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Human Trafficking: The Role of the Health Care Provider

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Abstract

Human trafficking is a major public health problem, both domestically and internationally. Health care providers are often the only professionals to interact with trafficking victims who are still in captivity. The expert assessment and interview skills of providers contribute to their readiness to identify victims of trafficking. The purpose of this article is to provide clinicians with knowledge on trafficking and give specific tools that they may use to assist victims in the clinical setting. Definitions, statistics, and common health care problems of trafficking victims are reviewed. The role of the health care provider is outlined through a case study and clinical practice tools are provided. Suggestions for future research are also briefly addressed.

Keywords

case study; human trafficking; immigrant; sex trafficking; women's health care

INTRODUCTION

> *"…[T]rafficking can only exist in an atmosphere of public, professional, and academic indifference."*[1]

Human trafficking is a global public health problem. Although difficult to quantify because of its underground nature, there are approximately 800,000 people trafficked across international borders annually. Of those, 80% are women or girls; 50% of these females are minors.[2-4] In the United States alone, 50,000 persons are trafficked into the country every year, and there are approximately 400,000 domestic minors involved in trafficking.[2,5] These statistics easily debunk the common myths that human trafficking only happens in other countries and that those who are trafficked in the United States are always of international origin. In fact, the United States is one of the largest market/destinations for trafficking in the world, second only to Germany.[3]

Health care providers are one of the few professionals likely to interact with trafficked women and girls while they are still in captivity.[2,5] One study found that 28% of trafficked women saw a health care professional while still in captivity. This represents a serious missed opportunity for intervention.[6] Health care providers are in a unique position to identify victims of trafficking and provide important physical and psychological care for victims while in captivity and after. This article provides clinicians with knowledge on trafficking and offers specific tools that they can use to assist victims in the clinical setting.

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DEFINITIONS AND DISTINCTIONS

According to the US Department of State, human trafficking is "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."[4] Sex trafficking is "When a commercial sex act is induced by force, fraud, or coercion, or when the person induced to perform such an act has not attained 18 years of age."[4] A victim need not be physically transported from one location to another in order for the crime to fall within these definitions.[4]

Sex trafficking and prostitution are not the same, but the distinction between the two is subtle and difficult to define.[7] The literature on the conceptual differences is conflicting and largely dependent on the author's beliefs about legalized prostitution. The main distinctions made in the literature between trafficking and prostitution are consent and coercion.[8] Sex trafficking and prostitution are similar in that both are exploitive; women may suffer sexual assault by clients and/or pimps; and women may suffer extreme stress reactions, trauma, depression, and multiple medical problems. Table 1 presents a summary of possible differences.[7-9]

THE SCOPE OF THE PROBLEM

The International Labor Organization estimates human trafficking to be a $32 billion per year industry.[10] Human trafficking is the third largest source of income for organized crime, and there are twice as many people enslaved today as during the African slave trade.[11-13] Human trafficking involves forced labor, bonded labor, debt bondage among migrant laborers, involuntary domestic servitude, forced child labor, child soldiers, and sex trafficking.[14] Individual victims suffer from numerous physical and psychological problems, but trafficking undermines the health, safety, and security of all nations it touches.[5,14] With the onset of a global financial crisis, there has been a shrinking global demand for labor and a growing supply of workers willing to take additional risks for employment. These trends will likely increase the numbers of persons trafficked in the coming year. The two largest source countries for trafficked persons in the United States are Mexico and East Asia, but victims also come from South Asia, Central America, Africa, and Europe.[14] Box 1 lists common ways that girls and women become victims of trafficking.

One of the most common questions that are asked about trafficking victims is, "Why do they stay?" Although there are certainly instances when traffickers forcibly hold victims captive, more commonly victims appear able to walk away at any time. Debt bondage, control of the victim's money, and confiscation of passports, visas, and identifying documents are common ways that traffickers maintain control.[15] For example, a woman might promise to pay a *coyote* to smuggle her across the border to the United States from Mexico. When she arrives in the country, she will be thousands of dollars in debt and must "work off" her debt in agricultural, hospitality, housekeeping, or other types of work. It is likely that a large portion of her wages will go to the trafficker during her first year in the United States or longer. Until she is able to pay, she may face physical threats against herself and her family, sexual harassment and assault, housing in squalid conditions, restriction of movement, and threats of deportation if she tries to escape. Traffickers may charge exorbitant interest and fees, making it difficult for her to ever pay her debt. Because she is in the United States illegally, it is unlikely that she will report any exploitation by her employer and/or trafficker, for fear of deportation.[16]

Traffickers also use isolation from family, friends, and the public to keep their victims in captivity. Limiting contact with outsiders and ensuring that any contact is superficial in

nature will ensure that the victim does not begin to build any social support networks in the community. Also, moving victims from place to place decreases the likelihood that the victim will form relationships and/or be recognized.[15] Perhaps most insidious, the victims are almost always subjected to harsh psychological and physical abuse, including repeated rape, in order to keep the victim submissive.[17] According to one study, trafficking victims generally only see three ways of escape from their situation: 1) to become unprofitable because of trauma, emotional breakdown, or advanced pregnancy; (2) to be helped by a client; or (3) death.[18]

HEALTH PROBLEMS ASSOCIATED WITH TRAFFICKING

The health problems seen in victims of trafficking are largely a result of several factors: deprivation of food and sleep, extreme stress, hazards of travel, violence (physical and sexual), and hazardous work. Because most victims do not have timely access to health care, by the time they reach a clinician it is likely that health problems are well advanced.[5] These women are at high risk for acquiring multiple sexually transmitted infections and the sequelae of multiple forced and unsafe abortions.[19,20] Physical abuse and torture often occur, which can result in broken bones, contusions, dental problems (e.g., loss of teeth), and/or cigarette burns.

Psychological violence results in high rates of posttraumatic stress disorder, depression, suicidal ideation, drug addiction, and a multitude of somatic symptoms.[17,19,21] When providers were asked in one study about their experiences working with victims of trafficking, they reported that these victims are less stable, more isolated, have higher levels of fear, more severe trauma, and greater mental health needs than other victims of crime. One trafficking victim can take the same amount of the provider's time as 20 domestic violence victims.[22] Box 2 provides a list of common problems seen in victims of trafficking.[2,5]

CLINICAL IMPLICATIONS: CARING FOR A VICTIM OF HUMAN TRACKING

Identification

The Campaign to Rescue and Restore Victims of Human Trafficking provides a list of possible clues that someone may be a victim of trafficking: 1) evidence of being controlled; 2) evidence of an inability to move or leave a job; 3) bruises or other signs of battering; 4) fear of deportation; 5) non–English speaking; 6) recently brought to this country; and 7) lack of passport, immigration, or identification documents.[23] Health care provider tools, including screening tools and posters for the office, are available on the campaign's Web site.[24] Although this list of clues could be used for multiple other problems (e.g., domestic violence), they indicate the need for further investigation by the provider.

Victims will likely fear authority figures and be reluctant to give out personal information, so interviewing the client can be difficult. The first steps to a successful encounter are getting the client alone (victims are often accompanied by another person), finding an interpreter if necessary, and building a trusting rapport with the client. Because the client is unlikely to identify herself as a trafficking victim, the provider needs to pay attention to subtle and nonverbal cues.

Treatment

Responding to all of the victim's physical and emotional needs is outside of the scope of the individual provider's practice, because the client will need long-term treatment with an interdisciplinary team of health care professionals. The provider should care for any

immediate needs, including treatment of physical trauma, sexually transmitted infections, diagnosis of pregnancy, and assessing for suicidal ideation.

Making a Plan

Once a victim of trafficking is identified, the clinician and client will need to put together a plan of care. The health care provider should be aware of the following: 1) the provider cannot force the victim to report the crime, and 2) the victim and/or victim's family may be at risk for immense harm if she reports the crime. If the victim is a minor, the provider is under legal obligation to phone child protective services.

The plan of care will be client-specific, but the provider should consider phoning the National Human Trafficking Resource Center (1-888-373-7888). This national referral line can assist in finding local resources for the victim and developing a safety plan that is acceptable to the client. Because victims of human trafficking have already experienced significant powerlessness, this is an opportunity for the provider to purposively give the client some decision-making ability. For example, the provider and client can anonymously call the referral line together and ask pertinent questions about the client's situation. Or the provider can give the client a phone, the phone number, and a safe space in which to make the call herself. The clinician is not mandated by law to call anyone (either the referral line or law enforcement) unless the client is under 18 years of age. While the clinician may call the referral line anonymously without the client's permission, it is not advisable to make an official report without the client's consent. Please note that this is a gray area and that each clinician will have to make his/her own moral decision regarding the reporting of suspected trafficking.

If the client does contact the National Human Trafficking Resource Center, the staff member on the line can help the victim get to a safe place. Once in a safe location, the victim can choose to pursue the certification process, which is part of the Victims of Trafficking and Violence Protection Act.[25] Certification provides the victim with the documentation required to remain in the United States legally and receive benefits and services under federal/state programs. If the victim is already a US citizen or a minor, she does not need to apply for certification, because she is already eligible. Examples of federally funded services and benefits are health care, translation, witness protection, legal representation, job training, transportation, and access to housing. In order to be certified, the victim must meet the following criteria: 1) be a victim of trafficking; 2) be willing to assist with the investigation and prosecution of trafficking cases (or be unable to cooperate because of physical or psychological trauma); and 3) have completed an application for a T visa.[26]

When a victim is undocumented, deportation will likely be of great concern and a possible barrier to reporting a crime. In response to this reality, the US Department of Justice created the trafficking visa (T visa), which allows the victim (and certain family members) to remain in the United States legally if the victim complies with "reasonable requests for assistance in the investigation or prosecution of acts of trafficking." Recipients of the T visa are eligible for legal employment and can become lawful permanent residents after 3 years.[27] Even with the availability of the T visa, the undocumented immigrant cannot be completely assured that she will not be deported if denied the visa, and it is important for the provider to not make any promises about immigration status.

As the omniscient reader of the case study presented in Box 3, how might you advise the clinician to proceed? There are multiple possible outcomes to this scenario. Two possible outcomes are:

1. The clinician conducts a medical history and physical examination with the help of the unknown male as interpreter. After taking cervical cultures for gonorrhea and chlamydia, the clinician makes a presumptive diagnosis of pelvic inflammatory disease (PID) and gives S.M. a prescription for antibiotics. She explains the serious nature of PID to S.M. and the importance of having her sexual partner tested. She makes a follow-up appointment, the clinician thanks the male for interpreting, and S.M. leaves the clinic with him. S.M. does not return for her next appointment.

2. The clinician begins obtaining S.M.'s history with the help of the unknown male as interpreter. She also asks the office secretary to try and find a language line interpreter who speaks Mixteco. She conducts her physical examination and collects cervical cultures for gonorrhea and chlamydia. She makes a presumptive diagnosis of PID and gives S.M. a prescription for antibiotics. The office secretary informs the clinician that she's found an interpreter on the language line, who speaks Mixteco. The clinician asks the male to leave the room, explaining that she would like to talk to S.M. alone about her medications. The male argues with the clinician, but leaves the room when she insists. Using the language line, the clinician is able to talk with S.M. freely. After some time has passed, S.M. begins to cry and tells her about the multiple sexual partners and the threats of the smuggler. The clinician talks with S.M. about trafficking and validates her fears. Together they make the decision to call the National Human Trafficking Resource Center and ask for advice on how to proceed. Through this phone call, the clinician and S.M. are connected with a local crisis center that assists S.M. with an escape from her smuggler and trafficker. S.M. and her child are safely sheltered and the process of applying for a T visa and certification begins. The clinician learns later that through the certification process, S.M. was able to stay in the US legally and bring her mother and other children over safely as well. A police investigation is ongoing.

DISCUSSION

The above case study serves as one example of how a trafficking victim might be completely missed or identified and assisted. The story of S.M. is not uncommon, and clinicians must consider the varied ways in which a trafficking victim might present in the clinic, at the office, in the hospital, or in the community. There are no easy answers, and the process is more likely to be frustratingly long and complicated than straightforward and simple.

The same complexities that exist in the clinical setting also make research in this area difficult. The population is hard to find because of its underground nature, and most studies have very small sample sizes. The involvement of organized crime can also make it a dangerous research topic. Because trafficking happens among men, women, and children in just about every country in the world, generalizability is problematic.[28] Even the definition of trafficking is sometimes contentious among researchers. The exact numbers of trafficked persons are only estimates, and in many cases the statistics are provided without explanation as to methods used to obtain them.[28] Both methodologic and ethical issues are complex, whether researching the trafficking victim or the trafficker.

If research in this area is to progress, the multiple disciplines that study trafficking issues will need to work together and develop a consistent theoretical framework with which to address the problem.[28] Governments and law enforcement agencies should share trafficking data with researchers so that larger studies can be conducted. Research on traffickers themselves should be developed.[29] Agencies that work with trafficking victims should work with researchers to develop best practices for the treatment of these individuals.

CONCLUSION

Human trafficking is a major global health problem, one that all health care providers cannot ignore. Although trafficking victims are unlikely to have adequate and timely access to health care, some victims will be seen in women's health care practices for STIs, pregnancy, and/or abortion services. Health care providers should be prepared to identify, treat, and assist victims of trafficking as part of their regular clinical practice.

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BOX 1. COMMON WAYS GIRLS AND WOMEN BECOME VICTIMS OF TRAFFICKING

- Abduction
- Meet traffickers advertising modeling jobs
- Promises of marriage, education, employment, or a better life
- Respond to ads to work or study abroad
- Seek the help of smugglers to get into the United States—and then debt bondage ensues
- Sold to traffickers by parents or intimate partner

BOX 2. COMMON HEALTH PROBLEMS AMONG TRAFFICKING VICTIMS

- Anxiety
- Chronic pain
- Cigarette burns
- Complications from unsafe abortion
- Contusions
- Depression
- Fractures
- Gastrointestinal problems
- Headaches
- Oral health problems
- Pelvic pain
- Posttraumatic stress disorder
- Sexually transmitted infections
- Suicidal ideation
- Unhealthy weight loss
- Unwanted pregnancy
- Vaginal pain

BOX 3. CASE STUDY

S.M. is a 26-year-old female who came to the United States from Mexico 2 years ago. She is from a small Mixtec farming community in Oaxaca and speaks Mixteco fluently. She speaks some Spanish and no English. S.M. left two young children behind in Mexico with her mother and came to the United States with her boyfriend and the help of a smuggler. She was told that when she arrived in the United States, she would be able to find work and pay the smuggler back the nearly $8,000 she owed for safe passage across the border. After paying her debt, she had plans to remit money to her mother in Mexico for the care of her children, hoping that they might eventually join her in the United States.

During the border crossing, S.M. walked for days in the Arizona desert with little food or water. Her boyfriend was not able to protect her during the crossing, and she was robbed and gang raped by a group of bandits. Upon arrival to the United States, she was transported to New Jersey, where she was placed with a family as their nanny. Shortly afterward, she discovered that she was pregnant with her third child. Her boyfriend found seasonal work nearby picking tomatoes, but when the season ended he disappeared, leaving her behind.

The New Jersey family treats her well and she enjoys caring for their two young children in addition to her own one and a half–year-old. They pay her $6 an hour and give her a room. Recently, the smuggler has been making harassing phone calls to the house about the money he is still owed, and S.M. is worried she will lose her job if he does not stop calling. She has been unable to pay him back because he continues to charge her high interest on her debt. He has threatened to harm her mother and children in Mexico if she does not pay him back soon. Fearing for her job and the lives of her family in Mexico, S.M. agreed to pay back some of her debt by having sex with the smuggler and his friends. She does not see any end in sight.

S.M. is being seen at the clinic today for abdominal pain, unusual vaginal discharge with a foul odor, painful intercourse, painful urination, and irregular menstrual bleeding. A male (the smuggler), who is interpreting for her, accompanies her into the examination room. He states that he is her boyfriend and is holding their child. There is no one at the clinic that speaks Mixteco.

Table 1

Differences Between Prostitution and Sex Trafficking

Prostitution	Sex Trafficking
Woman is generally aware of the type of work in which she will participate (voluntary involvement)	Woman is generally unaware of the type of work she will be doing (involuntary involvement)
Women work independently or with a pimp	Women always have a pimp or trafficker
Commonly work in the same geographic location	Commonly are moved by the trafficker to different locations
Women are paid	Women are generally not paid
May be legal or illegal	Always illegal
Does not always involve force, fraud, or coercion	Always involves force, fraud, or coercion