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Preparedness to Identify and Care for Trafficked Persons in South Carolina Hospitals: A State-Wide Exploration

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Medical University of South Carolina

Preparedness to Identify and Care for Trafficked Persons in South Carolina Hospitals: A State-Wide Exploration

Stephanie C. Armstrong

A dissertation submitted to the faculty of the Medical University of South Carolina in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the College of Nursing.

June 2018

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The Common Ground Preparedness Framework: A Comprehensive Description of Public Health Emergency Preparedness
P. Joseph Gibson, PhD, MPH
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"The Common Ground Preparedness Framework: A Comprehensive Description of Public Health Emergency Preparedness"
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My passion to help trafficked persons grew from experiences where human trafficking touched my life, without my awareness, at those times. I thank God for those moments, as they have stimulated a deep passion to help this vulnerable population. I will always be grateful to my friend Ellen, who knew something was "fishy" with a situation that occurred when I was a young adult. Her wisdom and actions prevented me from falling

into what I am now certain would have been a trafficking scenario. Because of her, I am able to give to others today.

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Abstract

Human trafficking is a growing crime impacting many victims from vulnerable populations. Due to the trauma and abuse endured, most victims are seen by a healthcare professional while still being trafficked. The majority of healthcare professionals and hospitals are not prepared to identify and care for trafficking victims, resulting in sub-optimal care and missed opportunities for intervention and assistance. The prepare section of the Common Ground Preparedness Framework was utilized to underpin this research; three separate studies were completed to gain empirical data related to preparedness. The first study examined screening instruments to identify commercially sexually exploited children and evaluated their feasibility for use in the emergency department. Findings included two instruments recommended for that setting. The second study synthesized empirical data collected from trafficking survivors, offering best practices for healthcare professionals and hospitals to use. Findings included behaviors that were modifiable by healthcare professionals; many found within trauma-informed, rights-based approaches to care. The third study used purposive sampling to identify South Carolina hospitals with known trafficking in their area. Emergency department directors/managers were interviewed to understand how prepared facilities were to identify and care for trafficked persons. Findings indicated that all hospitals were under-prepared; none had a response policy/protocol, one had provided training, and safety issues surrounding care of this population were largely unrecognized. Study findings give key stakeholders a better understanding of the steps that must be taken to ensure trafficking victims are recognized and provided with optimal care in hospital settings.

Keywords: screening, treatment, victims, human trafficking, healthcare

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Introduction

Human trafficking, the exploitation of a person for commercial sex or forced labor through the use of force, fraud, of coercion, is a growing public health issue.(1, 2) Although exact numbers are difficult to confirm because of the hidden nature of trafficking, recent data indicates that worldwide, approximately 40.3 million people are being affected and that revenues generated by this crime exceed US$150 billion dollars, annually.(3, 4)

There is tremendous variation in those who experience human trafficking(5, 6); however, many victims represent vulnerable, marginalized populations.(7) Factors that place individuals at higher risk for trafficking include family poverty or dysfunction,(5, 8-10) history of sexual abuse,(8, 9, 11) runaway or homeless status,(12) and lesbian, gay, bisexual, transgender, questioning and intersex (LGBTQI) individuals.(12-15) Individuals with a history of interaction with the juvenile justice or child protection systems are also at increased risk,(5, 10, 12) as are those with substance abuse issues,(9-11, 16) physical or intellectual disability,(7, 12) gang membership,(9) American Indian or Alaskan Native heritage, limited English proficiency, and those in migrant or domestic work.(12)

Human trafficking has begun receiving more publicity recently. This has resulted in the initiation of research and legislative changes; however, even with these improvements, the measures that exist to address the issue today bring to mind domestic violence in the early 1970's. Because there are many areas where human trafficking and domestic violence intersect,(17) a great deal can be learned about how to assist

trafficking victims through what was done to care for victims of domestic violence. Anti-domestic violence advocates documented actions taken to establish a hospital response program for battered women in the late 1970's; it included the creation of a multidisciplinary team of interested individuals, a literature review on the issue, identification of community service providers and establishment of relationships with them, development of a response protocol, creation of a 24-hour trauma unit, provision of educational offerings, legislative work and the development of a documentation system.(18) Many of these same steps are being recommended by experts in the anti-trafficking field today.(19, 20)

The importance of addressing the issue of human trafficking is clearly evident for those who are being directly impacted through exploitation as they face a plethora of physical and psychological health consequences as a result of the ongoing trauma, abuse, and neglect they endure.(21-23) Unprotected sex and gang rapes frequently lead to sexually transmitted infections and unwanted pregnancies,(6, 22, 24) while deplorable work and/or living conditions can result in physical injuries and communicable diseases such as tuberculosis, hepatitis, parasites, and other infections. Victims may also experience cardiac and respiratory issues, gastrointestinal symptoms, dermatologic issues, dental neglect, poor nutrition, starvation, dehydration, anxiety, depression, post-traumatic stress disorder (PTSD), and suicidality as a result of their exploitation.(5-7, 24-28)

As a result of the numerous health conditions victims experience, many will eventually seek health care. Recent survivor studies indicate that between 50%-88% of

trafficking victims receive care while they are still being trafficked,(22, 29, 30) with the majority being seen in hospital emergency departments.(22, 31) These hospital visits provide a unique opportunity for trafficked persons to be identified and offered assistance; however, this can only occur if hospitals and healthcare professionals (HCPs) are adequately prepared to respond to trafficking victims.

Three of the essential components of preparedness, based upon the lessons learned from domestic violence victims and current recommendations of experts in the anti-trafficking field, include utilization of screening measures, the training of HCPs and development and implementation of response protocols.(18, 19)

Gaps in Knowledge

Currently, there are a growing number of instruments available to screen for human trafficking victims; however, none of them have been validated in a healthcare setting.(19) The Vera Institute of Justice (2014) offers a validated instrument available in a long and short version; however, even the short version contains 20 questions with additional follow-up questions for many items, making it impractical for use in the fast-paced emergency department setting.

While resources to educate healthcare professionals about the identification and care of trafficking victims are increasing, the majority have not been evaluated and none address behavior change outcomes.(21) Empirical data is needed to understand what elements must be included in the training of HCPs to influence behavior change, provide optimal care, and impact victim outcomes.(32) The need for empirical data to ensure that

responses to victims improve outcomes is part of the Public Health Research Priorities to Address U.S. Human Trafficking.(2)

There currently is a paucity of research examining any aspect of human trafficking protocols. Of the 5,686 hospitals in the U.S., the number with policies or protocols is unknown.(33) In the only identified study of its kind, Stoklosa et al.(34) relayed the experiences of HCPs who had been involved in the implementation and use of a response protocol over the course of two years. Unanimously, the protocol was deemed to be beneficial, helping to facilitate identification, treatment, and referral of victims.(34) Additional studies on protocol use and implementation are needed.

To take steps toward "promoting and protecting the health of people,"(35) this study will utilize the prepare category of the Common Ground Preparedness Framework (CGPF),(36) described below, to define preparedness, and then address gaps in the science through three separate studies assessing various components of hospital preparedness to identify and care for trafficked persons.

Manuscripts

The first manuscript is an integrative review that examined current available screening instruments to identify children that have been trafficked for sex. Instruments were compared and characteristics, including number of questions, scoring system, intended demographics, and information sources, were examined to assess for their feasibility of use in an emergency department setting.

The second manuscript contains the results of a systematic review of studies. Data in the studies were collected directly from human trafficking survivors and covered the

health consequences of trafficking, or survivors' interactions with or recommendations for the health care system. The aim of this study was to gather empirical data from survivors' insights to provide HCPs with best practices for the identification and care of trafficked persons.

The third manuscript presents a qualitative descriptive study that obtained baseline data on how prepared South Carolina (S.C.) hospitals were to identify and care for trafficked persons. This study used purposive sampling to identify hospitals in geographic areas where human trafficking indicators had been reported to the National Human Trafficking Hotline during the calendar year of 2016. Telephone interviews were conducted with emergency department directors/managers from participating hospitals. The CGPF was utilized to guide data collection, analysis, and interpretation of study results.

Theoretical Framework

The Common Ground Preparedness Framework, developed by the Public Health Informatics Institute,(36) was used to underpin this dissertation. The framework was initially developed to help public health agencies prepare for and respond to public health emergencies. It was selected for this study due to its comprehensive ability to address all aspects of preparedness. It has been used by public health systems in response to the nH1N1 pandemic but can also be used for ordinary public health threats as well.(36) The framework uses simple terminology that is easily understood by most in the healthcare field and contains six interdependent categories, including: prepare, monitor, investigate, intervene, manage, and recover. For the purposes of this study, the prepare category of

the framework was utilized to guide the development of interview questions, data collection, analysis, and interpretation.(36)

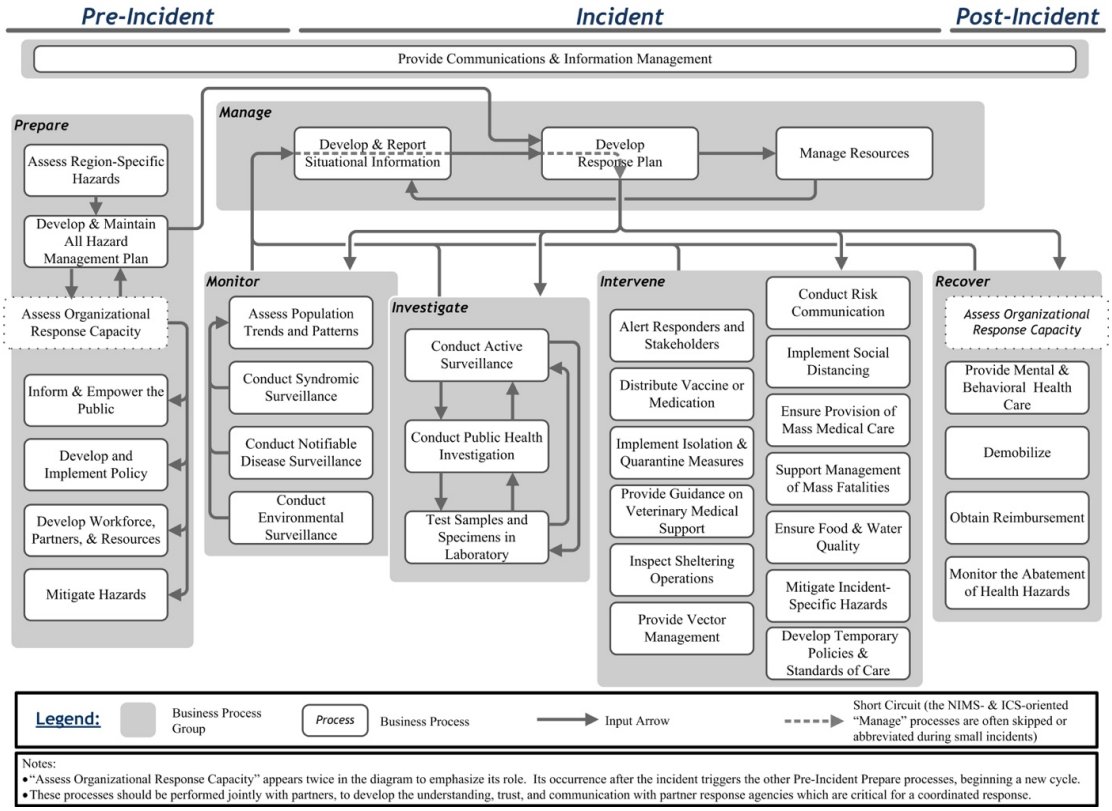

Figure 1. The Common Ground Preparedness Framework. Reprinted from "The Common Ground Preparedness Framework: A comprehensive description of public health emergency preparedness" by P.J. Gibson, F. Theodore, & J.B. Jellison, 2012, American Journal of Public Health, 102(4), 633-642. Copyright 2012 by the American Public Health Association. Reprinted with permission.

The prepare category is comprised of sub-categories which include: 1) region-specific hazards, 2) develop and maintain all hazard management plan, and 3) assess organizational response capacity. Assess organizational response capacity includes: a) inform and empower the public, b) develop and implement policy, c) develop workforce partners and resources, and d) mitigate hazards. Additionally, the five other categories of the framework (monitor, investigate, intervene, manage, and recover) are well-suited to

guide future research in this area and could serve as the scaffolding for the development of a robust framework adapted specifically to human trafficking.

Key Concepts/Terms

Preparedness: For the purposes of this study, the concept of preparedness is defined by the prepare category of the Common Ground Preparedness Framework. This includes its sub-categories: 1) assess region-specific hazards, 2) develop and maintain all hazard management plan, and 3) assess organizational response capacity, including: a) inform and empower the public, b) develop and implement policy, c) develop workforce partners and resources, and d) mitigate hazards.(37)

Human trafficking: Human trafficking includes sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.(1)

Victim/Patient: An individual who is experiencing trafficking.

Survivor: A person who is no longer experiencing trafficking.

Trafficker/Exploiter/Pimp: An individual who is exploiting another person.

John/Buyer: A person who purchases sexual services.

References

1. Trafficking Victims Protection Act of 2000, (2000).
2. Rothman EF, Stoklosa H, Baldwin SB, Chisolm-Straker M, Kato Price R, Atkinson HG, et al. Public Health Research Priorities to Address US Human Trafficking. Am J Public Health. 2017;107(7):1045-7.
3. Foundation ILOaWF. Global estimates of modern slavery: Forced labour and forced marriage. Geneva; 2017. Contract No.: ISBN 978-92-2-130130-5.
4. Organization IL. Profits and poverty: The economics of forced labour. Geneva; 2014.
5. Choi KR. Risk factors for domestic minor sex trafficking in the United States: a literature review. Journal of forensic nursing. 2015;11(2):66-76.
6. Hom KA, Woods SJ. Trauma and its Aftermath for Commercially Sexually Exploited Women as Told by Front-Line Service Providers. Issues in Mental Health Nursing. 2013;34(2):75-81.
7. Chisolm-Straker M, Stoklosa, H. . Human Trafficking is a Public Health Issue: A Paradigm Expansion in the United States.2017.
8. Macias Konstantopoulos W, Ahn, Roy, Alpert, Elaine J., Cafferty, Elizabeth, McGahan, Anita, Williams, Timothy P., Castor, Judith Palmer, Wolferstan, Nadya, Purcell, Genevieve, & Burke, Thomas F. An International Comparative Public Health Analysis of Sex Trafficking of Women and Girls in Eight Cities: Achieving a More Effective Health Sector Response. Journal of Urban Health : Bulletin of the New York Academy of Medicine. 2013;90(6):1194-204.
9. Estes RJ, Weiner NA. The commercial sexual exploitation of children in the US, Canada and Mexico: University of Pennsylvania, School of Social Work, Center for the Study of Youth Policy; 2001.
10. Varma S, Gillespie, S., McCracken, C., Greenbaum, V. J. Characteristics of child commercial sexual exploitation and sex trafficking victims presenting for medical care in the United States. Child Abuse & Neglect. 2015;44:98-105.
11. Clayton EW, Krugman, R.D., and Simon, P. Confronting commercial sexual exploitation and sex trafficking of minors in the United States. Washington, D.C.: The National Academies Press; 2013.
12. State USDo. Trafficking in Persons Report: June 2016. U.S. Department of State, Office of the Under Secretary for Civilian Security D, and Human Rights; 2016.
13. Holger-Ambrose B, Langmade C, Edinburgh LD, Saewyc E. The illusions and juxtapositions of commercial sexual exploitation among youth: Identifying effective street-outreach strategies. J Child Sex Abuse. 2013;22(3):326-40.
14. Reid JA. Exploratory review of route-specific, gendered, and age-graded dynamics of exploitation: Applying life course theory to victimization in sex trafficking in North America. Aggression Violent Behav. 2012;17(3):257-71.

15. Clarke RJ, Clarke EA, Roe-Sepowitz D, Fey R. Age at Entry into Prostitution: Relationship to Drug Use, Race, Suicide, Education Level, Childhood Abuse, and Family Experiences. J Hum Behav Soc Environ. 2012;22(3):270-89.
16. Gibbons P, Stoklosa H. Identification and Treatment of Human Trafficking Victims in the Emergency Department: A Case Report. J Emerg Med. 2016.
17. Violence APIoG-B. Intersections of human trafficking, domestic violence, and sexual assault 2016 [Available from: http://www.api-gbv.org/files/IntersectionsOfHumanTraffickingDomesticViolenceSexualAssault_API-GBV_2016.pdf.
18. McGrath PE, Schultz, P. S., Culhane, P. O., Franklin, D. B. The development and implementation of a hospital protocol for the identification and treatment of battered women. Rockville: National Clearinghouse on Domestic Violence; 1980.
19. Baldwin S, Barrows, J., Stoklosa, H. Protocol toolkit for developing a response to victims of human trafficking in health care settings 2017 [Available from: https://healtrafficking.org/linkagesresources/protocol-toolkit/.
20. Miller CL, Sartor, D. i:CARE - A health care provider's guide to recognizing and caring for domestic minor sex trafficking victims. Winston NS, E., editor. Vancouver: Shared Hope International; 2016.
21. Ahn R, Alpert EJ, Purcell G, Macias -Konstantopoulos W, McGahan A, Cafferty E, et al. Human trafficking: review of educational resources for health professionals. Am J Prev Med. 2013;44(3):283-9.
22. Lederer LJW, Christopher A. The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities. Annals of Health Law. 2014;23(1):61-91.
23. Muraya DN, Fry D. Aftercare Services for Child Victims of Sex Trafficking: A Systematic Review of Policy and Practice. Trauma, Violence, & Abuse. 2016;17(2):204-20.
24. Dovydaitis T. Human trafficking: the role of the health care provider. J Midwifery Womens Health. 2010;55(5):462-7.
25. Greenbaum VJ. Commercial sexual exploitation and sex trafficking of children in the United States. Curr Probl Pediatr Adolesc Health Care. 2014;44(9):245-69.
26. Macias-Konstantopoulos WL, Munroe, Deanne, Purcell, Genevieve, Tester, Kristina, Burke, Thomas F., and Ahn, Roy. The Commercial Sexual Exploitation and Sex Trafficking of Minors in the Boston Metropolitan Area: Experiences and Challenges Faced by Front-Line Providers and Other Stakeholders. Journal of Applied Research on Children: Informaing Policy for Children at Risk. 2015;6(1).
27. Powell CL, Bennouna, C. Sex Trafficking in the USA. Human trafficking is a public health issue: A paradigm expansion in the United States. Châm: Springer International Publishing; 2017.

28. Shandro J, Chisolm-Straker M, Duber HC, Findlay SL, Munoz J, Schmitz G, et al. Human Trafficking: A Guide to Identification and Approach for the Emergency Physician. Ann Emerg Med. 2016;68(4):501-8 e1.
29. Baldwin SB, Eisenman, David P., Sayles, Jennifer N., Ryan, Gery, & Chuang, Kenneth S. Identification of Human Trafficking Victims in Health Care Settings. Health Hum Rights. 2011;13(1):36-49.
30. Lumpkin CL, Taboada, A. Identification and referral for human trafficking in health care settings: Survey report 2017 [Available from: http://www.castla.org/assets/files/Identification_and_Referral_in_Health_Care_Settings_survey_report_2017.pdf.
31. Chisolm-Straker M, Baldwin S, Gaigbe-Togbe B, Ndukwe N, Johnson PN, Richardson LD. Health Care and Human Trafficking: We are Seeing the Unseen. J Health Care Poor Underserved. 2016;27(3):1220-33.
32. Powell C, Dickins K, Stoklosa H. Training US health care professionals on human trafficking: where do we go from here? Med Educ Online. 2017;22(1):1267980.
33. Stoklosa H, Dawson, M.B., Williams-Oni, F., & Rothman, E. A review of U.S. healthcare institution protocols for the identification and treatment of victims of human trafficking. Journal of Human Trafficking. 2016;3(2):116-24.
34. Stoklosa H, Showalter, E., Melnick, A., and Rothman, E. Healthcare providers' experience with a protocol for the identification, treatment, and referral of human trafficking victims. Journal of Human Trafficking. 2016;3(3):182-92.
35. Association APH. What is public health 2017 [Available from: https://www.apha.org/what-is-public-health.
36. Gibson PJ, Theadore F, Jellison JB. The common ground preparedness framework: a comprehensive description of public health emergency preparedness. Am J Public Health. 2012;102(4):633-42.

Manuscript 1

Armstrong, S. (2017). Instruments to identify commercially sexually exploited children: Feasibility of use in an emergency department setting. *Pediatric Emergency Care*, 33, 794-799, Available at: https://journals.lww.com/pec-online/pages/default.aspx

REVIEW ARTICLE

Instruments to Identify Commercially Sexually Exploited Children

Feasibility of Use in an Emergency Department Setting

Stephanie Armstrong, MSN, RN

Objective: This review examines the screening instruments that are in existence today to identify commercially sexually exploited children. The instruments are compared and evaluated for their feasibility of use in an emergency department setting.

Methods: Four electronic databases were searched to identify screening instruments that assessed solely for commercial sexual exploitation. Search terms included "commercially sexually exploited children," "CSEC," "domestic minor sex trafficking," "DMST," "juvenile sex trafficking," and "JST." Those terms were then searched in combination with each of the following: "tools," "instruments," "screening," "policies," "procedures," "data collection," "evidence," and "validity."

Results: Six screening instruments were found to meet the inclusion criteria. Variation among instruments included number of questions, ease of administration, information sources, scoring methods, and training information provided. Two instruments were determined to be highly feasible for use in the emergency department setting, those being the Asian Health Services and Banteay Srei's CSEC Screening Protocol and Greenbaum et al's CSEC/child sex trafficking 6-item screening tool.

Conclusions: A current dearth of screening instruments was confirmed. It is recommended that additional screening instruments be created to include developmentally appropriate instruments for preadolescent children. Numerous positive features were identified within the instruments in this review and are suggested for use in future screening instruments, including succinctness, a simple format, easy administration, training materials, sample questions, multiple information sources, designation of questions requiring mandatory reporting, a straightforward scoring system, and an algorithm format.

Key Words: commercially sexually exploited, CSEC, screening, instrument, identification

(*Pediatr Emer Care* 2017;33: 794–799)

The United States is considered one of the world's top destination countries for victims of child trafficking and exploitation. It is also a "source and transit" country where human trafficking has been reported in all 50 states.[1] Children of all genders, races, and nationalities and every socioeconomic status have been victimized.[2–4]

According to the Office of Juvenile Justice and Delinquency Prevention, "commercial sexual exploitation of children (CSEC) involves crimes of a sexual nature committed against juvenile victims for financial or other economic reasons."[5] Although the precise number of commercial sexual exploitation of children (CSEC) victims in the United States is unknown, it is estimated that approximately 200,000 children are victimized each year in the United States alone.[6] This number continues to grow, as indicated by a 610% increase in the number of sexually exploited children rescued during the FBI's annual Operation Cross Country event, since it began 9 years ago.[7]

Although there are a great number of ways that children can become victims of CSE, most victimization begins in the home environment by family or friends who exploit the child for monetary gain.[8] Evidence shows that these children suffer tremendously and face numerous physical and psychological health challenges as a result of the abuse they endure.[9–11] Because of injuries they incur, as many as 88% (n = 98) of sex trafficking victims are seen by a health care provider while still being trafficked.[10] Thus, health care providers are in a unique position to assist victims and provide them with an opportunity for safety and support services. This can only be accomplished if providers are able to recognize the signs and symptoms of CSE and identify victims through the use of CSEC screening instruments. Because most victims receive care through a hospital emergency department (ED) (63.3%),[10] this integrative review will examine the CSEC screening instruments that are in existence today and evaluate the feasibility of their use in an ED setting.

METHODS

Four electronic databases (PubMed, CINAHL, Scopus, and EBSCOhost) were searched between January 6 and February 14, 2016, to identify relevant screening instruments. The literature searches and consequent study selections were completed using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses method.[12] Search terms included "commercially sexually exploited children," "CSEC," "domestic minor sex trafficking," "DMST," "juvenile sex trafficking," and "JST." Those terms were then searched in combination with each of the following keywords: "tools," "instruments," "screening," "policies," "procedures," "data collection," "evidence," and "validity." No limitations were placed on the year of search.

Inclusion criteria consisted of any instrument that screened only for sexual exploitation or CSE of children aged 18 or younger and could be used in a health care facility. Exclusion criteria consisted of any instrument that included screening for labor trafficking or adults or was designed for primary use within juvenile justice/law enforcement systems.

In total, the databases provided 1436 articles; after screening titles, 1296 were removed because they were unrelated to the topic at hand. Of the remaining 140 records, 69 duplications were removed, and an additional 5 articles were located by bibliographic searches and hand searching of key journals. After the initial screening, titles and abstracts were closely reviewed for the remaining 76 studies. Through this process, another 52 articles were eliminated for failure to meet the inclusion criteria. The final 24 articles were reviewed in full text, after which another

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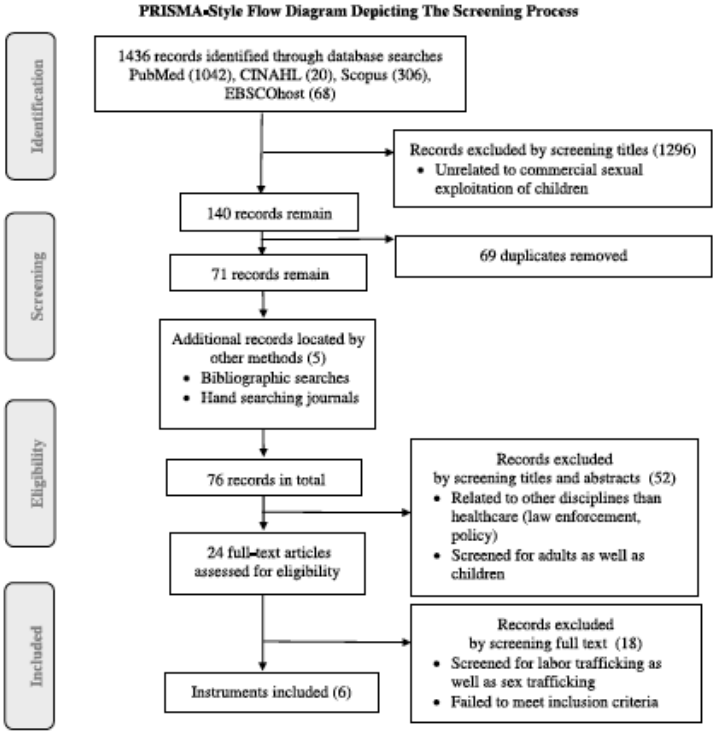

FIGURE 1. Flow diagram with a preferred reporting items for systematic reviews and meta-analyses style depicting the screening process.

18 instruments were eliminated for failure to meet the inclusion criteria, resulting in 6 instruments eligible for review (Fig. 1).

RESULTS

Six instruments met the inclusion criteria. Table 1 summarizes the name of the instrument, the individual(s) or organization that created it, the year it was developed, the number of items/questions, the scoring methods, target demographics, information sources, and whether any training information was included. Table 2 summarizes the validity and reliability of measurements, as well as the level of evidence based on the *Oxford Centre for Evidence-based Medicine—Levels of Evidence, March 2009*.[19] Table 2 also includes ratings of the instruments' strengths, weaknesses, and feasibility for use in an ED setting. Validity, reliability, and level of evidence are indicated within the Results section. Feasibility, strengths, and weaknesses are addressed in the Discussion section because these results are the opinion of this author.

All of the instruments were developed within the last 6 years; most (5) were created by health care providers or organizations on the West Coast of the United States.[13–17] The 1 remaining instrument was developed by health care providers in Atlanta, Georgia.[18] There were differences found across multiple features of the instruments.

The number of questions fluctuated greatly, ranging from 1 instrument with a 6-item questionnaire[18] to another instrument that included 97 questions between 2 tiers of screening levels.[14] Variety among the scoring methods also occurred, ranging from simply confirming 2 items within a list of high-risk questions or indicators[15,18] to mathematical calculations based on different point allocations for various answers.[13,16]

Because of the definition of CSEC, the demographic for all 6 instruments was children 18 years and younger; however, 2 instruments also designated use for specific age groups. The Asian Health Services and Banteay Srei's CSEC Screening Protocol[15] specified use for children aged 11 to 18 years, and the Sexually Exploited Children Screening Protocol[17] assigned high-risk questions only to children aged 10 to 18 years. The rationale for these distinctions was not provided with either instrument.

The 6 instruments also varied greatly regarding the source of patient information. Only 1 instrument relied solely upon self-reporting—the Intervene Tool by Shared Hope International.[14] The other instruments offered more flexibility with their data collection, ranging from health care provider observation to medical record review, and the reporting of information by self or others.[13,15–18]

Five of the 6 instruments included some training information; however, the amount and format varied considerably.[13–17] The Asian Health Services and Banteay Srei's CSEC Screening Protocol[15] offered 2 examples of leading questions for health care providers to initiate a conversation about survival sex. Similarly, the San Luis Obispo CSEC Screening Tool[16] also provided sample questions; however, they did so for all 22 questions within their instrument. The Commercial Sexual Exploitation Identification Tool (CSE-IT)[13] included a "Possible Action Checklist" within their instrument and provided training on the tool for all users at sites where pilot testing is currently occurring (D. Basson, personal

TABLE 1. Description of Screening Instruments

Reference No.	Instrument/Tool	Source	Year	No. Items/ Questions	Scoring	Demographics	Information Source(s)	Training Info Included
13	CSE-IT	West Coast Children's Clinic	2014	•48 items within 10 opic areas	•0-2 points per question Scores are totaled for overall risk appraisal	Minors, age ≤ 18 y	•Observation •Medical record review •Other	Yes •Training provided for users at pilot testing sites
14	Intervene	Shared Hope International	2010, revised 2013	•Tier 1: 42 questions •Tier 2: 55 questions	•No scoring	Minors, age ≤ 18 y	•Self-reporting	Yes •Extensive resource package
15	Asian Health Services and Banteay Srei's CSEC Screening Protocol	Asian Health Services and Banteay Srei	2012	•10-item, high-risk indicator checklist	•Positive screen is a child affirming/ exhibiting two or more of the high-risk indicators	Minors, aged 11–18 y	•Self-reporting •Observation •Medical record review •Other	Yes •Provides 2 examples of leading questions
16	San Luis Obispo CSEC Screening Tool	San Luis Obispo County CSEC Collaborative Response Team	2015	•22 questions	•Yes/no/uncertain check boxes •Varying points per question •Sum of all items determines level of CSEC risk	Minors, age ≤ 18 y	•Self-reporting •Observation •Medical record review •Other	Yes •User guide with sample questions for every item
17	Sexually Exploited Children Screening Protocol	Mays et al	2013	3-part design: •Part 1: 1 initial screening question; if positive, move on to part 2. •Part 2: screen for 12 high-risk indicators; if positive (≥1), move on to part 3. •Part 3: perform high-risk screening with 37 questions	•Clinician determines whether the final results are positive, questionable, or negative	Minors, age ≤ 18 y High-risk questions: ages of 10–18 y	•Self-reporting (first question) •All methods (high-risk indicators)	No
18	CSEC/CST 6-item screening tool	Greenbaum et al	2014	•6-item screen	•Positive screen is a child affirming or exhibiting 2 or more high-risk indicators	Minors, age ≤ 18 y Validation study: ages of 12–18 y	•Self-reporting •Observation •Medical record review •Other	No

TABLE 2. Psychometric Details of Screening Instruments

Reference	Instrument/Tool	Feasibility of Use in ED	Strengths	Weaknesses	Validity	Reliability	Level of Evidence
West Coast Children's Clinic[13]	CSE-IT	Low	•Developed by a multidisciplinary team •10 distinct topic areas •Scoring system •Possible action checklist	•High number of questions •Time to complete •Difficulty obtaining some information	•Face validity •Currently pilot testing with >50 groups	None established	N/A
Shared Hope International et al[14]	Intervene	Low	•Extensive resource package •Trauma-informed, strengths-based approach •List of strengths-based questions provided	Tier 1: •Requires self-reporting •High number of questions •Time to complete Tier 2: •Used by trained/licensed professionals only •Invasive questions require additional time for rapport building •High number of questions •Time to complete	None established	None established	N/A
Chang et al[15]	Asian Health Services and Banteay Srei's CSEC Screening Protocol	High	•Low number of questions •Multiple information sources •Established validity	•Used only for ages 11–18 y •Minimal training materials	•Predictive validity	None established	2b
San Luis Obispo County[16]	San Luis Obispo CSEC Screening Tool	Low	•Provides example questions for every item •Ease of use •Multiple information sources	•High number of questions •Time to complete •Scoring system	None established	None established	N/A
Mays et al[17]	Sexually Exploited Children Screening Protocol	Low	•Universal screening question for all teenaged patients •High-risk indicators in 5 distinct topic areas	•Complex design •High-risk screening used only for ages 10–18 y •Interventions listed are not generalizable to any location	None established	None established	N/A
Greenbaum et al[18]	CSEC/CST 6-item screening tool	High	•Low number of questions •Data-driven tool •Ease of use •Multiple information sources •Established validity	•Small study •Study only included children aged 12–18 y •Uncertainty of generalizability to all genders and cultures	•Predictive validity of screening items (area under the receiver operating curve of 0.97)	None established	2b

communication, March 8, 2016). Finally, the Intervene Tool[14] provided an extensive resource package covering the definition of domestic minor sex trafficking (analogous to CSEC except only including US-born children), common victim characteristics, terminology associated with sex trafficking, methods by which victims are controlled and manipulated (including the domestic minor sex trafficking power and control wheel), the impact of complex trauma, complex posttraumatic stress disorder, the psychological impact of sex trafficking, ground rules for interacting with and interviewing potential victims, and challenges to rehabilitation.[14]

Of the 6 instruments, validity measurements were reported for only two. Those included the Asian Health Services and Banteay Srei's CSEC Screening Protocol[15] and Greenbaum et al's CSEC/child sex trafficking (CST) 6-item screening tool.[18] The predictive validity of the Asian Health Services and Banteay Srei's CSEC Screening Protocol[15] was established through a retrospective cohort study; patient medical charts from 2008 to 2011 (n = 621) were examined for the number of patients who received CSEC screening (n = 177), demographic data and patterns of clinical testing requests, documentation on home environment and safety, school enrolment and performance, sexuality and birth control, and history of CSEC. The data were then analyzed through descriptive statistics to determine demographic trends, the prevalence of CSEC, and risk factors. This was followed by univariate and multivariate logistic regression to determine the odds ratios of independent CSEC predictor variables at a 95% confidence interval.

The selection of screening items found within the CSEC/CST 6-item screening tool[18] were validated through a cross-sectional study of 12- to 18-year-olds (n = 108) who presented to 1 of 3 metropolitan EDs or 1 child protection clinic. The study subjects were identified as either a suspected victim of CSE or CSEC/CST (n = 25) or a child alleging acute sexual assault without evidence of CSEC/CST (n = 83). Descriptive statistics were computed for all variables of interest, followed by a comparison of the 2 groups using independent 2-sample *t* tests for continuous variables and χ^2 tests for those that were categorical. Variables found to be significant at a 99% confidence interval were selected to be screening items. Multivariate logistic regression was then performed to determine which of the screening items best identified a CSEC/CST patient. The results supported a 6-question screening tool with a mean area under the receiver operating curve of 0.97, indicating an almost perfect ability to discriminate between CSEC/CST and acute sexual assault victims.[18] Currently, a multisite study is underway to prospectively validate the tool in a variety of medical settings including EDs, teen clinics, foster care clinics, and child advocacy center clinics (J. Greenbaum, personal communication, April 21, 2016).

Both the Asian Health Services and Banteay Srei's CSEC Screening Protocol[15] and the CSEC/CST 6-item screening tool[18] meet the criteria for a rating of 2b within the *Oxford Centre for Evidence-based Medicine—Levels of Evidence, March 2009* edition.[19] To date, no reliability data have been identified for any of the instruments included in this study.

DISCUSSION

The findings of this integrative review confirm that very few screening instruments exist to identify CSEC, and of those in existence, only two were determined to be highly feasible for use in an ED setting. The Asian Health Services and Banteay Srei's CSEC Screening Protocol[15] and the CSEC/CST 6-item screening tool[18] are recommended for use in the ED based upon the following features: a low number of screening items, ease of administration (both critically important in a fast-paced ED environment), multiple information sources, and a lack of reliance upon self-disclosure. The last feature is especially important because many CSEC victims will not self-disclose because of a lack of trust in health care providers or fear of mandatory reporting or because they are not even aware that they are being exploited.[3] For both of these instruments, a positive screen is designated when two or more of the questions/indicators were confirmed. Because of their simple format, both can be scored quickly, and a positive or negative screen can be determined easily.

It should be noted that both of the recommended instruments focus on the screening of adolescents, leaving a complete void of suggested CSEC screening instruments aimed at identification of the youngest, most vulnerable children. Although their victimization is less common than that of adolescents, CSEC screening instruments for the preadolescent demographic of children (age, ≤9 y) are still needed. This is evidenced by cases where children of that age group,[20] including those as young as 1 year old,[21] have been identified as CSEC victims.

An assessment of the training materials included among the instruments revealed a substantive amount of variation. Whereas both the Asian Health Services and Banteay Srei's CSEC Screening Protocol[15] and the CSEC/CST 6-item screening tool[18] included minimal training materials, others were more robust in this area. Shared Hope International's[14] Intervene Tool provided the most training materials of any instrument; however, it was rated low feasibility for use in the ED because of its 97 questions, as well as the requirement of a trained/licensed professional, with an understanding of trauma and trafficked children, to administer the 55 tier-2 questions. Although the Intervene[14] instrument may not be well suited for use in the ED, its extensive training materials could serve as an important educational resource for health care providers, facilitating their understanding of what CSEC is, who the potential victims may be, and how to properly respond to them. The training of health care providers is a tremendous existing need, as evidenced by a recent study where 97.8% of ED health care providers (n = 176) (including medical doctors, physician assistants, registered nurses, social workers, and medical students), reported that they had never been formally trained on the clinical presentation of trafficking victims and 95% had not ever received training on the treatment of trafficking victims.[22]

Although it is an excellent screening instrument, the CSE-IT[13] was rated low for feasibility of use in the ED because of its high number of questions (48). This instrument has many excellent attributes, making it highly recommended for use in other health care settings or in the social services area. The CSE-IT[13] is a research-based instrument that was developed using input gathered on content and administration methods from more than 100 individuals who participated in focus groups. These individuals included care providers from multidisciplinary backgrounds including medicine, primary care providers, registered nurses, social workers, mental health professionals, child welfare agencies, schools, and members of the juvenile justice system, as well as sex trafficking survivors from throughout the state of California. Instrument questions were categorized into 10 different sections based on their topic area, and questions with affirmative responses requiring mandatory reporting are designated as such, facilitating ease of administration. Today, the CSE-IT[13] is being piloted with more than 50 test groups, and phase I data collection will continue through May 2016. Once the data are analyzed, revisions will be made to the instrument. A new version is expected to be released in July 2016. This instrument is also undergoing testing for internal, audit, and triangulation validity (D. Basson, personal communication, March 8, 2016).

The San Luis Obispo County CSEC Screening Tool[16] is a 22-question instrument that is designed for use within the

Department of Social Services. This instrument has a very straightforward checkbox format (yes/no/unsure) with a comprehensive user guide that provides several sample questions for each screening item; however, it was rated as low feasibility for use in the ED because it is somewhat lengthy and uses a complex scoring system. This instrument also includes an area for documentation of any referrals made, and although the items listed are specific to San Luis Obispo County, they could easily be adapted to other geographic locations.[16]

The Sexually Exploited Children Screening Protocol[17] also received a rating of low feasibility for use in the ED because of its potentially high number of questions (1 initial screening question and 12 high-risk indicators, followed by a possible 37 high-risk screening questions) and a lack of clarity on how the high-risk questions are scored. This instrument is the only one in this review that begins with a universal screening question completed by every student visiting the center where the instrument is used (The Native American Health Center, Inc).[17] It is interesting to note that both the initial universal screening question and the high-risk indicator question found midway through completion of the screening are virtually the same question. It is also the only instrument designed in an algorithm form—a model that health care providers are accustomed to using and therefore likely to be comfortable working with. Finally, the Sexually Exploited Children Screening Protocol[17] includes the word *protocol* in its title; however, its primary function is that of a screening instrument. Technically, a portion of the instrument could also be considered a protocol because of the delineated instructions provided within the Intervention Section; however, the combining of screening instruments and protocols is not recommended.

It is recommended that CSEC screening instruments continue to be developed, including the creation of developmentally appropriate screening instruments for preadolescent children. The results of this review reveal several positive instrument features that should be considered when developing new screening instruments. These include succinctness, a simple format, easy administration, training materials, sample questions, multiple information sources, designation of questions requiring mandatory reporting, a straightforward scoring system, and an algorithm format.

This study was limited because it did not include instruments that screened for both sex and labor trafficking and searches outside academic publishing; these items could be included in future studies. Although effective CSEC screening instruments are critical, it is also important to remember that they are only 1 piece of the larger puzzle that must be put together to identify and assist CSEC victims. Increased awareness, the development of both screening instruments and protocols, and comprehensive training of health care providers each play an integral part in providing care and hope for CSEC victims.

REFERENCES

1. Unicef. Child protection and development child trafficking. Available at: https://www.unicefusa.org/mission/protect/trafficking. Accessed March 15, 2016.
2. Choi KR. Risk factors for domestic minor sex trafficking in the United States: a literature review. *J Forensic Nurs*. 2015;11:66–76.
3. Macias-Konstantopoulos WL, Munroe D, Purcell G, et al. The commercial sexual exploitation and sex trafficking of minors in the Boston metropolitan area: experiences and challenges faced by front-line providers and other stakeholders. *J Appl Res Child*. 2015;6:12.
4. Hom KA, Woods SJ. Trauma and its aftermath for commercially sexually exploited women as told by front-line service providers. *Issues Ment Health Nurs*. 2013;34:75–81.
5. Institute of Medicine (IOM) and National Research Council (NRC) of the National Academies. *Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States: A Guide for Providers of Victim and Support Services*. Washington, DC: National Academy of Sciences; 2013.
6. Polaris Project. Human trafficking cheat sheet. Available at: http://www.rescue.org/sites/default/files/resource-file/Human%20Trafficking%20Cheat%20Sheet_0.pdf. Accessed October 19, 2015.
7. The Federal Bureau of Investigation. Violent crimes against children. Available at: https://www.fbi.gov/about-us/investigate/vc_majorthefts/cac/innocencelost. Accessed April 2, 2016.
8. Albanese J. Commercial sexual exploitation of children: what do we know and what do we do about it? Availablet at: https://www.ncjrs.gov/pdffiles1/nij/215733.pdf. Accessed March 15, 2016.
9. Ahn R, Alpert EJ, Purcell G, et al. Human trafficking: review of educational resources for health professionals. *Am J Prev Med*. 2013;44:283–289.
10. Lederer LJ, Wetzel CA. The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities. *Ann Health Law*. 2014;23:61–91.
11. Muraya DN, Fry D. Aftercare services for child victims of sex trafficking: a systematic review of policy and practice. *Trauma Violence Abuse*. 2016;17:204–220.
12. Liberati A, Altman DG, Tetzlaff J, et al. The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate health care interventions: Explanation and elaboration. *PLoS Med*. 2009;6:e1000100.
13. WestCoast Children's Clinic. You can't stop something you don't see. Available at: http://www.westcoastcc.org/wp-content/uploads/2015/04/WCC-CSE_IT-Pilot-14Apr2015.pdf. Accessed Febrary 4, 2016.
14. Shared Hope International; Leitch L, Snow M. *Intervene Practitioner Guide and Intake Tool*. Vancouver, WA: Shared Hope International; 2013.
15. Chang KS, Lee K, Park T, et al. Using a clinic-based screening tool for primary care providers to identify commercially sexually exploited children. *J Appl Res Child*. 2015;6:15.
16. San Luis Obispo County. San Luis Obispo County CSEC collaborative response team commercial sexual exploitation of children (CSEC) screening tool. Available at: http://www.slocounty.ca.gov/Assets/DSS/Flyers/DSS800CSEC.pdf. Accessed February 4, 2016.
17. Mays A, Harvill Z, Mejia J. *Sexually Exploited Children Screening Protocol: A Multidisciplinary Model Designed for the Clinical and School Health Setting*. The Native American Health Center: Oakland, CA; 2013.
18. Greenbaum VJ, Dodd M, McCracken C. A short screening tool to identify victims of child sex trafficking in the health care setting. *Pediatr Emerg Care*. 2015. [Epub ahead of print].
19. Howick J, Phillips B, Ball C, et al. Oxford Centre for Evidence-based Medicine—levels of evidence (March 2009). Available at: http://www.cebm.net/oxford-centre-evidence-based-medicine-levels-evidence-march-2009/. Accessed February 13, 2016.
20. Salinger T. Houston man offered sex with sedated 4-year-old in Craigslist ad saying "come sleep with daddy's little girl." Available at: http://www.nydailynews.com/news/crime/houston-man-solicited-sex-sedated-4-year-old-girl-article-1.2436898. Accessed April 2, 2016.
21. The United States Attorney's Office. U.S. Attorneys, Eastern District, News. Available at: https://www.justice.gov/usao-edva/pr/virginia-beach-man-convicted-conspiracy-and-production-child-pornography. Accessed April 2, 2016.
22. Chisolm-Straker M, Richardson LD, Cossio T. Combating slavery in the 21st century: the role of emergency medicine. *J Health Care Poor Underserved*. 2012;23:980–987.

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Using Survivors' Voices to Guide the Identification and Care of Trafficked Persons by U.S. Healthcare Professionals: A Systematic Review

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Abstract

Evidence suggests that trafficked persons in the U.S. frequently seek healthcare, yet little is known of their experiences, including reasons for seeking assistance, interactions with professionals, and barriers to obtaining care. To gain a better understanding, a search was conducted for empirical data collected directly from trafficked persons about their U.S. healthcare experiences, published in peer-reviewed journals within the past 10 years, and in the English language. Four databases were searched and of the 1,605 articles initially identified, 8 met all inclusion criteria. Data from 420 participants demonstrated a wide range of physical and mental health complaints and 50-98% reported seeking healthcare services in diverse settings during their exploitation. Barriers to care occurred at various levels and while some are not modifiable, others are amendable by changes in the behaviors of healthcare professionals. A trauma-informed, rights-based approach to care would address many of these issues and create feasible treatment plans.

Keywords: treatment, victims, human trafficking, healthcare

Using Survivors' Voices to Guide the Identification and Care of Trafficked Persons by U.S. Healthcare Professionals: A Systematic Review

Background

Human trafficking is a crime involving the use of force, fraud, or coercion to exploit one individual for the benefit of another (U.S. DHHS OTIP, 2017). It is a human rights violation affecting millions of individuals worldwide. While precise prevalence rates are unknown, conservative estimates suggest approximately 24.9 million persons were victims of forced labor in 2016 (including forced labor in the private economy, state-imposed forced labor, and forced sexual exploitation of adult/child commercial sexual exploitation) (International Labour Organization, 2017; Zimmerman & Kiss, 2017). "Severe forms of trafficking in persons" are defined by the U.S. Trafficking Victim Protection Act (TVPA) of 2000 as:

> Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery. (U.S. Congress, 2000, p. 7)

High rates of exploitation may be partially explained by the high revenues that traffickers can generate in conjunction with the relatively low risk for prosecution (Polaris, 2015). Financial proceeds for traffickers can range from 50%-1,000%, after their initial investment, with persons trafficked for sex yielding the greatest returns (Human

Rights First, 2017). The International Labour Organization (2014) has reported that the illegal proceeds generated from human trafficking across the globe today exceed US$150 billion dollars, yet even as recently as 2016 there were only 9,071 convictions for human trafficking, worldwide (Human Rights First, 2017).

Within the United States (U.S.), human trafficking is occurring in every state across the nation (Polaris, 2016). While persons of any race, ethnicity, gender, and socio-economic status may be trafficked, many victims experience individual, family/relationship, community or societal risk factors (U.S. Dept. of State, 2016). Such vulnerabilities include: a history of abuse or neglect; high adverse childhood experience (ACE) scores; runaway or throwaway status; lesbian, gay, bisexual, transgender and questioning/queer status; exposure to intergenerational trauma or intimate partner violence; history of substance use; undocumented immigrants; migrant workers; persons with disabilities; racial and ethnic minorities; and persons with low incomes (U.S. DHHS - ACF, 2017, p. 19).

Regardless of how individuals are exploited or what type of trafficking they experience, many undergo trauma and abuse that results in significant health consequences. This may include physical injuries, complications of substance abuse, depression and suicidality, post-traumatic stress disorder (PTSD), sexually and non-sexually transmitted infections, and other conditions (Greenbaum, 2016; Lederer & Wetzel, 2014; Macias-Konstantopoulos, Munroe, Purcell, Tester, & Burke, 2015; Oram, Stockl, Busza, Howard, & Zimmerman, 2012). In the U.S., research suggests that 50%-88% of identified trafficked persons seek healthcare while they are being exploited

(Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011; Lederer & Wetzel, 2014; Lumpkin & Taboada, 2017). These visits provide a window of opportunity for healthcare professionals (HCPs) to identify victims and offer assistance. However, these chances are frequently missed because HCPs lack the knowledge and training to be able to identify victims (Barron, Moore, Baird, & Goldberg, 2016; Chisolm-Straker, Richardson, & Cossio, 2012; Powell, Dickens, & Stoklosa, 2017). Additionally, it is believed that less than 1% of hospitals in the U.S. have a human trafficking response protocol in place to guide HCPs on how to proceed, should they positively identify a trafficked person (Stoklosa, Showalter, Melnick, & Rothman, 2016).

While HCPs are becoming more aware of the need to address the issue of human trafficking, research surrounding the topic is still scarce, and empirical data to inform evidence-based practices on the identification and care of trafficked persons is lacking. Most existing studies include data collected from HCPs who work with trafficked persons (Macias-Konstantopoulos et al., 2015); very few have examined victims' health or their interactions with the health care system from the vantage point of the trafficked individual. This is likely due to the challenges of studying trafficked persons, such as gaining access to subjects due to the covert nature of the crime, increased safety requirements for research on vulnerable subjects, victims' frequent distrust of authority figures, concerns about re-traumatization of survivors, and some victims' lack of recognition of their own exploitation. To better understand how HCPs can identify and provide optimal care to trafficked persons, a systematic review of the literature was conducted to examine empirical data on survivors' perspectives about their health, the

health consequences of trafficking, and their interactions with HCPs within the U.S. healthcare system.

Methods

A comprehensive literature search was conducted by the primary author between December 2017 through February 2018. Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed, SCOPUS, and OVID were searched for the following terms: *human trafficking, sex trafficking, labor trafficking, commercially sexually exploited children, juvenile sex trafficking, domestic minor sex trafficking,* and *commercial sexual exploitation*. Each search result was exported to a separate Excel spreadsheet to facilitate clear documentation, integration of findings, and removal of duplicates.

Inclusion criteria required that the studies use data collected directly from trafficked persons, published in a peer-reviewed journal, and written in the English language. Required topic areas included health consequences of trafficking, and interactions with or recommendations for HCPs within the U.S. healthcare system. Only studies completed in the past 10 years were included in this review to ensure that content was current and relevant.

Studies were excluded if they focused on social services or aftercare services. Although these services are critically important to the care of trafficked persons, the current study focused on the healthcare experiences of survivors. Studies were also excluded if they were conducted outside the U.S. due to the differences between healthcare systems. Lastly, studies primarily relying on data from physical examinations,

psychological or social assessments and interview of healthcare professionals, caregivers and other professionals were also excluded to ensure a primary focus on victim voices.

The four database searches yielded a total of 1,605 articles. Titles were screened and article information (author, title, journal, date) from relevant articles (632) were exported into a spreadsheet utilizing a different worksheet for each database. Duplicates were then removed from each database's results. This process left a total of 259 articles. Abstracts were then reviewed, eliminating another 200 articles, followed by the merging of the 59 remaining results (from the four databases) and removal of between-database duplicates. A final list of 26 studies remained. Through ancestry searches and professional networking an additional 15 articles were added, bringing the total to 41. Those 41 articles received full text review by the primary author; a total of 8 studies met inclusion and exclusion criteria. The sample was comprised of five qualitative, one quantitative, and two mixed methods studies. A PRISMA-style flow diagram depicting the screening process can be seen in Figure 1. Table 1 outlines each study's author(s), title, format, sample, and applicable results and is available in Appendix A.

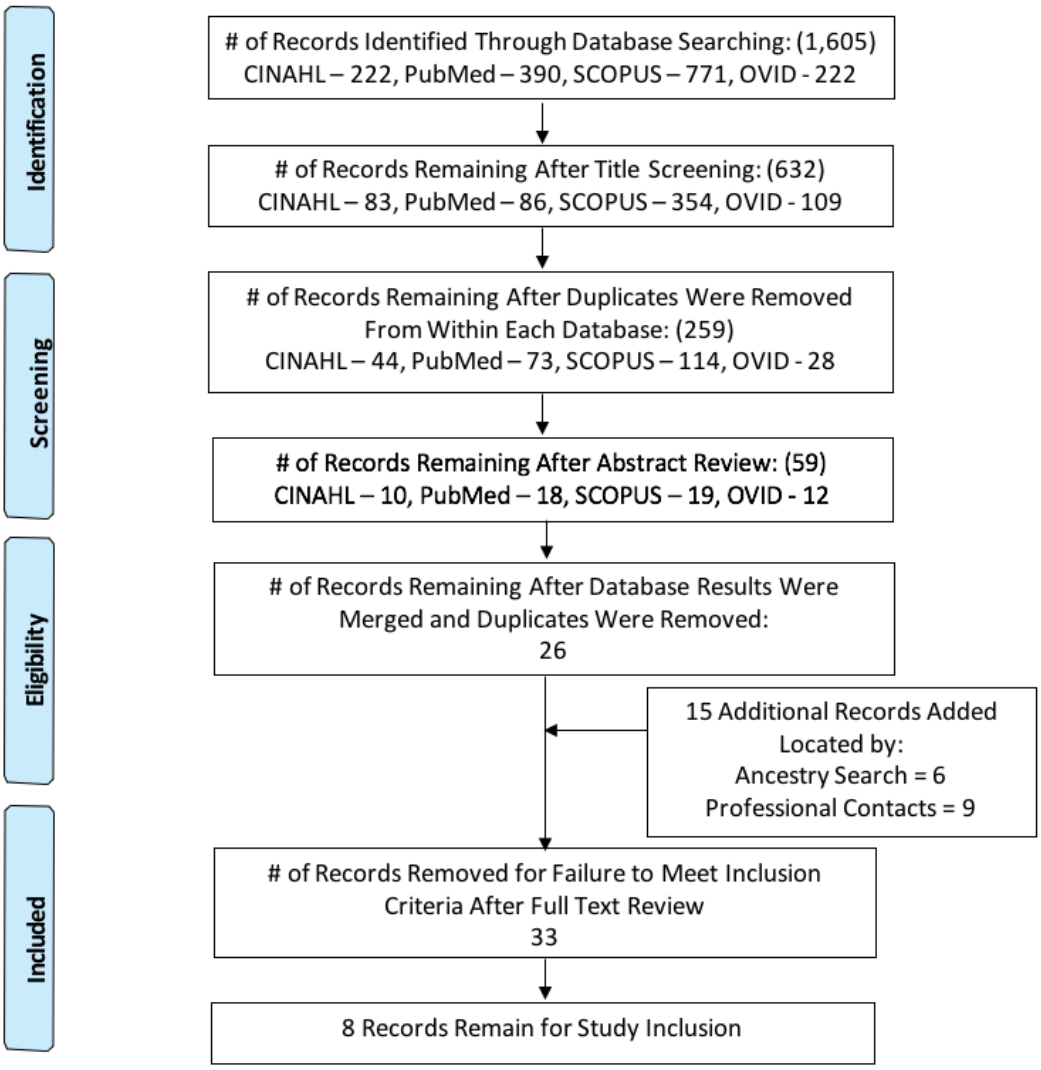

Figure 1. PRISMA flow diagram. Adapted from "Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement," by D. Moher, A. Liberati, J. Tetzlaff, and D. G. Altman, 2009, *PLoS Med* 6(7):e1000097. Doi:10.1371/journal.pmed.1000097

Data Analysis

A table was created by the primary author outlining each study's author, title, format, sample, and primary study results. The latter were copied into a spreadsheet, line-by-line so they could be reviewed and categorized. Categories were then sorted to aggregate similar items.

Results

Abuse and Violence

Five studies described abuse and violence experienced during the period of exploitation (Chisolm-Straker et al., 2016; Lederer & Wetzel, 2014; Ravi et al., 2017b; Williamson & Prior, 2009; Willis, Vines, Bubar, & Ramirez Suchard, 2016). Sixty-six percent of responders in the Chisolm-Straker et al. (2016) study reported physical abuse, and 69.2% of participants in the Lederer study reported physical injuries. Victims were beaten (sometimes to unconsciousness), burned, kicked, pulled from vehicles, punched, strangled, and struck in the head and face (Lederer & Wetzel, 2014; Ravi et al., 2017b; Williamson & Prior, 2009). Ninety-two percent of victims experienced at least one form of violence, while on average they experienced 6.25 types of violence (Lederer & Wetzel, 2014). Sexual violence included forced sex/rape, forced unprotected sex, gang rape, reenactment of pornography, and forcible filming for pornography (Lederer & Wetzel, 2014; Ravi et al., 2017b; Williamson & Prior, 2009). Psychological abuse occurred when victims were intimidated, forced to witness violence against others, and threatened with weapons. At times, threats involved harm to loved ones (Lederer & Wetzel, 2014; Ravi et al., 2017b; Williamson & Prior, 2009). Other forms of abuse included being imprisoned and deprived of sleep, food, and clothing (Ravi et al., 2017b). Traffickers, buyers, and persons of authority were reported as perpetrators of the violence and abuse (Lederer & Wetzel, 2014).

> I've had a hard life during this time – 16 years on the street, 10 to 20 customers per day. I've been hit, punched, kicked, beaten, whipped with a belt, forced to

> have sex, threatened with a weapon, shot at, and had my head split open… One of my regulars got together with some friends and kidnapped me. They held me against my will, put a belt around my neck, and forced me to do all kinds of horrible things. When I said I didn't want to they said they would kill my family. (Nicole, as cited by Lederer & Wetzel, 2014, p. 74)

Illicit Substances

Four studies assessed illicit substance use during the trafficking period (Lederer & Wetzel, 2014; Ravi, Pfeiffer, Rosner, & Shea, 2017a; Ravi et al, 2017b; Willis et al, 2016). Drug and alcohol use was reported by 84.3%-100% of victims (Ravi et al., 2017a; Lederer & Wetzel, 2014), with many individuals using substances as a coping mechanism for the exploitation and abuse they endured (Lederer & Wetzel, 2014; Ravi et al., 2017b). Lederer and Wetzel (2014) found that 28% percent of victims were forced to use substances so their traffickers could maintain control over them. The substances used included: alcohol (59.8%), marijuana (53.4%), cocaine (50.5%), crack cocaine (44.7%), heroin (22.3%), ecstasy (13.6%), and PCP (9.7%) (Lederer & Wetzel, 2014). Study respondents for Ravi et al. (2017b) reported using cocaine, heroin and marijuana to cope with trauma, while heroin was the drug of choice to numb the physical pain associated with sex work. They also utilized cocaine to reduce the need for sleep, thereby increasing the hours that victims could work and make money (Ravi et al., 2017b). Children of trafficked women and other sex workers were given drugs and alcohol: 93% of adults interviewed reported knowing of such cases (Willis et al., 2016).“I am telling you that you have to not be in your sober mind to run these tricks – you just can't do it straight so

everyone on the street is hooked on some drug…" (Taylor, as cited by Lederer & Wetzel, 2014, p. 68).

Physical Health Conditions Victims Experienced

Five studies discussed physical health complaints experienced by trafficked persons (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011; Chisolm-Straker, et al., 2016; Lederer & Wetzel, 2014; Ravi et al., 2017a; Willis et al., 2016). In Lederer and Wetzel's (2014) study, 99.1% of victims reported at least one health condition while being trafficked, including: reproductive health issues (pregnancy [71.2%], STIs [67.3%]; abortion [55.2%], gynecologic symptoms other than STI [63.8%]), neurological problems (memory issues, insomnia, dizziness, poor concentration, and headaches [91.7%]), physical injuries from abuse (most often to the face or head [69.2%]), poor dietary health (severe weight loss, loss of appetite, and eating disorders [71.4%]), gastrointestinal issues (nausea/vomiting [62%]), cardiovascular and respiratory issues (68.5%), dental problems (mostly tooth loss) (54.3%), and back pain. Other complaints included menstrual problems and chronic diseases such as hypothyroidism and asthma (Chisolm-Straker et al., 2016; Ravi et al., 2017a).

Mental Health

Four studies discussed mental health issues experienced by trafficked persons (Lederer & Wetzel, 2014; Ravi et al., 2017b; Williamson and Prior 2009; Willis et al., 2016). Lederer and Wetzel (2014) found that 98.1% of adolescent and adult female sex trafficking survivors experienced at least one psychological issue while being exploited and averaged 12.11 mental health complaints. Victims experienced both acute and

chronic stress, as well as anxiety, symptoms of post-traumatic stress disorder (PTSD), hypervigilance, feeling unsafe at night, and being easily startled (Ravi et al., 2017b; Williamson & Prior, 2009; Lederer & Wetzel, 2014; Willis et al., 2016). Self-reported depression occurred in 88.7% of trafficking victims (Lederer & Wetzel, 2014), and was found to be the most widespread health issue by Chisolm-Straker et al. (2016). Most victims reported or were diagnosed with depression (Williamson & Prior, 2009), and continued experiencing depressive symptoms even after they were no longer being trafficked (Lederer & Wetzel, 2014; Ravi et al., 2017b). Other self-reported mental health conditions occurred as well, including: bipolar disorder (30%), depersonalization disorder (20%), borderline personality disorder (13.2%), and multiple personality disorder (13.2%) (Lederer & Wetzel, 2014). Of note, the use of self-reporting methodology in these studies precluded determination of how many trafficked persons actually received formal psychiatric diagnoses.

> The mental health problems are the worst and most long lasting. I was diagnosed with chronic depression, have anxiety, post-traumatic stress syndrome, nightmares, flashbacks, disorientation. I've been suicidal at times. I don't think anyone is out on the street without having these long-lasting effects. (Amanda, as cited by Lederer & Wetzel, 2014, p. 70)

The trafficking experience impacted how victims felt about themselves; low self-esteem, self-confidence, and self-worth were noted, as were feelings of worthlessness, shame, and guilt (Williamson & Prior, 2009; Ravi et al., 2017b; Lederer & Wetzel, 2014). Forty-two percent of trafficked persons attempted suicide while being trafficked

(Lederer & Wetzel, 2014). Victims also reported issues surrounding personal relationships with family and significant others (Ravi et al., 2017b), and many lacked constructive support systems (Williamson & Prior, 2009).

Reproductive Healthcare Issues

Menstruation. It was typical for victims to experience violence when unable to meet their trafficker's "daily quota" requirements (Ravi et al., 2017a; Williamson & Prior, 2009); therefore, women used absorbent items to "stuff" their vaginal area during menstruation so they could continue working (Ravi et al., 2017a). Ravi et al. (2017a) also found that some women only allowed anal or oral sex during their menstrual cycle or would attempt to pass off "thigh sex" (penis on thighs) as vaginal intercourse if a client was altered and unlikely to recognize the difference.

> He told me that I couldn't come in every night unless I made $1,500. One night I only had maybe $700. I was tired. I didn't feel good and I was ready to go in. I got back to the hotel room and he tried strangling me, cuz I didn't have enough money. (Sammie, as cited by Williamson & Prior, 2009, p. 51)

Human immunodeficiency virus (HIV). Ravi et al. (2017a) reported that contracting HIV was the most significant health-related fear of trafficking victims. HIV-infected respondents were apprehensive of disclosing their status to their traffickers and buyers, and feared they had infected others. Survivors also shared that rapid HIV testing was not helpful to them because of their life circumstances, yet bloodwork to examine direct viral loads was not typically offered. As a result, some women would pretend to have symptoms of HIV to receive a direct viral load test. Women also reported being

fearful that others "in the life" would send an HIV-infected customer to them, as a method of revenge (Ravi et al., 2017a).

Birth control/infection control. At some point while being trafficked, 80.9% of victims reported using some method(s) of birth control (Lederer & Wetzel, 2014). This was acquired from doctors, hospitals, and clinics, as well as from traffickers, pharmacies, and hotels (Lederer & Wetzel, 2014; Ravi et al., 2017a). Victims stated that they were frequently alone when they obtained it (Lederer & Wetzel, 2014). Birth control methods included multiple types (22%), Depo-Provera (11.9%), birth control pills (10.2%), and intra-uterine devices (3.4%); however, condom use was the most prevalent (52.5%) (Lederer & Wetzel, 2014; Ravi et al., 2017a). Ravi et al. (2017a) discovered that victims faced several challenges related to condom use, including being paid more for sex without a condom, which was important if one had to earn 'quotas' each night; violence from customers who insisted upon not using a condom or from traffickers who objected to victims refusing such a customer; and substance abuse impairing the victim's ability to negotiate condom use. Additionally, some victims reported their traffickers expected them to abstain from condom use when having sex with the trafficker but to use them consistently when engaging with customers. With this arrangement, a STI diagnosis could be interpreted as a sign of non-compliance with the trafficker's rules and result in retribution (Ravi et al., 2017a). "He told me that I couldn't use a condom with him, but I had to use it with the johns" (Participant 20, as cited by Ravi et al., 2017a, p. 412).

Methods used to reduce infection risk. Trafficking victims used a variety of methods in an attempt to reduce their risk of infection after unprotected sex or condom

failure. These included changing condoms upon failure/breakage, douching, using over-the-counter antiseptics, frequently gargling with mouthwash, sitting in a tub of bleach, and scheduling an appointment for a pap smear (Ravi et al., 2017a).

Miscarriages. While being trafficked, many victims did become pregnant, and 54.7% of women had experienced at least one miscarriage (Lederer & Wetzel, 2014). In a study of teen and adult mothers who were trafficked or engaged in sex work in the U.S. (Willis et al., 2016), respondents estimated that 50-60% of adolescents/adults become pregnant and 35-50% have a miscarriage.

Abortions. Many survivors (55%) indicated that they had obtained at least one abortion while being trafficked; 30% indicated they had received multiple abortions, and 53% reported that at least one abortion was forced upon them (Lederer & Wetzel, 2014). Transportation and cost were occasional barriers to obtaining services, resulting in later-term abortions for some women (Ravi et al., 2017a). Abortions were primarily sought at clinics (67.6%), hospitals (16.2%), and other sites (13.5%) (Lederer & Wetzel, 2014). Forty-nine percent of respondents stated that teens they knew sought abortions at Planned Parenthood clinics (Willis et al., 2016).

Maternal, Newborn, and Child Health

Pregnancy. Many trafficking victims did not want to become pregnant due to fear of retribution from their trafficker in response to anticipated revenue losses (Ravi et al., 2017a). Nonetheless, 71% of trafficking victims became pregnant at least once while being trafficked and 21% were pregnant 5 or more times (Lederer & Wetzel, 2014). Willis et al. (2016) found that depression during pregnancy was extremely common

among teens and adults, with respondents estimating that it affected 95-100% of victims. Ninety-eight percent of respondents in their study also felt that teen and adult trafficking victims used alcohol daily while pregnant, with a median estimate of occurrence of 85% for teens and 71% for adults. Seventy-nine percent of their respondents felt that teen trafficking victims used marijuana while pregnant, while only 43% felt that adult victims smoked marijuana while pregnant (Willis et al., 2016). Eighty-six percent stated that trafficked women delivered their babies at a hospital (Willis et al., 2016).

> …when I did get pregnant…and still smoking, he was locking me in closets in the room…with guns and stuff like that…Because he didn't want me to go out…I was pregnant with his baby… I did break out a couple of times and went to hotels and got high. (Participant 7, as cited by Ravi et al., 2017a, p.412)

Prenatal Care. Some trafficked women received prenatal care, while others were not permitted to seek services (Ravi et al., 2017a). Respondents in the Willis study estimated that a minority of trafficking victims receive regular prenatal check-ups: the median estimate of occurrence was only 20% for teens and 45% for adults (Willis et al., 2016). They indicated the most common places for obtaining prenatal care were free clinics (Willis et al., 2016).

Neonates. Approximately 86% of respondents in Willis et al.'s (2016) study claimed that the infants of trafficked women had complications. Additionally, very few trafficked women were believed to breast feed their babies; only 12% of respondents said that teen victims breast fed, and just 27% believed that adult victims breast fed (Willis et al., 2016).

Children. The children of trafficking victims also faced health issues and abuse. Seventy-two percent of respondents in Willis et al.'s (2016) study stated that the children of victims are physically or sexually abused, and 11% knew of the death of a trafficking victim's child due to physical abuse. Ninety-three percent also affirmed that trafficking victims' children were given drugs or alcohol, and 81% felt that the children of trafficking victims had mental health problems. Respondents also stated that victims' children witnessed physical or sexual abuse of their mothers or another woman (median estimated occurrence 50-92% of children). Eighty-nine percent also shared that daughters of trafficking victims are forced into prostitution, with a median estimate of occurrence at 50%. Lastly, respondents indicated that most trafficking victims' children are raised by their maternal grandmothers (Willis et al., 2016).

Provision of Care

Six studies discussed the experiences of trafficked persons when they sought healthcare (Baldwin et al, 2011; Chisolm-Straker et al, 2016; Ijadi-Maghsoodi et al, 2017; Lederer et al, 2014; Ravi et al., 2017a and 2017b).

Chief Complaints. While trafficking victims experienced many health conditions, the ones for which they sought healthcare included reproductive health issues (unintended pregnancy, pregnancy testing, abortions, STIs, STI testing, and HIV testing), chronic disease management (hypothyroidism, asthma) and violence-related issues (rape, traumatic injuries, suicide attempts) (Baldwin et al., 2011; Ravi et al., 2017a).

Types of healthcare professionals and facilities visited. Victims (50%-89%) reported visiting a health care professional while being trafficked (Baldwin et al., 2011;

Chisolm-Straker, et al., 2016; Lederer & Wetzel, 2014). They sought care from primary care providers, dentists, obstetricians/gynecologists, pediatricians, and alternative healers (Chisolm-Straker et al., 2016; Lederer & Wetzel, 2014). Trafficking victims primarily sought healthcare at hospital emergency rooms, especially when they did not have any identification or insurance (Chisolm-Straker, et al., 2016; Lederer & Wetzel, 2014; Ravi et al., 2017a). Victims also received care at clinics, including urgent care, primary care, women's health (including Planned Parenthood), free clinics, and Health Department clinics (Lederer & Wetzel, 2014; Ravi et al., 2017a). For some, the only source of healthcare was the intake screening upon entering jail (Ravi et al., 2017a). "During the time I was on the street, I went to hospitals, urgent care clinics, women's health clinics and private doctors. No one ever asked me anything anytime I ever went to a clinic..." (Lauren, as cited by Lederer & Wetzel, 2014, p. 76).

Barriers to Care

There were numerous barriers related to victims seeking/receiving healthcare, including factors involving traffickers, the healthcare professional/health system, and the victims, themselves.

Trafficker-related barriers to care. Victims reported that some traffickers restricted access to healthcare (Chisolm-Straker, et al., 2016; Ravi et al., 2017a) and would attempt to treat injuries with supplies available at local pharmacies (Ravi et al., 2017a). Survivors reported that some traffickers were concerned that victims would escape, report the situation to the police or that time spent obtaining medical/mental health services would lead to financial losses (Ravi et al., 2017a). When healthcare visits

were permitted, the trafficker or another trafficked woman would accompany some victims to intimidate and maintain control over them (Baldwin et al., 2011; Ravi et al., 2017a). Some trafficked persons reported the trafficker completed healthcare forms, spoke for the victim during the encounter, and paid for services in cash (Baldwin et al, 2011).

> She [the trafficker] didn't ask me anything. She filled out everything. [When they called my name], she walked in with me. She called me her 'auntie.' [The doctor and nurse] talked to her. I couldn't even listen. I didn't speak English. (Desi, as cited by Baldwin et al., 2011, p. 41)

Healthcare professional or system-related barriers to care. Respondents were concerned about whether HCPs would respect their confidentiality, and whether the providers would judge them and give opinions without taking time to understand the complexities of their lives (Ijadi-Maghsoodi, Bath, Cook, & Textor, 2018). Victims also reported that they felt the health care system was not as concerned about providing care as receiving payment (Ravi et al., 2017b). Additionally, extended wait times prevented several women from receiving exams or staying until exams were completed (Ravi et al., 2017b).

Victim-related barriers to care. Victim-related barriers to care consisted of numerous fears, including fear of seeing a provider (Chisolm-Straker et al., 2016), fear of feeling judged, fear of retribution from traffickers for certain diagnoses (pregnancy or HIV), and fear of being arrested at the hospital for an outstanding warrant or for prostitution (Ijadi-Maghsoodi et al., 2018; Ravi et al., 2017a). Some felt intimidated by

HCPs (Lederer, 2014). Some victims did not seek care because they had become very self-reliant (Ijadi-Maghsoodi et al., 2018), or because substance use was a greater priority than obtaining healthcare (Ravi et al., 2017a). Lastly, victims faced challenges with seeking medical assistance because they lacked the resources to pay for care (Chisolm-Straker, et al., 2016) and did not feel they could afford to take time away from making money to seek healthcare (Ijadi-Maghsoodi et al., 2018; Ravi et al., 2017a). "…we don't wanna go to the hospitals because we feel like they're gonna check there. Or we go to the hospital, our names are ran. And the cops come and they take us. And that has happened a lot" (Participant 5, as cited by Ravi et al., 2017a, p. 411).

> …another girl…he beat her up really bad. She was pregnant and he beat her up really, really, really, really, really, really, bad and he put her into a full body cast. And she went into the hospital. But she didn't tell on him. She just told that a guy beat her up or whatever. (Participant 12, as cited by Ravi et al., 2017a, p. 411)
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> It hurt so much, but the next day I did go to the hospital, but the next day I had to work because they told me the $500 would be a liability to them and that would be added to my debt. (Linda, as cited by Baldwin et al., 2011, p. 41)

Facilitators to Care

There were some facilitators to care, including the wide availability of reproductive health care services, youths' knowledge of STIs, and mental health care provided in group homes and detention centers (Ijadi-Maghsoodi et al., 2018).

Barriers to Victim Disclosure When in Healthcare Settings

Victims faced a variety of barriers that discouraged disclosure of their exploitation, including fear, shame, feelings of helplessness and hopelessness, and feeling intimidated by HCPs (Baldwin et al., 2011; Ravi et al., 2017b). In some cases, there was a language barrier that inhibited disclosure, and in other cases it appeared that the trafficker had a personal relationship with the HCP (Baldwin et al., 2011). Additional barriers included concerns for the safety of oneself or others, as well as the close physical proximity that the trafficker maintained during the healthcare visit (Baldwin et al., 2011; Lederer & Wetzel, 2014). Lastly, some victims did not understand that they were being exploited, and thus disclosure did not occur (Baldwin et al., 2011).

> [I didn't tell the nurse about my situation] because the man was, like, around there, so we couldn't really talk about our situation. He was outside, but he would walk in the hallway where we were, where we were at. He would try to find a way to see if they could listen in. (Marisol, as cited by Baldwin et al., 2011, p. 41)

Screening and HCP Awareness of Trafficking

Nearly 52% of the women and adolescent females in the Lederer study reported that at least one HCP was aware they were 'on the street;' 19.5% of those who answered reported the HCP was aware that a trafficker was involved (Lederer & Wetzel, 2014). No mention is made of specific screening tools used to identify suspected victims. In Chisolm-Straker's study (2016), the majority of patients who were identified as human trafficking victims by HCPs, were either asked about their living situation or their work. While 90% of the participants in the sample reported being asked at least one question

that could be construed as a 'screening question' it is not clear how often these questions were asked as a conscious screening process, or whether a specific tool was used.

Payment for Healthcare Services

Trafficking victims most often paid for healthcare services in cash; however this was not always the case, as victims also paid by other methods, including Medicaid (Baldwin et al., 2011; Ravi et al., 2017a).

Barriers to Follow-Up Care

Challenges to follow-up occurred when victims used a fake name while seeking acute care, and when victims lacked a consistent mailing address or phone number to receive test results (Ravi et al., 2017a). HCPs would prescribe medication and treatment plans, but respondents stated that often they could not afford the medication or the prescribed treatment was incompatible with their lifestyle (Ravi et al., 2017a). Trafficker-related barriers to care (such as limited access to healthcare) also made follow-up difficult for victims (Ravi et al., 2017a).

Victims' Recommendations for Improving Care

Three studies included recommendations from trafficked persons to improve healthcare service and delivery (Baldwin et al., 2011; Ijadi-Maghsoodi et al., 2018; Ravi et al., 2017b). Suggestions covered the following areas: communication and interactions, provision of care, access to services, education and training, and follow-up measures.

Communication and interactions. Survivors suggested that HCPs receive education regarding commercial sexual exploitation. They recommended that providers and other staff be friendly, open, caring, compassionate, empathic and nonjudgmental

(Ijadi-Maghsoodi et al., 2018; Ravi et al., 2017b). They also recommended that HCPs emphasize safety and confidentiality when screening patients (Ravi et al., 2017b). Survivors felt that HCPs should observe patients' body language and cues to identify signs of fear, anxiety or other distress (Baldwin et al., 2011; Ravi et al., 2017b). It was also suggested by numerous respondents that HCPs should approach the issue of exploitation directly, although sensitive questions may cause discomfort. They recommended normalizing the questions so patients would not feel targeted and emphasized the importance of not pushing patients to answer questions (Ravi et al., 2017b). Lastly, HCPs were reminded to be aware of their own reactions when a patient discloses and to take care not to demonstrate negative emotions (Ravi et al., 2017b). "Read the person, their posture, body language, see if they're somebody that you think that could open up to you…Be gentle, because it's a tough topic to bring up with somebody, especially somebody you don't know" (Vicky, as cited by Ravi et al., 2017b, p. 1020). "…Take off that white coat. Become more personable with your patients, because 9 times out of 10, you make them comfortable, they will be comfortable enough to express things that you might need to know" (Lady Moet, as cited by Ravi et al., 2017b, p. 1020). "…I think you should ask 'have you ever been forced into prostitution'… I think it just should be simple, straight to the point… I feel that that should be a mandated thing to do…" (God's Child, as cited by Ravi et al., 2017b, p. 1020).

> … Being very friendly and nice and open, and showing that 'no matter what you've been through, it's okay, it doesn't mean anything to how I feel about

you…I'm still gonna give you the help that you need without showing judgement. (Corey, as cited by Ravi et al., 2017b, p. 1020).

Some respondents indicated that they felt judged by HCPs. The latter tended to occur with questions such as, "What were you doing at the time?" (of the sexual assault) (Ravi et al., 2017b). Some respondents indicated a desire to be notified of the results of the sexual assault evidence kit.

Access to services. Survivors suggested that health care facilities should not dismiss patients who do not have Medicaid (Ravi et al., 2017b). They also recommended increasing the availability of mental health care and public counseling, as well as non-pharmacological methods for mental health support such as meditation, yoga, or counseling on healthy relationships (Ravi et al., 2017b). Increasing treatment opportunities for those with substance addiction was also suggested (Ravi et al., 2017b). Twenty-five percent of respondents recommended that "wrap around" services be available in clinical facilities (Ravi et al., 2017b):

> Stop turning everybody away because they got no Medicaid…everybody don't know how to go to free doctors… when you don't (give people a chance), that's how a lot of germs and diseases go back out. It goes right back out, that's how everybody is getting sick… because it's spreadable… (Knight, as cited by Ravi et al., 2017b p. 1020)

"If people would take advantage of what they have here (jail), that would be good. But you shouldn't have to come here to get it. I think there should be more mental health in the clinics, the public clinics" (Jennifer, as cited by Ravi et al., 2017b, p. 1020).

Discussion

This systematic literature review highlights the very limited data addressing trafficked persons' perspectives about their health, the health consequences of trafficking, and their interactions with HCPs within the U.S. healthcare system. Only 8 peer-reviewed studies published in the English language in the past 10 years met inclusion criteria. However, these studies obtained data from 420 adults and youth, 51 of whom were male.

The health problems described by survivors in these studies are consistent with those documented in other types of studies, with high reported rates of violence, substance use, depression, PTSD symptoms, sexually transmitted infections and pregnancy (Edinburgh, Pape-Blabolil, Harpin, & Saewyc, 2015; Greenbaum, Dodd, & McCracken, 2015; Oram et al., 2012; Ottisova, Hemmings, Howard, Zimmerman, & Oram, 2016; Varma, Gillespie, McCracken, & Greenbaum, 2015; Zimmerman, et al., 2003; Zimmerman et al., 2006). Based on interviews with sex- and labor-trafficked adults and minors receiving services in S.E. Asia, Kiss et al. (2015) documented 48% reporting physical violence, sexual violence or both, while 47% reported being threatened and 20% indicated they had been locked in a room. Not surprisingly, self-reported symptoms of emotional distress were high: 61.2% of respondents reported symptoms of depression, 42.8% reported anxiety and 38.9% reported symptoms of PTSD. In their chart review of suspected victims of child commercial sexual exploitation, Horner and Sherfield (2018) determined that 44.4% of youth had a history of suicidal ideation; Edinburgh found that 47% of suspected commercially sexually exploited youths had attempted suicide within the past year (Edinburgh et al., 2015). Greenbaum et al. (2015) found rates of 47% and

32% for current and prior STIs among their sample of commercially sex trafficked youths. Thirty-two percent of their sample reported a history of pregnancy (Greenbaum et al., 2015).

While the current literature review excluded studies not involving the U.S. healthcare system, studies abroad have documented similar results in terms of physical complaints among trafficked persons. Oram et al. (2012) studied 120 labor- and sex-trafficked women returning to Moldova and receiving post-exploitation services. They found high rates of headaches (61.7%), stomach pain (60.9%), memory problems (44.2%), back pain (42.5%), loss of appetite (35%), and tooth pain (35%). Zimmerman et al. (2006) also found high rates of these and other complaints.

A particular advantage of studies assessing trafficking survivors' use of the healthcare system is the ability to compare the types of physical and mental health symptoms experienced during the period of exploitation with the conditions that led to medical care. The wide array of physical complaints reported by study participants contrasted with the limited focus of much of the actual healthcare assistance, which tended to involve genitourinary complaints and violence-related issues (Baldwin et al., 2011; Ravi et al., 2017a). This suggests that presenting complaints such as traumatic injury, acute sexual assault, pelvic/abdominal pain, vaginal/penile discharge, requests for pregnancy or STI testing, and requests for abortion or treatment of other pregnancy-related issues should alert HCPs to the possibility of human trafficking, particularly if voiced by patients who have risk factors for exploitation. Similarly, the very high rates of reported and diagnosed depression and suicidality imply that patients presenting with

suicidal ideation or suicide attempts should raise concerns of trafficking when other risk factors are present.

Patients with trauma, genitourinary or psychiatric complaints may present in a variety of healthcare settings (Chisolm-Straker, et al., 2016; Lederer & Wetzel, 2014), including emergency departments, urgent care centers, abortion clinics, free clinics, community mental health centers, psychiatric hospitals and private general or specialty clinics. Because of this, and because of the very high rates of trafficked persons seeking medical care during their period of exploitation, it is critical that all healthcare practitioners receive training on human trafficking so they can recognize at-risk patients and offer services. Several national healthcare associations have issued statements supporting the call for professional training (American College of Emergency Physicians, 2016; American Medical Association, 2015; American Medical Women's Association, 2014; American Public Health Association, 2015; Association of Women's Health, Obstetric and Neonatal Nurses, 2016; Emergency Nurses Association, 2015; Greenbaum, Bodrick, & AAP Committee on Child Abuse and Neglect, Global human trafficking and child victimzation: Policy statement, 2017).

The insight provided by the 420 participants in the studies summarized in this report helps to build the evidence base for identifying potential 'red flags' suggestive of human trafficking. While many fact sheets and training curricula caution that the presence of a controlling person accompanying the patient is an important potential indicator of human trafficking, there has been little empirical evidence to support this assumption in the general literature (Polaris Project, n.d.; U.S. Dept. of Homeland

Security, n.d.). However, trafficked persons from the studies by Baldwin et al. (2011) and Ravi et al. (2017a) suggest this is not an uncommon condition. Future studies of trafficked persons may begin to build an evidence base for common potential indicators of human trafficking by focusing on specific conditions and behaviors observable at the time of presentation for medical care (for example, whether or not the patient arrives with a companion; the demeanor of the patient and companion; the apparent power dynamics between the two; whether or not the patient carries identification or money and whether the visit is paid for in cash).

When trafficked persons were asked about their healthcare experiences, a variety of complaints were voiced, as were recommendations for improvement. Notably, many of the latter involved components of trauma-informed, rights-based care (SAMHSA, 2014; Zimmerman & Watts, 2003), including the need for an open, nonjudgmental attitude by the HCP, the critical importance of confidentiality, a caring and empathic response, a focus on safety, the HCP to watch closely for signs of patient distress during the visit, and staff to emphasize that patients may choose whether or not they answer questions (Baldwin et al, 2011; Ijadi-Maghsoodi et al, 2018; Ravi et al, 2017b). Many of these suggestions are included in current guidelines for the care of trafficked persons (Greenbaum & Crawford-Jakubiak, 2015; Zimmerman & Borland, 2009), and the data from survivors helps to provide an evidence base for these recommendations.

Formal screening of patients for possible human trafficking did not appear to be a common experience for the participants in studies summarized in this literature review. Most of the patients in the Chisholm-Straker study (2016) were asked at least one

question that may be considered a 'screening' question, but it is not clear whether a specific screening tool was used. While screening tools for use in the healthcare setting have been developed, published validation studies are lacking for some and limited in others so further research is needed (Chang, Lee, Park, Sy, & Quach, 2015; Greenbaum, Dodd, & McCracken, 2015; Macias-Konstantopoulos & Owens, 2018).

Some of the barriers reported by survivors that concerned seeking healthcare and disclosing their trafficking situation involved factors that are not modifiable by changes in HCP behavior (e.g., a trafficker being reluctant to allow a survivor to go to a clinic/hospital; a survivor experiencing a craving for drugs that outweighs their drive to seek medical care; a trafficker and/or survivor being concerned about sacrificing the time [and the potential to earn money] by seeking care) (Chisolm-Straker et al., 2016; Ravi et al., 2017a; Ravi et al., 2017b). However, other barriers were potentially modifiable by changes in HCP behavior and practice. For example, healthcare providers could take steps to allocate enough time to build trust and rapport with patients, to separate the patient from their companion, to obtain a professional interpreter, to discuss confidentiality concerns (including concerns that the trafficker would learn about certain diagnoses), and to demonstrate a desire to learn about the patient's circumstances and worries. This may require prioritization of suspected human trafficking cases in the triage process, and flexibility in clinic/ED flow when suspicion of exploitation arises during a patient visit. Such prioritization routinely occurs when a severely injured patient arrives to the emergency department, even during peak hours. In such cases, the danger to the patient's health and survival demand immediate and prolonged attention. The adverse

effects and risk of severe harm associated with human trafficking warrant similar prioritization. To manage the time demands, HCPs may be able to obtain help from other staff, including social workers or others in the medical setting. When all staff play a role in recognizing and responding to potential human trafficking, the patient is more likely to obtain needed services and the stress on clinic/ED flow is minimized.

To maximize the likelihood that survivors will receive care in a trauma-informed, rights-based manner and obtain necessary resources and referrals, HCPs should consider developing clinic/hospital protocols or guidelines to help staff recognize potential indicators, ask appropriate questions, conduct appropriate medical evaluations and make suitable reports and referrals to community service agencies and other organizations. There is some evidence to suggest that most hospitals lack such guidelines (Stoklosa, Dawson, Williams-Oni, & Rothman, 2017) but resources are readily available to develop these tools (www.HEALtrafficking.org; https://www.acf.hhs.gov/otip/training/nhttac; traffickingresourcecenter.org).

Some survivors reported frustration at HCP recommendations for treatment and follow-up, indicating that these recommendations were often incompatible with the realities of their lives (e.g., expensive medications or medications that required an unrealistic dosing schedule) (Ravi et al., 2017a). Again, this implies the need for a trauma-informed approach in which the HCP actively engages the patient in planning follow-up care that is reasonable and feasible. This empowers the patient, employs a strength-based approach and helps ensure compliance. However, it may require time and external resources, as well as a certain amount of creativity. Survivors who lack a

permanent address may be able to use that of a trusted person in the community; those who are closely monitored by their trafficker may be able to maintain communication with HCPs by using coded text messages on their phone.

Some barriers to care involve issues not easily addressed by HCPs at the individual patient level. Changing the fee structure at a given facility and increasing patient accessibility to Medicaid may require administrative or even legislative policy changes. Here, too, the HCP may have an impact by advocating for these and other changes to improve victim services. Healthcare professionals can play a role in combatting human trafficking by advocating for victims at the institutional, community and state levels (Greenbaum et al., 2017).

Limitations

While the studies in this review represent diverse geographic locations and study methods, 75% of the studies only included survivors of sex trafficking, with no representation of the labor trafficked population (Ijadi-Maghsoodi et al., 2018; Lederer & Wetzel, 2014; Ravi et al., 2017a; Ravi et al., 2017b; Williamson & Prior, 2009; Willis et al., 2016). Additionally, all but one of the study samples were comprised of 100% female respondents, possibly resulting in gender bias among the responses (Baldwin et al., 2011; Ijadi-Maghsoodi et al., 2018; Lederer & Wetzel, 2014; Ravi et al., 2017a; Ravi et al., 2017b; Williamson & Prior, 2009; Willis et al., 2016). Only one study included information on the length of time the respondents were trafficked, and it varied widely, between two weeks to seven years (Baldwin et al., 2011). The length of time trafficked could directly impact the number of interactions and experiences with the healthcare

system, as well as victims' health outcomes. When using interviews and surveys of trafficked persons, it is not possible to determine whether the reported symptoms/signs met criteria for formal diagnoses and therefore, percentages of victims reporting bipolar or multiple personality disorder (Lederer & Wetzel, 2014) must be interpreted with great caution. However, specific symptoms, such as back pain and headache, may be bothersome or even debilitating regardless of formal diagnoses and may be reliably reported by patients. Lastly, recall bias may be a limitation, as two of the included studies asked participants to report on events that happened as far back as 20 years (Ravi et al., 2017a; Ravi et al., 2017b).

Conclusions/Future Research Recommendations

While published studies examining survivor attitudes and experiences with the U.S. healthcare system are very limited, the information available offers important insight into the medical and mental health needs of trafficked persons and suggests important opportunities for improving the quality of survivor healthcare. Results of the literature review confirm that many trafficked persons do seek healthcare, often for genitourinary symptoms/signs, or violence-related issues. Results suggest that HCP screening for human trafficking is not widespread. Survivor recommendations that HCPs use components of a trauma-informed approach provide support for this model of medical care. Additional research with survivors is needed to ensure their voices are heard and that they contribute to the growing evidence base informing healthcare practice. It is recommended that future studies strive for larger sample sizes and diversity of subjects

both in gender and type of trafficking to ensure that the voices of all trafficked persons are represented.

References

American College of Emergency Physicians. (2016, April). Clinical & practice management ACEP policy statements - human trafficking. Retrieved from American College of Emergency Physicians: https://www.acep.org/Clinical---Practice-Management/Human-Trafficking/#sm.000115jk0eflccsoydd1k22k6fjqe

American Medical Association. (2015). Physicians response to victims of human trafficking. Retrieved from American Medical Association: https://policysearch.ama-assn.org/policyfinder/detail/H-65.966?uri=%2FAMADoc%2FHOD.xml-0-5095.xml

American Medical Women's Association. (2014, May). Position paper on the sex trafficking of women and girls in the United States. Retrieved from American Medical Women's Association: https://www.amwa-doc.org/wp-content/uploads/2013/12/AMWA-Position-Paper-on-Human-Sex-Trafficking_May-20141.pdf

American Public Health Association. (2015, Nov 3). Expanding and coordinating human trafficking-related public health research, evaluation, education, and prevention. Retrieved from American Public Health Association: https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2016/01/26/14/28/expanding-and-coordinating-human-trafficking-related-public-health-activities

Association of Women's Health, Obstetric and Neonatal Nurses. (2016, March). AWHONN position statement - human trafficking. Retrieved from JOGNN:

http://www.jognn.org/article/S0884-2175(16)30149-6/pdf?utm_source=awhonn.org

Baldwin, S., Eisenman, D., Sayles, J., Ryan, G., & Chuang, K. (2011, July). Identification of human trafficking victims in health care settings. *Health and Human Rights, 13*(1), 36-49.

Barron, C., Moore, J., Baird, G., & Goldberg, A. (2016, Sep). Sex trafficking assessment and resources (STAR) for pediatric attendings in Rhode Island. *Rhode Island Medical Journal*, 27-30.

Chang, K., Lee, K., Park, T., Sy, E., & Quach, T. (2015). Using a clinic-based screening tool for primary care providers to identify commercially sexually exploited children. *Journal of Applied Research on Children: Informing Policy for Children at Risk, 6*(1), 1-15.

Chisolm-Straker, M., Baldwin, S., Gaïgbé-Togbé, B., Ndukwe, N., Johnson, P., & Richardson, L. (2016, Aug). Health care and human trafficking: We are seeing the unseen. *Journal of Health for the Poor and Underserved, 27*(3), 1220-1233.

Chisolm-Straker, M., Richardson, L. D., & Cossio, T. (2012). Combating slavery in the 21st century: The role of emergency medicine. *Jounal of Health Care for the Poor and Underserved, 23*(3), 980-987.

Edinburgh, L., Pape-Blabolil, J., Harpin, S. B., & Saewyc, E. (2015). Assessing exploitation experiences of girls and boys seen at a child advocacy center. *Child Abuse & Neglect, 46*, 47-59.

Emergency Nurses Association. (2015, Feb). Position Statement - Human trafficking patient awareness in the emergency setting. Retrieved from Emergency Nurses Association: https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/humantraffickingpatientawareness.pdf?sfvrsn=cd0ad835_14

Greenbaum, J. (2016, Dec). Identifying victims of human trafficking in the emergency department. *Clinical Pediatric Emergency Medicine, 17*(4), 241-248.

Greenbaum, J., & Crawford-Jakubiak, J. E. (2015, Mar). Child sex trafficking and commercial sexual exploitation: Health care needs of victims. *Pediatrics, 135*(3), 566-574.

Greenbaum, J., Bodrick, N., & AAP Committee on Child Abuse and Neglect, AAP Section on International Child Health (2017). Global human trafficking and child victimzation: Policy statement. *Pediatrics, 140*(6), e20173138.

Greenbaum, V. J., Dodd, M., & McCracken, C. (2015). A short screening tool to identify victims of child sex trafficking in the health care setting. *Pediatric Emergency Care, 23*, 1-5.

Horner, G., & Sherfield, J. (2018, Feb). Commercial sexual exploitation of children: Health care use and case characteristics. *Journal of Pediatric Health Care*.

Human Rights First. (2017, Jan 7). Human trafficking by the numbers. Retrieved from Human Rights First: https://www.humanrightsfirst.org/resource/human-trafficking-numbers

Ijadi-Maghsoodi, R., Bath, E., Cook, M., & Textor, L. (2018, Feb). Commercially sexually exploited youths' health care experiences, barriers, and recommendations: A qualitative analysis. *Child Abuse & Neglect, 76*, 334-341.

International Labour Organization. (2014). Profits and poverty: The economics of forced labour. Geneva: Interational Labour Organization Publications.

International Labour Organization. (2017, September). Forced labour, modern slavery and human trafficking. Retrieved from International Labour Organization: http://www.ilo.org/global/topics/forced-labour/lang--en/index.htm

Kiss, L., Pocock, N. S., Naisanguansri, V., Suos, S., Dickson, B., Thuy, D., . . . Zimmerman, C. (2015, Mar). Health of men, women, and children in post-trafficking services in Cambodia, Thailand, and Vietnam: An observational cross-sectional study. *Lancet Global Health, 3*(3), e154-61.

Lederer, L., & Wetzel, C. (2014). The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities. *The Annals of Health Law, 23*(1), 61-91.

Lumpkin, C. L., & Taboada, A. (2017, Jan 13). Identification and referral for human trafficking in health care settings: Survey report. Retrieved from CAST - Coalition to Abolish Slavery & Trafficking: http://www.castla.org/assets/files/Identification_and_Referral_in_Health_Care_Settings_survey_report_2017.pdf

Macias-Konstantopoulos, W. L., Munroe, D., Purcell, G., Tester, K., & Burke, T. F. (2015). The commercial sexual exploitation and sex trafficking of minors in the

Boston metropolitan area: Experiences and challenges faced by front-line providers and other stakeholders. *Journal of Applied Research on Children: Informing Policy for Children at Risk, 6*(1).

Macias-Konstantopoulos, W., & Owens, J. (2018, Jan). Adult human trafficking screening tool and guide. Retrieved from National Human Trafficking Training and Technical Assistance Center: https://www.acf.hhs.gov/sites/default/files/otip/adult_human_trafficking_screening_tool_and_guide.pdf

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D., G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLoS Medicine*, 6(7):e1000097.

Oram, S., Stockl, H., Busza, J., Howard, L. M., & Zimmerman, C. (2012). Prevalence and risk of violence and the physical, mental and sexual health problems associated with human trafficking: Systematic review. *PLOS Medicine, 9*(5).

Oram, S., Ostrovschi, N. V., Gorceag, V. I., Hotineanu, M. A., Gorceag, L., Trigub, C., & Abas, M. (2012, July). Physical health symptoms reported by trafficked women receiving post-trafficking support in Moldova: Prevalence, severity and associated factors. *BMC Women's Health,* 12(20).

Ottisova, L., Hemmings, S., Howard, L., Zimmerman, C., & Oram, S. (2016). Prevalence and risk of violence and the mental physical and sexual health problems associated with human trafficking: An updated systematic review. *Epidemiology and Psychiatric Sciences, 25*, 317-341.

Polaris. (2015). Human Trafficking Overview. Retrieved October 19, 2015, from The Polaris Project: http://www.polarisproject.org/human-trafficking/overview

Polaris. (2016). 2016 Statistics from the National Human Trafficking Hotline and BeFree Textline. Retrieved from Polaris: http://polarisproject.org/sites/default/files/2016-Statistics.pdf

Polaris Project. (n.d.). Recognize the signs. Retrieved from Polaris Project: http://polarisproject.org/human-trafficking/recognize-signs

Powell, C., Dickens, K., & Stoklosa, H. (2017). Training U.S. health care professionals on human trafficking: Where do we go from here? *Medical Education Online, 22*(1), 1-12.

Ravi, A., Pfeiffer, M., Rosner, Z., & Shea, J. (2017a). Identifying health experiences of domestically sex-trafficked women in the USA: A qualitative study in Rikers Island Jail. *Journal of Urban Health, 94*, 408-416.

Ravi, A., Pfeiffer, M., Rosner, Z., & Shea, J. (2017b, Dec). Trafficking and trauma: Insight and advice for the healthcare system from sex-trafficked women incarcerated on Rikers Island. *Medical Care, 55*(12), 1017-1022.

SAMHSA. (2014, July). SAMHSA's concept of trauma and guidance for a trauma-informed approach. Retrieved from Substance Abuse and Mental Health Services Administration: https://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf

Stoklosa, H., Dawson, M. B., Williams-Oni, F., & Rothman, E. F. (2017). A review of U.S. health care institution protocols for the identification and treatment of victims of human trafficking. *Journal of Human Trafficking, 3*(2), 116-124.

Stoklosa, H., Showalter, E., Melnick, A., & Rothman, E. (2016, Oct). Health care providers' experience with a protocol for the identification, treatment, and referral of human-trafficking victims. *Journal of Human Trafficking, 3*(3), 182-192.

U.S. Congress. (2000, Jan 24). Trafficking Victims Protection Act of 2000. Retrieved from U.S. Government Publishing Office: https://www.gpo.gov/fdsys/pkg/BILLS-106hr3244enr/pdf/BILLS-106hr3244enr.pdf

U.S. Dept. of Homeland Security. (n.d.). Indicators of human trafficking. Retrieved from Blue Campaign: https://www.dhs.gov/blue-campaign/indicators-human-trafficking

U.S. Dept. of State. (2016, June). Trafficking in persons report: June 2016. Retrieved from Department of State - United States of America: https://www.state.gov/documents/organization/258876.pdf

U.S. DHHS - ACF. (2017, March 16). SOAR to health and wellness training. Retrieved from U.S. Department of Health & Human Services - Administration for Children & Families - Office on Trafficking in Persons: https://www.acf.hhs.gov/otip/training/soar-to-health-and-wellness-training

U.S. DHHS OTIP. (2017, Nov 21). Fact sheet: Human trafficking. Retrieved from U.S. Department of Health and Human Services Office of the Administration for

Children & Families Office on Trafficking in Persons: https://www.acf.hhs.gov/otip/resource/fshumantrafficking

Varma, S., Gillespie, S., McCracken, C., & Greenbaum, V. J. (2015). Characteristics of child commercial sexual exploitation and sex trafficking victims presenting for medical care in the United States. *Child Abuse & Neglect, 44*, 98-105.

Williamson, C., & Prior, M. (2009). Domestic minor sex trafficking: A network of underground players in the Midwest. *Journal of Child & Adolescent Trauma, 2*, 46-61.

Willis, B., Vines, D., Bubar, S., & Ramirez Suchard, M. (2016). The health of children whose mothers are trafficked or in sex work in the U.S.: An exploratory study. *Vulnerable Children and Youth Studies, 11*(2), 127-135.

Zimmerman, C., & Borland, R. (2009). Caring for trafficked persons: Guidance for health providers. Geneva: International Organization for Migration.

Zimmerman, C., & Kiss, L. (2017). Human trafficking and exploitation: A global health concern. *PLOS Medicine*, 1-11.

Zimmerman, C., & Watts, C. (2003). World Health Organization ethical and safety recommendations for interviewing trafficked women. World Health Organization.

Zimmerman, C., Hossain, M., Yun, K., Roche, B., Morison, L., & Watts, C. (2006). Stolen smiles: The physical and psychological health consequences of women and adolescents trafficked in Europe. London: The London School of Hygiene & Tropical Medicine.

Zimmerman, C., Yun, K., Shvab, I., Watts, C., Trappolin, L., & Treppete, M. (2003). The health risks and consequences of trafficking in women and adolescents: Findings from a European study. London: London School of Hygiene and Tropical Medicine (LSHTM).

Appendix A

Table 1. Included Studies

#	Author(s) Year/ Study Title	Research Question(s)	Study Design/ Location	Study Sample	Results
1	Baldwin, S. B., Eisenman, D. P., Sayles, J. N., Ryan, G., & Chuang, K. S. 2011. Identification of human trafficking victims in health care settings	Examine trafficking survivors' encounters at health care settings while they were still being trafficked	• Qualitative • In-depth, face-to-face, semi-structured interviews • Los Angeles, CA	<u>Phase 1:</u> • n=6 • Key informants who work with trafficking victims <u>Phase 2:</u> • n=12 • Female trafficking survivors, ages 22-63	• 50% were seen by a health care provide (HCP) while being trafficked • Sex trafficked victims were seen for STIs, pregnancy tests, and abortions • Sex trafficking victims were tested repeatedly for STIs • Most victims were brought by traffickers who completed any forms necessary, spoke with HCP for the victim, and paid for services in cash • <u>Barriers to disclosure included:</u> ▪ Trafficker's physical proximity to victim during health care services ▪ Language barrier ▪ Trafficker appeared to have a personal relationship with the health care provider ▪ Safety concerns for self and others ▪ Victims' fear and shame ▪ Victims feeling helpless & hopeless ▪ Lack of self-recognition as a victim • None of the survivors in this study were identified as victims by HCP when seeking care • None of the survivors or key informants knew of anyone who had been identified as a victim during a health care visit • Survivor's recommend that HCPs should observe the patient for cues such as their body language, and take note if the patient is scared and nervous
2	Chisolm-Straker, M., Baldwin, S., Gaïbé-Togbé, B., Ndukwe, N., Johnson, P. N., & Richardson, L. D. 2016.	What is the frequency with which trafficked people encounter health providers in the U.S.? Which are the health care settings most frequented by	• Quantitative • Anonymous, retrospective survey • Paper and on-line surveys • New York	• n=173 • Individuals who had been trafficked in the United States • Gender ▪ 121 Females ▪ 51 Males • Birth Countries ▪ USA (n=77, 44.5%)	• 73% (n=127) reported a desire to see a health care provider while being trafficked. • 68% (n=117) were able to see a health care provider while being trafficked • Reasons respondents (n=51) could not see a health care provider while being trafficked, included: ▪ Inability to pay (37%, n=19) ▪ Fear of seeing a provider (35%, n=18) ▪ Prevented by someone (31%, n=16) • The types of providers respondents saw for health care included: ▪ Emergency Medicine/Urgent Care (56%, n=65) ▪ Primary Care, (44%, n=52)

	Health care and human trafficking: We are seeing the unseen	victims of human trafficking? Are trafficking victims' situations being recognized by health providers? Which expert-recommended screening questions are being used by health providers?		▪China (n=18, 10.4%) ▪Mexico (n=15, 8.7%) ▪Philippines (n=12, 7%) ▪Vietnam (n=5, 2.9%) ▪Japan (n=4, 2.3%) ▪Korea (n=4, 2.3%) ▪Brazil (n=3, 1.7%) ▪Indonesia (n=3 1.7%) ▪India (n=2, 1.2%) ▪Lithuania (n=2, 1.2%) ▪Poland (n=2, 1.2%)	▪Dentist, (27%, n=31) ▪Obstetric/Gynecologist (26%, n=30) ▪Alternative Healer (9%, n=10) ▪Other (5%, n=6) ▪Pediatrician (3%, n=4) ▪Don't Know (1%, n=1) • The most common health issues respondents experienced while they were trafficked, included: ▪Physical Abuse (66%, n=113) ▪Self-diagnosed Depression (65%, n=112) ▪Headache (45%, n=78) ▪Back Pain (42%, n=72) ▪Weight loss (no data provided) ▪Menstruation problems (no data provided) ▪Nausea/vomiting (no data provided) • A significant majority of patients who were identified as being trafficked were asked about the following screening topics: ▪Their living situation (61%, n=31) ▪Their work (84%, n=43)
3	Ijadi-Maghsoodi, R., Bath, E., Cook, M., Textor, L., Barnert, E. 2018. Commercially sexually exploited youths' health care experiences, barriers, and recommendati	Examine commercially sexually exploited (CSE) youths' health care experiences, barriers to care, and recommendations for improving health care services	• Qualitative • Focus groups, semi-structured focus group guide • Los Angeles, CA	• n = 18 • 100% females • Ages 12-19 • Identified as ever being sexually exploited for another person's gain • Focus groups size (range, 2-5)	• Themes that emerged included facilitators to care, barriers to care, and recommendations for improving health services, as well as "lived experiences 'in the life.'" • <u>Facilitators to Care:</u> ▪Wide availability of reproductive health services ▪Mental health services were available while in detention centers or group homes. Mental health care was oftentimes provided irrespective of youth's desire to engage in it. ▪Youths' knowledge of sexually transmitted infections (STIs) • <u>Barriers to Care:</u> ▪Feeling judged by health care providers ▪Providers offering youths opinions without trying to understand the holistic picture of their lives ▪Concerns about confidentiality, especially related to probation officers or staff at group homes. ▪General fears, including traffickers, certain diagnoses, and the police (seeking health care and then being arrested for an outstanding warrant).

	ons: A qualitative analysis				▪Self-reliance and street smarts and the need to work frequently • Recommendations for Improving Care: ▪Improved understanding of CSE by health care providers ▪Provide long-term peer/survivor mentors ▪Improve awareness and communication about CSE in the community ▪Increase education about reproductive care and STIs early on, in schools ▪Use of a non-judgmental approach toward CSE youths by health care providers
4	Lederer, L. J., & Wetzel, C. A. 2014. The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities	• Examine health issues of sex trafficking victims • Analyze health care access & interactions of providers and victims • Collect data on symptoms experienced during & after trafficking	• Mixed method design • Focus groups with structured interviews, open-ended questions • 3-part health survey Locations: • Columbus, OH • Honolulu, HI • San Diego, CA • San Francisco, CA • Sacramento, CA • Los Angeles, CA • Minneapolis, MN • St. Paul, MN • St. Louis, MO • Washington, D.C. • Asheville, NC • Nashville, TN	n=107 • Domestic female survivors of sex trafficking • Ages 14-60 • Focus groups size $\bar{X}$=9, (range, 2-22)	Physical Health Problems: (n=106 unless otherwise noted) • At least one health problem (99.1%) • Neurological (91.7%), (memory problems, insomnia, dizziness, poor concentration, headaches/migraines) • Physical Injuries (69.2%), n=102 (most often to the face or head) • Cardiovascular/Respiratory (68.5%) • Gastrointestinal (62%) • Dental (54.3%), n=105 (tooth loss most common) • Poor Dietary Health, (71.4%) had at least one of the following: severe weight loss, malnutrition, loss of appetite, eating disorder Psychological Symptoms: (n=106 while trafficked, n=83 post trafficking, unless otherwise noted) • At least one psychological issue while trafficked vs. post trafficking (98.1% vs. 96.4%) • Average number of psychological issues while trafficked vs. post trafficking ($\bar{X}$=12.11 vs. $\bar{X}$=10.5) • Depression while trafficked vs. post trafficking (88.7% vs. 80.7%) • PTSD while trafficked vs. post trafficking (54.7% vs. 61.5%) • Shame & guilt while trafficked vs. post trafficking (82.1% vs. 71.1%) • Suicide attempt while trafficked vs. post trafficking (41.5% vs. 20.5%) • Acute stress (38.7%) • Bipolar (30.2%) • Depersonalization (19.8%) • Multiple personality (13.2%) • Borderline personality (13.2%) Reproductive Issues: • Victims contracted STD/STI (67.3%) • At least one gynecological symptom besides STD/STI (63.8%)

					• At least one pregnancy during trafficking (71.2%), n=66 • 5+ pregnancies during trafficking (21.2%), n=66 • At least one miscarriage during trafficking (54.7%), n=64 • At least one abortion during trafficking (55.2%), n=67 • Multiple abortions during trafficking (29.9%), n=67 • ≥ 1 abortion was partially forced upon the victim (53%), n=34 <u>Violence, Abuse, & Humiliation:</u> • Forms of abuse inquired about: being threatened with a weapon, shot, strangled, burned with cigarettes, kicked, punched, beaten, stabbed, forced sex (oral/vaginal/anal), penetrated with a foreign object, forced unprotected sex, abused by a person of authority, asked to perform scenes from porn, forced pornography, verbal abuse, threats, intimidation and humiliation. • Victim confirmed at least one form of violence (92.2%), n=103 • Victims reported experiencing a mean of 6.25 forms of violence • Victims reported experiencing the following: Forced sex (81.6%), Punched (73.8%), Beaten (68.9%), Kicked (68%), Forced unprotected sex (68%), Threatened with weapon (66.0%), Strangled (54.4%), Abused by person of authority (50.5%), Recreate scenes from pornography (29.3%), forcibly recorded for pornographic reasons (17.1%) <u>Substance Abuse</u>: • Either forced upon victims as a method of control, or utilized as a way to survive their exploitation and abuse • 84.3% used alcohol, drugs, or both while trafficked (n=102) • 27.9% reported forced substance use (n=102) • Victims reported using the following: Alcohol (59.8%), Marijuana (53.4%), Cocaine (50.5%), Crack Cocaine (44.7%), Heroin (22.3%), Ecstasy (13.6%), PCP (9.7%) <u>Provision of Health Care</u>: (n=98) • 87.8% of victims had contact with a health care provider (HCP) while being trafficked • 63.3% sought care at a hospital/emergency room • 57.1% sought care at a clinic: urgent care, women's health, neighborhood, or Planned Parenthood • 22.5% of victims sought care from a regular doctor • 13.3% of victims sought care from "other" <u>Where Victims Sought Abortions:</u> (n=37) • Clinics (67.6%) • Hospital (16.2%)

					• Other (13.5%) • Different site at different times (2.7%) <u>Type of Birth Control Utilized During Sex Trafficking</u>: (n=59 unless otherwise noted) • Condoms (52.5%) • Multiple Types (22%) • Depo-Provera (11.9%) • Birth Control Pill (10.2%) • IUD (3.4%) • 80.9% used some form of birth control for some portion of the time they were trafficked (n=73) • 51.7% obtained birth control from a doctor or clinic • 65.2% went alone to obtain birth control
5	Ravi, A., Pfeiffer, M. R., Rosner, Z., and Shea, J.A. 2017. Trafficking and Trauma: Insight and Advice for the Healthcare System from Sex-trafficked Women Incarcerated on Rikers Island	• Understand sex-trafficking survivors' experiences with trauma while being trafficked • Eliciting sex-trafficking survivors' advice on health care delivery	• Qualitative Single, in-person, audio-recorded interviews • New York, NY	• n = 21 • 100% female • Age 18+ • Inmates in New York City's women's jail (Rose M. Singer Center) • Comfortable completing the interview in English • Had been forced into prostitution or made to turn tricks by family members, boyfriends, friends, pimps, or other people they had met	<u>Interpersonal Violence</u>: • 19 had traffickers/2 sold sex as minors without a trafficker. Traffickers were comprised of: ▪ Exploiter who ran trafficking ring (42.9%, n=9) ▪ Drug dealer (23.8%, n=5) ▪ Mother (9.5%, n=2) ▪ Intimate partner (9.5%, n=2) ▪ Stranger (4.8%, n=1) • Women endured physical, sexual, and psychological violence, perpetrated by traffickers and buyers. Examples of violence included: ▪ Beaten to unconsciousness; gang rape; being choked, burned or imprisoned; threatened with weapons or harm to loved ones; deprived of sleep, food, and clothing; and witnessing violence against other women/girls. • Women in trafficking rings had "daily quotas" and experienced violence when those quotas were not met. <u>Behavioral Health:</u> • Substance use was employed to cope with the trauma women experienced. • 100% had histories of substance use at various points in their life. • Heroin, cocaine, and marijuana were the most frequently used substances to deal with trauma experienced. ▪ Heroin was used to numb physical pain that occurred during sex work ▪ Cocaine was used to reduce the need for sleep so one could continue working and meet the daily quota

					• Women were diagnosed with anxiety, depression and post-traumatic stress disorder (PTSD) after being trafficked. • Women also experienced feeling unsafe at night, easily startled, hyper-suspicious of normal interactions, low self-esteem, issues with intimacy and relationships with partners and family members. Health Care Delivery Advice: <u>General Perceptions</u>: • The women felt intimidated by health care providers • Feel that the health system cares more about receiving payment then providing care <u>Provider-Patient Communication</u>: • Women would feel more comfortable in health care settings, if health care providers and the front desk and support staff would communicate with compassion, and empathy, and not be judgmental. • Approaching the issue directly would make survivors feel more comfortable. • Normalize the question so people do not feel targeted, but do not require them to answer. • Emphasize safety and confidentiality while screening the patient. • It is important for health care providers to be self-aware of their reactions and avoid an adverse reaction when a patient makes a disclosure. <u>Sexual Assault Examinations</u>: • Women described feeling judged when asked routine questions such as, "What were you doing at the time?" (of the event). • Some women indicated that they felt coerced out of reporting. • Some women could not wait extended time periods for an exam, thus they did not engage in a forensic exam, or left before it was completed. • Women desire to be contacted about the results of the rape kit. <u>Improving Direct-Services:</u> • Increase opportunities for methadone treatment for those with substance addiction. • 25% of participants recommended "wrap around" services in clinical facilities • Women also frequently suggested providing non-pharmacological methods for mental health support, such as meditation, or yoga, or suggestions to avoid unhealthy relationships. <u>Prevention Measures:</u> • 20% brought up the need for trafficking prevention programs outside the clinic, in places such as jails and schools.

6	Ravi, A., Pfeiffer, M.R., Rosner, Z., Shea, J. A. 2017. Identifying Health Experiences of Domestically Sex-trafficked women in the USA: A Qualitative Study in Rikers Island Jail	• Understand healthcare access, reproductive health, and infectious disease experiences of domestically sex-trafficked women in the United States	• Qualitative • Single, in-person, audio-recorded interviews • New York, NY	• n = 21 • 100% female • Ages 19-60 • Inmates in New York City's women's jail (Rose M. Singer Center) • Comfortable completing the interview in English • Had been forced into prostitution or made to turn tricks by family members, boyfriends, friends, pimps, or other people they had met	• 100% of participants reported use of illicit substances while trafficked <u>Healthcare Access</u>: • *Reasons for Accessing Care*: ▪ STI and HIV testing ▪ Unintended pregnancy ▪ Violence-related issues (rape, traumatic injury, suicide attempt) ▪ Chronic disease management (hypothyroidism, asthma) • *Payment for Services*: ▪ Survivors from trafficking-ring-related sexual exploitation frequently paid for healthcare and prescriptions out of pocket ▪ Those trafficked by other methods/individuals frequently used Medicaid • *Most Common Care Locations*: ▪ Emergency Departments (ED) (Absence of personal identification and insurance compelled survivors to select the ED for care) ▪ Jails (This was the only care location for some survivors. As a result of their intake health screening, some survivors learned of new health diagnoses, including gonorrhea, chlamydia, HPV, Hepatitis C) ▪ Women's Health Clinics (Planned Parenthood) ▪ Free or Department of Health Clinics ▪ Non-trafficking-ring survivors also utilized private outpatient primary care or gynecologic clinics as well • *Trafficker-Related Factors*: ▪ Healthcare access was restricted out of concern that women would run, turn in the trafficker, or that loss of 'working time' would impact the trafficker financially ▪ Injuries were sometimes treated by traffickers (with medical supplies from a pharmacy), or by a private contact (assumed to be a physician) at the place the woman was held ▪ Health care was sometimes not sought, due to fear of retribution from the trafficker for specific diagnoses (pregnancy and infections - such as HIV) ▪ When healthcare visits were allowed the trafficker or another trafficked woman would accompany the victim to intimidate and maintain control. • *Non-trafficker Related Factors*: ▪ Some women shared that their substance use was a higher priority than their healthcare needs ▪ Some women expressed criminal-justice related fears in conjunction with seeking healthcare (fear of arrest for substance use and prostitution) • *Follow-up Care*:

					▪ Receiving test results was difficult due to the lack of a consistent telephone number or mailing address. ▪ Follow-up treatments were difficult due to trafficker and non-trafficker related factors. ▪ Some women used a fake name and/or address when registering for acute healthcare, making follow-up problematic ▪ Treatment medication challenges were a common theme due to incompatibility with lifestyle (no sex for 7 days, nightly vaginal antibiotic suppository). Women would sometimes not use the treatment or seek follow-up care at another location if they needed re-treatment ▪ Cost of medication was another challenge (women needed to see more buyers to offset the medication costs). <u>Reproductive Health</u>: • *Menstruation*: ▪ Some women did not see clients while menstruating ▪ Some women "stuffed" their vaginal area with absorbent items in order to continue meeting their trafficker's daily quotas ▪ Some women offered oral or anal sex while menstruating, or engaged in "thigh sex," especially if clients were using drugs and not likely to notice • *Pregnancy*: ▪ The possibility of pregnancy caused women stress, because they feared it would cause trafficker-initiated violence due to the financial loss associated with unintended pregnancy ▪ Women had a variety of abortion experiences. ➢ Transportation and cost were barriers that sometimes caused later-term procedures ▪ Women had a variety of prenatal care experiences ➢ Some received prenatal care (one woman engaged in family reunification and remained substance free during her pregnancy) ➢ Other women were not allowed to seek prenatal care ▪ Birth control methods included condoms (most common), and Depot-Provera injections. Three women had intrauterine devices, but all had them removed due to pain. Emergency contraception use was uncommon. Infectious Diseases: • *Condoms*: ▪ Access to condoms varied among the women ▪ Free condoms (from hospitals, clinics, and needle exchange programs) were obtained by women outside of trafficking rings

					▪Women in trafficking rings normally obtained condoms from their trafficker, or purchased them in hotels or pharmacies ▪Considerations regarding condom use negotiation included: ➢ Trafficker expectations of condoms use with customers - always, and never with the trafficker (STI diagnosis would indicate lack of condom use with buyers) ➢ Financial loss if customers only desired sex without condom use (some women would "break the rules" for regular buyers or those without visible signs of infection) ➢ Violence from buyers if the woman insisted on condom use ➢ Payment was higher for non-condom use, which outweighed health safety for some women ➢ Substance use impacted some women's ability to negotiate for condom use with buyers ▪If condoms were not used or failed, women used several practices in an attempt to reduce infection risk. They included: ➢ Frequently gargling mouthwash ➢ Sitting in a tub of bleach ➢ Douching ➢ Using over the counter antiseptics ➢ Changing condoms ➢ Making an appointment for a pap smear • *HIV*: ▪Women shared that HIV infection was their greatest health-related fear ▪Some women feared HIV infection because they had infected family members ▪Rapid HIV testing was not helpful to the women because of their circumstances, yet direct viral load testing was not frequently offered due to its cost. Some women would falsely report HIV-related symptoms to obtain a direct viral load test. ▪Women feared disclosing their HIV-infected status to traffickers or buyers, and feared they had potentially exposed others if condoms were not used or failed ▪Women feared that other traffickers or women in prostitution would send an HIV-infected buyer to them for intercourse, as a form of revenge.
7	Williamson, C. and Prior, M.	•Identify the experiences, well-being, and risk factors	• Qualitative • Face-to-face interviews	• n = 13 • 100% female • Ages 12-17	<u>Experiences of Victims While Involved:</u> *Trauma Through Physical Violence* • Youth experienced violence while trafficked. Robbery, rape, and physical assaults were the most common.

	2009. Domestic minor sex trafficking: A network of underground players in the Midwest	associated with youth who have been involved in prostitution.	• Toledo, OH	• 7 African Americans • 5 White • 1 Hispanic	• One woman was pulled out of her car, hit in the back of the head, knocked out, and then was beaten, receiving a broken nose and two black eyes and fattened lips. *Mental and Emotional Trauma* • Self-esteem of victims was severely affected, as well as self-confidence and self-worth. • Girls experienced shame and guilt. • Most reported depression, hypervigilance, and symptoms of posttraumatic stress disorder. • Some girls had been diagnosed with depression and bipolar disorder. • Chronic stress, periodic acute trauma, and daily hassles are always present with few positive informal support systems.
8	Willis, B., Vines, D., Bubar, S., and Ramirez Suchard, M. 2016. The health of children whose mothers were trafficked or in sex work in the U.S.: An exploratory study	• Understand the health problems of children whose mothers are trafficked or in sex work in the United States • Understand the health problems and health seeking behaviors of mothers who are trafficked or in sex work in the United States	• Mixed methods study • Questionnaire with quantitative and qualitative questions • Methodology used was similar to motherhood & neighborhood methodologies (reporting not on their own experiences, but on the experiences of individuals that they know) <u>Four Cities</u>: • Portland, OR • New York City • Boston, MA • Washington, DC	• 76 participants • 100% female • > 18 years of age • Had been trafficked or in sex work, and knew trafficked adolescents or adult women sex workers	<u>Health Problems & Health Seeking Behaviors of Mothers who are Trafficked or in Sex Work in the U.S.</u>: • 86% knew of a teen and 92% knew of an adult who was trafficked or a sex worker (T/SW) and became pregnant or had children. • 79% of respondents stated that teen T/SWs get abortions, with the median estimate of occurrence being 50% • 74% of respondents stated that adult T/SWs get abortions, the median estimate of occurrence was 50% • 49% of respondents said that teen T/SWs get abortions at Planned Parenthood. Other locations were not reported. • 84% of respondents stated that teen T/SWs have miscarriages, with the median estimate of occurrence being 35%. • 79% of respondents stated that adult T/SWs have miscarriages, with the median estimate of occurrence being 50% • 97% of respondents stated that both teen and adult T/SWs have children. The median for teen T/SWs being 2 children and the median for adult T/SWs being 3 children. • 89% of respondents stated that teen T/SWs get regular prenatal checkups, yet the median estimate of occurrence was only 20%. • 84% of respondents stated that adult T/SWs get regular prenatal checkups, yet the median estimate of occurrence was only 45%. • Respondents stated that both teen T/SWs (39%) and adult T/SWs (42%) went to free clinics for their prenatal checkups. Other locations were not reported. • 97% of respondents stated that teen T/SWs use alcohol daily while they are pregnant, with the median estimate of occurrence being 85%.

					• 99% of respondents stated that adult T/SWs use alcohol daily while they are pregnant, with the median estimate of occurrence being 71%. • 79% of respondents stated that teen T/SWs use marijuana while pregnant, and 43% stated that adult T/SWs use marijuana while pregnant. • 92% of respondents stated that teen T/SWs are depressed while pregnant, with a median estimate of occurrence at 95% • 99% of respondents stated that adult T/SWs are depressed while pregnant, with a median estimate of occurrence at 100%. • 86% of respondents stated that teen T/SWs delivered their babies at a hospital, and 85% stated that adult T/SWs delivered their babies at a hospital. • 38% of respondents stated that teen T/SWs had complications during pregnancy and 22% of respondents stated that teen T/SWs had complications during postpartum. • 48% of respondents stated that adult T/SWs had complications during pregnancy and 26% of respondents stated that adult T/SWs had complications during postpartum. • 85% of respondents stated that teen T/SWs infants had complications • 86% of respondents stated that adult T/SWs infants had complications • 12% of respondents stated that teen T/SWs breast-feed their infants • 27% of respondents stated that adult T/SWs breast-feed their infants • 92% of respondents stated that teen T/SWs are depressed after giving birth, with a median estimate of occurrence at 100% • 99% of respondents stated that adult T/SWs are depressed after giving birth, with a median estimate of occurrence at 100%. • 73% of respondents stated that teen T/SW's children are raised by the mother's family, 9% stated children are raised by their mother, and 5% stated children are raised by a government agency • 59% of respondents stated that adult T/SW's children are raised by the mother's family, 17% stated children are raised by the mother, and 3% stated children are raised by a government agency <u>Health Problems of Children Whose Mothers are Trafficked or in Sex Work in the U.S.:</u> • 72% of respondents stated that children of T/SWs are physically hurt • 72% of respondents stated that children of T/SWs are sexually abused • 11% of respondents stated that they know of deaths of children of T/SWs due to physical abuse

					• 81% of respondents stated that children of T/SWs have mental health problems. • 93% of respondents stated that children of T/SWs are given drugs or alcohol. • 92% of respondents stated that children of T/SWs see their mothers or other women physically abused, with a median estimate of occurrence at 92% as well. • 84% of respondents stated that children of T/SWs see their mothers or other women sexually abused, with a median estimate of occurrence at 50%. • 89% of respondents stated that daughters of both teen and adult T/SWs are forced into prostitution, with a median estimate of occurrence at 50%.

Manuscript 3

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Preparedness to Identify and Care for Trafficked Persons in South Carolina Hospitals: A State-Wide Exploration

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Abstract

This qualitative descriptive study utilized stratified purposive sampling to investigate how prepared hospitals throughout the state of South Carolina were to identify and care for individuals experiencing human trafficking. Hospitals were invited to participate if trafficking had been reported to the National Human Trafficking Hotline, in 2016, in their geographic location. Telephone interviews were conducted with Emergency Department (ED) directors/managers due to their knowledge of clinical practices and policies/procedures within the ED, as well as evidence that trafficking victims frequently seek care in this setting. Eighteen hospitals comprised the final sample with facilities from all four regions of the state represented. Statewide, hospitals were lacking human trafficking response protocols, health care professionals had not received training about human trafficking, and safety issues surrounding care of this population were frequently unrecognized. The majority of healthcare professionals (HCPs) believed trafficking occurred in their area; yet, few believed they had cared for a victim. South Carolina hospitals have many opportunities to improve their responses to trafficked persons, including developing and implementing human trafficking response policies/protocols; providing training for HCPs; ensuring the safety of victims, HCPs and others; fostering relationships with local service providers; and increasing community engagement and education on this topic.

Keywords: human trafficking, protocol, policy, training, healthcare

Preparedness to Identify and Care for Trafficked Persons in South Carolina Hospitals: A State-Wide Exploration

Introduction

Human trafficking is the act of exploiting an individual for personal gains through sex, labor, or various other forms, by way of force, fraud, or coercion (National Human Trafficking Hotline, n.d.). It is one of the fastest growing crimes in the world today (Department of Homeland Security, n.d.), estimated to impact 40.3 million people (Alliance 87, 2017; International Labour Organization, 2017), and generate more than $150 billion in proceeds each year (International Labour Organization, 2015).

Within the United States (U.S.), rates of sex and labor trafficking are increasing annually (Finklea, Fernandes-Alcantara, & Siskin, 2015; Polaris Project, 2016; Unicef, 2017; U.S. Dept. of State, 2016) due to high demand, enormous profitability, and low risk of prosecution for traffickers (Atkinson, Curnin, & Hanson, 2016; Macias-Konstantopoulos, et al., 2013; Polaris Project, 2015). This crime affects U.S. citizens and foreign nationals alike (Owen, et al., 2015; U.S. Department of State, 2016) and does not discriminate by age, gender, race, ethnicity, or socioeconomic status (Choi, 2015; Cole & Sprang, 2015; Cole, Sprang, Lee, & Cohen, 2016; Gibbons & Stoklosa, 2016; Gibbs, Hardison Walters, Lutnick, Miller, & Kluckman, 2015; Macias-Konstantopoulos, Munroe, Purcell, & Tester, 2015; National Human Trafficking Hotline, n.d.; Shandro, et al., 2016; U.S. Department of State , 2016; U.S. Department of State, 2017).

To maintain control over victims, traffickers may use non-violent measures such as manipulation, fraud or coercion; however, they also frequently employ violent

techniques including beatings, starvation, rape, forced drug use and even surgical implantation of tracking devices (Greenbaum, 2014; Gorenstein, 2016; Hom & Woods, 2013; Lederer & Wetzel, 2014; Macias-Konstantopoulos et al., 2015). Due to the severe trauma and abuse they are exposed to, many victims will develop physical and psychological health consequences. Examples include injuries, cardiac and respiratory issues, gastrointestinal symptoms, communicable diseases such as sexually transmitted infections and tuberculosis, dermatologic issues, dental neglect, malnutrition, starvation, dehydration, anxiety, depression, post-traumatic stress disorder (PTSD), and suicidality (Chisolm-Straker & Stoklosa, 2017; Choi, 2015; Dovydaitis, 2010; Greenbaum, 2014; Hom & Woods, 2013; Lederer & Wetzel, 2014; Macias-Konstantopoulos et al., 2015; Powell & Bennouna, 2017; Shandro et al., 2016).

Studies have found that as a result of the health consequences associated with human trafficking, the majority of victims (50-88%) will seek healthcare services at some point while they are still being trafficked (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011; Chisolm-Straker, et al., 2016; Lederer & Wetzel, 2014). Most (63.3%) will access a hospital emergency department (ED) (Lederer & Wetzel, 2014); therefore, ED health care professionals (HCPs) have a unique opportunity to intervene and offer assistance to victims (Barrows & Finger, 2008; Gibbons & Stoklosa, 2016; Grace, et al., 2014; Isaac, Solak, & Giardina, 2011; Schwarz, et al., 2016). This can only be accomplished, though, if HCPs and hospital facilities are adequately prepared to respond to human trafficking victims (Schwarz, et al., 2016).

To improve HCPs' ability to identify and care for trafficking victims, specialized training and the development of human trafficking response protocols have been suggested by researchers and clinicians as a key priority (Ahn, et al., 2013; CdeBaca & Sigmon, 2014; Powell, Dickins, & Stoklosa, 2017; Schwarz, et al., 2016). One critical component of such training includes the safety considerations that HCPs need to be aware of when dealing with suspected or confirmed victims of human trafficking. Traffickers can range from family members, to gangs, to criminal organizations (National Human Trafficking Hotline, n.d.; Miller & Sartor, 2016) and will frequently accompany their victims to the healthcare facility (Lederer & Wetzel, 2014; Bespalova, Morgan, & Coverdale, 2016). Victims may not be allowed to speak or spend time alone with the HCP (Hom & Woods, 2013; Lederer & Wetzel, 2014), and while separating suspected victims from the person(s) accompanying them can be difficult and possibly dangerous, it is essential for optimal screening (Miller & Sartor, 2016; Shandro, et al., 2016; Alpert, Ahn, Albright, Purcell, & Macias-Konstantopoulos, 2014; Baldwin, Barrows, & Stoklosa, 2017; Children's Healthcare of Atlanta, 2015; Greenbaum, 2014; Stevens & Berishaj, 2016). Delivering HCP training and having human trafficking response policies/protocols in place to guide HCPs with safety considerations will help ensure the safety of victims, HCPs, and other individuals within the healthcare facility (Shandro et al., 2016; Baldwin et al., 2017; Miller & Sartor, 2016).

The passage of the federal Trafficking Awareness Training for Health Care Act of 2015 has reinforced the need for development of best practices for HCPs to identify and respond to human trafficking victims (Atkinson et al., 2016). Additionally, numerous

professional healthcare associations have recently offered position/policy statements on human trafficking that call for the education of HCPs on the subject (American College of Emergency Physicians, 2016; American College of Obstetricians and Gynecologists, 2011; American Medical Association, 2015; American Medical Women's Association, 2014; American Public Health Association, 2015; Association of Women's Health, Obstetric and Neonatal Nurses, 2016; Emergency Nurses Association, 2015; Greenbaum, Bodrick, & AAP Committee on Child Abuse and Neglect, 2017; National Association of School Nurses, 2018), and 17 states have now enacted legislation to address HCP education on human trafficking, with three states mandating such training (Atkinson et al., 2016).

Despite these measures, current evidence indicates that HCPs are ill-prepared to identify and care for trafficked persons (Armstrong & Greenbaum, under review; Powell et al., 2017; Miller, Duke, & Northam, 2016). Most have not received training (63%-97%), are not confident in their ability to identify victims, and are unsure of who to call or how to proceed once a victim is identified (Atkinson et al., 2016; Beck, et al., 2015; Chisolm-Straker, Richardson, & Cossio, 2012; Grace, et al., 2014; Macias-Konstantopoulos, et al., 2013; Titchen, et al., 2017). As a result, victims are not being recognized, opportunities for assistance are being lost, and sub-optimal care is being provided to this vulnerable population (Chisolm-Straker, et al., 2016; Gibbons & Stoklosa, 2016).

While HCP training on human trafficking is essential for trafficked individuals to receive appropriate care, it is also imperative that HCPs have a human trafficking

response policy/protocol that can be referenced to guide them through victim identification, safety issues, immediate care and support, the use of trauma-informed and survivor-centered approaches to care, implications for mandatory reporting, and resources/referrals to assist in meeting victims' long-term needs outside the hospital (Alpert et al., 2014; Baldwin et al., 2017; Chaffee & English, 2015; Children's Healthcare of Atlanta, 2015; International Organization for Migration, 2009; Macias-Konstantopoulos W., 2016; National Human Trafficking Resource Center, 2016; Schwarz, et al., 2016; Stevens & Berishaj, 2016; Stoklosa, Dawson, Williams-Oni, & Rothman, 2016; Tracy & Macias-Konstantopoulos, 2017). To help meet this need, Health, Education, Advocacy, and Linkage (HEAL) Trafficking, an interdisciplinary network of HCPs committed to addressing and ending human trafficking, developed a protocol toolkit for use in healthcare settings (Baldwin et al., 2017). Since this toolkit and several other guidebooks have become available in recent years, hospitals are beginning to develop human trafficking response protocols (Alpert et al., 2014; Children's Healthcare of Atlanta, 2015; Institute of Medicine, National Research Council of the National Academies, 2013; International Organization for Migration, 2009; Miller & Sartor, 2016; National Human Trafficking Resource Center, 2016); however, even with these initial advances, it is currently believed that less than 2% of the United States' 5,686 hospitals have policies/procedures in place to guide HCPs with how to handle a human trafficking case (Stoklosa, Showalter, Melnick, & Rothman, 2017, p. 2).

A limited number of studies investigating human trafficking response policies/protocols in healthcare settings have been completed; thus, research in this area

will provide valuable information. Because it was unknown if S.C. hospitals were equipped to respond to trafficked persons, this study aimed to obtain baseline data on how prepared S.C. hospitals were to identify and care for trafficked persons. To the best of our knowledge, such a study has never been reported. The data generated will help identify any unmet needs, impediments, and facilitators in order to address this expanding public health issue (Rothman et al., 2017). These findings will help inform key stakeholders, including the SC Human Trafficking Taskforce, with how to best move forward and ensure that hospitals and HCPs are prepared to identify and care for this vulnerable population throughout the state.

Methods

Design

A qualitative descriptive approach was selected for this study because it allows the researcher to understand the context of an issue and what the data indicates without high levels of interpretation, ultimately leading to "true understanding" (Jiggins Colorafi & Evans, 2016; Sandelowski, 2000). The primary investigator (PI) was a master-prepared nurse faculty member and doctoral student, who developed this research for her dissertation project based upon an interest in social justice and health equality for vulnerable populations. She was guided through the research process by her mentor, an internationally recognized expert in qualitative research. The PI conducted highly structured interviews with study participants to gain a rich understanding of what measures hospital facilities had developed and implemented to identify and care for trafficked persons, or conversely, what areas were deficient. Qualitative descriptive research lends itself to discovery of "the who, what, and where" (Sandelowski, 2000, p.

339), which needs to be understood to create baseline data, particularly in areas that are devoid of research, such as the topic at hand.

Theoretical Framework

The theoretical framework used to underpin this study was the Common Ground Preparedness Framework (CGPF), developed by the Public Health Informatics Institute with support from the Robert Wood Johnson Foundation (Gibson, Theadore, & Jellison, 2012). It was selected because of its comprehensive capacity to address how public health agencies prepare for and respond to public health emergencies. Additionally, the processes found within the CGPF are viable concepts to support future research in human trafficking and the eventual development of a robust framework adapted specifically to this area.

The CGPF is categorized into six primary categories: prepare, monitor, investigate, intervene, manage, and recover. For the purposes of this study, the prepare category was used to guide data collection, analysis, and interpretation. The prepare category includes the following: 1) assess region-specific hazards, 2) develop and maintain all hazard management plan, and 3) assess organizational response capacity. Within organizational response capacity there are four sub-items: a) inform and empower the public, b) develop and implement policy, c) develop workforce, partners, and resources, and d) mitigate hazards (Gibson et al., 2012) (see Figure A1 for the CGPF).

Setting

The study was conducted with participants from hospital facilities across the state of S.C., including a combination of urban, suburban, and rural facilities from within the

four regions of the state (Upstate, Midlands, PeeDee, Lowcountry). Regions were defined by the S.C. Department of Health and Environmental Control (2017) (see Figure B2 for a copy of the S.C. regional map). Interviews took place over the telephone and participants were aware of the subject matter in advance, so they were able to select a location for optimal comfort while discussing the topic of human trafficking (Elwood & Martin, 2000).

Participants

Stratified purposive sampling was utilized for this study (Palinkas, 2015). The National Human Trafficking Hotline's 2016 S.C. State Report "heat map" was used to understand where trafficking indicators (phone calls, emails, and webworms) had been documented within the state of S.C. (National Human Trafficking Hotline, 2017) (see Figure B3 for a copy of the heat map). The heat map was then overlaid with a Google map of the state, and city locations were identified. Next, the S.C. Hospital Association website was used to find hospital facilities located within those cities (n.d.). All hospitals within those cities were recruited for participation, as it was presumed that they would have a greater probability of serving trafficking victims than cities without evidence of trafficking indicators. Inclusion criteria for the sample included: S.C. hospitals with an emergency department, in a geographic location where trafficking indicators were reported to the National Human Trafficking Hotline in 2016. Exclusion criteria for the sample included: hospitals without an emergency department, U.S. Veteran's hospitals, and hospitals with a primary focus on rehabilitation or orthopedics. Hospitals with a primary focus on substance abuse or behavioral health were also excluded from this

study, as their standard operating procedures may differ significantly from traditional hospitals.

A spreadsheet of eligible hospitals, their location, their region, and the number of beds in the facility, was created by the PI. Individual hospital websites were then accessed to determine if the facility met inclusion/exclusion criteria for the study. Phone calls were made directly to any hospital where eligibility information could not be obtained from the hospital website.

Participants recruited for the study included ED directors or managers from the eligible hospitals. Emergency department directors/managers were selected for the study due to empirical data indicating that up to 88% of trafficked persons will seek care while they are still being trafficked, with the majority (63.3%) seeking care through the emergency department (Chisolm-Straker, et al., 2016; Lederer & Wetzel, 2014). The PI did not have any established relationships with any of the participants prior to the study and their selection for recruitment was based upon their job title and associated knowledge of clinical practices, policies, and procedures within the ED. Participants were required to either be a nurse or physician and had to be accountable to hospital administration for the emergency department (ED). If the ED director or manager was not able to participate, they were able to designate an alternate participant; however, the alternate was also required to be a nurse or physician, practice patient care in the hospital's ED, and have knowledge of the policies and procedures of the ED.

Recruitment

To initiate recruitment, the PI made phone calls to eligible hospitals' emergency departments to obtain the name and email address of the ED director or manager, and initial contact about the study was sent by email. When facilities would not share an email address for the director/manager, the PI asked to be connected to the director/manager and initial contact was made by telephone with a follow-up email being sent, once the email address was obtained directly from the director/manager. The email described the purpose of the study, the time commitment required, incentives for participation, and informed potential participants that their answers would remain confidential. The email also included two attachments, a copy of the Medical University of South Carolina's (MUSC) Institutional Review Board (IRB) approval letter and a letter of support for the research study from the Director of Human Trafficking Programs for the state of S.C.

Within 5-7 days from when the emails were initially sent, the PI called potential participants to answer any existing questions about the study and formally request their participation. For those who agreed to participate, an interview date and time was agreed upon and an electronic meeting invitation was emailed to participants. The PI continued to make calls to any unreached directors/managers, approximately every three to four business days, until contact was made with each potential participant. To compensate participants for their time spent completing the interview, incentives were offered; they included the provision of a hard and soft copy of the Health, Education, Advocacy, Linkage (HEAL) Trafficking Protocol Toolkit, as well as a $25 Amazon gift card for

those who were eligible to receive it. An electronic copy of the study results, upon completion, was also extended to participants. A total of 29 hospital facilities were eligible for the study and one individual was recruited for participation from each site. Regionally, there were ten facilities invited to participate from the Lowcountry, 7 from the Midlands, 3 from the PeeDee region, and 9 from the Upstate.

Data Collection

Consenting the participants. The study did not include any personal health information or identifiers; therefore, it was considered exempt by MUSC's IRB and did not require written consent from participants. At the start of scheduled interviews, participants were asked if they would like to participate in the study and reminded of the study purpose. The PI also shared with participants that there were very limited risks, rewards or ethical concerns related to the study, that their participation was voluntary and would not impact their employment. Lastly, participants were reminded that they could stop the interview at any time. Once these items were addressed and if the participant assented, data collection began.

Data collection procedures. Data collection occurred between January and February 2018, through highly structured telephone interviews. This method allowed the researcher to ask a uniform set of questions and make comparisons between respondents (Hesse-Biber & Leavy, 2011). Interviews were not recorded because doing so would have resulted in identifiable voice markers and necessitated additional IRB requirements. To increase the dependability of the findings, an electronic interview form was created in Excel and utilized for each interview. The form provided space for the PI to document

respondents' answers, as well as a separate area to record field notes. It also ensured that all questions were asked in the same order at each interview and allowed the sole interviewer to enter responses quickly and methodically (Jiggins Colorafi & Evans, 2016) (see Table C1 for the list of interview questions). Study participants were informed that the interview was not being recorded and 100% of participants agreed to allow the PI to read back notes on selected responses to ensure their accuracy. The interview length averaged 30 minutes and participants were asked if they could be contacted again to either further clarify answers or validate findings; all agreed to future contact (Creswell & Miller, 2000).

Data Storage. Completed interview forms were housed electronically on a secure server through MUSC. Each completed interview form was labeled and saved according to a coded facility number. A separate file contained facility and participant information, to safeguard confidentiality. A master interview database and codebook were also created within Excel, to house collection of the interview results and field notes.

Data Analysis

"The expected outcome of qualitative descriptive studies is a straight forward descriptive summary of the informational contents of data, organized in a way that best fits the data" (Sandelowski, 2000, p. 339). Throughout the study, the PI performed data analysis in conjunction with data collection. Upon completion of each interview, the PI immediately explored the respondent's answers and the field notes, expanding on items that had been written in short hand and memoing on noteworthy entries. Emerging ideas were also documented to provide a comprehensive picture (Jiggins Colorafi & Evans,

2016). Responses and field notes were saved and copied into the electronic codebook. Open coding of responses was performed to identify, name, and describe phenomena (Hesse-Biber & Leavy, 2011), which was followed by more focused coding, aggregation, (Barroso, 1997) and the emergence of themes. The PI performed manifest content analysis to identify patterns in the data and provide a numerical summary through descriptive statistics (Sandelowski, 2000), as well as latent content analysis to interpret any underlying meanings from the content (Hsieh & Shannon, 2005).

A monitoring plan for coding was implemented, which involved the PI's mentor also coding the first five sets of responses to assess for agreement, and every 2-3 thereafter, to ensure the reliability of interpretations. Additionally, member checking was completed with >25% of participants to confirm validity of the findings and provide evidence of credibility (Cohen & Crabtree, 2006).

Results

The final sample included a total of 18 hospital facilities (see Table D2 for hospital characteristics). Participants in the study were primarily females (83%), with the majority being between 35-44 years of age (28%), with 15-19 years of experience working in the emergency department (28%), and five to nine years of employment at their current hospital facility (29%) (see Table D3 for participant characteristics). Fifteen of the 18 respondents were individuals recruited for participation; three alternates were designated to participate in the study by the recruited ED director/manager at their hospital facility. These individuals included a Director of Emergency Department Research and two Forensic Nursing Coordinators.

To assess for regional awareness, study participants (*n*=18) were asked if they believed that human trafficking was occurring in their geographic area and 13 (72.2%) stated that they believed that it was; however, when participants were asked if they had ever cared for a patient at their current hospital who was confirmed to be a trafficked person, 14 (77.8%) reported that they had not (see Figures E4 and E5). Nine of 17 respondents (53.0%) believed that labor and sex trafficking occurred in their geographic area, while four (23.5%) believed that only sex occurred, and four (23.5%) were unsure.

When the 13 (72.2%) respondents who believed that human trafficking was occurring in their area were then asked what made them believe that, the responses (*n*=24) varied greatly. The majority indicated that it was based on what they had seen in the media (*n*=9, 37.5%) (television, newspaper, crime statistics, publications, S.C. human trafficking website). Other reasons included the nature of the local population (*n*=4, 16.7%) (patients seen in the emergency department, high rates of foster children, varied population, and city size), geographic location with a major interstate nearby (*n*=3, 12.5%), confirmed identifications at the hospital facility (*n*=3, 12.5%), the result of conversations with law enforcement (*n*=3, 12.5%), from conversations with local community groups (*n*=1, 4.2%) and based on personal research on the topic (*n*=1, 4.2%).

The following responses (*n*=12) were provided by the five participants who were unsure if human trafficking was happening in their geographic area. They reported that they believed it *could* be happening because of "high rates of drug use and delinquent youths" (*n*=1, 8.3%), "a poor and uneducated local population" (*n*=1, 8.3%), "being a port city" (*n*=1, 8.3%), "media reports" (*n*=1, 8.3%), and "having an 'it can't happen

here' mentality" (*n*=1, 8.3%). The respondents were uncertain, though, as they also believed it *could not* be happening in their area because they "did not see a lot of sexual assaults or assault victims" (*n*=1, 8.3%), they believed that "sexual complaints are mostly just STD related" (*n*=1, 8.3%), there were "no interstates nearby - just local people" (*n*=1, 8.3%), they "had not heard of any cases" (*n*=1, 8.3%), they "had not personally witnessed any trafficking incidences" (*n*=1, 8.3%), and finally, "human trafficking victims are not the population we see" (*n*=1, 8.3%). One participant was uncertain due to being employed at their hospital facility for less than 6 months (*n*=1, 8.3%).

Four respondents had cared for a confirmed trafficking victim (through self-disclosure) at their current hospital facility, and reported that the following factors (*n*=25) helped to identify the individual as a trafficked person(s): information provided by the patient (*n*=14, 56.0%), the nurse felt that "something was not right" (*n*=2, 8.0%), the patient's unusual cell phone behavior (*n*=2, 8.0%), the patient spoke limited English (*n*=1, 4.0%), the patient did not have any identification (*n*=1, 4.0%), and the patient was brought into the ED by law enforcement (*n*=1, 4.0%) (see Table F4 for details of patients' stories).

> The individual came in for a sexual assault. The more she spoke of her history and what happened, we realized that she was a victim of human trafficking. She shared that her only form of communication was taken from her and she was blindfolded and moved around throughout the country and forced to have sex with people to pay off a debt that she stated 'didn't exist'... The patient needed a pelvic exam and needed to change into a gown for the exam; however, the patient was

holding her phone and would not hang up or even let go of it. The nurse offered to hold the phone so the patient could put her arm through the gown and the phone flashed that it was on, and on speakerphone so that obviously someone was listening to all of their conversation. (Participant from Facility #8)

Additional indicators included the patient's appearance (*n*=1, 4.0%), their obstetric history (numerous pregnancies and requesting a pregnancy test) (*n*=1, 4.0%), the fact that the patient was school-aged but not in school during daytime hours (*n*=1, 4.0%), as well as the patient's low cognitive functioning and concerns about their thought processes (*n*=1, 4.0%).

> The patient was a young Hispanic girl who spoke little to no English and came into the hospital for a pregnancy test after not having her period for three months. The HCP became suspicious because she was only 15 years old and was not in school, and she had already been pregnant three times. (Participant from Facility #20)

The same four respondents were then asked to share the steps that were taken to identify and care for the confirmed trafficked person. One respondent knew of a confirmed victim, but had not been involved in the case, so therefore could not provide any insight. The other three reported actions ranging from completing medical, social, assault, and sexual histories with the patient, to having the Federal Bureau of Investigation come to the hospital to assist with interviewing the patient (see Table G5 for details on steps taken by HCPs).

Two of the participants who had confirmed caring for trafficking victims also provided information on how they knew what to do under these circumstances. Answers included having attended trainings, continuing education, attendance at a human trafficking conference with a medical track, through other states' examples, and "We basically flew by the seat of our pants and hoped that we were getting it right" (Participant from Facility #13).

Eight respondents indicated that they had cared for a patient at their hospital that they suspected was a victim of trafficking, but it was never confirmed (see Figure 5E). The factors (*n*=30) that caused the HCPs to be suspicious that the patient was being trafficked included behavioral factors (*n*=9, 30%), indicators of control (*n*=7, 23.3%), physical indicators (*n*=4, 13.3%), the patient's history (*n*=4, 13.3%) and others (*n*=6, 20%) (see Table H6 for details on factors causing suspicion of trafficking). "It's usually their demeanor to begin with, they don't want to look at you, they have multiple phones, they want STI screening, they're in a hurry, they do not want to discuss assault history with you" (Participant from Facility #13).

> Um, their behavior, and the presence of a controlling individual with them, they decline use of an interpreter and have tattoos that we are always looking for…money bags, dollar signs, initials, names… I see the money bags a lot. (Participant from Facility #3)

Actions taken when respondents (*n*=8) had a suspected victim of human trafficking in the ED most frequently involved providing community resources (*n*=5, 62.5%) and calling law enforcement (*n*=4, 50%). "We gave her health care and we

carefully gave her resources. We gave her the number for the local women's shelter" (Participant from Facility #20). "If we suspect, we automatically call law enforcement, and sometimes we call law enforcement and the patient bails" (Participant from Facility #13). Others responses included having a conversation with the patient about the HCP's concerns (*n*=3, 37.5%) and discussing a safety plan (*n*=3, 37.5%). "We have a conversation with the patient and express our concerns, then we give them information on referrals to community-based agencies that can provide assistance to trafficking victims" (Participant from Facility #8). "She had two cell phones. One that her trafficker didn't know about. We recommended that she program the shelter's number under another woman's name and talked about always being sure the phone at work was charged" (Participant from Facility #20).

Participants also indicated that they inquired about the patient's safety (*n*=1, 12.5%), called in an interpreter (*n*=1, 12.5%), arranged for a private environment (*n*=2, 25%), performed a forensic exam (*n*=1, 12.5%), notified a victim's advocate (*n*=1, 12.5%), provided healthcare for the patient's chief complaint (*n*=2, 25%) and reinforced an open-door policy for the patient to return if they desired assistance (*n*=1, 12.5%). One respondent (12.5%) indicated that HCPs did not call law enforcement against the patient's wishes because they were worried it would make the situation worse for her, while another respondent (12.5%) said that HCPs did not call law enforcement because of threats against doing so, from the patient.

> We have had victims threaten the emergency department staff about calling law enforcement and some of them are very scared and so they don't call…threats

like, 'I know my rights and that's a HIPAA violation.' Who knows that? The majority of kids don't…It makes us wonder if it's the same pimp, because who knows that?! (Participant from Facility #13)

Participants (*n*=18) were asked if they believed that there were any safety concerns related to the identification and care of human trafficking victims. The majority of respondents (*n*=11, 61.1%) believed that there were, while another three (16.7%) said yes but seemed very unsure before replying to the question. Three more respondents (16.7%) stated that they were uncertain about any safety concerns, and one (5.6%) felt there were no safety considerations.

Sixteen participants shared what they felt those safety concerns would be. Results included victim safety (*n*=12, 75%), healthcare professionals' safety (*n*=5, 31.3%), non-specified safety issues (*n*=4, 25%), the victim's family members' safety (*n*=2, 11.1%), and the safety of others in the healthcare facility (*n*=1, 6.3%). "I think they [victims] might be afraid if they are identified that their family members could be at risk for harm, or they're afraid of going to jail, or afraid for their own personal health and safety" (Participant from Facility #12).

There are safety concerns for the staff as well. We are a small community hospital, and it is not hard to ask for the nurse that took care of so-and-so. The nurse would go right up to the front desk to see them, with a violent trafficker, that could be very dangerous… So yes, this can be a scary situation on both sides. (Participant from Facility #20)

To better understand how the hospitals handled and mitigated hazards, respondents were asked how their facilities protect the safety of patients, HCPs, and others, from threatening individuals and potentially dangerous situations. Answers (*n*=56) varied greatly, but the majority of responses were related to hospital security (*n*=19, 33.9%), restricting access (*n*=8, 14.3%), and the ability to lock down the emergency department (*n*=7, 12.5%). Others measures included support from law enforcement (*n*=6, 10.7%), overhead codes for various situations (*n*=4, 7.1%), items related to hospital entrances (*n*=3, 5.4%), and methods to provide patient (*n*=5, 8.9%) and HCP (*n*=4, 7.1%) protections (see Table I7 for details on hospital hazard mitigation measures).

> We have security and a very responsive police force, so I feel safe in the main emergency department. In smaller hospitals there is less security, no metal detectors or police force present. If anything happened it would probably happen at one of these places because they have less resources. (Participant from Facility #3)

> We have lock down procedures, confidential patient policies for anyone at risk…they are automatically placed under a confidential patient name, visitors are restricted and they are not allowed on social media until it is determined that there is no further threat to the patient, staff members, or the patient's family. (Participant from Facility #21)

The development of workforce, partners, and resources was assessed by asking the participants (*n*=18) whether their facility had a human trafficking work group or task force committee. Overwhelmingly the answer was no (*n*=14, 77.8%). Three respondents

were unsure (16.7%), and one respondent (5.6%) stated that the hospital was currently forming one. While the one affirmative hospital's human trafficking work group had not met at the time of the interview, invitations to participate had been extended to the following: ED physicians, nurses, techs, and secretaries, as well as respiratory therapists, x-ray technicians, social workers, case managers and medical students.

> Basically, everyone who is touching anyone in the emergency department. Also, our police department representative who has a special interest in human trafficking, representatives from local NGOs that work with human trafficking survivors, and representatives from the local child advocacy center and rape crisis center. (Participant from Facility #3)

Organizational response capacity was also assessed by evaluation of whether the hospital facilities had developed and implemented any policies around human trafficking. Specifically, participants were asked if their hospital had an official, written policy regarding the identification and care of human trafficking victims. Of the 18 participants, 15 (83.3%) answered that their hospital facility did not, and 3 (16.7%) stated that they were unsure, with one respondent sharing, "If there are, they [human trafficking policies/protocols] are not widely known about" (*Participant from Facility #3).*

When respondents (*n*=18) were asked about barriers preventing their current hospital facility from developing and implementing a human trafficking policy/protocol, factors named included lack of resources (*n*=8, 44.4%), lack of knowledge (*n*=7, 38.9%), not a high priority (*n*=5, 27.8%), lack of awareness (*n*=4, 22.2%), and no barriers (*n*=4, 22.2%) (see Table J8 for additional details on barriers).

> Uhm… I would guess a lack of knowledge is the problem. And then there is the thought that it [human trafficking] is 'not a problem in my area' and that it is 'not a burning platform' right now. Like if there had been an incident, we might be saying, 'Oh my gosh! We need to be better prepared for this in the future! That would cause it to rise up as a priority on the to-do list.' (Participant from Facility #26)

> We're like all ED's, over crowded with patients and long wait times. It's difficult to add one more screening issue. Patients are sick and we're busy, so sometimes it's just a rushed thing. Extended wait times and short staffing make it a challenge for us. (Participant from Facility *#3)*

Respondents (*n*=18) gave a wide range of answers when asked who they would reach out to for assistance with caring for a suspected victim of human trafficking. Most replied that they would contact the hospital's case management department (*n*=7, 38.9%) or law enforcement (*n*=7, 38.9%), followed by local service providers (*n*=6, 33.3%), the hospital social work department (*n*=4, 22.2%), and the National Human Trafficking Hotline (NHTH) (*n*=3, 16.7%) (see Figure K7 for additional resources for assistance). "Our first step would be to reach out to social work and case management because they are the keepers of all resources" (Participant from Facility #21). "Probably law enforcement, because I would not know where else to reach out" (Participant from Facility #6). "Oh goodness, um, our local [patient advocacy center for rape, domestic violence, or any type of abuse]" (Participant from Facility #24).

Fourteen participants were asked about their knowledge of any national resources related to human trafficking and the majority (*n*=9, 64.3%) confirmed that they were aware of some. Identified resources included the NHTH (*n*=5, 35.7%), posters with the NHTH number (*n*=4, 28.6%), Polaris Project (the company that hosts the NHTH) (*n*=1, 7.1%), SC State Attorney General's website (*n*=1, 7.1%), Department of Justice website (*n*=1, 7.1%), and the Emergency Nurses Association (*n*=1, 7.1%). Five respondents (35.7%) were either unaware or unsure of any national resources. "Uhm, we have posters in every bathroom with numbers but I think it's more for victims than healthcare providers" (Participant from Facility #19). "I know there's like posters, but I think they're more for domestic violence" (Participant from Facility #21).

Further assessment of the hospitals' development of workforce, partners, and resources included asking participants how their facility had prepared its HCPs to identify and care for victims of human trafficking. Of the 18 respondents, 15 (83.3%) indicated that their hospitals had not prepared their HCPs at all. "We, like other facilities, are behind in educating our health care providers…most have not had any training or very little" (Participant from Facility #3). "No, we don't. We probably need to put that on our list. It's not in our competencies, or orientation, or anything" (Participant from Facility #9).

Two respondents (11.1%) stated that they did not know if their hospital helped prepare HCPs to identify and care for human trafficking victims, and one participant (5.6%) said that their hospital had provided an online educational course on human trafficking. The course did not include the use of trauma-informed care, and when asked

if the course covered the care of trafficked children as well as adults, the participant responded, "Yes. It's the same as any other minors that have abuse or neglect. We would contact social work and law enforcement, as needed" (Participant from Facility #14).

Next, participants (*n*=18) were asked if they believed that their hospital facility informed and empowered the public about human trafficking. The majority of respondents (11, 61.1%) stated that the hospital did not, six (33.3%) were unsure if they did, and one (5.6%) said that they do. When asked how that was done, the respondent shared, "We have posters up in bathrooms and in the emergency department lobby. And they are in Spanish too" (Participant from Facility #25). Three other respondents (16.7%) also mentioned having human trafficking posters up in their hospital facilities; however, they did not feel that displaying the posters constituted informing and empowering the public.

Participants (*n*=17) were asked about any resources they would provide to an individual who requested assistance with a human trafficking situation. There was significant variation in their answers; however, law enforcement was named most frequently (*n*=10, 58.8%). Other answers included connecting the patient to the hospital's social work department (*n*=9, 52.9%), providing the NHTH phone number (*n*=6, 35.3%), and giving information on a safe house or shelter (*n*=4, 23.5%) (see Figure L8 for additional information on resources provided). "We would notify law enforcement and the victims advocate" (Participant from Facility #11). "I'd have to ask my case manager what we can help them with. We can always get them into shelters, women's shelters.

Not sure of anything other than calling the police if they are being exploited, drugged, or kidnapped" (Participant from Facility #12).

> So, depending on what was best for their safety, I would get them the National Human Trafficking Hotline number and a phone. I would also give them the BeFree text number because more people like to text than call these days. That's what I'd do if they wanted to take the information and go. If they wanted to disclose and ask for help, then I would reach out to our social worker or [the local organization that assists human trafficking victims]. (Participant from Facility #3)

When asked if there were any local service providers that their hospital partners with to meet the needs of human trafficking victims beyond their hospital stay, eight of the respondents (44.4%) were not aware of any, and one (5.6%) stated that there were none. The other nine (50.0%) named local organizations, including rape/domestic violence crisis centers (*n*=6, 37.5%), organizations specializing in support of trafficked persons (*n*=4, 25%), organizations specializing in sexual trauma services (*n*=2, 12.5%), child advocacy centers (*n*=2, 12.5%), a pediatric infectious disease clinic (*n*=1, 6.3%), and The United Way (*n*=1, 6.3%).

Participants were also asked if their hospital allowed "social admits" for patients whose health would permit them to be discharged, but whose social circumstances necessitated an overnight stay in the hospital. This was asked to better understand how hospitals might handle an identified trafficking victim if follow-on services were not immediately available. Thirteen respondents (72.2%) said that while it was not an encouraged practice, they would be able to keep a patient overnight under such

circumstances (most within the emergency department). One respondent (5.6%) was not sure if this would be allowed at their hospital facility and four (22.2%) indicated that such an admission would not be permitted. "No. It is so highly discouraged. It occurs mostly with the elderly. We don't put them out on the street, but we really discourage this practice" (Participant from Facility #23).

> Yes…We will not send someone home without a safe discharge plan…Problem is that they then spend a year in our hospital. We work really hard to place them rather than admit them. We've even had patients in the ED for over a week, trying to get them placed… it is always decided on a case by case basis. (Participant from Facility #19)

The last question to participants (*n*=18) was whether there was anything else related to the topic of human trafficking that they felt would be beneficial for the PI to know or that they felt was important to share. Seven participants (38.9%) responded; two (11.1%) emphasized the need for education and training on human trafficking, and two (11.1%) stated a desire for additional resources on the topic.

> I think that my biggest learning curve, and my staff's, is… we look at the patients from the side of being abused or neglected. Those are very difficult situations to confront and identify and I would expect it to be the same with human trafficking victims. If there is a different approach that needs to be done, then that is part of the education that we need. The education we've received, helps us to be aware that it is happening…if there is something different we need to do, we need

> education on it. If the process is different to care for human trafficking victims, we need education on that as well. (Participant from Facility #14)
>
> Any resources that can assist us here, we would be grateful for. We know it [human trafficking] is an ongoing problem and we want to do what we can to help tackle this problem and take care of our citizens here in this area. (Participant from Facility #24)

Two others (11.1%) shared that investigating whether their facility had an existing human trafficking response policy or protocol stimulated interest in the topic, and one respondent (5.6%) reported that a human trafficking response protocol was being developed by the S.C. Human Trafficking Taskforce's Healthcare Committee and would distributed to all S.C. hospitals upon completion.

> When I asked about a policy in preparation for this interview, we didn't have one, but it may have stimulated some interest, and they are now looking at a policy…Also, we have downloaded a video that someone found and I would like to look into making the training mandatory. (Participant from Facility #17)

"I'm just really glad that I participated in this because it's really making me think about this and I know it is important, so thank you" (Participant from Facility #9).

Discussion

Overall, the findings of this study demonstrated that hospitals throughout the state of South Carolina were underprepared to identify and care for trafficked persons. This study utilized stratified purposive sampling to increase the probability that respondents would have had interactions with trafficked persons and that the participating hospitals

would have a higher likelihood of addressing human trafficking because of reported trafficking in those areas. Yet, while the majority of study participants believed that human trafficking was occurring in their geographic area, most had never treated a patient who was confirmed to be a trafficked person. Lack of victim identification is not uncommon amongst HCPs (Beck, et al., 2015; Chisolm-Straker et al., 2012; Recknor, Gemeinhardt, & Selwyn, 2018; Titchen, et al., 2017) and may be partially attributable to the low percentage of HCPs who have received training on human trafficking (Chisolm-Straker et al., 2012; Lutz, 2018), as was the case in this study.

It is recommended that hospitals consider mandating human trafficking training among its annual competencies, which would ensure that HCPs of all disciplines are educated and receive consistent training (Stoklosa et al., 2017). Training of HCPs is essential, as it has demonstrated improved victim recognition (Beck, et al., 2015; Grace, et al., 2014). The training should be evidence-based, culturally and gender sensitive, trauma-informed and survivor-centered, and include information on the identification and care of both sex and labor trafficking victims (Miller & Sartor, 2016; Powell et al., 2017, p. 7; U.N. Women, 2012). Currently, it is unknown which educational components of training programs are critical to impact HCP change and improve patient outcomes. This information would be beneficial to attain through empirical studies, so trainings could be designed to be effective and efficient, and resources could be allocated appropriately.

There were a variety of reasons that study respondents became suspicious that their patients were victims of human trafficking. Many HCPs detected genuine red flags of human trafficking, indicating that they recognized that "something was not right;"

however, they were unable to then move from suspicion to confirmation. While training will assist with victim identification, it is recommended that HCPs have a human trafficking response policy/protocol that they can reference to guide their next steps in caring for trafficked persons or for those deemed to be at risk for exploitation (Baldwin et al., 2017; Institute of Medicine, National Research Council, 2013).

None of the respondents in this study were able to confirm that their hospital had a human trafficking response protocol in place at the time of their interviews. One participant did share that the State of SC's Human Trafficking Taskforce - Healthcare Committee was currently developing a hospital protocol and it would be disseminated to all hospitals statewide. This will be a step forward; however, it will also need to be coupled with administrative support, implementation procedures, HCP training, and ongoing fidelity and implementation evaluation at each hospital, to be effective.

Support for human trafficking response policies/protocols is consistent with findings in a recent study of the implementation of a protocol within a U.S. healthcare system. The study found that everyone involved felt the protocol was "valuable and that it enhanced victim identification, treatment, and referral" (Stoklosa et al., 2017, p. 6). One forensic nurse stated, "Wow, we have been letting a lot of victims slide through the door because of lack of knowledge…I wish [the protocol] had come a long time ago" (Stoklosa et al., 2017, p. 6).

Safety concerns surrounding the care of trafficked persons were recognized by just over half of the current study's respondents. One concern that was especially noteworthy was the use of both first and last names on some HCPs' identification badges.

This practice is not recommended as it could put HCPs at increased risk for retribution from violent traffickers who could use technology to obtain their home address and other personal data. Trafficker violence has been well established in the literature; thus, safety plans are an essential component of hospital response policies/protocols (Baldwin et al., 2017).

While several respondents mentioned that their facility restricted visitors in the ED, only one mentioned that at-risk patients were prohibited from accessing their technology/social media as a precautionary safety measure. This is an important issue for others to consider, as traffickers may monitor victims' conversations and whereabouts through cell phones and other electronic devices, as occurred in this study (Genesee County Medical Society, 2015). This also could be important if an underage victim does not desire assistance and reaches out to their trafficker for aid in leaving the hospital facility.

Safety measures that respondents identified as being in use at their hospital facilities included the hospital security department, the ability to restrict access/lock down the emergency department, quick access to local law enforcement, and the use of metal detectors. Hospitals without adequate security measures are at greater risk for harm to victims, HCPs, and others in the facility; thus, it recommended that all hospitals re-evaluate their safety measures and hazard mitigation plans in conjunction with human trafficking policy/protocol development.

Approximately half of this study's respondents said that they thought labor and sex trafficking occurred in their area; however, when asked about confirmed

identifications, only sex trafficking victims had been recognized. The disparity in recognition of labor trafficking may be attributable to the high percentage of HCPs that obtained their knowledge about human trafficking from the media, which typically highlights sex trafficking. In the neighboring state of North Carolina, the prevalence of labor trafficking amongst farmworkers was found to be approximately 25%, with 39% of respondents also having their type of work, or amount of pay, misrepresented (Barrick, Lattimore, Pitts, & Zhang, 2014, p. 209). It is essential that HCPs receive education that includes labor trafficking, particularly in states such as the Carolinas, which have multibillion-dollar agricultural businesses that are supported primarily by migrant farmworkers (Cooper-Lewter, 2014; Summers, Quandt, Talton, Galván, & Arcury, 2015).

During this study, it became apparent that the participants who had the most knowledge about human trafficking and how to appropriately respond to victims were the three individuals with sexual assault nurse examiner (SANE) certification. This is likely because of their experience working with other victims of violence and abuse, as well as the fact that human trafficking is touched upon in SANE training. Within this study, SANEs were discovered to be an informal source of training for the ED HCPs when they were called upon for a consult on a suspected victim presenting for care. While it is recommended that hospitals develop multidisciplinary human trafficking response teams (Baldwin et al., 2017; Miller & Sartor, 2016), the current findings demonstrate the importance of including SANEs or other providers with training in sexual assault and exploitation (e.g. child abuse physicians, nurse practitioners/physician assistants) on such a team. It is also suggested that because SANEs are already being utilized by other

HCPs as a resource, that all SANEs receive comprehensive training on both labor and sex trafficking in order to be prepared to fulfill that role effectively. The efficacy of such training and the use of SANEs in an educator role is another area for future research.

When participants were asked who they would reach out to for assistance with a suspected victim or what resources they would provide to a patient requesting assistance with a trafficking situation, the answers were wide ranging. The tremendous variation in responses provides additional evidence that HCPs lack the knowledge on how to handle such situations, thus highlighting the need for HCP training as well as response policies/protocols. For both questions, law enforcement was one of the respondents' top answers, even though engaging them may not be in the best interest of the patient (Baldwin et al., 2017). None of the respondents discussed obtaining patient consent prior to contacting the police (when reporting laws did not mandate it), nor did they mention concerns that law enforcement may be required to detain their patient if there were outstanding warrants for the patient's arrest (Miller & Sartor, 2016). Additionally, it is recommended that HCPs ask to speak to an officer that specializes in human trafficking cases when there is a need to involve the police. Informed consent and patient engagement in care planning are important considerations for the HCP to understand and were absent from the interview responses, demonstrating the need for additional HCP education in this area.

The current study found that only 22.2% of respondents reported having human trafficking posters on display in the emergency room; furthermore, some respondents were unsure of who the posters were meant for (victims vs. HCPs) and/or who was

reached when calling the posted number. This finding was surprising since legislation was passed in S.C. in 2015, mandating that National Human Trafficking Hotline (then National Human Trafficking Resource Center) posters be displayed in all S.C. hospital emergency rooms (S.C. Human Trafficking Task Force, 2015). This finding demonstrates the need for greater awareness of resources that are available to assist both HCPs and victims, as well as a call for research to understand the most effective methods to disseminate information about human trafficking to both hospital facilities and the HCPs employed therein.

In this study, concern was raised about what HCPs should do when victims disclose their situation and local resources are not available for them; or conversely, when services are available, but it is unknown if the providers are qualified to appropriately handle the complex needs of trafficked persons. Similar concerns were found to be barriers to HCP screening of victims in Recknor et al.'s recent study (2018), with non-maleficence, or "do no harm" suggested as the rationale (Recknor et al., 2018, p. 14). To ensure that communities have resources available for trafficked individuals, it is suggested that hospitals develop human trafficking task forces that can establish and foster relationships with local service providers to help meet the wide-ranging recovery needs of trafficked persons (Baldwin et al., 2017; Institute of Medicine and National Research Council, 2013).

Vetting of local service providers is also critical to ensure that survivors will not inadvertently be re-traumatized by those working to assist them, or re-victimized by individuals taking advantage of their known vulnerabilities. To assist with the vetting

process, it is suggested that essential criteria required of service providers become standardized and regulated. Empirical data to inform regulating agencies of the essential criteria would be beneficial.

Only one respondent in this study felt that their hospital informed or empowered the public about human trafficking, which was through display of the National Human Trafficking Hotline posters in the ED. Numerous benefits can be expected when hospitals are able to help heighten community awareness about human trafficking. These include an increase in public knowledge, which may result in a decrease of incidences of victimization, as well as possible stimulation of interest among those who could provide local resources to victims. Ultimately, improved community awareness about human trafficking will aid to reduce the stigma and shame associated with this growing crime and in turn foster victim disclosures and expand the number of persons receiving assistance.

Limitations

Some limitations of this study were a small sample size, which may be partially attributable to data collection occurring during the widespread influenza outbreak of January and February 2018 and the homogeneity of the participants' roles and responsibilities. Additionally, some individuals recruited for the study were unable to participate as a result of lengthy approval processes within their own hospital facilities. Nonetheless, this study was able to provide insightful data to better understand the level of preparedness of S.C. hospitals to identify and care for trafficked persons and contribute new data on recommendations for HCPs and hospitals.

Recommendations for Future Research

While there are abundant opportunities for future research in this area, it is recommended that the current study be repeated in 24 months to understand if, or how, South Carolina hospitals have improved their preparedness to identify and care for trafficked persons. It would also be beneficial to conduct similar studies in other states to assess for both differences and/or consistency of findings. Increasing the variation in the roles of study participants and the sample size in future studies may also yield richer data.

To understand best practices for the development and implementation of human trafficking response protocols, future studies comparing variances in protocol components, administrative support, implementation procedures, and training of healthcare professionals, are recommended. In addition, studying the utilization SANEs as a resource for healthcare professionals within the hospital, would provide valuable information on the efficacy of this approach. Lastly, it is recommended that empirical studies be conducted to better understand the service needs of trafficking survivors and the length of time they are required so that existing shortages can begin to be addressed.

Conclusion

Human trafficking is a growing crime impacting millions of vulnerable individuals annually and hospital emergency rooms are a common site for victims to seek care. As a result, hospitals need to develop and implement response protocols, create security plans, provide HCPs with training on both labor and sex trafficking, foster relationships with local service providers and promote community engagement. Only

through the accomplishment of these measures can we ensure that every trafficked person is provided with optimal care and given every opportunity for assistance.

References

Ahn, R., Alpert, E., Purcell, G., Macias-Konstantopoulos, W., McGahan, A., Cafferty, E., . . . Burke, T. F. (2013, March). Human trafficking: Review of educational resources for health professionals. *American Journal of Preventive Medicine, 44*(3), 283-289.

Alliance 87. (2017, Sept 19). Retrieved Sept 24, 2017, from 2017 Modern slavery global estimates: http://www.alliance87.org/2017ge/modernslavery#!section=0

Alpert, E. J., Ahn, R., Albright, E., Purcell G, B. T., & Macias-Konstantopoulos, W. L. (2014, Spetember). Massachusetts Medical Society. Retrieved March 2017, from Human trafficking: Guidebook on Identification, Assessment, and Response in the Health Care Setting: http://www.massmed.org/Patient-Care/Health-Topics/Violence-Prevention-and-Intervention/Human-Trafficking-(pdf)/

American College of Emergency Physicians. (2016, April). Clinical & Practice Management ACEP Policy Statements - Human Trafficking. Retrieved April 2018, from American College of Emergency Physicians: https://www.acep.org/Clinical---Practice-Management/Human-Trafficking/#sm.000115jk0eflccsoydd1k22k6fjqe

American Medical Association. (2015). Physicians response to victims of human trafficking. Retrieved April 2018, from American Medical Association: https://policysearch.ama-assn.org/policyfinder/detail/H-65.966?uri=%2FAMADoc%2FHOD.xml-0-5095.xml

American Medical Women's Association. (2014, May). Position paper on the sex trafficking of women and girls in the United States. Retrieved April 2018, from American Medical Women's Association: https://www.amwa-doc.org/wp-content/uploads/2013/12/AMWA-Position-Paper-on-Human-Sex-Trafficking_May-20141.pdf

American Public Health Association. (2015, Nov 3). Expanding and coordinating human trafficking-related public health research, evaluation, education, and prevention. Retrieved April 2018, from American Public Health Association: https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2016/01/26/14/28/expanding-and-coordinating-human-trafficking-related-public-health-activities

Armstrong, S. & Greenbaum, V. J. (2018). Using survivors' voices to guide the identification and care of trafficked persons by U.S. healthcare professionals: A systematic review. Manuscript submitted for publication.

Association of Women's Health, Obstetric and Neonatal Nurses. (2016, March). AWHONN Position Statement - Human Trafficking. Retrieved April 2018, from JOGNN: http://www.jognn.org/article/S0884-2175(16)30149-6/pdf?utm_source=awhonn.org

Atkinson, H. G., Curnin, K. J., & Hanson, N. C. (2016, May 31). U.S. state laws addressing human trafficking: Education of and mandatory reporting by health care providers and other professionals. *Journal of Human Trafficking, 2*(2), 111-138.

Baldwin, S. B., Barrows, J., & Stoklosa, H. (2017). Protocol toolkit for developing a response to victims of human trafficking in health care settings. (S. Baldwin, J. Barrows, A. Gribble, S. Poppema, H. Stoklosa, & H. G. Atkinson, Eds.) Retrieved Aug 2017, from HEAL Trafficking: https://healtrafficking.org/linkagesresources/protocol-toolkit/

Baldwin, S. B., Eisenman, D. P., Sayles, J. N., Ryan, G., & Chuang, K. S. (2011, July). Identification of human trafficking victims in health care settings. *Health and Human Rights, 13*(1), 36-49.

Barrick, K., Lattimore, P. K., Pitts, W. J., & Zhang, S. X. (2014). When farmworkers and advocates see trafficking but law enforcement does not: Challenges identifying labor trafficking in North Carolina. *Crime, Law and Social Change, 61*, 205-214.

Barroso, J. (1997). Social support and long-term survivors of AIDS. *Western Journal of Nursing Research, 19*(5), 554-582.

Barrows, J., & Finger, R. (2008). Human trafficking and the healthcare professional. *Southern Medical Journal, 101*(5), 521-524.

Beck, M., Lineer, M., Melzer-Lange, M., Simpson, P., Nugent, M., & Rabbitt, A. (2015, March). Medical providers' understanding of sex trafficking and their experience with at-risk patients. *Pediatrics, 135*(4).

Bespalova, N., Morgan, J., & Coverdale, J. (2016, Feb). A pathway to freedom: An evaluation of screening tools for the identification of trafficking victims. *Academic Psychiatry, 40*(1), 124-8.

CdeBaca, L., & Sigmon, J. N. (2014, Aug). Combating trafficking in persons: A call to action for global health professionals. *Global Health: Science and Practice, 2*(3), 261-267.

Chaffee, T., & English, A. (2015). Sex trafficking of adolescents and young adults in the United States: Healthcare provider's role. *Current Opinions in Obstetrics and Gynecology, 27*, 339-344.

Children's Healthcare of Atlanta. (2015, May 15). American Academy of Pediatrics District of Columbia Chapter. Retrieved March 2017, from Clinical practice guideline for assessment and treatment of potential victims of child sex trafficking and commercial sexual exploitation (CSEC) ≥ 11 yrs old: http://aapdc.org/wp-content/uploads/2013/12/Child-Sex-Trafficking-FINAL-published-guideline-may-28-2015.pdf

Chisolm-Straker, M., & Stoklosa, H. (2017). Human trafficking is a public health issue: A paradigm expansion in the United States. Cham, Switzerland: Springer.

Chisolm-Straker, M., Baldwin, S., Gaïgbé-Togbé, B., Ndukwe, N., Johnson, P., & Richardson, L. (2016, Aug). Health care and human trafficking: We are seeing the unseen. *Journal of Health for the Poor and Underserved, 27*(3), 1220-1233.

Chisolm-Straker, M., Richardson, L., & Cossio, T. (2012). Combating slavery in the 21st century: The role of emergency medicine. *Journal of Health Care for the Poor and Underserved, 23*(3), 980-987.

Choi, K. (2015). Risk factors for domestic minor sex trafficking in the United States: a literature review. *Journal of Forensic Nursing, 11*(2), 66-76.

Cohen, D., & Crabtree, B. (2006, July). Qualitative Research Guidelines Project. Retrieved Oct 4, 2017, from Member checks: http://www.qualres.org/HomeMemb-3696.html

Cole, J., & Sprang, G. (2015, Aug). Sex trafficking of minors in metropolitan, micropolitan, and rural communities. *Child Abuse & Neglect, 40*, 113-123.

Cole, J., Sprang, G., Lee, R., & Cohen, J. (2016, Jan). The trauma of commercial sexual exploittion of youth: A comparison of CSE victims to sexual abuse victims in a clinical sample. *Journal of Interpersonal Violence, 3*(1), 122-146.

Cooper-Lewter, S. (2014). From sun up to sun down: Migrant and seasonal farmworkers in South Carolina. Retrieved April 2018, from Sisters of Charity: https://sistersofcharitysc.com/wp-content/uploads/2017/09/Migrant-Farmworker-Brief.pdf

Creswell, J., & Miller, D. L. (2000). Determining Validity in Qualitative Inquiry. *Theory into Preactice, 39*(3), 124-130.

Department of Homeland Security. (n.d.). Blue Campaign. One Voice. One Mission. End Human Trafficking. Retrieved Sept 4, 2017, from What is human trafficking?: https://www.dhs.gov/blue-campaign/what-human-trafficking

Dovydaitis, T. (2010, Sept). Human trafficking: The role of the health care provider. *Journal of Midwifery & Women's Health, 55*(5), 462-467.

Elwood, S., & Martin, D. G. (2000). "Placing" interviews: Location and scales of power in qualitative research. *Professional Geographer, 52*(4), 649-57. Retrieved from "Placing" interviews: Location and scales of power in qualitative research:

https://www2.clarku.edu/departments/geography/pdfs/Deb%20Martin/elwood_martin2000.pdf

Emergency Nurses Association. (2015, Feb). Position Statement - Human trafficking patient awareness in the emergency setting. Retrieved April 2018, from Emergency Nurses Association: https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/humantraffickingpatientawareness.pdf?sfvrsn=cd0ad835_14

Finklea, K., Fernandes-Alcantara, A., & Siskin, A. (2015, January 28). Sex trafficking of children in the United States: Overview and issues for Congress. Congressional Research Service. Washington, D.C.: Congressional Research Service.

Genesee County Medical Society and Michigan Dept. of Health and Human Services. (2015). Human trafficking victim identification toolkit for physicians and other medical professionals. Retrieved April 2018, from Genesee County Medical Society: https://gcms.org/Bulletins/2015_10_01%20-%20Human%20Trafficking%20Victim%20Identification%20Toolkit.pdf

Gibbons, P., & Stoklosa, H. (2016, May). Identification and treatement of human trafficking vicitms in the emergency department: A case report. *The Journal of Emergency Medicine, 50*(5), 715-719.

Gibbs, D. A., Hardison Walters, J. L., Lutnick, A., Miller, S., & Kluckman, M. (2015, April). Services to domestic minor victims of sex trafficking: Opportunities for engagment and support. *Children and Youth Services Review, 54*, 1-7.

Gibson, P., Theadore, F., & Jellison, J. B. (2012). The Common Ground Preparedness Framework: A comprehensive description of public health emergency preparedness. *American Journal of Public Health, 102*(4), 633-42.

Gorenstein, D. (2016, March 2). Marketplace.org. Retrieved May 29, 2016, from Health care takes on the fight against trafficking: http://www.marketplace.org/2016/03/02/health-care/health-care-takes-fight-against-trafficking

Grace, A. M., Lippert, S., Collins, K., Pineda, N., Tolani, A., Walker, R., . . . Horwitz, S. (2014, December). Educating health care professionals on human trafficking. *Pediatric Emergency Care, 30*(12), 856-861.

Greenbaum, J., Bodrick, N., & AAP Committee on Child Abuse and Neglect, A. S. (2017). Global human trafficking and child victimzation: Policy statement. *Pediatrics, 140*(6), e20173138.

Greenbaum, V. J. (2014, October). Commercial sexual exploitation and sex trafficking of children in the United States. *Current Problems in Pediatric Adolescent Health Care, 44*, 245-269.

HEAL Trafficking. (2018). HEAL Trafficking and Hope for Justice's Protocol Toolkit. Retrieved Jan 2018, from HEAL Trafficking: https://healtrafficking.org/2017/06/new-heal-trafficking-and-hope-for-justices-protocol-toolkit-for-developing-a-response-to-victims-of-human-trafficking-in-health-care-settings/

Hesse-Biber, S. N., & Leavy, P. (2011). The practice of qualitative research (2nd ed.). Thousand Oaks, CA, United States: SAGE Publications, Inc.

Hom, K. A., & Woods, S. J. (2013). Trauma and its aftermath for commercially sexually exploited women as told by front-line service providers. *Issues in Mental Health Nursing, 34*(2), 75-81.

Hsieh, H., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277-88.

Institute of Medicine and National Research Council. (2013). *Confronting commercial sexual exploitation and sex trafficking of minors in the United States.* Washington, D.C.: National Academies Press.

International Labour Organization. (2015). International Labour Organization. Retrieved Sep 4, 2017, from Forced labour, modern slavery and human trafficking: http://www.ilo.org/global/topics/forced-labour/lang--en/index.htm

International Labour Organization. (2017, Sept 19). Retrieved Sept 19, 2017, from 40 million in modern slavery and 152 million in child labour around the world: http://www.ilo.org/global/about-the-ilo/newsroom/news/WCMS_574717/lang--en/index.htm

International Organization for Migration, United Nations Global Initiative to Fight Human Trafficking, and London School of Hygiene & Tropical Medicine. (2009). Retrieved Sept 3, 2017, from Caring for trafficked persons: Guidance for health providers: http://publications.iom.int/system/files/pdf/ct_handbook.pdf

Isaac, R., Solak, J., & Giardina, A. P. (2011, March 15). Health care providers' training needs related to human trafficking: Maximizing the opportunity to effectively screen and intervene. *Journal of Applied Research on Children:Informing Policy for Children at Risk, 2*(1), 1-32.

Jiggins Colorafi, K., & Evans, B. (2016). Qualitative descriptive methods in health science research. *Health Environments Research & Design, 9*(4), 16-25.

Lederer, L., & Wetzel, C. (2014). The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities. *The Annals of Health Law, 23*(1), 61-91.

Lutz, R. (2018). Human trafficking education for nurse practitioners: Integration into standard curriculum. *Nurse Education Today, 61*, 66-69.

Macias-Konstantopoulos, W. (2016, Oct). Human trafficking: The role of medicine in interrupting the cycle of abuse and violence. *Annals of Internal Medicine, 165*(8).

Macias-Konstantopoulos, W. L., Munroe, D., Purcell, G., & Tester, K. (2015). The commercial sexual exploitation and sex trafficking of minors in the Boston metropolitan area: Experiences and challenges faced by front-line providers and other stakeholders. *Journal of Applied Research on Children: Informing Policy for Children at Risk, 6*(1).

Macias-Konstantopoulos, W., Ahn, R., Alpert, E., Cafferty, E., McGahan, A., Williams, T., . . . Burke, T. F. (2013). An international comparative public health analysis of sex trafficking of women and girls in eight cities: Achieving a more effective

health sector response. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 90*(6), 1194-1204.

Miller, C. L., & Sartor, D. (2016). i:CARE - A health care provider's guide to recognizing and caring for domestic minor sex trafficking victims. (N. Winston, & E. Scaife, Eds.) Vancouver, WA: Shared Hope International.

Miller, C., Duke, G., & Northam, S. (2016). Child sex-trafficking recognition, intervention, and referral: An educational framework for the development of health-care-provider education programs. *Journal of Human Trafficking, 2*(3), 177-200.

National Association of School Nurses. (2018, Feb). Position Brief - Human Trafficking - Implications for 21st Century School Nurses. Retrieved April 2018, from National Association of School Nurses: https://www.nasn.org/advocacy/professional-practice-documents/positionbriefs/pb-human-trafficking

National Human Trafficking Hotline. (2017, March 8). Human Trafficking Hotline.org. Retrieved Sept 4, 2017, from National Human Trafficking Hotline Data Report - South Carolina State Report: 1/1/2016-12/31/2016: https://humantraffickinghotline.org/sites/default/files/2016%20State%20Report%20-%20South%20Carolina_0.pdf

National Human Trafficking Hotline. (n.d.). Retrieved Sept 25, 2017, from Hotline Statistics: https://humantraffickinghotline.org/states

National Human Trafficking Hotline. (n.d.). Human Trafficking. Retrieved April 2018, from National Human Trafficking Hotline: https://humantraffickinghotline.org/type-trafficking/human-trafficking

National Human Trafficking Hotline. (n.d.). Human Trafficking Hotline. Retrieved Sept 18, 2017, from The traffickers: https://humantraffickinghotline.org/what-human-trafficking/human-trafficking/traffickers

National Human Trafficking Resource Center. (2016, Feb). Framework for a human traficking protocol in healthcare settings. Retrieved February 25, 2017, from Polaris: https://humantraffickinghotline.org/resources/framework-human-trafficking-protocol-healthcare-settings

Owen, C., Dank, M., Breaux, J., Banuelos, I., Farrell, A., Pfeffer, R., . . . McDevitt, J. (2015, Nov). Understanding the organization, operation, and victimization process of labor trafficking in the United States. *Trends in Organized Crime, 18*, 348-354.

Palinkas, L. A. (2015, Sept). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research, 42*(5), 533-544.

Polaris Project. (2015). Polaris Project. Retrieved October 19, 2015, from Human trafficking overview: http://www.polarisproject.org/human-trafficking/overview

Polaris Project. (2016). Polaris Project 2016 Hotline Statistics. Retrieved Feb 7, 2017, from Polaris Project: https://polarisproject.org/resources/2016-hotline-statistics

Powell, C., & Bennouna, C. (2017). Sex Trafficking in the USA. In M. Chisolm-Straker, & H. Stoklosa, *Human trafficking is a public health issue: A paradigm expansion*

in the United States (pp. 43-64). Châm, Switzerland: Springer International Publishing.

Powell, C., Dickins, K., & Stoklosa, H. (2017, Jan). Training US health care professionals on human trafficking: Where do we go from here? *Medical Education Online, 22*(1).

Recknor, F. H., Gemeinhardt, G., & Selwyn, B. J. (2018). Health-care provider challenges to the identification of human trafficking in health-care settings: A qualitative study. *Journal of Human Trafficking, 4*(3), 213-230.

Rothman, E., Stoklosa, H., Baldwin, S. B., Chisolm-Straker, M., Price, R. K., & Atkinson, H. (2017, Jul). Public health research priorities to address U.S. human trafficking. *American Journal of Public Health, 107*(7), 1045-1047.

S.C. Dept. of Health & Environmental Control. (2017). Environmental Affairs Regional Offices. Retrieved June 11, 2017, from South Carolina Department of Health and Environmental Control: http://www.scdhec.gov/HomeAndEnvironment/DHECLocations/

S.C. Human Trafficking Task Force. (2015). Human Trafficking. Retrieved April 2018, from S.C. Attorney General: http://www.scag.gov/human-trafficking

Sandelowski, M. (2000). Whatever happened to qualitative description. *Research in Nursing & Health, 23*, 334-340.

Schwarz, C., Unruh, E., Cronin, K., Evans-Simpson, S., Britton, H., & Ramaswamy, M. (2016, June). Human trafficking identification and service provision in the

medical and social service sectors. *Health and Human Rights Journal, 18*(1), 181-191.

Shandro, J., Chisolm-Straker, M., Duber, H. C., Findlay, S. L., Munoz, J., Schmitz, G., . . . Wingkun, N. (2016, Oct). Human trafficking: A guide to identification and approach for the emergency physician. *Annals of Emergency Medicine, 68*(4), 501-508.

South Carolina Hospital Association. (n.d.). Hospital directory. Retrieved Oct 1, 2017, from South Carolina Hospital Association: https://www.scha.org/about/hospitals

Stevens, M., & Berishaj, K. (2016, Apr). The anatomy of human trafficking: Learning about the blues: A healthcare provider's guide. *Journal of Forensic Nursing, 12*(2), 49-56.

Stoklosa, H., Dawson, M. B., Williams-Oni, F., & Rothman, E. F. (2017). A review of U.S. health care institution protocols for the identification and treatment of victims of human trafficking. *Journal of Human Trafficking, 3*(2), 116-124.

Stoklosa, H., Showalter, E., Melnick, A., & Rothman, E. (2017). Health care providers' experience with a protocol for the identification, treatment, and referral of human-trafficking victims. *Journal of Human Trafficking, 3*(3), 182-192.

Summers, P., Quandt, S. A., Talton, J. W., Galván, L., & Arcury, T. A. (2015, Dec). Hidden farmworkers labor camps in North Carolina: An indicator of structural vulnerability. *American Journal of Public Health, 105*(12), 2570-2575.

The American College of Obstetricians and Gynecologists. (2011, September). Clinical Guidance & Publications, Committee Opinion - Human Trafficking. Retrieved

April 2018, from The American College of Obstetricians and Gynecologists: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Human-Trafficking

Titchen, K., Loo, D., Berdan, E., Rysavy, M., Ng, J., & Sharif, I. (2017, Feb). Domestic sex trafficking and minors: Medical student and physician awareness. *Journal of Pediatric Adolescent Gynecology, 30*(1), 102-108.

Tracy, E., & Macias-Konstantopoulos, W. (2017, Aug). Identifying and assisting sexually exploited and trafficked pateints seeking women's health care services. *Obstetrics & Gynecology, 130*(2), 443-53.

U.N. Women. (2012). Survivor-centered approach. Retrieved April 2018, from U.N. Women - End Violence Agains Women and Girls: http://www.endvawnow.org/en/articles/652-survivor-centred-approach.html

U.S. Department of State . (2016). Trafficking in persons report: June 2016. U.S. Department of State, Office of the Under Secretary for Civilian Security, Democracy, and Human Rights. A/GIS/GPS.

U.S. Department of State. (2017). U.S. Department of State. Retrieved Aug 27, 2017, from Trafficking in Persons Report 2017: https://www.state.gov/documents/organization/271339.pdf

Unicef. (2017). Child protection and development: Child trafficking. Retrieved Feb 6, 2017, from Unicef: United States Fund: https://www.unicefusa.org/mission/protect/trafficking

Appendix A

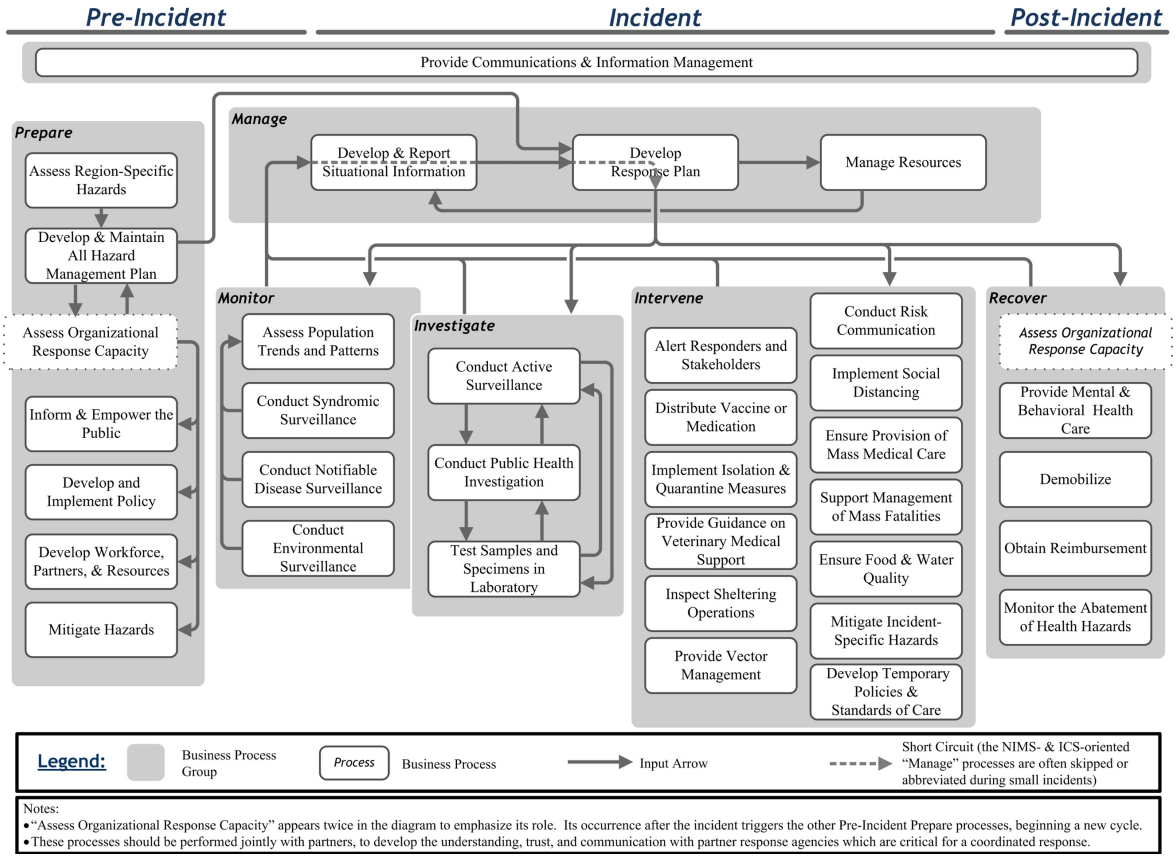

Figure A1. The Common Ground Preparedness Framework. Reprinted from "The Common Ground Preparedness Framework: A comprehensive description of public health emergency preparedness," by P.J. Gibson, F. Theadore, & J. B. Jellison, 2012, American Journal of Public Health, 102(4), 633-642. Copyright 2012 by the American Public Health Association. Reprinted with permission.

Appendix B

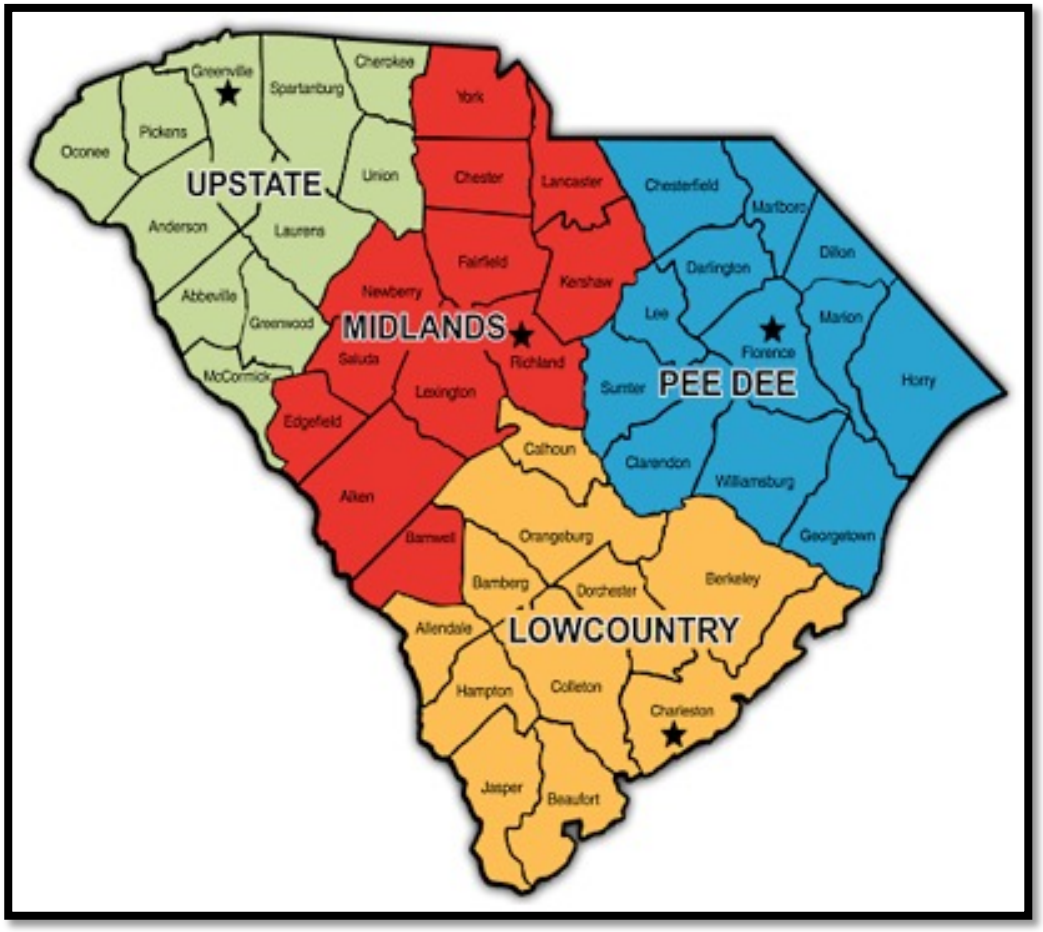

Figure B2. South Carolina Regional Map
Reprinted from S.C. Dept. of Health & Environmental Control. (2017). Environmental Affairs Regional Offices. Retrieved June 11, 2017, from South Carolina Department of Health and Environmental Control: http://www.scdhec.gov/HomeAndEnvironment/DHECLocations/

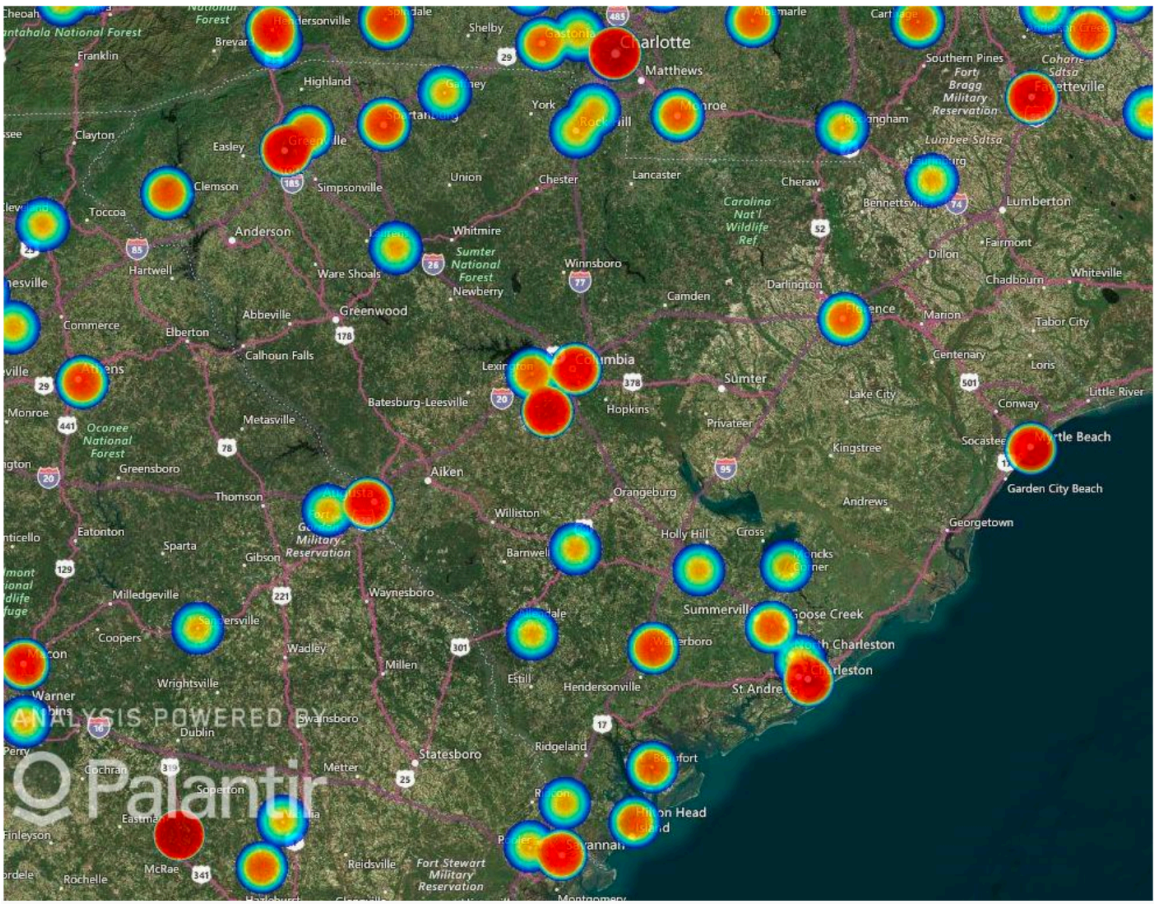

Figure B3. NHTH - South Carolina Heat Map for 2016. Reprinted with permission. National Human Trafficking Hotline. (2017, March 8). Human Trafficking Hotline.org. Retrieved Sept 4, 2017, from National Human Trafficking Hotline Data Report - South Carolina State Report: 1/1/2016-12/31/2016: https://humantraffickinghotline.org/sites/default/files/2016%20State%20Report%20-%20South%20Carolina_0.pdf

Polaris www.Polaris.Project.org
National Human Trafficking Hotline www.humantraffickinghotline.org
Mapping was made with Palantir www.palantir.com

Appendix C

Table C1. List of Interview Questions

1. Do you believe that human trafficking occurs in your geographic area?
   a. What makes you feel that way?
   b. What type of human trafficking do you believe exists in this area?
2. Have you ever cared for a patient at this hospital who was confirmed to be a victim of human trafficking?
   a. Please walk me through the steps that you took to identify and care for the trafficked individual.
   b. How did you know what to do to provide the proper care for that individual?
3. Have you ever cared for a patient at this hospital that you suspected was a victim of human trafficking, but it was never confirmed?
   a. What made you suspect that they may be a victim of human trafficking?
   b. What did you do in this situation?
4. Do you feel that there are any safety concerns related to identification and care of human trafficking victims?
   a. Could you please describe those safety concerns for me?
5. How does the hospital protect the safety of patients, health care professionals, and other individuals within the facility from threatening individuals and the potentially dangerous situation that can coincide with caring for trafficked individuals?
6. Does the hospital currently have a human trafficking work group or task force committee?
   a. What are the professional disciplines of the members?
   b. Do you feel that hospital administration is supportive of the group?
   c. Why or why not?
7. Does the hospital have official written hospital policies regarding the identification and care of human trafficking victims? (If yes, followed with questions 7a-7i. If no, followed with questions 7j-7o)
   a. Has the policy/protocol been implemented?
   b. How long has the policy/protocol been in place?
   c. Please tell me about what facilitated the development (and implementation) of the policy/protocol at this hospital.
   d. Do you feel that the human trafficking policy/protocol is effective?
   e. Why or why not?
   f. Do health care professionals know there is a protocol?
   g. How do health care professionals know there is a protocol?
   h. Who all is aware of the protocol?
   i. Do those who are aware of the protocol, follow it?
   j. Has the development of a human trafficking policy/protocol ever been attempted at this hospital?
   k. When did this occur?
   l. What was the outcome?

m. If you needed assistance caring for a suspected victim of human trafficking, who would you reach out to and why?
n. Are you aware of any national resources related to the topic of human trafficking?
o. What do you believe are the barriers that prevent this hospital from developing and implementing a policy/protocol for human trafficking at this facility?

8. Please describe how this hospital has prepared its health care professionals to identify and care for human trafficking victims?
9. Have you ever received any formal training from this hospital on how to identify and care for victims of human trafficking?
   a. Did the training include how to care for minors/children as well as adults?
   b. Did the training include the use of trauma-informed care?
   c. How did you receive the training?
   d. Was the training mandated by your employer?
   e. Did you feel that the training was beneficial?
10. Please share with me if you believe that this hospital informs or empowers the public about human trafficking?
    a. How so?
    b. What resource(s) would you provide to an individual who requested assistance with a human trafficking situation?
11. Please tell me about any local social service providers that the hospital partners with to meet human trafficking patients' needs beyond their hospital stay?
12. Do you know if the social service providers in your community would provide care for victims of human trafficking?
13. Does this hospital provide healthcare professionals with the opportunity to do a "social admit" for patients whose health would allow them to be discharged, but whose social circumstances necessitate an overnight stay in the hospital.
14. Is there anything else related to the topic we have been discussing today, that you feel would be beneficial for me to know, or that you would like to share?

Appendix D

Table D2. Hospital Characteristics (*n*=18)

Characteristic	*n* (%)
Hospital location	
Urban (population >50,000)	8 (44.4)
Suburban (population 10,000-49,999)	7 (38.9)
Rural (population <10,000)	3 (16.7)
Hospital size	
>400 beds	6 (33.3)
100-399 beds	8 (44.4)
<100 beds	4 (22.2)
Hospital region	
Lowcountry (10 invited to participate)	8 (44.4)
Midlands (7 invited to participate)	4 (22.2)
PeeDee (3 invited to participate)	2 (11.1)
Upstate (9 invited to participate)	4 (22.2)

Table D3. Participant Characteristics (*n*=18)

Characteristic	*n* (%)
Participant gender	
Male	3 (16.7)
Female	15 (83.3)
Genderqueer	0
Participant age	
>65 years	2 (11.1)
55-64 years	2 (11.1)
45-54 years	5 (27.8)
35-44 years	8 (44.4)
25-34 years	1 (5.6)
Years of experience working in the emergency department	
>25 years	4 (22.2)
20-24 years	4 (22.2)
15-19 years	5 (27.8)
10-14 years	3 (16.7)
5-9 years	2 (11.1)
<5 years	0

Length of time employed at current hospital facility (*n*=17)	
>20 years	2 (11.8)
15-19 years	3 (17.6)
10-14 years	1 (5.9)
5-9 years	5 (29.4)
1-4 years	3 (17.6)
<1 year	3 (17.6)
Participant job title	
Director of the ED	9 (50)
Assistant director of the ED	1 (5.6)
Director of ED research (designated respondent)	1 (5.6)
Director of nursing for the ED	1 (5.6)
Nursing manager of the ED	2 (11.1)
Clinical manager of the ED	2 (11.1)
Forensic nursing coordinator (designated respondent)	2 (11.1)
Participant educational degrees*	
Medical doctor	3 (16.7)
Doctorate of nursing practice	1 (5.6)
Master's of science in nursing	6 (33.3)
Bachelor's of science in nursing	6 (33.3)
Associate's degree in nursing	7 (38.9)
Master's in healthcare or business administration	3 (16.7)
Bachelor's in healthcare or business administration	2 (11.1)
Master's in information systems	1 (5.6)
Bachelor's of science in biology	1 (5.6)
Participant professional certifications/credentials*	
FACHE	1 (5.6)
FACEP	2 (11.1)
Certified emergency nurse	6 (33.3)
Certified pediatric emergency nurse	1 (5.6)
Sexual assault nurse examiner – adults	3 (16.7)
Sexual assault nurse examiner – pediatrics	2 (11.1)
MSN – education certificate	1 (5.6)
APIC certification in infection prevention & control	1 (5.6)

*Respondents provided all degrees, certifications and credentials, thus the total for educational degrees and professional certifications/credentials may not equal 18.

Appendix E

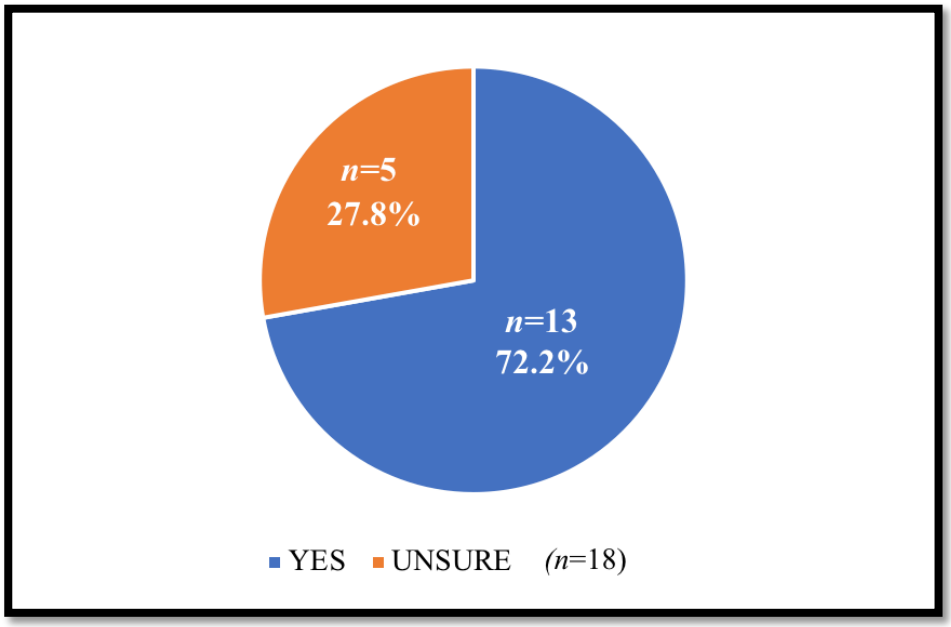

Figure E4. Respondents Who Believe HT Occurs in Their Area

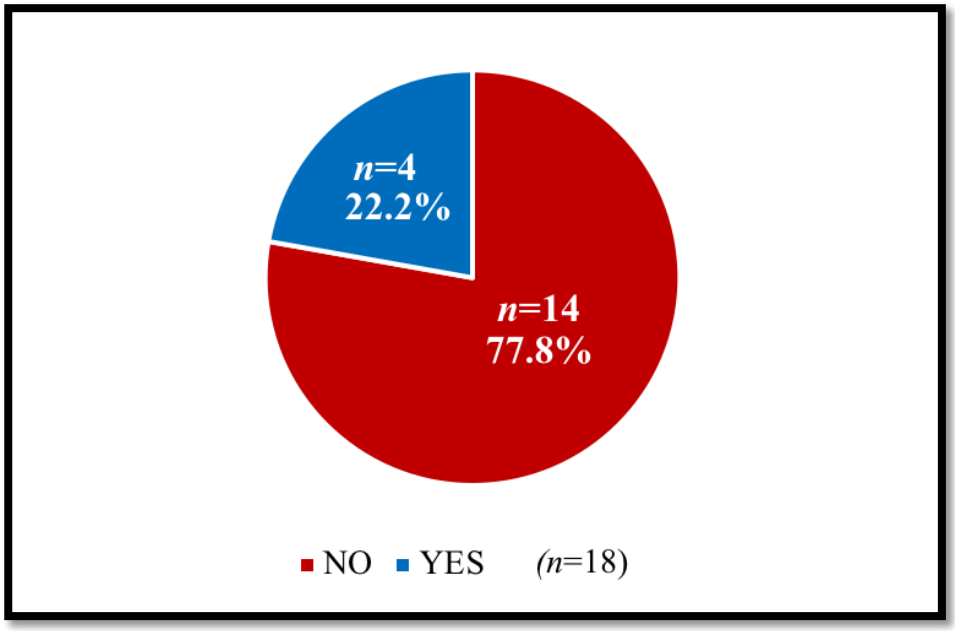

Figure E5. Respondents Who Had Taken Care of a Confirmed HT Victim

Appendix F

Table F4. Details of Patient History That Assisted HCPs to Identify Them as Trafficked

Communication had been taken away
Had been blindfolded
Experienced frequent location changes
Forced sex
Violent sexual encounter
Explanations "did not seem right"
No home address
Claim of "no idea" who would be the father during pregnancy test
Disclosure of family history of prostitution
Disclosure of previous prostitution work
Sent to the United States to live with a man, told to call him "uncle"
Forced to go places and "do what she was told to do" and give the money to a man
Received beatings from person to whom she gave money
Expressions of fear and hopelessness

Appendix G

Table G5. Steps Taken to Identify and Care for Confirmed Trafficked Persons

Facility Number	Steps Taken
Facility #8	•Emergency Dept. nurse noticed "something wasn't right" and requested the sexual assault nurse examiner (SANE). •SANE interviewed patient and determined victim status. •SANE determined next steps.
Facility #13	•Medical, social, assault and sexual history were completed to gain a holistic picture of the patient. •A forensic exam (including genital exam) was completed. •Sexually transmitted infections (STIs) were tested for and prophylaxis given, as indicated. •Dept. of Social Services (DSS) and law enforcement (LE) were involved as needed. •Follow-up meetings are held twice monthly between the hospital and local child advocacy center.
Facility #20	• Emergency Dept. HCPs got the SANE because "something wasn't right". •SANE asked the patient questions and determined victim status by examining patient's cell phone (with patient consent) and affirming that someone was controlling the patient. •DSS was called but could not assist due to patient's adult status. •A local rape crisis center was called and provided HCPs with recommendations. •SANE called law enforcement. •South Carolina Law Enforcement Division (SLED) was notified. •Federal Bureau of Investigation (FBI) agent came to assist with interviewing the patient.

Appendix H

Table H6. Patient Factors That Raised HCPs' Suspicions of Trafficking (*n*=30)

Category	Specific Factor	*n** (%)
Physical Indicators		4 (13.3)
	"Tattoos we watch for"	1 (3.3)
	Pattern of injuries	1 (3.3)
	Drug use	1 (3.3)
	Request for STI screening	1 (3.3)
Behavioral Indicators		9 (30.0)
	Refused to speak with/distrust of law enforcement	2 (6.7)
	Mental health issues	1 (3.3)
	Continual crying	1 (3.3)
	Expressing hopelessness	1 (3.3)
	Would not look at healthcare professional	1 (3.3)
	Declined use of an interpreter	1 (3.3)
	Refused family reunification	1 (3.3)
	Did not want to discuss assault history	1 (3.3)
Indicators of Control		7 (23.3)
	Patient feared harm or death if they left another person	3 (10.0)
	Patient was in a hurry/expressed they had been at the ED too long	2 (6.7)
	Controlling accompanying person	1 (3.3)
	Patient had multiple cell phones	1 (3.3)
Patient's History		4 (13.3)
	No recollection of events (felt drugged)	1 (3.3)
	Patient was unaware of who assaulted them	1 (3.3)
	Patient reported continuous beatings	1 (3.3)
	Patient was threatened with a weapon	1 (3.3)
Other		6 (20.0)
	Can't remember	2 (6.7)
	Met our red flags	1 (3.3)
	Patient was not local to the area	1 (3.3)
	Patient did not recognize self as a victim	1 (3.3)
	"Patient's career choice in street work"	1 (3.3)

Appendix I

Table I7. Hospitals' Hazard Mitigation Measures (*n*=56)

Category	Specific Measure	*n** (%)
Hospital Security	Security guard present in ED 24/7	2 (3.6)
	Physically guard a patient's room	2 (3.6)
	Provide weapons checks	2 (3.6)
	Office located in ED waiting room	1 (1.8)
	Escort HCPs to vehicles in parking lots	1 (1.8)
	Hospital Security - Unspecified	11 (19.6)
Lock Down Measures	Emergency Dept. is a locked unit	4 (7.1)
	Entire hospital can be locked down	2 (3.6)
	Emergency Dept. can be locked down	1 (1.8)
Law Enforcement	Responsive local law enforcement	3 (5.4)
	Armed police officer on-site at hospital	2 (3.6)
	Panic button in ED to local LE	1 (1.8)
Restriction of Access	Restrict visitors	3 (5.4)
	Visitor identification worn in facility	2 (3.6)
	Restrict hospital access after 7PM	1 (1.8)
	Prohibit patient use of social media	1 (1.8)
	Prohibit patient phone calls	1 (1.8)
Overhead Codes	Code calling for HCP backup	1 (1.8)
	Code for emergency de-escalation team	1 (1.8)
	Code to alert HCPs of endangered person	1 (1.8)
	Code to call for hospital security	1 (1.8)
Hospital Entrances	Metal detectors at ED entrance	1 (1.8)
	Notification of front desk to watch for threatening person(s) and report	1 (1.8)
	Hospital greeter	1 (1.8)
Patient Protections	Changed to anonymous status in computers	3 (5.4)
	Safety screen with every patient	1 (1.8)
	Prohibit law enforcement from seeing the patient if they do not desire to see them	1 (1.8)
HCP Protections	Training on safety and crisis prevention	2 (3.6)
	Safeguard HCP info and work schedules	1 (1.8)
	Administrative support for HCPs who want to file charges against threatening individuals	1 (1.8)

Appendix J

Table J8. Barriers Preventing Hospitals from Developing HT Policies/Protocols (*n*=18)

Factor	*n** (%)
Lack of Resources	8 (44.4)
Time constraints	2 (11.1)
Man power constraints	2 (11.1)
Local services for victims	1 (5.6)
Knowledge about the quality of local service providers	1 (5.6)
Money to develop	1 (5.6)
Financial burden to hospital if local services weren't available	1 (5.6)
Lack of knowledge	7 (38.9)
Not a high priority	5 (27.8)
Lack of awareness	4 (22.2)
None	4 (22.2)
Have not experienced it at our facility yet	2 (11.1)
Does not impact a high number of patients	2 (11.1)
Disbelief that it "occurs in my area"	1 (5.6)
Do not know	1 (5.6)
Has not been made a corporate directive	1 (5.6)
May never have been addressed before	1 (5.6)

Appendix K

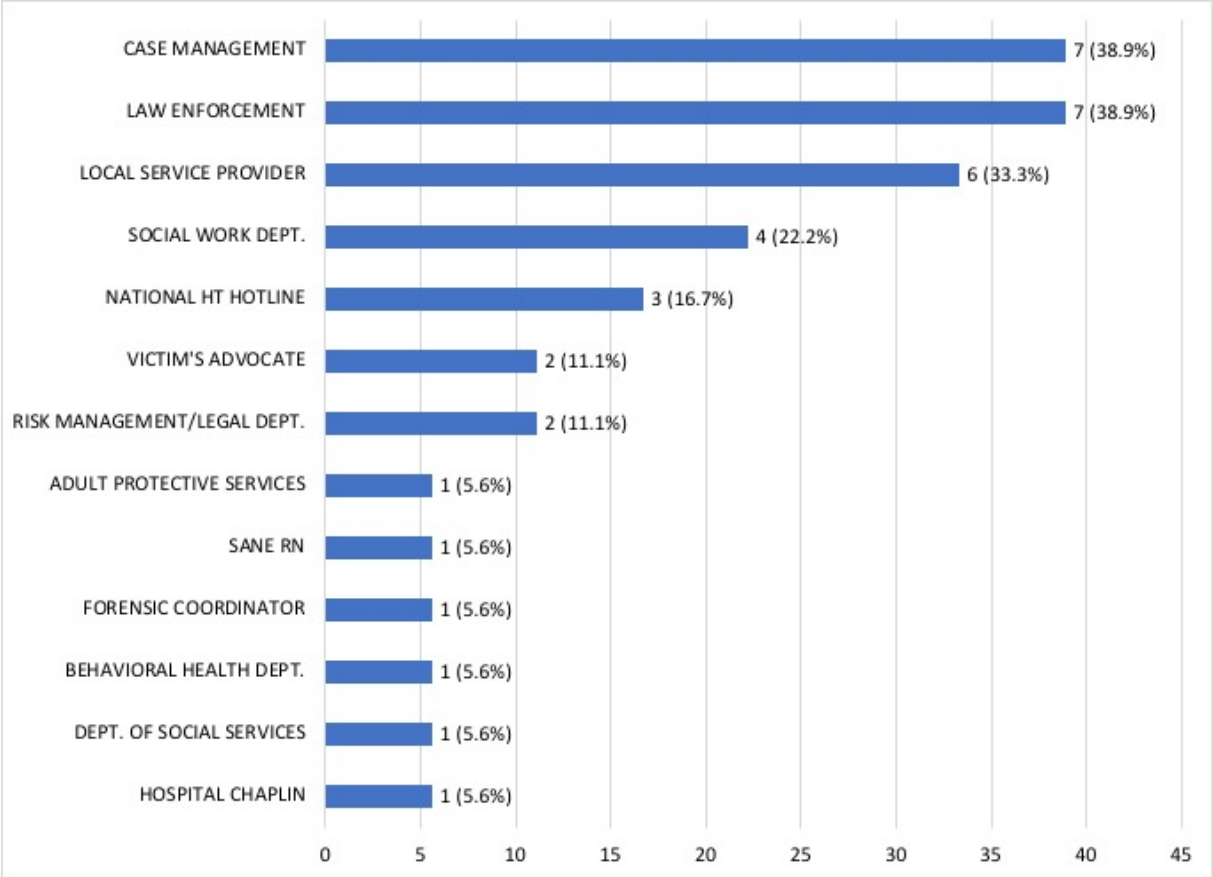

Figure K6. Who Healthcare Professionals Would Contact for Assistance with Care of a Suspected Trafficking Victim (*n*=18)

Appendix L

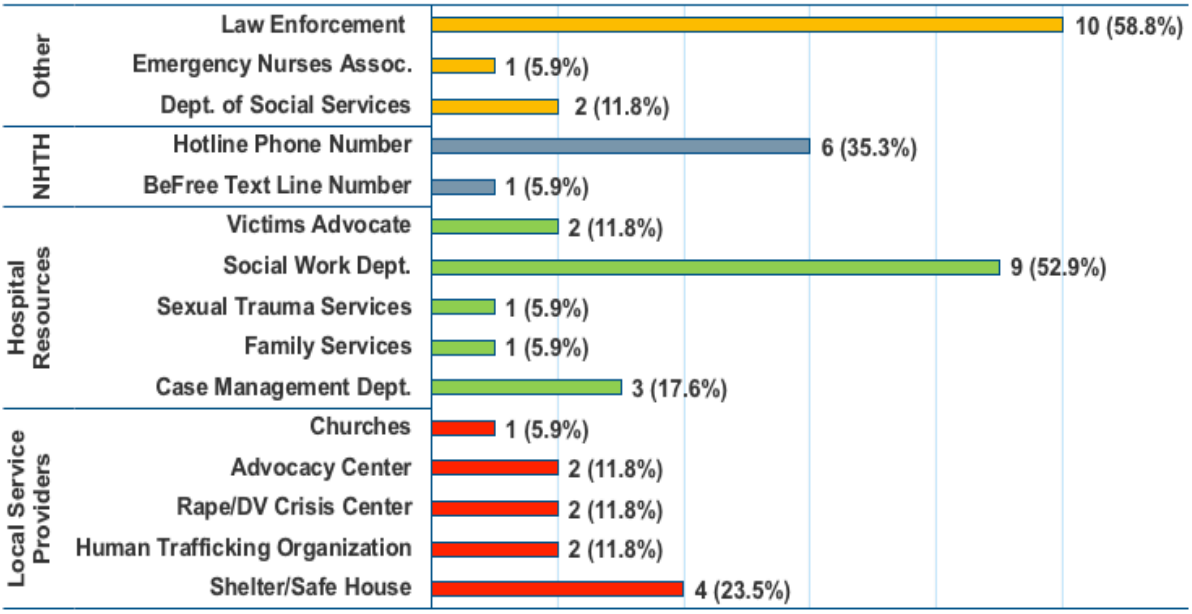

Figure L7. Resources Healthcare Professionals Would Provide to an Individual Requesting Assistance with a Human Trafficking Situation (*n*=17)

Summary

The three manuscripts included in this dissertation have each made empirical contributions toward addressing components of hospital preparedness to identify and care for human trafficking victims, an area that is in great need of additional research.

The prepare section of the Common Ground Preparedness Framework was essential to the development of this dissertation, as it provided the foundation from which all aspects of this research were generated. The subcategories of the prepare section were central to identifying the specific criteria to assess in order to evaluate preparedness. The categories and their applications included: *region-specific hazards* to assess trafficking occurring in the geographic area; *develop and maintain all hazard management plan* to assess hospital safety measures and security plans; *assess organizational response capacity,* which included *inform and empower the public* to assess community engagement, *develop and implement policy* to assess the development and implementation of a human trafficking response policy or protocol, *develop workforce partners and resources* applied as the existence of screening instruments, the training of healthcare professionals and fostering of relationships with local service providers; and lastly, *mitigate hazards* to assess emergency safety response measures.

The first of the three manuscripts addressed the category *develop workforce partners and resources* by examining the screening instruments that were in existence to identify children who had been sex trafficked or commercially sexually exploited. The results of this integrative review found that only eight instruments existed and of those, only two could be recommended for use in a hospital emergency department setting

based upon a low number of questions, ease of administration, multiple information sources, and a lack of reliance upon self-disclosure. It was also discovered that there were no screening instruments that addressed the pre-adolescent population, even though there have been numerous cases reported of school-aged children and younger being trafficked. Lastly, the review of various instruments allowed for a better understanding of positive features for consideration with development of future screening instruments. The recommended factors include succinctness, a simple format, easy administration, inclusion of training materials, sample questions, use of multiple information sources, designation of questions that require mandatory reporting, a straightforward scoring system, and an algorithm format.

The second manuscript, a systematic review, synthesized empirical data about trafficking survivors' health consequences and their interactions with the U.S. healthcare system. These findings can be used to educate HCPs, thereby assisting to *develop workforce partners and resources* to improve the identification and care of trafficked persons. Contributions include: 1) evidence that although trafficking victims experience an assortment of health conditions, they tend to seek care for genito-urinary complaints and violence-related issues, 2) confirmation that victims are oftentimes accompanied by their trafficker when seeking health care, 3) survivors valued many of the tenets of trauma-informed, rights-centered care, reinforcing the importance of their use, 4) modifiable barriers to disclosure were identified and thus can be acted upon, and lastly, 5) the need to prioritize suspected human trafficking patients in the triage process was also established.

The third manuscript addressed each of the categories and subcategories of the prepare section of the CGPF; they were utilized as the basis for question development, data collection, analysis, and interpretation of this qualitative descriptive study. The findings of this study provided evidence that hospitals throughout the state of South Carolina were under-prepared to identify and care for trafficked persons. Key findings included: 1) most HCPs believed human trafficking was occurring in their area, yet most had never cared for a confirmed victim; 2) safety concerns about caring for trafficked persons were recognized by just over half of the respondents; 3) safety measures varied greatly between facilities, with hospital security given as the primary response; 4) only one hospital had provided any education on human trafficking; 5) none of the participants could confirm that their hospital had a response policy/protocol in place; 6) only one hospital had a human trafficking task force/workgroup; 7) participants were equally as likely to call law enforcement as case management when they needed assistance with a trafficking case; and 8) 50% of respondents were not aware of, or said there were not any, local service providers to meet victims needs beyond their hospital stay.

Findings from this study will provide hospital administrators, key stakeholders, legislators and the S.C. Human Trafficking Task Force with empirical data about how inadequately prepared S.C. hospitals are to identify and care for human trafficking victims. This information will help to apprise decision makers with the steps that must be taken to ensure that hospitals across the state are ready to appropriately respond to trafficked persons.

While the findings from this dissertation study provide empirical data that can be used to guide the clinical care of HCPs from multiple disciplines as they interact with trafficked persons, there were limitations to the study. All three of the studies were inclusive of victims who had been sex trafficked, with little to no representation from those who had been exploited for labor trafficking. Many of the studies respondents were female, which could have led to gender bias amongst the responses. Study searches were inclusive of content only available through academic resources and did not examine or incorporate any sources of grey literature. Recall bias may also have been a factor with this study, as some of the survivors were interviewed about experiences that happened as far back as 20 years prior.

To ensure that the voices of all trafficked persons are represented, it is suggested that any future research conducted with survivors strive for more equal representation between males and females, as well as those who have been exploited for labor versus sex trafficking. To advance the body of research in this field, it will be important to examine the efficacy of response protocols as they are implemented, to understand which measures are imperative to increase victim recognition and improve health outcomes. The development and validation of efficient screening instruments specific to fast-paced healthcare environments is essential, as well as screening instruments that are proven to be generalizable to all healthcare settings. Finally, it is critical that empirical studies are conducted to determine what must be included in human trafficking training courses to influence practice changes and ensure optimal outcomes and opportunities for the identification and care for all trafficked persons.

Appendix A

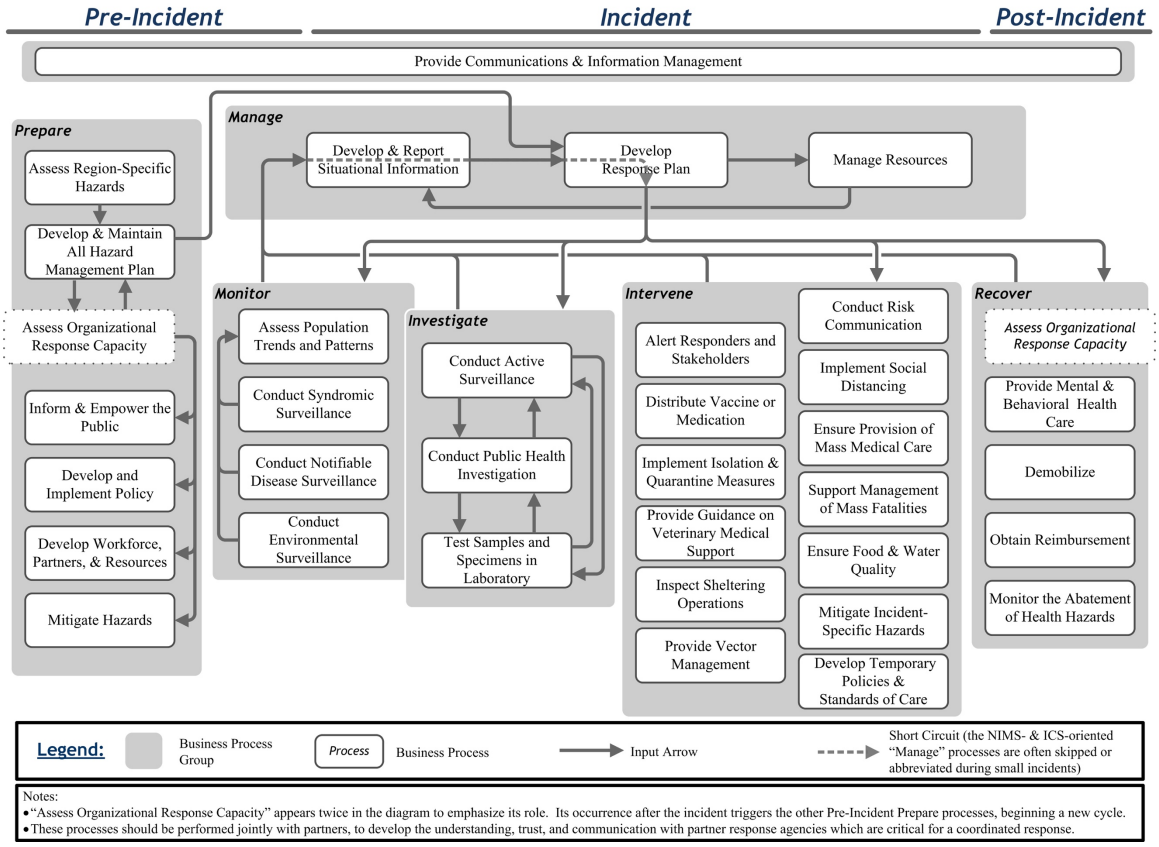

Figure 1. The Common Ground Preparedness Framework. Reprinted from "The Common Ground Preparedness Framework: A comprehensive description of public health emergency preparedness," by P.J. Gibson, F. Theadore, & J. B. Jellison, 2012, American Journal of Public Health, 102(4), 633-642. Copyright 2012 by the American Public Health Association. Reprinted with permission.

Appendix B

MUSC Institutional Review Board Approval Letter

Institutional Review Board for Human Research (IRB)
Office of Research Integrity (ORI)
Medical University of South Carolina

Harborview Office Tower
19 Hagood Ave., Suite 601, MSC857
Charleston, SC 29425-8570
Federal Wide Assurance # 1888

APPROVAL:
This is to certify that the research proposal **Pro00072754** entitled:
Human Trafficking Protocols in South Carolina Hospitals: A State-Wide Exploration

submitted by: **Stephanie Armstrong**
Department: **NURSING GROUP - MUSC**
Sponsor: **Robert Wood Johnson Foundation**

for consideration has been reviewed by **IRB-I - Medical University of South Carolina** and approved. In accordance with 45 CFR 46.101(b), the referenced study is exempt from Human Research Subject Regulations. No further action or Institutional Review Board (IRB) oversight is required, as long as the project remains the same. However, you must inform this office of any changes in procedures involving human subjects. Changes to the current research protocol could result in a reclassification of the study and further review by the IRB.

Because this project was determined to be exempt from further IRB oversight, consent document(s), if applicable, are not stamped with an expiration date.

Research related records should be retained for a minimum of three years after termination of the study.

Approval Date: **12/19/2017**

Type: **Exempt**

Chairman, **IRB-I - Medical University of South Carolina**
Susan Newman*

***Electronic Signature**: This document has been electronically signed by the IRB Chairman through the HSSC eIRB Submission System authorizing IRB approval for this study as described in this letter.*

Initial Review Approval of Exempt Research
06/01/2010
1/12/2018

Appendix C

South Carolina Human Trafficking Task Force Letter of Support

ALAN WILSON
ATTORNEY GENERAL

The Office of Research Integrity
19 Hagood Ave, Suite 601
MSC857
Charleston, SC 29425

November 9, 2017

To Whom It May Concern:

I am writing in support of Stephanie C. Armstrong's research study, *Human Trafficking Protocols in South Carolina Hospitals: A State-Wide Exploration.* As the Coordinator of the South Carolina Human Trafficking Task Force, I am acutely aware of the need for innovative approaches to combatting the crime, identifying victims, and providing support services to survivors. The proposed study would provide much needed information to support these efforts.

The South Carolina Human Trafficking Task Force has identified the need for in-depth knowledge regarding the status of human trafficking protocols throughout our state. We also recognize the need for increased training opportunities within the healthcare field. To most effectively execute a targeted approach, the Task Force needs data to identify the areas of greatest need within different regions of the state. Ms. Armstrong's research study will be the first of its kind in South Carolina. Undoubtedly, her work will make a substantial contribution in more effectively identifying and supporting victims of human trafficking.

I look forward to sharing her work with members of the South Carolina Human Trafficking Task Force and supporting healthcare providers throughout the state.

Sincerely,

Kathryn A. Moorehead

Kathryn A. Moorehead
Director of the VAWA and Human Trafficking Programs
Coordinator, South Carolina Human Trafficking Task Force

REMBERT C. DENNIS BUILDING • POST OFFICE BOX 11549 • COLUMBIA, SC 29211-1549 • TELEPHONE 803-734-3970 • FACSIMILE 803-253-6283

Appendix D

Participant Recruitment Email

Dear _____:

My name is Stephanie Armstrong and I am writing to request your participation in a research study examining hospital preparedness to identify and care for human trafficking victims throughout the state of South Carolina.

As you are likely aware, human trafficking is a growing public health issue. What you may not know is that 87% of victims will be seen by a health care provider while still being trafficked, and they primarily seek care through hospital emergency departments.[1]

Twenty-nine South Carolina hospitals have been invited to participate in this study. Findings will be published in aggregate; thus, individual hospital facilities will NOT be identified in any published reports of this study.

Because of the critical need to address this escalating issue, this study is supported by the South Carolina Attorney General's Human Trafficking Taskforce and their letter of endorsement is attached for your review. This study has been approved as an exempt research study through the Medical University of South Carolina's Institutional Review Board and a copy of the study approval letter is also attached for your review.

Your participation in the study would involve a one-time telephone interview, which is estimated to take approximately 30-60 minutes. Should your hospital facility have any policies/procedures or protocols involving the identification and care of trafficked persons, it would be requested that you have a copy of those documents present during the interview so that they could be discussed. Lastly, if you are unable to participate, you may designate an alternative participant who is aware of your hospital's policies, procedures, and clinical practices in the Emergency Department.

As a token of appreciation for time and participation, each interviewee will receive both a hard and soft copy of the HEAL (Health, Education, Advocacy, & Linkage) Trafficking - Protocol Development Toolkit, and a $25 Amazon gift card (if permitted by your facility).

I will reach out to you again next week, to answer any questions you may have about the study and discuss possible interview scheduling.

Thank you in advance for your consideration!

Sincerely,
Stephanie

Stephanie Armstrong, MSN, RN
Robert Wood Johnson Foundation Future of Nursing Scholar
Doctoral Candidate, Medical University of South Carolina, College of Nursing
Primary Investigator
Office: 843.792.7598
Mobile: 703.629.9555
Email: armstrst@musc.edu

[1] Lederer, L. J., & Wetzel, C. A. (2014). The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities. *The Annals of Health Law, 23*(1), 61-91.

Appendix E

Sample from the Data Collection Form

QUESTION 7: **Does the hospital have official, written hospital policies regarding the identification and care of human trafficking victims?** Y=Yes. (If Yes, proceed to Q7a-Q7k) N=No. (If No, proceed to Q7l-Q7p) U=Unsure. (If Unsure, proceed to q7l-Q7p)	
Q7. Reflexivity Note:	
Q7a. Has the policy/protocol been implemented? Y=Yes. N=No. U=Unsure.	
Q7a. Reflexivity Note:	
Q7b. How long has the policy or protocol been in place?	
Q7b. Reflexivity Note:	
Q7c. Please tell me about what facilitated the development (and implementation) of the policy/protocol at this hospital.	
Q7c. Reflexivity Note:	
Q7d. Do you feel that the human trafficking policy/protocol is effective? Y=Yes. (If Yes, proceed to Q7e) N=No. (If No, proceed to Q7f) U=Unsure. (If Unsure, proceed to Q7h)	
Q7d. Reflexivity Note:	
Q7e. Why do you feel the policy/protocol is effective?	
Q7e. Reflexivity Note:	
Q7f. Why do you feel that the policy/protocol is ineffective?	
Q7f. Reflexivity Note:	
Q7h. Do the health care professionals working in your current hospital facility, know there is a protocol? Y=Yes. (If Yes, proceed to Q7i) N=No. (If No, proceed to Q7j) U=Unsure. (If Unsure, proceed to Q7j)	
Q7h. Reflexivity Note:	
Q7i: How do the health care professionals know there is a policy/protocol?	
Q7i. Reflexivity Note:	
Q7j: Who do you believe is aware of the protocol?	
Q7j. Reflexivity Note:	
Q7k. Do those who are aware of the protocol, follow it? Y=Yes. N=No. U=Unsure. (For all - Proceed to Q8)	
Q7k. Reflexivity Note:	
Q7l. Has the development of a human trafficking policy/protocol ever been attempted at you current hospital? Y=Yes. (If Yes, proceed to Q7m & Q7n). N=No. (If No, proceed to Q7o) U=Unsure. (If Unsure, proceed to Q7o)	
Q7l. Reflexivity Note:	
Q7m. When was it developed?	
Q7m. Reflexivity Note:	
Q7n. What was the outcome?	
Q7n. Reflexivity Note:	

Appendix F

Sample from the Study Code Book

A	B	C	D	E	F	G	H
Source #	Note #	Facility #	Region	Bed	Years in Healthcare	Years in ED	Response to Q7 - Does the hospital have official, written hospital policies regarding the identification and care of human trafficking victims?
1	1	23					No.
3	1	24					No.
5	1	26					No.
9	1	22					No.
12	1	20					No.
13	1	29					No.
4	1	14					No.
6	1	13					No.
7	1	19					No.
8	1	17					No.
10	1	11					No.
2	1	8					No.
18	1	6					No.
15	1	9					No.
16	1	25					Uhm, no.
11	1	21					Unsure.
14	1	12					Unsure.
17	1	3					Unsure. If they are, they are not widely known.