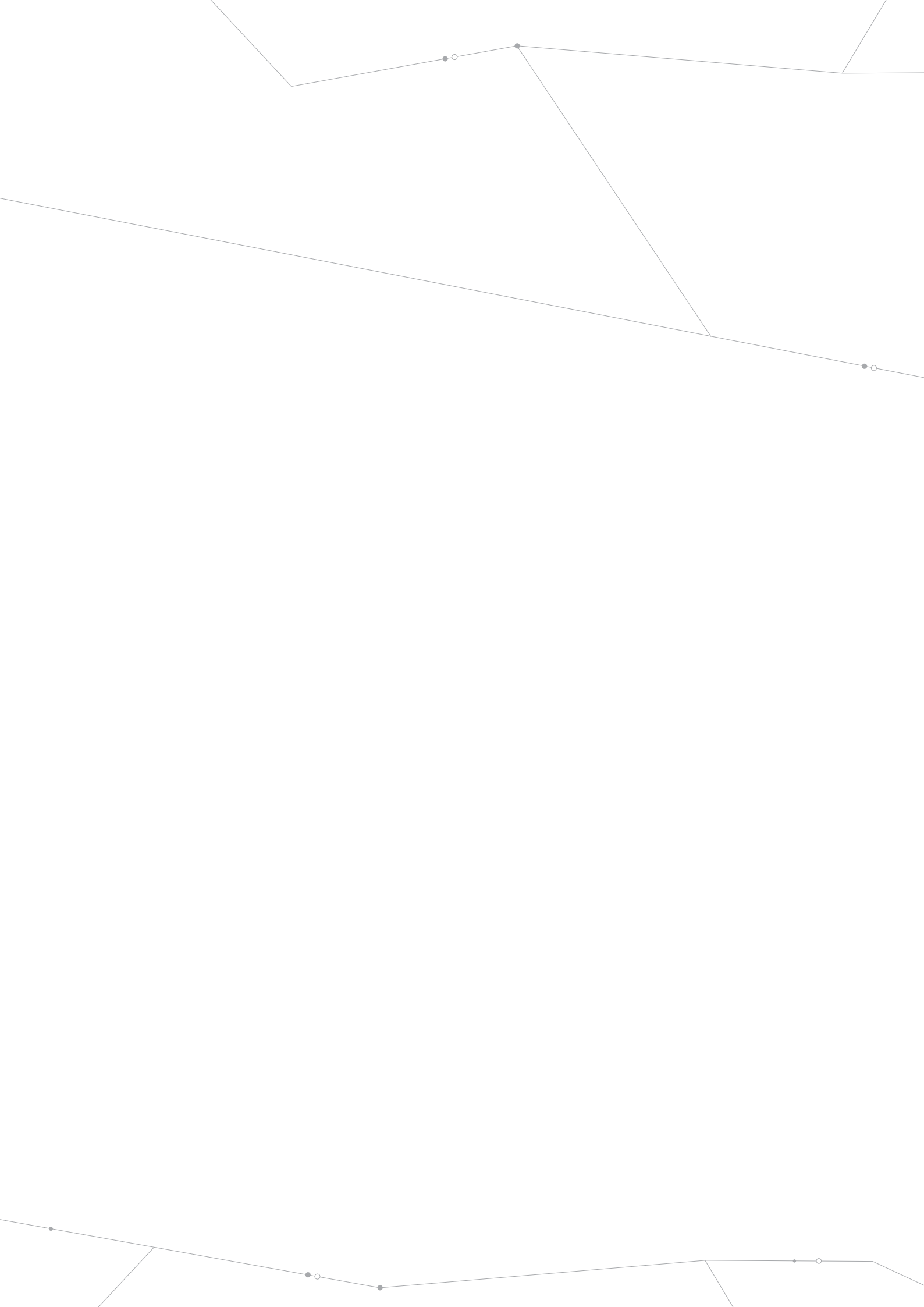


Addressing human trafficking through health systems

A SCOPING REVIEW





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Abstract

Human trafficking is a lucrative crime and violation of human rights that exploits women, children and men. It includes trafficking for forced labour, sexual exploitation, forced begging and military conscription. The health effects of trafficking and the health needs of trafficked individuals and trafficking survivors are well documented and urgent. WHO European Region Member States recognize their responsibility to prevent and respond to human trafficking and to mitigate its health effects. As frontline health professionals may be the sole public servants to meet trafficked individuals while they are trafficked, the health system also has both a responsibility and an opportunity to promote and protect the health and other rights of trafficked people. No country or sector alone can address the ongoing challenges of trafficking, nor of emerging challenges. This scoping review examines 237 articles, reports and grey literature containing research from Canada, the United States of America and the WHO European Region. It summarizes and synthesizes this evidence-informed research to help Member States in addressing the intersection of health care and trafficking and in attempts to prevent and respond to human trafficking. While considerable research covers the epidemiology of trafficking and the service delivery response, there is limited research on prevention efforts. The identified research shapes the considerations for policies to promote a comprehensive health systems approach to human trafficking.

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Abbreviations

ACE	adverse childhood experience
CSE	commercial sexual exploitation
EU	European Union
HCP	health-care provider
IOM	International Organization for Migration
LGBTIQA+	lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual people
MLMC	My Life My Choice
NGO	nongovernmental organization
PTSD	post-traumatic stress disorder
SDG	Sustainable Development Goal
SDH	social determinant of health
STI	sexually transmitted infection
UNODC	United Nations Office on Drugs and Crime

Executive summary

This report surveys current scholarly literature on health care and human trafficking to illuminate the critical role that health systems play in anti-trafficking activities. It provides an evidence base from which States and health systems can shape intersectoral policy and their efforts to prevent and respond to trafficking. The health effects of trafficking and the health needs of trafficked people, particularly women, adolescents and children, are well documented and urgent, yet by 2015 there was still little in the way of evidence-informed research that indicated the health consequences of trafficking or the best practices for serving trafficked people.

Human trafficking is a lucrative crime that exploits men, women and children. It can take many different forms, such as trafficking for forced labour, sexual exploitation, forced begging and military conscription. It is a violation of human rights and regulated in international law. In 2020 the European Commission registered 14 145 trafficked people in the European Union (EU) alone and the United Nations Office on Drugs and Crime (UNODC) identified nearly 20 000 people trafficked in 2020 in Europe and central Asia. All WHO European Region Member States have ratified the Palermo Protocol and its supplements, which recognize human trafficking as both a criminal enterprise and a violation of human rights. Improving health-care access and quality for trafficked people would also address several of the United Nations Sustainable Development Goals (SDGs).

Any effort to address human trafficking requires significant intersectoral collaboration; no country or sector alone can address the challenges presented by this violation of human rights. The health sector has a critical role to play both in supporting the health rights and needs of trafficked people and in combating human trafficking through intersectoral action. Frontline health-care providers (HCPs) may be some of the few public servants to meet individuals while they are being trafficked; consequently, the health system has both a responsibility and an opportunity to promote and protect the health and other rights of trafficked people.

Multisectoral coordinated systems and care have been shown to improve trafficking responses, and the International Organization for Migration (IOM) recommends that health systems adapt standard care protocols to treat trafficked individuals and survivors. Research shows that systems with trafficking-specific policies provide better care. Within the EU, the EU Gender Equality Strategy 2020–2025 contains a new EU strategy on the eradication of trafficking in people, which will offer WHO European Region Member States additional guidance on developing national strategies for interrupting both domestic and cross-border trafficking.

Most health systems and associations for HCPs largely lack trafficking-specific protocols, and HCPs are often unaware of or are untrained in the protocols that do exist. Member States could facilitate the integration of standardized systemwide protocols, screening and reporting systems that can be applied when indicators of trafficking are recognized in practice. These protocols should follow ethical guidelines for both reporting and documentation. WHO does not recommend including mandatory reporting laws, although it does urge HCPs to follow all local legal guidelines. WHO European Region Member States should consider protocols

that incorporate diagnostic codes for human trafficking; these have provided growing insight into health-care indicators and needs in the United States of America.

The review of recent literature conducted for this report suggests that any national plan for health care and human trafficking must address both prevention and response. Prevention of human trafficking includes not only intervening in trafficking and stopping it from ever occurring but also thwarting re-trafficking and supporting harm-reduction strategies for trafficked individuals. Unfortunately, there is currently little in the way of evaluative studies of health system prevention programmes, so it is impossible to determine best practices for a prevention-focused health system. While that body of research grows, Member States' approach to trafficking prevention should follow the guidance given by WHO's Commission on Social Determinants of Health and address the underlying societal risk factors for trafficking, including abuse, economic vulnerability, gender inequalities and the profitability of the sex trade and forced labour. Researchers have identified numerous individual-level social determinants of health (SDHs) correlated with human trafficking, including adverse childhood experiences (ACEs), mental illness, substance abuse, poverty and sexual assault, although there is insufficient evidence to determine the SDHs for men, individuals trafficked for labour and migrants. The findings of this report suggest that public-health-based prevention efforts need to attend to the root causes of trafficking, including all forms of social, economic and cultural marginalization, and to trigger protective protocols any time a patient presents with the risk factors identified by the research presented in this scoping review. Attendant harm reduction should include policies that reduce avenues into trafficking, particularly surrounding the sex trade and that mitigate individual-level risk factors such as barriers to reporting abuse.

There is more robust research on how WHO European Region Member States might guide their health systems to respond to human trafficking. The most crucial health-care response to human trafficking is providing access to care. Health systems should address the primary structural barriers to health-care access and utilization of services for trafficked individuals, which include understaffing and underfinancing, insufficient resources for specialty services and HCP's lack of knowledge about how to identify or treat trafficked individuals. Member States should also consider instituting universal, low-barrier and flexible access to health services, including for trafficked people regardless of status or available resources. Research repeatedly suggests that the primary personal barriers to health-care access for trafficked individuals include a sense of disenfranchisement; shame; distrust in HCPs and institutions; lack of health insurance or identification; and ignorance of their rights and entitlements. Each issue can be addressed in a comprehensive public health response. Racial, ethnic and sexual minorities, as well as refugees and migrants, may have more difficulty accessing trafficking-specific health care. To address these inequities, advocates recommend a so-called "no wrong door" policy, which seeks to identify and treat trafficked individuals at a variety of health-care locations.

When trafficked individuals do access care, that care should be trauma informed and patient centred. Many trafficked individuals experience multiple traumas and their mental health consequences, including post-traumatic stress disorder (PTSD), depression and suicidal ideation. Studies have, for example, found that 96.2% of young people who have experienced commercial

sexual exploitation (CSE) have also experienced potentially traumatic events, and 93.9% of all trafficking survivors experience PTSD. First-person narratives from women trafficked for sex and from survivors of labour trafficking have identified PTSD and similar mental health conditions as being among their greatest challenges after trafficking. Health systems must deliberately incorporate trauma-informed, survivor-centred care to effectively treat trafficking survivors. Macias-Konstantopoulos centred trauma-informed care around the promotion of the bioethical principles of respect for autonomy, nonmaleficence, beneficence and justice. Health systems should institute well-defined ethical guidelines through which HCPs could seek to mitigate or remove harms. The autonomy of survivors should be at the centre of care as much as possible. Preliminary research demonstrates the benefits of trauma-informed care, although extensive evaluations have yet to be performed. As Member States and health system policy-makers design this care, they should be sure to include survivor participation and feedback into all consultations regarding practice, protocols and policy relevant to trafficking in order to ensure appropriate trauma-informed services.

Member States, health systems and/or researchers should develop, require and evaluate standardized training on trafficking for all staff in all health-care settings, based on survivor-centred and trauma-informed care and addressing unconscious bias. Most HCPs lack the capacity to effectively identify and treat trafficked individuals. While HCPs recognize the need for that capacity, most report that they have not received training and/or do not feel confident in their knowledge or abilities. Existing training, in-person and online and both synchronous and asynchronous, has been shown to effectively increase HCPs' self-perceived confidence and knowledge related to treating and identifying trafficked people immediately after the training. There is longitudinal evidence, however, that these gains are lost shortly after. There is also no systematic evidence that these gains have translated into greater identification or better treatment in practice, although HCPs and health administrators attest to both. The development of an effective standardized training protocol with a lasting impact is still necessary.

Health systems and HCPs should prioritize quality of care over trafficking identification. WHO recommends ethical interviewing of potentially trafficked individuals rather than a universal screening protocol. Situationally appropriate screening tools, however, can serve as important complements to these interviews. Five screening tools have been validated as effective for various ages, sexes, genders and forms of trafficking. Several have been shown to be effective in multiple health-care settings, in more than one language and when administered either verbally or electronically. Most health-care facilities have not, however, adopted a screening tool for trafficking and one third of HCPs do not even know if their facilities have them. Member States should promote the incorporation and evaluation of standardized screening tools to identify trafficked individuals.

While this scoping review primarily addresses ongoing challenges to health-care response and prevention, WHO European Region Member States are perhaps less prepared for emergencies and newly emerging disruptions, which can increase the rate of human trafficking and decrease trafficked people's access to quality health care. Both human-generated and natural disasters and emergencies often increase the socioeconomic risk factors for trafficking, while temporarily jolting health systems, their capacity and their finances in ways that make the identification and treatment of trafficked individuals less likely.

The scoping review's findings and policy considerations regarding how Member States and health systems can prevent or respond to trafficking are derived from an evidence-driven scoping review, which identified 237 articles, reports and grey literature containing research in Canada, the United States and the WHO European Region. Only 47 of the publications from the WHO European Region met the inclusion criteria, and 28 of these were focused on the United Kingdom. The current published evidence base is overwhelmingly focused on non-migratory female sex trafficking and its survivors in the United States. While many men and migrants are trafficked, there is scant research conducted on health systems response to trafficking in Europe, on migration and cross-border trafficking, or on the health of trafficked men and boys and health system responses to their needs. Consequently, this report's findings and policy considerations are largely based on the experiences of women, children and non-migrants. Member States should encourage both increased data collection and research on trafficking – particularly on prevention and evaluation of services – and regularly share findings among human rights monitoring bodies at the national level.

1. Introduction

KEY POINTS

- All WHO European Region Member States have ratified the Palermo Protocol and its supplements, which recognize human trafficking as both a criminal enterprise and a violation of human rights.
- Socioeconomic characteristics, including sex, age, gender and migratory status, correlate with heightened risk for human trafficking.
- Trafficking in people for both labour and sexual exploitation creates significant negative health consequences.
- Improving health-care access and quality for trafficked people and survivors of human trafficking would address several of the United Nations SDGs.
- The body of evidence-informed research addressing the intersection of health care and human trafficking in the WHO European Region is underdeveloped and benefits from supplementation by research performed in Canada and the United States.

1.1 Human trafficking, health consequences and health systems

Human trafficking is a significant public health and human rights violation of importance to WHO Member States. Trafficking affects people in all WHO Member States, regardless of national economy, rates of migration or gender equality legislation. Human trafficking is a lucrative crime that exploits men, women and children. It can take many different forms, such as trafficking for forced labour, sexual exploitation, forced begging and military conscription. It is a violation of human rights and regulated in international law. In its most recent report, the European Commission found that there were 14 145 registered trafficked people in the EU (1) while the UNODC reported nearly 20 000 people trafficked in 2020 in Europe and central Asia (2).

In 2003 Zimmerman et al. first suggested that human trafficking represents a significant health risk, primarily to adolescents and women (3). In 2015 a systematic review of the literature found very few published evidence-informed studies regarding the health consequences of trafficking or the best practices for serving trafficked people (4).

The United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children (5), supplementing the United Nations Convention against Transnational Organized Crime (often called the Palermo Protocol), has been signed by all Member States in the WHO European Region. It defines trafficking in people as:

the recruitment, transportation, transfer, harbouring, or receipt of people 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 three key elements that must be present for an adult to be considered trafficked, therefore, are (i) action (recruitment, transport, receipt), (ii) means (threat, force), and (iii) purpose (exploitation). The Palermo Protocol includes an exception to the necessity to show the means in the case of children. Child trafficking is defined as "recruitment, transportation, transfer, harbouring or receipt of a child for the purpose of exploitation" (5). This report employed these definitions in determining if an article addressed trafficking.

Within Party States, this distinction regarding what constitutes child trafficking is particularly applied to sexual exploitation of children and rarely to other forms of labour trafficking.

Human trafficking is both a criminal offence and a violation of rights; it can occur to any person, of any age, religion, race, culture, nationality or sexuality. Trafficking victimization can occur to a citizen within the boundaries of his or her own nation or may involve a person crossing one or more international borders. There is increasing global awareness of the scale of human trafficking. WHO recognizes human trafficking of women as an issue of gender-based violence that must be addressed by health systems globally. Human trafficking is considered a form of gender-based violence because traffickers so often exploit women's particular vulnerabilities to push them into forced labour, including forced commercial sex. Gender inequalities, the normalization of exploitation, the objectification of women and male privilege all conspire to put women and girls at heightened risk of trafficking, as traffickers target their economic and social vulnerabilities. Migrant women are particularly at risk due to their vulnerability in the labour marketplace. Abused women are more likely than non-abused women to seek medical attention and they identify HCPs as the professionals to whom they are most likely to disclose abuse. For this reason, health-care systems are in a unique position to identify and respond to the needs of trafficked women and girls.

The IOM's *Caring for Trafficked Persons: Guidance for Health Providers* (6) recommends that health systems adapt standard care protocols to treat trafficked individuals and survivors, and research shows that systems with trafficking-specific policies provide better care.

The EU Gender Equality Strategy 2020–2025 announced the development of a new EU strategy on the eradication of trafficking in human beings, which will offer WHO European Region Member States additional guidance on developing national strategies for interrupting both domestic and cross-border trafficking (7).

Research suggests that both labour and sex trafficking result in significant negative health consequences that position HCPs as a frontline response to this human rights violation and as leaders in intersectoral response. Despite the heightened attention to trafficking among researchers, HCPs and the public, there is still a need for coordinated and deliberate protocols and practices to be integrated into national health systems among WHO Member States. This report offers an evidence base from which to build intersectoral policy and advocacy to prevent and respond to human trafficking through health systems.

1.2 Objectives of this scoping review

The purpose of this scoping review is to provide an evidence base on health, health care and human trafficking. Health policy-makers, health systems managers and WHO European Region Member States might leverage this evidence base to improve health system responses to trafficked people and survivors of trafficking, as well as to prevent human trafficking.

An emerging body of research exists on what the health system can do to both prevent and respond to trafficking, both as a separate sector and as a partner in intersectoral anti-trafficking collaborations. Although evidence about many aspects of trafficking and health (including, for example, contacts with the health sector among men trafficked for forced labour) is clearly scarce, it is important to highlight existing needs and gather available information that will remedy these evidence gaps.

Beyond the expressed need for this review, this scoping review provides evidence which supports Member States in their efforts to implement five recently adopted WHO strategies and action plans, namely:

- the 2016 WHO Global Plan of Action to Strengthen the Role of the Health System within a National Multisectoral Response to Address Interpersonal Violence, in Particular Against Women and Girls, and Against Children (WHA69.5) (8);
- the 2016 Strategy on Women's Health and Well-being in the WHO European Region (EUR/RC66/14) (9);
- the 2016 Action Plan for Sexual and Reproductive Health: Towards Achieving the 2030 Agenda for Sustainable Development in the WHO European Region – leaving no one behind (EUR/RC66/13) (10);
- the Strategy and Action Plan on Migration and Health in the WHO European Region (EUR/RC66/8) (11); and
- the United Nations Convention on the Rights of Persons with Disabilities, in particular Article 25 with its focus on health and its more inclusive definitions of disability (12).

The scoping review further contributes to the progress of reporting under these commitments to governing bodies.

This scoping review informs WHO input and engages in the development of the Convention on the Elimination of All Forms of Discrimination Against Women General recommendation No. 38 on trafficking in women and girls in the context of global migration (13), as well as providing guidance for implementing the commitments made to prevent, combat and eradicate trafficking in people in the context of international migration within the Global Compact on Safe, Orderly and Regular Migration (14). It will serve as a basis for further WHO technical guidance and for supporting WHO Member States in building capacity in this field.

1.3 Relevance of this scoping review for advancing the United Nations SDGs

The United Nations recommends that all States adopt legislation that addresses trafficking, including the provision of medical and psychological health services (5,13,15). The Convention on the Elimination of All Forms of Discrimination Against Women indicates that it is a human right to not be trafficked and mandates that States create the conditions under which women and girls can exercise that right (16). The United Nation's SDGs further articulate global ambitions to address human trafficking (Table 1).

Table 1. SDGs related to human trafficking

SDG	Target
3 (good health and well-being)	3.4 By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being
	3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
	3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education and the integration of reproductive health into national strategies and programmes
	3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
5 (gender equality)	5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation
8 (decent work and economic growth)	8.7 Take immediate and effective measures to eradicate forced labour, end modern slavery and human trafficking and secure the prohibition and elimination of the worst forms of child labour, including recruitment and use of child soldiers, and by 2025 to end child labour in all its forms
16 (peace, justice and strong institutions)	16.2 End abuse, exploitation, trafficking and all forms of violence against and torture of children

Working at the intersection of these important goals, WHO is committed to the implementation of gender equality, equity and rights-based approaches to health that enhance participation, build resilience and empower communities (17). As trafficking has increasingly been understood as a form of gender-based and economic violence, as well as a significant public health concern, health systems will need to address trafficking as a global health risk. Specific policy recommendations, including risk reduction and addressing the socioeconomic underpinnings of vulnerability to trafficking, are detailed below.

1.4 Methodology

This scoping review was undertaken to identify evidence available to answer the question “what can health systems do to prevent and respond to human trafficking?” This evidence is then used to support the policy considerations presented in the report. Global academic and grey literature published in English and Russian between January 2015 and August 2022 were reviewed for inclusion. As health-care-related research regarding human trafficking is fairly limited, the global search extended beyond the WHO European Region to include Canada and the United States, where research on human trafficking is more prevalent, in order to survey the widest range of research available. The vast majority of studies identified were conducted in the United Kingdom and United States.

The initial search yielded 16 823 articles. After removal of duplicates, 14 997 remained. A review of article titles and abstracts reduced this to 924. After a further review of the full texts, a final set of 237 documents were identified. Annex 1 provides more details on the methodology of the search strategy.

Of the 237 articles reviewed and included, 91 involved sex trafficking alone, while only three reported findings solely regarding labour trafficking. Another 143 involved both labour and sex trafficking or simply “human trafficking”. Approximately half of the included research addressed both adults and children, while children were the sole focus of many more studies than only adults. Studies conducted in the United States dominated the field, accounting for 190 articles, with the United Kingdom following with 28 articles. Six studies were conducted in Canada. There were only 19 evidence-informed studies conducted within or about WHO European Region Member States other than the United Kingdom since January 2015, 16 of which were published between 2020 and 2022. This lack of studies was the rationale for inclusion of studies conducted outside the Region (several studies examined overlapping regions.)

Although many men are affected by trafficking, particularly migrant men who are trafficked for labour, this scoping review largely describes evidence regarding the trafficking of women within national borders: not because men’s or migrants’ experiences are fewer or less important, but because there is not an adequate evidence base to ground policy and practice at this time. More research needs to be conducted regarding how health systems interact with those populations. Nonetheless, much of the evidence provided herein can inform the prevention strategies, identification protocols and clinical practices that health systems implement to care for trafficked patients of all genders.

It should be noted that this review included only research that specifically studied health systems responses to human trafficking. Research on asylum seekers, irregular migrants, sex workers, survivors of intimate partner violence, unaccompanied children and others who might be at risk of trafficking may be relevant here as well, but that research was not included if it did not directly address the research question. Annex 2 gives additional WHO resources that are relevant to trafficking.

It is also important to note that WHO solicited most case studies included in this scoping review directly from relevant nongovernmental organizations (NGOs). Groups working at the intersection of health care and human trafficking wrote about their first-hand experiences and those submissions are presented here with only light changes. As such, the contents of these case studies and the work of the relevant NGOs fall outside the scoping review's data collection methodology and analysis.

2. Findings

Thematic analysis revealed several identifiable trends that have dominated research in this field since 2015. The results are presented in three broad sections that reflect the guiding question of the review. Section 2.1 describes the findings of research that examines health-care needs of trafficked people and survivors, including those studies that examine the presentation of trafficked individuals in medical settings as well as those that explore the health consequences particular to trafficking. Section 2.2 outlines the research available on avenues for prevention of trafficking, which, although limited, provides insight into the SDHs that must be understood in pursuit of prevention, as well as promising practices for prevention. Section 2.3 discusses health-care responses to trafficking, including providing appropriate access to care; screening, identification and documentation of trafficking risk; standards of care and promising models of care; and capacity-building among the health workforce through medical education.

2.1 The role of the health system

KEY POINTS

- The WHO Global Plan of Action to Strengthen the Role of the Health System within a National Multisectoral Response to Address Interpersonal Violence, in Particular Against Women and Girls, and Against Children calls on Member States to create strong, multisectoral health systems capable of preventing and responding to human trafficking.
- Most trafficked people and survivors of human trafficking access health care during the period they are trafficked, primarily through emergency departments, but more than half are not identified as trafficked by HCPs.
- Women who are trafficked for commercial sex often access health care for sexual and reproductive services while they are being trafficked.
- Trafficked individuals typically present with psychological harm, including depression, PTSD or suicidal ideation, although comparative studies with other forms of trauma are lacking.
- The wide-ranging physical and psychological harms of trafficking mean that survivors often require a variety of physical and mental health-care services, including dentistry, sexual health care and counselling, following their experience.

Both the frequency with which patients access health care and the variety of health issues for which they seek care point to the need for a systemwide approach to trafficking that would increase opportunities for identification and assistance at every possible point of contact. Human trafficking has wide-ranging, well-documented negative effects on the lives and health of survivors and there is ample evidence showing that women and children

suffer significant health problems as a result of being trafficked. Survivors of all forms of human trafficking experience complex trauma, which can manifest in a variety of potentially overlapping symptoms, illnesses and disorders. Survivors of human trafficking – whether for sex or other forms of labour – often present with seemingly unrelated complaints and suffer from a wide range of harms and ailments that may not be immediately recognizable as related to trafficking.

The WHO Global Plan of Action to Strengthen the Role of the Health System within a National Multisectoral Response to Address Interpersonal Violence, in Particular Against Women and Girls, and Against Children is designed to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, particularly against women and girls (8). It identifies trafficking explicitly as a form of violence relevant to health systems. Every aspect of the health system can be mobilized to address human trafficking. WHO's framework to strengthen health systems explicitly articulated six building blocks for any functioning health system: service delivery, health workforce, health information systems, access to essential medicines, health financing, and leadership and governance.

The necessity to include a health-care perspective in combating trafficking in persons and smuggling of migrants is clearly stated in the United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children in Art. 6 para 3c on providing medical, psychological and material assistance to trafficked people, as well in the Protocol Against the Smuggling of Migrants by Land, Sea and Air on protection and assistance measures (Art. 16 para 2,3). This approach feeds into the United Nations Global Plan of Action to Combat Trafficking in Persons (18) and is also emphasized in the UNODC Global Report on Trafficking in Persons 2020 (2). The EU and the United States have also recently highlighted the issue of combating trafficking (the EU Strategy on Combatting Trafficking in Human Beings 2021–2025 and the United States Trafficking in Persons Report 2021).

Current research relevant to health systems' response to trafficking is primarily focused on understanding the epidemiology of trafficking and determining best practices for service delivery. This section synthesizes the research on how trafficked individuals and survivors engage with the health system and how they present in behavioural and health-care settings. There is little research addressing the other building blocks of the health system, such as outreach services.

2.1.1 Presentation in health-care settings

Studies show that as many as 90% of trafficking survivors report accessing health-care facilities during the period they were trafficked and shortly thereafter (19–26). Of 173 male and female survivors of labour and sex trafficking surveyed by Chisolm-Straker et al. (22), 68% recalled having been seen by a medical professional during their period of trafficking and 56% had been seen in emergency or urgent care settings. They had also been seen by gynaecologists, dentists and primary care physicians. HCPs failed to identify 56% of those trafficked patients. Trafficked people may primarily access health care through emergency rooms and urgent care facilities while they are being trafficked. After leaving trafficking situations, however, survivors

may access a much wider range of health services, including primary care, dentistry, sexual and reproductive health services, maternity care, mental health care and specialists, pointing to the necessity of training HCPs in all specialties and areas. Referrals to specialty services may come from emergency health departments, primary care or voluntary or compulsory psychiatric hospital admissions (20,27).

While individuals may suffer from a wide range of health issues while being trafficked, limitations on movement and interactions mean that individuals in trafficking often access health care for a much narrower set of health needs. Service availability may determine where a trafficked person chooses to seek services. Female sex trafficking survivors have indicated that their engagement with health systems was determined by the availability of testing for sexually transmitted infections (STIs) and HIV, sexual health education, reproductive health services, attention for unintended pregnancies, services for trauma (including rape, sexual and physical abuse and suicide attempts) and chronic disease management (21,28–32). Survivors who had been employed as domestic servants accessed health-care settings primarily for specific complaints related to physical injuries, as well as for respiratory illnesses (30).

2.1.2 Health consequences of trafficking

Research conducted since 2013 confirmed and expanded the body of evidence documenting the health consequences of human trafficking. Recognizing the complaints common to trafficked people is important because when a trafficked person presents to health care with a common chief complaint without any self-disclosure of trafficking victimization, this may lead to misdiagnosis and failure to screen for trafficking. This can result in treatment of the symptoms without a necessary referral to care specifically responsive to the trafficked individual's needs.

Recent research indicates that trafficked children and adults experience high levels of drug and alcohol abuse, increased presence of mental health disorders (including mood disorders, elevated reactions to stress, depression, complex PTSD, self-harm and suicidal ideation, anxiety, alterations in attention and consciousness, and hallucinations), behavioural disorders (oppositional behaviour, conduct disorders, affect dysregulation and compulsivity) and moderate to severe prevalence of physical health issues including headaches, digestive issues, STIs and sleep disorders (4,21,25,27,33–47).

Self-harm, including self-poisoning, attempted hanging and cutting or burning, was commonly observed among trafficking survivors who sought mental health services. In one study of 41 children trafficked by family members, more than half had attempted suicide and more than a third had been admitted to psychiatric hospitals subsequent to the trafficking experience (33,35,37,48).

A study of young people who have experienced CSE found 96.2% reported at least one potentially traumatic experience and 82.7% reported potentially traumatic experiences in more than one category (49,50). Another study found that 90% had had two or more

potentially traumatic experiences (51). A review of a clinic's medical records in the United States showed that 93.9% of trafficking survivors had screened positively for PTSD (52). Over 50% of asylum seekers in the United Kingdom were identified as trafficked, and 55% reported the trauma of sexual abuse or rape. More than 80% met the criteria for PTSD or complex PTSD (53). A retrospective study of asylum seekers in Israel found that those who experienced trafficking, torture or smuggling suffered from PTSD at more than twice the rate of those who did not have these experiences (54). First-person narratives of sex trafficking survivors list mental health issues, including PTSD, among the greatest barriers to recovery (55). One study found that PTSD levels in individuals trafficked for domestic servitude was similar to that of those experiencing sex trafficking and higher than those who experienced other forms of labour trafficking (56). Another found that the mental health-care needs of survivors of labour trafficking were at least as pressing as their physical health-care needs (57).

Analysis that employs comparative datasets is scarce, making it difficult to discern how specific these outcomes are to trafficked people and trafficking survivors compared with other high-risk groups. However, some comparative studies do point to statistically significantly elevated prevalence of some negative health sequelae among trafficked populations, including a significantly higher prevalence of depression, attention deficit hyperactivity disorder, bipolar disorder, PTSD, depression, anxiety conduct disorders, oppositional defiant disorder, avoidance symptoms and psychosis; a higher propensity towards engaging in risky behaviours, including sexualized behaviour during childhood and alcohol and substance use; and a higher likelihood of being compulsorily admitted as psychiatric inpatients and having longer admissions than non-trafficked adults (35,41,58–61). Notably, two studies found that child survivors of CSE did not experience significantly higher levels of PTSD or mental disorders following trafficking than young people experiencing other sexual abuse or assault (23,62).

While there is a dearth of evidence-informed research specific to health system responses in migrants who have been trafficked for commercial sex or labour, it is clear that migrants crossing the Mediterranean into Europe from north and west Africa are at particular risk of trafficking. A recent survey of 16 000 migrants revealed that 37% had personal experiences that indicated likely trafficking experiences. Very little evidence-informed research has focused on the health consequences specific to trafficked migrant labourers, although research on migrants in general suggests that they likely suffer from many of the same health consequences as trafficking survivors elsewhere in the world (including mental disorders, PTSD, physical injuries and sleep alterations). For survivors of trafficking who are also irregular migrants, negative mental health outcomes can be particularly significant. Research among one such sample in Canada indicated that, in addition to many of the above-mentioned health problems, irregular migrant trafficking survivors also experienced numbness of genital areas, self-mutilation, anger and mood changes, insomnia, nightmares and flashbacks associated with their trafficking and their tenuous status as migrants (63,64).

2.2 Prevention by the health system

KEY POINTS

- Prevention of human trafficking includes preventing trafficking from occurring, preventing the negative impacts of trafficking and preventing re-trafficking.
- Health system approaches to trafficking prevention should be rights based, trauma informed and survivor centred, and should focus on both building resilience and mitigating risks to patients.
- The approach to trafficking prevention in the WHO European Region should follow the guidelines set by the WHO Commission on Social Determinants of Health and address the underlying societal risk factors for trafficking, including abuse, economic vulnerability, gender inequalities and the profitability of the sex trade and forced labour.
- Researchers have identified numerous individual-level SDHs correlated with human trafficking, including ACEs, mental illness, substance abuse, poverty and sexual assault, although there is insufficient evidence to determine the SDHs for men, individuals trafficked for labour or migrants.
- Harm-reduction strategies can ensue from policy and public health measures that reduce avenues into trafficking, particularly surrounding the sex trade, and at the individual level through the mitigation of opioid abuse, STIs and other risk factors.

WHO is committed to the prevention of violence in all its forms and violence against women in particular. WHO's RESPECT women framework for preventing violence against women identifies 10 integral steps in implementing effective prevention efforts (65). At the foundation of such efforts must be the identification of a range of risk factors (including discriminatory laws, harmful gender norms, gender inequality and childhood exposure to violence) and a diverse range of protective factors (including laws that promote gender equality, norms that support non-violence, equitable household responsibilities and a home free of violence). These prevention efforts should concentrate on alleviating risk at the individual, family, community and society levels (65). Schools, community health programmes, empowerment programmes, and sexual health and sexuality education all play a role in prevention.

Prevention efforts focus on building resilience and mitigating risk in order to reduce the likelihood that at-risk people will be harmed. A socioecological model of trafficking takes into account the varied risk and resilience factors of trafficking and, therefore, informs prevention efforts at the societal, community, relationship and individual levels. These risks may include not only individual and familial vulnerabilities but also societal factors such as gender inequalities, normalization of exploitation/objectification of women, patriarchal attitudes/male privilege, profitability of sex trade/forced labour and corruption.

Prevention efforts may focus on primary prevention – the prevention of trafficking from occurring in the first place – and/or secondary and tertiary prevention, which reduce the

negative impacts from trafficking and prevent re-trafficking, respectively. This means shifting emphasis away from a reactive stance that relies on identifying and responding to trafficked people and punitive approaches to perpetrators, and towards a proactive approach that focuses on addressing the root causes of these rights violations and providing empowering interventions (66). A global study found that countries which made the most progress on human trafficking were less likely to punish survivors (67). This review repeatedly identified articles that underlined the necessity of health systems taking a rights-based, trauma-informed and survivor-centred preventive approach to trafficking. That attention to prevention means identifying and addressing the root causes of trafficking for men, women and children. Research findings regarding the SDHs, risk factors and ACEs all help to shape a portrait of the aspects of social and economic marginalization that health systems can address to encourage impactful prevention. However, only 10 articles focused exclusively or primarily on prevention, indicating a significant lack of evidence to support the generalized ambition to address prevention within the literature or in best practices.

The research identified by this review suggested two preliminary threads that might be useful for considering future directions for prevention within health systems: SDHs (section 2.2.1) and harm reduction (section 2.2.2).

2.2.1 SDHs for trafficked individuals and survivors

In most parts of the world, the primary response to trafficking has come from legislative and law enforcement arenas. However, it is clear that trafficking has significant health consequences and that a proactive public health approach, framed by consideration of the SDHs and preventive medicine, is necessary for health systems to adequately address the needs of people who have been trafficked and those at risk of trafficking. The WHO Commission on Social Determinants of Health supports Member States in adopting an SDH approach and in building capacity to reduce health-care inequalities. Many health systems are currently engaging in addressing SDHs but may not be evaluating this approach's impact on populations at risk for trafficking.

Recent research provides evidence of contextual factors that may make a child or young person vulnerable to traffickers. Those factors include child abuse, domestic violence, neglect or maltreatment, running away, substance abuse, difficulty in school, mental illness, low self-esteem, familial conflict, custody battles and negative behaviour modelling (44,46,68,69). Other push factors include poverty and lack of economic opportunity. Trafficked young people disproportionately have a history of foster care or child protective services involvement, juvenile justice involvement, residential treatment, sexual abuse, histories of prior violence, mental health issues and homelessness (36,42–45,70).

Research indicates that trafficked women are highly likely to have had previous experiences of sexual assault, rape, neglect, and physical or emotional abuse, and may have relatively high numbers of sexual partners in their youth (46,59,71,72). Anti-trafficking efforts within health systems should include prevention strategies that proactively reduce the potential harms that these vulnerabilities cause.

Researchers have recently begun to investigate the relationship between ACEs and trafficking. Research suggests that trafficked young people have higher rates for each ACE category surveyed, but in particularly higher rates of sexual abuse and a higher total number of ACEs. Some evidence suggests that children who are trafficked by family members may experience these ACEs with more severity (35,73,74).

No recent research of trafficking response within the health system identified in this review provides a strong evidence base for understanding the risk factors and SDHs for boys or men who are sex trafficked, for those trafficked for labour or for migrants. There is also an unfortunate lack of research illuminating how race or ethnicity may affect vulnerability to trafficking. This is likely because studies tend to sample from particular demographics in which all members share a particular vulnerability to trafficking (such as homeless young people or children in child protective custody) or from only one particular venue (where the demographics may be controlled by selection bias of the service provider). Anecdotally, however, most researchers suspect that race and ethnicity are likely to play a significant role in vulnerability to trafficking because trafficking affects those most vulnerable in society and vulnerability often falls along racial and ethnic lines.

The scoping review largely addresses the ongoing role of health systems in preventing and responding to human trafficking. However, quickly emerging disruptions, both human generated and natural, can alter the status quo and present new and immediate challenges (Box 1).

Box 1. Disasters, war, pandemics and trafficking

There is very little evidence-informed scholarship on the effects of disruptions, such as war, pandemics and natural disasters, on trafficking. At least one study supports the hypothesis that deleterious changes in economic opportunity and income, government support, familial connectedness, other social supports, governance and rule of law may render people from affected countries vulnerable to trafficking (75). Disasters and disruptions can lead to increased migration and displacement, which increases the risk of trafficking. Legal cases against traffickers who have exploited disaster suggest an increase of trafficking likely occurs in the wake of such disruptions. A rapid assessment of violence against women and children in the context of COVID-19 from the WHO Regional Office for Europe begins to address the need for data (76). Significantly more research is needed to investigate these connections more rigorously and to ensure that policies reflect the vulnerability of people in precarious situations in times of disaster and pandemic.

2.2.2 Harm-reduction strategies

Harm reduction is an effective public health approach that is focused on reducing the negative consequences of a phenomenon rather than its complete cessation. While harm reduction may at first seem counterintuitive, it aligns with behavioural change models and reduces morbidity and mortality. For example, among people who use intravenous drugs, the harm of acquiring infectious diseases via injections can be reduced by provision of clean needles. For those with opioid use disorders, treatment with buprenorphine/naloxone, rather than requiring complete abstinence, prevents relapse and death. In the realm of sex trafficking, there are many ways that health systems can employ a harm-reduction approach to promote the prevention of trafficking and of harms (such as STIs) that can result from trafficking (77).

Harm reduction may be incorporated at the policy level. In countries where commercial sex is prohibited by law, some public health researchers have argued that medical professionals should promote alternatives to the full criminalization of sex work. These researchers present evidence suggesting that people who trade sex are at risk of a wide variety of harms, including trafficking, but also murder, rape, physical assault, robbery and STIs (particularly for people from marginalized groups or those who trade sex outdoors rather than indoors). In places where commercial sex is criminalized, sex workers cannot report violence against them and they are at increased risk of being trafficked. Some researchers conclude on ethical grounds that the mandates of beneficence, nonmaleficence and autonomy that underpin medical ethics should lead physicians to oppose the criminalization of sex work, including the purchase of sex. Still, there remains some debate as to what policy alternatives would most reduce the risk of trafficking among those who engage in the sex trade. Some researchers recommend the Nordic model (which criminalizes the purchase of sex but not the sale of sex and has been adopted in France, Iceland, Ireland, Israel, Northern Ireland (United Kingdom), Norway and Sweden); others recommend full decriminalization, which would provide workers' rights protections, limiting exploitation and violence. In the countries that criminalize sex work, this is an intensely debated topic, the results of which have significant consequences for a harm-reduction approach (78–80). A prevention programme in the United States seeks to alter the behaviours and attitudes of young women who are deemed to be at disproportionate risk for CSE or trafficking (Case study 1).

•• Case study 1. United States prevention programme My Life My Choice •••••

Although programmes specifically focused on prevention of trafficking of particular vulnerable populations do exist, very few have been rigorously evaluated for inclusion in published research. My Life My Choice (MLMC), a prevention programme from the United States, is an exception. MLMC seeks to alter the behaviours and attitudes of young women who are deemed to be at disproportionate risk for CSE or trafficking. Designed by a survivor of sex trafficking and a public health professional, MLMC is a 10-session programme designed to train young women to avoid recruitment into the sex trade. In addition to building knowledge about the mechanisms of sex trafficking,

the curriculum focuses primarily on self-esteem, resilience, safety planning and behaviour change. External researchers evaluated the programme and found that participating young people were, compared with a baseline collected at the outset of the study, less likely to have engaged in behaviours that the researchers termed sexually explicit (that is, nude modelling, stripping and other sexual activities without contact), and less likely to have experienced dating violence or to have engaged in commercial sex. They also exhibited increased knowledge of sexual exploitation and were likely to have shared that knowledge with other young people. This is one of the few current prevention programmes that has been evaluated for effectiveness with results published in peer-reviewed journals; the researchers on the project still indicate further research with larger sample sizes and more longitudinal data would increase our understanding of the programme's long-term and practical efficacy, as well as its generalizability for other contexts (78,81,82).

Studies suggest that harm-reduction strategies among women engaged in the sex trade could be an important avenue for health system engagement with people at risk of trafficking, as well as for currently trafficked people. Many trafficked women report having been either coerced or physically forced to forgo contraceptive use in situations of trafficking and sexual assault. Hormonal forms of contraception are often preferred because they are invisible to clients and also discontinue menstrual cycles, but those forms of contraception do not provide any protection from STIs. While sex-trafficked people may have learned about sexual health, contraceptive use and STI prevention through HCPs and school education programmes, significant misinformation about the reliability and function of contraception remains, as do concerns about how to reduce a spectrum of potential harms in children and adults engaged in the sex trade, whether voluntarily or through force. This suggests that sexual health outreach among people engaged in sex work could be an avenue for harm-reduction interventions that could also lead to trafficking prevention (25,80,83) (see Case study 4 in section 2.3.1 on a mobile outreach initiative).

Although the very small sample sizes in these studies are not a representative sample of sex-trafficked individuals, the studies point to systemic adoption of harm-reduction strategies as a promising practice. Systemwide medical guidelines and evaluations could be created to address this consideration. Research on the efficacy of harm-reduction strategies for prevention of trafficking and prevention of harms resulting from trafficking is still in its infancy and requires significantly more investment.

2.3 Responses of the health system

- The WHO Global Plan of Action to Strengthen the Role of the Health System within a National Multisectoral Response to Address Interpersonal Violence, in Particular Against Women and Girls, and Against Children and its related Strategy and Action Plan on Migration and Health in the WHO European Region recommend that each Member State develop a nationwide plan for its health system to respond to human trafficking.
- Research shows that systems with trafficking-specific policies provide better care, yet most health systems and HCP associations either have no trafficking-specific policy or HCPs have not been sufficiently trained to implement them.

Access to care

- Research repeatedly suggests that the primary individual-level barriers to health-care access for trafficked individuals include a sense of disenfranchisement; shame; distrust in the health system; lack of health insurance or identification documents; and ignorance of their rights and entitlements.
- The primary structural barriers to health-care access for trafficked individuals include understaffing and underfinancing, insufficient resources for specialty services and HCPs' lack of knowledge about how to identify or treat trafficked individuals.
- Racial, ethnic and sexual minorities, as well as migrants, might have more difficulty accessing trafficking-specific health care. Advocates recommend a “no wrong door” policy that initiates anti-trafficking procedures in a wide variety of health-care settings to address these inequities.

Identification

- WHO recommends ethical interviewing guidelines rather than universal screening of all patients. WHO, experts and researchers suggest prioritizing appropriate care above disclosure.
- Research supports the use of validated screening tools created for various populations and trafficking types to improve identification, although most health systems have yet to implement these.

Training, care and competencies

- Research suggests that HCPs should adopt trauma-informed, survivor-centred approaches to the treatment of trafficking survivors. Challenges to providing this care include patients' legal and social instability, their inability or refusal to provide accurate histories, and mental health funding priorities that exclude trafficking survivors.
- Nearly all HCPs recognize the need for training on how to identify and treat trafficked individuals; most report that they have never received training and, therefore, are not confident in their ability to provide quality care. Both in-person

and online training about trafficking has been shown repeatedly to increase HCPs' self-perceived confidence and knowledge immediately following the training, although the limited longitudinal studies failed to find any long-term impact.

- The United States National Human Trafficking Training and Technical Assistance Center and a conference of anti-trafficking experts both suggested training HCPs in a number of overlapping core competencies that focus on the ability to ethically identify, assess and treat trafficking survivors within a framework of trauma-informed care that respects patient autonomy.

Documentation and reporting

- While WHO does not recommend mandatory reporting laws for child maltreatment, 42 Member States in the WHO European Region have implemented these, and WHO suggests HCPs follow local regulations.
- United States diagnostic codes for human trafficking have provided insight into health conditions, indicators and treatments for trafficked individuals, and similar systems might prove beneficial if implemented by Member States of the WHO European Region.

The WHO Global Plan of Action to Strengthen the Role of the Health System within a National Multisectoral Response to Address Interpersonal Violence, in Particular Against Women and Girls, and Against Children contained a commitment to strengthening health service delivery and health workers capacity to respond to trafficking (among other forms of violence) (8). It recommended that all Member States adopt a national protocol that specifies their health system response to survivors (8). Current research can help to inform Member States in the development of such national protocols. Section 2.3 is organized around important aspects of trafficking responses that could be integrated into those protocols, including access to care, identification of trafficked individuals, standards of care, behavioural health interventions and the capacity of health workforce.

The IOM's *Caring for Trafficked Persons: Guidance for Health Providers* reminds HCPs that, while individuals who have been trafficked can often be treated using standard clinical practices, they are often in circumstances that alienate them from services, and that when they do engage with health care, it may be a challenge to serve their needs and sustain long-term care. HCPs may modify intervention strategies that they employ with other difficult-to-reach or marginalized populations such as refugees, migrants and irregular labourers. IOM's guidance recommends that HCPs use trauma-informed, culturally appropriate individualized care, in line with much of the current research described below (6). Many health-care organizations currently have no trafficking policy or position statements, including 96 of 104 examined nursing associations in the United States (84).

As HCPs and health-care researchers become increasingly aware of human trafficking as

a public health issue, descriptions of and recommendations for interventions proliferate. However, there is practically no rigorous published research that evaluates the efficacy of these interventions. For example, residential programmes for survivors of human trafficking have been evaluated by independent researchers, but those reports typically remain in-house and very few of the findings have been published. As a result, little is known about the best practices associated with these resource-intensive programmes, which makes it difficult to understand any implications for a health system response to trafficking.

This section outlines some of the promising practices being developed based on evidence of need, programme evaluation or research that elicited survivor recommendations, in an effort to delineate potential evidence-supported avenues for health systems intervention. A robust research agenda would necessarily include increased attention to evaluating these interventions.

2.3.1 Access to care

Although researchers have identified individuals seeking the support of health-care institutions during and following their trafficking, there are significant barriers to trafficking survivors' engagement with the health system. Personal barriers include restrictions placed on survivors by traffickers (20,71,85), fear of traffickers and others discovering survivors who seek help (44), language barriers (20), lack of transportation (44,85), not self-identifying as trafficked (28), lack of trust in health-care institutions (33,43,86) and psychosocial impairments brought on by trauma (33). Trafficking survivors also report seeking medical care only in emergencies (85), fear of stigma and shame (28,87) and reluctance to be vulnerable with HCPs (43,44,88) or to engage in certain therapies or treatments (86,89).

Research indicating that survivors often lack access to services because of a sense of disenfranchisement from the health system is critical to a health system analysis of barriers. Some survivors report a sense that health systems prioritize profit over patients, which can be a particular barrier for migrant survivors even in countries with socialized medicine for citizens. They are sometimes thwarted from accessing care by a lack of necessary legal documentation, health insurance, understanding of their health-care entitlements or awareness of health-care facilities available to them. Trafficked people may also experience high barriers to enrolling for care, find no continuity of care, have had bad prior experiences with mental health services, distrust HCPs, encounter stressed, exhausted or uninterested HCPs and lack opportunities for informed and shared decision-making (20,28,33,34,42,44,71,85,89–95). A survey of survivors of child sex trafficking identified 18 consequential barriers to care organized around skills (e.g. "knowing how to make the health-care system work"), expectations (e.g. "doctors treating the symptom without finding out the cause of the illness"), marginalization (e.g. "being judged on your appearance, your ancestry or your accent") and pragmatism (e.g. "having to wait too many days for an appointment") (86). Furthermore, lack of knowledge of patient rights and entitlements among HCPs and health system administrators can exacerbate survivors' disenfranchisement (90,96,97).

HCPs list similar structural issues as barriers to survivors' health-care access. Common barriers cited include insufficient funding and staffing, a lack of organizational policy on human trafficking, health insurance limitations, insufficient resources to provide specialty services or continuity of care, lack of awareness of or belief in trafficking in their region, and an inability to identify trafficked patients in order to provide treatment, particularly for those trafficked from other States or countries. Many HCPs also cite their own lack of knowledge about both human trafficking in general and best practices for identification and treatment (96–99).

Research also suggests that there are significant inequities in access to health care among trafficking survivors. Black survivors of human trafficking may perceive white women as receiving preferential treatment in the provision of trafficking-related services, including those associated with mental health care and substance use disorder treatment. No trafficking-specific organizations in the United States midwest indicated whether they employed any advocates or therapists who specialize in services for lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual people (LGBTIQ+) (100). One experimental study found that psychology students were more willing to help female and foreign-born survivors and less likely to identify labour trafficking (101). Undocumented individuals also find it more difficult to access services, partly because of fear of being reported to law enforcement and partly because of a lack of connection to health services outside their home country. An NGO in Greece specifically provides services for those affected by gender-based violence (Case study 2).

•• **Case study 2. Greek Diotima Centre for Gender Rights and Equality** •••••

The Diotima Centre for Gender Rights and Equality is an NGO promoting gender equality and rights for survivors of gender-based violence, human trafficking and migrants, among others. It is engaged in research, advocacy, training and skills development, psychosocial counselling, legal aid and support services. The organization is based in Athens, Greece, and has local offices in Lesbos and Thessaloniki; it has special expertise in gender-based violence and works with all people over the age of 16 years, including members of LGBTIQ+ communities.

When you do not know the language and you don't have a supportive environment around you... It's extremely difficult.

Georgia Hatziioannidou, Diotima Centre for Gender Rights and Equality, Athens

Most survivors of human trafficking who are supported by Diotima – who have reached out directly or are referred from other organizations and/or public agencies – are young women from African countries, including Cameroon, the Democratic Republic of Congo and Sierra Leone. Most have been subject to sexual exploitation and their health concerns are often compounded; some are living with HIV/AIDS and/or have undergone female genital mutilation. Where survivors come without documentation or are not registered in Greece (so without papers), accessing the health system and associated support services becomes extremely difficult. This remains a key challenge for access to and fulfilment of fundamental human rights in this context.

It is often difficult or at least demanding for us and for beneficiaries to build a connection, a trust relationship...it is very important for us to find a way to continue, keep having a contact, have the contact with our beneficiaries or the people who are in urgent need to receive support.

Georgia Hatzioannidou, Diotima Centre for Gender Rights and Equality, Athens

The COVID-19 pandemic and associated lockdowns have placed particular strain on service provision. Face-to-face sessions had to be suspended and it was difficult to establish the relationships and trust needed to support people in an integrated and personalized way. In some instances where survivors were homeless or in accommodation without privacy, finding ways to make contact required more innovative approaches, including through telephone, online chat, social media and contact with other NGOs.

Access itself is a particular impediment to receiving services; there are many environments where access to mental health services is limited only to those with the most significant mental health issues, or to those with the ability to pay – whether this limit occurs through regulations, policies, discrimination or practice. Health systems that facilitate access and provide structures for continuity of care ensure that medical services are accessible and sufficient to address the unmet needs of survivors of trafficking. Research indicates that HCPs find it challenging to provide survivors of trafficking with adequate care when service thresholds are high and medical facilities are required to act as gatekeepers for services (particularly for migrants) (44,102). Online health-care access has the potential to lower those thresholds, allowing trafficked people to bypass many of the barriers to in-person care, particularly when smartphones and data allowances are provided (103). Tele-health has the potential to increase both identification of trafficking and treatments, although HCPs have concerns about its privacy and reliability (104,105).

Migrants who cross borders for work, education or other opportunities may be at high risk of being forced into labour or sex work, depending on their individual circumstances and support systems during migration. Women are particularly vulnerable to sexual exploitation and often find it difficult to access services due to migration and legal status in their countries of domicile (33). The Danish Foreign Ministry helped to create a health-care clinic for migrants in collaboration with the NGO AmiAmi (Case study 3) upon finding that 4.1% of all migrants had been trafficked, overwhelmingly for commercial sex (106). Emergency medical care at sites of transit and destination, at borders and in immigration detention facilities have played a crucial role in identifying individuals who have been trafficked, providing survivors and those at risk with medical services and information regarding their rights, and referring those individuals to further services and entitlements (63,107–109). Interviews with HCPs across the WHO European Region, however, point to the uneven availability of health care at different sites of transit and indicate that migrants might avoid available health care because they consider it a national resource to which they do not have access or because they fear being reported to immigration authorities (110). No published research to date evaluates emergency health-care programmes meant to address trafficked migrants' needs.

Case study 3. Danish NGO AmiAmi, improving access to services

In my experience, they don't know much about Denmark... They don't know how to get to the hospital or how the police work... We tell them about how things work.

Jette Velsø Mæng, AmiAmi, Fredericia

For AmiAmi, the mission is to improve the conditions for survivors of human trafficking and migrant sex workers. In collaboration with the Danish Centre against Human Trafficking, it is part of a nationwide effort to combat trafficking under Denmark's National Action Plan, its role being to seek out and support trafficked people through the provision of health and social services.

AmiAmi is primarily an outreach organization, connecting through text messaging and by visiting the many locations where trafficked people may be living and working. Nurses, midwives and social workers provide multilingual information and contact details and offer health checks and testing, either on the spot or by facilitating transport to a health centre as required. The safety, protection and voluntary informed consent of survivors and migrant sex workers is prioritized. Through its mobile network or in its part-time clinic staffed by female volunteer doctors, AmiAmi provides general check-ups, anonymous testing, condoms, vaccinations against hepatitis A and B and filling of prescriptions, as well as sexual health and family planning advice and referrals for abortion. During the COVID-19 pandemic, AmiAmi similarly provided information about testing and vaccination in coordination with other NGOs.

When trafficked people are identified by Danish authorities, they are fully supported with a package of rights and services under the National Action Plan, not only for health care, accommodation, social and juridical support, but also in the form of repatriation support, where survivors are supported if they want to return to their home countries, and throughout the reintegration period that ensues. AmiAmi contributes when possible by close collaboration with organizations across international borders to ensure continuity of care where possible.

I've known her for two years... I helped her with condoms, testing, talking... and one day she sent me an SMS – 'now I'm wanting to tell my story'. So, it takes time.

Jette Velsø Mæng, AmiAmi, Fredericia

The work of AmiAmi is principally focused on building trust and developing relationships, sometimes over very long periods of time. This is critical to enable survivors to seek help, to self-identify and to take steps to improve their situation in ways that are empowering to them. Building trust in this way is also a central part of prevention work, insofar as trafficked people can then tell their stories, support and refer others, and improve confidence to seek support in other areas of their lives.

We meet with police, tax authorities, health personnel, social workers and the Danish Centre against Human Trafficking.... Working across professional groups is so important. We can't do it by ourselves... it is not possible.

Jette Velsø Mæng, AmiAmi, Fredericia

Prevention and awareness raising are also key pillars of AmiAmi's work; for example, conducting training for other health-care professions, including emergency, infectious disease and gynaecology specialists, to improve recognition of the indicators of trafficking. The Danish Centre against Human Trafficking provides training for police, social workers and lawyers among others, ensuring a whole-of-society approach.

AmiAmi also contributes through the media in order to promote awareness and dialogue at the community level on the risks and signs of trafficking. This will require a sustained effort to continue to empower and educate.

Preliminary research also suggests that trafficked people may not adequately access follow-up care, such as receiving test results or additional treatments, as a result of being trafficked (25,107). Furthermore, trafficked people and trafficking survivors are often forced to move repeatedly, both during their experiences of trafficking and later, through relocation programmes intended to assist them or because of their own desire to relocate. This seems to be the case even for mothers who require maternal health care during and after pregnancy (71,90). Continuity of care can be a challenge, and several health systems may encounter the same survivor at times of differing need.

Advocates recognize that barriers to services can impair efforts to provide trafficking survivors with adequate care. They recommend that health systems operate under a “no wrong door” policy, which acknowledges that trafficking survivors may seek assistance in a wide variety of health-care settings. Health system policies and protocols are proven to significantly influence the accessibility of health-care provision for trafficking survivors. Low barriers to hospital admissions and access to primary care physicians, continuity of staffing, adequate translation services, attentive staff and explicit policies regarding confidentiality and reporting, all encourage disclosures and facilitate access to and continuity of care. Flexible hours of operation, extended appointment times, nonpunitive approaches to missed appointments, integrated and interdisciplinary co-location of services, intensive case management and streamlined referrals have all been found to facilitate better care for trafficking survivors (33,85,98). Case study 4 described a mobile outreach initiative in Denmark that combines provision of health care with support to prevent trafficking.

Case study 4. Danish Centre Against Human Trafficking mobile outreach: combining prevention and response to improve access to health care

The Danish Centre against Human Trafficking collaborates with Aarhus University Hospital to run a health service that provides outreach and health care to migrant women who trade sex in a remote region of Denmark. Qualified midwives and nurses travel to locations where women often trade sex to provide healthy sexuality resources, contraceptives, pregnancy advice and STI tests. They provide referrals for other medical

services and social workers as needed. Through these harm-reduction practices, the nurses build rapport and trust with the women they serve. They are able to use these visits as an opportunity to identify women who might be being exploited, coerced or forced to engage in the sex trade. The programme has significantly improved health-care access for vulnerable migrant women, decreased the risks of their engagement in the sex trade and of being trafficked, and increased the likelihood that trafficking survivors can be identified. Furthermore, social work referrals provide trafficked people with information regarding their rights as victims and the opportunities available to them. The programme is a model in intersectoral collaboration, with health services at the forefront of engaging and assisting trafficked individuals as well as those at risk of trafficking.

2.3.2 Identification

One primary focus of recent trafficking research is the development, validation and implementation of screening tools used to identify trafficked people and trafficking survivors – particularly girls trafficked for sex – in health care and other settings. WHO does not recommend that universal screening for abuse be implemented for all patients. Instead, HCPs should enquire about exposure to abuse within contexts that indicate that the patient’s problems may be caused by or exacerbated by abuse (111). WHO guidelines for ethically interviewing women who have been trafficked identifies the negative consequences that can result from untrained service providers enquiring about trafficking experiences, including retraumatization, extreme stress reactions, fear of (or actual) refusal of services and retaliation by abusers and even employers. For this reason, WHO has provided 10 guiding principles for interviewing trafficked women that are applicable in all health-care settings and with all patients who have been trafficked (112).

Integrating standardized screening tools for use *when risk is identified* is widely recommended within the research published since 2015. An increasing number of tools have been validated and evaluated in recent years (Table 2) (113–121).

Table 2. Screening tools

Tool	Developer	Population	Sex or labour trafficking	Validation
Trafficking Victim Identification Tool (113)	Vera Institute of Justice	Adults	Both	Validated
Human Trafficking Screening Tool (114)	Urban Institute	Children and young people (primarily in child welfare settings and homeless service settings)	Both	Validated
Short Screen for Child Sex Trafficking (115–117)	Greenbaum et al. (117)	Children in health-care settings, including paediatric emergency department	Sex	Validated
Rapid Appraisal for Trafficking (118)	Chisolm-Straker et al. (118)	Adults attending emergency department	Both	Validated
Commercial Sexual Exploitation-Identification Tool (120)	West Coast Children's Clinic	Children	Sex	Validated
Sex Trafficking Assessment Review (121)	Superior Court of the District of Columbia	Juvenile arrestees	Sex (risk assessment only)	Not yet externally validated

Note: the tools listed in this table are not the only ones available, but they are the ones that have been studied, tested or validated in health-care-relevant settings and subsequently published since 2015.

Without a screening tool, many trafficked individuals might not be identified because of factors such as the short length of most medical encounters, the discontinuity of care, lack of a safe disclosure environment and the tendency of some HCPs to conflate sex work with sex trafficking (122–124). Standardized screening surveys have greater sensitivity than physicians guided by their own concern and/or knowledge or through applying standard psychosocial tools as a proxy screen for trafficking (113,114). Use of one validated tool reportedly raised the rate that children screened positive for sex trafficking from 1.3% to 11.3% (125). Even a tool that has not undergone the more rigorous validation testing has been shown to increase HCP awareness and the amount of information other health-care workers share with physicians (126). Survivor interviews and reviews of case narratives show that standardized screening tools are more likely to coincide with the actual experiences of survivors (127–129).

Researchers have promoted screening methods that have as few as one question and as many as 13, with a four-question tool matching the sensitivity of longer questionnaires; HCPs anecdotally reported that longer tools were too time consuming. Most research studies have recommended limiting the number of standardized screening questions in order to avoid straining the client or discouraging disclosure (113,119,130–132). At least two of these tools have been successfully used in Spanish, in both Spain and the United States, following translation and

culturally appropriate modifications, and at least one has been successfully administered on an electronic tablet (133–135). Research indicates that individuals often experience both labour and sex trafficking and, therefore, HCPs should be trained to screen at-risk patients for both (114).

Many of the recently validated screening tools are designed to screen only children and young people, and often only for sex trafficking. Because of the diverse range of forms of trafficking, as well as the diverse experiences of those who experience trafficking, screening tools based on particular demographics or on perceptions of trafficked people's characteristics may reduce capacity to screen for diverse survivors (39). A content analysis of 13 screening tools, including the five validated tools in Table 2, determined that no one test covered all five dominant themes included in the tools overall: CSE, risk factors, forms of abuse, mental and physical health assessment, and unstable living conditions and caregiving (136).

Most health systems have not adopted screening for trafficking as part of their routine intake or care procedures. While researchers and HCPs largely believe that benefits significantly outweigh costs, implementation of a screening tool can be complicated and can require project management, clear responsibilities, a communication plan, budgeting and ongoing analysis (137). Studies on the prevalence of screening indicated that significantly fewer than half of health-care institutions surveyed had been screening patients for trafficking and where they were, they were only rarely having success in identifying survivors. While four in five federally qualified health-care facilities in the United States surveyed had screening policies for child maltreatment and sexual violence, only two in five had screening policies for human trafficking (138). Under a third of the surveyed HCPs said that their facility had a screening policy, and another third did not know if it did (139). Furthermore, survivors indicate that they do not recall being screened by an HCP during or after trafficking, even in cases in which researchers believe that they may have been screened (22,30,72,91,140). This disconnect could reveal a need for increased validating of screening tools and the implementation of standardized systemwide screenings. Furthermore, research needs to be conducted regarding survivors who are overlooked despite screening tools.

Despite a growing discourse on trafficking screening across health systems, the published studies indicate that disclosure cannot be the primary goal of screening within health systems. Enquiry concerning forms of interpersonal violence, including trafficking, is fundamentally different from screening for medical issues. Rather than disclosure, the goal of enquiry is to provide a safe environment in which patients feel empowered to share as much or as little as they choose and in which strengths and resilience are recognized. The context around which questions are asked, particularly for issues where a patient may feel emotionally and physically unsafe (due to shame, judgement, threats of deportation and so on) modulate how much a patient may feel comfortable disclosing at a given point in time.

Appropriate care for the patient, as well as education and empowerment, should be the HCP's key concerns. Survivors of trafficking may be reluctant to disclose their experiences of trafficking, even when they do seek medical care, for a number of reasons, including for fear of their traffickers as people; fear of the potential legal consequences they may face for engaging in such illicit industries (such as the sex or drug trades); lack of trust of HCPs to maintain confidentiality, to believe their reports of abuse or to treat their experiences in illicit industries with sensitivity and

respect; and a belief that follow-up on the part of HCPs will not occur (34,71,141). While many survivors find comfort in sharing their experiences with HCPs, mental health professionals or therapeutic group members, studies have consistently shown that many trafficking survivors (and young people in particular) are reticent to disclose trafficking experiences for fear that this may lead to negative consequences, including law enforcement involvement, loss of services, increased stigma, unwanted mental health interventions, experiences of judgement, and shame in both one-on-one interactions with health and mental health professionals and in group sessions with other survivors of trauma and retraumatization (32,114,141). The desire of some survivors to forget their experiences can be enough to keep them from disclosing their trafficking experience at all, or from engaging in the traumatic interpersonal exchanges that characterize many health-care settings. It is clear that survivors do not disclose their trafficking experiences for a wide variety of reasons; therefore, it is important that HCPs view screening merely as one of many tools employed when working with at-risk patients. It is also important to note that, while some survivors will not disclose, research suggests that most want HCPs to enquire. Most survivors want enquiries made with privacy, confidentiality, lack of judgement and in a stress-free environment, while young people may prefer medical rather than social service professionals and female patients may prefer female HCPs (142–143). This is well illustrated by the work of AmiAmi described in Case study 3 above.

2.3.3 Standards of care

As the mental health consequences of trafficking discussed above have become more apparent, trauma and trauma responses have been placed at the centre of standards of care for trafficked people and trafficking survivors. It is now common for trafficking intervention programmes, training and protocols to recommend trauma-informed care approaches for human trafficking survivors (144). Research reflects this trend, with numerous studies employing the term, although few define it with rigour.

It is critical to understand how a health system can integrate a trauma-informed approach in explicit and deliberate ways in order to inform policy and protocols. Macias-Konstantopoulos centred trauma-informed care around promotion of the bioethical principles of respect for autonomy, nonmaleficence, beneficence and justice (145). These concepts suggest that health systems should adopt ethical guidelines that recognize the agency of survivors when making informed decisions for their own health. They require that HCPs not only do no harm but also actively seek opportunities to remove and reduce harms patients might encounter. Their recommendations to survivors should be guided by a sense of the survivor's economic and social realities and the traumatic circumstances that may prevent survivors from accessing regular care or taking preventive measures themselves (144,145).

Few evaluations of trauma-informed, survivor-centred approaches within health-care settings have been performed to date. Furthermore, there are significant debates within the field as to how much agency can be ascribed to survivors who are severely traumatized and/or minors. However, some preliminary research supports the promotion of trauma-informed, survivor-centred approaches within health system standards of care. Young people who had experienced CSE and who took part in a health programme that incorporated trauma-informed health care had better

results and spent more time in the programme receiving care than those who chose options that did not use a trauma-informed approach (146). One study found that trauma-focused narrative exposure therapy reduced survivors' PTSD, depression and anxiety symptoms compared with those on the programme's waiting list (147). Other studies have suggested that young female survivors may be most likely to engage in services or accept health care when it is guided by a trauma-informed, survivor-centred approach focused on providing information necessary to make good choices, clearly delineating treatment goals, emphasizing constructive forms of coping and providing harm-reduction strategies (42,148–151). These practices facilitated rapport building and increased positive outcomes for patients. Shared decision-making provides survivors with the opportunity to make informed, age-appropriate decisions regarding their care, with knowledge of both risks and benefits, in an effort to counteract the restriction of agency that trafficking inflicts and to avoid retraumatization.

Significant research has documented that trafficked people and trafficking survivors often suffer mental illness, both as pre-existing conditions that make them vulnerable to traffickers and as a result of trafficking experiences; therefore, they are typically referred to and are in need of mental health services (21,27,33–36,38–43,47,55,152,153). Mental health professionals nonetheless report significant challenges in addressing the mental health needs of trafficked patients. These include patients' social and legal instability, risk of deportation, unstable housing, difficulties ascertaining accurate patient histories, memory loss, health service funding priorities that exclude their patients, and changes in structures that determine care provisions. These challenges can lead to an inability to provide continuity of care and postponement of necessary therapies and treatments (89). A review of case files from the University of Michigan's Human Trafficking Clinic indicated that the clinic resolved 57.1% of survivor's physical health-care needs, but only 16.7% of their mental health-care needs (154). Some research suggests that interdisciplinary co-location of services (medical clinic, mental health, social work, food, shelter) is the most effective facilitator of care for trafficking survivors reticent to engage with mental health systems and other service providers (34,98). Again, there are few research studies that have evaluated the efficacy of any particular mental health interventions.

HCP bias can interfere with appropriate service delivery to people who suffer from mental illness. Diagnostic overshadowing can focus their diagnosis and recommendations on mental illness and overlook the signs of trafficking. HCPs may fail to believe or understand the patient who reports trafficking or other victimization, consciously or unconsciously attributing the report to a symptom of the mental illness. HCPs should be vigilant to avoid such diagnostic overshadowing, not least because people with mental illnesses are at heightened vulnerability to trafficking (149).

Determining best and most effective practices for mental health care for trafficked people and survivors of trafficking is particularly critical because the cost of mental health care is high and availability is highly variable. In addition, professionals in Albania providing direct assistance to those who had been trafficked for sex or forced begging listed mental health conditions as a major impediment to individuals' reintegration into Albanian society, and findings pointed to the cost of health care to individuals and the Government as an important barrier to providing the necessary care (155).

2.3.4 Capacity of the health workforce

Perhaps unsurprisingly, studies suggest that HCPs who have undertaken training concerning sex trafficking are more likely to recognize that trafficking affects their community, and to have identified a trafficking individual in their practice (156,157). There are no equivalent studies for labour trafficking. Research studies indicate that medical professionals recognize the value of such training and encourage standardized training that is grounded in an established evidence base and rigorously evaluated. They believe funding and incentives should be available for training. HCPs also seek guidance, tools and impact metrics they can employ systemwide, as well as regular refresher courses on the knowledge they gain during training (157,158).

While medical education on trafficking is becoming more common within health systems and medical schools, many HCPs still never receive such training. Several studies have confirmed inadequacy of institutionalized training and the need for systemwide adoption of training on trafficking issues (44,71,90,159–164). Only 10 of 50 States in the United States legally require human trafficking training for HCPs with advanced degrees, while the others have no mandates or mandates so vague as to not require training (165). Human trafficking training varies by country, job, population density and age, as resident physicians, physicians older or younger than 41–50 years of age, and HCPs in rural areas are likelier to report that they have received no training (166–168). Significant barriers to medical education on trafficking include, but are not limited to, lack of HCP time for training, lack of funding and its concomitant lack of prioritization, inadequate numbers of trainers, and a lack of quality control and evaluation of the training programmes that do exist (158). These trends indicate a significant need for training throughout the health system.

This lack of medical education on trafficking leaves HCPs unaware and health systems unprepared to assist survivors. Several studies have shown that, while untrained HCPs in the United States and United Kingdom typically believe that it is important to know about trafficking, they largely did not have a sense of its prevalence, nor did they know how to identify or screen for trafficking, make referrals, assist survivors, distinguish trafficking myths from facts, or differentiate between sex work and sex trafficking (139,169–177). Despite the general population's greater awareness of child trafficking, studies of paediatricians, school nurses and child-serving advanced practice registered nurses reflect a similar lack of knowledge and capacity to serve trafficked people and trafficking survivors (160,171,178). Approximately 70% of Canadian HCPs, 87% of United Kingdom HCPs and 90% of United States physicians, nurses, emergency department staff and other HCPs report that they lack confidence in their ability to identify and treat trafficking survivors (163,168,179–182). Experienced midwives note that their work offers them unusual access to signs of trafficking, but they lack the training, action plans and confidence to act upon such signs (183). Small studies of Canadian physicians and nurse educators in the United States, however, have shown that HCPs have more actual knowledge of trafficking than self-perceived knowledge (179,184).

Recent evaluations of the training for HCPs that does exist (primarily pre- and post-tests) indicated that integrating training into health systems can improve the knowledge base on trafficking, increase HCPs' self-perceived confidence in identifying and treating survivors of trafficking, and raise their desire to implement that knowledge and confidence (158,185–211). The

improvements occurred across health-care roles, from doctors and nurses to counsellors and emergency service workers (212–215). While most training occurs in-person, both synchronous and asynchronous online training sessions appear to create similar improvements (216–222). It is, however, important to note that several studies found that, while participants showed short-term improvements in their understanding of trafficking, retesting after three, six or 12 months showed no significant difference from pre-test knowledge levels, indicating no long-term uptake of the information obtained (223–226). The issue could be compounded; as one small study found, HCPs' self-perceived confidence remained elevated while knowledge dropped to pre-training levels (225). Additionally, similar improvements in confidence and self-perceived knowledge are reported after training ranging in duration from one hour to eight weeks, casting some doubt on the importance of the measured impact (214,227). While these small studies amount to nearly anecdotal evidence, they do point to a need to develop rigorous, longitudinal evaluations of training in order to ensure that medical education on trafficking effectively improves HCP knowledge and capacity for providing adequate and appropriate care for survivors. Furthermore, training evaluation may not be adequately examining whether or not trafficking curricula are thorough, accurate, up to date or culturally appropriate (158).

There is a dearth of rigorous, longitudinal evaluative research on whether the training programmes that have been developed since the mid 2000s have achieved the higher-order changes described by Powell et al. (158). Organizations and experts have begun to build more evidence-informed training protocols, including participatory curriculum developed with HCPs, collaborations with United Nations Global Strategic Operatives and the incorporation of post-training feedback (228–230). Subject matter experts convened for a Delphi study, which concluded that human trafficking training for HCPs should focus on providing competencies in five domains: (i) intervention strategies and the helping relationship; (ii) trauma and sex trafficking; (iii) assessment of risk factors and indicators; (iv) ethical practice; and (v) cultural diversity and human growth and development (231). The United States National Human Trafficking Training and Technical Assistance Center proposed its own list of core competencies, including understanding the epidemiology of trafficking and following legal and ethical standards, all under the universal competency of culturally responsive, survivor- and trauma-informed care (232). Additionally, medical educators in the United States have recently developed simulation exercises as a promising practice for training HCPs with regard to trafficking, although little research exists to evaluate these programmes (233,234). While observational evidence from HCPs suggests that training improves outcomes, there seems to be few systematic data to prove whether training has led to increased identification, improved care or improved outcomes for survivors. This is clearly an issue that requires further research (235–237).

Beyond knowledge and confidence, HCPs' capacity to treat trafficking survivors includes the ability to sustain potentially traumatizing work. Two small studies found that HCPs working with survivors tended to experience moderately increased self-perceived stress, medium-to-high secondary trauma stress levels and low levels of burnout, suggesting a need for HCPs to obtain therapy and employ appropriate coping mechanisms (238,239). Some HCPs, particularly those who had experienced trauma, benefited from vicarious resilience and compassion satisfaction from treating survivors (238,239).

2.3.5 Documentation and ethical reporting

Based on research indicating that there can be negative consequences following reports made to law enforcement or other authorities, WHO does not recommend the reporting of intimate partner violence or other forms of gender-based violence to the police by HCPs. Instead, they should present options regarding the person's right to report to authorities, and only then report with consent. WHO does not recommend that States adopt mandatory reporting guidelines for child maltreatment, but it does recommend that HCPs follow local laws in States where reporting child abuse or threats to life is mandatory (111,240). Within this area, non-compliance is noteworthy; 42 Member States in the WHO European Region (86%) do not comply with WHO recommendations in this area and have adopted regulations that mandate that particular professionals, typically health professionals, are required to report child abuse immediately it is identified. Child trafficking falls under many of these regulations (241). It is important for HCPs to be aware of potential further traumatization when involved in a mandated reporting scenario, including discussion of limits of confidentiality prior to disclosure, and involving the patient as much as or as little as they prefer in the process. HCPs also report that potentially trafficked minors can become non-compliant once informed of mandatory reporting practices (242).

Reporting suspicion of trafficking to authorities could have the added value of allowing medical professionals and others in the health system to respond effectively and appropriately to the needs of trafficked individuals, as long as confidentiality and data security can be guaranteed (243–245). HCPs must, however, be aware that, depending on their local legal context, mandatory reporting laws can trigger law enforcement, immigration proceedings and social services responses, which may present risks to the patient reporting the crime (71,244–246). As a result, some trafficked people and survivors may be unwilling to disclose for fear of these repercussions and HCPs must consider their ethical duty to the patient.

In 2018, the International Classification of Diseases, Tenth Revision, Clinical Modification released diagnostic codes for human trafficking. Studies in the United States have used these diagnostic codes, and updated codes from the Eleventh Revision, to systematically identify the physical and psychological symptoms that trafficked people present in emergency departments in order to examine potential racial and gender biases in identification, to compare and contrast identification and treatment for labour and sex trafficking, and to determine the insurance status of trafficked individuals (247–249). Some researchers have recommended that other countries adopt the same codes to facilitate identification and to collect comparative global data on trafficking incidence, prevalence, contexts, risk factors, comorbidities and resource requirements (250).

3. The future of research and policy

3.1 Strengths and limitations of the review

This scoping review was designed to provide a full portrait of the state of research in the field covering prevention of and response to trafficking within health systems, with a view towards devising policy considerations that could be grounded in the current evidence base. It combines academic research and grey literature conducted in both English and Russian across a range of disciplines, including psychology, social work, medical education, medicine, nursing and ethics. The review identified research that described how trafficked people engage with the health system, approaches to prevention grounded in SDHs and several avenues for effective health intervention for survivors of trafficking.

The evidence base available to answer the guiding question (“what can health systems do to prevent and respond to human trafficking?”) is still relatively recent and, therefore, there are significant limitations in establishing guidance for health systems based on evidence. The majority of evidence-informed research being conducted on the health system’s relationship to trafficking is focused in the United States. Only 45 relevant articles were identified that studied trafficking in the WHO European Region, and even that research was primarily conducted in the United Kingdom. Although the search was conducted in both English and Russian, only four relevant Russian-language articles were identified in the first round of the search, and they were all excluded because they were commentaries that did not employ data to support the claims made by the authors. The majority of the available research focused on trafficking people was devoted to the study of domestic sex trafficking of minors in the United States; men, migrants and adult survivors are remarkably underrepresented. As a result, this report could not represent current health systems’ approaches to trafficking in the WHO European Region. All policy considerations had to be grounded primarily in a knowledge base drawn from outside the Region and may, therefore, not adequately reflect the reality of trafficking in the Region.

While the field is expanding rapidly, much of what has been published since 2015 is not evidence informed, presenting another limitation to the review. As Cannon et al. demonstrated (251), and as this review confirms, research is unavoidably limited in some respects because of trafficking’s hidden nature, the low number of patients presenting with stereotypical trafficking presentations, lack of rigorous and ethical research methods in the field, variation in definitions of trafficking globally and challenges in engaging representative samples. Most studies have used small and non-representative samples or employ sampling techniques that create convenience samples (which leave out people who are hidden or who are not seeking medical care or services and recruit people after their trafficking experience or at a particular moment in their experience). This limits the scope of what we can know about the health and health-care needs of trafficked survivors longitudinally. Furthermore, the demographic reach of these studies means that large populations of trafficking survivors remain underreported, including adults, particularly men; labour trafficking survivors; migrants; and racial and ethnic minorities. Research regarding prevention is very sparse.

Current research methods and rigour vary widely and make generalizable claims difficult. For these reasons, many prevention and intervention efforts and the resultant policy considerations cannot be included here for lack of evidential support for their efficacy. Lack of available evidence does not necessarily mean a programme or intervention is not effective, merely that its effects are currently unclear because a rigorous study has not occurred. Consequently, owing to the limited evidence available to support development of this scoping review, caution is needed when applying the policy considerations. This scoping review is not exhaustive and does not represent all of the work that is being conducted within health systems to address trafficking.

A scoping review does not evaluate the evidence presented, and so a wide range of studies of varying methodologies and rigour are included. The evidence presented here is often drawn from reports with relatively small sample sizes, limited demographic range or non-representative samples. Consequently, this scoping review is presented as a starting point from which to pursue relevant policies and to highlight future directions for research.

3.2 Summary of the findings

Research on health system responses to human trafficking has more than doubled since the systematic review by Hemmings et al. published in 2016 (4), yet the body of research still remains slim considering the magnitude of the issues at hand. However, this review has identified a much stronger foundation of evidence-informed studies on which to draw conclusions than in previous reviews.

Survivors of trafficking interact with health systems in a wide range of venues and with a diverse range of complaints, often unrelated to or identifiable as trafficking abuse. While many survivors access care in paediatric, mental health and emergency settings, HCPs and staff across fields and specialties are likely to encounter survivors of trafficking as their needs are complex and diverse. Despite the fact that human trafficking survivors are often isolated and typically have little interaction with professionals, men, women and children who have been trafficked report having turned to the health system for support both during and after their trafficking, presenting with both physical complaints (including headache, stomach ache and work-related injuries) and mental health concerns (including mental illness, psychotic disorders and suicidal ideation). Therefore, it is incumbent upon those working in health systems to recognize their role not only in supporting survivors within their own facilities but also in advocating on behalf of these patients within intersectoral efforts, as health systems are on the frontlines of support.

Prevention efforts are critical to any public health response to trafficking and there is increasing interest in promoting best practices for prevention. However, despite persistent recommendations by national and international bodies pointing to the importance of trafficking prevention efforts, very few studies that met the inclusion criteria of this review directly studied programmes, interventions or policies that promote health system preventive strategies (252). Numerous editorials, commentaries and even textbook chapters are dedicated to promoting prevention and a public health approach to trafficking, but there is little in the way of evidence-informed research on the subject. The current focus on reactive responses

to trafficking, to the detriment of studies that would inform the prevention of trafficking, means that research does not currently provide much evidence regarding effective routes in addressing the root causes of trafficking. This is a significant finding of this review. There has been significant work examining the SDHs for survivors of human trafficking, which has shown that this population has a heightened likelihood of having high numbers of ACEs, a history of sexual assault and a history of other abuses. For this reason, it is incumbent upon health systems to have processes to address these problems at both the medical and societal level as a route to decreasing the likelihood of trafficking. For those individuals who are at high risk of trafficking or that disclose engaging in risky work situations that could make them vulnerable to trafficking, early research suggests that harm-reduction strategies may provide a route to prevention.

If health systems are to take trafficking prevention seriously, research must be conducted on the efficacy of current efforts and on promising practices. Addressing the root causes of trafficking – inequality, racism, gender inequalities and gender-based discrimination, poverty, sexual abuse, homelessness, socioeconomic marginalization, forced migration, lack of access to health and economic and social rights, and inadequate education (particularly regarding exploitation) – should be at the centre of any policy, so that health systems can take a proactive rather than merely a reactive stance towards trafficking.

Survivors of trafficking have indicated that there are significant barriers to their achieving and sustaining engagement with health care, including difficulty with enrollment, high costs, lack of HCP compassion and lack of trust, all of which can affect other vulnerable groups such as migrants even within socialized health-care settings. Mental health needs rank very high among the needs of patients who have been trafficked, but again, there is some research to suggest that HCPs often struggle to provide adequate and unbiased mental health care to this population. Research suggests that health systems can prepare their staff to provide accessible and appropriate care to trafficked individuals by lowering barriers to entry and integrating standardized protocols and screening for responding to people who are identified to be at risk. There has been an increase in research that validates and evaluates the use of screening tools, particularly for use among minors, but there is still significant work to do to identify age-appropriate and inclusive screening tools and to determine best practices for applying them. Significant research suggests that the most important aspect of providing care and engaging with trafficked patients is through provision of trauma-informed care practices. Unfortunately, there is little research that suggests what precisely constitutes trauma-informed care within health settings, nor has there been significant evaluation of health-care programmes that have adopted trauma-informed care.

HCPs should be prepared to respond appropriately to trafficking when they identify it and to make referrals whenever possible. While medical professionals are increasingly receiving training on trafficking, it is by no means universal, nor is it standardized or even necessarily based on evidence. Furthermore, some evaluations of training suggest that there is significant room for improvement, as uptake of knowledge is not always guaranteed. Researchers nonetheless suggest that training is critical to effective identification, response and referral of at-risk and trafficked people, and studies have identified a significant need for additional support for, and evaluation of, medical education on trafficking throughout health systems.

Unfortunately, the research output on human trafficking remains insufficient, narrow and skewed towards certain countries and survivor populations. The existing body of research is not enough to adequately describe, assess and evaluate health system prevention and response measures for trafficking. Much of this extant research focuses on service delivery and identification of trafficked individuals, as well health issues common to trafficking survivors. Female survivors of sex trafficking dominate the research. Little research addresses labour trafficking, and studies that wholly focus on the prevention of sex or labour trafficking are very sparse, particularly regarding boys/men, migrants, LGBTIQ+, and black, indigenous and people of colour. The United Kingdom and United States are the focus of 93% of studies in the field and, consequently, their findings may not translate to the entirety of the WHO European Region. A greater volume and a wider range of research into the response and prevention of labour and sex trafficking within health systems across the WHO European Region must be a priority. The health systems/labour trafficking nexus, evaluation of existing clinical and care interventions and this scoping review's other suggestions for future research should take precedence. This evidence, and its limitations, implies several policies that WHO, international bodies and individual countries can consider to respond to and reduce labour and sex trafficking through a comprehensive health system approach. These policy considerations are discussed below.

3.3 Challenges for future research and data collection

This scoping review represents a diverse array of disciplinary approaches to addressing trafficking within health systems. However, it is evident there remain significant gaps in the field that must be addressed in order to pursue evidence-informed policy.

Future research should consider:

- further evidence of risk and protective factors, including gender and gender-equality perspectives;
- particularities, trends and incidence of health issues, presentation of symptoms and comorbidities for trafficking within and across borders in the WHO European Region;
- gender differences in health-care-seeking behaviour and access to health services among trafficked populations;
- differentiation of prevalence, risk factors, experiences and resultant health-care needs of diverse populations of trafficked people and trafficking survivors, including labour trafficking survivors, LGBTIQ+, young people, homeless people and disconnected young people, boys and men, migrant labourers, and current traffickers recruited from among trafficked populations;
- methods of empowering survivors that make them key decision-makers in their recovery and rehabilitation;
- prevention programmes that are sector specific and context specific;
- evaluation of existing clinical and care interventions, trauma-informed and survivor-centred care approaches and survivor outcomes;
- the relationship between trafficking and pandemics, disasters or conflict;

- economic valuations of the resources required to deliver specialized services to trafficking survivors; and
- health sector engagement in anti-trafficking policy.

It is of the utmost importance that resources be provided to support the rigorous, data-driven research that will be most useful to policy-makers. Research should be guided by high-quality methodologies, including clear definitions; engage significant sample sizes; delineate limitations clearly; define explicit and measurable outcomes; and be monitored by ethical review. Ethical considerations should explicitly guide the analysis and collection of data derived from trafficked individuals and survivors. Experts suggest that knowledge of survivor needs in evidence-informed health care would be greatly enhanced by large, longitudinal, epidemiological research studies that track outcomes and demographics and ask survivors about trafficking routes, their reasons for hospitalization or seeking care, and mental and physical health (253). The methodologies, foci and conceptual frameworks suggested by survivors and subject matter experts can help to guide this research (26,254). Health systems can support these efforts not only by deploying their research teams to conduct this research and holding them to the same high standards employed in other fields of health-care research but also by institutionalizing data collection protocols that include information on patients affected by or at-risk of human trafficking.

3.4 Policy considerations for Member States and health systems

The evidence base presented in this scoping review is particularly valuable for Member States in the WHO European Region attempting to create societies and health systems that effectively prevent and respond to human trafficking. Member States and their health systems must develop comprehensive strategies and policies that directly and indirectly address trafficking. While this scoping review's scoping review does not evaluate the content of its synthesized research, its findings point to key actions which Member States and health-care decision-makers should consider as part of a systemic response.

3.4.1 Preventing human trafficking

Prevention of human trafficking includes not only intervening in trafficking and stopping it from ever occurring, but also reducing harm for trafficked individuals and thwarting re-trafficking.

Public health-based prevention efforts. It is important for Member States to institutionalize public health-based prevention efforts that attend to the root causes of trafficking, including all forms of social, economic and cultural marginalization.

- Legal and societal changes not directly addressing human trafficking can still have enormous preventive impact on trafficking rates and attendant harms.
- Structural risk factors for trafficking include discriminatory laws, harmful gender norms, gender inequality and childhood exposure to violence.
- Structural protective factors include laws that promote gender equality, norms that support non-violence, equitable household responsibilities and a home free of violence.

SDHs associated with higher risks of human trafficking. Research suggests that Member States should address the SDHs that are associated with higher risks of human trafficking. Member States can follow WHO's Commission on Social Determinants of Health to identify and monitor the underlying societal risk factors for labour and sex trafficking that exist in each Member State.

- Society-level SDHs connected to human trafficking include economic vulnerability, gender inequalities, patriarchy and the economic power of employers and exploiters.
- Researchers have identified numerous individual-level SDHs correlated with human trafficking, including ACEs, mental illness, substance abuse, poverty and sexual assault.
- Relevant SDHs specific to men, migrants and individuals trafficked for labour have not been sufficiently identified.

Policies and programmes for harm reduction and tackling prominent avenues into trafficking. Member States can consider creating policies and investing in programmes that close off prominent avenues into trafficking, while prompting health systems to employ harm-reduction policies.

- Sex workers and others working in illicit trades or who are otherwise marginalized are sometimes subject to abuse and are unable to report violence and threats to authorities; therefore, they can be at increased risk of trafficking.
- There is significant academic debate as to the extent to which sex workers and migrants are vulnerable, as well as to what are the policy models that best address workers' vulnerability.
- Health system professionals and policy-makers can work to identify populations of workers that are at the highest risk of trafficking and implement preventive and harm-reduction programmes, aimed at addressing the root causes of trafficking vulnerability.

3.4.2 Responding to human trafficking

The preponderance of evidence on health care and human trafficking addresses response rather than prevention. Proper policy, training and health system design are necessary for an appropriate response that identifies and treats survivors of both labour and sex trafficking.

Access to health services. Member States should consider instituting and funding universal, low-barrier and flexible access to health services, including for all survivors of human trafficking, regardless of status or available resources.

- It is important for health systems to have integrated standardized systemwide protocols, screening and reporting systems that can be applied when indicators of trafficking are recognized in practice.
- Many of the individual-level barriers to health-care access for trafficked people and survivors, such as distrust in the health system, the need for health insurance identification and low public familiarity with legal rights and health-care entitlements, can be directly or indirectly addressed by policy and public health programmes.

- The structural barriers to trafficked people and survivors' health-care access that can be addressed directly include insufficient health-care funding, staffing shortfalls at health-care facilities and lack of evidence-informed trafficking-specific training for HCPs.
- An effective public health response would specifically address a country's racial, ethnic and sexual minorities, as well as migrants, who might have more difficulty accessing health care in general.
- Understanding within health systems should expand to encompass the diverse populations affected by trafficking and to integrate prevention and response efforts at every possible point of entry that a potentially trafficked patient might use. The significant resources of the health system can be leveraged to address trafficking among patients.

Health systems acting within a multisectoral coordinated system of care. The WHO Global Plan of Action to Strengthen the Role of the Health System within a National Multisectoral Response to Address Interpersonal Violence, in Particular Against Women and Girls, and Against Children (8) and the linked Strategy and Action Plan on Migration and Health in the WHO European Region (11) recommend that Member States create strong, multisectoral health systems capable of preventing and responding to human trafficking.

- Multisectoral coordinated systems and care have been shown to improve trafficking responses.
- Interdisciplinary partnerships with anti-trafficking service providers would help to coordinate services and provide allied services, such as substance abuse treatment or other psychosocial services.

Case study 5 is an example of one government's efforts to have a multisectoral approach to the issue of human trafficking.

•• **Case study 5. Greek Ministry of Migration and Asylum: a multisectoral approach to human trafficking** •••••

It is a culture of impunity; this is why we want to be more resourceful and more radical...in the way we approach protection, prosecution [and] prevention.

Heracles Moskoff, Ministry of Migration and Asylum

Operating within key national and international legal instruments, including the United Nations Convention against Transnational Organized Crime and other relevant Council of Europe and EU directives, the Ministry of Migration and Asylum in Greece is working to combat human trafficking through a multisectoral and multipronged approach.

In Greece, there are two key mechanisms. The first is the national referral mechanism, which operates as a hub for coordinated anti-trafficking action between civil society, law enforcement and other stakeholders, including international agencies and partners, under the supervision of the National Rapporteur on Trafficking in Human Beings. Protection packages include a range of legal, health and social services. The national referral mechanism also offers training programmes for frontline professionals to increase their awareness of the indicators and diverse typologies of trafficking and strengthen their

capacity to respond. Embedding anti-trafficking awareness within hospital systems, as well as equipping psychologists, psychotherapists and social workers with the capability to formally identify survivors, is of particular priority.

The second mechanism is the National Emergency Response Mechanism for Unaccompanied Minors in Precarious Living Conditions, which is a 24/7 hotline, referral system and mobile outreach service for the identification and accommodation of unaccompanied minors. At present, this Emergency Response Mechanism has accommodated more than 2000 children, as well as provided training for professionals on trafficking vulnerability in this context. The Emergency Response Mechanism is intended to take a more proactive approach to the identification and protection of vulnerable unaccompanied minors.

We focus on trafficking as a crime and not as a social phenomenon... it is a social phenomenon.

Heracles Moskoff, Ministry of Migration and Asylum

A comprehensive approach to human trafficking is, however, not only a practical challenge but also an ideological and conceptual challenge. This is particularly with respect to public opinion, which at times associates trafficking with insecurity and instances of crime. There is a need to change the narrative, make visible the exploitation, manipulation and vulnerability that is involved in trafficking and promote a human rights perspective. The Ministry of Migration and Asylum in Greece, therefore, also progresses a prevention agenda through a partnership with the Council of Europe that targets schools and educators. The programme Human Rights for Beginners works to engage young people on issues of anti-discrimination, tolerance, gender equality and sexual and reproductive health to empower a more democratic culture within schools.

Standardized training for all staff in all health-care settings. Member States, health system policy-makers and/or researchers can develop, require and evaluate standardized training on trafficking for all staff in health-care facilities, based on survivor-centred and trauma-informed care and addressing provider unconscious bias.

- Member States and health system policy-makers could consider making human trafficking training a requirement for HCPs at all health facilities. Undergraduate and postgraduate educational programmes for HCPs should include mandatory specialized training on trafficking.
- Extant training, both in-person and online and both synchronous and asynchronous, has been shown to effectively increase HCP's self-perceived confidence and knowledge related to treating and identifying trafficked patients immediately after the training.
- Most HCPs cannot effectively identify and treat trafficked individuals. While HCPs recognize the need for that capacity, most report that they have not received training or do not feel confident in their knowledge or abilities.
- The development of an effective standardized training protocol is necessary. There is anecdotal and experiential evidence, but no systematic data, showing that use of such protocols has

translated into more accurate and frequent identification or better treatment in practice. There is also longitudinal evidence that gains from training are often lost shortly after (224). HCPs' attestations to improved identification of trafficked people, as well as improvements in confidence and knowledge, even if only temporarily, suggest a need for health systems to invest in curriculum development and evaluation rather than forgoing training.

Screening tools. It is important for Member States to encourage the development and use of culturally appropriate, validated screening tools as complements to ethical interviews in the identification of trafficked patients. Member States can help to develop and validate screening tools and translation or adjustments appropriate for their populations and cultural contexts. Health systems and health facilities could consider incorporating validated screening tools into their regular protocols.

- WHO and anti-trafficking advocates recommend that HCPs prioritize quality care over identification or disclosure. Non-disclosure of trafficking experiences occurs for many reasons, including stigma, lack of trust in medical professionals, lack of follow-up by HCPs, and fear of law enforcement, losing services, judgement or unwanted treatment.
- WHO recommends ethical interviewing guidelines rather than universal screening of all patients. WHO, experts and researchers suggest prioritizing appropriate care above disclosure.
- Identifying trafficked individuals in health-care settings can both interrupt trafficking and guide HCPs to more appropriate care. Most trafficking survivors report having accessed medical care – in a variety of health-care settings – while they were being trafficked.
- Five screening tools, designed for various ages, genders and types of trafficking, have currently been validated, although not in all health-care settings.
- Screening tools have been shown to be effective in multiple languages and health facility types and when administered verbally or digitally.
- HCPs and advocates recommend surveys, screenings and the opportunity for anonymous feedback to ensure effectiveness of screening tools.

Provision of trauma-informed care. Health system professionals should recognize the trauma of trafficking and the likely benefits of providing trauma-informed care to trafficking survivors. Policies and training that institutionalize that standard of care should be considered and developed. Member States should consider addressing the structural challenges to providing trauma-informed care, which include patients' legal and social instability, and mental health funding priorities that exclude trafficking survivors.

- There is significant evidence indicating that trafficking survivors are likely to seek care from health systems both during and after the period they are trafficked.
- Nearly all trafficked individuals have experienced one or more traumas, often leading to mental health conditions, including PTSD and depression.
- Research suggests HCPs should adopt a trauma-informed, survivor-centred approach to the treatment of trafficking survivors and both anti-trafficking experts and United States agencies recommend that HCPs provide services within a framework of trauma-informed care that respects patient autonomy.

- Policy-makers and HCPs can integrate survivor leaders' input and survivor feedback into all consultations and decision-making regarding policy, practice and care for trafficking to ensure appropriate delivery of services.
- Increased collaboration is required between WHO and the UNODC in developing trauma-informed, victim-centred and gender-sensitive practices by health-care systems that respond to the trafficking of people and smuggling of migrants.

3.4.3 Building and sharing human trafficking knowledge

The 237 documents identified from publications between January 2015 and August 2022 did not provide a comprehensive understanding of how to address the numerous possible response and prevention activities and policies for health care and human tracking. Despite this, WHO strongly encourages Member States to consider the policy recommendations outlined in this document as a starting point for addressing this issue. It is crucial to acknowledge that, while our report provides valuable insights, there is still much that is not known about this complex challenge. There are opportunities for Member States to encourage data collection and sharing beyond academic and organizational research, which can enhance our understanding and inform future policy decisions, thus enabling strategies to be refined and improved over time.

Research into health care and human trafficking. Member States can consider encouraging and funding evidence-informed research into health care and human trafficking within their countries. Member States and researchers could regularly share their findings with human rights monitoring bodies at the national level. Health system professionals and States can promote ethical and coordinated data collection to help to identify and treat trafficked individuals, as well as to uncover data about prevalence and treatment effectiveness within Members States.

- In 2016 the WHO European Region Member States adopted an action plan to strengthen the use of evidence, information and research for policy-making in the Region (256). This included commitments from countries to ensure that evidence and research is used in all health policy-making.
- This scoping review identified only 47 evidence-informed publications addressing health care and human trafficking within the WHO European Region between January 2015 and August 2022. Twenty-eight of those studies occurred within the United Kingdom.
- Member States, with the cooperation of health system professionals, can promote increased data collection and research on trafficking in the Region. More research on prevention and the evaluation of services is particularly needed.
- Research on sex trafficking far outweighs research on labour trafficking. Member States, health system professionals and academics should encourage increased research aimed directly at labour trafficking and survivors of labour trafficking, including comprehensive studies that address the physical, mental and environmental health concerns specific to labour trafficking.

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Diagnostic codes for human trafficking within health-care reporting systems. Diagnostic codes enable consistent collection of data and access for analysis.

- The Member States of the WHO European Region could consider creating a system of diagnostic codes for human trafficking to use within health-care reporting systems across the Region.

4. Conclusions

Member States and their health systems can play a crucial role in responding to and preventing labour and sex trafficking. Health systems are uniquely situated to identify, treat and protect trafficked people and those most at risk of future trafficking. They are also in a position to provide thoughtful leadership in intersectoral anti-trafficking programmes. This scoping review suggests that Member States, health-care leaders, HCPs and researchers recognize this opportunity and seek to effectively intervene in human trafficking. The scoping review is based on a significant body of research pointing to the urgency of a health systems response to trafficking grounded in a public health approach that attends as much to identifying avenues for preventing individuals from being trafficked as it does to providing adequate and appropriate care to survivors of trafficking. A review of the studies in this scoping review points towards several practical policy and ethical considerations for improving and validating health systems responses.

References

1. Directorate-General for Migration and Home Affairs. Report from the Commission to the European Parliament and the Council: third report on the progress made in the fight against trafficking in human beings. Brussels: European Commission; 2020 (COM/2020/661 final; <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A52020DC0661>, accessed 17 January 2023).
2. Global report on trafficking in persons 2022. Vienna: United Nations Office on Drugs and Crime; 2022 (<https://www.unodc.org/unodc/en/human-trafficking/global-report-on-trafficking-in-persons.html>, accessed 17 January 2023).
3. Zimmerman C, Yun K, Watts C, Shvab I, Trappolin L, Treppete M et al. The health risks and consequences of trafficking in women and adolescents: findings from a European study. London: London School of Hygiene & Tropical Medicine; 2003.
4. Hemmings S, Jakobowitz S, Abas M, Bick D, Howard LM, Stanley N et al. Responding to the health needs of survivors of human trafficking: a systematic review. *BMC Health Serv Res.* 2016;16(1):320. doi: 10.1186/s12913-016-1538-8.
5. Protocol to prevent, suppress and punish trafficking in persons, especially women and children, supplementing the United Nations Convention against Transnational Organized Crime. New York: United Nations; 2000 (<https://www.ohchr.org/Documents/ProfessionalInterest/ProtocolonTrafficking.pdf>, accessed 17 January 2023).
6. Caring for trafficked persons: guidance for health providers. Geneva: International Organization for Migration; 2009 (<https://publications.iom.int/books/caring-trafficked-persons-guidance-health-providers>, accessed 17 January 2023).
7. Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions: a union of equality – gender equality strategy 2020–2025. Brussels: European Commission; 2020 (COM/2020/152 final; <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A52020DC0152>, accessed 17 January 2023).
8. WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children. In: Sixty-ninth World Health Assembly, Geneva, 23–28 May 2016. Geneva: World Health Organization; 2016 (WHA69.5; <https://apps.who.int/iris/handle/10665/252785>, accessed 17 January 2023).
9. Strategy on women's health and well-being in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2016 (<https://apps.who.int/iris/handle/10665/348974>, accessed 17 January 2023).
10. Action plan for sexual and reproductive health: towards achieving the 2030 Agenda for Sustainable Development in the WHO European Region: leaving no one behind. In: Sixty-sixth Regional Committee for Europe: Copenhagen, 12–15 September 2016. Copenhagen: WHO Regional Office for Europe; 2016 (<https://apps.who.int/iris/handle/10665/338130>, accessed 17 January 2023).
11. Strategy and action plan for refugee and migrant health in the WHO European Region. In: Sixty-sixth Regional Committee for Europe: Copenhagen, 12–15 September 2016. Copenhagen: WHO Regional Office for Europe; 2016 (<https://apps.who.int/iris/handle/10665/338085>, accessed 17 January 2023).
12. Convention on the rights of persons with disabilities. In: Sixty-first session of the UN General Assembly, 24 January 2007. New York: United Nations; 2007 (A/RES/61/106; <https://www.refworld.org/docid/45f973632.html>, accessed 17 January 2023).
13. General recommendation No. 38 (2020) on trafficking in women and girls in the context of global migration. New York: United Nations Committee on the Elimination of Discrimination Against Women; 2020 (<https://www.ohchr.org/en/documents/general-comments-and-recommendations/general-recommendation-no38-2020-trafficking-women>, accessed 17 January 2023).
14. Global compact for safe, orderly and regular migration. New York: United Nations; 2018 (https://refugeesmigrants.un.org/sites/default/files/180711_final_draft_0.pdf, accessed 17 January 2023).
15. Recommended principles and guidelines on human rights and human trafficking. New York: United Nations Office of the High Commissioner; 2002 (E/2002/68/Add. 1; <https://www.ohchr.org/Documents/Publications/Traffickingen.pdf>, accessed 17 January 2023).
16. General recommendation No. 36 (2017) on the right of girls and women to education, para. 21. New York: United Nations Committee on the Elimination of Discrimination Against Women; 2017 (CEDAW/C/GC/36; <https://www.ohchr.org/en/documents/general-comments-and-recommendations/general-recommendation-no-36-2017-right-girls-and>, accessed 17 January 2023).
17. Thirteenth general programme of work 2019–2023. Geneva: World Health Organization; 2018 (<https://www.who.int/about/what-we-do/thirteenth-general-programme-of-work-2019---2023>, accessed 17 January 2023).

18. United Nations Global Plan of Action to Combat Trafficking in Persons. In: Sixty-fourth session of the United Nations General Assembly, 12 August 2010. New York: United Nations; 2010 (A/RES/64/293; https://www.unodc.org/documents/human-trafficking/United_Nations_Global_Plan_of_Action_to_Combat_Trafficking_in_Persons.pdf, accessed 17 January 2023).
19. Ertl S, Bokor B, Tuchman L, Miller E, Kappel R, Deye K. Healthcare needs and utilization patterns of sex-trafficked youth: missed opportunities at a children's hospital. *Child Care Health Dev.* 2020;46:422–8. doi: 10.1111/cch.12759.
20. Westwood J, Howard LM, Stanley N, Zimmerman C, Gerada C, Oram S. Access to, experiences of, healthcare services by trafficked people: findings from a mixed-methods study in England. *Br Gen Pract.* 2016;66(652):e794–801. doi: 10.3399/bjgp16X687073.
21. Goldberg AP, Moore JL, Houck C, Kaplan DM, Barron CE. Domestic minor sex trafficking patients: a retrospective analysis of medical presentation. *J Pediatr Adolesc Gynecol.* 2017;30(1):109–15. doi: 10.1016/j.jpag.2016.08.010.
22. Chisolm-Straker M, Baldwin S, Gaïgbé-Togbé B, Ndukwe N, Johnson PN, Richardson LD. Health care and human trafficking: we are seeing the unseen. *J Health Care Poor Underserved.* 2016;27(3):1220–33. doi: 10.1353/hpu.2016.0131.
23. Varma S, Gillespie S, McCracken C, Greenbaum VJ. Characteristics of child commercial sexual exploitation and sex trafficking victims presenting for medical care in the United States. *Child Abuse Negl.* 2015;44:98–105. doi: 10.1016/j.chiabu.2015.04.004.
24. Hornor G, Sherfield J. Commercial sexual exploitation of children: health care use and case characteristics. *J Pediatr Health Care.* 2018;32(3):250–62. doi: 10.1016/j.pedhc.2017.11.004.
25. Geynisman-Tan JM, Taylor JS, Edersheim T, Taubel D. All the darkness we don't see. *Am J Obstet Gynecol.* 2017;216(2):135.e1–5. doi: 10.1016/j.ajog.2016.09.088.
26. Chisolm-Straker M, Miller CL, Duke G, Stoklosa H. A framework for the development of healthcare provider education programs on human trafficking part two: survivors. *J Hum Traffick.* 2020;6(4):410. doi: 10.1080/23322705.2019.1635333.
27. Ottisova L, Smith P, Oram S. Psychological consequences of human trafficking: complex posttraumatic stress disorder in trafficked children. *Behav Med.* 2018;44(3):234–41. doi: 10.1080/08964289.2018.
28. Ijadi-Maghsoodi R, Bath E, Cook M, Textor L, Barnert E. Commercially sexually exploited youths' health care experiences, barriers, recommendations: a qualitative analysis. *Child Abuse Negl.* 2018;76:334–41. doi: 10.1016/j.chiabu.2017.11.002.
29. Ravi A, Pfeiffer MR, Rosner Z, Shea JA. Identifying health experiences of domestically sex-trafficked women in the USA: a qualitative study in Rikers Island Jail. *J Urban Health.* 2017;94(3):408–16. doi: 10.1007/s11524-016-0128-8.
30. Shin J, Pender V, Mathewson K, Safford MM. Experiences of sex trafficking victims in healthcare settings. *J Gen Intern Med.* 2019;34:S219. doi: 10.1007/s11606-019-05007-5.
31. Barnert ES, Godoy SM, Hammond I, Kelly MA, Thompson LR, Mondal S et al. Pregnancy outcomes among girls impacted by commercial sexual exploitation. *Acad Pediatr.* 2020;20(4):455–9. doi: 10.1016/j.aca.2019.12.005.
32. Rossoni I, Gauci D, Gauci Farrugia A, Padovese V. Gender, migration and violence among third country nationals accessing the sexual health clinic in Malta. *J Eur Acad Dermatol Venereol.* 2022;36(9):1623. doi: 10.1111/jdv.18222.
33. Stanley N, Oram S, Jakobowitz S, Westwood J, Borschmann R, Zimmerman C et al. The health needs and healthcare experiences of young people trafficked into the UK. *Child Abuse Negl.* 2016;59:100–10. doi: 10.1016/j.chiabu.2016.08.001.
34. Ravi A, Pfeiffer MR, Rosner Z, Shea JA. Trafficking and trauma: insight and advice for the health system from sex-trafficked women incarcerated on Rikers Island. *Med Care.* 2017;55(12):1017–22. doi: 10.1097/MLR.0000000000000820.
35. Sprang G, Cole J. Familial sex trafficking of minors: trafficking conditions, clinical presentation, system involvement. *J Fam Violence.* 2018;33(4):185–95. doi: 10.1007/s10896-018-9950-y.
36. Hopper EK, Gonzalez LD. A comparison of psychological symptoms in survivors of sex and labor trafficking. *Behav Med.* 2018;44(3):177–88. doi: 10.1080/08964289.2018.1432551.
37. Oram S, Abas M, Bick D, Boyle A, French R, Jakobowitz S et al. Human trafficking and health: a survey of male and female survivors in England. *Am J Public Health.* 2016;106(6):1073–8. doi: 10.2105/AJPH.2016.303095.
38. Gerassi LB, Nichols AJ, Cox A, Goldberg KK, Tang C. Examining commonly reported sex trafficking indicators from practitioners' perspectives: findings from a pilot study. *J Interpers Violence.* 2021;36(11–12):NP6281–303. doi: 10.1177/0886260518812813.
39. Reid JA, Baglivio MT, Piquero AR, Greenwald MA, Epps N. No youth left behind to human trafficking: exploring profiles of risk. *Am J Orthopsychiatry.* 2019;89(6):704–15. doi: 10.1037/ort0000362.
40. Raj A, Baird GL, Moore JL, Barron CE. Incorporating clinical associations of domestic minor sex trafficking into universal screening of adolescents. *Clin Pediatr (Phila).* 2019;58(8):915–17. doi: 10.1177/0009922819843618.

41. Palines PA, Rabbitt AL, Pan AY, Nugent ML, Ehrman WG. Comparing mental health disorders among sex trafficked children and three groups of youth at high-risk for trafficking: a dual retrospective cohort and scoping review. *Child Abuse Negl.* 2020;100:104196. doi: 10.1016/j.chiabu.2019.104196.
42. Barnert E, Kelly M, Godoy S, Abrams LS, Bath E. Behavioral health treatment “buy-in” among adolescent females with histories of commercial sexual exploitation. *Child Abuse Negl.* 2020;100:104042. doi: 10.1016/j.chiabu.2019.104042.
43. Walters JH, Krieger K, Kluckman M, Feinberg R, Gremminger M, Orme S et al. Evaluation of domestic victims of human trafficking demonstration projects: final report from the first cohort of projects. Washington (DC): US Department of Health and Human Services; 2017 (https://www.acf.hhs.gov/sites/default/files/documents/opre/dvhtcohort2finalrpt_508b.pdf, accessed 17 January 2023).
44. Macias-Konstantopoulos WL, Munroe D, Purcell G, Tester K, Burke TF. The commercial sexual exploitation and sex trafficking of minors in the Boston Metropolitan Area: experiences and challenges faced by front-line providers and other stakeholders. *J Appl Res Child.* 2015;6(1):art. 4.
45. Moore JL, Goldberg AP, Barron C. Substance use in a domestic minor sex trafficking patient population. *Pediatr Emerg Care.* 2021;37(4):e159–62. doi: 10.1097/PEC.0000000000001749.
46. Hornor G, Hollar J, Landers T, Sherfield J. Healthcare use and case characteristics of commercial sexual exploitation of children: teen victims versus high-risk teens. *J Forensic Nurs.* 2022. doi: 10.1097/JFN.0000000000000402. Epub ahead of print.
47. Nichols AJ, Cox A. A pilot study comparing sex trafficking indicators exhibited by adult and minor service populations. *J Hum Traffick.* 2021;1:18. doi: 10.1080/23322705.2021.1898173.
48. Borschmann R, Oram S, Kinner SA, Dutta R, Zimmerman C, Howard LM. Self-harm among adult victims of human trafficking who accessed secondary mental health services in England. *Pyschiatr Serv.* 2017;68(2):207–10. doi: 10.1176/appi.ps.20150050.
49. Self-Brown SR, Osborne MC, Lee N, Perry EW, Kinnish K. Exploring the impact of trauma history on the mental health presentations of youth who have experienced commercial sexual exploitation and trafficking. *Behav Med.* 2022;48(4):261–72. doi: 10.1080/08964289.2020.1865255.
50. Perry EW, Osborne MC, Lee N, Kinnish K, Self-Brown SR. Posttraumatic cognitions and posttraumatic stress symptoms among young people who have experienced commercial sexual exploitation and trafficking. *Public Health Rep.* 2022;137(suppl 1):91–101S. doi: 10.1177/003335492111041552.
51. Perry EW, Osborne MC, Kinnish K, Lee NH, Self-Brown SR. The PTSD symptom presentation and the effect of polytrauma on PTSD symptom clusters among young people who have experienced commercial sexual exploitation and trafficking. *J Child Adolesc Trauma.* 2022. doi: 10.1007/s40653-022-00474-1. Epub ahead of print.
52. Ravi A, Shuman S, Shroff N, London-Orozco C, Walcott K. Physical, mental, socioeconomic health issues of sex and labor trafficking survivors engaged in primary care services. *J Hum Traffick.* 2022. doi: 10.1080/23322705.2022.2096368. Epub ahead of print.
53. Jowett S, Argyriou A, Scherrer O, Karatzias T, Katona C. Complex post-traumatic stress disorder in asylum seekers and victims of trafficking: treatment considerations. *BJPsych Open.* 2021;7(6):e181. doi: 10.1192/bjo.2021.1007.
54. Hileli R, Strous R, Lewis YD, Lurie I. Building the bridge: psychiatric treatment for asylum-seekers and survivors of human trafficking in Israel: the experience of the Gesher Clinic, 2014–2015. *Isr J Psychiatry.* 2021;58(1):30–7.
55. Chu K, Billings J. Mental health experiences of sex trafficking victims in western countries: a qualitative study. *J Hum Traffick.* 2021;8(4):367–89. doi: 10.1080/23322705.2020.1825897.
56. Rose AL, Howard LM, Zimmerman C, Oram S. A cross-sectional comparison of the mental health of people trafficked to the UK for domestic servitude, for sexual exploitation and for labor exploitation. *J Hum Traffick.* 2021;7(3):258–67. doi: 10.1080/23322705.2020.1728495.
57. Preble K, Nichols A, Cox A. Labor trafficking in Missouri: revelations from a statewide needs assessment. *J Hum Traffick.* 2020;9(1):15–32. doi: 10.1080/23322705.2020.1855900.
58. Cole J, Sprang G, Lee R, Cohen J. The trauma of commercial sexual exploitation of youth: a comparison of CSE victims to sexual abuse victims in a clinical sample. *J Interpers Violence.* 2014;31(1):1–25. doi: 10.1177/0886260514555133.
59. Oram S, Khondoker M, Abas M, Broadbent M, Howard LM. Characteristics of trafficked adults and children with severe mental illness: a historical cohort study. *Lancet Psychiatry.* 2015;2(12):1084–91. doi: 10.1016/S2215-0366(15)00290-4.
60. Bath E, Barnert E, Godoy S, Hammond I, Mondals S, Farabee D et al. Substance use, mental health, and child welfare profiles of juvenile justice-involved commercially sexually exploited youth. *J Child Adolesc Psychopharmacol.* 2020;30(6):389–97. doi: 10.1089/cap.2019.0057.
61. Brandt TW, Lind T, Schreier A, Sievers CM, Kramer TL. Identifying youth at risk for commercial sexual exploitation within child advocacy centers: a statewide pilot study. *J Interpers Violence.* 2021;36(5–6):NP2368–90. doi: 10.1177/0886260518766560.

62. Ghafoori B, Martinho G, Gonçalves M, Matos M. Clinical profiles and factors associated with treatment initiation in survivors of sex trafficking: a comparison with survivors of domestic violence and sexual assault. *Psychol Trauma*. 2022;6. doi: 10.1037/tra0001273. Epub ahead of print.
63. Galos E, Bartolini L, Cook H, Grant N. Migrant vulnerability to human trafficking and exploitation: evidence from the central and eastern Mediterranean migration routes. Geneva: International Organization for Migration; 2017 (https://publications.iom.int/system/files/pdf/migrant_vulnerability_to_human_trafficking_and_exploitation.pdf, accessed 17 January 2023).
64. Pashang S. Entrapped bodies: illegalized trafficked youth in Canada. *Int J Mental Health Addiction*. 2019;17:370–84. doi: 10.1007/s11469-018-0027-1.
65. RESPECT women: preventing violence against women. New York: UN Women; 2019 (<https://www.unwomen.org/en/digital-library/publications/2019/05/respect-women-preventing-violence-against-women>, accessed 17 January 2023).
66. Duger A. Focusing on prevention: the social and economic rights of children vulnerable to sex trafficking. *Health Hum Rights*. 2015;17(1):E114–23. PMID: 26204576.
67. Amantia R, Irvin VL, Smit E, Seifert JR, Garcia J. Human trafficking: the relationship between government efforts and survivor punishment. *Glob Public Health*. 2020;15(10):1496–508. doi: 10.1080/17441692.2020.1763421.
68. Cimino AN, Madden EE, Hohn K, Cronley CM, Davis JB, Magruder K et al. Childhood maltreatment and child protective services involvement among the commercially sexually exploited: a comparison of women who enter as juveniles or as adults. *J Child Sex Abus*. 2017;26(3):352–71. doi: 10.1080/10538712.2017.1282575.
69. Moore JL, Houck C, Hirway P, Barron CE, Goldberg AP. Trafficking experiences and psychosocial features of domestic minor sex trafficking victims. *J Interpers Violence*. 2020;35(15–16):3148–63. doi: 10.1177/0886260517703373.
70. Ellis AS, Brown AM, Martini AI, Page E, Lin L, Vaughn LM. Application of a child sex trafficking screening tool in patients with abuse: a retrospective chart review in the pediatric emergency department. *J Pediatr Health Care*. 2022;36(4):330–8. doi: 10.1016/j.pedhc.2022.01.002.
71. Bick D, Howard LM, Oram S, Zimmerman C. Maternity care for trafficked women: survivor experiences and clinicians' perspectives in the United Kingdom's National Health Service. *PLOS One*. 2017;12(11):e0187856. doi: 10.1371/journal.pone.0187856.
72. Chang KSG, Lee K, Park T, Sy E, Quach T. Using a clinic-based screening tool for primary care providers to identify commercially sexually exploited children. *J Appl Res Child*. 2015;6(1):art. 6.
73. Naramore R, Bright MA, Epps N, Hardt NS. Youth arrested for trading sex have the highest rates of childhood adversity: a statewide study of juvenile offenders. *Sex Abuse*. 2017;29(4):396–410. doi: 10.1177/1079063215603064.
74. Reid JA, Baglivio MT, Piquero AR, Greenwald MA, Epps N. Human trafficking of minors and childhood adversity in Florida. *Am J Public Health*. 2017;107(2):306–11. doi: 10.2105/AJPH.2016.303564.
75. Worsnop CZ. The disease outbreak-human trafficking connection: a missed opportunity. *Health Secur*. 2019;17(3):181–92. doi: 10.1089/hs.2018.0134.
76. Responding to violence against women and children during COVID-19: impact on service provision, strategies and actions in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2021 (<https://apps.who.int/iris/handle/10665/349504>, accessed 17 January 2023).
77. Clifton JM. Screening for chlamydia, gonorrhea, high-risk sexual behaviors in Utah's juvenile justice population: results and implications for practice. *J Pediatr Health Care*. 2018;32(4):374–80. doi: 10.1016/j.pedhc.2017.12.008.
78. Rothman EF. Should US physicians support the decriminalization of commercial sex? *AMA J Ethics*. 2017;19(1):110–21. doi: 10.1001/journalofethics.2017.19.1.sect1-1701.
79. Ahmed A. Addressing HIV/AIDS at the intersection of anti-trafficking and health law and policy. In: Kotiswaran, P, editor. *Trafficking and new forms of governance*. Cambridge: Cambridge University Press; 2017:305–28.
80. Kelly MA, Bath EP, Godoy SM, Abrams LS, Barnert ES. Understanding commercially sexually exploited youths' facilitators and barriers toward contraceptive use: I didn't really have a choice. *J Pediatr Adolesc Gynecol*. 2019;32(3):316–24. doi: 10.1016/j.jpag.2018.11.011.
81. Rothman EF, Farrell A, Paruk J, Bright K, Bair-Merritt M, Preis SR. Evaluation of a multi-session group designed to prevent commercial sexual exploitation of minors: the "my life my choice" curriculum. *J Interpers Violence*. 2019;36(19–20): 9143–66. doi: 10.1177/0886260519865972.
82. Rothman EF, Preis SR, Bright K, Paruk J, Bair-Merritt M, Farrell A. A longitudinal evaluation of a survivor-mentor program for child survivors of sex trafficking in the United States. *Child Abuse Negl*. 2020;100:104083. doi: 10.1016/j.chiabu.2019.
83. Barron CE, Moore J, Baird G, Hardy E, Goldberg A. The provision of HIV post-exposure prophylaxis in the context of child sex trafficking. *R I Med J* (2013). 2018;101(9):23–26. PMID: 30384515.
84. Peck JL, Doiron ML. Human trafficking policies of professional nursing organizations: opportunity for innovative and influential policy voice. *Nurs Forum*. 2022;57(5):968–76. doi: 10.1111/nuf.12752.

85. Price K, Nelson BD, Macias-Konstantopoulos WL. Understanding health care access disparities among human trafficking survivors: profiles of health care experiences, access, engagement. *J Interpers Violence*. 2021;36(21-22):NP11780–99. doi: 10.1177/0886260519889934.
86. Panda P, Garg A, Lee S, Sehgal AR. Barriers to the access and utilization of healthcare for trafficked youth in the United States. *Child Abuse Negl*. 2021;121:105259. doi: 10.1016/j.chiabu.2021.105259.
87. Fukushima AI, Gonzalez-Pons K, Gezinski L, Clark L. Multiplicity of stigma: cultural barriers in anti-trafficking response. *Int J Hum Rights Healthc*. 2020;13(2):125. doi: 10.1108/IJHRH-07-2019-0056.
88. Williams JR, Gonzalez-Guarda RM, Halstead V, Martinez J, Joseph L. Disclosing gender-based violence during health care visits: a patient-centered approach. *J Interpers Violence*. 2020;35(23–24):5552–73. doi: 10.1177/0886260517720733.
89. Domoney J, Howard LM, Abas M, Broadbent M, Oram S. Mental health service responses to human trafficking: a qualitative study of professionals' experiences of providing care. *BMC Psychiatry*. 2015;15:289. doi: 10.1186/s12888-015-0679-3.
90. Williamson V, Borschmann R, Zimmerman C, Howard LM, Stanley N, Oram S. Responding to the health needs of trafficked people: a qualitative study of professionals in England and Scotland. *Health Soc Care Community*. 2020;28(1):173–81. doi: 10.1111/hsc.12851.
91. Richie-Zavaleta AC, Villanueva A, Martinez-Donate A, Turchi RM, Ataiants J, Rhodes SM. Sex trafficking victims at their junction with the healthcare setting: a mixed-methods inquiry. *J Hum Traffick*. 2020;6(1):1–29. doi: 10.1080/23322705.2018.1501257.
92. Wallace C, Lavina I, Mollen C. Share our stories: an exploration of the healthcare experiences of child sex trafficking survivors. *Child Abuse Negl*. 2021;112:104896. doi: 10.1016/j.chiabu.2020.104896.
93. Blöcher J, Eyslein L, Shrum J, Wells A. intersectional approach to the process of integration in Europe for Nigerian survivors of human trafficking: strengthening opportunities and overcoming hindrances. Eichstätt-Ingolstadt: Catholic University of Eichstätt-Ingolstadt; 2020 (<https://edoc.ku.de/id/eprint/24124/>, accessed 17 January 2023).
94. Hurst TE. Prevention of child sexual exploitation: insights from adult survivors. *J Interpers Violence*. 2021;36(13–14):NP7350–72. doi: 10.1177/0886260519825881.
95. George JS, Malik S, Symes S, Caralis P, Newport DJ, Godur A et al. Trafficking Healthcare Resources and Intra-disciplinary Victim Services and Education (THRIVE) clinic: a multidisciplinary one-stop shop model of healthcare for survivors of human trafficking. *J Hum Traffick*. 2020;6(1):50. doi: 10.1080/23322705.2018.1530528.
96. Vollinger L, Campbell R. Youth service provision and coordination among members of a regional human trafficking task force. *J Interpers Violence*. 2022;37(7–8):NP5669–92. doi: 10.1177/0886260520961868.
97. Erwin S, Peter J, Dalla RL, Chaidez V, Encinger A, Kreimer L. Identifying and assisting human trafficking survivors: a post-training analysis of first responders. *J Sociol Soc Welf*. 2020;47(4):art. 2.
98. Jain J, Bennett M, Bailey MD, Liaou D, Kaltiso SO, Greenbaum J et al. Creating a collaborative trauma-informed interdisciplinary citywide victim services model focused on health care for survivors of human trafficking. *Public Health Rep*. 2022;137(suppl 1):30–37S. doi: 10.1177/00333549211059833.
99. Armstrong S, Greenbaum VJ, López C, Barroso J. Preparedness to identify and care for trafficked persons in South Carolina hospitals: a state-wide exploration. *J Hum Traffick*. 2020;6(3):281. doi: 10.1080/23322705.2019.1603747.
100. Gerassi LB, Skinkis S. An intersectional content analysis of inclusive language and imagery among sex trafficking-related services. *Violence Vict*. 2020;35(3):400–17. doi: 10.1891/VV-D-18-00204.
101. Babu J, Boland GM, Salami T. Accurate identification and prosocial behaviors towards human trafficking victims among psychology students. *J Hum Traffick*. 2022. doi: 10.1080/23322705.2022.2040075. Epub ahead of print.
102. Gerassi LB. Experiences of racism and racial tensions among African American women impacted by commercial sexual exploitation in practice: a qualitative study. *Violence Against Women*. 2020;26(5):438–57. doi: 10.1177/1077801219835057.
103. Malpass A, Garbers K, Saunders L, Horwood J, McLeod H, Anderson E et al. Overcoming digital exclusion during the COVID-19 pandemic: impact of mobile technology for survivors of modern slavery and human trafficking: a mixed method study of survivors and support service provider views. *J Hum Traffick*. 2022. doi: 10.1080/23322705.2022.2050991. Epub ahead of print.
104. Martinez-Sosa N, Hadjikyriakou M, Potter J, Alhaji L. Providers' perspectives on the use of telehealth in an outpatient collaborative care clinic for human trafficking survivors during the COVID-19 pandemic. *J Acad Consult Liaison Psychiatry*. 2022;63:S2–3. doi: 10.1016/j.jaclp.2022.03.012.
105. Wells A, Weiss A, Kiluk V. Addressing adolescent safety in the time of telemedicine: a modified human trafficking standardized patient case. *J Adolesc Health*. 2021;68(2):S55–6. doi: 10.1016/j.jadohealth.2020.12.114.
106. Knudtzen FC, Mørk L, Nielsen VN, Astrup BS. Accessing vulnerable undocumented migrants through a healthcare clinic including a community outreach programme: a 12-year retrospective cohort study in Denmark. *J Travel Med*. 2022;29(7):taab128. doi: 10.1093/jtm/taab128.

107. López-Domene E, Granero-Molina J, Fernández-Sola C, Hernández-Padilla JM, López-Rodríguez MDM, Fernández-Medina IM et al. Emergency care for women irregular migrants who arrive in Spain by small boat: a qualitative study. *Int J Environ Res*. 2019;16(18):3287. doi: 10.3390/ijerph16183287.
108. Plaza Torres JF, Martínez-Sánchez JA. El caso de la operación EUNAVFOR MED "Sophia" [Healthcare for migrants on the high seas. The case of the operation EUNAVFOR MED "Sophia"]. *Rev Esp Salud Publica*. 2020;94:e202007070; in Spanish. PMID: 32684619.
109. Jiménez-Lasserrotte MDM, López-Domene E, Hernández-Padilla JM, Fernández-Sola C, Fernández-Medina IM, Faqr KEME et al. Understanding violence against women irregular migrants who arrive in Spain in small boats. *Healthcare (Basel)*. 2020;8(3):299. doi: 10.3390/healthcare8030299.
110. Bradby H, Lebano A, Hamed S, Gil-Salmerón A, Durá-Ferrandis E, Garcés-Ferrer J et al. Policy makers', NGO, and healthcare workers' accounts of migrants' and refugees' healthcare access across Europe: human rights and citizenship based claims. *Front Sociol*. 2020;5:16. doi: 10.3389/fsoc.2020.00016.
111. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization; 2013 (<https://apps.who.int/iris/handle/10665/85240>, accessed 17 January 2023).
112. WHO, Zimmerman C, Watts C. WHO ethical and safety recommendations for interviewing trafficked women. Geneva: World Health Organization; 2003 (<https://apps.who.int/iris/handle/10665/42765>, accessed 17 January 2023).
113. Mumma BE, Scofield ME, Mendoza LP, Toofan, Y, Youngyunpipatkul J, Hernandez B. Screening for victims of sex trafficking in the emergency department: a pilot program. *West J Emerg Med*. 2017;18(4):616–20. doi: 10.5811/westjem.2017.2.31924.
114. Mostajabian S, Maria DS, Wiemann C, Newlin E, Bocchini C. Identifying sexual and labor exploitation among sheltered youth experiencing homelessness: a comparison of screening methods. *Int J Environ Res*. 2019;16(3):e363. doi: 10.3390/ijerph16030363.
115. Greenbaum VJ, Livings MS, Lai BS, Edinburgh L, Baikie P, Grant SR et al. Evaluation of a tool to identify child sex trafficking victims in multiple healthcare settings. *J Adolesc Health*. 2018;63(6):745–52. doi: 10.1016/j.jadohealth.2018.06.032.
116. Kaltiso SO, Greenbaum VJ, Agarwal M, McCracken C, Zmitrovich A, Harper E et al. Evaluation of a screening tool for child sex trafficking among patients with high-risk chief complaints in a pediatric emergency department. *Acad Emerg Med*. 2018;25(11):1193–203. doi: 10.1111/acem.13497.
117. Greenbaum VJ, Dodd M, McCracken C. A short screening tool to identify victims of child sex trafficking in the health care setting. *Pediatr Emerg Care*. 2018;34(1):33–7. doi: 10.1097/PEC.0000000000000602.
118. Chisolm-Straker M, Singer E, Rothman EF et al. Building RAFT: trafficking screening tool derivation and validation methods. *Acad Emerg Med*. 2020;27(4):297–304. doi: 10.1111/acem.13888.
119. Egyud A, Stephens K, Swanson-Bierman B, DiCuccio M, Whiteman K. Implementation of human trafficking education and treatment algorithm in the emergency department. *J Emerg Nurs*. 2017;43(6):526–31. doi: 10.1016/j.jen.2017.01.008.
120. Basson D. Validation of the commercial sexual exploitation-identification tool (CSE-IT): technical report. Oakland (CA): WestCoast Children's Clinic; 2017 (<https://www.westcoastcc.org/wp-content/uploads/2015/04/WCC-CSE-IT-PilotReport-FINAL.pdf>, accessed 17 January 2023).
121. Andretta JR, Woodland MH, Watkins KM, Barnes ME. Towards the discreet identification of commercial sexual exploitation of children (CSEC) victims and individualized interventions: science to practice. *Psychol Public Policy Law*. 2016;22:260–70. doi: 10.1037/law0000087.
122. Schwarz C, Xing C, Daugherty R, Watt S, Britton HE. Frontline workers' perceptions of human trafficking: warning signs and risks in the midwest. *J Hum Traffick*. 2020;6(1):61–78. doi: 10.1080/23322705.2018.1562316.
123. Richie-Zavaleta AC, Villanueva AM, Homicile LM, Urada LA. Compassionate care: going the extra mile: sex trafficking survivors' recommendations for healthcare best practices. *Sexes*. 2021;2(1):26–49. doi: 10.3390/sexes2010003.
124. De Shalit A, van der Meulen E, Guta A. Social service responses to human trafficking: the making of a public health problem. *Cult Health Sex*. 2021;23(12):1717–32. doi: 10.1080/13691058.2020.1802670.
125. Peterson LJ, Foell R, Lunos S, Heisterkamp B, Greenbaum VJ, Harper NS. Implementation of a screening tool for child sex trafficking among youth presenting to the emergency department: a quality improvement initiative. *Child Abuse Negl*. 2022;125:105506. doi: 10.1016/j.chiabu.2022.105506.
126. Stevens C, Dinkel S. From awareness to action: assessing for human trafficking in primary care. *J Nurse Pract*. 2021;17(4):492–6. doi: 10.1016/j.nurpra.2020.10.013.
127. Pate SS, Anderson VR, Kulig TC, Wilkes N, Sullivan CJ. Learning from child welfare case narratives: a directed content analysis of indicators for human trafficking. *Child Youth Serv Rev*. 2021;121:art. 105838. doi: 10.1016/j.childyouth.2020.105838.

128. Kennedy MA, Arebalos MR, Ekroos RA, Cimino AN. Sex trafficking red flags: confirming presentation patterns and childhood adversity risk factors. *Nurse Lead*. 2021;19(5):516. doi: 10.1016/J.MNL.2021.01.007.
129. Landers M. Examining evidence of reliability and validity in Florida's human trafficking screening tool [thesis]. Tampa (FL): University of South Florida; 2021 (<https://digitalcommons.usf.edu/etd/9162/>, accessed 17 January 2023).
130. Chisolm-Straker M, Singer E, Strong D, Loo GT, Rothman EF, Clesca C et al. Validation of a screening tool for labor and sex trafficking among emergency department patients. *J Am Coll Emerg Physicians Open*. 2021;2(5):e12558. doi: 10.1002/emp2.12558.
131. Kaltiso SO, Greenbaum VJ, Moran TP, Osborne AD, Korniotis J, Marazzi G et al. Feasibility of a screening tool for sex trafficking in an adult emergency department. *Acad Emerg Med*. 2021;28(12):1399–1408. doi: 10.1111/acem.14313.
132. Spadafore S, Lane M, Walker J, Jaikaran E, Chisolm-Straker M. Histories of trauma: a qualitative analysis of lifetime traumatic experiences among emergency department patients. *Acad Emerg Med*. 2021;28(12):1389–98. doi: 10.1111/acem.14346.
133. Scott-Wellington F. Sex trafficking screening tool in the emergency department. *J Pediatr*. 2021;234:286–8. doi: 10.1016/j.jpeds.2021.04.052.
134. Herrero-Villoria C, Picornell-Lucas A, Patino-Alonso C. Cultural adaptation and validation into Spanish of the scale to measure attitudes towards the sex trafficking of women and girls in students of the University of Salamanca. *Violence Against Women*. 2022;28(12–13):3242–65. doi: 10.1177/10778012211038971.
135. Hurst IA, Abdoo DC, Harpin S, Leonard J, Adelgais K. Confidential screening for sex trafficking among minors in a pediatric emergency department. *Pediatrics*. 2021;147(3):e2020013235. doi: 10.1542/peds.2020-013235.
136. Interiano-Shiverdecker CG, Romero DE, Anderson A, Castellon NE. A content analysis of sex trafficking instruments. *Int J Adv Couns*. 2022;44:373–94. doi: 10.1007/s10447-021-09463-9.
137. Clemmons-Brown C. Identification of victims of human trafficking: leading change through a global pandemic [thesis]. San Francisco (CA): University of San Francisco; 2020.
138. Munro-Kramer ML, Beck DC, Martin KE, Carr BA. Understanding health facility needs for human trafficking response in Michigan. *Public Health Rep*. 2022;137(suppl 1):102–10S. doi: 10.1177/00333549211048785.
139. Gonzalez-Pons KM. "We can work across agencies to build a powerful, statewide response": considering the public health department's response to domestic minor sex trafficking. *J Hum Traffick*. 2021;7:1–11. doi: 10.1080/23322705.2021.1951535.
140. Dols JD, Beckmann-Mendez D, McDow J, Walker K, Moon MD. Human trafficking victim identification, assessment, intervention strategies in south Texas emergency departments. *J Emerg Nurs*. 2019;45(6):622–33. doi: 10.1016/j.jen.2019.07.002.
141. Gerassi L, Edmond TE, Fabbre V, Howard A, Nichols AJ. Disclosing sex trading histories to providers: barriers and facilitators to navigation of social services among women impacted by commercial sexual exploitation. *J Interpers Violence*. 2017;36:NP1259–84. doi: 10.1177/0886260517746130.
142. Wallace C, Schein Y, Carabelli G, Patel H, Mehta N, Dowshen N et al. A survivor-derived approach to addressing trafficking in the pediatric ED. *Pediatrics*. 2021;147(1):e20200772. doi: 10.1542/peds.2020-0772.
143. Einbond J, Diaz A, Cossette A, Scriven R, Blaustein S, Arden MR. Human trafficking in adolescents: adopting a youth-centered approach to identification and services. *Prim Care*. 2020;47(2):307–19. doi: 10.1016/j.pop.2020.02.008.
144. Scott JT, Ingram AM, Nemer SL, Crowley DM. Evidence-based human trafficking policy: opportunities to invest in trauma-informed strategies. *Am J Community Psychol*. 2019;63(3–4):348–58. doi: 10.1002/ajc.12394.
145. Macias-Konstantopoulos, WL. Caring for the trafficked patient: ethical challenges and recommendations for health care professionals. *AMA J Ethics*. 2017;19(1):80–90. doi: 10.1001/journalofethics.2017.19.1.msoc2-1701.
146. Chambers R, Greenbaum J, Cox J, Galvan T. Trauma informed care: trafficking out-comes (TIC TOC study). *J Prim Care Community Health*. 2022;13:21501319221093119. doi: 10.1177/21501319221093119.
147. Brady F, Chisholm A, Walsh E, Ottisova L, Bevilacqua L, Mason C et al. Narrative exposure therapy for survivors of human trafficking: feasibility randomised controlled trial. *BJPsych Open*. 2021;7(6):E196. doi: 10.1192/bjo.2021.1029.
148. Sapiro B, Johnson L, Postmus JL, Simmel C. Supporting youth involved in domestic minor sex trafficking: divergent perspectives on youth agency. *Child Abuse Negl*. 2016;58:99–110. doi: 10.1016/j.chiabu.2016.06.019.
149. Stoklosa H, MacGibbon M, Stoklosa J. Human trafficking, mental illness, addiction: avoiding diagnostic overshadowing. *AMA J Ethics*. 2017;19(1):23–34. doi: 10.1001/journalofethics.2017.19.1.ecas3-1701.
150. Robitz R, Ulloa EC, Salazar M, Ulibarri MD. Mental health service needs of commercially sexually exploited youth: voices of survivors and stakeholders. *Violence Vict*. 2020;35(3):354–62. doi: 10.1891/VV-D-18-00213.
151. Godoy SM, Abrams LS, Barnert ES, Kelly MA, Bath EP. Fierce autonomy: how girls and young women impacted by commercial sexual exploitation perceive health and exercise agency in health care decision-making. *Qual Health Res*. 2020;30(9):1326–37. doi: 10.1177/1049732320913857.

152. Gibbs DA, Hardison-Walters JL, Lutnick A, Miller S, Kluckman M. Services to domestic minor victims of sex trafficking: opportunities for engagement and support. *Child Youth Serv Rev*. 2015;54:1–7. doi: 10.1016/j.chidyouth.2015.04.003.
153. Preble KM, Nichols A, Cox A. Working with survivors of human trafficking: results from a needs assessment in a Midwestern state, 2019. *Public Health Rep*. 2022;137(suppl 1):111–18S. doi: 10.1177/00333549221089254.
154. Munro-Kramer M, Beck D, Choi K, Singer R, Gebhard A, Carr B. Human trafficking victim's service needs and outcomes: an analysis of clinical law data. *J Hum Traffick*. 2020;6(1):95. doi: 10.1080/23322705.2019.1574476.
155. Ramaj K. The aftermath of human trafficking: exploring the Albanian victims' return, rehabilitation, reintegration challenges. *J Hum Traffick*. 2021. doi: 10.1080/23322705.2021.1920823. Epub ahead of print.
156. Beck ME, Lineer MM, Melzer-Lange M, Simpson P, Nugent M, Rabbitt A. Medical providers' understanding of sex trafficking and their experience with at-risk patients. *Pediatrics*. 2015;135(4):e895–902. doi: 10.1542/peds.2014-2814.
157. Hansen S, Melzer-Lange M, Nugent M, Yan K, Rabbitt A. Development and assessment of an online training for the medical response to sex trafficking of minors. *Acad Pediatr*. 2018;18:965–8. doi: 10.1016/j.acap.2018.07.009.
158. 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. doi: 10.1080/10872981.2017.1267980.
159. Arulrajah P, Steele S. UK medical education on human trafficking: assessing uptake of the opportunity to shape awareness, safeguarding and referral in the curriculum. *BMC Med Edu*. 2018;18(1):137. doi: 10.1186/s12909-018-1226-y.
160. Barron CL, Moore JL, Baird G, Goldberg AP. Sex trafficking assessment and resources (STAR) for pediatric attendings in Rhode Island. *R I Med J* (2013). 2016;99(9):27–30. PMID: 27579947.
161. Thompson CD, Mahay A, Stuckler D, Steele S. Do clinicians receive adequate training to identify trafficked persons? A scoping review of NHS foundation trusts. *JRSM Open*. 2017;8(9):2054270417720408. doi: 10.1177/2054270417720408.
162. Greenbaum J, Bodrick N. Global human trafficking and child victimization. *Pediatrics*. 2017;140(6):e20173138. doi: 10.1542/peds.2017-3138.
163. Allam R. G491 (P) Increasing awareness of modern slavery among healthcare professionals. *Arch Dis Child*. 2020;105(suppl 1):A175.3–176. doi: 10.1136/archdischild-2020-rcpch.420.
164. Mishori R, Stolarz K, Ravi A, Korostyshevskiy VR, Chambers R, Cronholm P. Assessing family medicine residency programs' training on human trafficking: a national survey of program directors. *J Hum Traffick*. 2020;7(4):384–96. doi: 10.1080/23322705.2020.1780082.
165. Borham KL, Eret C, Bernstein B, Rhodes S. Legislative perspectives on human trafficking training for physicians. *J Hum Traffick*. 2021. doi: 10.1080/23322705.2021.2001632. Epub ahead of print.
166. McAmis NE, Mirabella AC, McCarthy EM, Cama CA, Fogarasi MC, Thomas LA et al. Assessing healthcare provider knowledge of human trafficking. *PLOS One*. 2022;17(3):e0264338. doi: 10.1371/journal.pone.0264338.
167. Havig K, Mahapatra N. Health-care providers' knowledge of human trafficking: implications for building service capacity in a frontier state. *J Hum Traffick*. 2021;7(4):366–83. doi: 10.1080/23322705.2020.1747011.
168. Bechtel K, Passmore S, Kondis J, Walker Descartes I, Adewusi A, Greenbaum V. Training experiences of emergency department providers in the recognition of child trafficking. *Pediatr Emerg Care*. 2022;38(2):e988–92. doi: 10.1097/PEC.0000000000002511.
169. Titchen KE, Loo D, Berdan E, Rysavy MB, Ng JJ, Sharif I. Domestic sex trafficking of minors: medical student and physician awareness. *J Pediatr Adolesc Gynecol*. 2017;30(1):102–8. doi: 10.1016/j.jpag.2015.05.006.
170. Ross C, Dimitrova S, Howard LM, Dewey M, Zimmerman C, Oram S. Human trafficking and health: a cross-sectional survey of NHS professionals' contact with victims of human trafficking. *BMJ Open*. 2015;5(8):e008682. doi: 10.1136/bmjopen-2015-008682.
171. Fraley HE, Aronowitz T. Obtaining exposure and depth of field: school nurses "seeing" youth vulnerability to trafficking. *J Interpers Violence*. 2019;36:15–16. doi: 10.1177/0886260519836779.
172. Martinho G, Matos M, Gonçalves M. Professionals' knowledge and perceptions on child trafficking: evidence from Portugal. *Eur J Crim Pol Res*. 2022. doi: 10.1007/s10610-022-09522-w. Epub ahead of print.
173. O'Brien JE, DellaPenna R, Gonzalez-Pons K, Mitchell K. Medical first responders and child sexual exploitation: needs, efforts, next steps. *J Hum Traffick*. 2022. doi: 10.1080/23322705.2022.2061280. Epub ahead of print.
174. Mobasher Z, Baldwin SB, Navarro B, Bressler-Montgomery D, King J, Family L et al. Knowledge and perceptions of human trafficking among community-based and faith-based organization members in south Los Angeles. *Glob Health Promot*. 2022;29(3):45–56. doi: 10.1177/17579759211028177.
175. Gerassi L, Pederson A. "Have you ever traded sex for money or drugs?" Health care providers' perspectives on sex trafficking risk assessments in clinics. *J Health Serv Res Policy*. 2021;26(4):272–81. doi: 10.1177/1355819621997478.

176. Shin RJ, Oberlin AM, Rigby F, Chelmos F. Educating physicians on sex trafficking: who receives our empathy and whom do we blame? *J Hum Traffick*. 2022;8(3):265. doi: 10.1080/23322705.2020.1808776.
177. Preble KM, Tlapek S, Koegler E. Sex trafficking knowledge and training: implications from environmental scanning in the American midwest. *Violence Vict*. 2020;35(3):363–81. doi: 10.1891/VV-D-19-00042.
178. Peck JL, Meadows-Oliver M. Human trafficking of children: nurse practitioner knowledge, beliefs, experience supporting the development of a practice guideline: part one. *J Pediatr Health Care*. 2019;33(5):603–11. doi: 10.1016/j.pedhc.2019.05.006.
179. Nyhus-Runtz K, Pederson P, Clay A, Liskowich S, Beurivage B. Child sexual exploitation: a survey of knowledge and confidence of healthcare providers in Saskatchewan, Canada. *Child Abus Rev*. 2021;30(5):422. doi: 10.1002/car.2709.
180. Brooks B. The need for a mandatory sex trafficking component in physician assistant education. *J Physician Assist Educ*. 2021;32(3):150–3. doi: 10.1097/JPA.0000000000000365.
181. Wolf LA, Perhats C, Delao A. Educational needs of US emergency nurses related to forensic nursing processes. *J Trauma Nurs*. 2022;29(1):12–20. doi: 10.1097/JTN.0000000000000627.
182. Bekmuratova S, Richie-Zavaleta AC, Boyle C. Human trafficking: an evaluation of doctoral occupational therapy students' awareness, knowledge, self-efficacy, future training. *J Hum Traffick*. 2021. doi: 10.1080/23322705.2021.1980713. Epub ahead of print.
183. Ruiz-Gonzalez C, Roman P, Benayas-Perez N, Rodriguez-Arrastia M, Ropero-Padilla C, Ruiz-Gonzalez D et al. Midwives' experiences and perceptions in treating victims of sex trafficking: a qualitative study. *J Adv Nurs*. 2022;78(7):2139–49. doi: 10.1111/jan.15165.
184. Raker KA. An examination of nurse educators' knowledge, attitudes, instructional beliefs, and instructional practices of human trafficking [thesis]. Indiana (PA): Indiana University of Pennsylvania; 2021 (<https://www.proquest.com/openview/dbeafd9c2114ab3b5de0e83a176ad5f1/1?pq-origsite=gscholar&cbl=18750&diss=y>, accessed 17 January 2023).
185. Lutz RM. Human trafficking education for nurse practitioners: integration into standard curriculum. *Nurse Educ Today*. 2018;61:66–9. doi: 10.1016/j.nedt.2017.11.015.
186. Donahue S, Schwien M, LaVallee D. Educating emergency department staff on the identification and treatment of human trafficking victims. *J Emerg Nurs*. 2019;45(1):16–23. doi: 10.1016/j.jen.2018.03.021.
187. Taylor LE, Harris HS. Stewards of children education: increasing undergraduate nursing student knowledge of child sexual abuse. *Nurse Educ Today*. 2018;60:147–50. doi: 10.1016/j.nedt.2017.10.004.
188. Berishaj K, Buch C, Glembocki MM. The impact of an educational intervention on the knowledge and beliefs of registered nurses regarding human trafficking. *J Contin Educ Nurs*. 2019;50(6):269–74. doi: 10.3928/00220124-20190516-07.
189. Metcalf EP, Selous C. Modern slavery response and recognition training. *Clin Teach*. 2020;17(1):47–51. doi: 10.1111/tct.13011.
190. Cole MA, Daniel M, Chisolm-Straker M, Macias-Konstantopoulos W, Alter H, Stoklosa H. A theory-based didactic offering physicians a method for learning and teaching others about human trafficking. *AEM Educ Train*. 2018;2(suppl 1):S25–30. doi: 10.1002/aet2.10206.
191. Lawrence M, Bauer P. Knowledge base of nurses before and after a human trafficking continuing education course. *J Contin Educ Nurs*. 2020;51(7):316–21. doi: 10.3928/00220124-20200611-07.
192. Begley KJ, Aden M, Fuji KT, Johnson L, Patterson A, Pick A et al. Student perceptions of an interprofessional short course designed to increase awareness of human trafficking. *J Allied Health*. 2022;51(2):e53–57. PMID: 35640298.
193. Johnson LA, Patterson A, Begley K, Ryan-Haddad A, Pick AM, Todd M et al. Development and implementation of violence across the lifespan (VAL) interprofessional education modules for health sciences students addressing human trafficking, child maltreatment, intimate partner violence. *J Interprofessional Educ Pract*. 2022;29:100535. doi: 10.1016/j.xjep.2022.100535.
194. Parchment J, Stinson A. Clinical nurses: leading through the complexity of human trafficking. *Nurs Adm Q*. 2020;44(3):235–43. doi: 10.1097/NAQ.0000000000000423.
195. McDow J, Dols JD. Implementation of a human trafficking screening protocol. *J Nurse Pract*. 2021;17(3):339–43. doi: 10.1016/j.nurpra.2020.10.031.
196. Gaillard-Kenney SF, Kent B, Lewis J, Williams C. Effects of trauma-informed care training on healthcare providers caring for victims of human trafficking. *Internet J Allied Health Sci Pract*. 2020;18(3):art. 13. doi: 10.46743/1540-580X/2020.1886.
197. Iszler A, Conroy A, Rodriguez DNV, Lee M, Palmero P, Puli L et al. The role of healthcare workers in the care of human trafficking survivors. In: Research, Innovation, Service, and Education (RISE) Conference, 10 September 2021. San Francisco (CA): Cureus; 2021 (<https://www.cureus.com/posters/1859-the-role-of-healthcare-workers-in-the-care-of-human-trafficking-survivors>, accessed 17 January 2023).

198. Wilken L. Role play as an effective method for the identification and assessment of human trafficking paths to the prevention and detection of human trafficking. In: Andrews SK, Crawford CM, editors. *Paths to the prevention and detection of human trafficking*. Hershey (PA): IGI Global; 2022:223–46.
199. Parrish N, Barfield L. Impact of an educational intervention on Florida's healthcare providers' knowledge and confidence to identify and manage victims of human trafficking [thesis]. Tallahassee (FL): Florida State University; 2021 (<https://diginole.lib.fsu.edu/islandora/object/fsu%3A758351>, accessed 17 January 2023).
200. Gee PM, Gibbs HA, Sieczka MJ, Knapp H, Gee PM. Human trafficking readiness for clinicians: content validation of a survivor co-led education program. *Urban Stud Public Admin*. 2021;4(3):13. doi: 10.22158/usp.v4n3p13.
201. Alvarado J. Implementation of a protocol in the freestanding emergency department to screen for and identify possible victims of human trafficking [thesis]. Las Vegas (NV): University of Nevada; 2021 (<https://digitalscholarship.unlv.edu/thesesdissertations/4112/>, accessed 17 January 2023).
202. Blume SG. Identification of human trafficking victims in the emergency department. Forth Worth (TX): Harris Methodist Hospital; 2018 (https://sigma.nursingrepository.org/bitstream/handle/10755/21420/Blume_Poster.pdf, accessed 17 January 2023).
203. Greiner-Weinstein G. Implementing an interprofessional human trafficking program in the emergency department: an evidence-based quality improvement initiative. In: 34th Annual Ruth K Palmer Research Symposium, Loyola University of Chicago, Chicago, 19 March 2021. Chicago (IL): Loyola University of Chicago; 2021 (https://ecommons.luc.edu/loyola_palmerresearchsymposium/2021/Asynchronous_Posters/7/, accessed 17 January 2023).
204. Elberier A. Implementation and evaluation of the "human trafficking 201 workshop" pilot conducted in partnership with Seattle Children's Center for Diversity and Health Equity [thesis]. Washington (DC): University of Washington; 2021 (https://digital.lib.washington.edu/researchworks/bitstream/handle/1773/47584/Elberier_washington_02500_23204.pdf?sequence=1, accessed 17 January 2023).
205. Shah N, Patel S, Tracy K, Dissanayake V. TraffickED and TraumatizED: the effectiveness of a human trafficking seminar in building confidence in trauma-informed care. *Ann Emerg Med*. 2021;78(4):S64. doi: 10.1016/j.annemergmed.2021.09.169.
206. Rajaram S, Sethi S, Keeler H, Sayles H. Evaluation of human trafficking training/education of nursing professionals. In: APHA's 2020 VIRTUAL Annual Meeting and Expo, 24–28 October 2020, online. Washington (DC): American Public Health Association; 2020 (https://apha.confex.com/apha/2020/meetingapi.cgi/Paper/475566?filename=2020_Abstract475566.pdf&template=Word, accessed 17 January 2023).
207. Dellinger A. Program TESA: human trafficking: education, screening and action [thesis]. Hickory (NC): Lenoir-Rhyne University; 2021 (<https://lair.lru.edu/handle/20.500.12862/40>, accessed 17 January 2023).
208. Cummings KA. An educational intervention to increase emergency department nurse's knowledge and confidence in recognizing victims of human trafficking [thesis]. Denver (CO): Regis University; 2020 (<https://epublications.regis.edu/theses/982>, accessed 17 January 2023).
209. Ngui JK. Impact of training nursing and social services students on caring for victims of human trafficking [thesis]. Vantaa: Laurea University of Applied Sciences; 2020 (<https://www.theseus.fi/bitstream/handle/10024/343784/Master%20thesis.pdf;jsessionid=1B3B9C7C656773569F332AEF3C9F1E66?sequence=2>, accessed 17 January 2023).
210. MacDonald A. Creating buy-in from nurse leaders to implement inpatient education and screening for human trafficking: a quality improvement initiative [thesis]. Durham (NH): University of New Hampshire; 2020 (https://scholars.unh.edu/scholarly_projects/31, accessed 17 January 2023).
211. Fraley H, Aronowitz T. Psychometric evaluation of the School Nurses' Awareness and Perceptions Survey (SNAPS) for youth at-risk of trafficking. *J Nurs Meas*. 2021;29(3):462–75. doi: 10.1891/JNM-D-20-00018.
212. Litam SDA, Lam ETC. Sex trafficking beliefs in counselors: establishing the need for human trafficking training in counselor education programs. *Int J Adv Couns*. 2021;43(2):1–18. doi: 10.1007/s10447-020-09408-8.
213. Charron CM, Valenzuela BE, Donnelly EA, Oehme JDK. What do EMS professionals know about human trafficking? Assessing the impact of training. *J Hum Traffick*. 2020;8(4):451–62. doi: 10.1080/23322705.2020.1824964.
214. Lo V, Bland D, Bibal X, Chavoshan B, Chung W, Davis PM et al. Training residents on understanding trafficked humans (TRUTH). *J Hum Traffick*. 2022;8(3):282–93. doi: 10.1080/23322705.2020.1794746.
215. Sangha MR, Birkholz L. Nurses' ability to identify human trafficking victims. *J Nurses Prof Dev*. 2021. doi: 10.1097/NND.0000000000000798. Epub ahead of print.
216. Ma K, Ali J, Deutscher J, Silverman JA, Novak C, Dong S et al. Preparing residents to deal with human trafficking. *Clin Teach*. 2020;17(6):674–9. doi: 10.1111/tct.13187.
217. Hoffman JL, Argeros G. Researching the effectiveness of an online human trafficking awareness program among community health nursing students. *J Community Health Nurs*. 2022;39(2):107–20. doi: 10.1080/07370016.2022.2058202.
218. Normandin PA. Commentary: a global problem of human trafficking in need of transformational leaders. *J Nurs Manag*. 2022;30(6):1382–5. doi: 10.1111/jonm.13583.

219. Sreedhar J, Lanspa M, Gorman C, Orr J, Jacobs RJ. Results of a brief synchronous online training program for health professions students on providing optimal clinical services for victims of human trafficking. San Francisco (CA): Cureus; 2022 (<https://www.cureus.com/posters/2221-results-of-a-brief-synchronous-online-training-program-for-health-professions-students-on-providing-optimal-clinical-services-for-victims-of-human-trafficking>, accessed 17 January 2023).
220. Capodilupo C, Klein CJ, McGarvey J. Human trafficking education: an asynchronous approach to improve nurses' knowledge and application. *J Nurses Prof Dev*. 2022. doi: 10.1097/NND.0000000000000854. Epub ahead of print.
221. Normandin PA. Human trafficking online educational training to increase emergency nurses' knowledge, self-efficacy, skills in identification, referral of human trafficking survivors. In: EN20X, virtual conference, Tufts Medical Center, Boston, Massachusetts, 2020. Shaumburg (IL): Emergency Nurses Association; 2020 (https://sigma.nursingrepository.org/bitstream/handle/10755/21411/Normandin_Abstract.pdf, accessed 17 January 2023).
222. Engler LA, Mercer L. Assessment of human trafficking knowledge among staff in a tertiary care academic medical center [05G]. *Obstet Gynecol*. 2020;135:71S. doi: 10.1097/01.AOG.0000665216.74369.37.
223. Kenny MC, Helpingstine C, Long H, Perez L, Harrington MC. Increasing child serving professionals' awareness and understanding of the commercial sexual exploitation of children. *J Child Sex Abus*. 2019;28(4):417–34. doi: 10.1080/10538712.2018.1563264.
224. Lee H, Geynisman-Tan J, Hofer S, Anderson E, Caravan S, Titchen K. The impact of human trafficking training on healthcare professionals' knowledge and attitudes. *J Med Educ Curric Dev*. 2021;8:23821205211016523. doi: 10.1177/23821205211016523.
225. Awerbuch A, Gunaratne N, Jain J, Caralis P. Raising awareness of human trafficking in key professional fields via a multidisciplinary educational approach. *Int J Hum Rights Healthc*. 2020;13(2):159–69. doi: 10.1108/IJHRH-07-2019-0053.
226. Nordstrom BM. Multidisciplinary human trafficking education: inpatient and outpatient healthcare settings. *J Hum Traffick*. 2020;8(2):184–94. doi: 10.1080/23322705.2020.1775049.
227. Ruiz A, Deleon S, Baronia R, Antal C, Terry M, Wakefield S. Effectiveness of an 8-week curriculum in changing medical student self-assessment of knowledge and confidence toward sex trafficking. *J Hum Traffick*. 2022. doi: 10.1080/23322705.2022.2034379. Epub ahead of print.
228. Wakim N. A HealthCare organization partnership with United Nations to eradicate human trafficking. Miami (FL): Nursing Consortium of Florida; 2022 (<https://scholarlycommons.baptisthealth.net/cgi/viewcontent.cgi?article=5679&context=se-all-publications>, accessed 17 January 2023).
229. Fitzgerald M, Owens T, Moore J, Goldberg A, Lowenhaupt E, Barron C. Development of a multi-session curriculum addressing domestic minor sex trafficking for high-risk male youth. *J Child Sex Abus*. 2021;30(6):667–83. doi: 10.1080/10538712.2021.1937427.
230. Richie-Zavaleta AC, Bekmuratova S, Butler E, Homicile LM. Future public health anti-trafficking training: an exploratory inquiry among public health graduate students to understand their levels of awareness, knowledge, and self-efficacy in order to prevent, identify, assist survivors of human trafficking. *J Hum Traffick*. 2022. doi: 10.1080/23322705.2022.2108289. Epub ahead of print.
231. Interiano-Shiverdecker CG, Romero DE, Elliott J. Development of child sex trafficking counseling competencies in the United States: a Delphi study. *J Interpers Violence*. 2023;38(1–2):NP1397–423. doi: 10.1177/08862605221090569.
232. US Department of Health and Human Services, Administration for Children and Families, Office on Trafficking in Persons. Core competencies for human trafficking response in health care and behavioral health systems. Washington (DC): National Human Trafficking Training and Technical Assistance Center; 2021 (<https://nhttac.acf.hhs.gov/sites/default/files/2021-02/Core%20Competencies%20Report%20%282%29.pdf>, accessed 17 January 2023).
233. Stoklosa H, Lyman M, Bohnert C, Mittel O. Medical education and human trafficking: using simulation. *Med Educ Online*. 2017;22(1):1412746. doi: 10.1080/10872981.2017.1412746.
234. Stoklosa H, Grace AM, Littenberg N. Medical education on human trafficking. *AMA J Ethics*. 2015;17(10):914–21. doi: 10.1001/journalofethics.2015.17.10.medu1-1510.
235. Ropero-Padilla C, Rodriguez-Arrastia M, Molina-Torres G, Márquez-Hernández VV, Gutiérrez-Puertas L, Aguilera-Manrique G et al. Nursing students' perceptions of identifying and managing sex trafficking cases: a focus group study. *J Nurs Manag*. 2022;30(6):1540–8. doi: 10.1111/jonm.13486.
236. Scannell M, Conso J. Using sexual assault training to improve human trafficking education. *Nursing*. 2020;50(5):15–17. doi: 10.1097/01.NURSE.0000657028.81053.2f.
237. McClendon S, Dwyer C, Fiorta A. Human trafficking simulation in an undergraduate nursing program. *Clin Simul Nurs*. 2022;66:1. doi: 10.1016/j.ecns.2022.02.004.
238. Corbett-Hone M, Johnson NL. Psychosocial correlates of mental health work with human trafficking survivors: risk and resilience. *Psychol Serv*. 2022;19(suppl 1):84–94. doi: 10.1037/ser0000615.

239. Gutiérrez-Puertas L, Márquez-Hernández VV, Aguilera-Manrique G, Molina-Torres G, Rodríguez-Arrastia M, Román-López P et al. Coping strategies and stressors of nursing students in the care of sex trafficking victims. *Int J Ment Health Nurs*. 2022;31(1):222–9. doi: 10.1111/inm.12952.
240. The health system response to violence against women in the WHO European Region: a baseline assessment. Copenhagen: WHO Regional Office for Europe; 2019 (<https://apps.who.int/iris/handle/10665/346919>, accessed 17 January 2023).
241. Sethi D, Yon Y, Parekh N, Anderson T, Huber J, Rakovac I et al. European status report on preventing child maltreatment. Copenhagen: WHO Regional Office for Europe; 2018 (<https://apps.who.int/iris/handle/10665/342240>, accessed 17 January 2023).
242. Pederson AC, Gerassi LB. Healthcare providers' perspectives on the relevance and utility of recommended sex trafficking indicators: a qualitative study. *J Adv Nurs*. 2022;78(2):458–70. doi: 10.1111/jan.15019.
243. Bounds D, Julion WA, Delaney KR. Commercial sexual exploitation of children and state child welfare systems. *Policy Polit Nurs Pract*. 2015;16(1–2):17–26. doi: 10.1177/1527154415583124.
244. Todres J. Physician encounters with human trafficking: legal consequences and ethical considerations. *AMA J Ethics*. 2017;19(1):16–22. doi: 10.1001/journalofethics.2017.19.1.ecas2-1701.
245. Kerr PL, Dash R. Ethical considerations in mandatory disclosure of data acquired while caring for human trafficking survivors. *AMA J Ethics*. 2017;19(1):45–53. doi: 10.1001/journalofethics.2017.19.1.stas1-1701.
246. English A. Mandatory reporting of human trafficking: potential benefits and risks of harm. *AMA J Ethics*. 2017;19(1):54–62. doi: 10.1001/journalofethics.2017.19.1.pfor1-1701.
247. Garg A, Panda P, Malay S, Slain KN. Human trafficking ICD-10 code utilization in pediatric tertiary care centers within the United States. *Front Pediatr*. 2022;10:818043. doi: 10.3389/fped.2022.818043.
248. Kerr PL, Bryant G. Use of ICD-10 codes for human trafficking: analysis of data from a large, multisite clinical database in the United States. *Public Health Rep*. 2022;137(suppl 1):83–90S. doi: 10.1177/00333549221095631.
249. Sokat KY, Gutfraind A, Muscioni G, Alahmadi S, Hudlow J, Hershow RC et al. Medical journeys of victims of exploitation and trafficking: a retrospective cohort study using a large multi-state dataset and new ICD-10 codes. *medRxiv*. 2022.05.02.22274579. doi: 10.1101/2022.05.02.22274579.
250. Macias-Konstantopoulos WL. Diagnosis codes for human trafficking can help assess incidence, risk factors, comorbid illness and injury. *AMA J Ethics*. 2018;20(12):E1143–51. doi: 10.1001/amajethics.2018.1143.
251. Cannon AC, Arcara J, Graham LM, Macy RJ. Trafficking and health: a systematic review of research methods. *Trauma Violence Abuse*. 2018;19(2):159–75. doi: 10.1177/1524838016650187.
252. Such E, Laurent C, Jaipaul R, Salway S. Modern slavery and public health: a rapid evidence assessment and an emergent public health approach. *Public Health*. 2020;180:168–79. doi: 10.1016/j.puhe.2019.10.018.
253. Bird S. Public health perspective on UK-identified victims of modern slavery. *Crime Delinquency*. 2021;67(13–14):2295. doi: 10.1177/0011128720981887.
254. Stoklosa H, Miller CL, Duke G, Chisolm-Straker M. A framework for the development of healthcare provider education programs on human trafficking part one: experts. *J Hum Traffick*. 2020;6(4):388. doi: 10.1080/23322705.2019.1584724.
255. WHO Regional Committee for Europe resolution EUR/RC66/12 on an action plan to strengthen the use of evidence, information and research for policy-making in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2016 (<https://apps.who.int/iris/handle/10665/338122>, accessed 29 January 2023).

Annex 1.

Search strategy

This scoping review examines academic and grey literature published in English and Russian between January 2015 and August 2022. The aim of a scoping review is to comprehensively search, map, summarize, synthesize and identify gaps in an evidence base of a particular field of enquiry, often engaging a wide range of methodologies, in response to a relatively broad question (1,2). A scoping review is appropriate for the guiding question because it encompasses many aspects of medical systems interactions with trafficking survivors.

The methodology developed for this scoping review is a modified version of a 2016 systematic review conducted by Hemmings et al. entitled Responding to the health needs of survivors of human trafficking: a systematic review (3). Their review of research covered publications up to February 2015. Only 44 studies qualified for inclusion in this review, even when general guidance, non-profit-making organization websites and narrative discussions without a significant evidentiary base were included. Their review concluded that research at the time suffered from a “lack of empirical evidence to support the identification, referral and care of survivors of trafficking in health-care settings”.

Search protocol

Four electronic literature databases (Embase/Scopus, Google Scholar, PubMed and Web of Science) and two grey literature databases (Rutgers Gray Literature Database and the WHO Statistical Information System) were searched for relevant peer-reviewed and grey literature. Grey literature was included to assist in addressing the lag time in publication, biases in publication and the availability of some research only in White Papers. The search strategy did not set a limit for language, but the vast majority of the literature was published in English.

A search for relevant Russian-language literature was conducted by Nurshaim Tilenbaeva (National Professional Officer, Sexual, Reproductive, Maternal and Newborn Child Health, WHO Country Office Kyrgyzstan) and articles were identified through searches of the following databases:

<u>Bielefeld Academic search engine</u>	▶ <u>https://www.base-search.net/</u>
<u>Cyberleninka</u>	▶ <u>https://cyberleninka.ru/</u>
<u>Database of scientific publications</u>	▶ <u>http://www.scholar.ru/</u>
<u>East View</u>	▶ <u>http://eastview.com</u>
<u>eLibrary</u>	▶ <u>https://elibrary.ru</u>
<u>Nauka-rastudent</u>	▶ <u>http://nauka-rastudent.ru/</u>
<u>Open Science in Europe</u>	▶ <u>http://openaire.ru</u>
<u>Scientific library of the Ministry of Education of the Russian Federation</u>	▶ <u>https://edu.gov.ru/en</u> (NB this URL may not always function).

Search terms

Combinations of terms relevant to the synthesis question were used to search the databases. Searches combined free-text terms related to trafficking (such as “sex trafficking”) with free-text terms related to medical systems (such as “health”) and with Medical Subject Headings (MeSH) terms (such as “Disclosure”) (Table A1.1).

Table A1.1. Search terms

Concept 1: trafficking terms	Concept 2: medical system terms	Concept 3: MeSH terms
human trafficking	health*	Disclosure
sex trafficking	medic*	Harm reduction
labour trafficking	therap*	Referral and Consultation
labor trafficking	hospital	Education, Medical, Continuing
child trafficking	clinic	Quality Assurance, Healthcare
domestic servitude	emergency	Evaluation Studies
domestic slavery	psycho*	Feasibility Studies
forced labour	psychiatry*	Outcome Assessment (Healthcare)
forced labor	clinic*	Outcome and Process Assessment (Health Care)
sex* slave*	community health	Pilot Projects
modern* slave*	dentist	Project Evaluation
	doctor	Treatment Outcome
	general practitioner	Validation Studies
	nurse*	Professional-Patient Relations
	physician	Qualitative research
		Health services accessibility

Study selection

In order to synthesize the most recent evidence regarding medical systems approaches to trafficking and to provide up-to-date policy considerations, this review covers the period from January 2015 to August 2022, the period subsequent to that used by Hemmings et al. (3).

The strategy for selecting studies was modified from that used by Hemmings et al. (3) in order to efficiently and specifically address the guiding question of this review:

- **reducing the number of search terms:** removal of terms not relevant to health systems or to prevention and response to trafficking, or because they repeated terms already be included in the search ((health* would capture health provider and health professional);
- **limiting the number of databases searched:** four electronic literature databases and two gray literature databases searched following recent research suggesting that systematic reviews are typically inefficient because they search too many overlapping sources;

- **excluding studies with small sample sizes:** quantitative studies with fewer than 15 participants were excluded because they provide insufficient evidence upon which to base a policy consideration and there were sufficient rigorous studies with a sample size and definitional clarity support deriving the most appropriate, evidence-informed policy considerations; and
- **excluding all documents that were not evidence informed.**

Inclusion criteria

Peer-reviewed academic articles and grey literature were eligible for initial review if they:

- involved any form of human trafficking affecting people of any race, age, nationality, gender or sexual orientation;
- reported findings from studies in Canada, the United States or the WHO European Region;
- discussed prevention of or response to human trafficking; and
- engaged one of the six aspects of the health system (as defined by WHO: leadership and governance, health information systems, health financing, human resources for health, essential medical products and technologies, service delivery).

Exclusion criteria

All literature that:

- was conducted before 2015;
- was not evidence informed in its methodology (including guidance, editorials, newspapers, websites, textbooks, non-profit-making organization promotional materials and non-evidence-informed reports);
- involved a sample size of 15 subjects or fewer;
- was itself a synthesis/review;
- conflates commercial sex with sex trafficking or smuggling with trafficking, thereby disguising findings specific to trafficking; or
- did not contain findings relevant to health systems.

Screening and data management

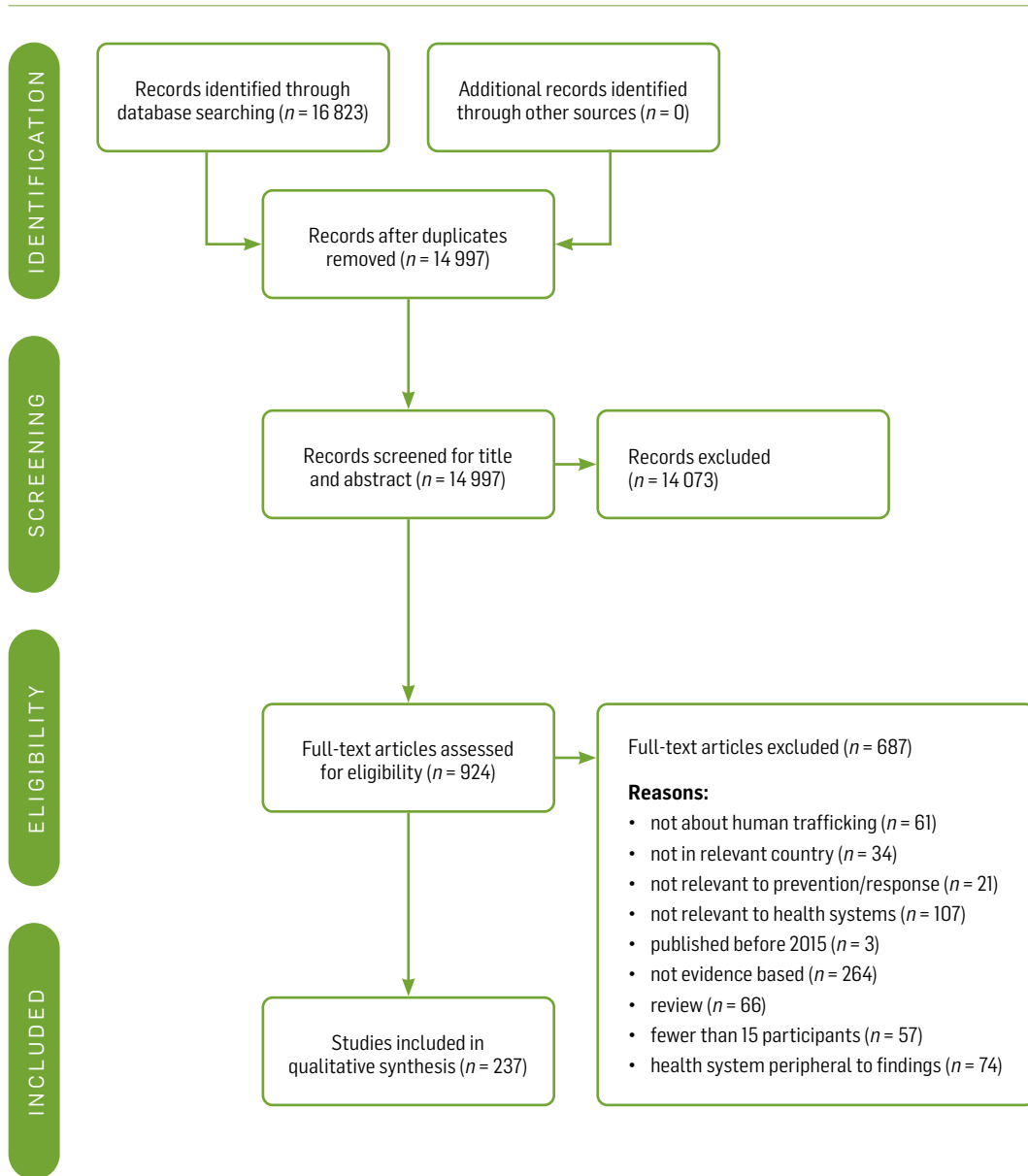
All citations were imported into Zotero reference management system. Citations were then imported into DistillerSR online software designed to assist the review processes. All papers identified for potential inclusion in the initial search were loaded into DistillerSR and all duplicates removed. Titles and abstracts of identified papers were initially reviewed by one reviewer; two reviewers then assessed the full texts of the remaining set to determine eligibility for inclusion. Conflicts between reviewers were resolved either through consensus or through referral to the third author. Themes were coded within DistillerSR.

The review employed grounded coding. Initial codes were anticipated by the original search strategy and discussions between research collaborators. The codes were then updated in the first phase of the review to reflect findings from that stage. Those codes were then employed in the second phase of the review to extract data for the analysis. Although a scoping review

does not appraise the quality of the articles included in the review, this review does outline the limitations of the studies discussed in the Findings.

Fig. A1.1 outlines the flowchart of included studies.

Fig. A1.1. Flowchart of included studies: summary of literature search and screening process



References

1. Arksey H, O'Malley L. Scoping studies: towards a methodological framework. *Int J Soc Res Method.* 2002;8(1):19–32. doi: 10.1080/1364557032000119616.
2. Pham MT, Rajić A, Greig JD, Sargeant JM, Papadopoulos A, McEwen SA. A scoping review of scoping reviews: advancing the approach and enhancing the consistency. *Res Synth Methods.* 2014;5(4):371–85. doi: 10.1002/jrsm.1123.
3. Hemmings S, Jakobowitz S, Abas M, Bick D, Howard LM, Stanley N et al. Responding to the health needs of survivors of human trafficking: a systematic review. *BMC Health Serv Res.* 2016;16(1):320. doi: 10.1186/s12913-016-1538-8.

Annex 2.

Relevant WHO literature on topics adjacent to trafficking

Any holistic health system responses for populations at risk of trafficking should be informed by guidance provided by WHO and other relevant bodies. Interested parties should also attend to relevant scholarly literature in other overlapping fields, including intimate partner violence, sexual assault, violence against women and migration.

- ▶ HIV and young people who sell sex: a technical briefing. Geneva: World Health Organization; 2015 (<https://apps.who.int/iris/handle/10665/179868>, accessed 17 January 2023).
- ▶ Priebe S, Giacco D, El-Nagib R. Public health aspects of mental health among migrants and refugees: a review of the evidence on mental health care for refugees, asylum seekers and irregular migrants in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2016 (Health Evidence Network Synthesis Report 47; <https://apps.who.int/iris/handle/10665/326308>, accessed 17 January 2023).
- ▶ Report on the health of refugees and migrants in the WHO European Region: “no public health without refugees and migrant health”. Copenhagen: WHO Regional Office for Europe; 2018 (<https://apps.who.int/iris/handle/10665/311347>, accessed 17 January 2023).
- ▶ Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. Geneva: World Health Organization; 2017 (<https://apps.who.int/iris/handle/10665/259270>, accessed 17 January 2023).
- ▶ Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization; 2013 (<https://apps.who.int/iris/handle/10665/85240>, accessed 17 January 2023).
- ▶ Sexual health, human rights and the law. Geneva: World Health Organization; 2015 (<https://apps.who.int/iris/handle/10665/175556>, accessed 17 January 2023).
- ▶ UNAIDS, WHO. Addressing violence against women and HIV: what works? Geneva: World Health Organization; 2010 (<https://apps.who.int/iris/handle/10665/44378>, accessed 17 January 2023).
- ▶ WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children. In: Sixty-ninth World Health Assembly, Geneva, 23–28 May 2016. Geneva: World Health Organization; 2016 (WHA69.5; <https://apps.who.int/iris/handle/10665/252785>, accessed 17 January 2023).
- ▶ WHO, UNFPA, UNAIDS, World Bank, Global Network of Sex Work Projects. Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions. Geneva: World Health Organization; 2013 (<https://apps.who.int/iris/handle/10665/90000>, accessed 17 January 2023).

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