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Coordinating Services for Survivors of Human Trafficking

By

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ABSTRACT

Jessica Himmelstein: Coordinating Services for Survivors of Human Trafficking (Under the direction of Sue Tolleson-Rinehart, PhD and Martha Carlough, MD, MPH)

Human trafficking has gained increased attention from the medical community. One study reported that 87.8% of those trafficked for sexual exploitation had contact with a health care provider , representing an opportunity for health care providers to intervene (Lederer and Wetzel 2014) Recent research has emphasized increased awareness and screening by health care providers as key to identifying victims of human trafficking (Simich et at 2014) However once identified, survivors require comprehensive care to address short-term and long-term needs that ensure an individual's safety, privacy and dignity. This study aims to understand how health care providers can improve utilization of resources that community advocates say survivors of human trafficking most need.

This study performed a systematic review of the literature along with four key stakeholder interviews to understand 1) the needed resources to aid survivors of human trafficking and 2) how medical providers can better understand and utilize these resources in referring an identified victim. One interview from a community advocates addressed resources most needed by survivors. Three interviews of medical providers addressed knowledge and utilization of resources by providers in referring patients. Results exposed gaps in health care provider identification of victims and referrals to needed community resources. Difficulty with identification resulted from lack of provider training and time constraints. Having an established interdisciplinary referral system seemed to provide the best coordination of aftercare services. These finding suggest the need to have adequate referral protocols and partnerships with community stakeholders when identifying victims of human trafficking.

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INTRODUCTION

Human trafficking has gained increased attention from various sectors including law enforcement, health care, and policy makers since 2000 with the passing of the Trafficking Victims Protection Act (TVPA) (Federal Strategic Action Plan 2012-2017). Human trafficking, also known as "trafficking in persons" and "modern slavery," encompasses various forms of human exploitation including sex trafficking; child sex trafficking; forced labor; bonded labor or debt bondage; domestic servitude; forced child labor; and the unlawful recruitment and use of children as soldiers (Trafficking In Persons Report 2015: 7). The exploitation of individuals for labor or sexual acts has been brought to societies' consciousness through increased awareness of human trafficking. The term human trafficking has allowed the re-categorization of individuals to be acknowledged and validated as victims of these dehumanizing conditions. The term not only allows the identification of victims but also helps establish and enable solutions to regain freedom and dignity for survivors.

Increased awareness of human trafficking and its meaning have stimulated the development of policy initiatives to change the national and international agenda. Research in human trafficking has tried to work on quantifying the problem as well as understanding the complex needs of those being trafficked. The focus of this paper will be on sex trafficking particularly in adults 18 years of age or older. Throughout this paper "survivors" and "victims" of human trafficking are terms that will be used interchangeably as part of the context being discussed and described. The term "victim" is not meant to be critical or derogatory but a recognition and acknowledgment of the exploitation and abuse suffered by individuals in trafficked situations.

This paper will first provide a background of human trafficking and the various health consequences of sex trafficking as well as the role of the health care system and providers in assisting survivors of human trafficking. Finally the paper will compile and analyze stakeholder interviews from health care providers and service organizations to understand how services can be better coordinated once a trafficked victim is identified in the health care system. This study aims to understand how health care providers can improve utilization of resources that community advocates say survivors of human trafficking most need.

BACKGROUND AND SIGNFICANCE

Policy Initiatives

In 2000 major international and national policy initiatives developed to combat human trafficking. The United Nations adopted the "Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children" in 2000 and it began to be enforced in 2003 (UN General Assembly Resolution 55/25 2000). As of 2016, 169 member states have signed the treaty (UN Treaty Collection 2016). This treaty was a crucial milestone since it provided a cohesive definition for human trafficking or "Trafficking in Persons" defined as

> 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. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs. The consent of a victim of trafficking in persons to the intended exploitation set

> forth… [above] shall be irrelevant where any of the means set forth… [above] have been used. (UN General Assembly Resolution 55/25 2000: 42-43)

The definition is best understood via its three "common elements" including what is done or the act; how it is done or the means; and why it is done or the purpose; see Figure 1 (Albert et al 2014:3). Apart from providing a definition, this UN protocol also established special considerations for housing, education and care of children, defined as those younger than 18 years old. It also provided guidelines for the legal protection and assistance needed for recovery by all victims of human trafficking.

Major US domestic legislation includes the Trafficking Victims Protection Act (TVPA) passed in 2000 and reauthorized in 2003, 2005, 2008, and 2013 (US Laws on Trafficking in Persons 2016). TVPA helped to establish an interagency task force in the development of the Department of State's Office to Monitor and Combat Trafficking in Persons (TIP). "The Office pursues policies, partnerships, and practices that uphold the '3P' paradigm of prosecuting traffickers, protecting victims, and preventing trafficking;" see Figure 2 (Office to Monitor and Combat TIP 2016). Additionally TVPA established legal assistance through the granting of temporary visas similar to those extended to refugees (under section 207 of the Immigration and Nationality Act.) to any "victim of a severe form of trafficking in persons" defined as

> (A) sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or
> (B) the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery. (TVPA 200: Division A Sec 103)

The granting of this temporary visa is contingent upon a certification period where the survivor is found to meet the definition criteria for “severe form of trafficking in persons” and also agrees to assist in the investigation and prosecution of her or his trafficker (TVPA 2000: Division A Sec 107).

Prevalence of Human Trafficking

Data on the scope of human trafficking are variable. The clandestine nature of human trafficking makes it difficult to get an accurate estimate of the extent of the problem domestically and internationally. Best estimate data on the prevalence of human trafficking come from various governmental agencies that capture different aspects of the problem. In 2012 the International Labor Organization (ILO) estimated that from 2002-2011, there were about “20.9 million people [who were] victims of forced labour globally, trapped in jobs into which they were coerced or deceived and which they cannot leave” (ILO Report 2012: 11). Of those victims of forced labor, it is estimated that about 4.5 million (22%) are victims of forced sexual exploitation, see Figure 3 (ILO Report 2012).

The 2015 Trafficking in Person (TIP) Report by the U.S. Department of State reported in 2014 approximately 10,051 trafficking-related prosecutions, 4,443 convictions, and 44,462 victims identified globally (TIP Report 2015: 48). According to the United States Department of Justice, there were 2,515 human trafficking incidents (of which 2,065 were sex trafficking) investigated by law enforcement from 2008 to 2010 (U.S. Department of Justice 2011). More recently, the Polaris Project reported that the National Human Trafficking Resource Center (NHTRC) received 21,947 calls, 1,535 webforms, and 1,275 emails to their reporting hotline in 2015, resulting in 5,544 cases of human trafficking. (Hotline Statistics 2015)

Some have questioned the methodology of human trafficking estimates particularly by the U.S. State Department. Yearly estimations have varied greatly, creating some mistrust and criticism of the true extent of human trafficking. A recent article by Fedina highlights this discrepancy in the data by analyzing estimates from multiple years:

> In 2001, the State Department estimated that 45,000–50,000 individuals were trafficked into the United States each year and as many as 700,000 victims were annually trafficked across the globe. In 2003, this statistic was revised, reducing the number from 50,000 to 18,000–20,000 victims trafficked each year into the United States. In 2004, the State Department reduced the estimate again to 14,500–17,500 and in 2007, revised its global estimate to 800,000 people trafficked annually (Fedina 2014: 191).

Fedina does not negate the existence of the human trafficking problem but instead advocates for the importance of and need for good data to further anti-trafficking advocacy and research. Flawed data, she argues, can be detrimental to legislative initiatives and can "result in inappropriate or insufficient allocations of resources to anti-trafficking efforts" (Fedina 2014: 194) Ultimately good data can further drive good research to make informed decisions at the policy and individual survivor level to bring justice to survivors of human trafficking.

Health Consequences of Sex Trafficking

With increased awareness and policy development, research efforts have also developed to address the complexity of this issue at the individual level. A recently updated systematic review of 31 studies assessed the health consequences associated with human trafficking (Ottisova et. al. 2016). This study covered the various forms of human trafficking in multiple countries and identified the violence and major physical, mental, and sexual health problems faced by victims of human trafficking. The study found "trafficked women, men and

children…report significant levels of physical health symptoms, including headaches, stomach pain and back pain" and "most commonly reported mental health problems include depression, anxiety and post-traumatic stress disorder" as shown in Tables 1 and 2 (Ottisova et. al. 2016: 1).

The systematic review assessed sexual health specifically by analyzing HIV infection in eight studies. It found in the pooled prevalence estimate an "increased odds of HIV infection among trafficked v. nontrafficked sex workers (OR 1.96, 95% CI 1.11–3.47)" (Ottisova et. al 2016: 18). Eighteen studies reported on incidence of violence and showed "high levels of physical and sexual violence experienced by trafficked people, including trafficked children." and four studies reported "high prevalence of drug and alcohol use among men, women and children that had been trafficked" (Ottisova et. al 2016: 18-19). The four studies analyzed did not specify whether the substance use was coerced or used as a coping mechanism during and after being trafficked (Ottisova et. al 2016).

Another study using mixed methods looked specifically "at the health consequences and health care experiences of women and girls trafficked in the United States for commercial sex" through focus groups of a total of 107 participants (Lederer et. al. 2014: 62). The study found physical signs such as "signs of being kicked, punched, or beaten" were reported in all victims and at least two thirds reported "signs of forced sex (reported by 81.6%), and head or facial injuries (each reported by more than half of survivors)" (Lederer et. al. 2014: 81). When addressing mental health concerns the study found "depression was the most common symptom for survivors (88.7%) and anxiety, irritability, nightmares, low self-esteem, and feelings of shame/guilt were all reported by more than 70% of survivors" (Lederer et. al. 2014: 81). For sexual health concerns the study found "more than two-thirds of these women (67.3%) contracted some form of sexually-transmitted [*sic*] disease or infection (STD/STI)" (Lederer et al

2014: 71). Evidence from both studies validate the complex health concerns for trafficked victims and demonstrate the need for a comprehensive approach to aftercare services after an individual is identified and able to leave the trafficked situation.

The Health Care System and Human Trafficking

Victims of human trafficking may come into contact with the health care system while being trafficked, which presents a unique opportunity for health care providers to intervene. The same study that assessed the health consequences of trafficking for sexually exploited women and girls also assessed the victims' experience with the health care system (Lederer et al 2014). The study found that 87.8% of female survivors "had contact with a health care provider while they were being trafficked" with the majority (63.3%) getting treatment from a hospital/emergency room (Lederer et al 2014: 77). "[C]ontact with clinical treatment facilities, most commonly Planned Parenthood clinics" was also reported by 29.6% of survivors (Lederer et al 2014: 77). These findings help to illustrate the need for the health care system and health care providers to be adequately prepared to identify and provide services for victims of human trafficking.

The Role of Health Care Providers

In order to maximize the opportunity afforded to health care providers to help victims of human trafficking, it is essential for providers to identify and treat individuals while being cognizant of their well-being and safety needs. People emerging from a trafficked situation have multifaceted concerns including physical, mental health, and legal needs therefore establishing trust by health care providers is crucial (Alpert et. al 2014). In order to establish and maintain trust, providers should know how to sensitively screen for human trafficking by understanding the signs of being trafficked but also know the needed next steps after identification (Alpert et. al

2014). Additionally after an individual discloses that he or she is in a trafficked situation, that victim's vulnerability and safety must be considered and "trauma-informed, resilience-oriented, human rights-focused, and culturally sensitive approach to [their] care" should be undertaken (Alpert et. al 2014: 17).

Recently studies have been published to help guide the creation and/or use of screening tools for health care providers. A 2016 study in *Academic Psychiatry* did an evaluation of nine screening tools and found that only two were designed specifically for health care providers and all nine varied in target population (e.g., children, adults, or both) (Bespalova et. al. 2016). Of the nine screening tools only one was "formally assessed to be valid and reliable in a pilot project in trafficking victim service organizations, although it has not been validated in the health care setting" (Bespalova et. al. 2016: 124). Though not formally validated, the authors suggest that the Polaris Project Medical Assessment Tool is "best suited for screening" based on length (six questions) and observation of warning signs along with its easy to follow flow diagram (Bespalova et. al. 2016: 124). Additionally the authors propose that the Polaris Project website (http://www.polarisproject.org/resources/tools-for-service-providersand-law-enforcement) provides information and resources to guide health care providers in helping survivors.

In conjunction with screening, providers need to be versed in providing trauma-informed care to victims of human trafficking. "Trauma-informed care is a strengths-based framework that incorporates acknowledgement of the prevalence and impact of traumatic events into clinical practice, placing an emphasis on instilling in the patient a sense of safety, agency, and reclamation of control and autonomy over one's life and decisions" (Alpert et. al 2014:17). The continual disempowerment and exploitation faced by many victims can result in ordinary medical procedures producing anxiety or being perceived as threatening (Alpert et. al 2014). The

purpose of providing trauma informed care is to "1) Reduce re-traumatization 2) Highlight survivor strengths and resilience 3) Promote healing and recovery and 4) Support the development of healthy short- and long-term coping mechanisms" (Alpert et. al 2014:17-18). It is important to be especially cognizant of the power dynamic physicians have, particularly in this vulnerable population. Trauma-informed care can equalize the power dynamics, allowing vulnerability and trust between victims of human trafficking and health care providers.

Referral to Resources and Ongoing Care

After identifying and providing the appropriate immediate medical care, it is important to have a network in place for the needed aftercare services required by survivors of human trafficking. "The needs of trafficked individuals often go well beyond medical needs to include emergency food and shelter, as well as legal support to deal with immigration, criminal or guardianship matter[s]" (Zimmerman and Borland 2009: 117). Knowing where to refer an individual for support services once he or she is identified is essential prior to the encounter in the health care system. Where a functioning referral system is not in place to address the needs of trafficked individuals then some suggested guidelines for providers include identifying and assessing services in local area and developing an inter-organizational referral arrangement (Zimmerman and Borland 2009). In the absence of a referral system, the assessment of these local resources may best be done through an interdisciplinary team to include the various resources needed by survivors.

The more informed the health care system and providers are about local resources to assist survivors of human trafficking the better prepared they can be to make the needed referrals. "These might include organizations providing social services, housing and legal aid; and government contacts in agencies such as law enforcement, consular services, and migration."

(Zimmerman and Borland 2009: 118). When identifying these organizations some key information to gather includes their confidentiality regulations and non-discriminatory procedures. Additional information to know about these organizations includes language capacity, location/security and potential implications of cultural or religious characteristics (Zimmerman and Borland 2009).

With this more complete understanding of local service organization aiding survivors of human trafficking, the health care system referral process can become a lot more efficient and safe. Though guidelines exist there is currently no consensus on how to best coordinate aftercare services between the health care systems and community service organizations. This brings us to the main research question of the present study.

METHODS

This study triangulated several different methods for gathering information about the aftercare needs of survivors of human trafficking. I conducted a systematic review of the literature to understand the aftercare services needed by adult survivors of sex trafficking in the United States. In addition to my limited systematic review of literature, I conducted a separate literature search on the role of the health care system and providers in assisting victims of sex trafficking, as noted in the background and significance. Finally, in-depth interviews with health care providers and community advocates assisting survivors of human trafficking provided an additional perspective on what was found in the literature and helped me derive new insights.

Systematic Review

I searched PubMed, Scopus, and PsycInfo for peer-reviewed articles from 1990 to April 13th 2016. Considering the TVPA of 2000 a conservative date of 1990 was selected to gather any articles prior to its enactment. Search terms for all databases included human trafficking OR sex

trafficking AND aftercare OR rehabilitation OR programs OR interventions OR services OR health OR health care. The search strategy resulted in 842 unique articles of which 715 were excluded based on title. Of the remaining 122 articles 28 articles were excluded based on being book sections or dissertation/thesis papers. I then assessed 94 articles that potentially met the search criteria. After further screening, 5 articles met the search criteria, 4 were identified using the electronic databases and 1 was found through the cited articles by the Macy et. al. paper. I extracted data based on study design, population characteristics, and qualitative data on expertise from key stakeholders and survivors, and outcome of aftercare services required for survivors of human trafficking. Findings from the systematic review are presented in Appendix1.

Stakeholder Interviews with Providers and Community Advocates:

After receiving exception from the Institutional Review Board at UNC Chapel Hill, I conducted four stakeholder interviews including three of health care providers and one community advocate. I identified health care provider participants through HEAL Trafficking organization research committee referrals as well as from UNC faculty who demonstrated interest in working with survivors of human trafficking. I identified community advocate participants through organizations listed in the National Human Trafficking Referral Directory under the Polaris Project website. The organizations I included provided aftercare services to adult survivors of sex trafficking.

Following identification of participants, I sent email messages requesting an interview. Telephone interviews were scheduled with two health care providers. One health care provider interview was done in person. Responses from the one community advocate were provided by an emailed typed response to guided interview questions. I sent all participants a copy of the guided interview protocol prior to the scheduled interview time. The complete interview protocol is

included in Appendix 1 and was developed with the guidance of Dr. Tolleson-Rinehart and Randy Teal from UNC School of Public Health. Beginning each telephone and in-person interview, I read a standard description of the project which is included in the interview protocol. Additionally participants verbally consented to participate in the interview, to be recorded, and to be identified. Those declining identification remained completely anonymous. Provider interviews consisted of one internist, one emergency medicine provider, and one pathologist. The community advocate interview came from an organizations located in the southeast. A list of respondents is presented in full in Appendix 2. All telephone and in-person interviews were transcribed by me and I provided a copy of his or her transcript to each respondent.

RESULTS

In this section I synthesize the stakeholder interviews from health care providers first, followed by the interviews of the community advocate from a service organizations providing aftercare to survivors of sex trafficking. I break the results down by the categorization of questions asked and themes within those categories. I used the data gathered from the interviews to supplement the information in the literature presented in the background and significance above as well as the findings from the systematic review.

Health Care Provider Interviews:

Awareness and Identification of Human Trafficking in the Health Care System

All providers asserted an increased public awareness of human trafficking in recent years for a variety of reasons, including increased media coverage, the worldwide migration crisis, and interagency collaboration and advocacy on the issue. When I asked them to share some ways they had identified victims of sex trafficking in the course of delivering care, all providers said it was difficult to identify victims. One participant summarized the group sentiment: "…it's very

hard to identify these people even if you are sensitized and concerned about it" (AW 2016). One provider stated not having identified a victim while delivering care but having suspicions that trafficking could have been occurring. The other two providers stated the patients they saw had mostly come to them through another referral pathway where there were already suspicions or otherwise had confirmation that trafficking was occurring or had occurred.

Next I asked providers about challenges to identification of victims. Two providers emphasized time constraints. One of those providers explained "sometimes, especially in the emergency department, it is not like a private office, it is very fast, and very busy…. and you have just a very short amount of time to…try [and] make a connection with people." (ES 2016) Additional barriers listed by providers included financial pressures, legal barriers, access to health care and the safety concerns of victims. One provider listed language as a barrier and added "depending on what language they're speaking…we would be talking with them on a telephone with [the] interpreter or be tempted to use their seemingly loving family member to help with interpretation [and] so we might completely miss the boat" (AW 2016). Another provider said the primary barrier to identification is that patients don't self-identify. The provider further explained that "I think the majority of the children that we see…both boys and girls…don't view themselves as victims. They would deny it if you flat out asked them [because] they just don't perceive themselves in that way. Because of the way they are responding to questions, it is not inherently clear that they are victims and we need to really think about how we ask questions" (JG 2016).

Service Provision for Victims of Human Trafficking

I asked providers what services a person needs once he or she is identified. Answers fell into two broad categories of medical and non-medical needs, with the majority of participants

focusing on non-medical needs. Medical needs included the need for general health care and health insurance coverage. One provider described medical needs in further detail to include behavior health assessment; inpatient psychiatric referral for suicidal patients; free accessible medical home for STI testing, HPV vaccine, immunizations, and family planning; drug assessment and rehabilitation; and genital exam by a trained professional. One provider argued for the importance of addressing medical needs but also added that "caring for [the] health problem [of victims] is just one on a long list [of needs] and it may not be the first thing on the list" (AW 2016).

All providers listed food, clothing, housing, and social support as major non-medical needs for survivors of human trafficking. One provider captured the group's sentiments about these non-medical needs: "They (victims of trafficking) don't have a home, they don't have food and they don't have a safe place. They don't have any supportive people in their lives. They don't necessarily have clothes. They may not be used to earning a living here if they they're here illegally. They may not have health insurance… [These are] many of the things that we take for granted as basic rights" (AW 2016). Additional non-medical needs included legal and immigration support along with school or work training.

I then asked providers how hard or easy has it been for them or their clinic to coordinate these needed services. Two of the three providers who had identified and treated victims of human trafficking stated that having a referral process made it easier to coordinate services. These two providers stated working in health care systems that partnered with a community referral agency that provided the entry point for survivors to get care. By the time the individuals were getting care from these health care providers, the additional non-medical needs had already been addressed by the referring agency. One provider discussed logistical challenges with

timing when coordinating services: "on the weekdays we have a lot of resources but that is not always when victims of trafficking are presenting at the emergency department unfortunately" (ES 2016).

Common Health Problems of Victims of Sex Trafficking

I asked providers to reflect on what, in their experience, are the most common health problems for trafficked victims. All providers listed sexually transmitted diseases as one of the major health concerns for victims. One provider stated "We found with kids, and I am assuming this would be [true] with adults as well, [that] STIs are very common; about 45% of our patients had an STI at the time we assessed them and approximately 33% of them had a prior [STI] history" (JG 2016). Along with STIs, providers also mentioned broader gynecological and urologic issues. Current or prior history of physical trauma or assault was also mentioned by all providers. Additionally all providers described some type of mental health or psychiatric health concern including depression, anxiety, aggression, PTSD and suicidality. Two providers mentioned drug use or addiction as a health concern. Further health concerns included malnutrition and stigma from being trafficked.

Provider Recommendations

My final set of questions asked providers for recommendations to more accurately identify trafficked victims and coordinate the services victims need. I asked providers about broader policy or practice recommendations that would benefit health care providers as they try to treat victims' health conditions. All providers suggested increasing provider training as a key to improving identification of trafficked victims. Some providers stated broader training to raise awareness and one provider also emphasized more specific training on possible indicators of trafficking and trauma-informed care. In order to coordinate the needs of survivors, two

providers suggested a multidisciplinary approach to provide trauma-informed care and include stakeholders outside the health care system. In addition providers stated the need for funding of non-medical services and dedicated social service staff to coordinate the aftercare needs of survivors.

Answers varied among providers when they gave me their thoughts on policy or practice recommendations. One provider practice recommendation included revamping screening questions to make them more general so that providers would be willing to ask the questions. Another provider suggested advocacy at the legislative level along with further research to produce better-quality data on human trafficking. The third provider suggested that more medical organizations produce polices and statements on human trafficking to move the legislative agenda forward. That provider further explained that "having [a] powerful statements at [the] organizational levels has an impact on members of the organization…..but it also will [have an] impact at the legislative level" (JG 2016)

Community Advocate Interview:

Awareness of Human Trafficking

The community advocate also stated an increased awareness of human trafficking with more organizations and not-profits getting involved. She elaborated, stating a variety of efforts including "more advertisement has taken place, more sting operations from the government, and from my point of view, more anti-trafficking events have been hosted (i.e. trainings, seminars, awareness, prevention, etc.)" (KD 2016). From an organizational perspective she stated that the emerging statistics and reports on human trafficking from the government have been able to show that trafficking is "not just a global issue, but a domestic one as well" (KD 2016)

Service Provision for Victims of Human Trafficking

The community advocate stated that her organization provides 24/7 residential services that encompass a wide range of medical and social services that target long term and short term needs. Services provided included medical, dental and mental health care; vision and hearing services; trauma informed care, pastoral care; counseling; substance abuse counseling; therapy; physical fitness; health and wellness; educational opportunities; job readiness; and employment. Within the social services provided she stated there being a need for more intense substance abuse counseling. Challenges with medical service provision included payment for health care services. She elaborated stating how payment for health care services can prove challenging since not all individuals qualify for Medicaid and some don't have the needed paperwork (i.e. ID, birth certificate, social security card) to apply for health insurance or receive healthcare.

Identification and Referral to Service Organization

When asked how a victim of human trafficking is usually referred to the service organization the community advocate stated "we have clients call for self-referral, we've received calls from law enforcement and the court system, we have other partners that rescue the ladies then bring them to us for recovery, hospitals have referred a couple ladies as well" (KD 2016). When asked about her organizations experience with victims referred from the health care system she stated that "they aren't usually ready to commit to recovery because they didn't make the decision to come to us on their own" (KD 2016). Additionally she stated that her organization has not noticed more individuals being identified and coming from the health care system. She stated if they do come from the health care system "it give[s] them a safe place temporarily, but they don't stay as often or as long if they don't come on their own and admit they're ready for recovery" (KD 2016).

Provider Recommendations

The community advocated also stated the need for more awareness and training for all providers (medical and non-medical) on how to identify and approach a victim. When asked about recommendations to help organizations provide better aftercare services for survivors of human trafficking she stated having "better follow up measures…[for] tracking resident's progress after they leave our program [as well as] surveys on what worked best for them" (KD 2016). Additionally from a community service perspective she stated the need for more collaboration and joint efforts to help victims of human trafficking. She elaborated to state it needs to be "a more collaborative approach to combin[e] resources and partners to best serve [survivors]" (KD 2016).

DISCUSSION

Victims of human trafficking need to be cared for in a holistic way to address their often complex and multifaceted needs. Being trafficked takes a toll on a person's physical, emotional and mental health which requires effective and compassionate short and long term solutions. Understanding the crucial role that health care providers can play in identifying victims of human trafficking is the first step to helping victims. Health care providers have a unique opportunity where they can engender trust perhaps far easier than if victims come in contact with other agencies such as law enforcement. Findings from the literature and provider interviews support the argument that building trust is crucial in the health care delivery system; one provider expressed it this way: "…having a caring relationship with a patient where they trust they can tell you whatever the secret awful thing they're experiencing is… very important" (AW 2016)

Furthermore, as supported by the literature and provider and community advocate interviews, it is important for health care providers to get training on the identification and treatment of human trafficking victims. This training allows providers to be aware that trafficking could be happening in their patient population, but also equips providers to ask the right questions and take the appropriate steps to provide care. One provider addressed the importance of this provider training this way: "…a lot of people feel like they don't have time to build rapport or ask the questions to really get into a conversation and build the trust so that somebody can disclose. So if they don't have the time they are not going to ask the questions, if they don't ask the questions you are not going to find out and the child or adult will fall through the cracks" (JG 2016).

Future and current research efforts are working toward building a validated screening tool and standardized protocols within the health care system to help providers screen for human trafficking in the course of delivering care. This screening tool must also be balanced in the context of the limited time providers are afforded with patients. In the development of the tool considerations must be include limiting the number of questions and potentially outsourcing some pre-screening questions to support staff such as triage nurses. This could ensure the tools incorporation into the work flow and that more individuals would be getting screened for potential trafficking.

A unique finding from the community advocate interview showed that very few referrals came to her organization from the healthcare system. In the few cases that came from the healthcare system individuals usually did not complete their stay in the residential community since they did not choose to come on their own. This finding highlights the importance of choice and autonomy for individuals being trafficked. If we as a health care system invest in screening

tools and improved processes for coordination of aftercare but fail to consider the individuals choice to recovery than we may be setting up victims to fail. This may be rooted in a difference in perceived needs by service organizations and health care providers. Providers may push an individual to get out of a trafficked situation due to their focus on the trauma and health consequences of being trafficked. Service organizations may want to focus more on an individual's empowerment and choice because they know that commitment improves long term outcomes for survivors. It is importance that these differences be reconciled as the healthcare system moves into anti-trafficking efforts.

Limitations to the study include a small sample size of providers and community service advocates. Additionally, these providers reported few incidents of identification of victims while providing care. Instead the majority of provider and community advocate interviewee stated getting referrals of victims from outside community referral networks who had already identified the individual as a trafficked victim. This finding suggests the having a "go to" or "one-stop" referral network to aid multidisciplinary providers in identifying and treating victims and the importance of collaboration among these various sectors. This apparent reality also demonstrates the need for providers to be able to receive and provide referrals to community referral networks once screening tools are in place that help providers identify victims.

Another limitation included the difficulty setting up phone interviews with community advocates from service organizations. This inability to arrange phone interviews required me to ask for written and emailed responses to my questions. This change in data gathering alters the results coming from responses from service providers, since I could not follow up or ask for more information, as I could do with providers. Both respondent groups, however, were allowed

to view the questions prior to the phone/in-person interview or written response, which helped modulate any differences that would have been observed from differences in interview mode.

It should also be noted that this study primarily focused on sex trafficking of adults 18 years of age or older, although one provider had most extensive experience working with minor trafficking victims. This provider offered generalizations to adults based on experiences with child sex trafficking and the assumption that more similarities than differences exist between adult and child sex trafficking victims. It should also be noted that the responses from this provider align very closely with those found in the published literature on adult sex trafficking victims.

CONCLUSION

Current trends are moving toward improving and expanding health care provider training to identify and treat the needs of human trafficking victims. As research efforts continue to expand it is important that these health system efforts align and coordinate community service organizations in order to have procedures and process in place to ensure the survivors are getting the coordinated services they need after they have been identified. Trends show that having a community referral agency that helps in the coordination of care can be crucial for all multidisciplinary providers. These community agencies need to be equipped to receive and refer survivors from all types of multidisciplinary providers, including those in the health care system. Further research must also take into account the victim's autonomy and choice to create systems that enable long term success in recovery. Our work to advance care for victims of human trafficking is far from finished. As the health care system and providers start getting engaged, however, improved aftercare for survivors can be achieved.

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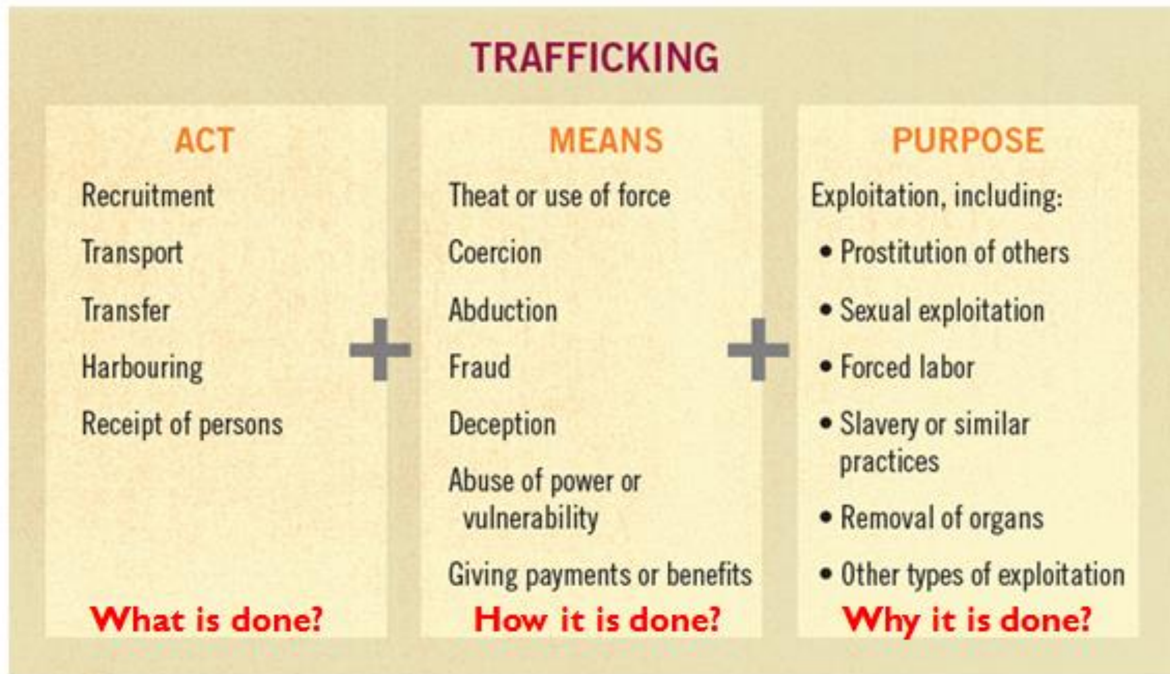
Figure 1: Three Common Elements of Human Trafficking



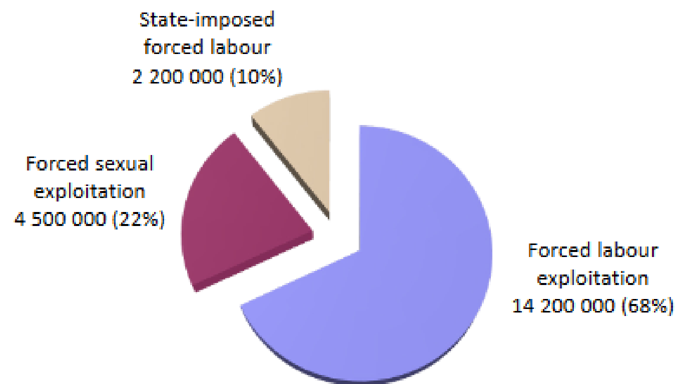
SOURCE: Alpert EJ, Ahn R, Albright E, Purcell G, Burke TF, Macias-Konstantopoulos WL. (2014) "Human Trafficking: Guidebook on Identification, Assessment, and Response in the Health Care Setting." MGH Human Trafficking Initiative, Division of Global Health and Human Rights, Department of Emergency Medicine, Massachusetts General Hospital, Boston, MA and Committee on Violence Intervention and Prevention, Massachusetts Medical Society, Waltham, MA. Retrieved April 26, 2014. Image on page: 3

NOTE: Red text added by author to image

Figure 2: Office to Monitor and Combat Trafficking in Persons Mission

SOURCE: Office to Monitor and Combat Trafficking in Persons (TIP). (2016) "About" U.S. Department of State. Under Secretary for Civilian Security, Democracy, and Human Rights. Retrieved April 26, 2016. Available at: http://www.state.gov/j/tip/about/index.htm
NOTE: Image created by author using Microsoft Word Smart Art 2010

Figure 3: Global Estimate by Form of Forced Labour



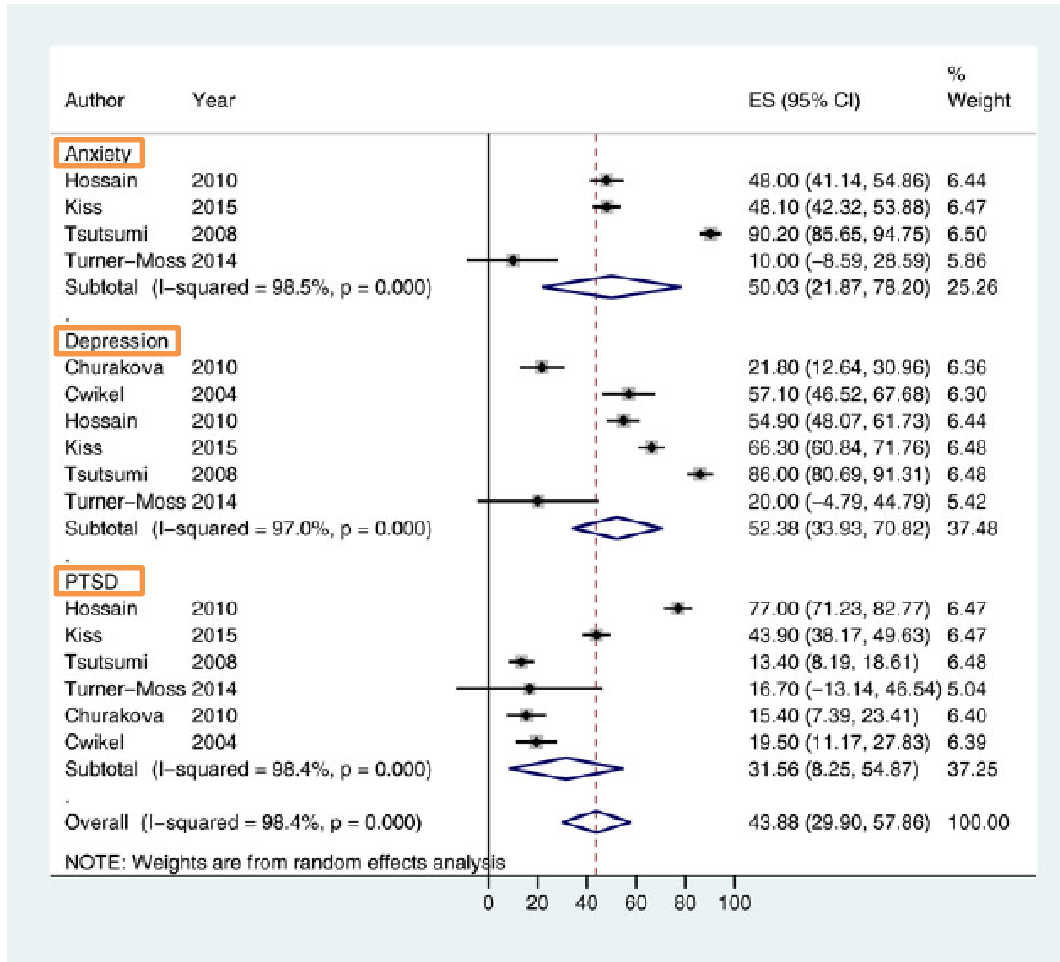
SOURCE: International Labour Organization (ILO) (2012) "Special Action Programme to Combat Forced Labour" (SAP-FL). Retrieved April 26, 2016. Available at: http://www.ilo.org/wcmsp5/groups/public/---ed_norm/---declaration/documents/publication/wcms_182004.pdf. Image on page:14

Table 1: Physical Symptoms Reported by People Who Have Been Trafficked (n = 6)

Author and year	Headache (%)	Back pain	Stomach pain	Dental pain	Fatigue	Memory problems	Weight loss	Dizziness
Crawford & Kaufman (2008) $n = 20$	35		25%		10%			
Cwikel *et al.* (2004) $n = 84$	60	40%	53%	57%				55%
Kiss *et al.* (2015) $n = 1015$	21	19%		10%	18%	16%	14%	20%
Oram *et al.* (2012*a*, *b*) $n = 120$	62	51%	61%	35%		44%	26%	
Turner-Moss *et al.* (2014) $n = 35$	43	36%	10%	23%	30%	13%	13%	10%
Zimmerman *et al.* (2008) $n = 192$	83	69%	61%	58%	81%	62%	47%	70%

SOURCE: Ottisova L, Hemmings S, Howard LM, Zimmerman C and Oram S. (2016) "Prevalence and risk of violence and the mental, physical and sexual health problems associated with human trafficking: an updated systematic review" Epidemiology and Psychiatric Sciences, available on Cambridge Journal Online. Retrieved April 26, 2016 doi:10.1017/S2045796016000135. Image on page: 19

Table 2: Forest Plot Displaying Weighted Random-Effect Pooled Prevalence Estimates of Self-Reported Symptoms of Anxiety, Depression and PTSD among Trafficked Women



The pooled prevalence estimates were:
50% for symptoms of anxiety (95% CI 21.9–78.2%),
52% for depression (95% CI 33.9–70.8%)
32% for PTSD (95% CI 8.3–54.9%)
However these estimates were associated with high heterogeneity (I2 = 97.0–98.5%)

SOURCE: Ottisova L, Hemmings S, Howard LM, Zimmerman C and Oram S. (2016) "Prevalence and risk of violence and the mental, physical and sexual health problems associated with human trafficking: an updated systematic review" Epidemiology and Psychiatric Sciences, available on Cambridge Journal Online. Retrieved April 26, 2016 doi:10.1017/S2045796016000135. Image on page: 17

APPENDIX 1: Systematic Review of the Literature

The aim of this systematic review was to understand the needed aftercare services for survivors of sex trafficking as described by qualitative stakeholder interviews with service providers as well as qualitative interviews by individuals who are identified as survivors of sex trafficking. To this end, the proposed systematic review will answer the following question: What aftercare services are needed for adult survivors of sex trafficking in the United States? Search was restricted to studies done in the United States and in English language with the purpose of understanding the aftercare service for those trafficked domestically.

METHODS

Identification of Literature

PubMed, Scopus, and PsycInfo were searched for peer-reviewed articles from 1990 to April 13th 2016. A combination of Medical Subject Headings (MeSH) and text words were used. The Pub Med MESH term "human trafficking" is new and was introduced in 2014 therefore designated an earlier timeline of 1990 allowed the inclusion of more articles. Terms were additionally added based on search terms from published paper by Macy et. al. to include the terms; "services", "programs", and "interventions." Electronic search was supplemented by screening of reference list of Macy et. al. paper that included seven papers with primary data. Additionally five articles were included based on internet searches (Alpert et. al. 2014; Zimmerman et. al 2009; TIP Report 2015; Federal Strategic Action Plan 2013-2017; Resource Guide DHHS 2012). Search terms for all databases included human trafficking OR sex trafficking AND aftercare OR rehabilitation OR programs OR interventions OR services OR health OR health care

Data Extraction

The author reviewed and independently screened the titles and abstracts found by the search using the inclusion criteria see Table A-1. When there was uncertainty if the article met the criteria it was included for retrieval of a full report. Currently only one author has reviewed the articles. Additional information from study authors was not obtained regarding questions about eligibility. Populations excluded included minors (less than 18 years old), migrant/immigrants, refugees, victims of organ/labor trafficking, victims of inter-personal violence or domestic violence, and sex workers. Data was extracted based on study design, population characteristics, qualitative data on expertise from key stakeholders and survivors, and outcome of aftercare services required for survivors of human trafficking.

RESULTS

The study selection process is presented in Figure A-1. The search strategy resulted in 842 unique articles of which 715 were excluded based on title. Of the remaining 122 articles 28 articles were excluded based on being book sections or dissertation/thesis papers. 94 articles were then assessed that potentially met the search criteria. After further screening 5 articles met the search criteria, 4 were identified using the electronic databases and 1 was found through the cited articles by the Macy et. al. paper. Description of individual study characteristics, results and strengths and weaknesses can be found in Table A-2. Below is a descriptive synthesis of all the results from the five studies categorized by common themes of aftercare service provision.

Diverse Need of Aftercare Services

All studies concluded that victims of human trafficking require a broad array of after care services. Some studies divided needs based on immediate post trafficking assistance while others focused on the long-term needs of survivors (Dewan 2014 and Busch-Armendariz 2011). Needs

also could be categorized into two broad categories of medical and social needs. Medical needs ranged from basic medical care to mental health and substance use treatment. One study described the medical needs in more detail listing "basic physical exams; gynecological exams; tests for infectious diseases; treatment for stomach problems and headaches (often symptomatic of an emotional problem); chronic back, hearing, cardiovascular, or respiratory problems; and eye and dental care" (Clawson 2008: 16). Another study addressed the important and often overlooked need for mental health services and "highlight[ed] the pervasiveness of PTSD, depression, and shame in women who have been commercially sexually exploited" (Hom 2013: 79).

Social needs include basic needs such as shelter, food, and clothing to broader legal assistance and employment training. When looking at short-term needs housing was an aftercare need that most studies identified but also found challenging to provide (Baker 2013, Clawson 2008, Hom 2013). One study concluded that victims need "a safe place to go to where they would not feel judged or feel like they were being punished" (Hom 2013: 78). Another study addressing long term care of victims emphasized that "time-limited services are not able to accommodate trauma-related needs that may not be evident during the first six or seven months of services" (Busch-Armendariz 2011: 13). This study found that the long term emotional and psychological needs including those of safety and stability are often not addressed appropriately in the long term care of survivors

Barriers to After Care Services

As part of identifying services needed, many of the studies also discussed some of the barriers to getting those services. Multiple studies indicated the need to take into account culture when providing care (Busch-Armendariz 2011, Dewan 2014, Clawson 2008, Hom 2013). One study concluded "at a macro-level, the service provision approach to this population must be multicultural and interdisciplinary while taking into consideration the unique characteristics and

experiences of trafficked persons" (Dewan 2014: 73). Many studies concluded the need to engender trust in order for victims to disclose and utilize services (Dewan 2014, Hom 2013, Clawson 2008). One study concluded "need for service providers to establish a relationship with trafficked persons" along with understanding that the "trafficking experience of the client will play a crucial role in their ability to utilize services" (Dewan 2014: 72-73). Lastly two studies noted that a barrier to accessing needed aftercare services was that trafficked individuals might not self-identify as a victim of human trafficking. One study concluded "victims themselves who often did not believe or understand that they were victims of crime…as a result, victims often went unidentified and unserved" (Clawson 2008: 9)

Strategies for After Care Service Provision

Some studies were able to address strategies that improve access and or utilization to aftercare services. One study concluded the importance of having interagency awareness and collaboration to improving services for victims The study noted that "interagency awareness is generated by word of mouth and community meetings...therefore…[it is important to] intentionally scheduling time to attend local organizations and task forces designed to address human trafficking" (Baker 2013: 317). Two other studies concluded the need for trauma informed care when providing services to survivors of human trafficking (Clawson 2008, Hom 2013). Trauma informed care was stated to be "vital to the recovery and reintegration process" because it allowed individuals to move forward with other aspects of their lives" (Hom 2013: 79). Clawson 2008 study provided more detail of strategies to improve access and use of after care services including: one-stop shop/mobile services, pro bono services, volunteer programs, consistent case management, and collaboration.

SYSTEMATIC REVIEW CONCLUSION

Overall the literature shows the complex and multifaceted needs of survivors of human trafficking. When considering these needs it is important to have a holistic approach to the delivery of care that is often possible through a multidisciplinary team. Additionally care must be delivered with cultural sensitivity and be trauma informed to meet the needs of those who have been trafficked. Studies also showed that engendering trust and safety for victims is paramount in order to provide the other medical and social needs that victims will need in for short-term and long-term care. Sex trafficking is a complex issue that will require multiple stakeholders to coordinate creative solutions to improve the care of survivors.

Figure A-1: Flow Chart of Primary Study Selection

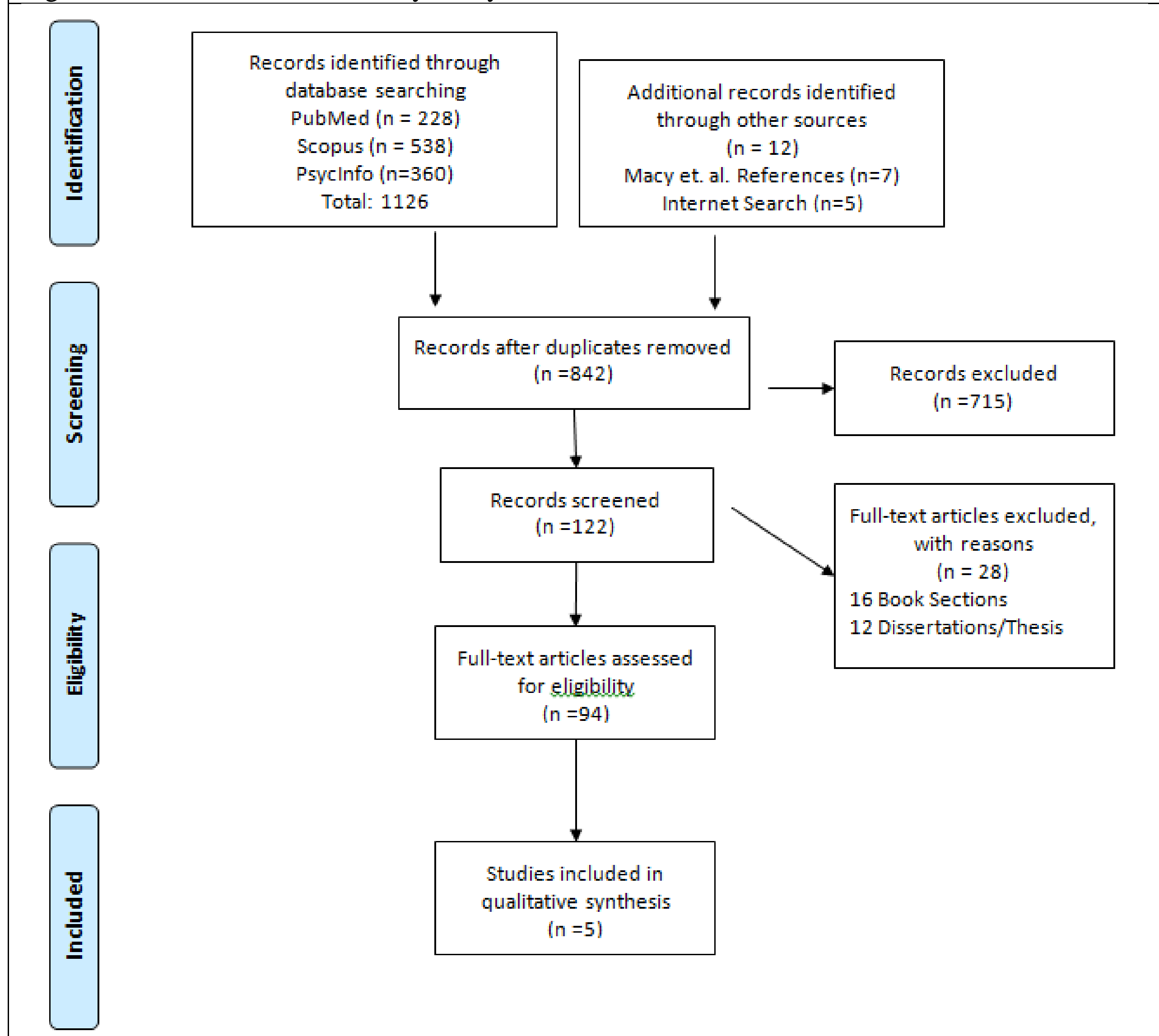


Table A-1: Study Eligibility Criteria

PICOTS	Criteria
Population	Two population of interest include key stakeholders providing aftercare services to survivors of sex trafficking and identified survivors of sex trafficking
Intervention	After care services for survivors of human trafficking
Comparators	No aftercare services provided to survivors of sex trafficking
Outcome	Descriptive data of aftercare services needed
Timing	Studies 1990 to present
Setting	Studies done in United States and with English language only

Table A-2: Characteristics of Included Papers (n=5)								
Author and Year	**Study Design**	**Sample**	**Outcome of Interest**	**Methods of Assessing Outcomes**	**Study Results**	**State**	**Study Strength**	**Study Weakness**
Baker 2013	Cross sectional-Mixed methods	35 agencies in five Southern California counties	Describe 1) number of agencies responding to sex trafficking in the area 2) types of services provided, and 3) level of inter-agency awareness.	Mixed Methods: 15 item survey with qualitative and quantitative data	Agencies: Respondents identified a total of 44 different agencies responding to sex trafficking Service Provision: wide variety of services offered by agencies Education 43% (n=6). Other 57% (n=8) among which referrals was most common with 29% (n=4). Most common need: housing 43% (n=6) Interagency awareness: 100% (n=14) of the agencies knew of other agencies	California	Mixed method study design Collaboration with an established community resource agency (CASE)	Low agency response rate: 14 agencies (40%) completed the online research tool Cross tabulations or chi-squared statistics was omitted for confidentiality Study is aimed at faith-based communities so risk of bias towards need for spiritual support Failed to gather data on how many individuals are served by agencies
Busch-Armendariz 2011	Cross Sectional-Qualitative questionnaire	9 women (18 years or older) who were trafficked into the U.S.	Evaluate the social service needs of trafficking victims/survivors and their immigrant	Semi-structured questionnaire with 22 opened-ended questions.	Four themes emerged: 1) basic communication needs and initial	Texas	Assessed needs of human trafficking survivor parents and their children	Small sample size (n=9) Addressing victims needs 12-24 months post

		and were 12-24 months "post-rescue" and currently receiving services	children.		services, 2) long-term needs, 3) self-efficacy 4) Looking forward.		Addressed long term care of victims interviews were digitally recorded and transcribed Qualitative content analysis with systematic coding by three reviewers	rescue which obscures the needed immediate post-trafficking needs
Dewan 2014	Cross-sectional-Retrospective data analysis	136 Records of by pre-certified clients at Safe Horizon's Anti-Trafficking Program from June 2006 to May 2010 who were trafficked into the United States	Quantify service utilization measured by 1) total count of 27 types of services used followed by 2) categorization of six major types of service provided: a) social services, b) legal services, c) health services, d) mental health services, e) information and referral services, and f) employment	Retrospective analysis of case records of service use using the Anderson-Newman Model (1973)	1) total number of services used ranged from 1 to 21 (M = 9.40, SD = 6.00) 2) categorization of service use: a) 72.1%, N=98 b) 72.1 %, N=98 c) 30.9 %, N=42 d) 83.8 %, N=114 e) 85.3 %, N=116 f) 27.9%, N=38	New York	Looks at the immediate post-trafficking services available to victims prior to being certified as a 'victim of human trafficking', a period referred to as 'pre-certification' Attempts to understand and quantify the pattern of service utilization for trafficked victims	Use of secondary data limited information available of service utilization Sample size was reduced to only include cases with information on at least one variable from each of the three domains of the Andersen-Newman model (1973) Findings limited to pre-certified population

			related services.					
Clawson 2008	Cross Sectional-Qualitative questionnaire	117 HHS-currently or previously funded programs and 341 representatives from those programs	study addressed the following topic areas: 1) defining human trafficking 2) identification of victims 3) promising outreach and identification strategies 4) needs of victims 5) services for victims 6) anticipated outcomes for victims	Semi-structured interview questions	All respondents stated first safety as a need <u>Short term needs:</u> Emergency housing, basic medical assistance, food/clothing, legal services, and translation services <u>Longer term needs</u>: assistance accessing legal documentation, life skills training, job training, education, mental health services, specialized medical assistance, permanent housing, child care, and reunification with family or repatriation. <u>Short and long term need:</u> assistance and advocacy to navigate the various systems	Massachusetts New York Washington D.C Maryland Virginia Georgia Florida Texas Washington State Illinois Missouri California	Large sample size Measured a variety of variables through qualitative interviews and some quantitative data per capita program obtained as part of funding grant Multi-site stakeholder analysis Qualitative content analysis with systematic coding by multiple reviewers	Unable to quantify the number and amount of services provided by organizations Limited to HHS funded programs therefore did not include non-profits or faith based organizations Interviews were not transcribed
Hom 2013	Qualitative	6 service provider:	Describe the experiences of	Semi-structured Interview: 11	3 themes and 7 subthemes emerged	Ohio?	Audio-recorded interviews were transcribed	Limited sample size (n=6)

		including nurses, clinical directors, anti-trafficking task force members, social workers, and anti-trafficking program developers Location of agencies not disclosed	trauma and its aftermath for women who have experienced commercial sexual exploitation as told by front-line service providers Questions were asking what they considered the greatest health needs of women being sexually exploited and how best to assist with helping these women to recover their health	open-ended questions	regarding the experience of sex-trafficking and its outcomes— 1) Pimp Enculturation a) Entry Into b) "The Life" 2) Aftermath a) Triggers "The Body Remembers" 3) Healing the Wound a) Street Outreach b) Engage the Survivor c) Unpack the trauma d) Holistic Meeting of Needs		Qualitative content analysis with systematic coding by multiple reviewers	

SYSTEMATIC REVIEW REFERENCES

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APPENDIX 2

Structured Interview Protocol

Coordinating Services for Survivors of Human Trafficking Identified in the Health Care System: The Role of Community Service Organizations and Health Care Providers

A Study by Jessica Himmelstein at the University of North Carolina at Chapel Hill

Information Sheet

IRB Study # 16-0963 **Consent Form Version Date:** 27 May 2016

Principal Investigator:	Jessica Himmelstein
UNC-Chapel Hill Department:	Public Health Leadership Program
Faculty Advisor:	Sue Tolleson-Rinehart PhD
UNC-Chapel Hill Department:	Assistant Chair for Faculty Development, Department of Pediatrics Co-Associate Director, HC&P MPH, SPH Adjunct Professor of Political Science
Advisor Phone #:	(919) 843-9477
Advisor e-mail:	suetr@unc.edu
Study Contact telephone number:	**(864) 387-9336**
Study Contact email:	jhimmels@email.unc.edu

[Introductory script, embedding fact sheet and consent information]:

Hello, I am Jessica Himmelstein. Thank you so much for talking with me today. I am a 4th year medical student at The University of South Carolina School of Medicine Greenville taking a year away from medical school to work on my master's degree in public health at UNC Gillings School of Global Public Health. I am doing this research for my Master's paper in the Health Care & Prevention degree program.

[For Health Care Providers]
For my master's paper research, I am hoping to understand how providers can better coordinate with community service organizations once a victim of human sex trafficking is identified. I have asked to interview you because of your understanding and experience in identifying victims of human trafficking in the health care system. I will be talking to providers with experience like yours as well as people in community service organizations providing varying levels of aftercare to survivors. I am interested in your perspective and views about how systems can coordinate with each other. My purpose is ultimately to understand how to provide the best care possible to survivors of human sex trafficking once they have been identified.

[For Service Organization Staff]
For my master's paper research, I am hoping to understand how the health care system coordinates with community service organizations once health care providers identify victims of human sex trafficking. I have asked to interview you because of your special knowledge of the aftercare needs of survivors of human sex trafficking. I am talking to people like you who work at community service organizations providing varying levels of aftercare to survivors. I am also talking with health care providers who have had experience identifying victims. I want to know

your perspective on how the health care system can better coordinate with organizations such as yours. My purpose is ultimately to understand how to provide the best care possible to survivors of human sex trafficking.

My faculty adviser is Dr. Sue Tolleson-Rinehart. She is a faculty member in the UNC Department of Pediatrics in the School of Medicine as well as the School of Public Health. My advisor and I do hope that we will be able to publish results from this study in a scholarly journal and we will be glad to make findings available to you. If you want to ask Dr. Tolleson-Rinehart any questions, please send a message to **suetr@unc.edu** or call **919.843.9477**.

In this interview I will be asking you several open-ended questions. It should last anywhere from 20 minutes to one hour, depending on your time and what you want to tell me. I would like to record this interview on a digital voice recorder to make absolutely sure that I have the most accurate record of your comments. I will not record this interview without your permission. If you do grant permission for this conversation to be recorded, you have the right to revoke recording permission and/or end the interview at any time. I will transcribe the interview, and I will give you a copy of the transcript at your request.

I will keep the digital interview files encoded on my computer and on my advisor's computer. We will delete the files after I have made transcripts of them. The digital files and my transcripts of them will be protected by passwords. Dr. Tolleson-Rinehart and I will be the only people who have the passwords.

I will provide you with a copy of the transcript of your interview.

If you have any questions about the research now, please ask. If you have questions later about the research, you may contact me by phone at **(864) 387-9336** or by e-mail at **jhimmels@email.unc.edu**.

This study has been reviewed by the Institutional Review Board at UNC and found to be exempt. You can reach them at (919) 966-3113 or IRB_subjects@unc.edu.

[Consent]

I will now ask your permission to interview you and record your response.

Do you wish to participate in the interview?

___Yes ___ No

Do you consent to be audio recorded during the interview? I will inform when the audio recording begins and ends, and may request to have the recorder stopped at any time during the interview.

___Yes ___ No

Because you are an expert in your field and your opinion is very valuable to advancing in advancing research on human sex trafficking, your name gives extra credibility to the research. Do you consent to having your name included in the final results? If you choose to remain anonymous, you will only be identified in a way such as “a community physician” or “an expert

direct care services”. Again, I plan to publish the results of my research in an academic journal in the future.

___Yes ___ No, I wish to remain anonymous

And do you consent to have direct quotes used along with your name?

___Yes ___ No

Finally, once my research is complete, would you be interested in a follow-up email from me with a description of my final results and analysis?

___Yes ___No

Name ___________________________________ Date _________________

[Script for Interview]

Thank you for your help on my project! Now we are ready to begin.

1. For this interview, I use the definition of the Victims of Trafficking and Violence Protection Act of 2000. As I know you know, it defines “human sex trafficking” as the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act…in which a commercial sex act is induced by force, fraud, or coercion or in which the person induced to perform such act has not attained 18 years of age.”

For the purpose of this study we will only be focusing on adults, 18 years of age or older.

My first question is broad: Do you think public awareness of human sex trafficking has changed in recent years? Why/why not?

2. Next I’d like to know how you came to be doing the work you are doing now. Had you always prepared to do this work, or did you come to it as a result of some other change or need?

3. And what about working with victims of human sex trafficking?

   3.a. How did you become involved or interested in working with this population?

   3.b. Has it been different or similar to other work you have done?

[For Health Care Providers]

These next set of questions are to better understand your role as a provider working in the health care system

4. How much direct patient care do you provide?

5. Please share some of the ways you have identified victims of human sex trafficking in the course of delivering care.

    5.a. What are some of your biggest identification challenges?
    (Probe) Practical problems? Emotional problems? Problems with other people such as health care providers, family, friends?

6. Once a person is identified, what services does she or he need?

    6.a.How hard or easy has it been for you or your clinic to coordinate these services? [probe if necessary: what do you think are the greatest challenges?]

7. In your experience, What are trafficked victims' most common health problems?

8. Has working with victims of human sex trafficking affected your medical decision making in any way? How?

9. Have you had the chance to work with or encourage other health care providers to improve care for trafficking victims?

10. What kind of barriers does the health system put up between providers and victims?

    10.a. Does anything work well?

Recommendations Section

11. What, if anything, would help providers more accurately identify trafficked victims?

12. What, if anything, would help providers coordinate the services these victims need?

13. What kind of policies or practices would benefit health care providers as they try to treat victims' health conditions?

[For Service Organization Staff]

14. What services does your organization provide to survivors of human sex trafficking?

    14.a. How did your organization begin providing those services?
    14.b. Do these victims still need services you are not yet able to provide?
    14.c. Are there differences between these victims' short term and long term needs?

15. How does a victim of human sex trafficking usually get referred to your organization? Probe: self-referral? Law enforcement? Clinics/hospitals?

16. Can you tell me about your experiences with having victims identified and referred by a health system?

16.a. Have you noticed more people coming from the health care system?

16.b. What has worked well for the victims who were identified in the health care system? What has worked not so well?

Recommendations Section

17. What, if anything, would help your organization provide better aftercare to survivors of human sex trafficking?

18. What, if anything, would help your organization coordinate with providers to deliver the services these victims need?

19. What kind of policies or practices would help your organization provide the best aftercare services to survivors of human sex trafficking?

[For all participants]

Thank you so much for your time and thoughts on this important topic!

What other suggestions do you have to improve partnerships between providers and direct care community resources when the health care system identifies a victim of human sex trafficking?

Is there anything else on this topic that we haven't talked about but that you want me to know?

APPENDIX 3

Health Care Providers:

ES, MD MPH, Emergency Medicine; extensive experience working with victims of trauma

AW, MD. Internal Medicine; extensive experience working with victims of domestic violence and providing trauma informed care

JG, MD. Pathology; extensive experience working with abuse and neglect

Community Advocates:

KD, Program Director. Large non-profit residential facility for survivors of human trafficking in the southeastern United States.