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IDENTIFICATION OF HUMAN TRAFFICKING VICTIMS IN HEALTH CARE SETTINGS

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ABSTRACT

Background

An estimated 18,000 individuals are trafficked into the United States each year from all over the world, and are forced into hard labor or commercial sex work. Despite their invisibility, some victims are known to have received medical care while under traffickers' control. Our project aimed to characterize trafficking victims' encounters in US health care settings.

Methods

The study consisted of semi-structured interviews with six Key Informants who work closely with trafficking victims (Phase I) and 12 female trafficking survivors (Phase II). All survivors were recruited through the Coalition to Abolish Slavery and Trafficking, an NGO in Los Angeles, and all were trafficked into Los Angeles. Interviews were conducted in English and six other languages, with the assistance of professional interpreters. Using a framework analysis approach that focused on victims' encounters in health care settings, we assessed interview transcript content and coded for themes. We used an exploratory pile-sorting technique to aggregate similar ideas and identify overarching domains.

Results

The survivors came from 10 countries. Eight had experienced domestic servitude, three had survived sex trafficking, and one had experienced both. Half the survivors reported that they had visited a physician while in their traffickers' control, and another worked in a health care facility. All Key Informants described other victims who had received medical care. For domestic servants, medical visits were triggered by injury and respiratory or systemic illness, while sex trafficking victims were seen by health professionals for sexually transmitted infections and abortion. Trafficking victims were prevented from disclosing their status to health care providers by fear, shame, language barriers, and limited interaction with medical personnel, among other obstacles.

Discussion

This exploration of survivors' experiences in health care settings supports anecdotal reports that US health care providers may unwittingly encounter human trafficking victims. Increasing awareness of human trafficking, and modifying practice to facilitate disclosure, could improve victim identification.

INTRODUCTION

Human trafficking is modern-day slavery, a global industry of exploitation that generates billions of dollars in international profits each year.¹ The United Nations defines human trafficking as “the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.”² In the US, the Trafficking Victims Protection Act (TVPA) of 2000 and subsequent TVPA reauthorizations codify human trafficking as a federal crime, create protections for victims, and strengthen the ability of the government to combat human trafficking internationally.

Though it is difficult to collect concrete data regarding the extent of human trafficking, the US is known to be a major trafficking destination.³ The State Department estimates that 18,000 women, men, and children are trafficked into the US each year from dozens of countries.⁴ Many victims arrive in the US through three main trafficking hubs: Los Angeles, New York City, and Miami, but as of 2004, forced labor victims had been identified in at least 90 US cities in 31 states.^{5,6} In addition, thousands of US citizens, mostly women and children, are trafficked within US borders, primarily for sexual exploitation.

Once in the US, trafficked victims are absorbed into underground, unregulated sectors of the economy, where wage, health, and safety law violations routinely occur.⁵ Often, trafficking victims work as enslaved domestic servants or as forced laborers in the restaurant, agricultural, or manufacturing sectors. Trafficking victims are also coerced into prostitution, pornography, and other sectors of the commercial sex industry. Regardless of the form of their exploitation, people who are trafficked suffer intense abuse that often results in physical and mental illness.⁷

Encounters in the health care setting may offer opportunities for identification of trafficking victims. Based on a sample of 21 victims from San Francisco, Los Angeles, and Atlanta, The Family Violence Prevention Fund reported in 2005 that 28% received medical care while in their trafficker’s control.⁸ The US Department of Health and Human Services (HHS), the federal agency responsible for assisting trafficking victims, supports the notion that health care providers can facilitate the identification and rescue of trafficking victims. In 2004, HHS initiated a campaign to increase awareness of human trafficking among professionals, including health care workers, who may unknowingly interact with trafficking victims in their daily work.⁹ According to subsequent HHS reporting based on information from law enforcement and service providers, health and dental clinic workers and emergency room personnel have served as sources of victim referrals.¹⁰

Despite such reports, few empirical data exist regarding trafficking victims’ interactions within US health care settings, and key questions require further examination. Are there certain settings, patient presentations and behaviors, or perpetrator characteristics that together may help identify a patient as a victim of human trafficking? What barriers prevent health care professionals from identifying trafficking victims? To better understand trafficking victims’ use of health services, this qualitative study explores and characterizes encounters in health care settings, as reported by trafficking survivors living in Los Angeles.

I. METHODS

This study consisted of two phases, each employing face-to-face, in-depth, semi-structured interviews, allowing for the exploration of themes.¹¹ Phase I consisted of interviews with key informants — people who work closely with trafficking victims. Data from Phase I informed the domains and interview script development for Phase II, which included interviews with adult female trafficking survivors now residing safely in Los Angeles County. The Principal Investigator (SB) conducted all interviews between

June 2006 and April 2008. The Institutional Review Board of the University of California, Los Angeles, approved the study and all associated materials.

In Phase I, we recruited a convenience sample of Key Informants who participate in an anti-trafficking workgroup in Los Angeles. Key Informant interviews (n=6) were conducted privately at participants' offices; all interviews were done in English, and were audio taped and professionally transcribed. These interviews assessed the key informants' knowledge of how survivors are identified, their thoughts on barriers to and facilitators of victim identification in health care settings, and information about the health effects of human trafficking.

We recruited trafficking survivors in partnership with the Coalition to Abolish Slavery and Trafficking (CAST). CAST is a nonprofit organization based in Los Angeles that advocates for an end to human trafficking and provides direct services to trafficking survivors, including shelter, case management, and legal assistance. Survivors learned of the study through fliers posted at the CAST office and through referrals by CAST case managers who received an educational briefing on the study.

To meet trafficking survivors' diverse language requirements, we translated the recruitment and informed consent materials into Spanish, Korean, Russian, Tagalog, and Thai at the suggestion of Key Informants. Interviews were conducted with the assistance of professional interpreters in six languages, including Spanish, Korean, Russian, other Asian and African languages, plus English. (To protect participants' identities, we cannot specify all languages used during the study). Before working on the study, each interpreter received certification in the protection of human subjects, completing an online course with the UCLA Office for the Protection of Research Subjects. In addition, each interpreter met privately with the Principal Investigator for an orientation to human trafficking and the potentially jarring and emotional content of the upcoming interviews.

Eleven survivor interviews were conducted in a private room in the CAST office and one was conducted in a private office at the Los Angeles County Department of Public Health. Each participant provided her age and country of origin. To protect the participants' privacy and safety, we did not collect any other demographic data in the context of the study. Participants received a \$25 gift card as compensation for their time.

Survivor interviews explored all encounters the victim had with individuals other than her trafficker/ employer while in the trafficking situation. Questions focused on encounters in health care settings and those that led to escape or rescue (Table 1). Survivors provided their opinions about barriers to, and facilitators of, victim identification in health care settings and elsewhere. Discussions were audio taped (with participants' permission) and independently translated and transcribed in a double-step process for Spanish interviews (first transcribed in Spanish and then translated) and a single-step process for other languages. Interviews continued until saturation of themes had been achieved with victims of domestic servitude, and until recruitment efforts ended for sex trafficking survivors.

Two Principal Investigators (SB and DE) reviewed the transcripts to identify major themes. Next, the investigators independently performed a line-by-line review of the transcripts and used a framework analysis approach to hand code for each major theme.¹² Text corresponding to each theme was grouped and reviewed. Analysis continued as an iterative process through discussions and refining of the major themes. Subthemes were then established using a method of constant comparison to break down higher-level codes (themes) into smaller categories or subthemes within the framework.¹³

Table 1. Domains explored in trafficking survivor interviews

General background, home country and family, means of arrival in US/Los Angeles
Health problems
a. Type of problem(s), signs, symptoms, diagnoses
b. Duration
c. Causality
Receipt of medical care during trafficking
a. Precipitation of medical visit
b. Delays in seeking medical attention
Health care encounters during trafficking
a. Condition(s) treated
b. Type of facility
c. Location and appearance of facility
d. Accompaniment, travel arrangements
e. Interactions with medical personnel: communications, privacy
f. Behavior of trafficker/employer
g. Treatment provided
h. Payment for health care services
i. Reasons for non-disclosure to health care personnel
Utilization of alternative medicine during trafficking
a. Condition(s) treated
b. Type of facility
c. Location and appearance of facility
d. Accompaniment, travel arrangements
e. Interactions with medical personnel: communications, privacy
f. Behavior of trafficker/employer
g. Treatment provided
h. Payment for services
i. Reasons for non-disclosure
Medication use during trafficking
Substance use and abuse during trafficking
Other encounters during trafficking with people outside trafficking situation
a. Law enforcement
b. Neighbors
c. Friends and family of trafficker
d. Bystanders
e. For sex trafficking victims: clients, workers in bars and hotels
Encounters that led to rescue or escape from trafficking situation
a. Persons involved
b. Sequence of events
Barriers to and facilitators of medical personnel identifying trafficking victims

II. RESULTS

The 12 participants were trafficked into Los Angeles from ten countries in Africa, Asia, Europe, North America, and South America. All were enslaved in LA: three in forced prostitution, eight in domestic servitude; one woman was exploited for both labor and sex. The period of captivity ranged from several weeks to more than seven years. All the women resided in LA at the time of their interviews, and their ages ranged from 22 to 63.

Six (50%) of the survivors interviewed had visited a physician or other health care provider while under their trafficker's control. Another survivor worked for traffickers in a health care facility. In addition, all key informants shared reports of additional clients who had received health care services while enslaved. Table 2 summarizes major themes relating to survivors' experiences in health care settings. All survivor and Key Informant names have been changed to protect their identities.

Health care encounters

Survivors described visiting small, private medical establishments, as well as large, public ones, for a variety of conditions. For domestic servants, medical visits were triggered by respiratory or systemic illness or bodily injury that prevented the performance of household duties. One labor trafficking victim received dental treatment. One study participant, "Desi," was taken to the doctor after a workplace accident:

One time, I was cleaning the restroom. I was cleaning the wall, and I was on a chair. And I slipped and I fell to the floor. It was a hard fall; it's a cement floor. I couldn't get up. I was very dizzy ... For 10 days, I had some fluid coming from my left ear ... I couldn't hear. I had a lot of pain ... [Then] her sister

came from San Francisco visiting, and she insisted that they take me to the doctor.

For sex trafficking victims, medical visits focused on sexually transmitted infections, pregnancy tests, and abortions. Participant "Linda" said, "After one week passed, I had a severe vaginal infection, and I couldn't go to work. That's the extent. It hurt so much, but the next day I did go to the hospital."

One participant, "Marisol," reported, "Once I asked them to take me in so I could do a check-up, to check my HIV."

Sex trafficking survivors also reported visiting traditional healers, known as *curanderas*. Participant "Teresa" said, "They used to take us to people who used to ... do cleansing, like witches, like *curanderas*. They used to take us maybe twice a week, or sometimes daily, when they said that we were not getting enough clients."

One sex trafficking survivor, in describing who accompanied her to the clinic, reported that the traffickers took the adult women to one clinic for STD and HIV services and took the underage girls to a different place. These Latin American traffickers evaded detection of crimes of forced child prostitution and sexual abuse, while managing to repeatedly get their victims tested and treated for sexually transmitted infections.

III. BARRIERS TO DISCLOSURE

In most encounters that survivors described, the traffickers or their agents accompanied patients to health care facilities. In all of these cases, survivors reported that their traffickers completed paperwork for them and communicated with clinic staff and health care providers on their behalf.

Table 2. Trafficking victims in health care settings: Representative statements from identified themes

<p>Chief complaint</p> <p>“I threw up and then I had that very bad headache, and I didn’t get up, like, I think, two days I didn’t get up – Penny</p> <p>“She has a lot of acne problems and that’s mostly what she was worried about, mostly what she went to the doctor about. Because she worked in the front of the shop, the trafficker was concerned about her appearance. Also, she has arthritis really bad because of all the work she was doing. So she had back pain and hand pain, and so she would go in for pain medicine.” – Nancy, Key Informant</p>
<p>Location of health care encounter</p> <p>“Her sister came from San Francisco visiting and she insisted that they take me to the doctor. It was a big hospital. It looked like public [hospital].” – Desi</p> <p>“It was a clinic around here, downtown. There were many people.” – Marisol</p> <p>“It was private. He told me that the clinic was private. I did not really look at any more of the things at that moment, because I felt bad since I was with the pain and the fever.” – Sonia</p> <p>“[The doctor’s office was] really nice. I think it was [private office], because not many kind of people. ... It’s small. It’s really nice furniture.” – Penny</p>
<p>Communication</p> <p>“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 the nurse] talked to her. I couldn’t even listen. I didn’t speak English.” – Desi</p> <p>“[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</p> <p>“I was afraid that she would go against my family. And she told me that with the other girl that she was taking a lot of things away from her back in [name of home country]. And like this, she would always say to me, so I was very afraid. ... At that moment I thought that everybody was evil and I didn’t know what to do. I used to feel, how should I say it, like, jailed, because I could not ask for help from anybody.” – Sonia</p>
<p>Cost</p> <p>“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</p>
<p>Recommendations</p> <p>“I think they should be more friendly to the patient and at least assure them — before anything, before they start talking about anything — you know, you can just look at somebody and know that this person is having problems before they even talk to you. So in such cases, just tell them that you have any secrets, like assure them and approach them in a friendly way. Talk to them ... [Assure them it’s] confidential, they are at the right place, they can open up, tell their problems.” – Abi</p> <p>–“Medical doctors and nurses don’t really know the person and don’t really know what’s going on. They only see them in that one instance. ... So, I think a lot of times it’s kind of scary, because you don’t want to just approach their family ... to automatically say, “You’re a trafficking victim” and call out someone, unless they really know that this is the instance.” – Ricki, Key Informant</p>

The physical proximity of the traffickers perpetuated their coercion and control of the victims, preventing them from communicating with health care personnel directly. In some instances, the trafficker, victim, and physician all spoke the same non-English language, but in other cases a language barrier further complicated communication between victims and health care providers. Participant “Sonia” explained that her trafficker’s presence limited her communication with the doctor:

When she [the trafficker] got there, she spoke English with the doctor. He came in and asked me what was wrong, and I said my throat. And he started touching my throat and made me open my mouth and that was it. He only asked me how long has the pain been present, and I told him it’s been a month that I’ve had this pain. And I was not able to say anything more because the lady was with me.

In three cases, trafficking victims interacted with doctors privately. However, even without the trafficker physically present in the exam room or in the clinic, fear and shame prevented patients from disclosing their situation to health care providers and precluded them from attempting to use their clinic visit as a chance to escape. For example, one survivor, “May,” who was trafficked from Asia to the US at the age of 17 and enslaved in a Los Angeles home for seven years, described shame and embarrassment as the reason she did not consider disclosing her situation to staff at the doctors’ or dentists’ offices she visited:

Because I don’t know these people, you know? It’s hard for me to, to trust people. ...I can’t, I’m afraid they going to laughing at [me]. ... I just feeling, oh,

if I told them my story, they [would say to] me, for what you such a stupid, or for what you don’t tell earlier? That’s why I’m afraid.

The participant known as Linda, who gained the privilege of walking the streets and visiting a doctor’s office independently, explained that guilt and shame kept her from attempting to escape:

I was feeling guilty and shameful. I couldn’t think ... [about running away, escaping] because I kept thinking it would go to my family would hear something about this and it’s going to be so shameful, and I was still having to ... hoping to make money ... and start to saving the money and send it to my mom.

In most health care encounters described by Key Informants and survivors, the trafficker appeared to have a personal relationship with the physician at the facility where the victim was brought for care, minimizing any possibility of the patient interacting candidly with medical personnel. In two cases, the doctor was a relative of the trafficker. Linda told her interviewer that she attended an obstetrics and gynecology clinic five times for reproductive tract infections and reported that the “other girls” (also victims of sexual slavery) also regularly sought care there with the permission of their “brokers.” Though the traffickers did not accompany her to the clinic, Linda believed the doctor worked on their behalf and not hers:

The doctor was asking, like, what was my problem, and I think he just prescribed me a medicine, like antibiotic or something, and then I remember, like, he was telling the nurse like, “Oh, she

just came from [name of home country].” I got kind of the sense that they knew, you know, what we were about, and that a lot of people like me came and that they knew what was going on.

Even when the trafficker did not know the physician personally, survivors reported few opportunities for disclosure. They observed their traffickers lying to health care providers, and reported that the traffickers specifically instructed them about which lies to tell if and when they themselves were questioned:

I couldn’t speak honestly, because he was right there. And they told us not to say anything. And [they said] if they ask you, you say that you share rent with us, and that you have no job because you’ve just arrived. The [clinic staff] asked me, you know, about work, if you had any work, and I told them no, and I felt embarrassed because I knew I had just lied. — Marisol

When asked why they did not attempt to communicate honestly with health care professionals they encountered, survivors also described feelings of hopelessness and helplessness. They feared for their own safety and the safety of their families back home. For example, Marisol said her traffickers threatened to hurt her family if she tried to escape:

They threatened me and my family. They told us that if we tried to escape, our families would suffer for that, would pay for that. ...If I didn’t have any family, I would have opened up, I would have done it. I don’t care what would have happened to me. [But] if they ever touched my family, my mom, that’s what hurts me most in the world.

One survivor did not visit any medical facilities as a patient, but labored more than 20 hours a day for over two years as a caregiver in a private, long-term elder care facility. Participant “Tracy” explained that her trafficker told her not to interact with patients’ families:

We were not allowed [to talk to the families]. The employer said that... sometimes white people can cause us trouble — or any American here. He said that if they know that you don’t have the papers, they might call the immigrations and send you to [name of home country] or it might get worse — you’re going to be in jail first before they’re going to send you home.

However, the nature of caregiving work regularly brought this participant into contact with her patients’ families, requiring her and the other victim she worked with to lie. One family member noticed that Tracy didn’t seem to receive days off work, and Tracy responded with false reassurance that she was given time off:

Her mother, she has dementia ... so every day, every lunch time, [the daughter] was there, or if she can’t go there ... the grandchildren [would be there]. The daughter said, “Don’t you have a day off?” Sometimes we just lie, “Oh, I have day off last week!” [She’d say] “No, I was here and you were here.” “No, we have a day off.” [And she’d say] Oh, I am so confused!”

Another barrier to disclosure is that some trafficking victims, especially those who have grown up in servitude or in societies without labor protections, do not recognize themselves as victims. Ricki, a Key

Informant, said, “It takes a long time for them to realize that they’re in a traffic situation, because in their countries, the eight-year-old got sold from her mom. She didn’t know what’s wrong with it. ... They don’t know they’re human.”

May explained that she didn’t know her trafficker was breaking laws:

I feel like, OK, you know, I’m here and I was working in [name of home country] before and then — it’s the same, you know? The boss is terrible, so I feel like it’s normal ... normal to work their housekeeper, like, hard. I’ve been working, like, five years in the same situation — I don’t know what is legal, what is illegal.

Payment for health services

Payment for trafficking victims’ use of health services in the US was typically rendered in cash. One survivor reported that she received free care at a public facility, but most survivors explained that their traffickers charged them for the cost of their medical care and added the incurred debt to their overall debt burden. Linda said her trafficker gave her money to pay the doctor and then added it to her balance:

In the morning, the guy gave me the cash [so I could pay the doctor]. He was giving me, like, \$400 cash, and he added [it] to the debt, and then I go to the doctor. I think I gave the doctor, like, \$300-something. And so he kind of knew how much it would be without the insurance, how much I have to spend.

Marisol said, “[They took us to get the HIV test] but on the way there, we had to stop and work, to be able

to pay for that.”

IV. RECOMMENDATIONS: THE SURVIVOR PERSPECTIVE

The 12 participants escaped slavery and trafficking through law enforcement intervention, assistance from acquaintances made in captivity, or by taking their own actions to escape. The survivor who worked in a health care facility was identified after a neighbor observed and reported labor violations, which led to a federal investigation. None of the survivors who visited health care facilities were identified as victims by health care personnel or assisted as such, and none of the survivors or Key Informants knew personally of any case in which a trafficking victim had been identified during a health care visit.

All survivors who received health care denied that they had been questioned about their personal safety or history of abuse, as with domestic violence screening questions (for example, “Is anyone hurting you?” or “Are you ever forced to have sex when you don’t want to?”) However, as described above, the survivors generally lacked the autonomy and/or language skills to complete clinic paperwork or answer health care personnel’s questions directly; those who did have the autonomy and skills did not necessarily provide truthful answers because of their extreme fear and shame.

While the survivors were aware of barriers to the identification of trafficking victims, they offered their opinions on how health care professionals might better be able to identify victims unwittingly encountered in clinical practice. They suggest that health professionals observe patients’ body language and other visual cues, use common sense, and approach patients sensitively. May said:

I think doctor can tell, you know, the body language ... They can see the [difference] — I think my boss tell them that I'm her relative, but you can tell the different between the way they dress, you know, the way they act. It's very, very different. Most trafficking victim is scared, nervous, you know — very nervous and very scared. You can even see this in their eyes or in their face.

Teresa said, “Well, if they say that this is my brother or my sister, and they don't look anything alike, then you can ask [more questions]. She's light-skinned (the trafficker), and I'm dark.”

Marisol expressed confidence that people at the clinic she visited would have helped her if she had been able to reach out to them (she did not out of concern for her family's safety). She said, “I feel that if ... I had said something, ‘Look, this is what's happening, help me,’ they would've been able to help me by telling me, ‘Here, stay here if you want to awhile.’ Well, I know that they would've done that.”

V. DISCUSSION

This study supports anecdotal reports that human trafficking victims in the US interact with health care personnel, including providers of primary care, sexual and reproductive health care, dental care, and traditional or alternative remedies. Trafficking victims may even be found working within health care facilities. While trafficking patients reported a variety of presenting complaints, preventing us from creating a portrait of a “typical” patient victim, certain patient behaviors and accompanying trafficker behaviors can alert health care professionals to a potential human trafficking case.

Women who were trafficked into domestic servitude all described a delay between the onset of their illness or injury and their visit to a doctor. Since most uninsured patients (and even many insured patients) in the US routinely delay medical care, in many clinical settings a history of delayed care is not unusual enough to arouse any suspicion. However, in the context of other signs and circumstances, including evasive behavior by the patient and controlling behavior by the accompanying person, delayed care may serve as a red flag to prompt further inquiry. By taking a more nuanced history about the presenting complaint, along with a brief social history assessing home and work environments, clinicians may be able to discern a potential trafficking situation.

As survivors themselves described, a patient's body language, affect, and attitude all may convey her or his victim status. As with women who suffer intimate partner violence, the presence of an overbearing or controlling companion should trigger concern. To allow patients the opportunity to speak for themselves, clinic or hospital staff should attempt to interview and assess all patients privately.

Language poses another barrier to identification of international trafficking victims in health care settings. Most of the survivors interviewed had limited English proficiency while they were enslaved, and many who received health services reported that medical personnel communicated only with their trafficker, who served as their interpreter. In a place like Los Angeles County, where an estimated 150 languages are spoken and more than 2.5 million people have limited English proficiency (LEP), language barriers to health services present a tremendous challenge.¹⁴ Under federal and state laws, LEP persons have a right to language assistance in accessing health and social services programs, including clinics, hospitals, and health plans. However, health care facilities typically lack the resources to make

language services available to all who need them. Accordingly, in most clinical settings, any bilingual person accompanying a patient may be engaged as their interpreter. This practice has dangerous implications for trafficking victims.

Survivors in this study described medical encounters that would arouse suspicion among many health professionals—even those unfamiliar with human trafficking. A sex trafficking survivor reported that one physician treated her repeatedly for reproductive tract infections and also performed an abortion. She expected him to inquire about the high-risk behaviors causing her condition, but he never did; nor did he address contraception, safe sex, or her general welfare. This physician's indifference to his patient's condition may have reflected a pre-existing relationship with her trafficker—a situation that several survivors reported. However, it is unlikely that all of the personnel in the office, including nurses, medical assistants, and receptionists, would also have a personal relationship with the trafficker. Because anyone working in health care can potentially recognize patients in need of special assistance, it is essential that all team members learn about human trafficking and are trained to identify suspicious behavior or signs of coercion. Simple educational efforts can expand health care workers' awareness of local and national human trafficking hotlines, which can serve as the first point of intervention in suspected cases. [See Figure 1, "Strategies to improve identification of human trafficking victims in US health care settings."]

Clinicians may miss important clues about patients who are victims of trafficking not only because of their lack of awareness and training, but lack of time. As physicians in many settings

are pressured to see more patients more quickly, opportunities to explore patients' histories are diminished. While validated screening questions for identifying trafficking victims do not yet exist, it is possible that simple questions might enable health care providers to better identify these patients. The domestic violence screening question, "Are you safe in your home?" can potentially serve to identify trafficking victims, as can routine social history questions about home and work environments. One key informant suggested asking patients, "Do you owe your employer money?" to identify cases of debt bondage and indentured servitude — key illegal elements of human trafficking. Figure 1 lists recommendations for improving identification of victims in clinical settings.

Although the prevalence of human trafficking victims in the general US population is likely very low, increasing awareness of human trafficking may improve identification of victims in clinical settings, especially among high-risk youth and in immigrant communities. Studies of foreign-born patients in ambulatory care settings have revealed a surprisingly high prevalence of patients who report histories of violence and torture that they did not disclose to their physicians. David P. Eisenman et al found that 54% of 638 Latin American patients in three Los Angeles primary care clinics had been exposed to political violence in their home countries, and 8% had been tortured.¹⁵ Only 3% of the patients who had experienced political violence reported ever telling a clinician about it. Other studies, conducted in ambulatory care clinics in New York City and Boston, found that 7% and 11% of foreign-born patients, respectively, reported a history of torture.¹⁶ In New York, none were recognized as torture victims by their physicians, while in Boston six years later, 39% had discussed torture with their health care provider.¹⁷ These studies reveal that health care workers in the U.S. often remain unaware of their immigrant patients' experiences of extreme

violence; patients with past or current histories of trafficking and forced labor are likely also going undetected.

As more American citizens and some legal immigrants acquire health insurance coverage through the Patient Protection and Affordable Care Act, undocumented immigrants, recent immigrants, and other vulnerable uninsured patients may increasingly concentrate in safety net hospitals and community health centers. Targeted efforts to increase awareness of human trafficking among health care providers in these settings may maximize the impact of educational interventions. However, because the trafficking survivors interviewed in this study visited a variety of medical settings, including small, private doctors' offices where they paid cash for services, increasing awareness of human trafficking among health care personnel in all types of settings remains a worthy

goal. In light of an expected increase in adoption of electronic medical records and incentives to screen patients for public insurance program eligibility, the implementation of health care reform may present new opportunities to screen for human trafficking. Focusing these efforts among immigrant or LEP patients, or those who pay cash for services, may facilitate identification of international trafficking victims.

As an exploratory qualitative project, this study has a number of limitations. The small sample size and recruitment of survivors through one agency in one metropolitan area means that the information the survivors provided may not represent the full range of trafficking victims' experiences in the US as a whole. The circumstances and personal characteristics of women who successfully escape trafficking and subsequently connect with support services may differ

Figure 1. Strategies to improve identification of human trafficking victims in US health care settings

- Train health care personnel, including physicians, nurses, dentists, medical assistants, technicians, and receptionists to increase awareness of trafficking and coercion.
- Mitigate language barriers; provide professional interpreters
- Interview and/or examine all patients privately at some point during their medical visit
- Incorporate social, work, home history, and domestic violence screening questions into routine intake
- Carefully observe body language and communication style of patients and those who accompany them
- Learn about local resources to help with suspected trafficking cases (many US metropolitan areas have a Human Trafficking Task Force)
- Call for assistance if you suspect trafficking:

National Human Trafficking Resource Center

1.888.373.7888

The National Human Trafficking Resource Center (NHTRC) is a national toll-free hotline available to answer calls from anywhere in the US, 24 hours a day, seven days a week, every day of the year.

The Coalition to Abolish Slavery and Trafficking

1.888.KEY.2.FRE(EDOM)

from those of individuals who remain in captivity, as well as those who escape but remain socially isolated. Nonetheless, this project explores key issues around identification of trafficking victims in US health care settings, and as such provides an essential foundation for understanding the barriers to and facilitators of victim identification. Remarkably, qualitative data in seven languages, collected from women from all over the world who were trafficked into a variety of horrible circumstances, reveal numerous common experiences and themes.

CONCLUSION

This study confirms reports that health care settings can serve as sites of trafficking victim identification, and underscores the point that many factors prevent trafficking victims from disclosing their situation to health care providers. Coercion and control by traffickers, language barriers, social and cultural alienation, and pervasive fear and shame all impede victim identification in clinical settings. However, recognition and mitigation of these barriers, coupled with greater awareness of human trafficking among physicians and other health care professionals, should enable providers to more effectively assess risk among vulnerable patients in the US and could improve victim identification.

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