



***(Please note this document is structured with responses to one or more than one of the question prompts as outlined in Public Notice: 10970, 84 FR 67505)***

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HEAL Trafficking submits this information in response to the “Request for Information for the 2020 Trafficking in Persons Report,” Public Notice: 10970, 84 FR 67505, December 10, 2019.

**The majority of trafficking victims access health care while being trafficked. HEAL Trafficking is building a worldwide movement in health care to respond to trafficking.**

HEAL Trafficking is a network in 35 countries of over 3100 trafficking survivors and multi-disciplinary professionals building the capacity of health care to respond to trafficking, from a public health lens. We tackle issues at the crux of health and trafficking, including Education and Training, Protocols, Research, Direct Services, Prevention, Advocacy, Media and Technology. HEAL Trafficking brings together physicians, advanced practice clinicians, nurses, dentists, emergency medical services (EMS) personnel, psychologists, counselors, public health workers, health educators, researchers, clinical social workers, administrators, and other health professionals who work with and advocate for the health of survivors of human trafficking. Our mission is to mobilize a shift in the anti-trafficking paradigm toward approaches rooted in public health principles and trauma-informed care by expanding the evidence base; enhancing collaboration among multidisciplinary stakeholders; educating the broader anti-trafficking, public health, and health care communities; and advocating for policies and funding streams that enhance the public health response to trafficking and support survivors. HEAL Trafficking engages in work that combats all forms of human trafficking; supports trafficked people of all genders, ages, races/ethnicities, religions, origins, cultures, and sexual orientations; believes all trafficked persons deserve access to a full range of health care including medical, mental/behavioral health, reproductive health, dental, and substance use disorder treatment services; approaches human trafficking from a public health perspective that incorporates a socio-ecological framework and prevention strategies; and promotes a survivor-centered, trauma-informed, evidence-based, practice-based approach to anti-trafficking efforts. Our protocol toolkit is being used in 35 countries and has been downloaded by health systems 2800 times. Our assessment tool for human trafficking curricula for health professionals is being integrated across the country to set standards for health professional trainings on trafficking; for example the state of Texas is currently adopting it to implement a recent educational mandate for all health professionals.

*1. How have trafficking methods and trends changed in the past 12 months? For example, are there victims from new countries of origin? Have new vulnerable groups at particular risk of human trafficking emerged? Is internal trafficking or child trafficking increasing? Has sex*



*trafficking changed, for example from brothels to private apartments? Is labor trafficking now occurring in additional types of industries or agricultural operations? Is forced begging a problem? Does child sex tourism occur in the country or involve its nationals abroad, and if so, what are their destination countries?*

*2. What were the government's major accomplishments in addressing human trafficking?*

*33. Did the government fund any anti-trafficking information, education, or awareness campaigns or training? Were these campaigns or trainings targeting potential trafficking victims, potential first responders or other trusted authorities, known trafficking sectors or vulnerabilities, and/or the demand for human trafficking (e.g. buyers of commercial sex or goods produced with forced labor)? Does the government provide financial support to nongovernment organizations working to promote public awareness?*

The U.S. Department of Health and Human Service's Office of Trafficking in Person's SOAR to Health and Wellness Training Program, through the National Human Trafficking Training and Technical Assistance Center, has reached an unprecedented number of U.S. health professionals and health systems with training on human trafficking. (<https://www.acf.hhs.gov/otip/training/soar-to-health-and-wellness-training>).

*3. What were the greatest deficiencies in the government's anti-trafficking efforts? What were the limitations on the government's ability to address human trafficking problems in practice?*

*5. Please provide observations regarding the implementation of existing laws, policies, and procedures. Are there laws criminalizing those who knowingly solicit or patronize a trafficking victim to perform a commercial sex act and what are the prescribed penalties?*

*34. Were there government policies, regulations, and agreements relating to migration, labor, trade, and investment that had an impact, positive or negative, on forced labor or sex trafficking or vulnerabilities to such crimes? Please describe how this has impacted anti-trafficking efforts.*

A). Governmental policies which create a climate of fear for immigrants lead to fewer victims disclosing their exploitation and receiving assistance, even in health care settings. In one study of female foreign national labor and sex trafficking victims, **the main reason they did not disclose their trafficking exploitation to a health care provider was fear of deportation** (Restore NYC, 2019, see attached and below)



### What impacted lack of disclosure of trafficking to a healthcare provider?

Respondents who did not disclose trafficking to a healthcare provider stated the following impacted their non-disclosure.

**Table 3.** Levels of impact to not disclosing trafficking to healthcare providers\* (N = 25)

Not having immigration status, fear of deportation	3.20	
Not aware that you had been victimized	2.88	
Fear of harm of retaliation by a trafficker	2.84	
Feeling hopeless or helpless	2.84	
Distrust of healthcare provider	2.52	
Shame or guilt	2.36	
Felt health care provider would not understand	2.32	

\*Scores are based on a 0-4 scale: the closer to 4, the more helpful a question is.  
See Appendix B for more information about the scoring process and raw data.

B). Current laws perpetuate the hidden nature of child labor trafficking in the United States.

**I) Exclusion of child labor trafficking data collection in child welfare systems** is one reason child labor trafficking in the United States is underrecognized.

The Preventing Sex Trafficking and Strengthening Families Act of 2014 (Public Law 113–183) amended the Child Abuse Prevention and Treatment Act (Public Law 93–274 and subsequent revisions) to require state child welfare agencies to establish policies and procedures to identify, document, screen, and define services for children under their supervision who are victims of, or at risk of, sex trafficking. Preventing Sex Trafficking and Strengthening Families Act is *specific to sex trafficking*, whereas language in the Justice for Victims of Trafficking Act encompasses labor trafficking without specifying it. The National Child Abuse and Neglect Data System (NCANDS) is a voluntary data collection system that gathers information from all 50 states, the District of Columbia, and Puerto Rico about reports of child abuse and neglect. **The National Child Abuse and Neglect Data System (NCANDS) has defined an allegation category for sex trafficking, but not labor trafficking** (Gibbs DA, Henninger AM, Tueller SJ, Kluckman MN. Human trafficking and the child welfare population in Florida. Children and Youth Services Review. 2018 May 1;88:1-0). **If state child welfare agencies only document sex trafficking, they will never understand labor trafficking, nor develop capacity to respond to it** (Richard, Stephenson, & Knickodem, 2015).



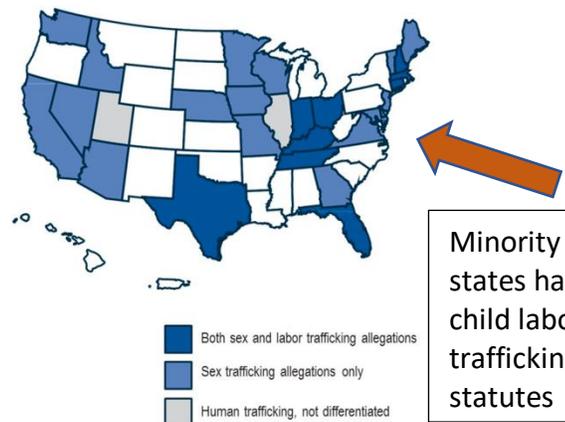
II) **Labor trafficking should be explicitly included in federal and state policies addressing minor victim trafficking.** Currently that is not the case (Gibbs, 2018) Murphy, 2016; Polaris Project, 2015).

## RQ3: System response: Documentation

- Less public attention to labor trafficking than sex trafficking
- Federal laws directing child welfare efforts focus more explicitly on sex trafficking
- Child welfare agencies may not specify labor trafficking within their human trafficking allegation categories

*“In general, there is so much more attention paid to domestic [sex] trafficking of minors. That’s where the media coverage is and that’s where law enforcement dollars [are] focused ... Labor trafficking is mostly an afterthought, if a thought at all.”*

—Amy Fleischauer, International Institute of Buffalo



(slide credit: Dr. Deborah Gibbs, 2019)

4. *In what ways have the government's efforts to combat trafficking in persons changed in the past year? What new laws, regulations, policies, and implementation strategies exist (e.g., substantive criminal laws and procedures, mechanisms for civil remedies, and victim-witness security, generally and in relation to court proceedings)? Have government policies undermined or otherwise negatively impacted anti-trafficking efforts within that country? Does the country's legislation require proof of force, fraud, or coercion (the “means”) even in the case to meet the legal definition of sex trafficking for minors?*

A growing number of states have mandated education of health professionals on trafficking, and some have even required health systems to have trafficking response protocols in place (Politico, Goldberg:



<https://healtrafficking.org/2018/10/anti-trafficking-activists-enlisting-health-providers/>).

*7. Please provide observations on overall anti-trafficking law enforcement efforts and the efforts of police and prosecutors to pursue trafficking cases. Were any trafficking cases investigated and/or prosecuted, and any traffickers convicted during the reporting period? **Is the government equally vigorous in pursuing labor trafficking and sex trafficking**, internal and transnational trafficking, and crimes that involve its own nationals or foreign citizens? Please note any efforts to investigate and prosecute suspects for knowingly soliciting or patronizing a sex trafficking victim to perform a commercial sex act.*

*8. Do government officials understand the nature of all forms of trafficking? If not, please provide examples of misconceptions or misunderstandings.*

*15. Did the government make a coordinated, proactive effort to identify victims of all forms of trafficking? Did officials effectively coordinate among one another and with relevant nongovernmental organizations to refer victims to care? Is there any screening conducted before deportation or when detaining migrants, including unaccompanied minors, to determine whether individuals were subjected to trafficking? Were such individuals referred for protection services? Does the government also partner with nongovernmental organizations to conduct screenings? What happens if a potential case of human trafficking is identified?*

### **Labor trafficking is systematically deprioritized.**

According to “Policing labor trafficking in the United States, Farrell et al, 2019,” “despite new mandates to identify and respond to labor trafficking crimes, US law enforcement struggles to integrate labor trafficking enforcement with traditional policing routines and roles. As a result, human trafficking enforcement has primarily focused on sex trafficking and few labor trafficking cases have been identified and prosecuted. This study utilizes data from 86 qualitative interviews with municipal, state, county and federal law enforcement, victim service providers and labor trafficking victims in four US communities to inform our understanding of police responses to labor trafficking in local communities. Through the coding of these interviews across a series of themes, we identify **three major challenges that impact police identification and response to labor trafficking crimes**. These include **1) lack of clarity about the definition of labor trafficking, 2) lack of institutional readiness to address labor trafficking, 3) and routines of police work that undermine police responsiveness to labor trafficking in local communities**. Considering these challenges, we explore strategies law enforcement can take to improve identification, including developing non-traditional partnerships with labor



inspection and local regulatory agencies. Additionally, interview data suggest a role for the police in ensuring labor trafficking victims are safe and their needs are met, regardless of the outcomes of the criminal justice process.”

One illustrative quote from law enforcement from the above Farrell study:

They [officers] know what labor trafficking is but again I think it’s a little bit difficult because sex is so much easier. This woman is being raped thirty times a night. We have a case. With labor trafficking, I’ve heard comments where agents will say, ‘My dad had a farm. I picked tomatoes on his farm when I was a kid. Am I a victim of labor trafficking?’ It’s a bit like ‘we all work hard.’ It’s easier to dismiss people working really hard as victims of trafficking as opposed to people who are forced to have sex and controlled. (Northeast Urban, Federal law enforcement)

According to “Failing victims? Challenges of the police response to human trafficking Farrell et al, 2019” (see attached) **“Because police in the study communities were more closely connected to service providers who work with children and individuals involved in commercial sex, they were more likely to receive sex trafficking victimization referrals. Lack of outreach and partnership to providers serving migrant workers or other vulnerable labor populations was identified as explaining the low numbers of identified labor trafficking victims.** An agent in the South explained that despite widespread agriculture in the local area that draws vulnerable migrant laborers, “where we’re at there’s not a lot of outcry for it [services for migrant workers]. There’s not a lot of reporting it [wage theft or labor trafficking]. So therefore, we don’t have the referrals. We don’t have the cases and then therefore we don’t have the investigations.”

*16. What victim services are provided (legal, medical, food, shelter, interpretation, mental health care, employment, training, etc.)? Who provides these services? If nongovernment organizations provide the services, does the government support their work either financially or otherwise? Are these service providers required to be trained on human trafficking and victim identification?*

*17. What was the overall quality of victim care? How could victim services be improved? Was government funding for trafficking victim protection and assistance adequate? Are there gaps in access to victim services? Are services available regardless of geographic location within the country? Are services victim-centered and trauma-informed?*

In “Using Survivors' Voices to Guide the Identification and Care of Trafficked Persons by U.S. Health Care Professionals, Armstrong & Greenbaum, 2019” ().



“Survivors suggested that health care facilities should not dismiss patients who do not have Medicaid. They also recommended **increasing the availability of mental health care and public counseling, as well as nonpharmacological methods for mental health support such as meditation, yoga, or counseling on healthy relationships**. Increasing treatment opportunities for those with **substance addiction** was also suggested. Twenty-five percent of respondents recommended that **“wrap around” services be available in clinical facilities**”

According to the study, “Identifying Gaps in Human Trafficking Mental Health Service Provision Powell et al., 2019” (attached) “Analysis of interview data underscored the challenges of addressing severe human trafficking survivor mental health needs **with limited service provider capacity and poor accessibility**. These findings are consistent with other studies examining general human trafficking service delivery (see Figure 1; Clawson & Dutch, 2008; Domoney, Howard, Abas, Broadbent, & Oram, 2015; Potocky, 2010). In regard to mismatch of capacity, in an evaluation of three human trafficking service programs, Davy (2015) noted **inadequate organizational capacity** and resources as negatively impacting service delivery. Furthermore, Davy (2015) cited **untrained NGO staff in terms of human trafficking pathology and cultural and language needs** as inhibiting service delivery. Moreover, the findings of our study highlight the multifactorial barriers to service access. In particular, **past and current substance use disorders** further exacerbate already complex physical and mental health concerns. Jaffé, Jakab, Szilárd, and Weekers (2004) and Clawson et al. (2008) both note **the inextricable relationship of mental health trauma with physical health concerns**. In addition, these findings further elucidate the pattern of disproportionate long-term survivor needs met with a service delivery environment characterized by short-term service delivery opportunities (Gibbs et al., 2015; Macias-Konstantopoulos et al., 2015; Zimmerman et al., 2008). Also, our findings aligned with other reports of **chaotic, intermittent health care service delivery represented by urgent medical care provision either in an emergency or clinic setting, with limited or nonexistent follow-up for longterm medical concerns** (Aron et al., 2006; Potocky, 2010). In response to these barriers, there is a general consensus that there is a **need for building the capacity of delivery models to be tethered to the unique personal, cultural, and contextual features of the survivor** (Dewan, 2014; Gibbs et al., 2015). Our study’s finding is corroborated by an evaluation of three human trafficking programs from which the authors concluded that “the single most successful approach to encouraging service utilization was **in-house or colocated services**” (Gibbs et al., 2015). Increasing mental health professional capacity was imperative as a means to improve mental health service delivery. Our findings are in line with the body of human trafficking literature, which highlights a **need for mental health professionals who are trained in trauma**

intervention and able to provide culturally sensitive and multilingual services (Baráth et al., 2004; Hemmings et al., 2016; Muraya & Fry, 2016; Yakushko, 2009).”

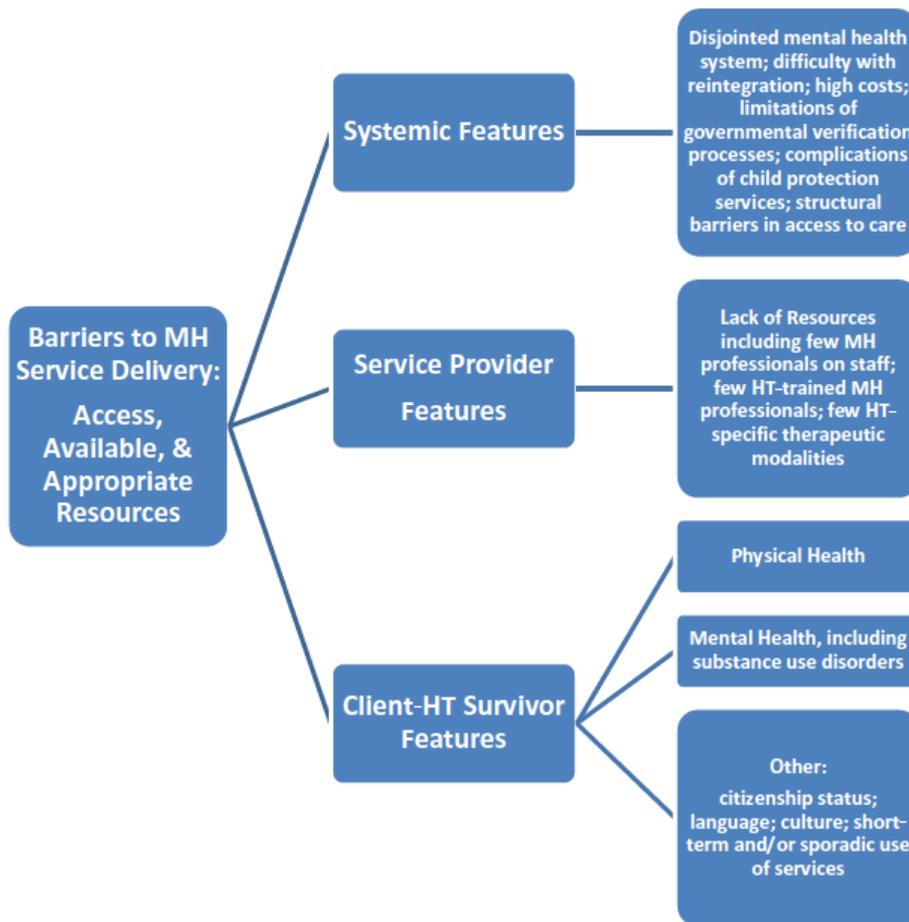


Figure 2. Thematic framework of barriers to mental health service delivery.

25. What efforts has the government made to **prevent** human trafficking? Are there laws prohibiting employers or labor agents from confiscating workers' passports or travel documents, switching contracts without the workers' consent, or withholding payment of salaries as a means of keeping workers in a state of compelled service? Are these laws implemented to hold violators accountable and/or are such crimes investigated by law enforcement as potential indicators of trafficking?



A) HEAL Trafficking believes that we cannot arrest or prosecute our way out of trafficking—that we need upstream, **prevention** approaches to stop trafficking from happening in the first place, addressing vulnerabilities on the individual, neighborhood, and societal level.

(<https://www.springer.com/us/book/9783319478234> &

<https://www.communitypsychology.com/preventing-human-trafficking/>

**Individual level<sup>3,4,8-10</sup>:**

- History of adverse childhood experiences or trauma
- History of sexual and physical abuse or neglect
- Migrant status
- Indigenous status
- Runaway and homelessness
- Involvement in child welfare
- LGBTQ status
- Gang involvement
- Limited education and intellectual disability
- Substance use disorder
- Teen pregnancy
- Need for basics including food and shelter
- Low self-esteem

**Family/neighborhood level<sup>3-5</sup>:**

- Lack of worker rights and enforcement of worker rights
- Poverty and unemployment
- Limited education
- Family dysfunction
- High crime
- Lack of resources, such as affordable housing
- Social norms tolerating exploitation
- Adult commercial sex
- Natural disasters

**Societal level<sup>1,3-5</sup>:**

- Ideologies of exclusion
- Demand for cheap goods
- Demand for purchased sex
- Lack of awareness
- Sexualization and devaluation of children and youth
- Gender-based discrimination and violence
- Labor exploitation
- Political/social upheaval
- Law enforcement/political corruption
- Lack of resources to combat trafficking

B) While “awareness raising” is often seen as a form of prevention, there is little data to support this, and awareness raising done incorrectly may even cause harm.

One rigorous USAID funded study, “Reducing Vulnerability to Human Trafficking An Experimental Intervention Using Anti-Trafficking Campaigns to Change Knowledge, Attitudes, Beliefs, and Practices in Nepal” **found that information**



**campaigns do not lead to an increase in a person's perceptions that human trafficking is a big problem locally.**

([https://www.usaid.gov/sites/default/files/documents/1860/DRG\\_Center\\_Working\\_Paper-Vanderbilt\\_2018.pdf](https://www.usaid.gov/sites/default/files/documents/1860/DRG_Center_Working_Paper-Vanderbilt_2018.pdf),

[https://usaidlearninglab.org/sites/default/files/resource/files/usaid\\_nepal\\_ctip\\_infographic.pdf](https://usaidlearninglab.org/sites/default/files/resource/files/usaid_nepal_ctip_infographic.pdf), <https://www.vanderbilt.edu/lapop/insights/IGI002en.pdf>)

**C) Health care can and must be a place for prevention and early intervention.**

**Community health centers** provide a model that integrates care in vulnerable communities, and provide comprehensive, integrated health services to victims

(<https://www.ncbi.nlm.nih.gov/pubmed/30597227> and

<https://polarisproject.org/sites/default/files/A%20Roadmap%20for%20Systems%20and%20Industries%20to%20Prevent%20and%20Disrupt%20Human%20Trafficking%20-%20Health%20Care.pdf>).

*35. Please provide additional information and/or recommendations to improve the government's anti-trafficking efforts.*

*36. Please highlight effective strategies and practices that other governments could consider adopting.*

**The majority of trafficked persons in the United States access healthcare while being exploited.**

What this means is that **health care must be equipped to respond when a victim comes through its doors.** For health care to be properly equipped to respond to trafficked persons requires 1) Education and Training 3) Protocol Development 3) Access to Integrated, Comprehensive, Multidisciplinary services 4) Prevention (see above) 5) Research

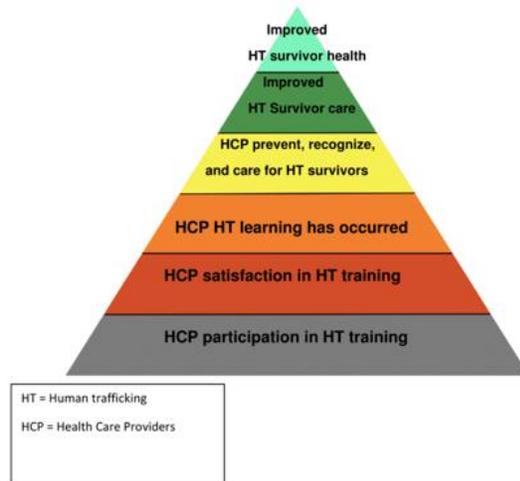
Recommendations

**1. Education and Training**

Clinical responses to human trafficking are complex and nuanced. Therefore, it is not enough for all health professionals to be simply aware of trafficking, but rather they must be empowered with skills to assess for trafficking and to care for trafficked persons. Educating clinicians about trafficking is about training them to translate knowledge into practice with the ultimate goal of improving the health and well-being of trafficked persons.



Figure 1. Assessing impact of human trafficking medical education, a hierarchical, patient-centered model.



Powell C, Dickins K, Stoklosa H. Training US health care professionals on human trafficking: where do we go from here? *Med Educ Online*. 2017; 22(1):1267980.

## Standards for health professional training

There is the potential for harm if health professionals are given incorrect information about human trafficking. For example, because many trafficked persons are forced to commit crimes as part of their exploitation, calling law enforcement may put a potential victim at further risk, resulting in arrest or deportation ([https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(17\)32453-4/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)32453-4/fulltext) ). Moreover, trainings that focus exclusively on sex trafficking, neglecting other forms of trafficking, may result in a workforce that builds an entire response to one form of exploitation to the exclusion of other forms of exploitation. It is important that content of training is standardized, comprehensive, trauma-informed and survivor-informed.

HEAL Trafficking has created an **assessment tool** that allows those developing curriculums to determine gaps in their training (<https://healtrafficking.org/2018/12/assessment-tool-for-health-care-provider-human-trafficking-training/> ). This tool is currently being utilized by the state of Texas in implementing their mandated education and training law for health professionals. The United States Department of Health and Human services is currently in the process of creating core competencies for health provider education on trafficking. They also have created a suite of free, accredited trainings for health professionals (SOAR) which can be integrated into health system learning management systems



(<https://www.acf.hhs.gov/otip/training/soar-to-health-and-wellness-training> ).

And the International Organization for Migration (IOM) manual “Caring for Trafficked Persons: Guidance for Health Providers” covers topics including ethics, physical exam, data storage, interactions with law enforcement and self-care ([https://publications.iom.int/system/files/pdf/ct\\_handbook.pdf](https://publications.iom.int/system/files/pdf/ct_handbook.pdf)).

### **Trainings should directly address barriers to disclosure**

Trafficking victims report that they do not disclose their exploitation because of bias and judgement experienced in the health care setting as well as fear of deportation. Based on their own life experiences, health professionals have unconscious and conscious bias around the race, gender, type of exploitation, and behaviors of trafficked persons.

(<https://polarisproject.org/sites/default/files/A%20Roadmap%20for%20Systems%20and%20Industries%20to%20Prevent%20and%20Disrupt%20Human%20Trafficking%20-%20Health%20Care.pdf> and <https://static1.squarespace.com/static/59d51bdb6f4ca3f65e5a8d07/t/5c705af74e17b658d074c7fc/1550867206256/Healthcare+Access+Restore+2019.pdf> ).

Chisolm-Straker M, Miller C, Duke G, Stoklosa H. A Framework for the Development of Healthcare Provider Education Programs on Human Trafficking Part Two: Survivors. *Journal of Human Trafficking*. 2019.

Miller C, Chisolm-Straker M, Duke G, Stoklosa H. A Framework for the Development of Healthcare Provider Education Programs on Human Trafficking Part Three: Recommendations. *Journal of Human Trafficking*. 2019.

Stoklosa H, Miller C, Duke G, Chisolm-Straker M. A Framework for the Development of Healthcare Provider Education Programs on Human Trafficking Part One: Experts. *Journal of Human Trafficking*. 2019

Health professional trainings must use de-biasing strategies to directly address these barriers to caring for trafficking victims.

One instructional methodology, simulation, incorporates adult learning principles and is being used to teach clinician trainees to identify, treat and refer victims of human trafficking in the United States and Canada. Simulation is the “artificial representation of a complex real-world process with sufficient fidelity with the aim to facilitate learning through immersion, reflection, feedback, and practice minus the risks inherent in a similar real-life experience.” Essentially, simulation gives learners an opportunity to put skills into practice and cement



learning, while also making mistakes without any risks to their patients (<https://www.ncbi.nlm.nih.gov/pubmed/29228882> ).

## 2. Protocol Development

At the moment a trafficked person is identified, the health professional needs to know the next steps to take. The development of health provider trainings must be done in parallel with creation of policies, procedures and protocols that link health systems to community partners. One such resource to assess health systems in building these protocols is the **HEAL Protocol toolkit** (<https://healtrafficking.org/2017/06/new-heal-trafficking-and-hope-for-justices-protocol-toolkit-for-developing-a-response-to-victims-of-human-trafficking-in-health-care-settings/> ).

### **Beyond Screening**

Research from the domestic violence literature demonstrates it is effective to provide universal education, and create emotionally and physically safe spaces for disclosure, rather than directly asking a checklist of screening questions. The goal in a health care encounter with a potential victim is not disclosure, but creating an open door for the individual to return for care.

In response to this evidence, and with input from survivors of trafficking, Dignity Health, HEAL Trafficking, and Pacific Survivor Center created the PEARR Tool (<https://www.dignityhealth.org/hello-humankindness/human-trafficking/victim-centered-and-trauma-informed/using-the-pearr-tool> ) to assess for forms of violence, including human trafficking.

## 3. Access to Integrated, Comprehensive, Multidisciplinary services

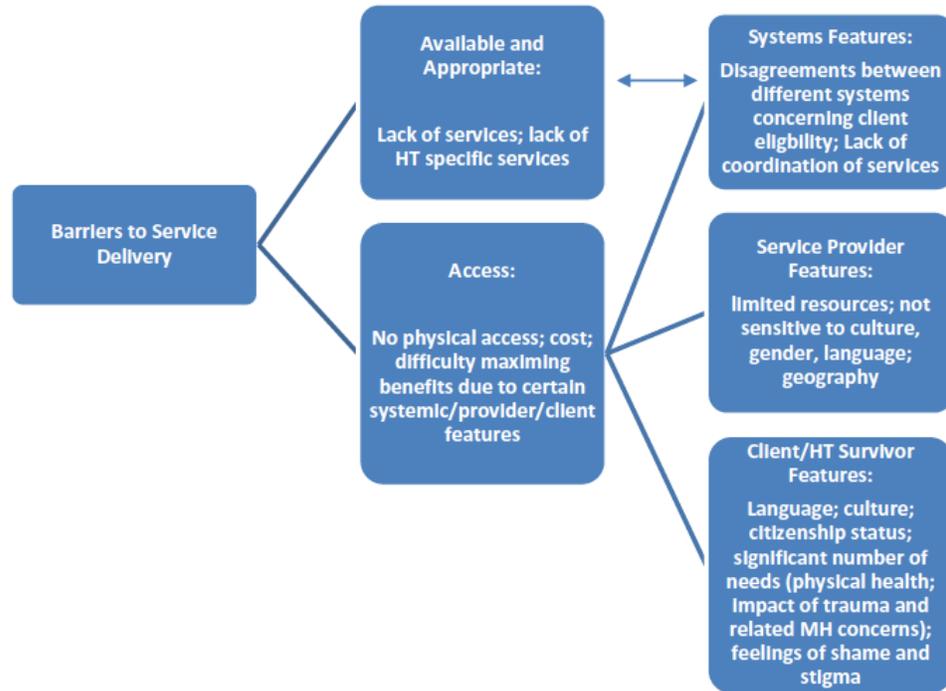


Figure 1. Barriers to general human trafficking service delivery: A conceptual framework.

Powell C, Asbill M, Louis E, Stoklosa H. Identifying Gaps in Human Trafficking Mental Health Service Provision. *Journal of Human Trafficking*. 2018; 4(3):256-269.

Trafficking survivors have a myriad of acute and longterm physical, dental, and mental health needs. Many survivors also experience substance use disorders, including opioid addiction. Unfortunately, when these health care needs are not met in an integrated, multidisciplinary, patient-centered, trauma-informed, evidence-based fashion, a survivor of trafficking may become re trafficked, or suffer retraumatization (<https://www.ncbi.nlm.nih.gov/pubmed/28107153> ). The conceptual framework above outlines the macro and micro-level barriers to serving trafficking victims that must be proactively addressed for health systems to comprehensively care for trafficking survivors. Addressing health needs must go hand and hand with addressing victims' social determinants of health. If the social determinants of health, including food insecurity, homelessness, legal needs, are not met, trafficking victims may be re trafficked.

#### 4. Research

To better inform responses to trafficking in the health care setting, we need a stronger evidence base. HEAL Trafficking published a public health research



agenda in the American Journal of Public Health which outlines a comprehensive approach to this research:

<https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2017.303858>

In particular, health professionals are ill-informed about how labor trafficking victims present to the health care setting. This is a critical data gap that must be filled.

Much of the research on the health needs of trafficking victims in the United States has focused on sex trafficking victims. It is past time for us to have a comprehensive understanding of the unique health concerns of the thousands of individuals trapped in forced labor in the United States.

Additional research and data can inform health care professionals to develop data driven treatments and response protocols for all survivors of human trafficking.

Such a study should:

- Address a full scope of the physical, psychological, and environmental health concerns and symptoms of labor trafficking victims both during and after their trafficking experience.
- Include labor trafficking survivors representing all types of labor trafficking business models or industries.
- Include diverse genders, ethnicities, ages, sexual orientations, education backgrounds, and not be limited in scope to one state or region of the United States.
- Collect data on health care access during exploitation such as types of health care facilities used, presenting health issues, health care coverage, workers compensation access, and experiences with health care professionals.
- Provide survivor-informed recommendations for health care professionals when assessing and treating labor trafficking survivors.

(<https://polarisproject.org/sites/default/files/A%20Roadmap%20for%20Systems%20and%20Industries%20to%20Prevent%20and%20Disrupt%20Human%20Trafficking%20-%20Health%20Care.pdf> )