HEALTH PROMOTION AND DISEASE PREVENTION **A Handbook for Teachers, Researchers, Health Professionals and Decision Makers**	
Title	**Violence and Injury Prevention – Challenges For Health Promotion in Macedonia**
Module: 5.9	**ECTS: 0.5**
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Key words	Unintentional injuries, violence, health promotion, safety, public health approach, burden, risk factors, prevention, challenges
Learning objectives	The aims of this Module are to: draw attention to the magnitude of the injuries and violence as a public health problem; highlight the burden and costs of injuries and violence; describe the main challenges faced and the health sector response in Macedonia applying public health approach and focusing on primary prevention.

Abstract	World Health Organization estimated 5.1 million deaths from injuries in 2002 in the world or 9% of all deaths, disproportionately affecting the young. These are a leading cause of premature death and DALYs at age of 5 to 45 years. In Europe injuries are third leading cause of death, after cardiovascular diseases and cancers with 800,000 or 8.3%. Injuries can be avoided and prevented. Many effective strategies can be used to target high risk groups and to reduce health consequences for victims of injuries. The health sector can play a key role in injury and violence prevention and control, by providing care and services to victims, prevention and advocacy, and engaging in partnerships with other sectors and across all levels of government and society. Decreasing the burden from injuries will require political commitment across all government levels and with this the allocation of adequate resources to take these activities forward. Future challenges for injury and violence prevention and health promotion, that the countries including Macedonia would face are: developing national action plans for unintentional injury and violence prevention**, f**orming an intersectoral injury prevention committee, improving national surveillance system, strengthening national capacity to respond to the burden of injuries and violence through both primary prevention and care**, p**romoting evidence-based practice by facilitating the exchange of knowledge and experience across the Region, **r**ecognize gaps in knowledge and prioritize research and development in both primary prevention and care, as well as studies on costs
Teaching methods	Teaching methods will include public health approach and ecological model applied through lectures, interactive small group discussions and case study. The students will apply new knowledge working in small groups, identifying the problem, risk factors and prevention interventions for injury and violence, preparing country projects.
Specific recommendations for teachers	This module will be organised in 0.5 ECTS credits with 70% work under teacher supervision and 30% individual students' work. Teaching venue with available computers, internet access, LCD projector and flip charts will be needed for interactive teaching and group work.
Assessment of Students	Assessment will be done through the group work, seminar paper and case problem presentations.

VIOLENCE AND INJURY PREVENTION – CHALLENGES FOR HEALTH PROMOTION IN MACEDONIA

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Methods and conceptual framework

This Module provides a theoretical basis for understanding injuries and violence as a public health problem, suggesting implementation of prevention programmes in line with the WHO recommendations and identifies future challenges for action at global and national level.

The public health approach has been presented in this Module as a conceptual framework for injury and violence risk assessment and prevention interventions.

The aims of this Module are to: draw attention to the magnitude of the injuries and violence as a public health problem; highlight the burden and costs of injuries and violence; describe the main challenges faced and the health sector response in Macedonia applying public health approach.

Injuries and violence as a global public health problem – burden and trends at global, regional, national level

Injuries and violence are serious public health problem leading to a premature death and disability with growing burden of disease, which is the result of fast modernization and urbanization, not followed by appropriate preventive programs. Injuries and violence have a very significant impact on health and health services placing a high economic and societal burden (1, 2).

An injury is the physical damage that is a result of a human body being suddenly subjected to energy in amounts that exceed the threshold of physiological tolerance or a result of the lack of one or more vital elements, such as oxygen. This energy could be mechanical, thermal, chemical or radiant (1). The main causes of unintentional injuries are road traffic injuries, poisoning, drowning, falls and burns. Intentional injuries are caused by violence, although not all violence (e.g. threats) results in injuries. Violence is defined as the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in injury, death, psychological harm, maldevelopment or deprivation. Violence can be divided into: self-directed (as in suicide or self-harm), collective (in war and by gangs), and interpersonal (child, partner, elder, and acquaintance, stranger) (3).

Although injuries significantly impact upon public health and health services, their importance has never been recognized nor have they been prioritized on the health policy agenda. This resulted in lack of awareness of the magnitude of the problem;. a lack of awareness of the preventability of injuries; unwillingness to take ownership and leadership in view of the multi-sectoral nature of the response required which also involves other sectors, e.g. transport, justice, education, social affairs; and inadequate attention to evidence-based trauma care in the prehospital, hospital and rehabilitation phases, which all represent challenges for the public health.

As a result, there is an overall lack of visibility and political commitment to the issue and inadequate allocation of financial and human resources to scale up the public health response to injuries, particularly in relation to prevention, safety promotion and working across different

sectors; inadequate information collection to define the magnitude and consequences of non-fatal injuries and to evaluate the effectiveness of programmes. Such information could be used to increase the visibility of problems and solutions to both policy makers and the public's insufficient capacity to provide an effective response for prevention, care and rehabilitation; to a previously fragmented approach to violence and unintentional injuries, which needs to be replaced by a coordinated strategy; and to the need to optimise the quality of trauma care in the continuum of care from prehospital care, hospital care to rehabilitation by improving the evidence base, capacity and the organisation of trauma services.

Injuries are present in all countries and regions, at all ages, and dependently of the economic power of the country different types are dominant. In the world injuries are the fifth cause among 15 leading causes of death (after cardiovascular diseases, malignant neoplasms, cerebrovascular and chronic respiratory diseases), with 5.8 million deaths in 1998, and with projection of 8.4 annual deaths for 2020. Every day in the world 16 000 people die from injuries, on every dead person few hundreds are injured, and many of them have permanent sequels and disability. Injuries participate with 16% in total burden of disease in the world. Injuries are the third cause of death in the European Region with mortality rate of 50 per 100 000. In Europe 80 million accidents happen annually, with incidence rate of road traffic injuries of 340 per 100 000 in EU countries i.e. 1.5 million injured in EU countries and 3.5 million in whole Europe (4).

Road traffic accidents are the leading cause of death from all injuries (20.3 %); 10th of all causes of death (2.2%); they are at the 9th place in the total burden of disease in the world with 41 million DALY-s for both sexes and participation of 2.8% in total number of DALY-s, while 14% of all DALYs lost in Europe. In the world in 2000 there were 1.2 million deaths from road traffic injuries (out of which 88% in the developing countries with increasing trend, and 12% in the developed countries with decreasing trend), 815 000 deaths from suicide, 520 000 from interpersonal violence, 310 000 deaths from war and conflict and 3 million deaths from accidents.

The number of injury-related deaths in the European region was estimated as 800,000 or 8.3 % of all deaths in the Region as the third leading cause of death, after cardiovascular diseases and cancers, out of which 534,000 were from unintentional injuries and 257,000 from intentional injuries or violence. Three leading causes account for nearly 50 % of all deaths related to injuries: suicides (164,000), road traffic injuries (127,000) and poisoning (110,000). Every death due to injuries results in hundreds of individuals who suffer non-fatal physical and mental disabilities, often life-long. There is a lack of information about the health consequences of unintentional injuries and violence, and thus, it is necessary to develop and implement appropriate plans of action.

Violence may lead to fatal injuries (homicide is the 5th leading cause of injury death in the Region), and psychological and sexual violence (child abuse, intimate partner violence) which are more difficult to measure using routine surveillance, and the burden from these remain largely unmeasured, except when surveys have been undertaken (3). In the case of intimate partner violence, in addition to physical injuries surveys have shown a high prevalence of mental and reproductive health problems and negative health behaviours (5).

The burden of injury is unequally distributed across the world: low- and middle-income countries, show the highest mortality rates, while high-income countries report the lowest rates. However, even within high-income countries, there are marked differences, with economically deprived and socially vulnerable groups being at comparatively greater risk.

Similarly, inequalities exist among age and sex groups**.** A disproportionately large burden is inflicted on young people under 45 years old, making injuries a leading cause of loss of productive life, of high medical care costs and significant degrees of disability.

In developing countries around 1 million children under 15 years annually die from injuries, out of which 240 000 are due to road traffic accidents. In developed countries 20 000 children die from injuries. In OECD countries 10 000 children die from road traffic accidents annually. On every 100 000 children born in OECD countries less than 200 will die from injuries at age under 15, while in the developing countries over 1000. Road traffic accidents and drowning are main causes of death for around one million children annually in the countries of Africa, Asia and Latin America. Mortality from injuries is three times higher among male children under 15 in the OECD countries. One third of all injured in road traffic accidents are at the age between 15 and 29 (6).

In the year 2002, about 26,000 children below 15 years of age lost their lives from injuries in the European region, equivalent to 70 deaths per day, or about 3 per hour. Children are particularly at risk: road traffic injuries are the leading cause of childhood mortality in children between 5 and 14 years of age and drowning is the third leading cause, being particularly prevalent in the low and middle income countries of Europe. Deaths are the tip of the iceberg; there may be long-term physical and psychological consequences in children, with serious repercussions on their health in later life. These may be difficult to measure using routine information systems. Children are also vulnerable to violence, with the loss of nearly 3000 lives in the European Region every year. The health sector has a critical role in the early detection of violence in children. Child abuse, whether physical, sexual or psychological may be difficult to detect, but its consequences are nevertheless long standing (3). For example, exposure to child abuse is associated with a 4 to 12 fold increase in risk for alcoholism, drug use disorders, depression, and suicide attempts in later life (7).

Injuries can be avoided and prevented. Many effective strategies exist, which can be used to target different injury causes and high-risk groups and to reduce health consequences for victims. The health sector can play a key role in addressing this major problem, by providing care and services to victims, but also by putting prevention and advocacy at the core of its public health activities, and engaging in partnerships with other sectors and across all levels of government and society.

Many evidence based preventive measures and interventions (use of seatbelts, child seats, helmets etc.) show that this type of injuries can be prevented even if the accident has happened. Preventive programs, interventions and strategies are developed in rich countries and can help in developing similar appropriate cost-effective strategies for prevention of road traffic injuries in poor countries, based on the complexity of this problem and available resources and commitment of the country. Mortality from injuries in childhood in OECD countries within period 1970-1995 has been decreased from 22.8 to 11.5 per 100000 as a result of successful implementation of preventive programs: research, lobbing, legislative, environment modification, population education and improvement of emergency services. Significant results in decreasing injury mortality have been achieved in 5 countries: France, Ireland, Italy, Sweden and Great Britain.

Injury mortality has shown a downward trend since the 1990s in 15 European Union (EU 15) countries and those of South Eastern Europe. In contrast, trends for the Baltic countries and the Commonwealth of Independent States (CIS) has shown a marked peak in between 1990-1994, followed by a downward trend and then an alarmingly upward trend again since

1999. The upward trends in some of these countries in transition are thought to be due to a variety of factors ranging from increased motorised road transport, an increase in inequalities in wealth, unemployment, decreases in social capital, the liberalisation and increased availability of alcohol and poor regulatory and enforcement mechanisms (8).

Violent death rates, from suicides and self-inflicted injuries as well as from homicides and intentional injuries, in most of the countries of South-Eastern Europe (Russian Federation, Moldova, Hungary, Croatia, Bulgaria, Albania, Serbia and Montenegro, Bosnia and Herzegovina, Slovenia), had increasing trend in the period 1990-1995, while decreasing in the second half reaching rates as presented in Table 1. (9) The situation in the Republic of Macedonia was the opposite with increasing trend in the second half of the nineties reaching the highest rates in 2000. Suicides have the highest rates in Russian Federation, Hungary and Slovenia, higher than the CIS and EU average rate. Homicide rates are the highest in Russian Federation, as well as in the Republic of Moldova and Albania, compared to CIS average 19.07 and EU average rate of 7.96 in 2000.

Table 1. Injury and violent death rates in South Eastern Europe (9)

Countries	Suicides 2000	Suicides Last available	Homicides 2000	Homicides Last available
Albania	2.30	4.84	5.99	4.31
Bosnia and Herzegovina	...	9.94	…	
Bulgaria	15.00	11.02	3.32	2.65
Croatia	20.81	16.98	2.62	1.27
Greece	3.25	2.78	1.07	0.84
Hungary	29.17	23.2	2.49	1.8
Italy	5.98	5.93	0.97	0.91
Republic of Moldova	16.31	17.65	12.68	8.39
Romania	12.44	11.96	3.58	3.06
Russian Federation	37.78	29.8	27.59	23.69
Serbia and Montenegro	15.08		2.23	
Slovakia	13.44	11.93	2.17	1.56
Slovenia	27.17	21.98	1.03	1.08
Sweden	11.60	12.15	1.02	1.15
Republic of Macedonia	7.56	7.01	3.10	3.18
Europe	18.31	11.23	7.96	1.17
EU-25 average, 25 Member States, European Union (from 1 May 2004)	11.80	15.67	1.28	2.38
CIS average	29.20	22.72	19.07	15.93

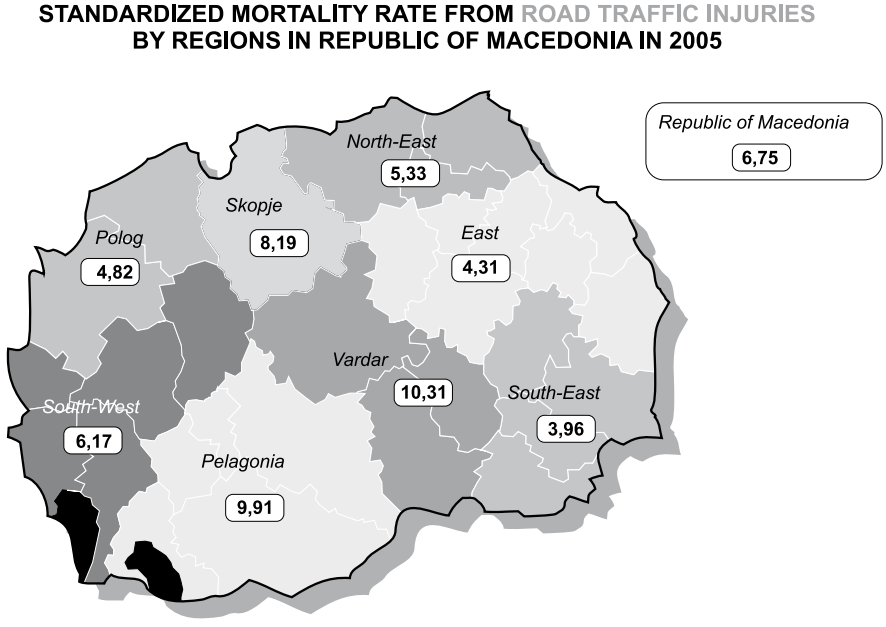
Source: WHO. Health for all Database (9)

Injuries in Macedonia are a high priority public health problem with increasing trend and with increasing participation of intentional injuries in deaths from all injuries. Injuries were the third cause of death after diseases of the circulatory system and malignant neoplasms with 750 deaths in 2002, mortality rate of 36.8 per 100 000 and participation of 4.4% in total number of deaths. Mortality from injuries decreased within the period 2001-2005 with

rate of 28.8 per 100,000 in 2005, (compared to 36.4 in 2001), and SDR of 29.5 per 100,000, becoming the fourth cause of death. Mortality rate increases with the age and it is three times higher among males 41.2 per 100000 (compared to 16.4 among females). Unintentional injuries are dominant in the structure of fatal injuries participating with 66.8% (out of which 33.7% are traffic injuries), followed by suicides with 24.4% and homicides with 8.8% (10).

Distribution of SDR from injuries by regions shows that it is much higher in some regions where the exposure to risk factors is higher, such as Vardarski 44.1/100000, East 35.3, North-East 35.2, Pelagoniski 31.2 and Skopje 30.3 when compared to Poloski 15.5, South West 26.1 and South East 27.4 (Fig. 1). There are differences in injury mortality rates among different municipalities within each of these regions.

Figure 1. Standardized mortality rates from injuries by regions in Macedonia in 2005



Source: Medical Map 2005, Republic Institute for Health Protection, Skopje 2007

The number of drivers and vehicles in Macedonia has an increasing trend in the last 10 years with cyclic variations of road traffic accidents of five years. There is a positive correlation between number of road traffic accidents and number of injured and dead in these accidents (11). The severity degree (deaths per 1000 injured) in Macedonia was still very high in 2000 (69%o), decreasing to 30%o in 2006.

Mortality due to injury and violence is only the tip of the iceberg (587 deaths from injuries in Macedonia in 2005, 11 797 hospitalized and 52 428 visits to the primary health departments). Information for the death is easy to obtain, but non-fatal injuries and psychological traumas remain unrecorded. It is important to use more than one source of information in order to cover all injuries.

Number of all injuries in Macedonia, fatal and non-fatal, have a decreasing trend, but the risk factors can not be explored using the official routine statistics. Therefore, there

is need of community household injury survey with defined multistage sample (applying WHO guidelines for community injury survey) and of national Report, that by implementing WHO recommendations, will develop national Strategy for Injury and Violence Control and Prevention and national action plan.

Socio economic costs

Severe injuries are treated in hospitals (in developed countries 10% of hospital beds occupied), 15% with in-patient and 30% with out-patient rehabilitation, 10% of injured have permanent disability. Average figures from the Netherlands, Sweden and the USA suggest that for every injury fatality, an estimated 30 people are hospitalised and 300 require outpatient treatment in hospital emergency departments (12). This results in high health care costs, making demands on already overstretched resources. Health care costs for injuries in the European Region are not widely available. Estimates for the EU15 suggest that hospital admissions in 1999 for injuries arising at home and from leisure activities cost about € 10 billion, equivalent to 5.2% of the total inpatient expenditure (13). When all injuries and violence are considered, then the proportion of health care expenditure is substantial. Rough estimates suggest that the health care costs of treating injuries, which result in fatality would be in the order of €1-6 billion (average cost of health care from €1,250 to €7250 per fatal injury) and that of non-fatal injuries from € 80 billion to 290 billion (average cost of health care from €4800 to €12000 per non-fatal injury).

The economic consequences of injuries are high, estimated as 518 billion US dollars annually. Total annual costs from road traffic injuries in developing countries are 1% from GDP, 1.5% in transition countries and 2% in developed countries. Studies show that for road traffic injuries, in Europe, 1-3% of country GDP is lost due to this cause (14). The estimated economic costs of motor vehicle traffic accidents are in the order € of 180 billion in the EU15 (about 2% of GDP), while in countries with economies in transition in central and eastern Europe, the average annual cost of road crashes was estimated in the order of 1.5% of gross national product, totalling about US$ 9.9 billion (15). The majority of these costs are related to the injury, in which medical care costs and loss of productivity predominate. Data for violence for the Region are scarce (16). In England and Wales, a study estimated total costs from crime of $63.8 billion. Sixty-three percent, or $ 40.2 billion, of this amount is attributable to violence – including homicide, wounding, and sexual assault including both direct costs such as police, judicial system and health service costs, and indirect costs including foregone output and physical and emotional costs (17). Economic valuations underestimate the real cost paid by society, as they do not capture the suffering caused to families and social support networks of victims, as well as to communities, workplaces and school classes. The benefits of effective preventive strategies would far outweigh the huge economic and societal costs.

Need for action - prevention

Injuries can be prevented, and there is a large and growing evidence base of proven and promising effective strategies for both unintentional injuries and violence, which can be used to target injury causes of concern and high-risk groups (1). In the area of road traffic injuries, effective preventive strategies have been documented in the *World Report on Road Traffic Injury Prevention* and in *Preventing Road Traffic Injury: a public health perspective for Europe (18)*. They include: speed control and provision of safer conditions for vulnerable road users, safer road infrastructures, motorcycle helmets, seat belts and child seats for cars,

and setting and enforcing legal blood alcohol concentration limits for traffic injury prevention (18).

For other unintentional injuries effective interventions include: child resistant containers and safer storage to prevent poisonings; poison control centres for better post-event management; preventing production of, and access to impure alcohol products to prevent poisoning in adults; exercise and home hazard modification to prevent falls in the elderly; appropriate ground surfacing in playgrounds, window bars and stair guards to prevent falls in children; fencing of pools and other water areas and provision of lifeguards and water flotation devices to reduce the risk of drowning; smoke detectors, flame resistant clothing and cooking surfaces at heights for burns prevention (19). The implementation of these cost-effective interventions can often result in quick and visible gains in reducing mortality and morbidity.

Violence is often seen as an inevitable part of human life, events which are responded to, rather than prevented. The World Report on Violence and Health challenged this notion and has shown that violence can be predicted and is a preventable health problem. In the area of violence prevention effective strategies have been documented: individual-level interventions, such as pre-school enrichment or life skills training programmes, and incentives to complete secondary schooling; at the relationship level home visitation, parent training and mentoring; at the community level reducing alcohol availability, and improving institutional policies in schools, workplaces, hospitals and residential institutions, and at the societal level public information campaigns, reducing access to means (such as firearms), reducing inequalities and strengthening police and judicial systems (3).

The implementation of cost-effective interventions can often result in quick and visible gains in reducing mortality and morbidity. In France the 34% reduction in road traffic injury deaths over a two year period (2002-4) resulted from the implementation of preventive measures (traffic slowing, seat belt use and control of drinking) with strong political leadership where the health sector played an important contributory role (20).

Political commitments, partnerships and networks – international and national

Unintentional injuries and violence are now regarded as largely avoidable and prevention policies have been placed firmly on the public health agenda: EB190/15 Violence and health; WHA49.25: Prevention of violence: a public health priority; WHA50.19 Prevention of violence; WHA56.24: Implementing the recommendations of the World report on violence and health; WHA57.10: Road traffic safety and health; WHA57.12 Reproductive health: draft strategy to accelerate progress towards the attainment of international development goals and targets; Regional Committee Resolution EUR/RC54/R3 on Environment and Health and Children's Environment and Health Action Plan for Europe (CEHAPE); Regional Committee Resolution EUR/RC53/R7 on the health of children and adolescents in WHO's European Region; Regional Committee Resolution EUR/RC51/R4 Progress report on the European Alcohol Action Plan, including follow-up to the WHO Ministerial Conference on Young People and Alcohol; Regional Committee Resolution EUR/RC49/R8 on European Alcohol Action Plan – Third Phase; Regional Committee Resolution EUR/RC49/R4 on Environment and Health; UN resolution 58/289 on Improving global road safety.

In addition, there are other relevant commitments from the Council of Europe, the European Commission, and UNECE and the related WHO European policies and strategies, such as the European Alcohol Action Plan 2000-2005, as well as the Mental Health Declaration

and Action Plan for Europe, adopted at the WHO European Ministerial Conference on Mental Health (Helsinki, Finland 12 -15 January 2005). The commitment to the Millennium Development Goals, in particular Goal 4 - to reduce under-five child mortality by two thirds by 2015 - will not be achieved unless sufficient attention is paid to reducing mortality from injuries.

The establishment and expansion of many international networks are crucial for injury and violence prevention: network of National Focal Points and other stakeholders for injury and violence prevention; the European Child Safety Alliance, European Network for Safety among Elderly, the Health Promoting Schools, Healthy Cities, and International Society for Spinal Cord Injury. In addition, the Safe Community Network, promotes the "safe community concept" which recognizes safety as a 'universal concern and a responsibility of all' (21).

International partnerships have been developed with stakeholders from different sectors, both national and international, to provide co-ordination and promote synergy in the response to injury and the use of available resources and competences: the European Commission (such as the Working Party on Accidents and Injuries), the Council of Europe, the European Conference of Ministers of Transport, the OECD, UNICEF, the United Nations Economic Commission for Europe, the European Crime …

The Republic of Macedonia is a signatory and implements the above listed international documents as well as all international acts on protection of human rights and prevention of discrimination, torture and maltreatment which are incorporated in the national legislation: The International Covenant on Civil and Political Rights (ICCPR); The International Covenant on Economic, Social and Cultural Rights (ICESCR); The International Convention on the Elimination of All Forms of Racial Discrimination (ICERD); The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; The Convention on the Rights of the Child (CRC) and The European Social Charter.

In the Republic of Macedonia there are legislative, regulatory, and administrative provisions covering the areas included in the programme of Community action in the field of public health – Decision 2002/1786/EC. The Constitution guarantees the right to health care for all citizens of Macedonia, as well as the right and obligation for protection and improvement of own and the health of others.

Every citizen of the Republic of Macedonia has a right to health care in accordance with the Health Care Law (Official Gazette of the Republic of Macedonia No. 38/91, 46/93, 55/95 and 10/04), (22) and the Health Insurance Law (Official Gazette of the Republic of Macedonia No. 25/2000, 34/2000, 96/2000, 50/2001, 11/2002 and 31/2003), (23) that regulate the health insurance relations and rights, the procedure for obtaining health care services, and the health care system and organisation.

In line with the Health Insurance Law the Fund for Health Insurance of Macedonia was founded as a unique and independent financial institution for the territory of the whole country to implement the obligatory health insurance. The Health Insurance Fund has branch offices in municipalities where the insured persons exercise their health care rights, and the funds for obligatory health insurance are collected.

The Law for Local Self-Government (Official Gazette of the Republic of Macedonia No. 5/2002) (24) was adopted in 2002 and its goal is decentralisation of public services at a municipality level providing the local authorities the right to participate in the management of the primary health care through its representatives in the managing boards of the primary

health care institutions, promotion of health, surveillance of communicable diseases, health education of the population, surveillance of the general health status and participation in dealing with health problems of certain vulnerable categories of population.

WHO, European and National Targets for injury and violence

The WHO Health for all policy sets international targets for reducing mortality and disability from injuries and violence in all member countries and at all ages especially among children and youth (25). Target 9: By the year 2020, there should be significant and sustainable decrease of the number of injured persons with disability and mortality from injuries and violence in the Region. Particularly: (i) mortality and disability from road traffic injuries should be decreased for at least 30%; (ii) mortality and disability from all injuries at working place, home and leisure, should be decreased for at least 50%, with the highest decrease in the countries where there is a high mortality rate from accidents; (iii) incidence and mortality from domestic types of violence, related with gender or organized violence and its consequences, should be decreased for at least 25% (26).

Target 4: By the year 2020, young people in the Region should be healthy and capable to fulfil their roles in the Society. Particularly :(i) mortality and disability from violence and accidents, involving young people should be decreased for at least 50%; (ii) mumber of young people with risk behaviour, using drugs, cigarettes and alcohol, should be significantly decreased (26).

The European Commission has adopted the goal of reducing road fatalities by 50% by 2010. This target represents an ambition to reduce the number of deaths more quickly than continuation of past trends would imply. The European Conference of Ministers of Transport has adopted a target of reducing road deaths by 50% by 2012, to serve as a benchmark for its 43 member states.

The Republic of Macedonia accepting the WHO strategy "Health for All by the year 2000" and later on the strategy "Health for All in the 21 century", has oriented its strategic health activities to achieve these targets (25, 26). In the Strategy for improvement of the health care in Macedonia, prepared by the Macedonian Academy of Science and Art and Ministry of Health in 2001, target 9 for injury and violence control was incorporated as own target 9: By the year 2010 injuries, mortality and disability caused by accidents and violence should be significantly decreased: (i) mortality and disability from road traffic injuries should be decreased for at least 30% i.e. mortality rate of 5 per 100000; (ii) mortality and disability from all injuries should be decreased for at least 50% i.e. mortality rate of 16 per 100000 (27). In the Strategy of the Republic of Macedonia 2006-2015, injuries and violence are set as priority in target 9: there should be a significant and sustainable decrease in injuries, disability and death arising from accidents and violence (28)

The World Health Day 2004 – Road Safety Is No Accident –focused on road safety, an issue that affects men, women and children around the World and expressed WHO global perspective for preventing road traffic injuries (18).The First United Nations Global Road Safety Week 23-29 April 2007 was dedicated to youth safety (29).

Need for action and framework and recommendations for prevention and control

In order to achieve these targets, there is a need governments to undertake activities which will enable to implement the recent World Health Assembly resolutions on violence and health (WHA56/24) and on road safety and health (WHA57/10) which recognise the multi-sectoral approach, encouraging the health sector to take a lead role in violence and road traffic injury prevention, inviting member states to appoint national focal points and to engage in the development of national action plans.

The Global Campaign for Violence Prevention is built around 6 country-level and 3 international-level recommendations made in the *World report on violence and health* and endorsed by the World Health Organisation (3). The 6 national-level recommendations are to: Create, implement and monitor a multisectoral national action plan for violence prevention; Enhance capacity for collecting data for violence; Define priorities for, and support research on, the causes, consequences, costs and prevention of violence; Promote primary prevention responses; Strengthen responses for victims of violence; Integrate violence prevention into social, educational policies, and thereby promote gender and social equality;

The 3 international-level recommendations are to: Increase collaboration and exchange of information on violence prevention; Promote and monitor adherence to international treaties, laws and other mechanisms to protect human rights; and Seek practical, internationally agreed responses to the global drugs trade and the global arms trade.

The 2004 World Health Day message was: Governments should give high priority to preventing road traffic deaths and injuries in their policy statements and mobilize resources and political commitment to carry this out. The WHO and World Bank prepared the World Report on Road Traffic Injury Prevention which identifies the six main recommendations for improving road safety at global level (18):

Identify a lead agency in government to guide the national road traffic safety effort; Assess the problem, policies and institutional settings relating to road traffic injury and the capacity for road traffic injury prevention in each country; Prepare a National road safety strategy and plan of action; Allocate financial and human resources to address the problem; Implement specific actions to prevent road safety crashes, minimize injuries and their consequences and evaluate the impact of these actions; Support the development of national capacity and international cooperation.

Additional recommendations are given by WHO Regional Office for Europe aiming to facilitate the implementation of the global recommendations in Europe (14): Strengthen and expand the role of the health sector as a champion of road safety; Improve implementation mechanisms and tools; Consider speed as the most important determinant for safety in road transport system; Strengthen the role of international organizations in preventing road safety.

In terms of implementing these recommendations, future challenges for injury and violence prevention and health promotion, that the countries including Macedonia would face are (1)

- Develop national action plans for unintentional injury and violence prevention;
- Form an intersectoral injury prevention committee;
- Improve national surveillance to gather information on injury burden and risk factors;
- Strengthen national capacity to respond to the burden of injuries and violence through both primary prevention and care;
- Promote evidence-based practice by facilitating the exchange of knowledge and experience across the Region;
- Recognize gaps in knowledge and prioritize research and development in both primary prevention and care, as well as studies on costs.

Decreasing the burden from injuries will require political commitment across all government levels and with this the allocation of adequate resources to take these activities forward.

Challenges for health promotion for injuries and violence prevention in Macedonia

An important strategic step in overcoming these challenges consists of addressing violence together with unintentional injuries, as both share a number of underlying determinants (e.g. economic, social, political and environmental) and risk factors (e.g. alcohol and drugs), and disproportionately affect vulnerable groups in the population. This requires multi-sectoral approaches to develop programmes to deal with common risk factors, such as alcohol, which is a leading risk factor for the whole spectrum of unintentional injuries and violence.

The health sector can play an important role not only in providing care and support services for the victims, but also in primary prevention, including advocating evidence-based strategies. Health service responses to victims of unintentional injuries and violence often involve the same providers: emergency pre-hospital and trauma care, toxicology care for poisonings (whether intentional or unintentional), psychological support to deal with post-traumatic stress disorder, and rehabilitation services for victims.

Evidences from some high income countries have shown that improvements in trauma care have led to decreases of around 30 percent in mortality from trauma (30). Lives could be saved, disabilities and long-term negative health impacts avoided if the quality of care were systematically evaluated and improved.

Regardless of the underlying cause of injury, the health sector is uniquely positioned to provide support for victims, identify and promote the implementation of evidence-based strategies, lead research and innovation, promote advocacy, and work closely with other sectors to address this issue, by facilitating the mainstreaming of injury prevention across different policies within and outside the health sector (31, 32)..

Macedonian Ministry of Health has followed the above mentioned recommendations aiming to achieve the set targets, appointing a focal point – coordinator for injury and violence control and prevention in July 2003 as well as establishing Department for Injury and Violence Control and Prevention in the Republic Institute for Health Protection Skopje in May 2004 as a leading agency in health sector for injury prevention and control in the Republic of Macedonia. At the same time it is a teaching base for research and safety promotion at the Medical Faculty, University “Ss Cyril and Methodius” Skopje, included in the Department for Social Medicine.

Based on WHO Recommendations the priority activities in the area of injury control and prevention in Macedonia are the following:

(i) *Develop the newly established Department for Injury Control and Prevention* as modern agency with the following scope of activities:

(ii) *Improve data collection, needs assessment and safety promotion research:* create database for injuries and violence especially for road traffic injuries and risk factors; create database for successful evidence based intervention programs; preparation of guidelines for interventions in violence prevention and road safety.

(iii) *Develop national health policy:* develop Strategy for injury and violence control and prevention and national action plan;

(iv) *Develop integral information system for injury surveillance* within the global health information system linked with other relevant information systems; establish national register for road traffic injuries (web oriented) in accordance with the current legislation; preparation of guidelines for injury surveillance in Macedonia in accordance with WHO recommendations; define indicators for surveillance of road traffic injuries in accordance with EU directives; revision of the registration form for road traffic injury in accordance with EU standards; revision of the current legislation: Law for evidence in health.

(v) *Capacity building*: develop curriculum for safety promotion – TEACH VIP; train public health experts in governmental organisations as well as in non-governmental.

The Department for Injury Control and Prevention, is working closely with multidisciplinary and inter-sector group of experts, in implementing of the proposed and agreed activities, mainly focused in the area of road safety and violence prevention. There are major achievements in health and safety promotion, since the establishment of this Department in 2004, in the area of ***road safety****:*

National study on Road traffic injures among children and students – conducted (11); Draft Strategy for road safety prepared (11); Law for road safety amended and empowered; World Health Day 2004 promotion activities; 27 International Medical Student Association Congress held with introductory lecture for World Health Day 2004, workshop on road safety and workshop on violence poster exhibition, 2004; World Health Day – promotion and oral presentation at the International Congress of Occupational Medicine in Ohrid, 2004; World Health Day 2004 and 2005 – promotion and lecture in the WHO Collaborative Center in the Institute of Occupational Medicine in Skopje; WHO Certificate for the Republic Institute for Health Protection, Department for Injury and Violence Control and Prevention – issued; Stability pact – Pre-hospital trauma life support Project – in progress; Survey on evaluation of the emergency medical services in Macedonia conducted in collaboration with WHO and Report prepared – 2007; Elective course for Injury research and safety promotion in the Master for Public Health curriculum – prepared by applying "Healthy Planit"; TEACH-VIP – in preparation; Environment and Health and Children's Environment and Health Action Plan for Europe (CEHAPE) activities – in progress; Outline for Community injury household survey prepared 2007; Focal point and National Committee for UN First Global Road Safety nominated and activities accomplished – 2007; Information on road traffic injuries prepared and adopted by the Government with recommendations for future promotion activities for Campaign "Safe Roads" - 2007;

and in ***violence prevention***:

Draft National Action Plan prepared; Institutionalization: by establishment of the Department for Injury and Violence Control; Violence is priority in Biannual Country Agreement between Macedonian Ministry of Health /WHO 2004-2005 and 2006-2007; National Campaign against Violence – ongoing; Health promotion activities for the 16 Days of Activities Against Gender Violence since 25 November 2003 every year; Anniversary of the Republic Institute for Health Protection – violence poster exhibition, 2004; Study visit to Croatia for family violence prevention – multi-sectoral group – cooperation with UNICEF, 2004; Co-hosted 53 General Assembly of the International Federation of Medical Student Associations in Ohrid, Macedonia, 2004, with main topic Violence and Health: plenary session, lecture and workshop ; Advocacy of the passed Law for family - Section for family violence, 2004; Designed and published brochure "Recognize and stop violence", 2005; Legal and social policy activities; Survey on youth violence - collaboration with Macedonian Medical Student Association and WHO; Survey on interpersonal violence – collaboration with Medical Student Association and daily news; Project for documentation of interpersonal violence prevention programs, collaboration with WHO Department for Injury and Violence Prevention in Geneva; Report Violence and Health in Macedonia and guide for prevention – collaboration with WHO European Region Office in Copenhagen within the BCA - 2006 - published in Macedonian and English, promoted and distributed (32); National task force – Inter-ministerial and multidisciplinary group has been established and business plan developed; Development of Protocol for victims of violence – joint Project with Ministry of Labour, Ministry of Interior, 2 NGOs (Zdruzenska and ESE) and financially supported by UNIFEM; Curriculum development for the Medical Faculty: Undergraduate studies and Master of Public Health program – facultative course on Burden of Injuries and Safety Promotion; Advocacy and media; Sharing information through the web site of the Republic Institute for Health Protection; UNIFEM Regional Conference on violence budgeting in Skopje 2006; Regional Conference on domestic violence in Ohrid 2006; Public Health congress in Ohrid 2006; ASPHER Conference – building partnerships for violence prevention – the Macedonian case – 2006;Preparation of the Strategy for domestic violence prevention in collaboration with governmental and non-governmental institutions – 2007.

Injury prevention

Injury prevention is set as priority in the Health Strategy of the Republic of Macedonia 2006-2015, prepared by the Ministry of health, i.e., Goal No. 9 refers to achievement of significant and sustainable reduction of the number of injuries, disability and occurrence of death due to accidents and violence (29). The Ministry of Health has undertaken the leading role in primary, secondary and tertiary prevention of injury and violence, through the following activities:

- Commencement of National Campaign for violence prevention as part of the Global campaign organized by the Republic Institute for Health Protection in 2003, in collaboration with WHO, UNICEF, Open Society Institute and NGO for Emancipation, solidarity and equity of women - ESE;
- Establishment of Department for Injury and Violence Control and Prevention within the Republic Institute for Health Protection in 2004, as a leading agency in the health sector for prevention and control of injuries and violence, with activities focused on preparation of strategic documents, organization, research and safety promotion through web site, media and publishing promotion materials;
- Violence and injury set as priority in the Biannual collaborative agreement signed between the Ministry of Health and WHO;
- Established inter-ministerial and multidisciplinary National Commission for violence prevention and health protection, with representatives from Ministry of Health, Ministry of Labour and Social Policy, Ministry of Interior, Ministry of Education and Science, Ministry of Justice, Republic Institute for Health Protection, State Statistical Office, Institute for Promotion of Social Affairs, NGOs, media and WHO;
- Implementation of the Pilot project for documentation of interpersonal violence prevention programs in Macedonia: established national electronic database with 47 systematically documented programs for prevention of interpersonal violence;
- Amendment of the legal documents related to family violence: Family Law and Criminal Code;
- Preparation of Report on violence and health in Macedonia and guide for prevention with comprehensive analysis of the epidemiology of violence in the country, its influence on health, public health approach in recommendations for violence prevention and support for victims of violence, particularly women and children;
- Preparation of Report on Survey of the emergency medical services in the Republic of Macedonia has been done in 2007 with situation analysis, challenges and perspectives recommendations for improvement;
- Focal point, youth delegate and National Intersect oral Commission for the First UN Global Road Safety Week have been appointed and many activities have been undertaken before, during and after the Week 23-29 April 2007.

Among the biggest achievements in the area of injury and violence prevention and safety promotion, which is worth to elaborate in more details are the achieved results and future challenges in National campaign against violence in Macedonia. The Macedonian Ministry of Health started the Campaign Against Violence in Macedonia in collaboration with WHO Headquarters, WHO Regional Office for Europe, WHO Office in Macedonia, UNICEF Office in Skopje, Foundation Open Society Institute Macedonia (FOSIM), NGO ESE and

Republic Institute for Health Protection, launching the WHO World Report on Violence and Health and 2 series of posters against violence, on 25th of November 2003, the first day of the 16 International Days Against Women Violence. The launch was another step towards Macedonian's international commitment to draw further attention to the dimension of violence and to support appropriate measures to decrease this public health problem.

The main goals of National campaign are: to obtain visibility for the World Report on Violence and Health, to build up a network of parties who will be supporting and contributing to its national implementation, to lay the grounds for national implementation of the recommendations and to plan follow-up activities as presented in the Report Violence and Health in Macedonia and Guide for Prevention; and develop plans of action for violence prevention and networks for the prevention of violence. The Campaign continued during the "16 days Against Women Violence" in the following years, at national and local levels. On the Conference Milestones of Global Violence Prevention Conference in Geneva 2004 – Republic of Macedonia has been selected among five countries to present the results achieved in violence prevention.

The main achievement of the national Campaign is institutionalization of activities through establishment of the Department for Injury and Violence Control and Prevention in the Republic Institute for Health Protection and appointment of the national focal point for injury and violence control.

Future challenges for safety promotion and injury prevention

Future plans are to follow and implement the recommendations of the World Report Violence and Health and the World Report on Road Traffic Injury Prevention (1).

- Improving injury surveillance, by improving the documentation of the different causes, risk factors, consequences and costs of injuries and violence;
- Conducting more descriptive and analytic epidemiological studies documenting the magnitude, characteristics and causes of unintentional injuries and violence;
- Applying the public health approach systematically to reduce the burden of injuries and violence;
- Engaging in stronger advocacy to draw the attention of politicians and get political commitment for injury and violence prevention;
- Promoting the development of national injury prevention plans by developing an overarching vision and strategy, which places primary prevention at the core of activities, with the health sector playing a coordinating role in a multi-sectoral response;
- Strengthening national capacity to respond to the burden of injuries and violence;
- Equipping stakeholders with the tools for planning, implementing and evaluating violence prevention programmes;
- Strengthening national capacity for provision of services for victims of injuries and seek to improve pre-hospital, hospital care and rehabilitation of victims;
- Developing and strengthening partnerships of all kinds and at all levels (local, national and international), with stakeholders from different sectors, to provide co-ordination and promote synergy in the response to injury and the use of available resources and competences;
- Sharing knowledge and experiences in injury and violence prevention within and between different sectors, communities, countries and regions of the world;
- Identifying and disseminating good practice;

- Advocating for injury prevention activities, and promote the implementation of effective measures and raise public awareness about injuries and opportunities for their prevention in different settings (e.g. schools, workplace);
- Addressing priorities at local level especially in countries in transition such as the Baltic countries, the Commonwealth of Independent States and South Eastern European countries to respond to the marked variation in injury patterns, implementing the cost-effective solutions locally, with strong political leadership, across all levels of society.

Decreasing the burden from injuries will require political commitment across all government levels and with this the allocation of adequate resources to take these activities forward.

Our vision: healthy and safe communities without violence and fatal injuries – Zero vision.

Exercise

Task 1:

The students will work in small groups, applying the newly learnt methods of the public health approach to injury and violence prevention and the ecological model to the situation in their own countries with regards to the following aspects of selected type of injury or violence: definition of the problem; identification of multilevel root causes and risk factors; existing and potential multilevel prevention interventions

Task 2:

Case problem analysis will be used for evaluation of violence prevention programmes, analysing three different evidence-based prevention programmes.

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HEALTH PROMOTION AND DISEASE PREVENTION **A Handbook for Teachers, Researchers, Health Professionals and Decision Makers**	
Title	**Public Health Aspects of Trafficking in Human Beings – Health Promotion and Prevention Tasks and Possibilities**
Module: 5.9.1	**ECTS: 2**
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Key words	Trafficking in human beings, migration health, sexual and reproductive health, prevention & health promotion, victims' protection & psychosocial assistance, international collaboration
Learning objectives	After completing this module students and public health professionals should: • be familiar with the concept of trafficking, its roots and dynamics in modern/postmodern societies; • have a comprehensive understanding of the trafficking process as experienced by the trafficked persons; • understand the specific health (public,- sexual & reproductive - and mental health) consequences of trafficking; including medico-legal issues; • understand the need for multidisciplinary, interagency, intersectoral and international cooperation as essential components of combating trafficking and related violence against fundamental human rights; • possess sound knowledge and communication skills needed to recognize vulnerable individuals, families and social groups for trafficking; • be able to understand the essentials, the methods and techniques of preventive actions in the context of counter-trafficking on individual, community, national and international level; • be familiar with basic principles, helping strategies, and ethical standards essential to ensure a multi-faced, holistic, high-quality psychosocial assistance to trafficked persons; with an emphasis on recognizing the special needs of trafficked women and children; • be familiar with basic principles of self-help, prevention and control of role stressors that threaten the mental health of both the professionals and non-professional helpers working in the realms of counter-trafficking.

Abstract	In the last decades trafficking in human being has become one of the most lucrative criminal enterprises all over the world, with strong links to other illegal activities, such as money laundering, drug trafficking, document forgery, and smuggling. The US Justice Department estimated that annually some 700,000 women and children are bought, sold, transported and held in slavery-like conditions for sexual and labour exploitation. IOM estimates that around 120,000 women and children are being trafficked into the European Union each year, primarily through the Balkans, and 10,000 women, mostly from Moldova, Romania and Ukraine, are working only in the sex trade industry in Bosnia-Herzegovina. However, trafficking is not only a criminal act against human rights and dignity, but an ever increasing public health issue as it is stated in the **Budapest Declaration** adopted by the participants of the ministerial level Regional Conference on Public Health & Trafficking in Human Beings in Central, Eastern and Southeast Europe, held on 19-21 March 2003, in Budapest. Providing appropriate health promotion and care services for trafficked persons is ***not only a humanitarian obligation, but also a public health concern*** for countries of origin, transit and destination alike. (Eg.: Medical records from Moldavia show that some 88 per cent of the ex-victims return to their homeland with sexually transmitted infections (STI), and about the same number (84 per cent) exhibit chronic anxiety disorders with the mix of depression and post-traumatic stress syndrome (PTSD). The module provides a framework not only for the assessment and treatment of specific health and mental health needs of the ex-victims of trafficking, but takes a large-scale public health perspective of a community approach to prevention and health promotion of most vulnerable social groups to this kind of abuse and violence.
Teaching methods	A well-planned sequence of five lectures will constitute the teaching module that begins with a historical overview of trafficking, and its re-emergence in the modern/post-modern societies. It continues with outlining the trafficking process itself, i.e., the process of victimization, both from medico-legal, and the victims' perspectives. The next two lectures will focus on trafficking related health hazards and specific issues regarding victims' protection, rehabilitation and reintegration and community networking both in host, and home countries. The last lecture in the series will provide basic knowledge of and opportunities for practical skills training in health education and awareness raising programmes . Lecturing *per se* should take approximately one-third of the total teaching time, and the rest should be provided to students' experiential learning activities, including small-groups discussion, focus group discussion on selected issues, and an extensive use of PBL (problem-based learning) method.

Specific recommendations for teachers	The continuity and sequencing of material is of utmost importance. The personal learning, the sharing of personal and professional experience and the development of personal/professional competencies in the realms of counter-trafficking is highly significant as well as taking the perspectives of a holistic approach to prevention and the heuristics of continuing education on the subject. Students would feel devoted to study and act upon on a life-long basis.
Assessment of Students	The assessment of students takes three, interrelated stages: (1) entrance assessment for eligibility, (2) ongoing activities assessment and (3) final assessment based on tangible project proposal. As far as teaching-learning process assessment is concerned, a five minute quiz of one or two questions should start each lecture. The first one should be the students' statement on what they expect to learn from the course. Based on small group discussions, students should explore sources (the internet, the library) to find evidence supporting or rejecting what is being discussed. A one page summary of this material should be submitted at the end of each session. The summary of the first session submitted at the start of the second discussion group, and continues in sequence. A five page essay, following the criteria stated in the *task***,** serves to demonstrate the students' understanding, application, and creativity regarding the concepts and modalities that constitute the thesis of this module. The essay counts for 60%, the quizzes 20%, and the summaries for 20%.

PUBLIC HEALTH ASPECTS OF TRAFFICKING IN HUMAN BEINGS, HEALTH PROMOTION AND PREVENTION TASKS AND POSSIBILITIES

Istvan Szilard, Arpad Barath

Definitions

Different definitions and expressions are used to describe smuggling of migrants and trafficking in human beings. Hereafter reference is made to the definitions in the protocols supplementing the United Nations Convention Against Transnational Organized Crime (1), in particular in Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Especially Women and Children (2). Interpol also adopts these definitions.

> Trafficking in Human Beings is "the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs." (Interpol)

Although men are also concerned, human trafficking in Europe affects mostly children and women.

Trafficking differs from people smuggling because it involves the exploitation of people for forced labour and prostitution. People smuggling involves people who are willing to pay (using cash or other favours) in order to gain illegal entry into a state or country of which they are neither citizens nor permanent residents. From health and public health point of view regarding the required assistance, the required assistance between this two most common form of irregular migration is not significantly different.

> Smuggling of migrants means „the procurement, in order to obtain, directly or indirectly, a financial or other material benefit, of the illegal entry of a person into a State Party of which the person is not a national or a permanent resident." (Interpol)

Short history of trafficking in human beings

Children, adolescents, women and men have been the victims of trafficking for sex and other purposes for thousands of years. Nowadays, international trafficking of human beings is a growing phenomenon, as hundreds of thousands of men, women and children are trafficked by businessmen into dens around the world. Surprisingly, many follow the trafficking routes of the Middle Ages or the Renaissance when mainly Eastern European women and children were sold in slave markets in Western Europe.

The first known phase of trafficking occurred during the Middle Ages, when each year thousands of women and children from East Prussia, the Czech lands, Poland, Lithuania, Estonia and Latvia were sold in the slave markets of Italy and southern France.

The second phase occurred during the latter part of the Middle Ages and the early Renaissance when Eastern European women and children were trafficked, mainly from Russia and the Ukraine, and sold into slavery in Italy and the Middle East. Others came from Bosnia, Albania and the Caucasian Mountains. They also ended their days as slaves in Italy and France. This trafficking route into Western Europe ceased when the Ottoman Empire conquered Constantinople. Western European countries then turned their attention to West Africa as a source of slaves.

The modern slavers from Serbia, Albania, Bosnia, Turkey, Russia and Eastern Europe model themselves on the slavers of the Middle Ages and the early Renaissance. Not much has changed, except they now dress in expensive suits, carry mobile phones and drive flashy automobiles. Contemporary slavery takes various forms and affects people of all ages, sex and race (3).

Estimated magnitude of this 'modern' type of slavery

When it comes to trafficking, it is nearly impossible to come up with well-established statistical figures. The nature of this crime – underground, often under-acknowledged – contributes to the inability to pin down the number of people who are victimized by traffickers each year.

Nevertheless, the US Department of Justice yearly reports (2002 – 2006) estimated that annually some 700,000 women and children are bought, sold, transported and held in slavery-like conditions for sex and labour exploitation (4). According to the Swedish NGO, Kvinna Till Kvinna, an estimated 500,000 women from all over the world are trafficked each year into Western Europe alone. A large proportion of these come from former Soviet Union countries.

According to International Organization for Migration (IOM) estimates, 120,000 women and children are being trafficked into the European Union (EU) each year, primarily through the Balkans and that 10,000 women, mostly from Moldova, Romania and Ukraine, are working only in the sex trade industry in Bosnia Herzegovina (5). However it is difficult to verify these figures with the information from particular regions or countries.

Economists estimate that in the 'crime industry' drogue, weapons and trafficking are the highest three income generating black businesses.

Subject overview

Health and public health professionals' understanding of trafficking, and their capability to prevent its further spread and deadly impacts both in own countries and worldwide certainly asks for a kind of special knowledge that goes beyond the knowledge of sheer descriptive statistics on its magnitude, geographic distribution and trends and the like. To advance this knowledge, professionals are expected to understand, at the first place, the attitudes, misperceptions, prejudices and myths about the phenomenon in the general (lay) public that make most people passive "by-standards", hence ignorant to this particular form of mass violence and crime.

Secondly, one has to understand the phenomenon as a special kind of migration process that shares, on one hand, certain common characteristics with other types of migration (e.g. economic migration), while on the other hand, it has vast many unique features never if ever observed before in the history of migrations.

Last but not least, one has to understand the very intricate fabrics, dynamics health, public health and mental health consequences of the trafficking process as a whole, without which effective and meaningful efforts invested in counter-trafficking would be unthinkable.

Until recently, much of the support in the fight against trafficking has focused on information exchange, criminal and juridical cooperation, and return and reintegration assistance. In the last few years, however, a number of protocols, declarations, published studies and reviews have also called attention to the serious health concerns related to trafficking (6 –10). These documents also highlight the need to develop minimum standards of care and provide specialized services that specifically match the needs of the victim.

Trafficked persons – regardless of whether trafficking is for the purpose of labour, sexual or any other form of exploitation – are exposed to a range of health-related problems. During captivity, they experience physical violence, sexual exploitation, psychological abuse, poor living conditions and exposure to a wide range of diseases, which may have long-lasting consequences on their physical, reproductive, and mental health.

In recognition of these health concerns, the *Budapest Declaration* (Annex I) notes that "more attention should be dedicated to the health and public health concerns related to trafficking". Specifically, it recommends that trafficked persons should receive "*comprehensive, sustained, gender, age and culturally appropriate health care (...) by trained professionals in a secure and caring environment.*" To this end, "minimum standards should be established for the health care that is provided to trafficked victims" with the understanding that "different stages of intervention call for different priorities". This module offers a set of information and overview for meeting these recommendations.

It should be noted that providing appropriate health promotion and care services for trafficked persons is not only a humanitarian obligation, but also a public health concern for countries of origin, transit and destination alike. Since the general population is also exposed to the high health risks associated with trafficking, states should commit themselves to both disease prevention and control in this area. This problem does not merely appear in the context of spreading sexually transmitted infections (STIs) and 'common' infectious diseases, such as the (re)-emerging problems of TB, HIV/AIDS and of Hepatitis B and C. A significant public health risk may also emerge if – as a consequence of the demolished public health system in the majority of countries of origin – 'vaccine preventable diseases' are spread to transit and destination countries where most physicians have not been confronted with these pathologies before. Providing appropriate and adequate care in the first line of service is the best security measure against such a risk. *To achieve significant advances in this field, governments must harmonise their public health policies including service provision, availability of specially trained practitioners, and data and information sharing.*

Myths about trafficking

It is a known fact that the general public's awareness about trafficking all over the world countries is blurred with prejudices and myths about trafficking and its victims, on one hand, and with very low-level, incoherent, sporadic knowledge of its very nature, on the other, as the consequence utmost biased and sensationalistic media communication about the entire phenomenon. To illustrate the case, here we quote a few common myths about the victims of trafficking that Ukrainian researchers and health professionals can hear and record on a day-to-day basis (11):

Myths about awareness. According to this myth: "All the girls and women who go abroad (from Ukraine) know what will be awaiting them there… These women are guilty because they broke the law and agreed to work illegally; they naively believed all the tales about big money in other countries, so they don't deserve our compassion and help."

Myths about prostitution. "A woman who returns after trafficking is a prostitute. She had fun; she earned a lot of money. Why should anyone help her? …Once a prostitute, always a prostitute. She'll never change. Why should she get help?"

Myths about choice. "The woman went there of her own accord and earned money, just as she wanted to. So what does it have to do with us?" (…)"Look at the way she's all dolled up and covered with make-up. She's just a whore, not someone who was victimized by traffickers."

Myths about responsibility: "All these women, who went onto trafficking about all the things the claim to went through. They just want to get help, to gain basic benefits from her lies (...).These women could have escaped from their pimps. Why didn't they?"

One can find virtually the same or similar myths about trafficking in many other countries as well, such as: "All prostitutes are willing to participate in trafficking", "All participants involved in human trafficking are criminals", and the like.

Behind all myth-makings and violent attitudes one can easily discover a "double-bind" (Janus-faced) morality typical for the value structure of modern (Western-type) societies, in particular regarding sex & labour, as the two most sensitive moral issues that persist and regenerate themselves probably since colonial times (12). The essence of this double-faced morality lays, on one hand, in the historic fact that modern mainstream societies typically and permanently tend to create, enforce and reinforce a full range of myths about own "clean morality", "high-standard values", the "superiority of own culture" (over others), while on the other side, they create, maintain and re-incarnate prejudices, violent attitudes and diverse mechanisms of social exclusion towards all those social groups, who – for one or another reason – are considered "unfit" to the normative standards of the "general public". These are usually labelled as "outcast" groups, many of them "underclass", and can be of very diverse kind and origin – the "poor", the "Gypsies", the prostitutes, the gays, the immigrants, trafficked & smuggled people, to name only a few. Needless to emphasize then, that one of the first and most important steps in a public health approach to trafficking seems to lay, indeed, in the task of debunking public myths and biased attitudes both about the victims and their perpetrators.

Understanding the dynamics and process of trafficking

From a sociological point of view, trafficking in humans is a special kind of migration process, and as such, it shares to some extent two basic features common to other types of migration. One of these features is the dynamics of mass migrations, which rests, among others, on balancing between two forces. One of these forces is the complex of push factors that makes the exodus side of migration (moving from, flight from), and another is the complex of pull factors that makes the teleonomic, i.e. goal-seeking aspect of migration (moving towards, attracted to certain values and goals). This two-factor model is one of a classic (economic) approaches to migration, also known by name "the laws of migration", and it was invented by a British economist, E. Ravenstein way back in 1880's (13). As far as the trafficking in humans is concerned, this theory certainly can highlight many personal motivation factors that "move" great many victims onto the web of trafficking, but there

are still great many other push & pull factors that have little or nothing to do with personal motivation of potential victims. In Table 1 we listed a sample of this factor specific to the dynamics not only of trafficking but to other types of modern migration (e.g. smuggling).

Another base of comparison of trafficking with other types of migration lays in the fact that virtually all migrations are a stage-wise process with rather distinctive phases of change both in life conditions, and in social identity. Researchers in the past usually distinguished three major phases in this change process: (A) pre-departure stage, (B) transient stage, and (C) adaptation or integration stage (14) This rather simplistic three-stage model rests on the assumption that the migration trends are linear moves of people from one social setting to another, from one's country of origin to one or more other setting, where some of those other settings will be a kind of life-long "final" destination. At the time being, however, such kind of three-step linear moves appears to be rather atypical in more recent trends of migration, both within countries and in trends of cross-border migration. Specifically, more typical is for the currently unfolding migration trends the kind of, so called, "open-ended" migration process, where moving from one site of residency to another is not at all a linear, but rather a circular process, where "circularity" means moving forth-and back to one place or country of residence to another, and that goes along with permanent changes both in individual and social identities (15, 16).

Table 1. A sample of latent push & pull factors underlying trafficking

Push factors	**Pull factors**
Natural or man-made disasters in home countries, including war Civil unrest, inter-ethnic conflicts, escalation of community violence and crime at sites of residence Corrupt political & bureaucratic regimes, weak law enforcement Weak democratic institutions, deepening social inequalities High unemployment rates, general poverty, forced labour, mass exploitation Poor educational opportunities in the country Poor health & social care Flight from family violence & child abuse (...) any many more.	The „illusion of prosperity & good life" in Western societies Illusion of "personal freedom" and self-determination as part of the post-modern value climate Faked self-presentation of home-coming migrants (guest workers) Lasting impact of globalized "Hollywood-effect" (easy-going life) through media on mass culture Peer pressure towards norm-breaking, adventure & delinquency Attraction to prostitution & prostitutes as 'role models' for easy and luxury life (...) and many more.

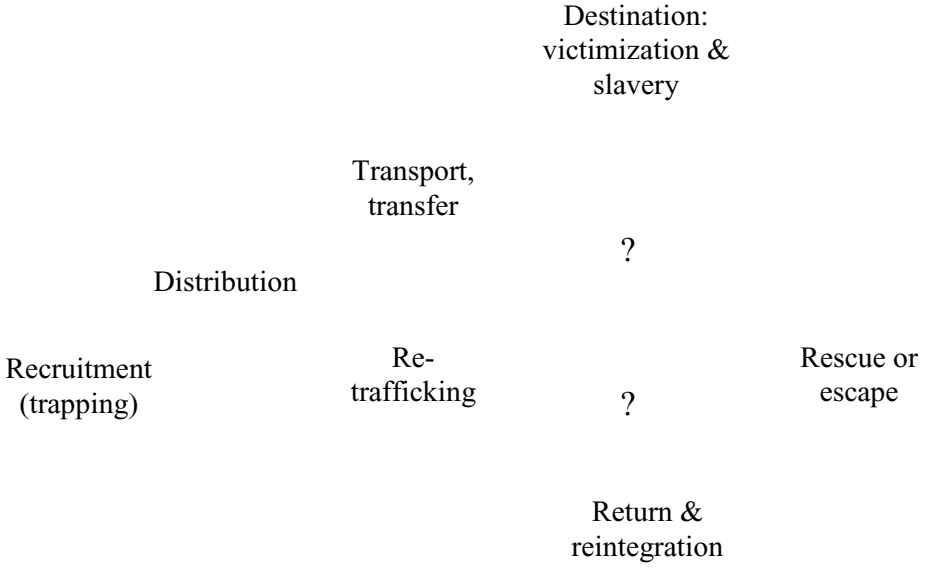
Viewed from this perspective, trafficking apparently represents an extreme case of fully "open-ended" migration processes, which typically starts at some "fixed" point both in space and time, yet it is fully uncertain whether and how, if ever, it ends at any point in space and time. The most frequently quoted stages of trafficking experience in the literature are the followings (17):

- pre-departure stage,
- travel and transit,
- "destination" stage, and if the victim is lucky enough, the trafficking experience continues with

- rescue or escape, detention and deportation, criminal evidence, and eventually ends with
- return and
- social reintegration in the country of origin (or else).

The flow-chart below clearly indicates that after one or more, so called, "destination" sites the future of a trafficked person is typically blurred and full with uncertainties, and her/his fate is completely out of personal control. The truth is that the bulk of victims never if ever would reach any of the last two closing phases of trafficking experience. According to rough estimates, some 85-90 per cent of victims is never if ever able to return home and back to civil life. Moreover, an unknown number of ex-victims even after rescue and fortunate return home would be re-trafficked under life-threatening pressure from the side of local and/or international traffickers.

Figure 1. Major stages of the trafficking process



Now, let us take a somewhat closer look what happens most likely (typically) with the victims all along their way in labyrinths of trafficking.

Recruitment and distribution

Traffickers usually use different, carefully ambushed techniques of complete or partial deception in targeting the potential victims personally, or using peer pressure or in the case of minors, they would manipulate with parents, relatives or close others (e.g. blackmailing). In some countries, kidnapping, faked marriage offers, abduction, and the like are not rare. Far the most used recruitment techniques among the youth in many European, in particular in CEE countries are, however: advertisements offering work and/or study abroad; agencies offering work, study, marriage or study abroad; false pre-arranged marriages, or simply relatives or friends offering "good-heart" help to a young persons facing life crisis and/or

live in desperate need for taking control over own life. The life story of a young girl from Romania quoted in the text-box below illustrates the case (18).

> "I was just 15 when I left Romania. When I was 12 my mother died, my father became an alcoholic and would beat my brother and me. A cousin said he would get me out of this situation and into a 'normal' life. He sold me like a slave"

As soon as the potential victim (or any of her/his significant others) make the first move towards the offered "help" in migration, the perfectly organized networks of pimps and traffickers both within the country and abroad get mobilized, and organize the distribution of potential victims in various directions, according to "supply needs" as dictated by their national or international "bosses" in the trafficking business, including the arrangement of their travel documents (if needed), paying their travel costs (later used against them as debt bondage), arranging for them the most appropriate modes of legal or illegal pass across international borders etc.

Travel and transit stage

The travel and transit stage begins at the time of recruitment and ends upon arrival at the work destination. Recruitment is followed by a movement phase, which is far to be based upon the transported persons' free and informed consent. Already during the journey, the victim may suffer grave human rights and physical abuse, and a variety of other crimes. Most trafficked persons have never left their country of origin before and they are therefore completely dependent on the traffickers. Some leave their country without international passports, but for many, even if they do hold a passport, it is often taken from them and held by the traffickers as a way of securing greater compliance.

Traffickers often use legal modes of transportation, as this is cheaper and may convince the trafficked person that her/his travel has a legitimate purpose. But there are also instances where trafficked persons are exposed to dangerous modes of transportation, high-risk border crossing and arrest, threats and intimidation, and violence including rape and other forms of sexual abuse. Trafficked persons are vulnerable to abuse by many individuals during the movement phase, including the trafficking agents, escorts, drivers, border officials, etc. It is also not unusual to find trafficked persons who have had several cycles of travel and transit and have been re-sold or re-trafficked several times along the way. For most trafficked persons, the movement phase is also the stage of initial trauma since this is the time when illicit activities begin, as the following case report illustrates (18).

> "We were kept as cattle, with no exaggeration. We did not even have the possibility to wash. We even had limited drinking water, without even mentioning food. We were poorly fed – once a day."

The destination stage

The destination stage is when the trafficked person is put to work and subjected to a combination of coercion, violence, forced labour, debt bondage or other forms of abuse. In order to coerce victims into provide services they were simply sold and bought for like a

cattle, trafficked persons, in particular women, report being subjected to physical, mental and sexual violence/abuse, such as severe beatings, rape or gang-rape. They are deprived of basic elements for survival such as food and water, human and social contact.

Debt bondage is a tactic typically used by traffickers to control them: enslavement occurs under the pretence of repaying an accumulated debt which includes the price the 'owner' paid for the person's travel, false documents and purchase. In some instances, traffickers increase the victims debt by charging for accommodation, re-sale to other 'owners', penalties, food, lodging, etc.

The physical and mental torture is compounded by threats to their families' safety, prohibition to contact any family member or friend, frequent monetary fines and seizure of money, valuables, and limited assets that they may have, forced use of alcohol, and other substances and other coercive techniques to ensure their 'cooperation' and prevent them from escaping. An excerpt from a case study below would provide a full picture of the tortures and brutalities that most victims face in slave-like conditions (18).

"In the country of destination, the girls were delivered to a hotel, assembled in one room and told to wait for the company owner. Some time later a man arrived and told the girls in poor Russian, that they were sold to him and now they had to repay their debts by providing sex-services to clients. Initially all the girls refused and were severely beaten. A couple of days later, the hosts transported 4 girls to another place, while Christina and 2 other girls remained in the hotel. When they served clients, the hosts distributed them between separate rooms. Usually, every girl from the group served from 8 to 12 clients daily. To make women less tired and more submissive the hosts forced them to drink alcohol with sedatives and psychotropic substances. For the whole period of her stay in the hotel, Christina was never allowed to leave it; sometimes she was only allowed to walk on the hotel roof with other girls. Windows in the hotel were trellised, rooms were equipped with video cameras and the girls were not allowed to make phone calls to their relatives. Oksana, a friend of Christina's, once tried to make a call from a mobile phone she had been given by a client, but was severely beaten afterwards."

Rescue and/or escape detention, deportation and criminal evidence gathering

Another series of painful events begins when the trafficked person is rescued or manages to escape from the traffickers and is now in police custody or care of immigration authorities for alleged violation of criminal or immigration law, or cooperating in legal proceedings against the traffickers, or abusive employers.

Even when relatively 'safe' and out of the traffickers' clutches, victims are generally observed to be anxious, frightened, in a confused state. They are also often suspicious of any assistance initially provided, and worry about what awaits them from the time of their escape, rescue and their stay at the transit centre up to their return home stage. In some countries of destination or transit, the harsh conditions of detention facilities may pose additional physical health risks.

Additionally from a mental health angle, an almost exclusive contact with authorities (e.g. arrest, giving evidence, testifying in a criminal proceeding) will have severe psychological effects on a trafficked person. The trafficked individuals may experience memory lapses, fear of law enforcement officials and feel deep insecurity about own futures and fear for the safety

of loved ones left back home. While the stage may be unavoidable, it may be alleviated by sufficient psychosocial support. 'Z' the 26 years old victim has explained it as follows (18):

> "In the prison where I was held, they would not feed the women who had worked as prostitutes. These women had to pay the prison's staff in order to be fed. Since I had no money, I was starved. During my detention period, I lost 6 kilograms. Sometimes, I was fed by other women who had money and who would pity me."

Who are victims?

Trafficked persons are women, children and men. Women and children are particularly vulnerable. They are bought, sold, transported and re-sold mostly for sexual and labour exploitation, but a substantial minority may also end up in situations such as forced begging, delinquency, debt bondage, false marriage, adoption, or as victims of the trade of human organs. The profile of trafficked persons is constantly changing. They are currently observed to be getting younger, and children are increasingly being caught up in the process.

Frequently victims:

- Do not speak any foreign, and are unfamiliar with the culture and society they are dragged into;
- Distrust outsiders, especially law enforcement (fear of deportation);
- Typically do not identify themselves as victims; often blame themselves as predicaments;
- Although many victims have been beaten and/or raped, the current situation and life conditions still may feel and claim "better" than were they came from;
- May be unaware of their rights or may have been intentionally misinformed about any rights in the country they been transported;
- Fear for the safety of families in their home countries, who are often threatened by local traffickers.

Health consequences of trafficking, highlights of case management

The model of types and sequence of health harms of trafficked persons counts with nine categories (19):

- physical abuse/physical health;
- sexual abuse/sexual and reproductive health;
- psychological abuse/mental health;
- forced, coerced use of drugs and alcohol/substance abuse and misuse;
- social restrictions and manipulation/social well-being;
- economic exploitation and debt bondage/economic well-being;
- legal insecurity/legal security;
- abusive working and living conditions/occupational and environmental well-being, and
- risks associated with marginalization/health service utilization and delivery.

Although many of the risks and abuses associated with trafficking occur simultaneously or overlap, it is possible to delineate the different forms in order to gain a better understanding of

their attendant effects on health. This approach attempts to show the reciprocal and connected nature of harm and its consequences - how harm in one category can have consequences in another (e.g., physical violence causes physical disability that in turn creates economic problems such as when the individual has difficulty working) and the way that these can have a mutually reinforcing effect on one another (e.g., inability to work and economic problems exacerbate mental health problems, such as stress and fear). For helpers and health practitioners, it is critical to understand how these various forms of violence - both separately and in combination with each other - interact to destroy the health of a trafficked person.

Within the frame of this module we can only highlight some of the basic ethical standards in physical and mental health case management (20).

Basic ethical principles of case management:

Do no harm

"Do no harm" is the first principle of most medical ethical guidance. Given the extreme risks associated with trafficking, the fragile state of many of its victims and the potential for increased trauma, the significance of this basic rule cannot be overrated. It is the ethical responsibility of every health practitioner to assess the potential for harm, and if there is any reason to believe that carrying out an interview, or conducting an examination or procedure, will cause the individual to be worse off than before, it should not be undertaken at that time. Treat each individual and situation as though there was a significant potential for harm until there is evidence to the contrary.

It is important to recognise that for a person who has been trafficked every meeting with a service provider becomes part of the recovery process, because each positive interpersonal encounter helps build his/her faith in others, increases self-confidence, and fosters hopes s/he has for the future. Providers should be prepared to react to questions and possible distress with clear and patient responses (20).

Ensure safety, security and comfort

Before speaking with a trafficked person it is essential to make certain that s/he feels safe and secure. Even if the risks to an individual's safety have been reviewed at other times for other purposes, support persons must ask whether the individual feels safe at that particular moment and whether there is anything more that could be done that would allow her/him to feel more secure.

At the same time, it is mandatory that all trafficked persons be asked very specifically whether they are in immediate need of medical care (e.g., not simply "are you feeling okay?") and, if so, that (something seems to be missing for clarity of the sentence, such as " addressing the needs" or "this" should take precedence over an interview or any other service activity. Physical and psychological symptoms can become especially acute when an individual is under pressure - such as in an interview or service setting.

Sexual and reproductive health

Trafficking in women has serious implications for sexual and reproductive health. Even women who are not trafficked into forced prostitution frequently suffer sexual abuse or exploitation. Sexual and reproductive health has social, psychological, and medical implications, each of which must be treated professionally and with all due care (21, 22).

Table 2. Health Risk, Abuse and Consequences of Trafficking

Risks and Abuse from Sexual Violence	**Reproductive and Sexual Health Consequences**
• Forced vaginal, oral or anal sex; gang rape; degrading sexual acts • Forced prostitution, inability to control number or acceptance of clients • Forced unprotected sex and sex without lubricants • Unwanted pregnancy, forced abortion, unsafe abortion • Sexual humiliation, forced nakedness • Coerced misuse of oral contraceptives or other contraceptive methods • Inability to negotiate sexual encounters	• Sexually transmitted infections (STIs), reproductive tract infections (RTIs) and related complications, including pelvic inflammatory disease (PID), urinary tract infections (UTI), cystitis, cervical cancer, and infertility • HIV/AIDS • Amenorrhea and dysmenorrhoea • Acute or chronic pain during sex; tearing and other damage to vaginal tract • Negative outcomes of unsafe abortion, including cervix incontinence, septic shock, unwanted birth • Difficulties forming intimate relationships

STI/RTI Screening Options for Women

IOM advise is that among high-risk populations such as trafficked women, routine screening for common reproductive tract infections (RTIs) and sexually transmitted infections (STIs) should be implemented in all organized assistance structures. This includes using history taking, clinical screening, and laboratory screening. Many women will only seek treatment when they are symptomatic. The use of screening strategies is an essential method for detecting and treating infections among asymptomatic women. Syphilis, gonorrhoea, HPV, Hepatitis B, and chlamydia are examples of often mild or asymptomatic infections with serious consequences that may not be recognized by the patient and can be missed by the provider. WHO estimates that 60-70% of women with gonococcal and chlamydial infection go undetected when using algorithms based on symptoms, since women have an asymptomatic infection (23).

Screening options:

- Syphilis
- Hepatitis B
- Cervical Infection (Gonorrhoea and/or Chlamydia
- Cervical Dysplasia
- HIV

HIV testing should be encouraged for all women but should not be mandatory. Active management of HIV/AIDS is recommended. That is, a woman should be aware of all the tests and treatment options available to her. Women should be counselled on the benefits of testing and assured of confidentiality. HIV/AIDS education should be provided by trained staff and testing should be always completed with pre- and post test counselling.

Contraception

Victims of trafficking should be advised on available contraceptive methods and share culturally appropriate health education material explaining contraceptive choices, methods

and techniques, in accordance with international standards established by WHO and UNFPA.

In many countries women have no or only little choice regarding their pregnancies. The subject of contraception might, therefore, be addressed within the broader framework of a woman's right to information without the threat of coercion or violence (24).

Mental health consequences of trafficking

According to available evidence, the mental health consequences of the trafficking experience must be virtually countless, and on a long run, they surely impact not only the victims themselves, but their entire social environment wherever they live, in particularly their families and local communities after, if ever, they return home. Although we do not have any extensive and much reliable epidemiological evidence on the kinds and magnitude of mental health injuries that trafficked persons contract and accumulate all along the way of trafficking experience (and it is doubtful as whether such data base ever will be available at national and international levels), we have at least some partial evidence on this matter. The following figures are evidence on the kind and magnitude of major categories of mental health disorders diagnosed in a sample of ex-victims of trafficking from Moldavia (N = 171), after their return home, and received professional help at the IOM Rehabilitation Centre in Chisinau, including medical, psychiatric and psychosocial care (25):

- Neurotic disorders, including PTSD (84%)
- Affective disorder (35%)
- Personality disorders (18%)
- Mental disorders due to alcoholism/drug addition (14%)
- Mental retardation (15%)
- Sexual aversion disorder (5%)
- Manic-depressive psychosis (3%)
- Schizophrenia (3%)
- Epilepsy (3%)
- Mental disorder due to physical trauma (2%)

Similar clinical evidence was made available on somewhat larger samples of ex-victims from Ukraine (N=427), helped in 2004 at the IOM Rehabilitation Centre in Kiev.

The above listed statistics indicate only the rates of "major" (prime) diagnosed disorders, and other (e.g. secondary) diagnoses are omitted. The rates of multiple disorders must be extremely high, presumably much higher then one would diagnose in any other population of victims hit by any natural and/or man-made mass disaster, including the morbidity rates among war veterans.

Children and adolescents

Far the most vulnerable populations to trafficking are the children and minors, who make more than half of the total population of victims, according to UNICEF estimates (30). Children and adolescents are trafficked into many of the same forms of labour and for similar purposes as adults (e.g., factory work, domestic service, sex work, and as brides). They are also exploited in ways that are more particular to children (e.g., child pornography, camel jockey, begging, mining, and organ donation) (26).

During a trafficking experience, a child is exposed to a physical and psychological

environment that damages her/his potential for normal and healthy development. Chronic abuse likely affects personality development and can cause pathological personality development. For example, children learn to "survive" in taking the path of very diverse criminal activities; feeling compelled, even while they are abused; they tend to form attachments and develop trust with their criminal caretakers. After all, children tend to trust adult caretakers, comply with authority figures and blame themselves and feel guilty even for what others impose on them. This has disastrous effects on their future capacity to form healthy relationships based on mutual trust and intimacy.

Children are not small adults, and the medical staff and other persons assisting children victims of trafficking should not treat them as such, but be sensitive to the special needs of a child in such difficult conditions (27).

Caring for children and adolescents who have been trafficked requires:

- Developing approaches that demonstrate respect and promote participation.
- An understanding of the complex ways in which their past experience has harmed them.
- Tailoring services to meet the needs of each age group and in ways appropriate to the age and characteristics of the child concerned and never merely following programmes designed for adults.
- Implementing strategies aimed at mitigating the effects of past trauma and fostering healthier patterns of development.

The right of children and adolescents to health and to health services appropriate to their age and particular requirements are not only essential for their survival and well-being, but are also fundamental human rights grounded in international human rights instruments, - in particular the Convention on the Rights of the Child (CRC), which states that the best interests of the child shall be a primary consideration (28).

Special considerations:

Cultural competence

The term "cultural competence" is often used in medical and non-medical settings to refer to the ways ethnic, racial, national, social and linguistic factors affect health care, and the relationship between patients and providers. Gaining cultural competence involves developing an awareness and acceptance of and responsiveness to cultural differences in all of these senses. Responding appropriately to these differences is not only essential to providing effective care, but also an obligation dictated by internationally accepted human rights instruments, such as the of International Covenant on Economic, Social, and Cultural Rights (29).

Cultural competence has been defined as "the complex integration of knowledge, attitudes and skills that enhances cross-cultural communication and appropriate/effective interactions with others." It includes at least three aspects:

- Knowledge of the effects of culture on the beliefs and behaviour of others;
- Awareness of one's own cultural attributes and biases and their impact on others;
- Understanding the impact of the socio-political, environmental and economic context on the specific situation (30).

The ways in which their family, community, and society experience trauma and how they respond is likely to have a major impact on how a trafficked person responds.

Conceptual models from one society may be inadequate or inappropriate to address the suffering of individuals from another culture or background. Support strategies common in western settings may be alien or even offensive compared to how others deal with traumatic events. For example, offering debriefing sessions or encouraging individuals to recount past events (common to some western treatment strategies) may provide little solace for individuals from cultures where forgetting is a normal means of coping with past difficulties, or where revealing intimate or embarrassing details is not acceptable except within a family setting (31).

Why counter-trafficking so weak in many countries?

According to trafficking in persons surveys in some 140 countries conducted annually by the US Department of State, a strikingly small number of national governments (17-18 per cent) comply fully with international standards and measures of counter-trafficking (TIER 1 level), whereas the rest of countries either applies only a limited number of measures or does effectively nothing on the matter (32).

One of the reasons, as we pointed out earlier, surely lays in the poor awareness and ambivalence of the general public to pay even attention to the phenomenon in own country. However, this is only one of many barriers to combat trafficking. Brian Iselin, an international expert on trafficking from the UN Office on Drugs and Crime makes a list of eight major barriers in law enforcement to tackle human trafficking in an effective and co-ordinated way (33):

- No coherent; comprehensive international strategy on trafficking;
- Environments of crime without complains;
- Lack of competent, reliable witnesses;
- Absence of quality evidence;
- Seamless partnership required between law enforcement, communities, NGOs, psycho-social workers;
- Victims 'present' as illegal migrants;
- First level traffickers mostly women, girls, and former victims;
- All in environment of apathy and values that facilitate trade.

Perspectives to tackle trafficking in a more effective way

There is an abundance of scholarly papers, case studies, handbooks, guidelines and training manuals aiming to assist both the professional and general public to take role and responsibility in combating trafficking in a meaningful, effective and organized way (34, 35). Given the limited space for this module, certainly we are not able to discuss at any length any of counter-trafficking programs and strategies. The only thing we can do is to highlight briefly three interlocking perspectives which, sooner of later, surely will make the building blocks of a new paradigm to tackle human trafficking and related crimes.

Health promotion perspectives

It is a generally acknowledged fact that one of the most salient changes in entire philosophy of public health came around in the mid '80s, with the WHO initiated Ottawa Charter on Health Promotion (36). The turning point was, indeed, the critical re-conception

of health as a positive social construct, and paradigm shift was, indeed, in moving away from its rather narrow, largely "disease-focusing", mostly bio-medical conception as it was propagated over decades by clinical health sciences. One of the key axioms of Declaration one can find in the statement, which says: "Health is a positive concept emphasizing social and persona resources, as well physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond health life-styles to well-being."

Another famous axiom of the Declaration was a brief call, as it is: "Act locally, think globally!"

Put it differently, the Ottawa Charter '86 on Health Promotion made quite clear, for the first time in the history of health sciences and related disciplines, the health and the future of the modern societies is not, and cannot be left anymore to illusionist (utopist) thinking, rather it out to be a grand plan of social action drawn upon the following ground principles:

- social change
- physical (environmental) change
- healthy policy development
- empowerment
- community participation
- equity and social justice
- accountability (of any social action).

Although the document was not about to address any kind of crime prevention, and it was created far ahead in time before trafficking became one of the key public health issues world-wide, the above listed ground principles of social action equally apply to violence and crime prevention in modern societies. As far as counter-trafficking is concerned, of the above listed range of interlocking principles, *community participation strikes out as one of most and urgently needed avenue for social action.* As community development, in general, drawn on existing human and material resources in a community to enhance *self-help and social support, in the case of counter-trafficking*, it seems to offer, at the time being, one of most viable strategies both for early prevention and victims' protection.

A feminist perspective

If take this perspective seriously and critically, it must have little, if any, connection with the fact that the vast majority (some 90-95 per cent) of the trafficked persons in Europe are young girls and women. Rather, the importance of this perspective dwells on the historic fact that not the men, but the women became first watchful about the rise of trafficking and many other mass violence in modern societies (the bulk of which, if not all, are committed by men). On the other hand, women's care for, and understanding of the roots and lasting consequences of this particular kind of violence on family life, in particular their care for its consequences on children and the reproductive health of a society as a whole, seems to make the feminist perspective more viable and important on the whole scene of counter-trafficking than any other, mostly men-dominated, "strong-hand" law enforcement. Hence, it is no wonder that so far most of counter-trafficking programs and helping resources for victims of trafficking are created mostly by women's voluntary organizations, indeed, both on national and international levels, such as "White Ring" in Hungary, Payoke in Belgium and Holland, La Strada in Italy, Albania, Macedonia and Bulgaria, Winrock International in Ukraine, Moldova, Rumania and Russia, to name only a few. That is also the reason that

the International Organization for Migration (IOM) the most powerful intergovernmental organization that is active in this field is widely cooperating with these NGOs within the frame of its Counter Trafficking programs.

Law enforcement perspectives

It is also a known fact, that in the last one-and-half decade or so (since the mid '90s), the entire system of law enforcement in more developed parts of the world entered an era of radical changes in terms of moving away from the orthodoxy authoritarian "punitive" measures and policing of the, so called, "social order" in the direction more human strategies of care for the safety of the general public. This paradigm shift is often symbolized with the acronym "3 Ps": Prevention – Protection – Prosecution, as interlocking strategies in very diverse field and disciplines of law enforcement, from police education to care for future generations of lawyers and judges at university law schools (37).

As far as the regulation of trafficking and other illegal cross-border criminal activities is concerned, the first important push towards paradigm shift in law enforcement has arrived in 2000, in the form of the UN Protocol to Prevent, Suppress, and Punish Trafficking in Person, Especially Women and Children (3-4). In the meantime, vast many important research and proposed standards were set to assist national governments to "soften" their immigration policies and criminal laws towards steadily growing masses of illegal migrants, including victims of trafficking and smuggling on domestic "black" labour market. One of the model documents created on this line, was the US' Trafficking Victims Protection Act – TVPA (Public Law 106-386), enacted in 2000, and re-authorized in 2003 by the Federal Government to set some $200 million to continue domestic fight against human trafficking (38). The TVPA addressed three key areas:

- Prevention: public awareness and education;
- Protection: T-visa, certification, benefits and services to help victims rebuild their lives;
- Prosecution: new law reinforcement tools and efforts.

To make sure, the US's TVPA is not the only and single model act created for the cause to prevent further escalation of trafficking in humans. The impact and the challenge of the TVPA, however, is in the fact that it was one of the most important "ice-breaking" documents that mobilized both the lay and professional public to "stand up" against trafficking in a meaningful, community-based, and effective way. The agenda for social action as featured in the TVPA is clear, and viable to be applied in vast many other countries. Below, we summarized a selected number of recommendations of the TVPA document for effective law enforcement:

- Create new laws that would criminalize trafficking regarding slavery, involuntary servitude, peonage or any kind of forced labour;
- Create laws that permit prosecution where non-violet coercion used to force victims to wok in belief they would be subject of serious harm;
- Permit prosecution where victim's services compelled by confiscation of documents such as passports or birth certificates;
- Increase prison terms for all slavery violations from 10 to 20 years; add life imprisonment where violation involves death, kidnapping, or sexual abuse of victim;
- Enable victims to seek witness protection and/or other types of assistance;
- Give prosecutors and agents new tools to get legal immigration status for victims of trafficking during investigation, prosecution.

Principles for Promoting the Health Rights of Trafficked Women

1. The right to health of trafficked women, including the right to necessary care and treatment, is a fundamental human right.
2. Trafficked women have the right to be asked specific questions to determine whether they require medical assistance (physical or psychological). State authorities must fully inform women of their rights to health care, and the health service options available to them. Medical assistance must be provided to trafficked women who request it or require it, before any other action may be taken.
3. No legal proceedings, or other actions that are likely to negatively impact the physical security, or physical or psychological health of trafficked women should be taken by State authorities unless women's health and wellbeing can be assured.
4. Trafficked women, given the level of harm and mistreatment they have experienced, should be offered access to quality health care on the same basis as citizens of the country which they are in.
5. Trafficked women have the right to non-discriminatory, gender-appropriate health care.
6. In all health interventions for trafficked women, the best interests of the woman must be the primary consideration. Governments, medical professionals, public health workers, and NGOs should collaborate to ensure that necessary and appropriate medical resources, including physical health care and psychological support, are made available. Care should be provided in women's own language, whenever possible.
7. Trafficked women should not be subjected to mandatory medical investigation, procedures or clinical testing, including for HIV/AIDS.
8. Trafficked women's right to privacy and confidentiality must be respected. This includes the right to a private setting for interviews, confidential testing, treatment, and medical files, and non-disclosure of personal information.
9. Trafficked women have the right to their medical and health records. In cases of deportation, removal or voluntary return, these records must be made available to women prior to their departure.
10. Trafficked women have the right to timely forensic examinations and medical reports to pursue cases of sexual or other violence against traffickers

APPENDIX I

Budapest Declaration

The participants of the Regional Conference on Public Health & Trafficking in Human Beings in Central, Eastern and Southeast Europe, held on 19-21 March 2003, in Budapest:

Affirming that trafficking in human beings is a violation of human rights;

Concerned that victims of trafficking in central, eastern and southeast Europe have been and continue to be exposed to a range of health-related problems, including, but not limited to, physical and psychological abuse and trauma, sexually-transmitted and other infectious and non-infectious diseases and complications, including HIV/AIDS and tuberculosis;

Recognizing that some countries in the region are currently experiencing epidemic levels in the incidence of HIV and tuberculosis, particularly drug-resistant tuberculosis;

Convinced that there is a need to address the health and public health aspects of trafficking in human beings;

Have agreed and committed themselves to the following:

Despite much effort and progress in combating trafficking in human beings both regionally and globally, more attention and resources should be dedicated to the health and public health concerns related to trafficking;

Victims of trafficking must be given access to comprehensive, sustained, gender, age and culturally appropriate health care which focuses on achieving overall physical, mental, and social well-being;

Health care should be provided by trained professionals in a secure and caring environment, in conformance with professional codes of ethics, and is subject to the principle that the victim be fully informed of the nature of care being offered, give their informed consent, and be provided with full confidentiality;

Minimum standards should be established for the health care that is offered to trafficked victims. These standards should be developed through a partnership of governments, inter-governmental and non-governmental organizations, and academic institutions, and should be based on comprehensive research and best practices;

Different stages of intervention call for different priorities in terms of the health care that is offered to victims.

During the initial rescue phase, which begins at the first point of contact between a victim and a health professional and often occurs in the country of destination and/or transit, care should focus on treatment for injury and trauma, crisis intervention, and basic health care, including counselling.

During the rehabilitation phase, which often occurs in the country of origin, care should focus on the long-term health needs and reintegration of the victim. Victims should be provided with health care which is tailored to their individual needs and circumstances.

Some examples of long-term health needs, without attempting to provide a complete and definitive list, might include counselling, follow-up care, and testing and/or treatment for sexually-transmitted infections, HIV/AIDS, tuberculosis, physical and psychological trauma, substance abuse, and other related problems.

Trafficked children and adolescents are an especially vulnerable group with special health needs. The provision of health care to this group should follow a long-term, sustained approach, and must take into consideration the possibility of long-term mental and psycho-social effects.

Moreover, the phenomenon of trafficked children and adolescents raises complex legal issues, including those relating to guardianship, that must be resolved if minimum standards for treatment and care are to be established.

In all cases, the best interests of the child must be the primary concern and motivating factor;

Shelters and rehabilitation centres play an important role in providing protection, assistance, health care, and security to victims. The operation and management of shelters and rehabilitation centres should follow a professional, standardized approach;

Specialized training programs for multi-disciplinary health teams should be developed which focus on sensitizing health professionals about the special needs of trafficked victims;

Psycho-social counselling plays a critical role in building trust, identifying the needs of the victim, gaining consent for the delivery of health care, engaging the person in setting out recovery goals, and assisting in long-term rehabilitation and empowerment;

Social, recreational, educational and vocational activities organized in shelters and rehabilitation centres play an important role in re-building self-esteem, and therefore have positive health benefits for victims;

Increased understanding is needed regarding the public health issues associated with trafficking. Non-stigmatizing and culturally-appropriate public awareness campaigns targeting at-risk groups, on both the supply and demand sides, should be implemented across the region;

Governments should take increasing responsibility for prevention, as well as the provision of security, legal rights, protection and care to trafficked victims, especially children and adolescents, by ensuring access to national health structures and institutions;

Governments, inter-governmental and non-governmental organizations should increase cooperation amongst themselves and across borders by coordinating and integrating the health care offered in destination, source and transit countries. Sharing of medical data, subject to the informed consent of the victim, and with the assurance of maximum levels of confidentiality and protection of information, is essential in ensuring continuity of care, effective case management and rehabilitation and reintegration.

The participants hereby commit themselves to the promotion and realization of the recommendations contained herein.

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