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ORIGINAL PAPER

Health Care and Human Trafficking: We are Seeing the Unseen

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Abstract: **Objectives.** This study aimed to build the evidence base around human trafficking (HT) and health in the U.S. by employing a quantitative approach to exploring the notion that health care providers encounter this population. Furthermore, this study sought to describe the health care settings most frequented by victims of human trafficking. **Methods.** This was an anonymous, retrospective study of survivors of U.S.-based human trafficking. **Results.** One hundred and seventy-three participants who endured U.S.-based human trafficking were surveyed. The majority (68%, n=117) of participants were seen by a health care provider while being trafficked. Respondents most frequently reported visiting emergency/urgent care practitioners (56%), followed by primary care providers, dentists, and obstetricians/gynecologists (OB/GYNs). **Conclusions.** While health care providers are serving this patient population, they do not consistently identify them as victims of human trafficking.

Key words: Vulnerable, human trafficking, emergency medicine, slavery.

Human trafficking, colloquially called "modern-day slavery," is the second largest illegal international trade, surpassed only by arms trafficking.[1] The United Nations defines human trafficking as "the recruitment, transportation, transfer, harboring or

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receipt of people, by means of the threat or use of force or other forms of coercion, or 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."[2[p.42]] Victims include adults and children of all genders, language abilities, and citizenship statuses.

Given the stealthy nature of the problem, collecting reliable and valid data on human trafficking victims remains difficult, but the United States government has estimated that between 14,500–50,000 people are brought into the U.S. and trafficked each year;[3,4] in 2014 the U.S. Department of State reported receipt of more than 21,000 calls to its trafficking hotline.[5] Along with Japan and Australia, the U.S. is one of the top destination countries worldwide, meaning people are brought into the U.S. for the purpose of being trafficked.[6] The U.S. Department of State also categorizes the U.S. as a source and transit country for human trafficking. In recent years, the federal government and advocates across the nation have increasingly focused on the problem of minors being trafficked within U.S. borders, which may involve hundreds of thousands of youths under the age of 18 years.[7,8,9] Because trafficking victims of all types are hidden and generally do not self-identify to authorities, the U.S. government has increased efforts to detect human trafficking, including increased training of law enforcement officials on victim identification.[10]

Health care settings are generally recognized to be safe spaces for patients to speak freely with providers, creating a unique opportunity for victims to be identified, treated, and offered intervention. While much of the literature on the intersection of health and human trafficking describes health problems reported by survivors after they become free, health professionals may have access to this population *while* they are being trafficked.[11–14] However, the data to support this reasonable claim derive from small, qualitative studies and anecdotal reports; case reports indicate that providers routinely fail to recognize when presenting patients are being trafficked.[11,13] If health care providers are unknowingly seeing this population in significant numbers, provider awareness levels should be improved through consistent, targeted education on how to identify and appropriately care for this population.[15]

Failure to identify victims stems both from victims' reticence to disclose and, more importantly, from providers who fail to recognize victims of trafficking.[11,14] Perceptions about who can be trafficked may bias providers into missing opportunities to identify victims.[14] Given that victims do not all fit a specific profile, a screening tool to help providers determine which patients are at risk might be useful, but to date no validated screening tools exist for use in health care settings.

This study aimed to quantify the frequency with which trafficked people encounter health providers in the US. Furthermore, this study sought to describe the health care settings most frequented by victims of human trafficking, whether their situations are recognized by providers, and which expert-recommended screening questions are being used.

Methods

Study design and setting. This was an anonymous, retrospective study of survivors of U.S.-based human trafficking. Human trafficking survivors, of all genders and ages, residing in the United States were eligible to participate in the survey. The survey was available on paper and online via SurveyMonkey in English, Haitian Creole, and Spanish.

Anti-trafficking organizations listed on the Polaris website,[16] encountered at topical conferences and those referred by other organizations, advocates, or survivors, were invited via email to participate. More than two dozen organizations were contacted; these participated in recruitment: Breaking Free, Coalition to Abolish Slavery and Trafficking, Colorado Legal Service, Male Survivor, My Sister's Place, Polaris, Safe Horizon, Willow Way, and Worker Justice of NYC. Paper surveys were distributed to participants through these anti-trafficking organizations. The online survey was advertised in anti-trafficking organization offices and websites, via a survivor-advocate blog and Facebook. The study, approved by the IRBs of the Icahn School of Medicine at Mount Sinai and Columbia University Medical Center, began in May 2012 and concluded in December 2013. No identifying information was collected and written and verbal consent were waived to protect anonymity; an explanation of the survey describing its purpose, the investigators' identities, and possible risks and benefits to the participants was provided to participants in written form.

Selection of participants. Those who completed the survey on paper were identified as survivors of trafficking by anti-trafficking advocates and experts at recruiting service organizations. It is not known how many survivors were told about the survey but declined to participate. Those who completed the online version of the survey self-identified as survivors of trafficking. All surveys asked the participants, "Are you a survivor of slavery, or were you made to work or made to do sexual acts?" Any surveys that answered "no," were excluded from analysis.

Methods and measurements. Questionnaire content included basic demographics, items about type of exploitation experienced while being trafficked, medical ailments survivors suffered, and whether health care was desired and/or received. For those who visited a health care provider, the survey asked about the type of health care provider, whether providers asked what were referred to as "screening" questions that could help identify them as trafficking victims, whether they were correctly identified as being trafficked, and if they were offered assistance. Survey questions were developed based upon a previous qualitative study of 12 survivors' experiences in health care settings.[13] The questions were then revised via collaboration with advocates with direct experience working with victims and survivors, and survivor-advocates themselves. The screening questions were drafted based upon recommendations from the U.S. Department of Health and Human Services (DHHS)[17] and previous reports of human trafficking survivor experiences in health care settings.[13,18,19] The survey was designed in English. The Spanish and Haitian Creole versions were created using a translation-back translation-reconciliation process using native Spanish speakers and native Haitian Creole speakers.

Paper surveys were collected by recruiting organizations and mailed to the research team, where staff entered them into the SPSS database. Surveys completed via Survey-

Monkey were downloaded into Excel format, then imported into SPSS for analysis. Ten dollar gift cards were provided to organizations for distribution to participants; participants who completed the online survey had gift cards emailed or mailed to the postal address of their choosing. A team of trained research assistants and the principal investigator (MCS) coded the surveys and entered the data. When illegible data were encountered, they were coded as missing. Incongruous data were included in the crude analysis but noted; these data were not considered missing, as they may represent accurate reports from an as yet poorly understood population.

After receipt of the 22nd survey, the investigators reviewed feedback from participants and participating organizations about the survey and made the following adjustments: 1) Survey question language was changed from "forced work/worked the streets," to "made to work," and "in your situation"; 2) "Traditional healer/alternative healer" was added to the list of provider types visited and; 3) "I did not have my legal papers," and "I was less than 18 years old" were added to reasons a participant wanted to visit a health care provider but did not; 4) Finally, question 17, was changed to be question 1: "Are you a survivor of slavery, or were you made to work or made to do sexual acts?" All surveys were included in the analysis and the results from the first 22 surveys were not significantly different from those that followed.

Analysis. Data were analyzed using SPSS, version 20.[20] Outcomes of interest were explored based on gender, U.S. versus non-U.S. born, and exploitation types using chi square for categorical variables and t-test for continuous variables.

Results

Participant characteristics. A total of 173 participants who experienced U.S.-based human trafficking were surveyed. Forty-three percent (n = 75) of surveys were completed in paper form. Six percent (n=10) of respondents completed the survey in Spanish while all else completed the survey in English.

The cohort's characteristics are described and disaggregated by gender in Table 1 (one participant did not provide a gender identity) and by nativity (U.S. or foreign-born) in Table 2; birth countries are listed in Table 3. Participants reported experiencing trafficking in 38 states. Study investigators compared the online versus paper surveys to determine if these groups were different, as those who completed online surveys were not independently assessed for study eligibility. The mean age of escape for participants who completed paper surveys was 31 years compared with 26 for online respondents ($p < .001$). Online respondents were more likely to be male ($p < .001$), more educated ($p < .001$), and non-U.S. born ($p < .001$). However, there were no differences in any of the questions regarding use of health care, likelihood of disclosure or being offered assistance.

Stratification by gender and nativity. Compared with male respondents, a significantly greater proportion of female respondents were born in the United States (56%, n = 68 vs. 18%, n = 9; $p< .001$) and were trafficked as minors (44%, n = 53 vs. 10%, n = 5; $p<0.001$); compared with male respondents, a significantly smaller proportion of female respondents had completed at least a high school degree (66%, n = 80 vs. 92%, n = 47; $p <.001$). The mean age at which female participants were initially trafficked was significantly lower than for males (18 years vs. 23 years for males; $p < .001$).

Table 1.

PARTICIPANT CHARACTERISTICS (N = 173)

	All	Female (Total: 121)	Male (Total: 51)	p-value
US-Born	44.5% (n = 77)	56.2% (n = 68)	17.6% (n = 9)	< .001
Mean Age at Study Completion	34.3 yrs (SD 9.7)	34.1 yrs (SD 10.9)	34.8 yrs (SD 6.1)	.68
Mean Age First Trafficked	20 yrs (SD 7.2)	18.7 yrs (SD 7.6)	23.2 yrs (SD 5.4)	< .001
<18 Years When First Trafficked	34.3% (n = 58)	43.8% (n = 53)	9.8% (n = 5)	< .001
Mean Age of Escape	27.8 yrs (SD 8.1)	28.3 yrs (SD 9.1)	26.9 yrs (SD 4.8)	.31
At Least High School Education	73.4% (n = 127)	66.1% (n = 80)	92.2% (n = 47)	< .001
Wanted to See Doctor	73.4% (n = 127)	71.9% (n = 87)	78.4% (n = 40)	.59
Able to See Doctor	67.6% (n = 117)	70.2% (n = 85)	62.7% (n = 32)	.35
Talked with Doctor Being Trafficked	43.6% (n = 51)	22.3% (n = 27)	47.1% (n = 24)	< .001

Table 2.

PARTICIPANT CHARACTERISTICS WITH RESPECT TO BIRTH LOCATION

	US Born	Not US Born	p-value
Female Gender	88.5% (n = 69)	53.4% (n = 47)	< .001
Mean Age First Trafficked	16.5 yrs (SD 6.5)	23.3 yrs (SD 6.5)	< .001
<18 Years When First Trafficked	55.1% (n = 43)	13.6% (n = 12)	< .001
Mean Age of Escape	28.8 yrs (SD 10.1)	27.1 yrs (SD 5.9)	.22
At Least High School Education	69.2% (n = 54)	78.4% (n = 69)	.35
Wanted to See Doctor	67.9% (n = 53)	81.8% (n = 72)	.30
Able to See Doctor	62.8% (n = 49)	72.7% (n = 64)	.41
Talked with Doctor about Being Trafficked	14.1% (n = 11)	44.3% (n = 39)	< .001

Table 3.

PARTICIPANTS' BIRTH COUNTRIES[a]

Brazil	1.7% (n = 3)
China	10.4% (n = 18)
India	1.2% (n = 2)
Indonesia	1.7% (n = 3)
Japan	2.3% (n = 4)
Korea	2.3% (n = 4)
Lithuania	1.2% (n = 2)
Mexico	8.7% (n = 15)
Philippines	7% (n = 12)
Poland	1.2% (n = 2)
USA	44.5% (n = 77)
Vietnam	2.9% (n = 5)

[a]One respondent from each of the following countries: Angola, Argentina, Bolivia, Czech Republic, Ethiopia, Ghana, Indonesia, Italy, Jamaica, Malawi, Malaysia, Morocco, Netherlands, Russia, Senegal, Thailand, Trinidad, Ukraine, Zimbabwe.

Though all respondents were trafficked within the U.S., participants' characteristics varied significantly by nativity. Compared with foreign born survivors, a significantly greater proportion of U.S. born survivors were female (89%, n = 69 vs. 53%, n = 47 p<.001) and were trafficked as minors (55%, n = 43 vs. 14% n = 12; p<.001). U.S. born survivors also had a significantly lower mean age of initial trafficking (16 years vs. 23 years; p<.001).

Table 4 shows the types of trafficking experienced; participants may have endured more than one type of trafficking. The majority of participants underwent trafficking for sex work (56%, n=96); this includes escort service, stripping, prostitution, pornography,

Table 4.

TRAFFICKING TYPES PARTICIPANTS EXPERIENCED[a] (N = 173)

	All	Female (n = 121)	Male (n = 51)	p-value
Sex Work (sex work, escort service, prostitution, stripping, pornography)	55.5% (n = 96)	76.9% (n = 93)	3.9% (n = 2)	< .001
Service Industry (massage parlor, nail salon, restaurant work)	27.2% (n = 47)	20.7% (n = 25)	43.1% (n = 22)	.01
Domestic Work (child care, nanny, housekeeper, elder care, hotel/motel housekeeping)	21.4% (n = 37)	24% (n = 29)	13.7% (n = 7)	.18
Outdoor Labor (agricultural work, construction, forestry)	11.6% (n = 20)	3.3% (n = 4)	31.4% (n = 16)	< .001
Factory Work	9.8% (n = 17)	3.3% (n = 4)	25.5% (n = 13)	< .001
Begging/Peddling	5.8% (n = 10)	5% (n = 6)	7.8% (n = 4)	.48
Mail-Order "Bride"	3.5% (n = 6)	2.5% (n = 3)	5.9% (n = 3)	.28

[a]Some respondents experienced more than one type of trafficking.

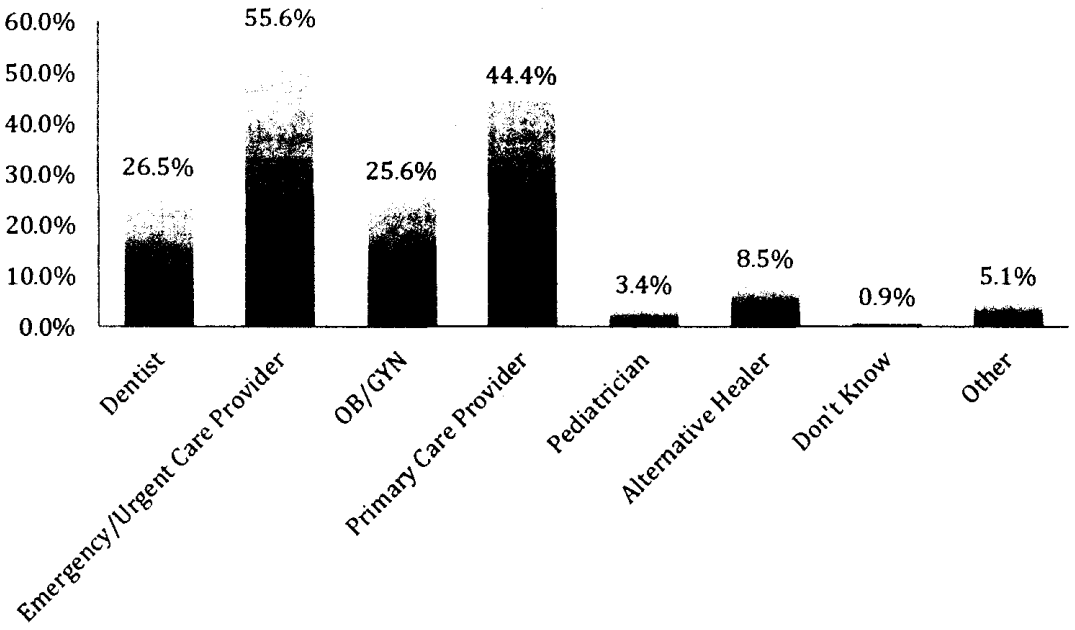

Figure 1. Provider types that victims of human trafficking visited.[a]
[a]Some participants saw more than one provider type while being trafficked.

and undefined sex work. Only 12% (n=20) reported experiencing trafficking for outdoor work. This category consisted of participants who performed agricultural work, construction, and forestry.

Health care interactions. The majority (73%, n=127) of respondents reported wanting to see a health care provider and 68% (n=117) were actually able to see a provider. Among the 51 who could not see a provider, the three most common reasons were: inability to pay (37%, n = 19), fear of seeing a provider (35%, n = 18), and being prevented from seeing a provider by someone (31%, n = 16); respondents could choose multiple reasons for not seeing a provider. Gender and birth location showed no correlation with whether participants wanted or were able to see a provider. Those born outside the U.S. and males were identified as being trafficked more often than those born in the U.S. or females (both $p < .001$). Types of providers seen are illustrated in Figure 1, with emergency medicine/urgent care (56%, n = 65) and primary care (44%, n = 52) being the most common encounters. Some participants saw more than one type of provider during their trafficking time. The most common health problems experienced by participants while being trafficked included suffering physical abuse (66%, n = 113), self-diagnosed depression (65%, n = 112), headache (45%, n = 78), and back pain (42%, n = 72). Other common problems reported were weight loss, menstruation problems, and nausea/vomiting.

Screening at health care visits. Table 5 compares screening topic frequency between those identified and those not identified as being trafficked. Here, investigators examined whether, of the two trafficked patient groups—those identified by their provider(s) as being trafficked and those not identified—one group was more frequently asked particular questions. Respondents who were identified by providers reported a statistically higher frequency of being asked about six of the eight expert-recommended screening

Table 5.

THOSE WHO SAW A PROVIDER THAT WERE ASKED A SCREENING QUESTION

Question Topic[a]	Identified (n=51)	Not Identified (n = 66)	p-value
Asked about his/her living situation (Vera TVIT items 5a-b; 5d,f; 5p,q)	60.8% (n = 31)	34.8% (n = 23)	.02
Asked about his/her work (Vera TVIT items 5b-e; 5h-k; 5p,q)	84.3% (n = 43)	39.4% (n = 26)	< .001
Asked if anyone was hurting him/her (Vera TVIT items 5k-m)	56.9% (n = 29)	34.8% (n = 23)	.03
Asked about having ID taken away (Vera TVIT item 5f)	47.1% (n =24)	27.3% (n = 18)	.04
Asked if s/he owes employer money (Vera TVIT item 3g,h; 5o)	52.9% (n = 27)	16.7% (n = 11)	< .001
Asked if s/he felt safe at home (Vera TVIT items 5d,e; 5i,j)	45.1% (n = 23)	27.3% (n = 18)	.07
Asked if s/he was forced to perform sexual acts against her/his will (Vera TVIT items 5l-n)	51% (n = 26)	31.8% (n = 21)	.03
Asked about sexual partners (Vera TVIT items 5l,n)	51% (n = 26)	45.5% (n = 30)	.77

[a]The Vera Institute developed a validated, 32-point Trafficking Victim Identification Tool (TVIT). Investigators have included how our study questions relate to the TVIT screening questions.

topics. Two screening topics were asked of a significant majority of patients identified as being trafficked: 61% (n = 31) were asked about their living situation and 84% (n = 43) were asked about their work (see Table 5). Of those who spoke to a health care provider about their situation, 72% (n=36) reported being offered information on how to escape.

Discussion

The primary objectives were to determine whether substantial numbers of victims seek or receive health care while being trafficked; to which type of health care providers victims of trafficking are presenting; and if they are being identified as trafficking victims. The results indicated that most (68%, n=117) of those trafficked presented to a health care provider at least once. Providers most likely to see this patient population were emergency and urgent care practitioners (56%), followed by primary care providers, dentists, and OB/GYNs (see Figure 1). While trafficked patients are not being consis-

tently identified, this study's results suggest that certain screening question topics may improve victim identification.

Investigators note that a larger proportion of male and foreign born participants reported talking with their health care practitioner about being trafficked than females and those born in the U.S. Perceptions about who is trafficked usually bias toward the assumption that only women and girls experience human trafficking.[14,21] Because it is outside of the expected norm, when a male is found to have a risk factor for exploitation perhaps providers are more apt to further inquire and subsequently identify trafficking. Also, nearly twice as many males as females participating in the survey were foreign-born, and it is possible that providers are more inclined to consider trafficking when a foreign-born patient presents. More research is needed to ascertain if patient characteristics are associated with being identified by a health care provider.

Study investigators queried survivors about expert-recommended screening questions they had been asked during health care visits in order to determine if providers are using these assessment tools to identify vulnerable patients. The screening questions that providers may have asked were based upon expert opinion and DHHS recommendations because, as yet, there is no evidence-base to support which questions or which combination of questions is best for victim identification in a health care setting. Nearly 90% (n = 105) of victims who sought health care reported that providers asked them at least one question that experts consider an introductory screening question for identifying human trafficking. Among participants who were identified as human trafficking victims by health care providers, large majorities reported that medical personnel asked them about their living situation and their work. These data suggest that these questions assessing patients' social histories may play an important role in victim identification in health care settings.

After this study, in June 2014, the Vera Institute of Justice shared validated 32- and 16-point screening tools that are intended for use by victim service agency staff and other social service providers. These tools were *not* designed for health care professionals and a significantly shorter instrument would be required to make either practical for use in health care settings.[22] Still, a variation of each of this study's screening questions is contained in the Vera Institute's Trafficking Victim Identification Tool (see Table 5). Because this study did not investigate which screening questions were asked at individual health care visits, investigators cannot assess the performance of various screening topics in identifying trafficking victims, nor can the validity and reliability of these screening questions' use in a health care setting be assessed. Further research could illuminate the efficacy of a short-form version of the Vera tool for use in medical settings. In addition, future studies should assess other factors that may affect victim disclosure to health care practitioners, such as the sensitivity with which providers ask questions, and use of trauma-informed approaches to service delivery.

Though a large percentage of respondents reported being recognized as trafficked, providers missed an opportunity for a life-changing intervention with more than half (56%, n = 66) of the surveyed trafficking victims who presented as patients. From this study, it is not possible to determine if providers failed to identify trafficking victims because patients were not ready or able to disclose their status, or whether they were

not asked questions to aid in identification. Due to the small sample size of the study and because participants were not asked to report about each provider encounter separately, it is not possible to determine which particular pattern of screening questions is best for identifying trafficked people when they present clinically.

The medical conditions reported by these participants were similar to complaints and prevalences that have been reported in previous studies of women who have been sex trafficked.[23–26] It is challenging for a medical practitioner to assess risk for trafficking based on such clinical complaints, as they are common in many patient populations and do not indicate that a patient is being trafficked. Further documentation of presenting complaints of trafficking victims and of other accompanying "red flags" would help providers identify this patient population more consistently and efficiently. This study demonstrates that because there is no validated screening tool for this population in the health care setting but providers are seeing this patient population, the training of providers about known indicators of human trafficking is particularly important.

Though the largest of its kind to date, this survey sample is small in comparison with the tens of thousands[4] who are trafficked within U.S. borders and is not necessarily representative of all those who are trafficked in the U.S. Organizations that had poorly functioning webpages or inaccurate email contacts could not be reached, limiting recruitment to organizations that were well established and had relatively good technologic support. Generalizability is also limited as not all survivors have access to the Internet or an advocacy organization, and not all victims leave their trafficking situations. Many victims never connect with organizations that provide services and many may not even recognize themselves as victims or survivors of human trafficking. Further, as with any retrospective study, this one is subject to recall bias: Survivors may not correctly remember all health care visits, types of providers seen, screening questions asked, and so forth. The $10 gift card available to those who completed the survey may have encouraged non-survivors to participate. Online surveys were completed by those who self-identified as having been trafficked; no advocate or human trafficking expert vetted these participants, however, most participants were recruited through trafficking survivor-advocates and anti-trafficking organizations.

Importantly, this is a written survey. For participants recruited via anti-trafficking organizations, some were able to complete the survey with the assistance of an advocate but most organizations found the time required to include the poorly literate prohibitive. Conclusions drawn from this survey must be carefully applied to the generally trafficked population in the U.S., as not all are as literate as this study population. Though investigators offered organizations the opportunity to have the survey translated into additional languages, investigators only received surveys completed in Spanish and English. Only Haitian Creole was requested, though no surveys in this language were received. This limits any generalization of the results beyond those who read Spanish or English.

In summary, these findings indicate that human trafficking victims are commonly presenting to emergency and primary care providers, as well as dentists, OB/GYNs, healers alternative to Western traditions, and other provider types, but are not being consistently identified. When they are identified, they report frequently being offered information on how to escape the exploiting situation. This suggests a need for sys-

tematic training of health care providers in these specialties to improve their ability to identify and appropriately treat this patient population.

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