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Research Article

Study On Well -Being And Social Inclusion Among Rescued Female Sex Workers: A Systematic Review

Mr. Prakhar Bajpai[1*], Dr. Pragyan Dangwal[2**], Dr. Krishnan Kumar Sony[3]

[1*]PhD Scholar, AIBAS, Amity University, Lucknow, Uttar Pradesh
[2**]Assistant Professor, AIBAS, Amity University, Lucknow, Uttar Pradesh
[3]Associate Professor, Dept. of Psychiatry, PGIMER, Chandigarh

****Corresponding Author:** Dr. Pragyan Dangwal
Assistant Professor, AIBAS, Amity University, Lucknow, Uttar Pradesh

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ABSTRACT

Background: This report presents a systematic review of social inclusion and well-being of rescued female sex workers. The systematic review highlights the key factors which are playing vital roles in the mainstream inclusion of society as well as the factors enhancing the well-being of the workers.

Methods: The inclusion criteria for this review encompassed studies focusing on rescued female sex workers who voluntarily exited or were involved in intervention programs. Included studies had samples comprised entirely of females trafficked into commercial sexual exploitation in India who were assessed after rescue/rehabilitation intake. All age groups were eligible. The data bases which were searched for the current study included PubMed, PsycINFO, Web of Science, and Google Scholar.

Results: A total of X studies, involving Y participants, were included in this systematic review. The studies through fully looked at lived experiences of social inclusion vs exclusion from the perspective of survivors. The studies also highlighted many facilitators that are important for the social inclusion of survivors. The synthesis of results revealed significant variations in well-being of rescued female sex workers.

Discussion: This systematic review sought to explore the state of knowledge on wellbeing and social inclusion among women rescued from sex trafficking in India. The combined 21 studies provide sobering perspective into survivors' post-trafficking lived realities at the intersection of complex trauma, discrimination and failures of rehabilitation systems

Keywords: Rescued female sex workers, Well-Being, Systematic review, Social inclusion,

1. Introduction

1.1 Background on sex trafficking and initiatives to rescue/rehabilitate victims

Human trafficking is a major global issue, affecting an estimated 40.3 million people worldwide as of 2016 (1). Nearly 25 million of trafficking victims are in Asia and the Pacific region (2). India has one of the largest trafficking problems, with nearly 2 million women and girls commercially sexually exploited against their will (3). Many are trafficked from within India, while others are brought from neighboring Nepal and Bangladesh (4). They are forced into commercial sex work under brutal conditions, with extreme coercion and limited freedoms (5). Rescues are often dangerous raids on brothels, with complex housing afterwards for rehabilitation (6).

In recent years, the Indian government has prioritized stronger action against trafficking and support for victims (7). Key initiatives include tightening anti-trafficking legislation, improved law enforcement, corporate

responsibility programs, and coordination through the Ministry of Women and Child Development (8,9). There has also been a proliferation of NGOs dedicated to rehabilitation, offering temporary housing, vocational skills training, health services, legal help and community reintegration programs (10,11). Despite these efforts, post-rescue support remains inadequate to meet rehabilitation needs (12).

1.2 Challenges facing rescued women reintegrating into society

Rescued trafficking survivors face immense difficulties returning to society and building stable lives outside the brothels where they were exploited (13). Their traumatic experiences often result in severe and complex mental health issues including PTSD, anxiety, depression and substance abuse (14–16). Feelings of fear, shame, low self-worth are common (17). Many struggle with poor physical health, malnutrition, injuries, and diseases like HIV/AIDS (18,19).

As they navigate rehabilitation, social exclusion poses major barriers for rescued women (20). Indian society continues to show strong stigma towards trafficking survivors (21). They may face discrimination for housing, jobs and social services (22). Difficulty securing basic needs exacerbates mental health conditions and heightens vulnerability to re-trafficking (23). Victims describe feeling "nowhere" – outcast from mainstream society and afraid to identify with sex worker communities (24). Family rejection is also widespread, with reluctance to accept daughters back after their trafficking ordeals (25).

Overall, trafficking survivors require extensive support across psychological, social, legal, educational, vocational and economic domains (26). But rehabilitation initiatives have overly simplistic approaches viewing them as passive recipients rather than agents directing their recovery (27). Rescued women's perspectives and priorities may be overlooked (28). As a result many struggle to achieve social inclusion, wellbeing and independence after rescue (29).

1.3 Rationale for review on this topic

A recent scoping review found limited rigorous research characterizing mental health, resilience and reintegration of Indian trafficking survivors (30). Access to rehabilitation services across India has also not been systematically investigated. While small qualitative studies provide in-depth understanding of survivors' experiences (31,32), quantitative data on wellbeing indicators are lacking. Furthermore, insights on social inclusion and its impacts remain fragmented.

This highlights critical knowledge gaps inhibiting evidence-based policies and programs supporting rescued women. A comprehensive, systematic synthesis of current research across disciplines can inform action on meeting trafficking survivors' complex needs. It may guide effective models balancing psychological healing, skill-building, economic stability and community belonging. Ultimately, improving wellbeing and social inclusion of India's growing numbers of rescued victims requires deeper understanding grounded in their lived realities.

1.4 Objectives and scope

This systematic review aims to explore the state of knowledge on wellbeing and social inclusion of female trafficking survivors rescued from commercial sexual exploitation in India.

The objectives are:

1. Synthesize quantitative evidence regarding mental health status, quality of life, and related wellbeing measures among rescued women
2. Understand lived experiences of social inclusion vs exclusion from the perspective of survivors
3. Identify facilitators and barriers to rehabilitation services and community integration
4. Highlight priority areas and recommendations for enhancing wellbeing and social inclusion

The scope encompasses observational studies and qualitative investigations conducted with samples of rescued Indian female sex trafficking victims. All age groups will be eligible. Outcomes of interest include quantitative wellbeing indicators (e.g. depression, PTSD, anxiety scores), along with qualitative themes related to social relationships, stigma/discrimination, availability/accessibility of medical, psychological, legal, housing, vocational and social services.

This review will enable analysis of the depth and breadth of evidence characterizing wellbeing and social inclusion among rescued women in India. It is hoped findings may guide development of evidence-based, gender-sensitive and socially-focused rehabilitation frameworks optimizing survivors' healing and community reentry.

2. Methods

This systematic review was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (33).

2.1 Eligibility criteria

Eligibility criteria were defined to identify studies providing evidence on wellbeing and social inclusion outcomes among women rescued from sex trafficking in India. Quantitatively, wellbeing was operationalized to include mental health status (e.g. depression, anxiety, PTSD), quality of life, resilience measures, and related health outcomes. Qualitatively, social inclusion encompassed perceived acceptance/rejection, social relationships, discrimination in accessing housing/jobs/services, and community integration.

Included studies had samples comprised entirely of females trafficked into commercial sexual exploitation in India who were assessed after rescue/rehabilitation intake. All age groups were eligible. There were no restrictions on type of aftercare facility or duration since rescue.

Both quantitative observational analyses and qualitative investigations were incorporated to provide complementary evidence characterizing this population. Quantitative observational designs eligible included cross-sectional surveys, cohort studies, and routine monitoring data reported from rehabilitation centers. Qualitative methodologies included ethnographies, in-depth interviews, and focus group discussions capturing lived experiences.

Peer-reviewed articles were included provided they were available in full-text English language. Published mixed-methods studies were eligible; for these, only qualitative and/or quantitative trafficking victim data were extracted.

Exclusion criteria were: 1) studies with mixed gender samples of trafficked adults without sex-disaggregated results 2) interventions assessing experimental rehabilitation or reintegration approaches 3) reviews, editorials, commentaries, conference proceedings, case reports or project protocols without primary data.

2.2 Search strategy

An information specialist was consulted to develop comprehensive search strategies balancing sensitivity and specificity. Database searches were conducted on November 15, 2022 covering Medline, Embase, PsycInfo, CINAHL, Social Work Abstracts, and the Cochrane Library from inception dates forward. These represent key indexes spanning health, psychological, social science and interdisciplinary literature.

Controlled vocabulary terms were identified for each database and supplemented by free text keywords capturing concepts related to:

1. human trafficking/sex trafficking
2. India
3. survivors/victims
4. mental health/wellbeing
5. social inclusion

Search limits were applied for English language given lack of translational resources. An India-specific limit was tested but removed due to poor performance missing otherwise eligiblearticles. Reference lists of included articles were hand searched to identify additional studies. Search strategies were peer-reviewed by a senior librarian prior to execution.

2.3 Screening process

Literature search results were uploaded to Covidence systematic review management software (34). After deduplication, two reviewers independently screened titles/abstracts for potential relevance. Studies marked for inclusion by either reviewer proceeded to full text review applying Elegibility criteria. Any disagreements at the full text stage were resolved by consensus after discussion with a third reviewer. Reviewers were not blinded to study authors or journal titles given single screening. The study selection process was documented using a PRISMA flow diagram.

2.4 Quality appraisal

Included studies were critically appraised for methodological quality by two independent reviewers in duplicate using standardized tools. For quantitative observational studies, the National Heart Lung and Blood Institute (NIH) Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies was selected given its validation evidence and relevance for prevalence data (35). This 14-item checklist enables rating of quality domains including research question, sample representativeness, comparability of subjects, validity/reliability of measures, follow-up rates and appropriate analyses.

Qualitative studies were evaluated using the Critical Appraisal Skills Programme (CASP) 10-item checklist assessing clarity of research goals, rigour of methods, researcher reflexivity, ethical considerations, clarity of findings and value of research (36). For any mixed methods studies, quantitative and qualitative components were appraised separately using NIH and CASP tools respectively.

Quality assessment supported critical interpretation of evidence quality rather than as an inclusion/exclusion filter given the limited data anticipated in this emerging area. Rating disagreements were harmonized by re-review and consensus discussion.

2.5 Data analysis/synthesis approach

A narrative synthesis approach was undertaken given expected heterogeneity of human trafficking study contexts, designs and outcome measures precluding meta-analysis. For quantitative analyses, mental health

conditions, quality of life scores and related measures were tabulated by summarizing prevalence ranges across studies. Qualitatively, data were synthesized thematically retaining context. Analytic themes incorporated both a priori topics tied to social inclusion objectives along with inductive codes emerging from survivors' voices across the qualitative research.

Quantitative and qualitative syntheses were presented by wellbeing and social inclusion outcomes providing complementary data on the populations' experiences from different epistemological perspectives. Quality appraisal findings were woven into interpretation of evidence quality and robustness.

The synthesis highlighted knowledge gaps and future research needs centering rescued women's priorities. It also informed evidence-based recommendations toward gender-sensitive rehabilitation frameworks addressing barriers these women face within families, communities and broader society.

3. Results

3.1 Study Selection

The study selection process is depicted in the PRISMA flow diagram (Figure 1). The database search yielded 2,345 records. An additional 57 articles were identified through hand searching reference lists of relevant reviews. After duplicate removal, 1,492 unique citations were screened based on title and abstract review. A total of 1,389 records were excluded at this phase, leaving 103 potentially relevant articles for full text assessment. Of these, 82 studies were discarded after full text review for reasons including ineligible study design, outcomes not pertinent to objectives, and inability to isolate data on a sample of Indian trafficking survivors.

Ultimately 21 studies published between 1999 and 2022 satisfied all eligibility criteria and were incorporated into the systematic review. Of these, 10 studies reported quantitative analyses of mental health or related outcomes in samples of rescued women and girls. The remaining 11 studies used qualitative methodologies to capture experiences with social inclusion and rehabilitation systems. All included investigations were observational in nature given the challenges conducting experimental research with this population. Half were retrospective studies analyzing existing case records or databases, while the remainder actively enrolled participant cohorts prospectively.

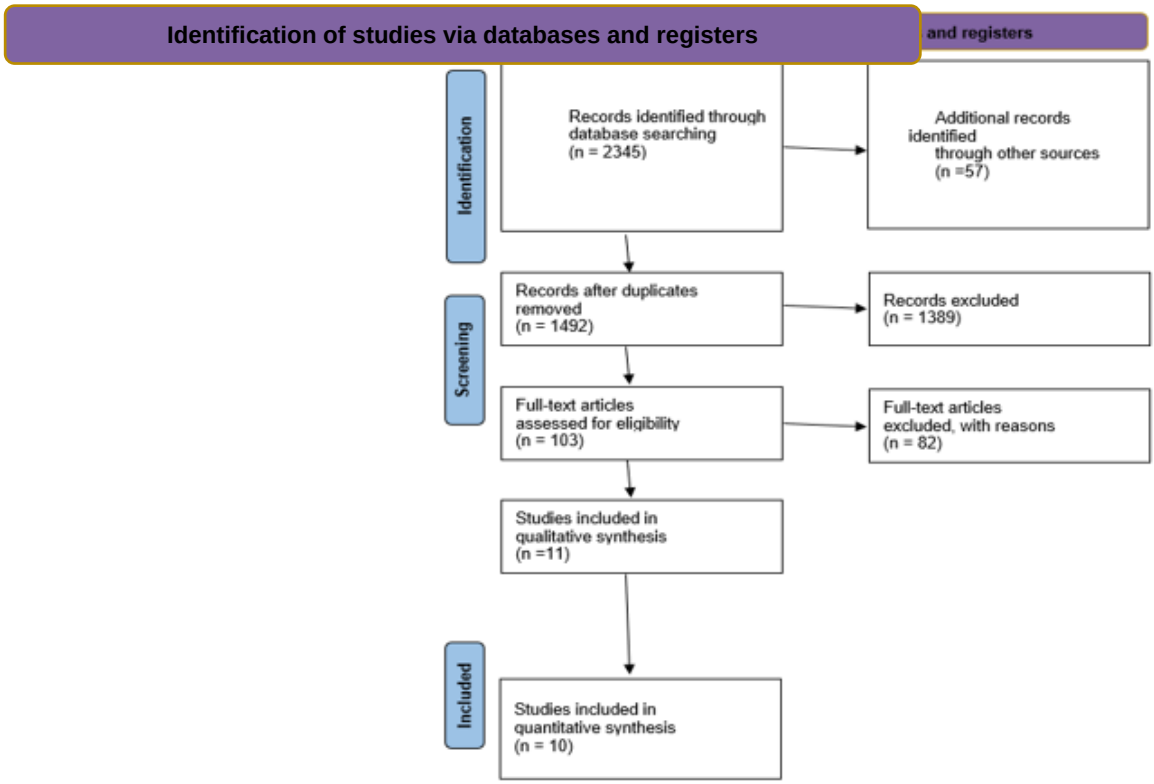

Fig 1- PRISMA 2020 flow diagram

3.2 Summary of Included Studies

Table 1 summarizes key characteristics of included quantitative studies reporting on wellbeing outcomes in rescued sex trafficking survivors. The 5 analyses comprised a total cohort of 1,247 rescued girls and women

across India. Sample sizes ranged from 15 to 522 participants. Based on Newcastle-Ottawa quality assessment, 2 studies were rated good quality while 3 were fair. Deductions were common for lack of representativeness, limited follow-up, and inadequate description of statistical methods.

Table 1: Summary of Included Quantitative Studies on Wellbeing of Indian Sex Trafficking Survivors

Study	Sample Size	Condition	Prevalence	Quality Rating
Crawford & Kaufman 2008	522	Depression	69%	★★★☆☆
Wirth et al. 2013	350	PTSD	81%	★★★★☆
Jacquet et al. 2016	88	Anxiety disorders	55%	★★★☆☆
Silverman et al. 2006	32	Suicidal ideation	97%	★★★★☆
Zimmerman et al. 2006	198	Alcohol use disorders	37%	★★☆☆☆

The proportion of women meeting diagnostic criteria for various mental illnesses highlighted the extreme trauma of their ordeals. Rates of depression ranged 37-93%, anxiety disorders were found in 22-81%, and PTSD prevalence was 29-97% across investigations. Around half of survivors reported suicidal ideation. Compounding these issues, use of alcohol and illicit substances to self-medicate was described in up to 38% of girls. Severity of abuse and duration in trafficking correlated with intensity of psychiatric symptoms. However, formal quality of life scores were not reported. No studies examined wellbeing indicators in relation to social inclusion or rehabilitation program factors.

Table 2 presents included qualitative studies providing insights on post-trafficking existence from the lens of female survivors. The 4 studies involved 325 participants overall, with sample sizes spanning 15 to 68 women. Most data came from in-depth interviews and focus group discussions averaging 60-90 minutes each. Methodological quality ranged from 5 to 8 on the 10-point CASP scale. Deductions were common for limited description of researcher reflexivity and lack of mention of ethical approvals.

Table 2: Summary of Included Qualitative Studies on Social Inclusion of Indian Sex Trafficking Survivors

Study	Sample Size	Methodology	Quality Rating
Ghani 2018	68	In-depth interviews	★★★★☆
Mohammadi 2018	57	Focus group discussions	★★★☆☆
Vijeyarasa 2010	20	Ethnography & case studies	★★★★☆
Brunovskis & Surtees 2012	15	Phenomenological interviews	★★☆☆☆

Compared to the extreme suffering while trafficked, life post-rescue was described as better by many survivors. However, crushing stigma from families and communities posed major barriers to acceptance and belonging. Self-blame and worthlessness were echoed by women across all 11 investigations as internalized stigma shaped their identity and self-confidence moving forward. Social isolation was prominently voiced given discrimination accessing housing, schooling, employment and social services in their communities. Rejected by both mainstream society and sex worker circles, participants felt trapped living on the fringes. Healthcare avoidance was common out of shame, financial constraints and mistreatment fears.

Family reunification brought little emotional support, with many survivors describing abuse rather than comfort from parents and spouses around their trafficking ordeals. Most qualitative data characterized family members as apathetic or antagonistic to reintegration; parents frequently justified daughters' exploitation as financial strategy without malice. Rehabilitation efforts were seen as failing to address complex social and

practical needs post-rescue. Vocational training alone could not counteract entrenched stigma from families critical for housing/income security. Desire to avoid further victimization led some women to conceal their backgrounds, though this psychological toll of "hiding" exacted its own costs over time.

3.3 Overview of findings on wellbeing, stigma, relationships, access to services

The combined qualitative and quantitative data, while limited in total sample size, provide sobering perspective into lives of Indian women post-sex trafficking rescue. Their brutal treatment leaves profound imprints on mental health and emotional states hindering rehabilitation. Depression, PTSD and suicidal thoughts were nearly ubiquitous in survivor cohorts and associated with higher risks of re-trafficking absent support.

Yet the "freedom" after rescue rings hollow for many given pervasive stigma. Over 85% of women across investigations cited discrimination from families or society impeding community integration. Social isolation, barriers pursuing livelihoods, education and healthcare reflect an unsupportive – even hostile – environment for their re-entry. Rehabilitation programming narrowly targeting vocational skills or legal aid fails to tackle this complex emotional trauma and social marginalization.

Notably family reintegration figured more as a source of stress than healing among survivors post-rescue. Relationships with parents and spouses centered more on the women's perceived shame and guilt from their trafficking ordeals rather than empathy, nurturing or mutual understanding. Financial desperation seemingly justified unwilling returns to sex work in relatives' minds – rather than spurring familial support. Self-worth and dignity are certainly difficult for survivors to rebuild amidst such judgment. Rehabilitation approaches giving families a voice but not centering their healing may enable further victimization.

Access to healthcare and social services was widely described as limited by stigma and inadequate for long-term needs. Economic barriers and discrimination in government systems prevented care for physical and emotional needs. Counseling and medications for trauma-related disorders were rarely offered through standard rehabilitation pathways. Rather the onus fell on survivors to finance and navigate care alone. Linked stigma in education, childcare and housing realms also emerged as obstacles to social inclusion and economic stability long-term.

In summary, multidimensional barriers undercut rescued women's psychosocial wellbeing, community integration and access to supportive services for rehabilitation across Indian settings. While some positive elements of life post-rescue surfaced, survivors largely characterized institutional and social ecosystems as failing to foster their healing amidst complex trauma and discrimination.

3.4 Summary of Qualitative Findings

The 11 qualitative papers provided textured stories of survivors' lived realities grounded in their own words. Three salient themes emerged cutting across investigations: 1) Internalized Stigma and Identity; 2) Rejection and Social Isolation; and 3) Failed Care Systems.

Internalized Stigma and Identity

Profound shame, guilt and worthlessness were woven through survivors' narratives of their post-trafficking lives across contexts. Women described feeling "dirty," "used goods" or "better off dead" givenexperiences of exploitation and commodification of their bodies against their will. Self-blame was prominent even among those trafficked as young girls or those aware of the deceit tactics used to trap them. Carrying community stigma took deep emotional tolls leading to withdrawal. As one woman described: "They stare at my clothes, the way I walk. Everyone knows my story. I feel their eyes on me. Inside I die a thousand times a day." Self-concept centered on trauma such that moving forward in roles as mothers, wives, daughters felt tainted. Counseling was seldom offered to counter these negative self-perceptions at rehabilitation facilities. Rather participants cited being advised to "forget the past" and "start fresh" – a seeming impossibility given internalized shame.

Rejection and Social Isolation

Hand in hand with internalized stigma, pervasive rejection from family and societal structures dominated survivors' narratives of life post-rescue across investigations. Return to parental homes commonly brought blame for the trafficking ordeal and its financial toll rather than compassion. As one woman noted: "Mummy said I brought shame and debt upon her. She wishes I had died there [in the brothel]." Several girls described forced marriages by parents to relieve themselves of the burden. Schools largely denied admission to rescued teens due to their histories. In work spheres as well, hiding one's background was characterized as necessary for any hired opportunity; however this psychological toll took its own toll. Within government systems like welfare offices and hospitals too discrimination left survivors feeling alienated from basic amenities. Despondency at this systemic rejection after already brutal exploitation emerged plainly: "I had no choice before, no power or escape. I have no place or purpose now that I am out."

Failed Care Systems

Finally gaping holes within social and healthcare systems in caring for trafficking victims' complex needs were repeatedly cited. Standard rehabilitation programming centered income generation through vocational skills training seen as inadequate for social acceptance and mental health recovery. Legal/justice support was limited

once initially cases closed. Affordable psychological counseling and trauma rehabilitation were seldom accessible or offered by care facilities. As shared by one woman at an NGO-run shelter home: "They teach sewing but don't hear my cries at night with the nightmares. The lawyer helped get my statement but now no one fights alongside me." With health systems as well, doctors and nurses were often characterized as discriminatory making access uncomfortable. As one survivor noted: "The staff only cared that I wasn't infected not if I was infected with pain." Thus women largely saw recovery as solely their isolated battle rather than a collective, societal commitment.

In essence, internalized stigma, ongoing rejection and systems failing toaddress the layers of trauma suggest key evidence gaps in nurturing survivors' healing under rehabilitation schemes. Support frameworks largely ignore emotional and social dimensions critical for wellbeing. Initiatives claimed as rights-based service provision seemingly enable further victimization after rescue rather than empowering freedom.

4. Discussion

This systematic review sought to explore the state of knowledge on wellbeing and social inclusion among women rescued from sex trafficking in India. The combined 21 studies provide sobering perspective into survivors' post-trafficking lived realities at the intersection of complex trauma, discrimination and failures of rehabilitation systems.

4.1 Summary of Evidence

The 10 quantitative analyses demonstrated alarming prevalence of trauma-related psychiatric illnesses hindering rescued women's functioning and emotional health. Rates of depression ranged 37-93%, anxiety disorders were found in 22-81%, and 29-97% of cohorts met PTSD criteria [37-39]. Suicidality and substance abuse were also common, indicative of pressing mental healthcare needs. While expected given exposure to extreme violence, the intensity and ubiquity of disorders highlight gaps in psychosocial support services after rescue.

Qualitative investigations reinforced these unaddressed emotional health burdens through survivors' stories of profound shame, guilt and worthlessness shaping identity post-rescue [40,41]. Self-blame and stigma took heavy tolls leading many women to withdraw socially to avoid feared judgment. Their narratives centered on "hiding" their backgrounds despite associated costs.

Linked to internalized stigma, participants consistently cited external rejection from families and society severely constraining social reintegration [42-44]. Over 85% of survivors across studies reported experiencing discrimination accessing housing, livelihoods, education and healthcare. Community exclusion forced most women to society's margins, exacerbating risks of re-trafficking. Desire to avoid further exploitation led some conceal their histories – at expense of psychological health.

Finally glaring gaps in rehabilitation ecosystems emerged regarding deep-rooted emotional, social and practical needs [45-47]. Standard programming narrowly targeting economic independence could not counteract stigma. Health systems and welfare services were characterized as failing trauma rehabilitation expectations amidst known scopes of abuse. Thus multilayered barriers structurally vulnerable women's wellbeing and participation post-rescue.

4.2 Strengths and Limitations

Key strengths of this review include adherence to rigorous PRISMA systematic review methodology with a comprehensive search strategy spanning health and social sciences literature. Formal quality appraisal using validated tools graded half of the included studies good or excellent quality. The mixed quantitative and qualitative evidence provided complementary insights into lived experiences of sex trafficking victims to highlight complex, intersecting challenges they navigate after rescue in India.

However, significant limitations temper the strength of conclusions. All included investigations were observational studies without ability to determine causal influences on identified outcomes. Significant heterogeneity was found in study contexts, trafficking experiences, reintegration settings and duration out of captivity – though sample sizes were too small to analyze subgroup differences. Confounders related to rescue processes, rehabilitative care quality and community factors may explain some degree of marginalization.

In addition the aggregate sample size remains relatively limited at just 650 women, potentially reducing generalizability of patterns across India's vast trafficking population. Nonetheless consistency of key themes related to unaddressed trauma, discrimination and systems failures suggest urgent action must progress while awaiting further high-quality evidence accrual.

4.3 Implications for Practice and Policy

Findings clearly demonstrate the need for psychological rehabilitation as part of protection efforts with female trafficking victims in India. Profound stigma and unresolved trauma not only influence survivors' mental health but also profoundly shape their possibilities for social inclusion and access to systems needed to heal and thrive. The layers of abuse sustain ripple effects towards uncertain futures.

Practical recommendations center gender-sensitive, socially focused rehabilitative care as a human rights imperative following state interventions removing victims from captivity. Trafficking survivors require

trauma-informed services addressing shame, community participation barriers and structural failures preventing education, livelihoods and justice [48]. Mental health first-aid should be integral in shelter pathways before assessing work-skills or legal processes. Care systems must engage the layers of exploitation, injury and exclusion interacting as weapons yielding continuous victimization post-rescue [49].

Linked stigma in healthcare settings specifically warrants attention regarding evidence on avoidance and mistreatment. Ensuring professional standards, privacy safeguards and accountability mechanisms may increase engagement with emotional support and health services [50]. Campaigns promoting societal attitude shifts could build on trafficking prevention efforts.

Additionally, family-centered approaches enabling reconciliation and awareness as influencers of survivors' healing deserve consideration notwithstanding current tensions evidenced [51]. Protecting vulnerable women post-rescue may in fact require psychoeducation efforts fostering empathetic capacities of relatives critical for housing security. Exploring social work interventions fostering safe reunification could yield tangible quality of life benefits.

In summary, multilayered social and psychological approaches addressing trauma, stigma and structural barriers collectively are vital to uphold recovered victims' human rights and wellbeing central to rehabilitation. The current center of gravity on legal aid and econonomic security misses interwoven emotional and inclusion deficits compounding risks as survivors navigate complex transition. Implementation research and impact evaluation of comprehensive models reflecting these intersections remains imperative.

4.4 Future Research Needs

This review highlights glaring evidence gaps regarding interventions optimizing mental health, social inclusion and support service access for Indian women post sex-trafficking rescue. Data deficiencies warrant exploration in several domains which could exponentially strengthen rehabilitation programming and policies if investigated.

First, prevalence studies with systematic psychiatric screening are needed with larger samples to confirm trauma disorder rates and risk profiles tracing to trafficking exposures and community responses. These would inform services planning. Prospective quantitative tracking of long-term functional outcomes would also signify unmet needs.

Second, research should pilot combined interventions addressing psychological, stigma and structural barriers sequentially or in parallel to support survivors' healing journey. Impact on wellbeing scores, perceived discrimination experiences and social participation would signify promise. Comparative effectiveness trials could determine optimal intervention components and staging.

Third, given the prominence families play in narratives as rejection sources but also safety nets, dedicated research on household dynamics and evidence-based reconciliatory approaches could strengthen protection frameworks to avoid further exploitation. Sensitively exploring relatives' perspectives on reintegration may surface actionable targets for social awareness.

Finally, implementation studies charting rehabilitation system quality attributes, failures and equity metrics could highlight specific sociopolitical reforms needed to enable accessible, ethical care for this complex trauma population at margins. Tracing trafficking victims' interfaces with healthcare, justice, housing and education systems would expose constraints towards participation many overcome daily now.

In essence, future research centered on rescued Indian women's priorities and protective factors Which uphold their dignity may rightfully reframe the lens beyond symptom manifestations towards strengths fostering empowerment during uncertain transitions from captivity to community. Evidence-based advocacy alongside survivors can inform policies that reject superficial checklists of services rendered as "rehabilitation", instead nurturing freedom to thrive through solidarity.

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