Slavery in New Zealand: What is the role of the health sector?

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ABSTRACT

Contemporary forms of slavery and associated adverse health effects are a serious, complex and often neglected issue within the New Zealand health sector. Slavery in New Zealand has most recently been associated with the fishing and horticulture industries. However, victims may be found in a number of other industry sectors, including the health and aged-care sectors, or outside of the labour market such as in forced, early (underage) and servile forms of marriage. Victims of slavery are at increased risk of acute and chronic health problems, injuries from dangerous working and living conditions, and physical and sexual abuse. These issues are compounded by restricted access to high-quality healthcare. Slavery is a violation of many human rights, including the right to health. New Zealand has obligations under international law to ensure that all victims of slavery have access to adequate physical and psychological care. The health sector has opportunities to identify, intervene and protect victims. This requires doctors and other health practitioners to demonstrate their leadership, knowledge and commitment towards addressing slavery and its health consequences in ways that are effective and do not cause further harm. Key recommendations for a safe approach towards identifying and managing people in situations of slavery include building rapport, and culturally competent practice with an empathetic non-judgmental approach. We also recommend that health organisations and regulatory and professional bodies develop culturally competent guidelines to respond safely to those identified in situations of slavery. These responses should be based on the respect, promotion and protection of human rights, and occur within a robust person-centric coordinated government response to addressing slavery in New Zealand.

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ontemporary forms of slavery and accompanying serious health consequences exist in New Zealand today.1–5 The International Labour Organization estimates there are 40.3 million victims of slavery worldwide.6 While there are no official figures specifically for New Zealand, New Zealand was first described in the US State Department Trafficking in Persons (TIP) Report in 2004 as a destination country for people trafficked for sexual exploitation.7 Subsequent TIP reports and current research findings have identified a range of industry sectors in which exploitation is occurring, including: dairy, horticulture, construction, fishing, hospitality, domestic work as well as the health, and aged-care sectors.1,5 More recently there have been reports of slavery involving forced, early (underage) and servile forms of marriage.2,3

Slavery is a violation of many human rights, including the right to health. New Zealand has obligations under international law to ensure that all victims of slavery have access to adequate physical and psychological care.2,8 Victims suffer serious health consequences, including increased risk of acute and chronic health problems, injuries from dangerous working and living conditions, and physical and sexual abuse.3,4,9–11 They also face considerable barriers to accessing healthcare and support services.2–4,12

The health sector has opportunities to identify, intervene and protect victims.5,10,13 This requires doctors and other health practitioners to demonstrate their leadership, knowledge and commitment towards addressing slavery and its health consequences, in ways that are effective and do not cause further harm.
In this article, we first provide a definition of slavery in the contemporary context before discussing scenarios where slavery is likely to occur within New Zealand. We then describe the associated adverse health effects and highlight the opportunities for doctors and health practitioners to address slavery and its health consequences at system, organisational and practitioner levels.

Definition of slavery in the contemporary context

Whereas historical slavery involved the legal ownership of a person, and has long been forbidden in law, contemporary forms of slavery imply the commodification of a person such that their situation is similar to that of the historical definition. The 1926 Slavery Convention defines slavery as, “the status or condition of a person over whom any or all of the powers attaching to the rights of ownership are exercised”. Its 1956 Supplementary Convention states that such institutions and practices of debt bondage, serfdom, servile forms of marriage and the exploitation of the labour of children are all similar to slavery. The United Nations Human Rights Council’s mandate of the Special Rapporteur on contemporary forms of slavery includes the aforementioned issues, but also forced labour, human trafficking, children in slavery and slavery-like conditions, sexual slavery and forced and early marriages.

Contemporary slavery is complex. It may include people voluntarily entering into an employment agreement and from that point becoming a victim because they lack the agency to exit from an exploitative situation. Or, they may become a victim due to unreasonable debts imposed on them by recruitment agents. It may be difficult to define the point when unacceptable work conditions and limited choices driven by poverty progress to slavery, or determine the degree of coercion or loss of agency for people in situations of forced, early and servile forms of marriage.

Legislation to address slavery in New Zealand is limited in that it does not define slavery in the contemporary context. However, certain forms such as human trafficking are now included under the Crimes Act 1961, which previously defined human trafficking narrowly as the use of coercion or deception to arrange or attempt to arrange the entry of a person into New Zealand or another state. Trafficking that took place internally was not recognised until the enactment of the Organised Crime and Anti-Corruption Legislation Bill in 2015, which amended Section 98D of the Crimes Act. Human trafficking was then redefined for the purpose of exploitation that does not just require transnational movement of persons. It involves the, “means to cause, or to have caused, that person, by an act of deception or coercion, to be involved in (a) prostitution or other sexual services (b) slavery, practices similar to slavery, servitude, forced labour or other forced services (c) the removal of organs”. What this revised definition does not include however, is the provision for making the sex trafficking of children (regardless of deception or coercion) a crime in New Zealand.

Using the international definitions aforementioned, slavery is occurring within New Zealand. It has been most recently described in the fishing and horticulture industries. It is also found among a number of other industry sectors, as well as outside the labour market, for example in forced, early and servile forms of marriage. Doctors and other health practitioners can thus be expected to encounter patients who are in living in slavery in New Zealand.

Slavery in New Zealand and its health consequences

Evidence in New Zealand comes from academic research, court and media reports, and submissions to Parliament. Research into the fishing industry identified migrant fishers on many South Korean foreign charter vessels as being subjected to economic exploitation and severe physical and sexual abuse. In 2016, New Zealand had its first human trafficking conviction. Fijian workers were coerced and deceived to work in the horticulture industry where they were promised well-paying jobs and work permits. The actuality was vastly different with one worker earning as little as $25 for three weeks’ work. More recent research has identified disturbing cases of exploitation in different industry sectors, including the health and aged-care sectors. The reality is that exploitation remains largely hidden.
The introduction of the Prostitution Reform Act 2003 (PRA) increased protections for sex workers, including access to the Employment Relations Authority, having implications not only for preventing economic exploitation but for improving workplace health and safety. However, the PRA explicitly excludes those on temporary visas, including international students so those working illegally in the industry are not offered the same protections. They are vulnerable to exploitation and adverse health consequences due to this lack of protection. Women trafficked into sex work are less likely to use health and social services than non-trafficked sex workers. Therefore, those who are at more risk of being exploited (including underage sex workers) face considerable barriers to accessing high-quality healthcare.

Slavery includes forced marriage, when marriage is forced on people without full and free consent, where duress exists due to the use of coercion, threats or deception. Forced marriage is distinct from that of arranged marriage (where the involved individuals have the right to say no), common in many cultures. ‘Full and free’ consent should be viewed in the context of power imbalances between the individuals understood to be consenting, and those seeking their consent. Forced marriages can include early and servile forms of marriage, and have been reported in the literature to occur within some Asian, Middle Eastern and African diaspora communities in New Zealand.

Some women brought into New Zealand on the temporary Culturally Arranged Marriage Visitor Visa are reported to be at risk of forced, early and servile forms of marriage where ongoing immigration sponsorship can be used as a tool of abuse. The added dynamics of dowry abuse compound the issue. Women have ended up being ‘indebted’ for having being brought to New Zealand and are required to ‘pay this debt off’ through forced labour on farms/other work areas in addition to domestic servitude. They may have no access to financial means, poor access to healthcare and other support services, and are prevented from applying for permanent residency for several years. Women may be frightened to report their situation to statutory agencies due to fear of ‘honour-based’ violence, or deportation. Stigmatisation of divorced women and single mothers in communities within home countries is an added factor that keeps women in exploitative abusive relationships. Forced, early and servile forms of marriage come with increased risks of domestic violence, rape, sexually transmitted infections and unwanted pregnancy. Evidence suggests that those who have been forced into marriage may present to health services with self-harm, eating disorders or suicidal tendencies, and that people with mental illness or intellectual and learning disabilities may be at increased risk.

In New Zealand, pursuant to section 32 of the New Zealand Public Health and Disability Act 2000, the Minister of Health established a narrow definition of eligibility for non-New Zealand citizens/residents accessing health and disability services, limiting access to those persons who are ‘proven’ victims of human trafficking. This essentially excludes access to high-quality healthcare for people (including children) who are victims of forced, early and servile forms of marriages, and other forms of slavery occurring in New Zealand.

Persons of any ethnicity may be in situations of slavery in New Zealand. Victims are at increased risk of acute and chronic health problems, including physical, psychological and sexual violence; injuries from dangerous working and living conditions; malnutrition; mental health problems, including depression, anxiety and post-traumatic stress disorder; communicable diseases including HIV/AIDS, tuberculosis and sexually transmitted infections; and unwanted pregnancy, forced and unsafe abortions. Restricted access to healthcare compounds the issue.

Possible presentations to health services in New Zealand

There are opportunities across the health sector to identify and intervene to improve health outcomes for victims of slavery in New Zealand. Contact may occur at any entry point, including emergency departments or general practice, public health services, outpatient services, mental health services, counseling or psychotherapy services, maternity and child health services, and sexual health services.
Victims may or may not be able to present to health services due to control by the person exploiting them. Practitioners need to know how to identify victims who may present with other primary issues. For instance, a person may be prevented from accessing healthcare at the time of a health crisis related to their exploitation, however, they may be allowed to access routine care such as general practice visits or outpatient clinic appointments. Practitioners may therefore see victims who present for routine care such as contraception but not as the result of associated illness or injury, including intimate partner violence. They may seek help for their situation either directly or indirectly, such as presenting with medically unexplained symptoms at times of distress or increased risk of harm. The presenting complaint may not identify the person as being a victim of slavery but there may be other elements that are red flags.

Research from New Zealand pertaining to victims from the fishing industry has highlighted they may be identified by the nature of their injuries and incongruities in their history and/or demeanour. There may also be an implicit or explicit sense of urgency to return to the vessel or to have injuries/illness ‘signed off’ to allow the person to return to work. Other red flags may include, for example, not knowing one’s home address or how to get home, and a paucity of personal identification.

However, no one red flag has adequate predictive value to ‘make the diagnosis of slavery’ and there are no validated screening tools in this area. Unsurprisingly, only a small percentage of practitioners report confidence in identifying victims of slavery in the contemporary context, and there are widespread misconceptions regarding the definition and how victims may present.

Given the nature of the situations in which they are held, it is highly likely that victims will be reluctant to disclose their situation. This may be due to risk of violent retribution, mistrust of institutions, lack of perceived alternatives, loss of agency secondary to psychological trauma, fear of forfeiting what autonomy they do retain, inability to access private confidential consultations with health providers, fear for dependent children and other family members, or fear for legal consequences such as deportation.

Potential harms from interventions

There are potential harms to victims of slavery if identification or intervention occurs without appropriate expertise or access to support services for victims, or those treating them. Potential harms include the re-traumatising of victims through: disclosure of current or prior trauma without offering appropriate and ongoing support and safety, lack of promised access to follow-up supports within the health sector or other sectors, and/or negative consequences if individuals perceive a practitioner or organisation as judgmental or ‘victim-blaming’ in approach. Potential harms may also include unintended consequences of identification, including exposure to risk of harm or loss of right to remain in New Zealand for those on temporary visas, wherein slavery is misunderstood as primarily an immigration issue. There is some evidence of these harms in New Zealand, particularly among young persons involved in sex work who have been shown to view contact with any health and other services as emotionally harmful.

Contact with the health system represents an opportunity for intervention, acknowledging that there are significant barriers to identification of, and positive interventions for, victims of slavery. It is imperative that New Zealand has a responsive system in place, supported by an informed health workforce.

Doctors and other health practitioners as advocates for change: addressing slavery and its health consequences in New Zealand

The New Zealand Medical Association describes doctors as advocates for improved population health and equity, and having a role in sector leadership, including driving and facilitating change. Doctors have used their positions of influence to lead for change on numerous health issues frequently at odds with the status quo, including nuclear war, climate change and the abuse of children in Australian prison camps on Nauru.

A robust health response to slavery has been described as the ability to identify those at risk, or current victims, and to treat them in a compassionate, culturally competent and trauma-informed manner.
Doctors and other health practitioners in New Zealand have many opportunities to lead for change through advocating for a cross-government approach to address this issue with its health, legal, immigration, societal and cultural complexities.

The Domestic Violence Act 1995 and related family violence laws are currently being strengthened by Government around forced marriage through the criminalisation of coercion to marry. Practitioners can advocate for Government to further strengthen other legislation such as the Crimes Act and PRA to ensure children and adults are not exploited in New Zealand. They can also advocate for Government to review emerging international law, such as that of the UK Modern Slavery Act 2015, to ascertain whether New Zealand should be implementing analogous legislation that prohibits companies with slavery in their supply chain to operate within New Zealand.

At the health system level, practitioners can advocate for leadership by the Minister of Health to ensure that all levels of the health sector have procedures in place to identify and respond appropriately to slavery. This includes improving access to high-quality healthcare for those at risk of, or victims of, slavery. A starting point is for the Minister of Health to strengthen health legislation by broadening the eligibility criteria for access to services under the Health and Disability Services Eligibility Direction 2011, from that of only being eligible to receive services if a ‘victim of trafficking in people offence’ to aligning with the current evidence on all practices of slavery in New Zealand. It requires the development of robust and useful policies and guidelines that strengthen existing referral pathways for children who are being exploited, for example, under the broad mandate of the Children, Young Persons, and Their Families Act 1989. It also includes pathways for referral to the Ministry for Vulnerable Children, Oranga Tamariki and when to contact the police; education and training for practitioners in victim identification and support; and resourcing for continued research into slavery and associated health consequences in New Zealand.

In addition to improving their own cultural competency, knowledge and expertise, practitioners can lead their organisations to develop culturally competent protocols and guidelines (including referral processes) within their local context to respond appropriately to slavery. This includes building alliances with local organisations working with migrants and refugees, and women’s refuges, both to facilitate victims accessing healthcare and to support practitioners in caring for them. This would include best practice use of trained interpreters. They can also lead their regulatory and professional bodies (such as the Medical Council of New Zealand, medical colleges and associations) to develop culturally competent policies and resources that address slavery and its health consequences in New Zealand. Health organisations must not be complicit in enabling structures that propagate slavery, for example, that the agencies health organisations contract with are not exploitative of migrant workers. Practitioners can ensure that their health organisations have structures to prevent this from occurring, including robust monitoring.

There are resources in the international literature that could be adapted for New Zealand, which cover identification of individuals in situations of slavery, culturally competent and trauma-informed treatment, service referral, legal issues, security (of the victim and practitioner) and prevention. One example is a tool developed for practitioners to support a person who is at risk of, or living within a forced marriage. Components of the tool include seeing the person in private, taking a detailed family history, assessing any immediate risk and developing a safety plan, shared decision-making, liaising with local organisations with expertise in the area and arranging a follow-up visit as a safety check.

Victims of slavery can perceive providers as being unable or unwilling to hear disclosures about sensitive topics and respond without judgment. There is evidence, however, that supportive and empathetic responses, and a collaborative process may encourage and allow disclosure in future interactions. There is the opportunity for skilled practice by a culturally competent health workforce to support disclosure and identification of victims, or those at risk,
through practitioners continuing to further develop and maintain their own cultural and professional competencies, and support their colleagues and peers to do so.

Conclusion

Slavery is a serious, complex and often hidden problem in New Zealand. We have endeavored to raise awareness about this neglected issue and highlight the numerous opportunities for doctors and other health practitioners to address slavery and its adverse health effects. Practitioners can, and should be leading advocates for change at government, health system and organisational levels. Key recommendations for a safe approach towards identifying and managing people in situations of slavery include building rapport, and culturally competent practice with an empathetic non-judgmental approach. Responses should be based on the respect, promotion and protection of human rights, and occur within a robust person-centric coordinated government response to addressing slavery and its health consequences in New Zealand.

REFERENCES:

8. Bhoola U. Report of the Special Rapporteur on contemporary forms of slavery, including its causes.


