

Understanding the link between trafficking in persons and HIV and AIDS risk in Tanzania

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Abstract: The magnitude of trafficking in persons in Tanzania is unknown. Consequently, available information on health risks of persons trafficked for different forms of exploitation is extremely scanty. We conducted a baseline study in eight administrative regions of Tanzania using both qualitative and quantitative methods to generate data on the health conditions of trafficked persons to inform trafficking in persons control measures through HIV and AIDS interventions. Study participants included the national, regional and district community development officers, district medical officers, local government leaders, managers or representatives of non-governmental organizations involved in anti-trafficking in persons activities, members of the community and victims. Findings indicated that common forms of labour into which persons are trafficked include domestic services, agriculture (farming), construction, mining/quarrying, fishing, lumbering and manufacturing. Trafficked persons are reported to be exposed to risks like overcrowding, long working hours, psychological problems, physical injuries, impotence, breathing problems and sexually transmitted infections including HIV. It is concluded that the reported occupational hazards in industries where trafficked persons are forced into are not specific to trafficked persons as they affect all labourers. However, the underground nature of the trafficking in persons process increases health problems and risks, including the vulnerability to HIV infection. More tailored research is needed, especially to find means of how to reach out and provide services to this particular vulnerable population, validate labour forms of exploitation into which persons are trafficked to enable the integration or mainstreaming of HIV and AIDS and trafficking in persons at the policy and programmatic levels. In addition, findings would facilitate the understanding of the link between increased risk of HIV and trafficking in persons.

Keywords: HIV, trafficking in persons, labour, Tanzania

Introduction

In 2006, the Tanzanian Parliament ratified the United Nations (2000) protocol to prevent, suppress, and punish trafficking in persons, especially women and children. The protocol tasked governments to pay attention to an endemic crime facilitating the exploitation and cruelty of a huge number of citizens around the globe (Cameron, 2007). On April 11, 2008, the Tanzania National Assembly passed a comprehensive legislation to address all aspects of trafficking in persons in the country and beyond. The Anti-Trafficking in Persons Act of 2008 became effective in June 2008. The law stipulates clearly the roles and obligations of ministries and departments, Non-Governmental Organizations (NGOs), communities and individuals in

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the control of this crime that violates human dignity, human rights and the right to health of trafficked persons. The Ministry of Health and Social Welfare (MoHSW), among other roles, is directed by the law to integrate or mainstream HIV and trafficking in persons preventions at the programmatic level. To achieve this long-term objective, the MoHSW needs data to inform the implementation of short and long-term comprehensive strategies to curtail the spread of HIV associated with trafficking in persons.

Trafficking in persons is not a new phenomenon. It is one of the fastest growing transactional organized crimes in the world. Only limited global and regional trends and developments are documented (Silverman, 2011; Kloer 2009). The records indicate the origin of trafficked persons, their transit and countries of destination, as well as victim and offender profiles. Available evidence suggests that there is limited data about the health problems facing trafficked persons, particularly in Africa. Where data exist, the prevalence of HIV infection has been shown to be disproportionately high among people trafficked for the purpose of sexual exploitation, ranging from 40% to up to 90%. Women and girls are most at risk, but so are young boys. Conditions in which sexual exploitation occurs commonly include high numbers of sex clients, violent and/or unprotected sex, poor hygiene (of both the setting and the clientele), voluntary or induced drug use (including unsafe injecting practices) and inadequate screening and treatment of common sexually transmitted infections (UNODC, 2010).

The magnitude of trafficking in persons in Tanzania is unknown. Consequently, available information on health risks of persons trafficked for different forms of exploitation is extremely scanty. The aim of this study was to capture the health problems facing trafficked persons for labour to enlighten on the link between HIV spread and trafficking in persons. In turn, this information would inform trafficking in persons control measures through HIV and AIDS interventions.

Materials and methods

Study design

A cross-sectional baseline assessment was conducted in eight administrative regions of Tanzania, namely, Arusha, Dodoma, Iringa, Morogoro, Manyara, Singida, Tanga and Dar es Salaam. These eight administrative regions were purposefully selected because were either considered to be leading sources of trafficked persons or as victims' (men, women and children) end-points on demand for domestic work, mining, construction, fishing, agriculture (tea, flower and wattle plantations and animal keeping), factories and in the lumbering industry. Two districts (one urban and one rural) were selected from each region except for Dar es Salaam where all three municipalities (Ilala, Kinondoni and Temeke) – the perceived major destinations of trafficked persons – were included in the study.

Data collection

Qualitative information was collected from eight (8) community leaders from each district. All District Medical Officers (DMOs) and District Social Welfare Officers (DSWOs), available Non-Governmental Organization Managers dealing with human trafficking-victims, five community leaders from each district and accessible trafficking in persons victims. Key informants for this

study were purposely selected given their administrative roles and responsibilities that have direct or indirect link to trafficking in persons prevention, control or rehabilitation and reintegration of trafficking in persons survivors.

On the one hand, the study team conducted in-depth interviews (IDIs) with Regional Medical Offices (RMOs), Regional Community Development Officers (RCDOs), District Medical Officers (DMOs) and District Social Welfare Officers (DSWOs), Non-Governmental Organization Managers dealing with trafficking in persons-related issues and community leaders available at the time of conducting this study. Members of the team arranged for the IDIs at the regional, district and village levels well in advance. Where the identified informant was not available at the time of the scheduled interview, rescheduling was inevitable. These government officials were informed about trafficking in persons and were open throughout the interviews. At the village level, the community leaders were able to identify trafficking in persons survivors who were, in turn, interviewed by the study teams. The IDI guide question sought information on the magnitude of the problem, root causes and dynamics, trafficking flows, characteristics and behaviours of both the traffickers and the victims, control measure in place and their suggestions to the planning, implementation, monitoring and evaluation of anti-trafficking in persons interventions through HIV and AIDs interventions in the country.

The teams interviewed accessible trafficking in persons survivors (2 in Arusha, 2 in Tanga and 1 in Iringa regions). These informants were similarly open and participated in the interviews than expected. Their willingness to share their trafficking life stories/experiences with the researchers made data collection process relatively manageable given resources that were available for this study. The plan was to conduct IDIs for one and half hours. However, majority of the IDIs lasted longer than planned. The trafficking in persons were interviewed between 2 and 4 times each. All government officials and community leaders were interviewed 2 times or more, which allowed gaining an in-depth understanding of issues around trafficking in persons from the informants' perspectives. The explanation, could be, in part, that the informants had more information to provide; but more important, the study team comprised of experienced in-depth interviewers with rich skills on posing questions, listening, understanding, thinking and probing.

IDIs were conducted in Kiswahili the national language. However, at some points some informants mixed Kiswahili and English. As initially anticipated, all study participants allowed tape recording of the interviews conducted. The tapes were then transcribed verbatim by research assistants at each study site under the supervision of the site study coordinator who checked quality by comparing the transcriptions and the recorded information.

In a quantitative component, the study team aimed to interview 50 heads of households aged 18 years and above in each district of the two selected districts per region. For Dar es Salaam, we split 100 targeted households to Ilala (38), Kinondoni (31) and Temeke (31). Data collected included (but not limited to) socio-demographic characteristics of trafficking in persons victims, pushing and pulling factors behind trafficking in persons behaviour and practices, sending and receiving areas and the perceived actual and lived experiences of trafficking in persons including health conditions of persons trafficked into labour in their areas.

A sampling frame of villages per pre-selected district was obtained from the District Administrative Officer. In each village, the number of households was also obtained. Therefore, it was possible to get the number of households per village, cumulative households and the number of selected households in a particular selected village. This is a probability proportional to size (PPS) sample of households. In each selected household, the head of the household was interviewed.

Data analysis

Translation of data from Kiswahili to English was conducted centrally in Dar-es Salaam under the supervision of the principal and co-investigators to ensure all data received was accurately transcribed and translated. The translated transcripts were analyzed using the NVIVO 8 qualitative data analysis software that facilitated exploring, organizing and managing data. Coding begun with an open coding approach using participants' language and combining emerging emic concepts with preconceived theoretical constructs. Constant comparative techniques were used to analyze the data (Strauss & Corbin, 1998) around trafficking in persons themes and issues investigated.

Ethical considerations

Ethical clearance for the study was obtained from the Medical Research Coordinating Committee of the National Institute for Medical Research. Permission to conduct the study was requested from the District Executive Directors and from all Institutions directly involved in the study. Informed verbal consent to participate in the study was sought from respondents (none of them was a minor) and assurance of confidentiality of the gathered information was given. Strict confidentiality was adhered especially to information provided by trafficking in persons victims.

Results

Characteristics of study participants

For the qualitative component of the study, we interviewed 78 community leaders from Babati (3), Ilala (6), Iramba (5), Kilolo (5), Kilosa (5), Kinondoni (6), Kondoa (10), Lushoto (6), Meru (8), Morogoro Urban (4), Mufindi (2), Muheza (5), Simanjiro (3), Singida Urban (5) and Temeke (5) districts. Forty seven (60.3%) of these community leaders were males. The mean age of these respondents was 45±11.7 years (range =24-80 years). Similarly, 112 individuals were interviewed in the study sites: DMOs 17, DSWO 17, NGO managers 10, HT victims 15 and community members 53. Their age ranged between 18-73 years. Education level of the community members ranged from no formal education to primary education, while all victims had primary education or below. NGO managers, DMOs and DSWOs had formal education ranging from secondary to university levels.

For the quantitative component of the study, we interviewed 799 individuals from the household survey. Majority of the respondents 516 (64.6%) were females and 283 (35.4%) were males. Majority of the respondents (53.9%; N=431) were in the 30-49 years age group followed by those aged 50 and above years and 145 (18.1%) were 30 years old and below (Table 1).

Majority of the respondents (57.9%; N= 463) had completed primary education, 150 (18.8%) had attended above primary education level and a few, 18 (10.1%) had had no formal education. About a half of the respondents (49.4%) were peasants and a few, 53 (6.6%) were employed in the formal sector. Almost all respondents belonged to the two main religious groups: Christianity 400 (50.1%) and Islam 396 (49.6%) (Table 1).

Table 1. Characteristics of respondents (household sample) (n = 799)

Characteristic	Response	Number (%)
Sample origin (Region)	Arusha	99 (12.4)
	Dar es Salaam	100 (12.5)
	Dodoma	99 (12.4)
	Iringa	102 (12.5)
	Manyara	99 (12.4)
	Morogoro	100 (12.5)
	Singida	100 (12.5)
	Tanga	100 (12.5)
Sex	Male	283 (35.4)
	Female	516 (64.6)
Age group (years)	< 30	145 (18.1)
	30 – 49	431 (53.9)
	50+	223 (27.9)
Highest education level	None	81 (10.1)
	Some primary education	105 (13.1)
	Completed primary education	463 (57.9)
	Post primary education	150 (18.8)
Main occupation	Peasantry	395 (49.4)
	Housewife	116 (14.5)
	Petty business	152 (19.0)
	Formal sector	53 (06.6)
	Other (fishing, unemployed, etc)	83 (10.4)
Religion	Christianity	400 (50.1)
	Islam	396 (49.6)
	Others	3 (0.3)

The perceived magnitude of HT, characteristics and health conditions of victims

Of the 799 heads of households interviewed, 241 (30.2%) reported that at least one member of the household had been trafficked. Findings indicated that common forms of labour into which persons were trafficked included domestic service, food vending, petty business and farm activities. Others include construction, mining/quarrying, fishing, lumbering and manufacturing. The majority of the trafficked persons from the surveyed households 135 (71.1%) reported to end up doing domestic work as house-girls/ boys or gardeners (Figure 1). Five trafficking in persons survivors interviewed reported that majority of victims end up within the country (within the same district or region) and a few outside the region but within the country. The DSWOs for Morogoro, Singida and Iringa regions commented that majority of girls are trafficked out of the regions, mainly to Dar es Salaam and a few to Zanzibar. The Tanga

DSWO reported three cases of girls rescued from being trafficked into Kenya where they had been promised to receive vocational training and later good paying jobs.

The reported level of exploitation, health risks and diseases affecting trafficked persons varied with the type of labour they were forced into. From the in-depth interviews, the survivors reported experiencing psychological problems, physical injuries and infectious diseases. For instance, trafficked persons forced into the domestic sector (the house girls/boys), reported working for long hours (from 5.00 am to mid-night or after), getting low and irregular wages and lacking freedom of movement and activities. Some reported experiencing sexual and physical abuse or rape by husbands or other male relatives. Such acts could lead to contracting HIV and other STIs or unwanted pregnancies or termination of their work. Cases of returned ex-house girls that had died of AIDS, were living with HIV and AIDS or had children to unknown fathers were also reported in every community studied. In some interviews, house-boys were reporting being sodomized or forced to have sexual relationships with their female employers or relatives. Rare cases were also reported where the employers killed their house girls/boys. A female community leader interviewed in Dar es Salaam, for instance, reported “we know a few cases reported to our office where ‘the bosses’ were suspected to contribute to deaths of their house girls ... We reported the matters to the police for further investigation” (Interview, Dar es Salaam, November 18, 2008). The Arusha DSWO recalled two cases reported on the local radio of “a husband and wife were being interrogated by the police following the death of their *shamba* boy [being suspected to have killed him]” (Interview, Arusha, November 18, 2008).

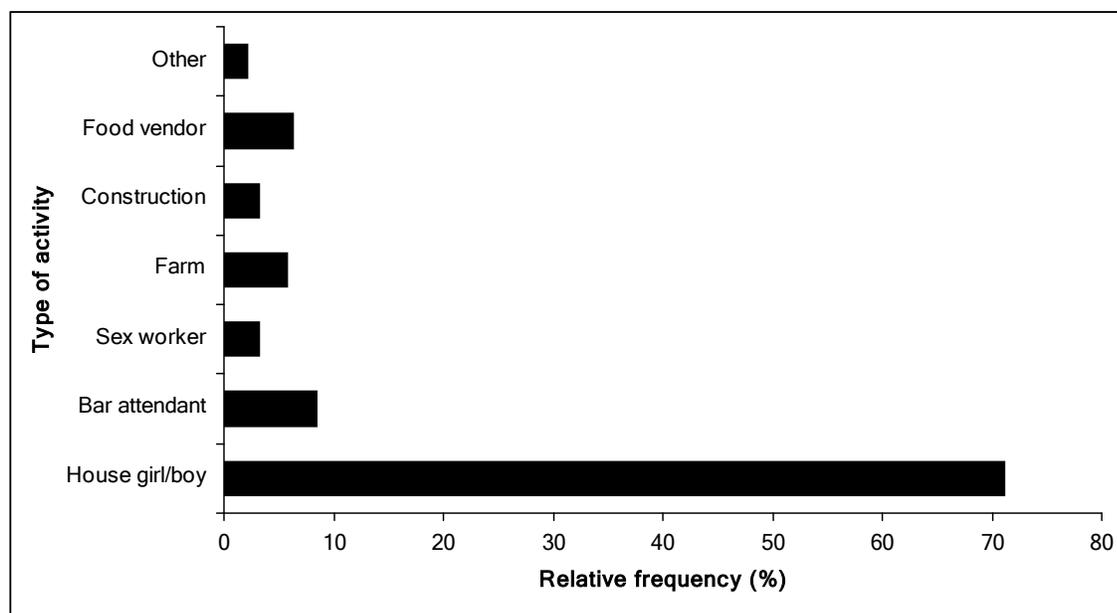


Figure 1: Reported major activities performed by victims of human trafficking

Trafficked persons forced into the agricultural sector were categorized into three sub-groups namely, plantations, animal keeping and poultry. For example, men, women and children working in flower and sugarcane plantations in one of the study areas reported working for

long hours, being paid low wages, with ill-health conditions like difficulties in breathing, skin diseases, injuries, impotency and poor eyesight (possibly from constant contacts with insecticides used in plantations). Previous farm labourers reported to be living in poorly ventilated and overcrowded camps, which put them at risk of infectious diseases such as hepatitis and tuberculosis and being at high risk of contracting diseases from animals. Some labourers reported to engage in risky sexual behaviours such as unsafe sexual practices (unprotected sex and having multiple partners) among themselves and with members of surrounding communities, which put them at higher risks of HIV infection and other STIs. Substance use and abuse were also reported to be common among camping farm labourers.

Key informants reported that with the mushrooming of vast construction in the country, there has been an increasing number of persons trafficked into this industry from within and outside the country over the past five years. The RSWO interviewed in Dodoma, for instance, pointed out that labourers in this industry were facing several health risks due to long working hours, lifting heavy materials without adequate protection, dust, falling objects/buildings, extreme heat or cold, working at immense heights, substance use and abuse, working with poor quality equipment, operating heavy machinery without proper training and protective gear, which puts them at risk of injuries, amputation or death. The official added "They [labourers] live in overcrowded camps exposing them to risks of infectious diseases such as tuberculosis" (IDI, Dodoma, November, 2008). Such health hazards have been reported among trafficked persons working in the fishing industry. In addition to these risks, sexual assault, use of substances such as alcoholic beverages, marijuana and illicit drugs were reported common among labourers in this sector (IDIs, Dodoma, Arusha and Dar es Salaam, November 2008).

The findings showed that the level and complexity of exploitation faced by trafficking in persons victims varied with type of activity engaged in. Nevertheless, majority of the key informants in urban districts reported that victims experienced psychological problems, physical injuries and other health problems. The house girls/maids, for instance, were reported to be working for long hours (from 05:00am to midnight or after), paid low and irregular wages, lacked freedom and time to relax and some were sexually abused. The NGO manager who works with the most at risk and rescued women and girls in Arusha puts it clear that:

These girls [house girls] face a number of problems, sometimes husbands or male relatives in the house will have sex with them, and this is not always consensual sex... No Sometimes they are raped ... some actually end up being pregnant and then expelled from the house (Interview, Arusha, November 18, 2008).

Similar health risks were reported in the mining industry. Labourers in this sector reported working under harsh conditions deep in the earth's crust, lack of oxygen and sunlight and prolonged exposure to heat and dust. Reporting to one mining area in one of the study sites, a key informant noted that groups of miners lived together in isolated and congested locations – at risk of infectious diseases. Referring to lifestyles in the mining areas, all key informants in Arusha region recalled miners spending their money drinking and engaging in risky sexual practices. Similarly, child labour and abuse were reported common in the mining camps in this region.

Almost all study participants interviewed, the trafficking in persons survivors in particular, reported that trafficking in persons victims were at heightened risk of HIV infection

and other STIs “because their living conditions [at their destinations] often force them to indulge in sexual activities for survival or in exchange for money with multiple partners” (IDI, Tanga, November, 2008). The Arusha-based NGO manager quoted earlier summarized the health problems facing rescued women and girls they support as follows:

Majority of our clients report suffering high levels of stress and violence at places of origin, transit and destination Women trafficked for sexual exploitation, for example, are forced to live in life-threatening conditions limiting them from escaping, seeking health care or legal support Abuse, exploitation and degradation experienced often lead to long-term complicated damages to their health, physical, mental, social-wellbeing and self esteem Health and psychological problems are rarely overcome ... Women who survive are likely to live with these conditions for a long time. Some women completely lose hope; run away from the centre, families and communities ... returning into prostitution, often in distant urban areas. (IDI, Arusha, November 2008).

Discussion

The understanding of the intersection of trafficking in persons and HIV spread is literally new, intricate and under researched in Tanzania. However, it has been established that the similar problems seem to share common fundamental factors: poverty, discrimination and unsafe mobility, especially in the context of gender and human rights (UNDP, 2007). Using information available from other parts of the world on these issues and findings from this baseline survey could facilitate building evidence why the Tanzania government should implement programmes that include both prevention of trafficking in persons – rescuing, rehabilitating and reintegrating survivors – and HIV transmission.

Poverty was reported a primary factor why individuals would become trafficked in or out of Tanzania. Similarly, poverty is known to be a prime mover why individuals would engage themselves in HIV-infection risk activities, behaviours and practices (MoHSW, 2010a; 2010b). According to the estimations of the International Fund for Agricultural Development (IFAD, 2008), Tanzania has a total population of 42,483,923 of whom 31,642,025 live in rural areas and the number of rural poor is approximately 12, 245,464. A Household Survey (2000/01) indicated that about 20% of the rural populations lived in extreme poverty with 30% considered poor. Agriculture is the main occupational sector, which faces obstacles like drought and flooding, lack of inputs, insecure markets, low market prices, lack of credits and poor quality education. The proportion of households producing food for consumption has declined by more than 10% (IFAD, 2008). Few rural households access safe drinking water from improved source (47.0%), lack of education among rural females and males (31% and 21.6%, respectively) and health care services which worsen the acute poverty experienced in these areas. Nearly all regions of Tanzania are by any international standard poor (40.5% below the middle wealth quintile) (TDHS, 2011). However, the poverty level varies between regions; being highest among families in arid and semi-arid regions that depend solely on livestock for food production. Recent statistics suggest that some women, men and youth in poverty stricken parts of Tanzania are desperate and thus vulnerable to trafficking in persons with expectations of a better and prosperous life in the areas of destination (Kamazima *et al.*, 2011). The

implementation of poverty reduction initiatives – micro financing, small business or agricultural improvements – integrated within HIV and AIDS intervention programmes may prevent people from being recruited into trafficking and hence prevent them from acquiring HIV.

Like in other parts of the world, males and females in Tanzania are at a risk of trafficking in persons. However, women, followed by girls and boys, form the majority of trafficked persons. The girls and boys targeted are at young ages (≤ 14 years), unable to make informed decisions based on false promises given by the traffickers about life at places of destination. As adolescents, they are likely to engage in high risk sexual behaviours and experimenting with drugs, which exposes them to HIV infection (ZACP, 2007). They usually have a low level of education – no formal education, primary school dropouts or have just completed primary school (MoHSW, 2010a) – thus their knowledge of HIV risk factors and prevention measures may also be compromised, which increases the risk for HIV infection and other STIs. Certainly, incidences of gender inequality and violence are still vivid in many aspects of life in Tanzania. The TDHS (2010), for instance, indicates that 23.7% of women aged 15-45 years in rural areas have no formal education compared to 11.9% of their counterparts. Similarly, only 10% of the same women had some secondary education compared to 15.6% their counterpart (TDHS 2010).

Coupled with other forces such as violence, poverty and young age, lack of education makes boys and girls in the rural areas at risk of being trafficked, which in turn, could expose them to HIV-risk lifestyles. Improvements in the accessibility and quality of primary and secondary education in the country, in the rural areas in particular, could prevent the youth from being recruited into trafficking and may also prevent them from acquiring HIV. Kilolo District in Iringa Region that had been impacted by trafficking in persons and HIV and AIDS has introduced by-laws requiring every child in the district to complete both primary and secondary school education. Failure of which, the parents and local authorities are held responsible (MoHSW, 2010a). This is a good start. However, the challenge is lack of capacity to offer education of recommended quality and standards whose solutions call for joined forces from different administrative ministries and sectors.

Given the underground nature of trafficking in persons process (recruitment, transportation and harbouring) no victim undergoes HIV testing. The observed increasing number of trafficked persons – internally or from the Far East – into the domestic, construction and prostitution industries in this country is raising alarm on this issue. It is possible, therefore, that trafficked persons could be infected with HIV and other STIs before departure increasing chances of infecting others or being re-infected during transit or at places of destination (Kloer, 2009). In turn, trafficked persons, specifically bar maids unaware of their HIV status, could be labelled as HIV reservoirs and conduits as they move to places of destination or go back to their communities (MoHSW, 2010a). Silverman *et al.* (2008) recommended the investigation of co-infections among HIV-infected trafficked women and girls for sexual exploitation in Nepal because those found HIV positive were more likely to be co-infected with syphilis and/or hepatitis B. This may suggest the need to improve clinical skills and practices to screen for HIV, syphilis, hepatitis B and several co-infections, among trafficked persons as well as among the general population.

Current research shows that trafficked persons forced into prostitution or labour are put under conditions that force them to have unprotected sexual acts with multiple partners, are raped and face violence that increase the risk for the spread of HIV and other STIs (Kloer, 2009; UNODC, 2010, MoHSW, 2010a). Kloer (2009) observed that sadistic sex can cause scratches and tearing of tissues, making HIV transmission more likely. Persons trafficked into labour had limited access to health care services available in their areas. As this study showed, they had no time and money to pay for medical care services. Their freedom of movement and meeting other people was quite limited and the secret nature of this crime makes them undetectable, which further reduces their access to health services, including HIV and AIDS intervention programmes. This situation leads, in turn, to missed detection of cases, incomplete or partial treatment and suboptimal clinical follow-up (Silverman *et al.*, 2008).

Myths about HIV transmission and AIDS cure in some parts of the world are likely to fuel trafficking in persons. Surfacing beliefs among men that 'having sex with virgin girls could cure AIDS' (Kloer, 2009) and that 'young girls are HIV-infection free' cause infected and non-infected men to search for unsafe sex with younger girls. As a result, female children (<14 years) are trafficked into prostitution where customers are willing to pay more (Silverman *et al.*, 2007; MoHSW, 2010b). Truck drivers, independent *mamas* or *maids*, male trafficker, brothel owners and informal groups of trafficked persons, such as prostitutes, were reported active in trafficking, harbouring and forcefully orienting young girls and women into prostitution (MoHSW, 2010b). This finding explains, in part, why there is an increasing number of girls, as young as 9 years, observed and reported working in the sex industry in Tanzania and other parts of the world (Silverman *et al.*, 2007; Kloer, 2009; MoHSW, 2010b). However, the fact is that young girls are more vulnerable to HIV and other STIs because they are biologically immature (extremely fragile and at risk to injuries) and often lack power to negotiate for safe sex (Alam, 2009).

Similarly, the reported increasing demand of preferred young girls and boys from selected regions and communities forced into prostitution and the domestic sector is likely to fuel trafficking in persons in Tanzania. For various reasons such as body attractiveness, trustworthiness, a strong work ethic, and highly compliant, young girls from north-eastern, central and southern highland regions were preferred for domestic services and prostitution (MoHSW, 2010a). Trafficked persons into domestic services remain in this sector for two to three years before escaping from harsh working conditions and exploitation. The majority, unfortunately, do not return to their places of origin, they get oriented into prostitution by fellow trafficked persons (MoHSW, 2010b) or become barmaids who may also be underground female sex workers. The implication is that trafficking in young girls and boys would contribute to members of the most at risk populations whose health needs and demands are unmet by the current HIV and AIDS control programs (MoHSW, 2010a).

In conclusion, findings from this study suggest that despite trafficking in persons being illegal in Tanzania, it is flourishing, complex in nature and under-researched. All forms of trafficking – internal, out of and in the country – are taking place with insignificant attention from the government and the public. Data indicated that occupational hazards are not specific to trafficked persons, they affect all labourers. However, the characteristics of persons trafficked for labour; the (underground) conditions they experience before departure, on transit and at

destinations increase their risk of health problems including HIV infection and other STIs. Data accentuate the need for further research to generate knowledge that would inform government-initiated strategies to combat trafficking in persons. The MoHSW has been mandated by The Anti-Trafficking in Persons Act, 2008 to respond to trafficking in persons from the health perspective by providing appropriate health care services to survivors and their families, implementing rehabilitative and protective programmes for (potential) victims, providing counselling and temporary shelter to victims and developing a system for accreditation among NGOs for the purpose of establishing centres and programmes for intervention at various levels of the community.

Certainly, in the absence of concrete data on trafficking trends, root causes, and dynamics, the environment for trafficking (supply and the demand), risk and pre-departure vulnerability factors, community awareness of the crime, targeted locations of crime and corruption, strength of rule and law to support anti-trafficking efforts, trafficked persons profiles and their susceptibility to infectious diseases, the traffickers' profiles and other health-related dangers would jeopardize the implementation of HIV programmes that include the prevention of trafficking in persons. The MoHSW and other partners should design and coordinate a comprehensive multidisciplinary longitudinal study that would continuously capture and document (including potential) victims' health needs, conditions and demands at pre-departure, transit and destinations. Such data would inform the integration of HIV and AIDS and trafficking in persons prevention efforts at the policy and programmatic level and facilitate the understanding of the increased risk of HIV and trafficking in persons.

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