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The Health of Human Trafficking Victims in San Diego, California: A Retrospective Study

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Abstract

Background/Purposes/ Aims: Human trafficking (HT) is a threat to human rights globally. Studies indicate between 28% and 87% of HT victims encountered a health care professional during their trafficking period. Nonetheless, little is known about the health care needs of victims of HT. The purpose of this study was to examine the health care needs of a self-identified group of trafficked women in San Diego County, California.

Conceptual Basis: The *Model of Human Trafficking and Health* by Zimmerman et al. (2011) was used to identify multiple determinates of health following the trafficking period including demographic factors (age at assessment, age at entry into trafficking, ethnicity, history of homelessness, history of foster care), exploitation factors (motivation for trading sex), needs assessment (drug rehabilitation, methadone maintenance, counseling), sexual health factors (use of condoms), and mental health factors (depression, anxiety, and posttraumatic stress disorder).

Method: Retrospective, descriptive study of previously collected data (2012-2015) from first-time offenders arrested for prostitution participating in a law-enforcement diversion program. 191 were interviewed, 31 (16.6%) self-identified as HT victims. Descriptive and inferential statistics were used to describe the sample and examine the relationships between the variables.

Results: All HT victims were women, significantly younger (M=23.3, SD 6.67), versus (M=26.95, SD 9.21); t(55) = 2.51, p = .015, more likely to have a history of homelessness, $x^2(1, N = 188) = 11.18$, p = .001, been in the foster care system $x^2(2, N = 191) = 5.93$, p = .048, "feeling depressed" [$x^2(2, N =31) = 13.205$, p = .001], "difficulty concentrating" [$x^2(2, N =31) = 10.809$, p = .004], "hopelessness/desperation" [x^2(2,

N=31) = 15.556, p < .001], and the PTSD indicator questions: “Do you have a sense of leaving your body”, x^2(2, *N*=30) = 9.785, p = .006; and “flashbacks, nightmares or fears”, x^2(2, *N*=31) = 12.56, p = .002 than the non-trafficked group.

Conclusions and Implications: HT victims are a hidden population often encountering a health care professional during the trafficking period. Screening and intervention strategies are needed. Further research is needed on the physical and psychological comorbidity patterns of trafficking victims to facilitate identification, intervention, and treatment strategies.

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Chapter 1

Introduction

Slavery has existed since ancient times, was integral to building most civilizations, and was written into the Code of Hammurabi (Wells, 2008). It has appropriately been called "the world's oldest trade" (Vink, 2003). Although Mauritania became the last country in the world to criminalize slavery in 2007, it is estimated there are over 45 million people enslaved worldwide today (McDougall, 2015; Walk Free Foundation, 2016). By means of comparison, historians generally agree approximately 12 million slaves were traded during the entire 400-year Trans-Atlantic slave trade (Manning, 1992; Nunn, 2008).

Modern-day slavery is also known as human trafficking and has been documented in all 50 states (U.S. Department of State, 2016). Although the United States and international communities have cooperated to outlaw trafficking activities and protect victims with the passage of the Trafficking Victims Protection Act (TVPA) in 2000, much of the focus has been on legal protection. Little progress has been made in addressing the health needs of victims of human trafficking (Hom & Woods, 2013). Human trafficking harms people physically and emotionally, but health is the least understood aspect of the trafficking process. Notably, trafficking has been called a "public health crisis", and a "pandemic" (de Chesnay, 2013, p. 901; Goodwin Veenema, Thornton, & Corley, p. 864). The health care response, however, has been "largely neglected in anti-trafficking work", particularly when compared to efforts in law enforcement, immigrant law, and public policy (Zimmerman, Hossain, & Watts, 2011, p. 327).

According to the 2016 *Trafficking in Persons Report* issued by the United States Department of State, the U.S. is a "source, transit, and destination country for men, women, transgender individuals, and children – both U.S. citizens and foreign nationals – subjected to sex trafficking and forced labor (p. 387)." The report cites the top three countries of origin for trafficking victims in the United States; they are the U.S., Mexico, and the Philippines. The states with the highest reports of trafficking activity are California, New York, Texas, and Florida. Populations specifically vulnerable to trafficking include children in the juvenile justice system, persons with limited English proficiency, American Indians and Alaskan Natives, migrant laborers, and gay, lesbian, bisexual, and transgender individuals (U.S. Department of State, 2016).

Godziak and Collett's 2005 report for the International Organization for Migration found that most of the research on trafficking in North America has been limited to female victims of sex trafficking. A more recent systematic review suggests this remains true (Oram, Stocki, Busza, Howard, & Zimmerman, 2012). More recent research has identified migrant farmworkers are at significant risk for trafficking, and are also typically socially isolated, poor, malnourished, and have unreliable access to health care (Thompson, Snyder, Burt, Greiner, & Luna, 2015; Zhang, 2012). Very little is known about the health needs of the children of itinerant workers, including farmworkers, and carnival employees (Kilanowski, 2009).

Nurses have significant training and experience in caring for vulnerable populations, and are the main sentinels of surveillance in the United States (Butterfield, 2002). Nurses work within the public health setting, the emergency department, schools, and clinics in their communities. As the most numerous and most visible

health care providers in the U.S., nurses should have information about the identification and treatment of human trafficking victims. There is a dearth of empirical literature related to the health of trafficking victims and the role of the health care provider (Choi, 2015; Omole, 2016; Parcesepe, Martin, Pollock, & Garcia-Morena, 2015; Sabella, 2011).

Purpose

The purpose of this study was to examine the health care needs of a self-identified group of trafficked women in San Diego County, California. This sample is from a group of women enrolled in a prostitution first offender diversion program, "Freedom From Exploitation" (FFE). This study will seek to answer the following general research questions:

1. What are the general demographic characteristics of a sample of self-identified trafficked women in San Diego County?
2. What are the self-reported physical and emotional health care needs of this population?
3. Are there similarities or differences between the group of women who identified themselves as trafficking victims and those who did not, with regards to general demographic characteristics or self-reported health care needs?

Specific Aims

- AIM 1: To describe the characteristics a sample of self-identified trafficked women in San Diego County, California
- AIM 2: To identify unmet health care needs among this sample of self-identified trafficked women

- AIM 3: To gain a deeper understanding of the self-reported health care needs of the participants

This study provides an initial step toward understanding the health of trafficked women in San Diego County and contributes to the limited knowledge of the needs of this population. Health care providers, especially nurses, have been called to action to help identify and to treat victims of trafficking, and research is needed to provide the framework to assist their intervention (Cole, 2009; Peters, 2013).

Conceptual Framework

The Model of Human Trafficking and Health by Zimmerman et al. (2011) was used to guide the study (Figure 1). The model explores the stages of trafficking and the flow of victims through the trafficking process. The model is grounded in trauma theory and incorporates principles of migration theories. This conceptual approach integrates public health while allowing for individual response to environmental influences, threats to safety and bodily integrity, and trauma.

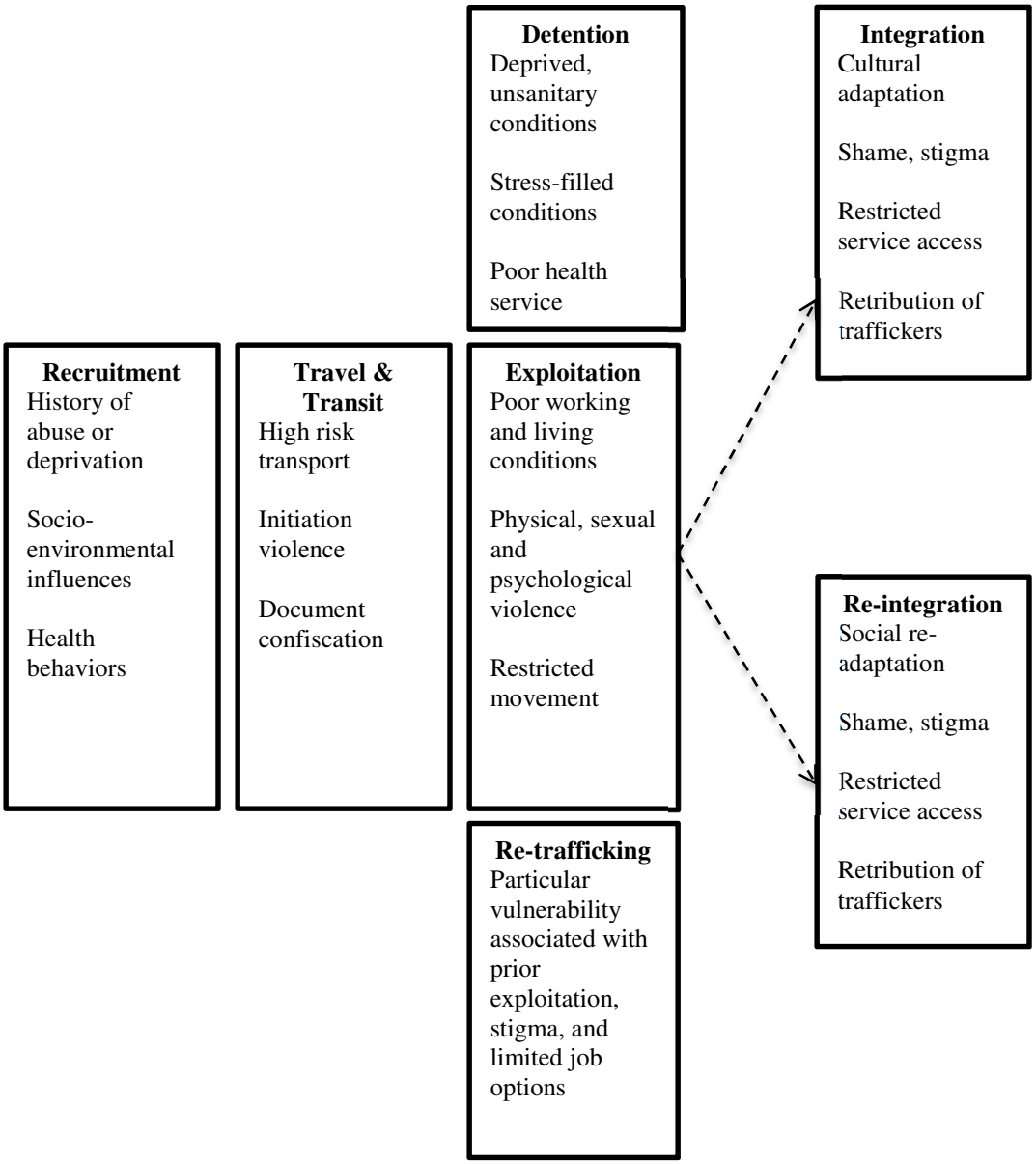

Figure 1. Stages of the Human Trafficking Process (Zimmerman et al., 2011).

It is necessary for nurses and other health care providers to recognize the trafficking stages as potential intervention points. Nurses possess unique skills that law enforcement personnel typically do not. Nurse contact may represent the only opportunity for a trafficking victim to communicate his or her plight. In interviews of the survivors (n=11) of the high-profile *United States v. Cadena-Sosa* case, Coonan (2004) found the survivors had encountered not only law enforcement officers during captivity, but also doctors and nurses for treatment of emergencies. These contacts represent underutilized opportunities for potential intervention.

Understanding the multiple risks in context may also inform prevention efforts (e.g. via pamphlets, video clips, staff at border crossings), alert victims to potential risks (e.g. environmental toxins, sexually transmitted infections), and provide personal protective equipment and instructive behaviors (e.g. condoms, protective eyewear). The framework provides a practical basis for assessment of personal and public health considerations.

Significance to Nursing

There is a demonstrated lack of literature regarding the health status of victims of human trafficking (Baldwin, Eisenmann, Sayles, Ryan, & Chang, 2011; Choi, 2015; Omole, 2016). This study describes the general characteristics and health needs of a self-identified population of trafficking victims for similarities and differences and for pattern identification. Findings from this study informs care of trafficking victims, and when considered in the context of other studies, have implications for nursing research, policy, education, and practice.

Prior to the enactment of the Trafficking Victims Protection Act in 2000 and other state legislation, law enforcement personnel were less likely to search for human trafficking victims and only the most egregious cases were discovered. Now, there is more focus on human trafficking training for law enforcement at the local level, and there is a recognized need for local law enforcement personnel to understand and identify the complex risk factors that may indicate human trafficking so they may intervene (Farrell, McDevitt, & Fahy, 2010). Similarly, nurses and other health care personnel need training and information about trafficking victims' health status to aid in identification and to provide appropriate care. This study begins to address the demonstrated gap in the research and contribute to the knowledge in the field.

Chapter II

Review of the Literature

This chapter describes the literature addressing the health of human trafficking victims. Key concepts are identified and the barriers to identifying victims, as well as methodological challenges to studying their health care needs, are examined. Pertinent studies from law enforcement, psychology, and social work have been reviewed to provide historical context and a social/ecological framework. The model of Human Trafficking and Health by Zimmerman et al. (2011) was used to guide the study and is presented in this chapter.

Published and unpublished literature were reviewed from the following computerized databases: Computerized Index to Nursing and Allied Health Literature (CINAHL), Google Scholar, ProQuest Dissertations and Theses Global, MEDLINE, and PubMed using the key search terms: *human trafficking, sex trafficking,* and *modern slavery*. These terms were matched with the terms *health care* and *nursing*. The literature search was limited to articles from 2006-2016. Reference lists for articles of interest were examined and pertinent articles were retrieved.

There is a paucity of literature describing the health of human trafficking victims. A total of 55 articles and reports met criteria for review, the majority of which were review articles (Figure 2). Additional materials were also examined for background information (e.g. definitions, history).

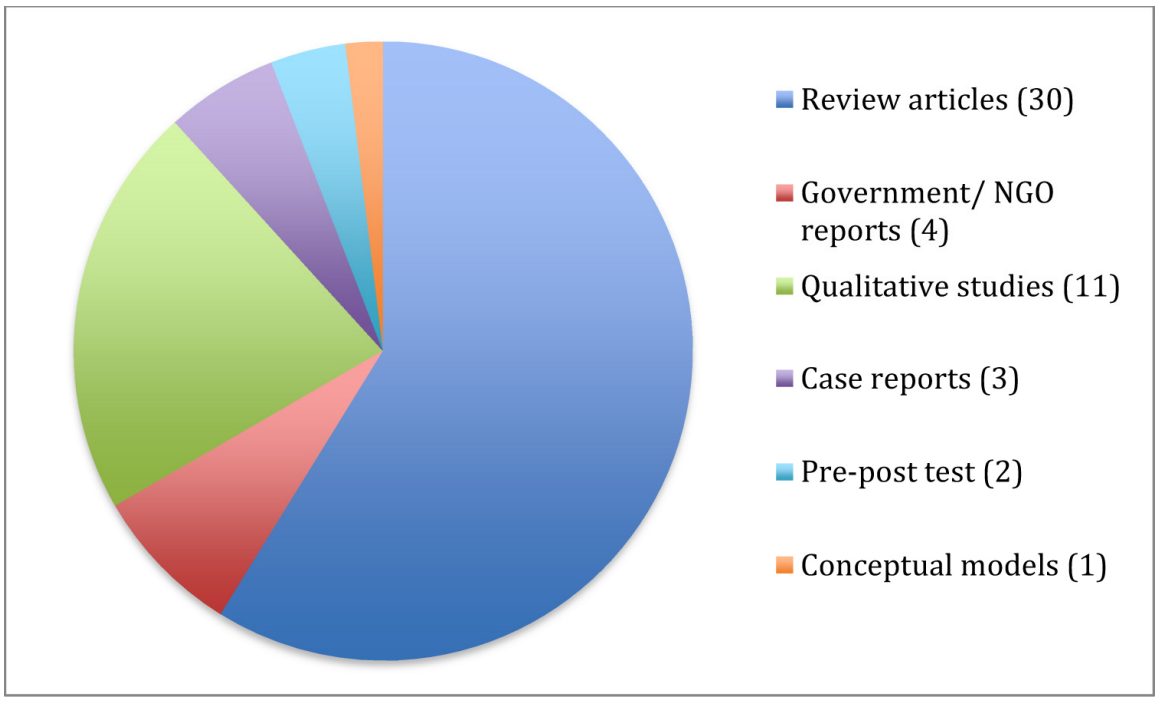

Figure 2. Literature Search Results

Definitions

It is necessary to define the terms and their origins as used in this document and in the health care lexicon. Because human trafficking is an emerging research field in health care, law, and social work, equivalent definitions cannot be assumed between disciplines. The working definitions for this research are presented in alphabetical order:

Bonded labor (also debt bondage): As defined by the United Nations, victims become "bonded" when their own labor is used to repay a debt for a loan or service, often at an exorbitant rate of interest, 25% or higher, which can never be paid off. The individual is typically paid less than a living wage, and his/her debt continues to accrue. The victim's family may depend on the creditor for food or shelter. According to the

United Nations Office on Drugs and Crime (2013), this is the most widely used method of enslaving people worldwide.

Child labor*:* Child labor is a form of trafficking that involves the work of minors, which is likely hazardous to their mental, moral, physical, social, or spiritual development (International Labor Organization, 2013). It interferes with their schooling or prevents them from attending. According to the 2013 report by the International Labor Organization (ILO), as many as 85 million children worldwide are engaged in hazardous labor, and 168 million children worldwide are employed in some form of labor, accounting for over 10 percent of the world's child population.

Forced labor*:* In forced labor, people must work against their will under some threat of punishment. This may overlap with other abuses. In the United States, forms of forced labor include domestic servitude, agricultural labor, sweatshop factory labor, and other service industries (ILO, 2013).

Fraud*:* Fraud involves deceit, false offers of employment, housing, citizenship, or other favors (ILO, 2013).

Human trafficking*:* The United Nations defines human trafficking as the "recruitment, transportation, transfer, harboring, or receipt of persons by improper means (such as force, abduction, fraud, or coercion) for an improper purpose including forced labor or sexual exploitation" (United Nations Office on Drugs and Crime, 2013). The Department of Homeland Security defines trafficking as "modern-day form of slavery involving the illegal trade of people for exploitation or commercial gain". (Department of Homeland Security, n.d.)

Survivor*:* There is debate in the literature regarding the language used to refer to persons who are trafficked, or have been trafficked, specifically related to those who have consented to travel for work, but have subsequently been defrauded or coerced. Practitioners whose work is informed by feminist theory tend to prefer "survivor." Egan (2016) argues the word removes the sense of blame and powerlessness. For the purposes of this project, a "survivor" is a person who has exited the human trafficking process to the integration or re-integration stages as defined by Zimmerman et al. (2011). This does not negate the need for ongoing physical and psychological treatment (Hockett & Saucier, 2015), or the possibility survivors may self-identify as victims (Thompson, 2000).

Victim*:* The definition of "victim" is fraught with challenges when discussing gender issues, sex work, and power differences between groups. For the purposes of this project, the definition in the United Nations General Assembly Resolution 60/147 was used: "...victims are persons who...suffered harm, including physical or mental injury, emotional suffering, economic loss or substantial impairment of their fundamental rights, through actions that constitute gross violations of international human rights law..." (United Nations General Assembly, 2008). The term "victim" is used frequently in legal and criminal justice literature.

The Scope of Human Trafficking

Human trafficking is a global problem that is difficult to define and to measure (Laczko & Gramegna, 2003). There are many methodological challenges to estimating the numbers of trafficking victims. Some of the challenge lies in the ambiguities of the definitions. Many of the victims are undocumented migrants, or are minors. When the

victims are identified and are also physically ill and live in squalid conditions, the label of “human trafficking victim” does not adequately delimit the many needs of the individual, including health care. Thus, victims may be misclassified and uncounted.

The ILO estimated in 2014 that over 20 million people were enslaved worldwide. Some estimates are much higher. Since 2014, the Walk Free Foundation (2016), in cooperation with Gallup teams, surveyed over 42,000 respondents worldwide in 53 languages, and has estimated a much higher number of over 45 million people in human slavery. Walk Free Foundation estimates are extrapolated from the findings of nationally representative, face-to-face random sample surveys conducted in 25 countries, collectively representing 44 percent of the global population (Walk Free Foundation, 2016).

Human trafficking is not only a scourge of the developing world. The U.S. Department of State conservatively estimates between 17,000 and 20,000 are trafficked into the U.S. each year. Although there is no official estimate of the number of victims of human trafficking within the U.S., unofficial estimates from the Polaris Project (2016) and the National Trafficking Resource Center suggest the total number of victims is “into the hundreds of thousands when estimates of both adults and minors and sex trafficking and labor trafficking are aggregated.”

While the international community acknowledges human trafficking is a significant threat to human rights and public health, the actual number of victims identified and cases investigated has cast doubt on the estimates of trafficking activity (Wilson, Walsh, & Kleuber, 2006). According to the Trafficking in Persons Report published annually by the U.S. State Department, approximately 44,462 trafficking

victims were identified worldwide in 2014 and 10,051 cases were prosecuted. In 2015, those numbers increased to 77,823 victims and 18,930 prosecutions. These numbers, while staggering, are far lower than the estimates of the millions of people thought to be enslaved this year. The increasing numbers of identifications and prosecutions indicate increased awareness of human trafficking and are a result of the evolving legislation worldwide.

The identification of one human trafficking victim can yield information about hundreds of other victims. For example, in the case of *United States v. Ramos,* three laborers spoke to a human-rights worker about the abuses in his/her workplace (Coalition of Immokalee Workers, 2012). Their conversations ultimately led to the investigation, arrest, and conviction of his/her employers, and the discovery of over 800 citrus workers who had been subjected to forced labor. In the case of *United States v. Kil Soo Lee* in American Samoa, one woman's horrific beating led to the prosecution of a factory owner for crimes against over 200 employees (French & Liou, 2016).

Misidentification of victims is a significant problem for law enforcement. While local police are the law enforcement officers most likely to encounter human trafficking victims, they may not actively be looking for these crimes. In the post-September 11 era, Homeland Security has become a primary focus for local police agencies (Farrell et al., 2010). Law enforcement officers are far more likely to be trained to look for terrorists, drug traffickers, and prostitutes (Thacher, 2005). Because trafficking victims are not a primary focus, they may instead be misclassified as undocumented migrants, and if the legal circumstances are ambiguous, police officers are likely to rely on established routines that treat the victims as perpetrators (Farrell et al., 2010). These

routines are built on the fact that lack of immigration status documentation, even in the absence of any criminal activity, is reason enough for law enforcement to question and detain anyone, acting as “force multipliers” in the enforcement of national immigration laws (Sweeney, 2014). The history of the criminalization of immigration is well documented and has been termed “crimmigration” (Rosenbloom, 2016).

Law enforcement officers may also become frustrated with victims who seem confused, or who change their testimony as a case evolves, which is a common reaction to a traumatic experience, and may be heightened by a fear of deportation. A study by Zimmerman et al. (2008) described victims who suffered memory problems secondary to trauma. The victims also had physical illnesses causing pain that delayed their abilities to recall details of their trafficking history.

The scope of human trafficking is difficult to measure not only because of its illegal nature and association with multiple criminal enterprises including drug trafficking and prostitution, but because its victims are often reluctant to seek help or self-identify (Zimmerman et al., 2011). Those who are brought from other countries are often stripped of any official documentation and are threatened with exposure to immigration authorities if they are discovered (Zimmerman et al., 2008). They are often psychologically manipulated to believe either they or their family members will be harmed or killed if they speak out. Often, victims do not know their rights. These uncertainties prevent victims from seeking assistance and reinforce their dependence on their traffickers for survival (Zimmerman et al., 2011).

Despite the public attention on human trafficking, some have argued the research is not evidence-based, nor verifiable (Weitzer, 2014). Claims regarding the

number of trafficking victims are often derived from reports provided by agencies that may not provide clear, transparent descriptions of the methodology used to arrive at their conclusions (Zhang & Cai, 2015). For example, the "Methodology" section of the 2015 Trafficking in Persons Report from the U.S. Department of State describes no specific, rigorous data collection but instead reads,

> "U.S. diplomatic posts and domestic agencies reported on the trafficking situation and governmental action to fight trafficking based on thorough research that included meetings with a wide variety of government officials, local and international NGO representatives, officials of international organizations, journalists, academics, and survivors. U.S. missions overseas are dedicated to covering human trafficking issues. The *2015 Trafficking in Persons Report* covers government efforts undertaken from April 1, 2014 through March 31, 2015." (p. 47).

Although the scope of trafficking is difficult to estimate for several reasons and lacks empirical data, there is no question victims need health care. There also is a need to expand the knowledge and the ability to identify those in need when in the environment of potential care, such as an emergency department.

Conceptual Framework

The model of Human Trafficking and Health by Zimmerman et al. (2011) was used to organize and interpret the study (Figure 1). The model explores the stages of trafficking and the flow of victims through the trafficking process. The model was chosen for its general applicability to many trafficking situations and fit regardless of gender, age, ethnicity, or other circumstances of victim or trafficker. According to the authors, the theory was intended to highlight the public health implications of trafficking and formally explicate the multiple stages of harm trafficking victims experience. The model draws from research in trauma theory and migration models.

The Recruitment phase of the model lists socio-environmental factors as a vulnerability to entry to trafficking. These may be recognized as classic "push and pull" factors from Ravenstein's work in migration theory (1885). Push factors may include political instability, natural disasters (droughts, earthquakes), and economic reasons (collapse of native economy). Pull factors include political stability, temperate environment, and economic growth. The same exposures that influence one's decision to migrate voluntarily are often the same circumstances that make them vulnerable to trafficking. Further, these events can interrupt the ability to properly care for one's self or family. For example, in January of 2010, a catastrophic 7.0 M_W earthquake struck the island nation of Haiti. In the days and weeks following, despite multinational relief efforts, many Haitian people continued to lack access to food or water. A cholera outbreak began in October of 2010. Much of the infrastructure of the country remains in disrepair. In its 2016 Trafficking in Persons Report, the U.S. State Department listed Haiti as a Tier 3 Country, downgrading it from Tier 2 status, which the country had held for the four years prior. The report documented multiple structural factors contributing to human rights violations, and noted the Haitian government was not in full compliance with the Trafficking Victims Protection Act of 2000 (TVPA). The "push" factors in Haiti include extreme poverty, lack of education, lack of basic health care, homelessness, and multiple environmental disasters. Individual health vulnerabilities may include previous illness or injury, malnourishment, anxiety, depression, post-traumatic stress disorder (PTSD), physical or sexual abuse, poor dentition, environmental exposures, and other health problems. Any or all of these factors could make an individual more susceptible to trafficking.

Following the Recruitment stage is the Travel and Transit stage, which begins when the individual begins his or her journey, either by consent or by coercion. It is likely the majority of victims do not travel by airplane or safely in motor vehicles. They may be brought in large groups in vehicles designed for freight, or brought by boat or raft to elude detection (Mountz, 2004). These individuals may have endured arduous travel on foot or have been locked in a trunk or container (Duara, 2015). This stage marks the beginning of illegal activity, either in the form of false imprisonment, kidnapping, falsification of documents, human smuggling, or illegal entry (Zimmerman et al, 2011). The victim may begin to understand his or her plight during this phase.

The Exploitation stage is the time when the victim performs the service or labor, or he/she is simply abused. Zimmerman et al., (2011) noted meanings of "exploitation" and "harm" are critical to the concept of human trafficking, but are not clearly defined by the United Nations. While a full analysis of these concepts is beyond the scope of this dissertation, it is important to note, this period of time is defined by physical and/or psychological neglect, abuse, or torture. Because the victim has restricted access to health care, those affected become extremely hard to reach in this phase. Many victims have been taken to foreign countries and thus have no cultural skills and may not speak the local language. They may not be aware of their rights, or even their location. Consequently, this isolation can reinforce feelings of helplessness, contributing to depression and suicidality (Zimmerman et al., 2011).

Some trafficking victims may progress to the Detention stage, when a victim is in custody or detention of a state authority. Although victims are likely to receive emergency health care treatment, unless they are a U.S. citizen, it is unlikely that more

chronic conditions will be addressed while they are awaiting disposition. The ongoing stress and deprivation contributes to poor physical health (Zimmerman et al., 2008).

It is unclear how many victims may be vulnerable to Re-trafficking, a potential phase in the trafficking cycle. Victims may be more vulnerable to financial difficulties after a period of marginalization and abuse (Zimmerman et al., 2011). The United Nations General Assembly Resolution 60/147 of 2008 provides for restitution and reparations paid to victims of serious human rights violations but this can only be paid if responsible parties are brought to justice.

The most desired outcome is to find safe, permanent shelter and enter the Integration or Reintegration stage. For victims in their homeland, "reintegration" is appropriate. Those who have sought asylum or settled in a host country will seek "integration." Victims in both groups will likely have physical and mental health needs as they enter these stages (Zimmerman et al., 2011).

Health Implications

Physical Symptoms

Although there is little research investigating the health of human trafficking victims in general, most of the research has focused on the victims of sex trafficking, especially women (Omole, 2016; Oram et al., 2012). This is likely in part due to the illegality of prostitution in most jurisdictions, resulting in the arrest and misclassification of victims, and subsequent opportunities for treatment and diversion programs (Farrell et al., 2010). Thus, most of the literature describes studies of women who were trafficked for sex work.

The protracted nature of the physical and psychological trauma of trafficking often results in multiple somatic complaints. Zimmerman et al. (2008) found two-thirds of trafficked women experienced at least ten concurrent physical symptoms, including neurological complaints, abdominal pain, gynecological complaints, and musculoskeletal complaints. The study of 192 European women, enrolled in a post-trafficking social services program, found the most commonly reported physical complaints were dizziness and back pain. These findings are consistent with studies of sex trafficking survivors in Nepal (Crawford & Kaufman, 2008) and Israel (Cwikel, Chudakov, Paikin, Agmon, & Belmaker, 2004).

In a 2015 multi-country study of migrant workers and victims of human trafficking, Buller, Vaca, Stoklosa, Barland, and Zimmerman found similar physical complaints among the victims of human trafficking. The most common complaints were lacerations on hands or fingers, due to the type of work done, usually manufacturing or construction. Respiratory complaints were common, as were musculoskeletal complaints, sleep deprivation, poor nutrition, and substandard living and working conditions.

Injury due to violence was identified as a significant contributor to physical illness. Hossain, Zimmerman, Abas, Light, and Watts (2010) found 80% of female trafficking victims (n = 204) had been exposed to physical or sexual violence during the trafficking phase. Zimmerman et al. (2008) found an astonishing 95% of trafficking victims (n = 192) reported injuries due to violence. Injuries in both studies included fractures, sprains, and facial and dental injuries. Gupta, Reed, Kershaw, and Blankenship (2011) found a 53.5% reported rate of violence among 157 female workers who reported being trafficked.

Victims of human trafficking are likely to be exposed to infections, especially during the Travel/Transport and Trafficking phases. The systematic review by Oram et al. (2012) reported Human Immunodeficiency Virus (HIV) prevalence from 13.1% to 45.8% among trafficked women. An ethnographic study of 30 formerly trafficked women in Tijuana found 5 (16.7%) were positive for any STI/HIV (Goldenberg, Silverman, Engstrom, Bojorquez-Chapela, & Strathdee, 2013). Silverman and colleagues (2008) found 30.1% HIV prevalence and syphilis infection in 20.4%, among 246 female survivors of sex trafficking in Nepal. The same study found co-infection was more common for those who were HIV positive than for those who were HIV negative (31.0% vs. 15.9% respectively). Hepatitis B was documented in 3.8% of the women. Unplanned pregnancies and sexual assaults were also reported among victims of sex trafficking (Miller et al., 2011).

Zimmerman and colleagues (2008) did not investigate HIV as a specific outcome, but 58% of the 192 respondents reported gynecological infections, and 30% described upper respiratory infections. The working conditions of trafficking victims, combined with the physical and mental stress, increase the victims' susceptibility to infection. Living in close quarters with substandard sanitation may increase the likelihood of communicable diseases including influenza, tuberculosis, or measles. Adolescents and adults from abroad may not have had the immunizations that are standard in the United States, including Hepatitis B (de Chesnay, 2013).

Encounters and Provider Knowledge

There is scant research regarding the health of trafficking victims, but some studies indicate trafficking victims are likely to encounter a health care provider during

the trafficking period. In a multi-site study of trafficking survivors within the U.S., Lederer and Wetzel reported 87.8% (N = 161) of respondents had contact with a health care provider while they were being trafficked. Victims indicated they had been seen at a hospital or emergency department (63.3%), a clinic (57.1%), Planned Parenthood (29.6%), or a doctor's private practice (22.5%). Other sites included urgent care centers and women's health centers. Of those who were seen by a medical provider, only 43.1% indicated the doctor had asked them about their lives and the circumstances leading to their visit (Lederer & Wetzel, 2014).

A qualitative study of 12 survivors of human trafficking in Los Angeles revealed half had seen a health care provider while under their trafficker's control (Baldwin et al., 2011). Medical visits were either for injuries or for systemic illnesses that prevented performance of duties (either domestic, labor, or sex work). Sex trafficking victims also reported visits to traditional healers or *curanderas*.

Even if a victim of human trafficking visits a health care practitioner during the trafficking period, there is no certainty he or she will be recognized as a potential trafficking victim. In addition to barriers to disclosure, many front-line health care providers do not possess the knowledge or confidence to identify or treat human trafficking victims. Data from a 2012 study of 180 emergency department personnel in the northeastern U.S. showed 79.4% knew the definition of human trafficking. Only 6.1% of respondents reported ever treating a human trafficking victim. Only 2.2% reported receiving formal training on the clinical presentation of trafficking victims, and 5% received training on the appropriate treatment of trafficking victims (Chisholm-Straker, Richardson, & Cossio, 2012).

In conclusion, there is limited research regarding the health of human trafficking victims in the U.S. (Omole, 2016). There is a lack of understanding of the characteristics of human trafficking victims, and for several reasons victims may be misclassified and summarily deported or even prosecuted. There is a need for research to identify the health care needs of trafficking victims, and for studies that will guide the formulation of best practices and evidence-based practice into transition to post-trafficking care.

Chapter III

Methodology

The purpose of this research was to examine the health care needs, both physical and psychological, of a self-identified group of human trafficking victims in San Diego County, California. This chapter describes the study design, data collection, and analytic procedures. The protection of human subjects is also presented.

Study Aims

- Aim #1: To describe the characteristics of a sample of self-identified trafficked women in San Diego County, California.
- Aim #2: To identify unmet health care needs of the sample
- Aim #3: To gain a deeper understanding of the self-perceived health care needs of the participants

Research Questions

1. What are the general characteristics of a sample of self-identified trafficked women in San Diego County?
2. What are the self-reported physical and emotional health care needs of this population?
3. Are there similarities or differences between the group of women who identified themselves as trafficked and those who did not, with regards to demographic characteristics or self-reported health care needs?

Research Design

This was a retrospective, non-experimental descriptive study. A descriptive design is useful to develop theory, identify issues in current practice, and determine

practice in similar situations. This type of design is appropriate for acquiring knowledge in an area where little research has been conducted (Grove, Burns, & Gray, 2013). A descriptive study is used in a natural setting without any intervention to control or modify the environment (Polit, 2010).

Sample and Setting

The sample was comprised of women, men, transgender, and trans-sexual individuals who had been identified as first-time offenders for prostitution and had voluntarily chosen to enter a diversion program as an alternative to incarceration (Hardy, 2016a). Enrollees were arrested in San Diego County and referred by the City Attorney's office. Participants' ages ranged from 16–60. The data were collected from September 2005 to November 2015.

Power, Effect, and Sample Size

This was a retrospective study using previously collected data on a small, difficult to reach population, precluding a robust power analysis. In the future, once salient variables have been identified and standards of care established, it will be possible to estimate sample size using effect size, desired power, and acceptable significance level.

Protection of Human Subjects

This study was conducted using previously collected, de-identified data. An Institutional Review Board (IRB) application was submitted to the University of San Diego on May 2, 2016, and Exempt status was granted on June 2, 2016 (Appendix A). All study personnel completed required human subjects protection training. Intake specialists from the Freedom From Exploitation project administered the original questionnaire. Participation was voluntary.

The data for this study were delivered in the form of a secure computerized file and no original documents were provided. All data will remain in the custody of the principal investigator for 7 years and will then be destroyed per institution IRB protocols.

Data Collection Instrument

Data were collected using the Freedom From Exploitation Intake Assessment (FFE-IA, Appendix B) (Hardy, 2016a), a 63-item questionnaire adapted from the SAGE Project (Standing Against Global Exploitation) (SAGE, n.d.). Intake specialists administered the questionnaire in a face-to-face interview, and responses were transcribed and coded after the interview.

Demographics

Demographic data collected included gender, age at enrollment, race, ethnicity, homelessness (previous or at enrollment), history of foster care, and zip code at enrollment.

Exploitation Assessment

Seventeen items assessed the respondent's age of entry into prostitution and the reasons given for trading sex including for money, housing, or drugs. Item Ten specifically ask if the participant is a victim of human trafficking. This question was first incorporated in the interview and the data captured beginning in August 2012.

Needs Assessment

There are 12 items related to perceived needs to depart a life of prostitution, including housing, job training, drug detoxification, and counseling.

Sexual Health

Four items are related to sexual health, and inquire about condom use and whether sex buyers pressure the respondents to have sex without condoms, or pay more for sex without condoms.

Mental Health

Sixteen items assess mental health, and include questions about symptoms of depression, anxiety, and PTSD.

Children

There are six items related to the number and age of children living with the respondent. These items also assess the health and dental care status of any children.

Data Analysis Plan

Quantitative Analysis

The Statistical Package for the Social Sciences (IBM Corp., 2015) was used for quantitative data analysis. Descriptive statistics summarized age at enrollment in the program, homelessness, and foster care. Race/ethnicity and gender were reported in both raw numbers and percentages. Bivariate associations were determined for categorical variables using Chi-square analysis; Fisher's Exact Tests, and Student's *T*-tests were used for continuous variables. Many of the questions comprising the FFE-IA were sensitive and not always completed by the respondents. Analysis was performed on a variable-by-variable basis because of missing data from particular questions. Counts and percentages are presented.

Qualitative Analysis

Intake specialists interviewed the participants upon entry to the program. The FFE-IA (Appendix B) was used to guide the interviews. Several items allowed for open-ended responses. Data were entered and coded by intake specialists; *verbatim* transcription was not used. Thematic content analysis was used to organize and describe the themes that emerged from the transcribed text. Content analysis is appropriate when there are few previous studies of a phenomenon, or when concepts are fragmented (Elo & Kyngäs, 2008).

Chapter IV

Study results

The purpose of this study was to examine the health care needs of a self-identified group of trafficked women in San Diego County, California. This sample is from a group of women enrolled in a prostitution first offender diversion program, "Freedom From Exploitation" (FFE). **Specific Aims:** AIM 1: To describe the characteristics a sample of self-identified trafficked women in San Diego County, CA., AIM 2: To identify unmet health care needs among this sample of self-identified trafficked women, and AIM 3: To gain a deeper understanding of the self-reported health care needs of the participants. A descriptive profile of the sample is presented. The results related to the specific aims of the study follow.

Characteristics of the Sample

The FFE program is a First Offender Diversion program offered by the City Attorney's office and refers first-time offenders to the program. Each person referred to the program completed an intake assessment (Appendix B), which was administered by a trained interviewer. Responses were voluntary. Although 732 participants enrolled in the FFE program during the data collection period from 2005–2015, the question, "Are you a victim of human trafficking?" was not incorporated until August 2012 and was asked of 191 participants (Hardy, 2016b). The sample of 191 participants was used for analysis (Figure 3).

Thirty-one participants (16.2%) self-reported having been trafficked. All participants who identified themselves as being human trafficking victims were women.

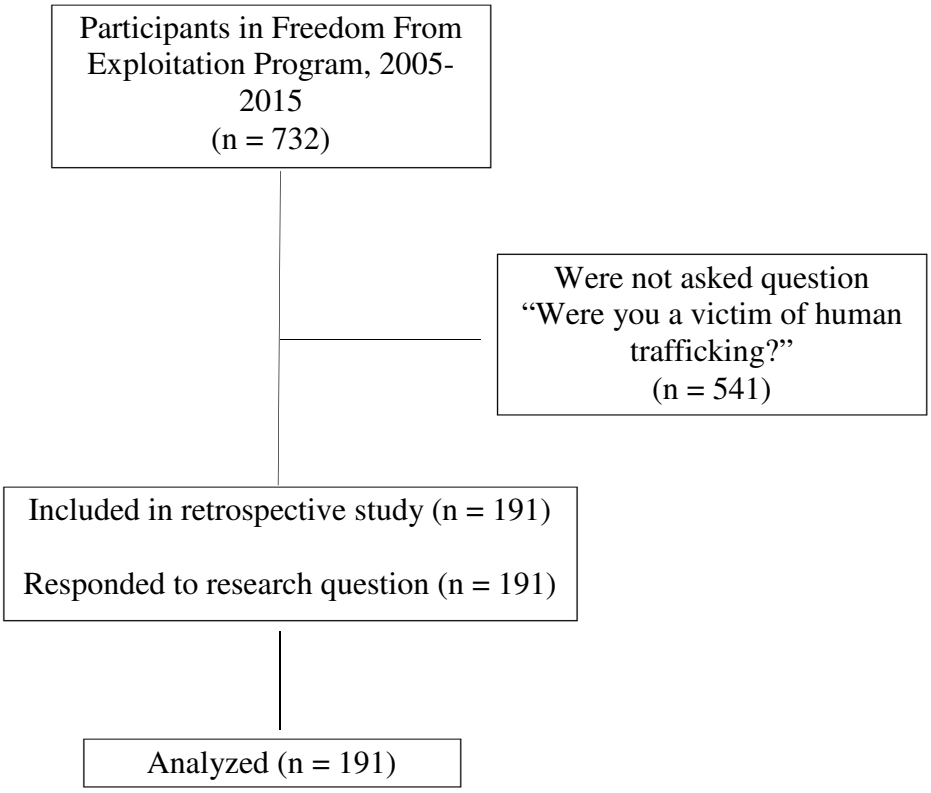

Figure 3. Consort diagram and flowchart of the study.

Twenty-three (74.2%) indicated they had been homeless at some time in their lives. Fourteen (45.2%) had been in the foster care system (Table 1). There was significant diversity among the trafficked sample. Eleven women (35.5%) were biracial. Seven (22.6%) were white, and 6 (19.4%) were black or African-American, two each were Latino, Asian/Pacific Islander, and Native American (6.5% for each ethnicity). One respondent answered "other." Ages ranged from 18 to 54 (mean 23.3 years). Eighteen residential zip codes were reported: the most frequent were 91945 (4), 92020 (3), and 92105 (3), although individuals lived throughout the county (Table 1). These zip codes represent Lemon Grove, El Cajon, and the City Heights neighborhoods of San Diego,

respectively. According to public records, these areas have significantly higher arrests for prostitution than other areas of San Diego (Crimemapping.com, n.d.). The numbers are small, but the results do suggest those areas of San Diego are initial areas where feasibility studies and initial outreach might be more viable.

Table 1.

Characteristics of Participants by Trafficked Status

	Total Group N=732	**Trafficked Yes N= 31**	**Trafficked No N=160**	**T-value**	***Chi*-Square**	***P* value**
Demographics						
Age, mean (SD), y	(N = 706) 25.9 (8.70)	23.3 (6.66)	26.9 (9.21)	2.51		.004
Age at entry, mean (SD)	(N = 560) 20.2 (6.58)	16.5 (5.69)	20.3 (5.05)	7.63		.001
Ethnicity, n, (%)					9.39	.11
Black/ African Am	222 (31.3)	6 (19.4)	40 (26)			
Latino	98 (14.0)	2 (6.5)	27 (17.5)			
White	169 (24.1)	7 (22.6)	39 (25.3)			
Asian/ PI	46 (6.6)	2 (6.5)	11 (7.1)			
Native Am	8(1.1)	2 (6.5)	1 (0.6)			
Mixed/ Bi-racial	134 (19.2)	11 (35.5)	31 (20.1)			
Other	24 (3.4)	1 (3.2)	5 (3.2)			
Gender, n, (%)						
Female	591 (95.8)	31 (100)	139 (89.7)			
Male	14 (2.3)	0	5 (3.2)			
Transgender	11 (1.8)	0	10 (6.5)			
Transsexual	1 (0.2)	0	1 (0.6)			
Push Factors						
Homelessness, n, (%)	296 (41.6)	23 (74.2)	65 (41.4)		11.81	<.001
Foster care, n, (%)	123 (17.2)	14 (45.2)	37 (23.1)		6.89	< .05
Sex for needs, n, (%)						
Place to stay	177 (24.2)	12(38.7)	37(23.1)		3.31	(.076)
Kids' needs	159 (21.7)	17 (55)	26 (16)		22.23	< 001
Clothes or jewelry	156 (21.3)	14 (45)	29 (18)		10.88	.002
Drugs	113 (15.4)	13 (42)	20 (12.5)		13.78	
Victim of violence, n, (%)						
Abused bc of condom use/request?	88 (12)	13 (42)	15 (9)		23.17	
Sex to avoid beating	108 (14.8)	16 (52)	16 (10)		32.42	
Sex for pimp or violent partner	154 (21)	18 (58)	22 (13.7)		30.80	

Mental health consequences, n, (%)				
Felt humiliation	319 (43.6)	24 (77.4)	72 (45)	10.49
Felt dirty	403 (55.1)	26 (83.8)	95 (59)	6.37
Felt depressed	339 (46.3)	26 (83.8)	77 (48)	13.21
Difficulty concentrating	265 (36.2)	23 (74.1)	66 (41.2)	10.81
Loss sexual pleasure	291 (39.8)	24 (77.4)	74 (46.2)	10.37
Hopelessness/desperate	260 (35.5)	24 (77.4)	61 (38.1)	16.48
Flashbacks/nightmares	258 (35.2)	22 (70.9)	57 (35.6)	13.68

Research Aim 1

The primary aim of the research was to assess the characteristics of a sample of self-identified trafficked women in San Diego County, California. The analysis of those who reported having been trafficked (n=31) illustrated a primarily young, ethnically diverse sample who reside throughout the county. Most had experienced homelessness during their lives. Nearly half had been in foster care in their youth (Table 1).

The reported age at entry (into trafficking) ranged from 2 to 28 years (mean age 16.5 years). Twenty-eight women (97%) reported having sex for money. Of the three who replied “no” to the sex-for-money question, two gave no other reason than human trafficking for having sex with paying customers, and one respondent indicated “sex for children’s needs, sex for clothes or jewelry, and sex for food or candy” as reasons for trading sex.

Thirteen women reported trading sex for drugs (41.9%). Nine respondents (29%) indicated they had sex to obtain drugs for their partner. Twelve (38.7%) reported having sex for “a place to stay.” Seventeen (54.8%) indicated they were motivated by their children’s needs.

The trafficking victims had been exposed to threats or violence. Sixteen (51.6%) of the women reported they had sex at least once to avoid a beating. Eighteen (58%) indicated they had sex for a pimp or a violent partner. Thirteen (41.9%) had been

threatened or abused by a sex partner because the partner did not want to use a condom. Of the 16 women who had sex to avoid a beating, 10 also had sex for drugs (62.5%).

Twenty-four of the respondents (77.4%) reported feelings of humiliation, 26 (83.8%) reported feelings of dirtiness, and 26 (83.8%) felt mistrust or hatred of men. Twenty-six women (83.8%) had feelings of depression, 23 (74.2%) had difficulty concentrating, and 24 (77.4%) reported feelings of hopelessness and desperation. Dissociative symptoms ("a sense of leaving your body") were reported by 21 respondents (67.7%), and flashbacks, nightmares and fears were reported by 22 women (71%).

Comparison to Non-Trafficked Sample

Of the 191 participants who were asked directly if they were victims of human trafficking, 31 participants (16.9%) answered "yes." One hundred and sixty (87.4%) answered "no." Several characteristics were compared between the groups. The characteristics of the 732 participants are provided in Table 1 for comparison.

The non-trafficked group was 89.7% female, 3.2% male, 6.5% transgender, and 0.6% transsexual (5 missing responses). Significant ethnic diversity was reported (Table 1). The ages of the non-trafficked group ranged from 18 to 54, with a mean of 26.9 years ($p = .015$). Fifty-five zip codes were reported, most frequently 92105 (15), 92113 (12), and 92115 (11). These zip codes represent the neighborhoods of City Heights, Logan Heights, and Talmadge/El Cerrito, respectively. While there was overlap in both the trafficked and non-trafficked women areas in the area of City Heights, the zip codes indicated there were notable differences in reported residence among those who did and did not report having been trafficked.

Of the non-trafficked group, 92 (58.6%) reported being homeless at some point in their lives (Table 1). Sixty-five (41.4%0 reported they had never been homeless (3 missing responses). Only 37 (23.1 %) of the non-trafficked group had been in the foster care system, 74.4% had not (4 missing responses). A *chi*-square analysis of responses showed a statistically significant relationship between a history of homelessness and self-identifying as a human trafficking victim [$x^2(1, N = 188) = 11.18$, $p < .001$]. Although a statistically significant relationship was found, the effect was small with a Cramer's V of .190. A statistically significant relationship was found between a history of foster care and self-identifying as a victim of human trafficking [$x^2(2, N = 191) = 5.93$, $p < .01$].

Research Aim 2

The secondary aim of this research was to identify the unmet health care needs of those who reported being trafficked. Three of those who responded having been trafficked (10%, one missing) reported a need for a drug detoxification program. Two respondents (6.6%) indicated a need for methadone maintenance treatment. One respondent replied affirmatively to needing both programs. Fifteen women (51.7%, two missing) indicated a need for emotional support. The same number indicated a need for therapy or counseling. Ten of the respondents who specified a need for emotional support also indicated a need for therapy or counseling. All of the respondents (100%) would accept health care for themselves and their children if offered to them.

Chi-square analysis was conducted to examine associations with entering prostitution. Self-identified human trafficking victims were significantly more likely to indicate children's needs as a motivation than their non-trafficked counterparts χ^2 [1, N = 191] = 19.52, $p < .001$. Human trafficking victims were also more likely to have sex to

avoid a beating, or for clothes or jewelry than those who did not identify as a trafficking victim χ^2 [1, N = 191] = 29.33, $p < .001$, χ^2 [1, N = 191] = 9.34, $p < .001$ respectively. A statistically significant difference was found in the measures of depression between the two groups. The trafficked group reported higher measures of feeling depressed, difficulty concentrating, and hopelessness/desperation.

Significant differences were found between the groups on the PTSD indicator questions. The trafficking victims were significantly more likely to answer affirmatively to the questions regarding dissociative symptoms and persistent re-experiencing symptoms.

Research Aim 3

The third aim of this research was to gain a deeper understanding of the self-perceived health care needs of the trafficked sample. The responses to open-ended questions asked during the interview were used to explore these needs. Specifically, as part of the assessment, participants were asked, "What do you need most?" Emotional support and counseling were frequent replies. Eight participants indicated a need for counseling. Responses included the following:

- "Emotional support and therapy."
- "Therapy, because I can't forget what happened."
- "It's hard to escape without having any support or talking about it with someone that wants to help."
- "Emotional support to remember myself in the past before prostitution."
- "Therapy. I need to accept certain things I've experienced."
- "Therapy, I sometimes think there is nothing else I am good for."

- "Therapy, the mental and emotional damage is the worst."
- "Therapy. been traumatized [sic]."

Three respondents mentioned drug treatment as a health care need. Examples of responses included:

- "I am a heroin addict and methadone would help but it is very expensive and I have no job."
- "Drug detox."
- "Drug detoxification and housing."

Eight participants indicated their greatest needs were simply shelter and food. Examples included the following:

- "Housing and eating."
- "Housing and food."
- "…I need help with home and food and every day necessities."
- "Housing! My children and I bounce from place to place every night."

The qualitative responses help to expand and to illustrate the statistically significant differences between the groups on variables such as history of homelessness, motivating factors, depressive symptoms, and post-traumatic stress disorder symptoms.

The findings from this study are supported by the Model of Human Trafficking and Health by Zimmerman et al. (2011). The trafficking survivors were significantly more likely to report a history of foster care and homelessness, which may have been factors in their recruitment. In the Recruitment phase of the model, a history of abuse or deprivation, and multiple socio-environmental influences contribute to the victim's

vulnerability. There was no temporal assessment of homelessness (i.e. whether the victims were homeless prior to the recruitment), but given the ages of the participants, it is likely they were in foster care at some point prior to trafficking recruitment.

The trafficked group was significantly more likely to have sex to avoid a beating. According to the model, physical, sexual, and psychological violence are hallmarks of the exploitation period. The participants report significantly higher rates of symptoms of depression, anxiety, and features of PTSD, which may all be consequences of exploitation.

Finally, the survivors described difficulty meeting basic needs of housing and food, in addition to the need for counseling or therapy. These difficulties are described in the Integration/Reintegration phase of the model. Some of the responses described feelings of shame (i.e. “there is nothing else I am good for”), which is also a characteristic of the Integration/Reintegration phase of the model.

Chapter V

Conclusions, Implications, and Recommendations

Summary of the Problem

Human trafficking is a growing problem globally, and in Southern California women, and their health, are disproportionately affected. Although women may receive emergent health care during the Trafficking Phase, little is known about the health status of women during the Reintegration or Integration Phases. There is limited research regarding the immediate and long-term health care needs of trafficked women. There is no evidence-based model of health care addressing the complex health care needs of human trafficking survivors.

Summary of the Purpose

The purpose of this study was to examine the health care needs of a self-identified group of trafficked women in San Diego County, California. Data were obtained from individuals enrolled in a prostitution first offender diversion program, Freedom From Exportation ([FFE], Hardy, 2016b). Characteristics of the trafficking victims were compared to those who did not self-identify as having been trafficked, and through open-ended questions, a deeper understanding of the self-perceived health care needs of the participants was obtained.

Discussion of Findings

Thirty-one (10.9%) women from a group of 191 participants self-identified as victims of human trafficking. Given the multiple barriers to identifying victims of human

trafficking, this is a profound finding. Simply identifying victims of human trafficking is a small, but crucial step in understanding the importance of the problem.

There were several significant differences in the characteristics of the women who were trafficked and the participants who did not identify themselves as trafficked. Self-identified victims of trafficking were younger than participants who were not trafficked. A statistically significant difference [x^2 (1, N=188) = 11.18, p = .001] was found in the percentage of participants who had experienced homelessness and a smaller, but still statistically significant difference [x^2 (2, N = 191) = 5.93, p < .01] was found between the trafficked and non- trafficked groups in the proportion of those who had been in foster care.

The trafficked group was significantly more likely to have sex to provide for children's needs (p < .001), to avoid a beating (p < .001), and for drugs (p < .001). These findings are consistent with studies that suggest human trafficking victims frequently suffer injuries from violence, and may use illicit drugs either willingly or forcibly (Macias Konstantopoulos et al., 2013; Oram et al., 2012; Zimmerman et al., 2008).

The trafficked women reported a statistically significantly higher rate of depressive (p =.001) and PTSD symptoms (p <.05) than the group who was not trafficked. There were no studies from the United States at the time examining the prevalence of depression or anxiety disorders in human trafficking survivors to provide context or comparison.

This study describes a small group of women who identified themselves as victims of human trafficking. They were likely to be victims of violence, and had sex for needs including food, housing, and drugs. They also had sex to provide for their

children's needs. These findings are consistent with the limited research done in this population.

The health care needs of this sample focused on three themes: emotional support or therapy, drug treatment, and basic survival needs including housing. There is very little known about drug use in victims of human trafficking but it has been suggested alcohol and other drugs are used to control trafficking victims (Cwikel et al., 2004; Zimmerman et al., 2008). The findings from this study suggest further inquiry and research are needed.

Study Limitations

The small sample size of those identifying as having been trafficked reflects the primary aim of those participating. They may not prioritize their health care needs appropriately, however, this was a study of perceived needs.

The findings of this study should be viewed in the context of the study design: descriptive, retrospective review of previously collected data. Data for this study were obtained from a community-based sample enrollment in a law enforcement diversion program for first-time offenders arrested for prostitution. Self-identification of trafficked status was limited to approximately 11% (n = 31) of the sample. The original purpose of the data collection was not for health care use but for intake assessment for a law enforcement diversion program. The focus of the program was on addressing life changes rather than emergent health issues, thus few health care needs are specifically captured in this database. The database does capture self-described health care needs of the human trafficking victims. It is not known whether a health care provider evaluated these individuals.

Human trafficking victims are a historically difficult-to-reach population. Victims may have been trafficked across international borders illegally, lack proper documentation, and are often forced into illegal activity including prostitution, or using illegal drugs (Zimmerman et al., 2011). Often they are unaware of their rights as victims. Data were not available to enable the examination by the respondents' country of origin, and potential trafficking victims may have been misclassified due to underreporting. This sample was from a population enrolled in a diversion program, so it is unclear if there was any perceived benefit to disclosing trafficking victim status.

No validated instrument to assess the health of human trafficking victims was available in the literature at the time of this publication. The instrument used in this study was the FFE-IA (Appendix B). This was adapted from an instrument used by the SAGE project (Standing Against Global Exploitation), a non-profit community organization with headquarters in San Francisco, CA (SAGE, n.d.). The questionnaire was designed for intake into the program; it is not a validated instrument.

The 67-item questionnaire was delivered via interview format. There were missing item answers for several questions. The administration of the questionnaire in interview format may have resulted in unanswered questions if the respondent felt them to be too sensitive. Given the small sample size and the difficult-to-reach population, each item was analyzed independently. Missing data were noted but cases were not excluded. Missing data were not assumed to be random. Because interviewers were not specifically identified with intakes inter-rater reliability could not be determined. For the survey questions requiring short-answer response, it is not known whether the participants' responses were recorded *verbatim* for every item. There is no mention of the

conditions of the facility where interviews were occurred, i.e. whether participants had adequate time and privacy to complete the interviews.

Nonetheless, many of the questions about mental and physical health care issues illustrate health needs and the potential role of the experiences of foster care and/or homelessness as a significant risk factor for trafficking.

Implications for Nursing Practice, Education, Research, and Policy

Nursing Practice

Although this study did not examine contact with health care providers during the trafficking period, the literature demonstrates significant opportunities for practicing nurses to identify human trafficking victims. To date, the American Nurses Association does not have a formal position statement on human trafficking, but does address the issue in a 2008 news article (Trossman, 2008). The Emergency Nurses Association released a full position statement in 2015, describing the role of emergency nurses in identifying and treating victims of human trafficking (Gurney et al., 2015). The International Council of Nurses (ICN) revised a position statement in 2011 to reflect the complexity of the ethics of nursing's role in human rights issues (ICN, 2011). Nurses in emergency departments, urgent care centers, walk-in clinics, and community clinics should be aware of the potential of encounters with victims of human trafficking. Nurses should investigate their facilities' policies regarding assessment and care of suspected trafficking victims, and if no policies are in place, encourage or initiate such policies. There is a clear opportunity for nursing leaders to develop institution-based and community-informed patient care.

There is not a significant body of research on the health of trafficking victims, thus, there are few educational resources for health care professionals. A review by Ahn et al. (2013) of 27 educational resources for health professionals regarding the identification, treatment, health consequences, and referral to treatment of human trafficking victims noted varying themes including trauma-informed care, patient-centered care, legal obligations in documentation, patient confidentiality, and security. There was a lack of uniformity in the content and quality of the educational resources. This reflects the lack of knowledge about the population in question, and underscores the need for further research.

Human trafficking activity varies widely from state to state, and within states, some cities experience more trafficking than others due to geographic and transportation factors (U.S. Department of State, 2016). Nursing practice will need to respond in an appropriate manner. Some facilities in border towns and located near major transport centers will have a more urgent need to educate staff about recognizing and treating trafficking victims. Rural areas, however, are not immune to trafficking activities and health care facilities should collaborate with law enforcement and social services to determine the most appropriate educational opportunities for their staff.

Nursing Education

It is easier to add content to a nursing school curriculum than to remove content from it (Candela, Dalley, & Bendel-Lindley, 2006). This may be an unfortunate consequence of teaching students to prepare for certification examinations (Diekelmann & Smythe, 2004). Individual nursing programs in high-risk areas may find a need to add content to the curriculum or partner with local health care agencies to provide education

for students on the specific human trafficking activities and the likely patients who may be encountered in nursing practice.

Research

There are few studies in the U.S. describing the health care needs of human trafficking victims. This is a hard to reach population, often initially identified by law enforcement personnel and subject to misclassification. Since an encounter with a health care professional during the trafficking period could be a critical opportunity to rescue an individual from a trafficking situation, research in identifying the common health care complaints and any patterns associated with trafficking could potentially change outcomes for thousands of trafficking victims.

Nurse scientists can design studies to identify these patterns in patients presenting at emergency departments and walk-in clinics. As the age at entry into trafficking is often during adolescence, pediatric nurses and school health officials may participate in research designed to identify trafficking victims and those at-risk. They should be aware of the risk factors of being in foster care and/or being homeless. The literature suggests a high rate of substance abuse among trafficking victims (Lederer & Wetzel, 2014, Zimmerman et al., 2008).

Policy

The Trafficking Victims Protection Act protects individuals from human trafficking in the United States, and provides for restitution in cases of human rights abuses. Laws vary from state to state, however. Nurses can influence policy by advocating for victims' rights, and contacting state legislators in support of stronger

legislation. Nurses can advocate for policy change at the local level, by supporting anti-trafficking campaigns and services for survivors.

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APPENDIX A – IRB

University of San Diego

ENTERED 6/3/16

Institutional Review Board
Project Action Summary

Action Date: June 2, 2016 *Note: Approval expires one year after this date.*

Type: __New Full Review ___New Expedited Review ___Continuation Review _X__Exempt Review
____Modification

Action: _X__Approved ___Approved Pending Modification ___Not Approved

Project Number: 2016-06-240
Researcher(s): Noelle Lipkin Leveque Doc SON
Dr. Cynthia Connelly Fac SON
Project Title: The Role of Nursing in Human Trafficking

Note: We send IRB correspondence regarding student research to the faculty advisor, who bears the ultimate responsibility for the conduct of the research. We request that the faculty advisor share this correspondence with the student researcher.

Modifications Required or Reasons for Non-Approval

None

The next deadline for submitting project proposals to the Provost's Office for full review is N/A. You may submit a project proposal for expedited review at any time.

Dr. Thomas R. Herrinton
Administrator, Institutional Review Board
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APPENDIX B

FREEDOM FROM EXPLOITATION
Intake Assessment
(adapted from the SAGE Project, San Francisco, CA)

Demo1	**Date:**		_____		
Demo2	**What gender/sex are you?**	Male	Female	Transgender	Transsexual
Demo3	**What is your current age?**		_____		
Demo4	**What is your Race/Ethnicity? (please circle all that applies)**		1 – Black/African American 2 – Latino/Hispanic 3 – White/Caucasian 4 – Asian/Pacific Islander 5 – Native American 6 – Mixed/Multi-racial describe: _____ 7 – Other		
Demo5	**Are you now, or have you ever been homeless?**		Yes	No	
Demo6	**Have you ever been in the foster care system?**		Yes	No	
Demo7	**Zip Code of where you currently live?**		_____		
Sex1	**Have you ever traded sex or had sexual contact *without really wanting to***				
	For money?		Yes	No	
Sex2	For a place to stay?		Yes	No	
Sex3	For your children's needs?		Yes	No	
Sex4	To avoid being beaten?		Yes	No	
Sex5	For clothing or jewelry?		Yes	No	
Sex6	For Drugs?		Yes	No	
Sex7	To get your partner drugs?		Yes	No	
Sex8	For a pimp or violent partner?		Yes	No	
Sex9	For food or candy?		Yes	No	
Sex10	Are you a victim of Human Trafficking? (which includes force, fraud or coercion)		Yes	No	
Exp1	**If you answered yes to any of the above questions, how old were you when this began? (the age you started)** _____				
Exp2	**Have you used you sexuality or had sexual contact to meet your needs anytime in the past month?**		Yes	No	

Exp3	**Have you used your sexuality or had sexual contact to meet your needs any time in the past year?**	Yes	No
HIV1	**Have you ever had a sex-buyer (date/john/trick) (doesn't mean you did it, but did the sex-buyer ask):**		
	Refuse to use a condom?	Yes	No
HIV2	Give you extra money or drugs to not use a condom?	Yes	No
HIV3	Tell you they will find someone else that will not use a condom unless you change your mind?	Yes	No
HIV4	Become abusive because you want to use a condom?	Yes	No
	Have you ever:		
MH1	Lied and told a date how attractive you thought they were?	Yes	No
MH2	Felt repulsed by the person who picked you up, but went anyway?	Yes	No
MH3	Fantasized about causing your date physical harm?	Yes	No
MH4	Felt disgusted by the person you were having sex with?	Yes	No
MH5	Wanted to quit prostitution, but didn't know how?	Yes	No
	If you are sexually exploited as a prostitute, describe some of your feelings? Do these feelings include:		
MH6	Humiliation?	Yes	No
MH7	Feelings of dirtiness?	Yes	No
MH8	Depression?	Yes	No
MH9	Difficulty concentrating?	Yes	No
MH10	Mistrust and/or hatred of men?	Yes	No
MH11	Loss of sexual pleasure?	Yes	No
MH12	Hopelessness and desperation?	Yes	No
MH13	A sense of leaving your body?	Yes	No
MH14	Had Flashbacks, nightmares, and fears?	Yes	No

OP1 **In your opinion, what are the advantages of being sexually exploited as a prostitute?**

_____

_____

OP2 **In your opinion, what are the disadvantages of being sexually exploited as a prostitute?**

OP3 **If you have been sexually exploited as a prostitute or done survival sex and gotten out, how did you get out?**

NEEDS 1 **If you were to stop being sexually exploited as a prostitute, what would you like to be doing instead?**

NEEDS 2 **If you are currently being sexually exploited as a prostitute, do you have a plan for leaving?**

(Please circle either Yes or No) Yes No

NEEDs 2a **If so, please describe how:**

What kind of assistance do you need in order to escape being sexually exploited as a prostitute? Please check all that apply

NEEDS 3	Housing?	Yes	No
NEEDS 4	Child Care?	Yes	No
NEEDS 5	Drug detoxification?	Yes	No
NEEDS 6	Methadone maintenance?	Yes	No
NEEDS 7	Emotional support?	Yes	No
NEEDS 8	Job training?	Yes	No
NEEDS 9	GED?	Yes	No
NEEDS 10	Therapy?	Yes	No
NEEDS 11	Legal Services?	Yes	No
NEEDS 12	Other?	Yes	No

NEEDS 13 **Of these services, which do you feel would help you the most? Why?**

NEEDS 14 **Where would you need to go in order to leave being sexually exploited as a prostitute or to stay out?**

_____

_____

Children:

Ch1. **If you have children: How many children do you have?**_____

Ch2. **Do your children live with you?** **Yes** **No** **Part-time**

Ch3. **Please give me the sex and age of each child in your care:**

	(girl or boy)	(age of child)
Ch3a.	_____	_____
Ch3b.	_____	_____
Ch3c.	_____	_____
Ch3d.	_____	_____
Ch3e.	_____	_____
Ch3f.	_____	_____
Ch3g.	_____	_____
Ch3h.	_____	_____
Ch3i.	_____	_____
Ch3j.	_____	_____

Ch4. **Do you have a regular doctor or facility you take your child/ren to for medical or dental care?**

Ch4a. Medical **Yes (please describe i.e. clinic, private, HMO)**

_____

No

Ch4b. Dental **Yes (please describe i.e. clinic, private, HMO)**

_____

No

Ch5. **Would you be willing to participate in free health care for you and your children?**
Yes **No**