the trafficked person does not necessarily lead to ethical or morally right actions (Reynolds, 2011). In this study, I outlined how the commodified conceptualization of the person who is trafficked into easily identifiable categories such as the smuggled migrant or the racialized prostitute is a dangerous reduction that leads to totalization and consequently, the subordination of persons who are trafficked for personal and professional gain (Ben-Ari & Strier, 2010). In this way, we narrow our understandings of who the person who is trafficked can be. Consequently, we deny ourselves because any intervention we create is also limited (Ben-Ari & Strier, 2010). This realization, however, leaves the dilemma that some knowledge is required to practice.

Rossiter (2011) suggests practicing on the ‘razor’s edge’, a space of critical practice where we decide between using the theories we know to represent the person who is trafficked and suspending our assumptions and allowing them to reveal themselves. Putting ‘ethics before knowledge’, we embrace the contradiction between needing to know everything and leaving space for self-representation. In order to place ethics before knowledge, Rossiter suggests an unsettled practice where we eschew our quest for and satisfaction with knowledge acquisition for “a chronic alertness of its effect on ethics” (p. 11). We have to come to regard uneasy feelings as

an indication of conscious practice and growth. We need what John Keats defines as negative capability, that is “being capable of being in uncertainties, mysteries, doubts without any irritable reaching after fact and reason” (as cited in Rossiter, 2001, p. 6).

To cultivate an unsettled practice, Rossiter (2011) proposes the following: reconceptualizing active listening, questioning instead of answering and valuing the dignity and worth of the individual. I examine these concepts to determine if and how they can make an ethical difference in the way health stakeholders approach the issue of human trafficking-related health policy and services.

Kirby redefines active listening as “alertness that is beyond our grasp, a desire to hear that which is not comprehensible to us, that which inspires our suspension of knowledge and moves us beyond what we know” (as cited in Rossiter, 2011, p. 13). In other words, we are to listen for that which challenges our preconceived notions and assumptions of the person who is trafficked. Over time, we can repudiate our deeply ingrained preconceptions that persons who are trafficked need to be *rescued* or *saved* and open ourselves up to other representations of persons who are trafficked. My hope is that this study contributes to that end.

Second, Rossiter encourages a post-modern perspective that challenges socially accepted meanings and representations that, in turn, inform interventions. When we value questions over a continual search for answers, we open a space to confront *truth* and the accepted ways of doing. This approach, which I have attempted to employ in this study, has the potential to prompt anti-trafficking initiatives that are more critical in nature.

Third, Rossiter proposes that we value the dignity and worth of the individual and to “treat others how they wish to be seen” (p.14). Doing so is pertinent if anti-human trafficking work is to be ethical. The whole basis of this work is that the person who is trafficked is treated as a

human being because human trafficking dehumanizes the person. However, in order for the work to be ethical, we cannot stop there. An ethical practice asks society to treat persons who are trafficked as the persons they take themselves to be, not who we define them to be based upon essentialized representations and imposed subjectivities. That means that when we approach this work, we are “prepared to come to know the ways in which they are not like the others” (Spelman, as cited in Rossiter, 2011, p. 14). We have to refrain from producing prescriptive models that are informed by generalizations. As long as we create prescriptive models of who persons who are trafficked are and who they can be, our interventions can never be person or rights-centered. The healing can only begin when persons who are trafficked have presence and agency and define themselves - not when we define them, do something *for* them and certainly not when we create initiatives they have not even identified they need. This is “ethics before practice” (Rossiter, 2011, p. 12). This is ethics before knowledge.

Conclusion

“There is a crack in everything. That is how the light gets in” Leonard Cohen

In this thesis, I interrogated and challenged commonly held views of human trafficking and persons who are trafficked in the context of health. Because my arguments may be considered radical by those more accustomed to dominant trafficking discourse, I encourage health stakeholders to sit with these differing perspectives and pay attention to where cracks or ruptures appear in the dominant discourse. Deliberate reflection on subjectivity, discourse and power relations in the context of human trafficking and health is a process that takes time. Rather than attempting to fit persons who are trafficked into the categorical boxes our limited understandings of an incredibly complex issue allow, as health professionals, we need to accept new configurations of subjectivity that may be beyond our current knowledge-base to ensure that the

human trafficking-related health policy and services that we create are appropriate and genuinely helpful.

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Appendix

Appendix A: UVIC Invitation to Participate



Research Title: “How is Human Trafficking Understood within Health Care? A Discursive Analysis of Understandings and Perceptions of Human Trafficking Among Health Stakeholders”

Dear _____,

My name is Alison Clancey and I am currently completing the Master of Social Work degree at the University of Victoria. My graduate research examines human trafficking from a health perspective. I am interested in exploring the understandings front-line health care providers, program managers and health policymakers have about human trafficking and persons who are trafficked.

You have been chosen because of your position in the health sector and your insights are highly valued. Whether directly or indirectly in the field in which you work, you may encounter a case of human trafficking at some point throughout your career. Previous experience working on a case of human trafficking or developing programs or policy to address human trafficking is not a requirement to participate in the study. If you have worked on cases of human trafficking, you will not be asked to divulge details of any particular case. No preparation is required for the in-person, audio-taped interview that will take approximately one hour.

Your participation in this research will add to very limited literature on human trafficking and health and your participation may result in increased awareness of human trafficking from a health perspective.

If you are interested in participating in this very important work, please contact me at aclancey@uvic.ca or 604 355 3124 and I will provide you with a more thorough outline of what is involved.

Thank you in advance for your time and consideration.

Best Regards,

Alison Clancey BA, BSW
MSW Candidate
School of Social Work
University of Victoria

Victoria, BC
604 355 3124
aclancey@uvic.ca

Appendix B: UVIC Participant Consent Form



Research Title: “How is Human Trafficking Understood within Health Care? A Discursive Analysis of Understandings and Perceptions of Human Trafficking Among Health Stakeholders”

Researcher: Alison Clancey BA, BSW
MSW Candidate
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604 355 3124

aclancey@uvic.ca

You are invited to participate in a study entitled, “How is Human Trafficking Understood within Health Care? A Discursive Analysis of Understandings and Perceptions of Human Trafficking Among Health Stakeholders” that is being conducted by Alison Clancey.

Alison Clancey is a graduate student in the department of Social Work at the University of Victoria and you may contact her if you have further questions at 604 355 3124 or aclancey@uvic.ca.

As a graduate student, I am required to conduct research as part of the requirements for a Master’s degree in Social Work. It is being conducted under the supervision of Dr. Teresa Macias. You may contact my supervisor at 250-721-8045 or tmacias@uvic.ca.

Purpose and Objectives

The purpose of this research project is to examine human trafficking from a health perspective. In Canada, human trafficking has attracted increasing attention in the past decade. However, from a policy perspective, protection-based responses including the provision of appropriate health care services for persons who are trafficked are minimal. Starting from the premise that health policy has addressed human trafficking in a limited manner, this study seeks to explore perceptions and understandings of human trafficking among health care stakeholders, and the implications of such perspectives for health service provision for persons who are trafficked.

Importance of this Research

Research of this type is important because it will contribute to the limited academic literature on human trafficking from a health perspective.

Participants Selection

You are being asked to participate in this study because because of your position in the health sector and your insights are highly valued. Whether directly or indirectly in the field in which you work, you may encounter a case of human trafficking at some point throughout your career. Previous experience working on a case of human trafficking or developing health programs or policy to address human trafficking is not a requirement to participate in the study. If you have worked on cases of human trafficking, you will not be asked to divulge details of any particular case. Rather you will be asked to discuss your perceptions and understandings of human trafficking in a broad sense.

Participants were selected according to three tiers of health stakeholders: policy makers, program managers and front-line health care providers.

What is Involved

If you agree to voluntarily participate in this research, an in-person, audio-recorded interview lasting one hour to one hour and a half will be carried out at your workplace or another location that is convenient for you. You will be asked 10-15 questions about your perceptions of human trafficking. At a later date, the transcript of the interview will be made available to you to verify accuracy. You are free to accept or decline the offer to review the transcript.

Inconvenience

Participation in this study may cause some inconvenience to you. The total estimated time the participant will spend on this project including scheduling, being interviewed and reviewing the transcript (optional) is three hours maximum. Although the required participation time may be an inconvenience to busy professionals, the benefits of the project will outweigh the time spent participating.

Risks

There are no known or anticipated risks to you by participating in this research.

Benefits

The potential benefits of your participation in this research include contribution to limited academic literature on human trafficking and health; raised awareness of human trafficking from a health perspective; and an opportunity to critically reflect on your work in regard to human trafficking.

Voluntary Participation

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study, your data will not be used unless I receive written permission to do so.

Researcher's Relationship with Participants

The researcher may have a relationship to some participants as a former colleague. While the researcher was not in a supervisory position, you should not feel obligated to participate based on a prior working relationship.

Anonymity

There may be limits to anonymity given the researcher's recruitment methods (for example, referrals). You will, however, be provided with the option of using a pseudonym and having all identifying information about your department, agency, or health authority removed from the written results. In such cases, participants will only be referred to as a nurse in a hospital emergency room or an outreach worker with a women's organization for example. Please indicate your preference(s) below:

I agree to be identified by name/agency and credited in the results of the study: _____
(Participant to provide initials)

I agree to have my responses attributed to me by name/agency in the results: _____
(Participant to provide initials)

I wish to use a pseudonym and have all identifying information removed in the written results
_____ (Participant to provide initials)

Confidentiality

Regardless of the level of anonymity that you chose, the confidentiality of the data will be preserved by using the following procedure. The audio file of the interview will be downloaded onto my computer which is password protected and will be deleted from the digital recorder. Electronic files of the typed transcripts will be stored in password protected files. Hard copies of the transcripts will be stored in a locked cabinet at my home office where I am the lone occupant.

Dissemination of Results

It is anticipated that the results of this study will be shared with others in the following ways: thesis/class presentation, directly to participants in an information session (if requested), published article and/or presentation at health conferences.

Disposal of Data

I will shred consent forms and erase audio recordings stored on my computer within six months of the completion of the study. I will shred hard copies and erase electronic copies of the transcripts within five years of the completion of the project.

Contacts

Individuals who may be contacted regarding this study include the researcher (Alison Clancey – 604 355 3124/aclancey@uvic.ca), the thesis supervisor (Dr. Teresa Macias - 250-721-8045/tmacias@uvic.ca) or thesis committee member (Dr. Annalee Lepp - 250 721 6157/alepp@uvic.ca).

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545/ethics@uvic.ca).

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researcher, and that you agree to participate in this research project.

I would appreciate your response to participate or decline by month/date, 2012.

_____	_____	_____
Name of Participant	Signature	Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix C: UBC/BC Women's Hospital Letter of Initial Contact



Letter of Initial Contact

Research Title: How is Human Trafficking Understood within Health Care? A Discursive Analysis of Understandings and Perceptions of Human Trafficking Among Health Stakeholders

Principal Investigator:

Dr. Neora Pick, MD
 Clinical Assistant Professor
 Department of Infectious Diseases
 Faculty of Medicine
 University of British Columbia
 Email: npick@cw.bc.ca
 Tel: 604 875 2212

Dear _____,

My name is Alison Clancey and I am currently completing the Master of Social Work degree at the University of Victoria. My graduate research examines human trafficking from a health perspective. I am interested in exploring the understandings front-line health care providers, program managers and health policymakers have about human trafficking and persons who are trafficked.

You have been invited because of your position in the health sector and your insights are highly valued. Whether directly or indirectly in the field in which you work, you may encounter a case of human trafficking at some point throughout your career. Previous experience working on a case of human trafficking or developing programs or policy to address human trafficking is not a requirement to participate in the study. If you have worked on cases of human trafficking, you will not be asked to divulge details of any particular case but rather discuss your understandings of human trafficking in a broad theoretical sense. No preparation is required for the in-person, audio-taped interview that will take approximately one to one and a half hours.

Your participation in this research will add to very limited literature on human trafficking and health and your participation may result in increased awareness of human trafficking from a health perspective.

Please do not feel obligated to participate. However, if you are interested in participating, I will follow-up with a phone call 10 days after the receipt of this invitation at which time I will provide you with a more thorough outline of what will be involved.

Thank you in advance for your time and consideration.

Best Regards,

Alison Clancey BA, BSW
MSW Candidate
University of Victoria
Tel : 604 355 3124
Email: aclancey@uvic.ca

Appendix D: UBC/BC Women's Hospital Letter of Initial Contact



Consent Form

Title of Study: "How is Human Trafficking Understood within Health Care? A Discursive Analysis of Understandings and Perceptions of Human Trafficking Among Health Stakeholders"

Principal Investigator: Dr. Neora Pick, MD
 Clinical Assistant Professor
 Department of Infectious Diseases
 Faculty of Medicine
 University of British Columbia
 Email: npick@cw.bc.ca
 Tel: 604 875 2212

Co-Investigators: Dr. Teresa Macias BSW, M.Ed, PhD
 Assistant Professor
 School of Social Work
 Faculty of Human and Social Development
 University of Victoria
 Phone: 250 721 8045
 Email: tmacias@uvic.ca

Alison Clancey BA, BSW
 MSW Candidate
 School of Social Work
 University of Victoria
 Email: aclancey@uvic.ca
 Tel: 604 355 3124

Alison Clancey is a graduate student in the department of Social Work at the University of Victoria and is required to conduct research as part of the requirements for a Master's degree.

INTRODUCTION

You are invited to participate in a study entitled, “How is Human Trafficking Understood within Health Care? A Discursive Analysis of Understandings and Perceptions of Human Trafficking Among Health Stakeholders” that is being conducted by Alison Clancey.

You are being invited to participate in this study because of your position in the health sector and your insights are highly valued. Whether directly or indirectly in the field in which you work, you may encounter a case of human trafficking at some point throughout your career. Previous experience working on a case of human trafficking or developing health programs or policy to address human trafficking is not a requirement to participate in the study. If you have worked on cases of human trafficking, you will not be asked to divulge details of any particular case. Rather you will be asked to discuss your perceptions and understandings of human trafficking in a broad theoretical sense.

BACKGROUND

Human trafficking is most often talked about as a migration, modern-day slavery, prostitution, human rights and/or transnational crime issue. However, due to the exploitative working and living conditions persons who are trafficked endure, health issues are probable. This project examines how health stakeholders’ common everyday understandings of human trafficking may affect the extent to which human trafficking is being seen as a health care issue.

PURPOSE

The purpose of this research project is to examine human trafficking from a health perspective. In Canada, human trafficking has attracted increasing attention in the past decade. However, from a policy perspective, protection-based responses including the provision of appropriate health care services for persons who are trafficked are minimal. Starting from the premise that health policy has addressed human trafficking in a limited manner, this study seeks to explore perceptions and understandings of human trafficking among health care stakeholders, and the implications of such perspectives for health service provision for persons who are trafficked.

WHO CAN PARTICIPATE IN THE STUDY?

Subjects are considered health professionals and not patients, clients or service users. All subjects are required to work in the health field either in policy, program management or front-line service provision in an area where there is a possibility of encountering a case of human trafficking. You will be asked to provide your own professional opinions on human trafficking. You may or may not have encountered persons who are trafficked in their work.

YOUR PARTICIPATION IS VOLUNTARY

Your participation is entirely voluntary, so it is up to you to decide whether or not to take part in this study. Before you decide, it is important for you to understand what the research involves.

This consent form will tell you about the study, why the research is being done, what will happen to you during the study and the possible benefits, risks and discomforts.

If you wish to participate, you will be asked to sign this form. If you do decide to take part in this study, you are still free to withdraw at any time and without giving any reasons for your decision.

If you do not wish to participate, you do not have to provide any reason for your decision not to participate.

WHAT DOES THE STUDY INVOLVE?

If you agree to voluntarily participate in this research, an in-person, audio-recorded interview lasting one hour to one hour and a half will be carried out at your workplace or another location that is convenient for you. You will be asked 10-15 questions about your perceptions of human trafficking. At a later date, the transcript of the interview will be made available to you to verify accuracy. You are free to accept or decline the offer to review the transcript.

STUDY PROCEDURES

- 1) Read and accept the study invitation.
- 2) Confirm participation and arrange interview time and place.
- 3) Read and sign the consent form.
- 4) Read the interview questions (optional).
- 5) Conduct 1 – 1.5 hour audio-taped interview.
- 6) Review transcription (optional).

The confidentiality of the data will be preserved by using the following procedure. The audio file of the interview will be downloaded onto my computer which is password protected and will be deleted from the digital recorder. Electronic files of the typed transcripts will be stored in password protected files. Hard copies of the transcripts will be stored in a locked cabinet at my home office where I am the lone occupant. I will shred consent forms and hard copies, and erase electronic copies of audio recordings and transcripts stored on my computer data 5 years after publication.

POTENTIAL RISKS

There are no known or anticipated risks to you by participating in this research.

POTENTIAL BENEFITS

You may not receive any benefit at all from participating.

WITHDRAWING CONSENT TO PARTICIPATE

Your participation in this research is completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study, your data will not be used unless I receive written permission to do so.

You have the right to withdraw from the study at any time during the audio-taped interview or when the interview is completed without consequence or explanation. If, during the course of the interview, you wish to withdraw, I will turn off the audio recorder. At this time, I will ask you if any or all parts of the interview may be retained as part of the research. If you do not want the interview included in the research, I will erase the audio recording immediately.

REMUNERATION/COMPENSATION

You will not incur any personal expenses as a result of participation. You will not be paid for participating.

CONFIDENTIALITY

Your confidentiality will be respected. No information or records that disclose your identity will be published without your consent, nor will any information or records that disclose your identity be removed or released without your consent unless required by law.

ANONYMITY

There may be limits to anonymity given the researcher's recruitment methods (for example, referrals). You will, however, be provided with the option of using a pseudonym and having all identifying information about your department, agency, or health authority removed from the written results. In such cases, you will only be referred to as an outreach worker with a women's organization for example. Please indicate your preference(s) below:

I agree to be identified by name/agency and credited in the results of the study: _____
(Provide initials)

I agree to have my responses attributed to me by name/agency in the results: _____
(Provide initials)

I wish to use a pseudonym and have all identifying information removed in the written results
_____ (Provide initials)

WHO DO I CONTACT IF I HAVE QUESTIONS ABOUT THE STUDY DURING MY PARTICIPATION?

Individuals who may be contacted regarding this study include the principal investigator (Neora Pick – 604 875 2212/npick@cw.bc.ca), or the co-investigator (Alison Clancey – 604 355 3124/aclancey@uvic.ca).

CONTACT FOR CONCERNS ABOUT THE RIGHTS OF RESEARCH SUBJECTS

If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598/toll-free at 1-877-822-8598, or by e-mail to RSIL@ors.ubc.ca.

SUBJECT CONSENT TO PARTICIPATE

Research Title: “How is Human Trafficking Understood within Health Care? A Discursive Analysis of Understandings and Perceptions of Human Trafficking Among Health Stakeholders”

Your signature below indicates that you have read and understood the conditions of participation in this study including the following:

- I have read and understood the subject information and consent form and am consenting to participate in the study “How is Human Trafficking Understood within Health Care? A Discursive Analysis of Understandings and Perceptions of Human Trafficking Among Health Stakeholders”.
- I have had sufficient time to consider the information provided and to ask for advice if necessary.
- I have had the opportunity to ask questions and have had satisfactory responses to my questions.
- I understand that all of the information collected will be kept confidential.
- I understand that my participation in this study is voluntary and that I am completely free to refuse to participate or to withdraw from this study at any time without effecting my participation in the main study and without changing in any way the quality of care that I receive.
- I understand that I am not waiving any of my legal rights as a result of signing this consent form.
- I understand that there is no guarantee that this study will provide any benefits to me.
- I have read this form and I freely consent to participate in this study.
- I have been told that I will receive a dated and signed copy of this form.

Name of Subject

Signature

Date

Appendix E: Fraser Health Letter of Initial Contact



Letter of Initial Contact

Research Title: How is Human Trafficking Understood within Health Care? A Discursive Analysis of Understandings and Perceptions of Human Trafficking Among Health Stakeholders

Dear _____,

My name is Alison Clancey and I am currently completing the Master of Social Work degree at the University of Victoria. My graduate research examines human trafficking from a health perspective. I am interested in exploring the understandings front-line health care providers, program managers and health policymakers have about human trafficking and persons who are trafficked.

You have been invited because of your position in the health sector and your insights are highly valued. Whether directly or indirectly in the field in which you work, you may encounter a case of human trafficking at some point throughout your career. Previous experience working on a case of human trafficking or developing programs or policy to address human trafficking is not a requirement to participate in the study. If you have worked on cases of human trafficking, you will not be asked to divulge details of any particular case but rather discuss your understandings of human trafficking in a broad theoretical sense. No preparation is required for the in-person, audio-taped interview that will take approximately 20 minutes.

Your participation in this research will add to very limited literature on human trafficking and health and your participation may result in increased awareness of human trafficking from a health perspective.

Please do not feel obligated to participate. However, if you are interested in participating, I will follow-up in a few days and provide you with a more thorough outline of what will be involved.

Thank you in advance for your time and consideration.

Best Regards,

Alison Clancey BA, BSW
MSW Candidate
School of Social Work
University of Victoria
Tel : 604 355 3124
Email: aclancey@uvic.ca

Appendix F: Fraser Health Subject Consent Form



Subject Consent Form

Title of Study: “How is Human Trafficking Understood within Health Care? A Discursive Analysis of Understandings and Perceptions of Human Trafficking Among Health Stakeholders”

Principal Investigator: Dr. Teresa Macias BSW, M.Ed, PhD
 Assistant Professor
 School of Social Work
 Faculty of Human and Social Development
 University of Victoria
 Phone: 250 721 8045
 Email: tmacias@uvic.ca

Fraser Health Co-Investigator: Lynn Gifford MA BScF FHC SANE-A RN
 Coordinator
 Forensic Nursing Services
 Surrey Memorial Hospital Emergency Program
 604-585-5688
lynn.gifford@fraserhealth.ca

Co-Investigator: Alison Clancey BA, BSW
 MSW Candidate
 School of Social Work
 University of Victoria
 Victoria, BC
 604 355 3124
aclancey@uvic.ca

Sponsor: Un-sponsored

INTRODUCTION

You are being invited to participate in a study entitled, “How is Human Trafficking Understood within Health Care? A Discursive Analysis of Understandings and Perceptions of Human Trafficking Among Health Stakeholders” that is being conducted by Alison Clancey.

You are being invited to participate in this study because because of your position in the health sector and your insights are highly valued. Whether directly or indirectly in the field in which you work, you may encounter a case of human trafficking at some point throughout your career. Previous experience working on a case of human trafficking or developing health programs or policy to address human trafficking is not a requirement to participate in the study. If you have worked on cases of human trafficking, you will not be asked to divulge details of any particular case. Rather you will be asked to discuss your perceptions and understandings of human trafficking in a broad theoretical sense.

YOUR PARTICIPATION IS VOLUNTARY

Your participation is entirely voluntary, so it is up to you to decide whether or not to take part in this study. Before you decide, it is important for you to understand what the research involves. This consent form will tell you about the study, why the research is being done, what will happen to you during the study and the possible benefits, risks and discomforts.

If you wish to participate, you will be asked to sign this form. If you do decide to take part in this study, you are still free to withdraw at any time and without giving any reasons for your decision.

If you do not wish to participate, you do not have to provide any reason for your decision not to participate.

BACKGROUND

Human trafficking is most often talked about as a migration, modern-day slavery, prostitution, human rights and/or transnational crime issue. However, due to the exploitative working and living conditions persons who are trafficked endure, health issues are probable. This project examines how health stakeholders’ common everyday understandings of human trafficking may affect the extent to which human trafficking is being seen as a health care issue.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this research project is to examine human trafficking from a health perspective. In Canada, human trafficking has attracted increasing attention in the past decade. However, from a policy perspective, protection-based responses including the provision of appropriate health care services for persons who are trafficked are minimal. Starting from the premise that

health policy has addressed human trafficking in a limited manner, this study seeks to explore perceptions and understandings of human trafficking among health care stakeholders, and the implications of such perspectives for health service provision for persons who are trafficked.

WHO CAN PARTICIPATE IN THE STUDY?

Subjects are considered health professionals and not patients, clients or service users. All subjects are required to work in the health field either in policy, program management or front-line service provision in an area where there is a possibility of encountering a case of human trafficking. You will be asked to provide your own professional opinions on human trafficking. You may or may not have encountered persons who are trafficked in their work.

WHAT DOES THE STUDY INVOLVE?

If you agree to voluntarily participate in this research, an in-person, audio-recorded interview lasting one hour to one hour and a half will be carried out at your workplace or another location that is convenient for you. You will be asked 10-15 questions about your perceptions of human trafficking. At a later date, the transcript of the interview will be made available to you to verify accuracy. You are free to accept or decline the offer to review the transcript.

WHAT ARE MY RESPONSIBILITIES?

- 7) Read and accept the study invitation.
- 8) Confirm participation and arrange interview time and place.
- 9) Read and sign the consent form.
- 10) Read the interview questions.
- 11) Conduct 1 – 1.5 hour audio-taped interview.
- 12) Review transcription (optional).

WHAT ARE THE POSSIBLE RISKS OF HARM AND SIDE EFFECTS OF PARTICIPATING?

There are no known or anticipated risks to you by participating in this research.

WHAT ARE THE BENEFITS OF PARTICIPATING IN THIS STUDY?

The potential benefits of your participation in this research include contribution to limited academic literature on human trafficking and health; raised awareness of human trafficking from a health perspective; and an opportunity to critically reflect on your work in regard to human trafficking.

WHAT HAPPENS IF I DECIDE TO WITHDRAW MY CONSENT TO PARTICIPATE?

Your participation in this research is completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study, your data will not be used unless I receive written permission to do so.

You have the right to withdraw from the study at any time during the audio-taped interview or when the interview is completed without consequence or explanation. If, during the course of the interview, you wish to withdraw, I will turn off the audio recorder. At this time, I will ask you if any or all parts of the interview may be retained as part of the research. If you do not want the interview included in the research, I will erase the audio recording immediately.

WHAT HAPPENS IF SOMETHING GOES WRONG?

Rights and Compensation

By signing this form, you do not give up any of your legal rights.

CAN I BE ASKED TO LEAVE THE STUDY?

If you do not wish to be interviewed, the study investigator will withdraw you from the study.

AFTER THE STUDY IS FINISHED

If requested by you, the study investigator will provide an information session.

WHAT WILL THE STUDY COST ME?

You will not incur any personal expenses as a result of participation. You will not be paid for participating.

WILL MY TAKING PART IN THIS STUDY BE KEPT CONFIDENTIAL?

Your confidentiality will be respected. No information or records that disclose your identity will be published without your consent, nor will any information or records that disclose your identity be removed or released without your consent unless required by law.

You will be assigned a unique study number as a subject in this study. Only this number will be used on any research-related information, including personal data and research data, collected about you during the course of this study, so that your identity [i.e. your name or any other information that could identify you] as a subject in this study will be kept confidential.

Information that directly discloses your identity will remain only with the Principal Investigator. The list that matches your name to the unique identifier that is used on your research-related information will not be removed or released without your consent unless required by law.

ANONYMITY

There may be limits to anonymity given the researcher's recruitment methods (for example, referrals). You will, however, be provided with the option of using a pseudonym and having all identifying information about your department, agency, or health authority removed from the

written results. In such cases, subjects will only be referred to as an outreach worker with a women's organization for example. Please indicate your preference(s) below:

I agree to be identified by name/agency and credited in the results of the study: _____
(Subject to provide initials)

I agree to have my responses attributed to me by name/agency in the results: _____
(Subject to provide initials)

I wish to use a pseudonym and have all identifying information removed in the written results
_____ (Subject to provide initials)

WHO DO I CONTACT IF I HAVE QUESTIONS ABOUT THE STUDY DURING MY PARTICIPATION?

Individuals who may be contacted regarding this study include the principal investigator (Dr. Teresa Macias - 250-721-8045/ tmacias@uvic.ca), Fraser Health co-investigator (Lynn Gifford - 604-585-5688/Lynn.Gifford@fraserhealth.ca), or co-investigator (Alison Clancey – 604 355 3124/aclancey@uvic.ca).

WHO DO I CONTACT IF I HAVE ANY QUESTIONS OR CONCERNS ABOUT MY RIGHTS AS A SUBJECT DURING THE STUDY?

If you have any concerns or complaints about your rights as a research subject and/or your experiences while participating in this study, contact either Dr. Marc Foulkes or Dr. Allan Belzberg, REB co-Chairs by calling 604-587-4681. You may discuss these rights with one of the co-chairmen of the Fraser Health REB.

SUBJECT CONSENT TO PARTICIPATE

Research Title: “How is Human Trafficking Understood within Health Care? A Discursive Analysis of Understandings and Perceptions of Human Trafficking Among Health Stakeholders”

Your signature below indicates that you have read and understood the conditions of participation in this study including the following:

- I have read and understood the subject information and consent form and am consenting to participate in the study “How is Human Trafficking Understood within Health Care? A Discursive Analysis of Understandings and Perceptions of Human Trafficking Among Health Stakeholders”.

- I have had sufficient time to consider the information provided and to ask for advice if necessary.
- I have had the opportunity to ask questions and have had satisfactory responses to my questions.
- I understand that all of the information collected will be kept confidential and that the result will only be used for scientific objectives.
- I understand that my participation in this study is voluntary and that I am completely free to refuse to participate or to withdraw from this study at any time without effecting my participation in the main study and without changing in any way the quality of care that I receive.
- I understand that I am not waiving any of my legal rights as a result of signing this consent form.
- I understand that there is no guarantee that this study will provide any benefits to me.
- I have read this form and I freely consent to participate in this study.
- I have been told that I will receive a dated and signed copy of this form.

Name of Subject

Signature

Date

Appendix G: Interview Questions



Research Title: How is Human Trafficking Understood within Health Care? A Discursive Analysis of Understandings and Perceptions of Human Trafficking Among Health Stakeholders

Researcher: Alison Clancey
MSW Candidate
School of Social Work
University of Victoria
Victoria, BC
604 355 3124
aclancey@uvic.ca

Semi-structured interview questions

1. Please state your position and describe your role in your organization.
2. What areas of health care does your organization provide?
3. What clients do you generally serve?

Individual Perceptions

4. When you hear the term human trafficking, what comes to mind?
(Prompt: Is there any particular case or any particular type of case that comes to mind?)
5. How would you define human trafficking in your own words?
6. Do you use other words or phrases to refer to what you define as human trafficking?
- B. Have you heard others use other words or phrases to refer to what you define as human trafficking?
7. Where have you acquired knowledge on human trafficking?
(Prompt: Where do your understandings and perceptions of human trafficking come from?)
8. Have you ever received formal training or attended workshops on human trafficking? If so, please provide details.

9. How prevalent do you believe human trafficking is in the health region that you serve on a scale of 1 to 10, with 1 being non-existent to 10 being very prevalent?
B. What makes you think so?
10. How prevalent do you believe human trafficking is in Canada on a scale of 1 to 10, with 1 being non-existent to 10 being very prevalent?
B. What makes you think so?

Organizational Perceptions

11. Based on your involvement with your organization, how does this organization think and talk about human trafficking?
B. How do you colleagues speak about human trafficking?
12. Where do you think the organization's understandings and perceptions of human trafficking come from?
13. Can you think of a time in which the organization's ideas about human trafficking came to the forefront, for example, in making a decision or employing a strategy?