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Identifying Human Trafficking Victims - World Leaders and Health Institutions

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Abstract

Human trafficking involves harsh exploitation of victims and is a deplorable human rights violation. It can be a danger to one's health and is a major public health issue. Roughly, 12.3 to 27 million men, women, and children are trafficked worldwide. Close to 17,500 people are trafficked yearly into the United States. Human trafficking victims often suffer from many health problems while being trafficked. Trafficking victims often seek medical care while in captivity, placing health care professionals in a unique position to interrupt the abuse cycle and prevent further exploitation and the risk of death. However, caregivers often do not detect trafficking victims' delicate health needs. Despite training, care providers still lack the extent of knowledge that is needed to assess and rescue victims of trafficking. Furthermore, the World Health Organization (WHO) international classification of diseases (ICD) 11th version system excludes the diagnostic codes for sex trafficking and labor trafficking, hindering the requisite global public health efforts to research, monitor, and diagnose labor and sex trafficking. One of the barriers to human trafficking identification involves challenges in breach of confidentiality with ICD coding and electronic health record. Documentation or reporting via ICD coding may also violate HIPAA. Although reporting laws are designed to protect certain victims, the laws can potentially create further harm to them. The purpose of

this paper is to review the human trafficking victim identification process for healthcare institutions and the global International Classification of Diseases (ICD) system for human trafficking.

Keywords: human trafficking, trafficking, health care, emergency department, trafficking victims, identification tools, sex trafficking, labor trafficking, warnings signs, red flags, barriers to identification, health consequences of human trafficking, screening tools, screening protocols, sex trafficking health policies, Centers for Disease Control and Prevention (CDC), World Health Organization (WHO) on human trafficking, United Nations (UN) on human trafficking, validated screening tools, Health Insurance Portability and Accountability Act (HIPAA), human trafficking hotline, international classification of diseases (ICD), National Human Trafficking Hotline (NHTH), National Human Trafficking Resource Center (NHTRC), and mandatory reporting

Introduction

Human trafficking involves harsh exploitation of victims and is a deplorable human rights violation (Bespalova, Morgan, & Coverdale, 2016; Gibbons & Stoklosa, 2016; Kaltiso, Greenbaum, Agarwal, McCracken, Zmitrovich, Harper, & Simon, 2018; Nguyen, Lamkin, Coverdale, Scott, Li, & Gordon, 2018; Stanford, Cappetta, Ahn, & Macias-Konstantopoulos, 2021). It can be a danger to one's health and is a major public health issue (Bespalova et al., 2016; Kaltiso et al., 2018; Nguyen, P. T. et al., 2018; Stanford et al., 2021). Victims of trafficking may suffer from sexually transmitted infections, physical injuries, mental health issues, and unintended pregnancies (McDow & Dols, 2021; Stanford et al., 2021). Trafficking victims often seek medical care while in captivity (Bespalova et al., 2016; Dols, Beckmann-Mendez, McDow, Walker, & Moon, 2019; McDow & Dols, 2021). While under care, the victims are likely to speak to a health care worker as opposed to the police, placing health care professionals in a unique position to interrupt the abuse cycle (Bespalova et al., 2016; Testa, 2020). While law enforcement agencies or the legal communities look at the legal aspects surrounding potential victimization, clinicians are more likely to discover useful diagnostic signs or symptoms that can be used to identify trafficked victims (Bauer, Brown, Cannon, & Southard, 2019). Trafficking assessment and intervention efforts of the care providers may prevent further exploitation and lessen the risk of severe physical and mental

consequences (Dols et al., 2019; Kaltiso et al., 2018; Testa, 2020). However, human trafficking victims often go unnoticed in health care settings and their delicate health needs are often undetected (Gibbons & Stoklosa, 2016; McDow & Dols, 2021; Nguyen, P. T. et al., 2018; Testa, 2020). In an emergency department setting or during the process of caring for multiple emergently ill patients in an acute setting, clinicians may miss significant signs that would indicate that a patient is the victim of trafficking (Gibbons & Stoklosa, 2016). Care providers lack the experience, training, and knowledge that is needed to assess and rescue victims of trafficking (Dols et al., 2019; Nguyen, P. T. et al., 2018; Testa, 2020). In particular, health care providers are reluctant to ask sensitive questions of a potential trafficking victim because they are uncomfortable in doing so (Nguyen, P. T. et al., 2018). The World Health Organization (WHO) international classification of diseases (ICD) 11th version system excludes the diagnostic codes for sex trafficking and labor trafficking, hindering the requisite global public health efforts to research, monitor, and diagnose labor and sex trafficking (Greenbaum & Stoklosa, 2019). One of the barriers to human trafficking identification involves the challenges in possible breach of confidentiality as it relates to ICD coding and electronic health record (Greenbaum, Garrett, Chon, Bishop, Luke, & Stoklosa, 2021). Although reporting laws are designed to protect certain victims, the laws can potentially create further harm to them (Boswell, Temples, & Wright, 2019).

Statement of the Problem

Low human trafficking detection results from lack of training, lack of investigations, and ineffective laws (Stevens & Berishaj, 2016). Human trafficking victims come into contact with the healthcare system while being trafficked, with the emergency department being the most frequented setting for medical treatment (Stevens & Berishaj, 2016). Emergency room clinicians are in an advantageous position to identify these victims and intervene (Shandro, Chisolm-Straker, Duber, Findlay, Munoz, Schmitz, . . . Wingkun, 2016). Nevertheless, only few clinicians know how to identify victims of human trafficking amongst their patients (Stoklosa, Showalter, Melnick, & Rothman, 2017). Thus, many trafficked persons go undiscovered in the health systems (Gibbons & Stoklosa, 2016; Leslie, 2018; Testa, 2020). An established protocol for victim identification can proactively facilitate healthcare providers' assistance with human trafficking victims (Shandro et al., 2016). To address the problem of identifying and assisting victims of human trafficking, some hospitals developed their own protocols (Stoklosa, Showalter, Melnick, & Rothman, 2017). However, the wide variation in what is included on human trafficking healthcare protocols make it difficult to

hold up any particular protocol as a national model (Stoklosa, Showalter, Melnick, & Rothman, 2017). Furthermore, the World Health Organization (WHO) international classification of diseases (ICD) 11th version system excludes the diagnostic codes for sex trafficking and labor trafficking, hindering the requisite global public health efforts to research, monitor, and diagnose labor and sex trafficking (Greenbaum & Stoklosa, 2019).

Purpose of the Paper

The goal of the paper is to review current strategies in the identification of human trafficking victims within healthcare settings, and to bring awareness to world leaders and health institutions of the challenges in the absence of a global International Classification of Diseases coding system for human trafficking, to aid in the research, monitoring, and diagnostic effort in combatting human trafficking.

Research Question

There were two research questions to be answered by this paper. What were the necessary strategies in identifying human trafficking victims within healthcare settings; and how could effective implementation of the global International Classification of Diseases coding system for human trafficking be achieved?

Significance to World Leaders and Health Institutions

Through the paper, world leaders and health care administrators should understand the significance of providing clinicians with the necessary tools to help identify trafficked victims.

Review of Literature

Definition of Human Trafficking

Human trafficking is the compelling of someone using coercion, force, or fraud to do laborious work or involuntary commercial sexual acts (Cokar, Ulman, & Bakirci, 2016; Preble, Cook, & Fults, 2019; Rollins, Gribble, Barrett, & Powell, 2017). Human trafficking is often called modern day slavery and is a violation of human rights (Bespalova et al., 2016; Chisolm-Straker, Sze, Einbond, White, & Stoklosa, 2019; Cokar et al., 2016). Trafficking is also a crime that involves controlling and transporting people to be exploited through labor or sex for monetary gain (Cokar et al., 2016; Testa, 2020). Children who are engaged in

prostitution are victims of trafficking even in the absence of coercion or fraud (Preble et al., 2019; Rollins et al., 2017). The United States federal law defines human trafficking as the recruitment, transportation, harboring, obtaining, or provision of an individual for labor or commercial sex act by fraud, force, or coercion (Chisolm-Straker et al., 2019; Testa, 2020). The United Nations international definition of human trafficking is the recruitment, transportation, harboring, transfer, or receipt of individuals through the use of coercion, abduction, fraud, deception, abuse of power, or commercial exchange, for the purpose of labor, sex, or human organs exploitation (Testa, 2020; Tripp & McMahon-Howard, 2016).

The Nature of Human Trafficking

Human trafficking involves criminal behaviors linked to the recruitment, transportation, and exploitation of people (Cokar et al., 2016). Men have used methods to locate vulnerable adults and children, isolate them from their friends and families, and coerce them into sexual slavery or domestic servitude (Yousaf, 2018). Trafficking victims often have minimal control over their lives (Byrne, 2019). The trafficker may prevent victims from leaving an unsafe work condition (Byrne, 2019; Chisolm-Straker et al., 2019). With no alternative options, the victims may stay in work situations that are dangerous (Byrne, 2019; Chisolm-Straker et al., 2019). Also, the victims may be restricted from keeping their earned money and from speaking for themselves as patients (Byrne, 2019; Chisolm-Straker et al., 2019). Traffickers tend to speak for the patient during which time there is little or no opportunity for the patient to give honest answers to questions that health care clinicians may ask (Byrne, 2019). Traffickers give dishonest answers to questions asked by the clinicians, and protect themselves by asking the victims to refrain from talking to health care providers about the sex or labor trafficking work they are involved in and instead to lie about the kind of work that they do (Byrne, 2019; Chisolm-Straker et al., 2019). The trafficking victim may have no identification documents and little or no personal possession (Byrne, 2019). Young homeless adults, who are estranged from their families, may have limited options to meet their basic needs, including food and sheltered accommodation (Chisolm-Straker et al., 2019). Although traffickers are predominantly male, women also play a major role in the trafficking operations (Tripp & McMahon-Howard, 2016). Labor trafficking constitutes low wages and long working hours (Tripp & McMahon-Howard, 2016). In addition, victims may experience restrictions, physical threats, isolation from relatives, and entrapment on the job (Tripp & McMahon-Howard, 2016). Traffickers usually have the same nationality as their victims (Tripp & McMahon-Howard, 2016). However, traffickers do not have any particular set of

physical characteristics (Tripp & McMahon-Howard, 2016). Traffickers could be relatives, friends, pimps or madams, massage parlor owners, labor subcontractors, gang members, or smugglers (Tripp & McMahon-Howard, 2016). The victim's family members and friends may be deliberately acting as traffickers (Tripp & McMahon-Howard, 2016). Other family or friends may not be aware that they are recruiting the victim into trafficking (Tripp & McMahon-Howard, 2016).

Types of Human Trafficking

There are seven forms of human trafficking: (a) Commercial sexual exploitation of children and sex trafficking of minors, (b) Adult sex trafficking, (c) Forced labor trafficking, (d) Forced child labor, (e) Child soldiering, (f) Debt bondage/bonded labor, and (g) Organ trafficking (Hachey & Phillippi, 2017).

(a) Commercial sexual exploitation of children and sex trafficking of minors: This is the sexual exploitation of children and youth under 18 years of age for economic purposes. Forms may include trafficking for sexual purposes, sex tourism, prostitution, pornography, strip clubs, or child marriage (Hachey & Phillippi, 2017; Kaltiso et al., 2018).

(b) Adult Sex trafficking: This is the recruiting, transporting, receiving, harboring, or obtaining of an adult for commercial sexual exploitation through means of physical force, threat, or fraud (Hachey & Phillippi, 2017; Tripp & McMahon-Howard, 2016).

(c) Forced labor trafficking: This is the recruiting, transporting, receiving, harboring, or obtaining of individuals for involuntary servitude through the use of physical or psychological force, threat, or fraud (Chisolm-Straker et al., 2019; Hachey & Phillippi, 2017; Tripp & McMahon-Howard, 2016).

(d) Forced child labor: This is the entrapment of children under the age of 18 years old in forced, bonded labor, or slavery, without an economic benefit or the option to leave (Hachey & Phillippi, 2017).

(e) Child soldiering: This is the unlawful recruitment of children for labor, sexual exploitation, or combatants in conflict areas (Hachey & Phillippi, 2017).

(f) Debt bondage/bonded labor: This is the use of a debt or bond by a trafficker to subjugate and unlawfully exploit the worker, using an initial debt as part of the terms of employment (Hachey & Phillippi, 2017).

(g) Organ trafficking: This is the recruitment, transportation, or harboring of a person for organ removal through force, fraud, or coercive means, including the abuse of a position of vulnerability (Hachey & Phillippi, 2017).

Human trafficking comprises of two main categories. Sex trafficking includes 79% while labor trafficking includes 18% (Moore, 2018). Other types of trafficking include forced marriages, selling babies, organ harvesting, and international human trafficking (Moore, 2018; Tripp & McMahon-Howard, 2016). Sex trafficking involves prostitution induced by force, fraud, or coercion (Tripp & McMahon-Howard, 2016). This form of trafficking is considered to be a complicated type of gender-based violence (Hachey & Phillippi, 2017). In the United States, sex trafficking victims are exploited on the streets, in strip clubs, and in whorehouses (Tripp & McMahon-Howard, 2016). Child sex trafficking involves the act of prostitution regardless of consent or the absence of coercion, force, or fraud, in which the child is under 18 years old (Kaltiso et al., 2018). Labor trafficking involves forced labor and is considered modern-day slavery (Chisolm-Straker et al., 2019; Tripp & McMahon-Howard, 2016). Labor trafficking is the recruitment, transportation, harboring, obtaining, or provision of an individual for domestic or involuntary servitude by coercion, fraud, or force (Tripp & McMahon-Howard, 2016). This form of trafficking includes domestic servitude, forced labor in huge farm operations, factories, hotels, construction, manufacturing, and janitorial industry (Tripp & McMahon-Howard, 2016).

International human trafficking involves misusing immigration laws or recruitment under pretenses while focusing on exploitation instead of transportation or legitimate employment (Tripp & McMahon-Howard, 2016). Victims of international labor or sex trafficking are often recruited in their country of origin under false pretenses or coercive methods along with arranged transportation to the United States (Tripp & McMahon-Howard, 2016). During the recruitment in both international labor and sex trafficking cases, traffickers use false promises of lucrative job opportunities in the face of the victims' desperate financial situation (Tripp & McMahon-Howard, 2016). Victims who are experiencing financial hardships typically agree at first to travel with and work for the traffickers without being aware that the job offers are not genuine (Tripp & McMahon-Howard, 2016). Women and girls are usually trafficked for sexual exploitation, forced marriage, or domestic work (Zimmerman & Kiss, 2017). On the other hand, males tend to be more vulnerable to trafficking into armed conflicts (Zimmerman & Kiss, 2017). Men in Southeast Asia are more likely to be recruited for commercial fishing or sea slavery (Zimmerman & Kiss, 2017). The extremes of wealth and poverty contribute to the issue of trafficking in regions of Mexico, Canada, and the United States (Hachey & Phillippi, 2017). The United States and Canada are destination countries for sex and labor trafficking (Hachey & Phillippi, 2017). Canada is also a transit country through which

foreign nationals are relocated into the United States (Hachey & Phillippi, 2017). Mexico is mainly a source of origin for foreign nationals (Hachey & Phillippi, 2017). Mexico is also considered a transit country through which foreign nationals migrate into the United States (Hachey & Phillippi, 2017). Cross-border migration from Mexico to the United States tends to be associated with deceptive tactics or deportation (Hachey & Phillippi, 2017). In Asia, Turkey is the main destination country in human trafficking because of its higher economic status and geographical location to other localities including Eastern Europe (Cokar et al., 2016). Organ harvesting or trafficking for the removal of organs occurs when people are trafficked for the removal and sale of their organs in the black market (Cokar et al., 2016; Loua, Feroleto, Sougou, Julius Kasilo, Nikiema, Fuller, Kniazkov, & Tumusiime, 2020; Moore, 2018).

Incidence of Human Trafficking

Globally, human trafficking occurs in every nation with victims from 124 countries and 152 nationalities (Hachey & Phillippi, 2017). An estimated 40.3 million people are victims of forced physical or sexual labor (Coughlin, Greenbaum, & Titchen, 2020; Zimmerman & Kiss, 2017). 29.4 million of those people are considered to be in situations of forced labor (Zimmerman & Kiss, 2017). Every year, about 18,000 people are trafficked into the United States and coerced into labor or sex work (Bauer et al., 2019; Cheshire, 2017; Gibbons & Stoklosa, 2016). The number may even be as high as 45,000 to 50,000 (Gibbons & Stoklosa, 2016). At least six of ten trafficking victims are from a foreign country having crossed one or more international borders (Hachey & Phillippi, 2017). Victims are typically trafficked from poor to more affluent countries (Hachey & Phillippi, 2017). The criminal activities of human trafficking are very profitable worldwide (Cokar et al., 2016; Lemke, 2019). Traffickers make profits estimating $15 billion to $150 billion a year (Preble et al., 2019). Over US$31 billion in profits were made in 2008 (Cokar et al., 2016; Lemke, 2019). Less than one million trafficking victims have been identified globally (Lemke, 2019).

History, Cause, and Risk Factors of Human Trafficking

Historically, trafficking was a problem that affected only White women and children (Preble et al., 2019). Today, communities and families vary in their vulnerability to trafficking (Rollins et al., 2017). In human trafficking, females are often recruited into labor or domestic work and later sold into the sex trafficking market (Hachey & Phillippi, 2017). In certain regions, especially in Asia, most of the labor trafficking victims are women (Cokar et al.,

2016). Human trafficking victims vary by age, race, and gender (Gibbons & Stoklosa, 2016; Hachey & Phillippi, 2017). The mean age of trafficking victims and survivors is 15 years (Basu, Doshi, Malinow, Huang, Kivlahan, & Mann, 2021). The younger child is more vulnerable to exploitation due to a lack of maturity (Basu et al., 2021). Trafficked victims can also be of any ethnicity (Hachey & Phillippi, 2017). In the West Coast of the United States, there is a high number of Hispanic victims in labor trafficking, particularly in the field of janitorial services, manufacturing, agriculture, landscaping, food processing, and construction (Tripp & McMahon-Howard, 2016). Victims of trafficking can also be of any socioeconomic status (Hachey & Phillippi, 2017). However, the risk of trafficking increases in geographical locations with lower economic status and social conditions associated with poverty (Hachey & Phillippi, 2017; Stanford et al., 2021). One example of such condition is homelessness (Basu et al., 2021; Hachey & Phillippi, 2017). Increased risk of trafficking also occurs among emotionally needy and vulnerable children and adolescents who can be coerced easily into compliance (Basu et al., 2021; Hachey & Phillippi, 2017). Groups that are more vulnerable to trafficking include children who have been abused (Basu et al., 2021; Hachey & Phillippi, 2017). Eighty to ninety percent of trafficked victim have a history of sexual abuse during childhood (Hachey & Phillippi, 2017). Other groups that are more vulnerable to trafficking include children who (a) have been neglected, been a foster or runaway child, been a part of the juvenile justice system, disabled or undocumented people, migrant workers, poor individuals with low income; (b) people from the lesbian, gay, bisexual, transgender, and queer group; and (c) racial and ethnic minorities (Gibbons & Stoklosa, 2016; Moore, 2018; Rollins et al., 2017). Mental illness, domestic violence, substance misuse in the home, and family dysfunction are predisposing factors in the vulnerability to trafficking (Basu et al., 2021; Hachey & Phillippi, 2017). Globally and in the United States, women and girls are more at risk for sex trafficking than men or boys (Hachey & Phillippi, 2017). The advancement of digital technology, such as social media and certain websites, make it easier for traffickers to recruit and exploit victims (Hachey & Phillippi, 2017).

Role of the Healthcare Institution

Human trafficking victims have unique health care needs (Gibbons & Stoklosa, 2016). Up to 88% of trafficked persons see a healthcare provider while they are held captive (Bauer et al., 2019; Tiller & Reynolds, 2020). Lederer and Wetzel surveyed over 100 survivors of sex trafficking in a study, and 63% of the survivors reported going to an emergency room while being trafficked (Tiller & Reynolds, 2020). Trafficked persons may present to a variety of

health settings, including an emergency room, urgent care, obstetrician or gynecologist, primary care physician, and dentist (Coughlin et al., 2020). Because of the violent nature of human trafficking, girls often experience physical injuries and seek medical care (Armstrong & Greenbaum, 2019; Hachey & Phillippi, 2017). The presence of such injuries represents an opportunity for a trained health care clinician to recognize the patient as a victim who is being trafficked (Armstrong & Greenbaum, 2019; Phillippi, 2017). Victims and survivors are unlikely to self-identify (Tiller & Reynolds, 2020). Therefore, the healthcare provider must commit to utilizing a screening criterion, which if there is a positive answer to one of the screening questions, or any observed risk factors, the provider will conduct an in-depth screening (Tiller & Reynolds, 2020). Upon recognition of the victims, clinicians play a crucial role in caring for their health needs (Gibbons & Stoklosa, 2016). The increase in victims' identification enhances access to interventions and resources (Nguyen, P. T. et al., 2018). Such identification followed by the appropriate intervention removes the victim from any further risk of harm (Dols et al., 2019; Kaltiso et al., 2018; Testa, 2020). Traffickers tend to have several victims and being able to identify one victim may benefit other victims and save the lives of others (Gibbons & Stoklosa, 2016).

Identifying the Trafficked Victims

Victims are mainly identified through reporting by friends or family (Stanford et al., 2021). It is important for clinicians to be comprehensively trained to identify signs of human trafficking during a patient encounter (Powell, Dickins, & Stoklosa, 2017; Testa, 2020). Training content should include identifying the trafficker and victim, understanding victim behaviors, and assessment of a potential victim (Powell et al., 2017; Testa, 2020). The content should be standardized to ensure correct information, trauma-informed and patient-centered care, and consistent messaging for care providers. In addition, evaluation metrics for the training should be developed to show behavior change and impact on patient-centered outcomes for victims (Powell et al., 2017).

Observing the Warning Signs and Health Consequences of a Trafficked Individual

Agricultural labor and sex trafficking victims may be subjected to health consequences and may present with many warning signs (Gibbons & Stoklosa, 2016; Stanford et al., 2021). Individuals who work in the agricultural sector may present with lacerations from tools; exposure to insects, pesticides, and extreme heat; and injuries from carrying heavy loads (Stanford et al., 2021). Agricultural labor trafficking victims may also present with

organophosphate toxicity from extreme exposure to the agricultural environment (Gibbons & Stoklosa, 2016). During a hospital admission interview, a patient's information consisting of many sex partners or unintended pregnancies may be a sign of sex trafficking (Basu et al., 2021; Gibbons & Stoklosa, 2016). A sex trafficking victim may present with complaints of sexual assault or signs of sexually transmitted diseases, rectal or vaginal trauma, and vaginal or rectal foreign bodies (Gibbons & Stoklosa, 2016). Indicators of human trafficking may include signs of severe physical abuse, such as bone fractures, skin bruises, wound scars, and burns (Basu et al., 2021; Gibbons & Stoklosa, 2016). A victim may also complain of substance misuse, depression, anxiety, post-traumatic stress disorder, and suicidal ideation (Basu et al., 2021; Gibbons & Stoklosa, 2016; Landers, McGrath, Johnson, Armstrong, & Dollard, 2017). Other symptoms that a victim may complain of include memory problems, headaches, back pain, stomach pain, and (Gibbons & Stoklosa, 2016). Other red flags of trafficking may include extreme fear and inconsistent stories (Basu et al., 2021; Gibbons & Stoklosa, 2016; Tiller & Reynolds, 2020).

Healthcare clinicians should be on the alert for the telltale signs of human trafficking and know how to follow up by asking the right questions (Byrne, Parsh, & Ghilain, 2017). Physical warning signs of trafficking may include evidence of physical or sexual violence, discrepancy between suspected and reported age, self-inflicted injuries, addiction use disorders, chronic medical conditions, multiple or recurrent sexually transmitted infections (STIs) (Hachey & Phillippi, 2017; Tiller & Reynolds, 2020); and the presence of a controlling person who won't allow the patients to speak for themselves (Basu et al., 2021; Hachey & Phillippi, 2017; Tiller & Reynolds, 2020). Victims have minimal opportunity for disclosure when their trafficker insists on speaking for them (Byrne, Parsh, & Ghilain, 2017; Tiller & Reynolds, 2020). Victims fear for their lives and for the lives of their families if they speak up or attempt to escape (Byrne, Parsh, & Ghilain, 2017; Tiller & Reynolds, 2020). Traffickers often "test" their victims to see if they're loyal to them when questioned (Byrne, Parsh, & Ghilain, 2017). Other warning signs are that victims have very little control over their lives, do not manage their own money or have ID documents, and have very few personal possessions (Byrne, Parsh, & Ghilain, 2017; Tiller & Reynolds, 2020). Mental health warning signs may include responses of Post-Traumatic Stress Disease (PTSD), ranging from aggression and combative behaviors or extreme fear with an exaggerated startle response to a submissive, emotionless, and withdrawn posture (Hachey & Phillippi, 2017). Hence, for any patient with discrepancy between suspected and reported age, signs of

multiple or new STIs, physical, emotional, sexual trauma; or a patient that does not have access to valid identification or is unable to state a verifiable residential address, sensitive screening should be conducted (Hachey & Phillippi, 2017; Tiller & Reynolds, 2020).

Screening Method

The healthcare worker must separate the patient from anyone accompanying her or him and refrain from screening for trafficking or violence if the person refuses to leave (Hachey & Phillippi, 2017; NHTRC, n.d.). Refusal of a person to leave may indicate that the patient is a victim of trafficking (Hachey & Phillippi, 2017; NHTRC, n.d.). The care provider should use a certified translator or translator phone service to ask screening questions, if there is a language barrier (Hachey & Phillippi, 2017; NHTRC, n.d.).

Screening Questions

Screening questions may include the following:

(a) Is there a history of drug or alcohol use? (Basu et al., 2021).

(b) Has the youth ever run away from home? (Basu et al., 2021).

(c) Has the youth ever been involved with law enforcement? (Basu et al., 2021).

(d) Has the youth ever broken a bone, had traumatic loss of consciousness, or sustained a significant wound? (Basu et al., 2021).

(e) Has the youth ever had a sexually transmitted infection? (Basu et al., 2021).

(f) Does the youth have a history of sexual activity with more than 5 partners? (Basu et al., 2021).

(g) "Tell me about your living situation." (Hachey & Phillippi, 2017);

(h) "Has anyone ever asked you to have sex in exchange for money, food, shelter, or other items?" (Bauer et al., 2019; Hachey & Phillippi, 2017);

(i) "Has anyone ever threatened violence if you attempted to leave?" (Bauer et al., 2019); Hachey & Phillippi, 2017).

(j) "Has anyone ever threatened your family if you leave?" (Hachey & Phillippi, 2017).

Follow-Up Questions to Ask about living/work conditions

(a) "Are you free to come and go in your home as you please?" (Bauer et al., 2019; Byrne, Parsh, & Ghilain, 2017).

(b) "Have you ever worked without receiving the payment you thought you would get?" (Byrne, Parsh, & Ghilain, 2017).

(c) "Have you ever worked in a place that was different from what you were promised or told it would be?" (Bauer et al., 2019; Byrne, Parsh, & Ghilain, 2017).

(d) "Does anyone at your work make you feel scared or unsafe?" (Byrne, Parsh, & Ghilain, 2017).

(e) "Did anyone at your workplace threaten to harm you?" (Byrne, Parsh, & Ghilain, 2017).

(f) "Have you ever felt you couldn't leave the place you work/live?" (Bauer et al., 2019; Byrne, Parsh, & Ghilain, 2017).

(g) "Do you live with your employer?" (Byrne, Parsh, & Ghilain, 2017).

(h) "How many hours do you work in a week?" (Byrne, Parsh, & Ghilain, 2017).

(i) "Do you owe your employer money?" (Byrne, Parsh, & Ghilain, 2017).

(j) "Does your home have bars on windows, windows you can't see through, or security cameras?" (Byrne, Parsh, & Ghilain, 2017).

Physical Examination

Signs of trauma or assault may indicate a violent situation regardless of the patient's story (Hachey & Phillippi, 2017). Physical examination should include a detailed documentation of injuries involving the genital and anal areas, mouth, and skin, with a written description of size, shape, color, location, and pattern of bruising, contusions, scars, lacerations, or other evidence of physical or psychological trauma (Hachey & Phillippi, 2017). Victims of labor trafficking may have injuries consistent with occupational hazards or neglect (Hachey & Phillippi, 2017).

Validated Screening Tools

There are no validated adult screening tools for use in the emergency department (Tiller & Reynolds, 2020). Many institutions purport to screen for trafficking but none of the tools are validated for the setting or population for which it is used, and most are actually assessments, not screening tools (Chisolm & Dr Kline, 2018; Tiller & Reynolds, 2020). However, several expert authors in the field have published a variety of screening questions to identify persons involved in human trafficking (Tiller & Reynolds, 2020). A clinical screening tool should be applied to a particular population (Chisolm & Dr Kline, 2018).

A clinically appropriate, validated screening tool used in an emergency room setting for child sex trafficking only, is the Greenbaum Tool (Chisolm & Dr Kline, 2018). A positive screen should lead to a specialist's evaluation (Chisolm & Dr Kline, 2018). A urine pregnancy test

for an underage girl at triage is a good example of a reliable screening tool (Chisolm & Dr Kline, 2018).

The National Human Trafficking Resource Center (NHTRC)

NHTRC General Indicators of Human Trafficking

The National Human Trafficking Resource Center [NHTRC] (n.d.) notes that aside from the above health indicators of human trafficking, the following general indicators that medical providers may see in a victim of human trafficking are as follows:

(a) Shares a scripted or inconsistent history;

(b) Is unwilling or hesitant to answer questions about the injury or illness;

(c) Is accompanied by an individual who does not let the patient speak for themselves, refuses to let the patient have privacy, or who interprets for them;

(d) Evidence of controlling or dominating relationships (excessive concerns about pleasing a family member, romantic partner, or employer);

(e) Demonstrates fearful or nervous behavior or avoids eye contact;

(f) Is resistant to assistance or demonstrates hostile behavior;

(g) Is unable to provide his/her address; Is not aware of his/her location, the current date, or time;

(h) Is not in possession of his/her identification documents; Is not in control of his or her own money.

The recognition of several indicators may point to the need for referrals and further assessment (NHTRC, n.d.).

NHTRC Indicators of Labor Trafficking

NHTRC notes that the indicators of labor trafficking are as follows:

(a) Has been abused at work or threatened with harm by an employer or supervisor;

(b) Is not allowed to take adequate breaks, food, or water while at work;

(c) Is not provided with adequate personal protective equipment for hazardous work;

(d) Was recruited for different work than he/she is currently doing;

(e) Is required to live in housing provided by employer;

(f) Has a debt to employer or recruiter that he/she cannot pay off.

NHTRC Indicators of Sex Trafficking

NHTRC notes the indicators of sex trafficking as follows:

(a) Patient is under the age of 18 and is involved in the commercial sex industry;

(b) Has tattoos or other forms of branding, such as tattoos that say, "Daddy," "Property of…," "For sale," etc.;

(c) Reports an unusually high number of sexual partners;

(d) Does not have appropriate clothing for the weather or venue;

(e) Uses language common in the commercial sex industry

NHTRC Recommendations for Assessments

NHTRC's Recommendations for Assessments are as follows: Allow the patient to decide if they would feel more comfortable speaking with a male or female practitioner; always use professional interpreters who are unrelated to the patient, if the patient requires interpretation; if the patient is accompanied by someone, find a time and place to speak with the patient privately; take time or find someone else on staff to build rapport with potential victims; ensure that the patient understands confidentiality policies and practices, including mandatory reporting laws; use multidisciplinary resources, such as social workers; refer to existing institutional protocols for victims of abuse/sexual abuse; and contact the National Human Trafficking Resource Center hotline (1-888-373-7888) for help with victim assessment if needed, in the absence of a protocol.

Barriers to Identifying Human Trafficking

There are multiple barriers that prevent trafficked victims from being identified in a healthcare setting (Basu et al., 2021).

Trafficker-Related Barriers

Traffickers often restrict victims' access to health care facilities and instead obtain treatment supplies for victims' injuries at local pharmacies (Armstrong & Greenbaum, 2019). Such restriction is from the trafficker's concern that victims could escape, alert law enforcement, or lose money from excess time spent obtaining professional medical care (Armstrong & Greenbaum, 2019). In the event that a female sex trafficking victim visits a health care facility for treatment, the trafficker or his female affiliate typically stays with the victim to maintain intimidation and control of the victim, and may even fill out the necessary forms, speak for the victim, and pay cash for the services (Armstrong & Greenbaum, 2019; Tiller & Reynolds, 2020).

Caregiver-Related Barriers

Trafficking victims are not easy to identify due to their complications and caregivers' inability to handle complex medical cases (Gibbons & Stoklosa, 2016). Such complexity along with inadequate training to health care clinicians result in missed opportunities to identify human trafficking victims (Dols et al., 2019; Stoklosa, Showalter, Melnick, & Rothman, 2017). Clinicians lack the requisite knowledge to assess and detect human trafficking victims, and in doing so, providers also fail to apply trauma-informed care (Dols et al., 2019; Rollins et al., 2017). In the presence of multiple medical emergencies, clinicians may also miss the warning signs that indicate a patient is being trafficked due to the time limitations placed on emergency department clinicians (Stoklosa, Showalter, Melnick, & Rothman, 2017). Caregiver-related barriers to identifying trafficking also include inherent cultural assumptions that the caregiver may have about the victim (Rollins et al., 2017). Also, there may be complacency from psychological cohesiveness and conformity to group norms around an inadequate status quo (Cheshire, 2017). Sex trafficking victims have been known to be concerned as to whether the health care clinicians respected their confidentiality (Armstrong & Greenbaum, 2019; Basu et al., 2021). Victims have also been concerned if care givers would judge them wrongfully without understanding their life's complexity (Armstrong & Greenbaum, 2019; Basu et al., 2021). Furthermore, long wait times may prevent female victims from waiting long enough to receive thorough examinations (Armstrong & Greenbaum, 2019; Basu et al., 2021).

Victim-Related Barriers

Victim-related barriers to the identification process include the patient's failure to disclose information about his/her victimization due to fear and shame of the trafficker (Basu et al., 2021; Boswell, Temples, & Wright, 2019; Cheshire, 2017; Rollins et al., 2017). The numerous fears may include fear of seeking care from a clinician, fear of being judged, or fear of revenge from traffickers and concerns for his/her safety and the safety of others (Armstrong & Greenbaum, 2019; Basu et al., 2021). The victims concern for safety is in light of the fact that the trafficker maintains a close physical proximity to the victim during health care visits (Armstrong & Greenbaum, 2019; Tiller & Reynolds, 2020). The victim may also be fearful of being arrested at the health care facility for prostitution or an outstanding warrant (Armstrong & Greenbaum, 2019; Basu et al., 2021). In addition, victims may lack the financial ability to pay for needed care or feared that they could not afford to spend the time needed for care away from earning money (Armstrong & Greenbaum, 2019; Basu et al.,

2021). Victims may also be discouraged from disclosing their exploitative situation due to fear, shame, or feelings of hopelessness (Armstrong & Greenbaum, 2019; Basu et al., 2021; Tiller & Reynolds, 2020). Victims have also been known to be discouraged from disclosure of information due to feeling intimidated by their care provider (Armstrong & Greenbaum, 2019; Tiller & Reynolds, 2020). Another victim-related barrier may be that the victim has literacy and language barriers that inhibit disclosure (Armstrong & Greenbaum, 2019; Rollins et al., 2017; Zimmerman & Kiss, 2017). Finally, the victim may lack awareness of his/her rights and status as a victim (Rollins et al., 2017). In the case of labor trafficking, the victim lacks knowledge of labor laws and his/her contractual obligation (Rollins et al., 2017). Furthermore, some victims may not be aware that they are being exploited and, therefore, may not disclose information about their exploitation (Armstrong & Greenbaum, 2019).

Policy Management-Related Barriers

Barriers in human trafficking identification may occur from challenges in implementing International Classification of Diseases (ICD) codes for human trafficking (Greenbaum et al., 2021). ICD codes implementation challenges may pertain to providers lack of knowledge or experience on human trafficking assessment, care, and documentation, as well as, patient's reluctance to disclose trafficking experiences due to concerns of potential bias, possible breach of confidentiality, possible deportation), or physical harm by their trafficker (Greenbaum et al., 2021). In addition, organizations may lack policies and procedures on reimbursement, recording, and protecting sensitive data, in EHR documentation and ICD codes (Greenbaum et al., 2021). Certain legal requirements pertaining to mandated reporting, patient consent, and subpoenaed records, may provide confidentiality protections to victims of human trafficking (Greenbaum et al., 2021). Such restrictions may limit a provider's ability to implement effective policies and procedures (Greenbaum et al., 2021).

With inadequately equipped workers and misidentification, less than optimal readiness to address the needs of trafficked victims will continue to be a major barrier to end trafficking (Testa, 2020). Multidisciplinary stakeholders including medical, nursing and mental health clinicians, social workers, risk management specialists, billing and coding experts, insurance representatives, health information management and privacy experts, EHR analysts, victim advocates, prosecutors and defense attorneys, and relevant government agency representatives, should collaborate to develop the applicable statutory and regulatory framework (Greenbaum et al., 2021).

Significance of the International Classification of Diseases (ICD)

The International Classification of Diseases (ICD) is the system used by clinicians and medical coders to document diseases, symptoms, social circumstances, and external causes of illness and injury (Macias-Konstantopoulos, 2018). ICD is the reference diagnostic classification standard for reporting the diseases and health conditions (Otero Varela, Doktorchik, Wiebe, Quan, & Eastwood, 2021); and is the basis for identifying the comparison of health trends and statistics globally (Otero Varela et al., 2021). This coding system enables governmental agencies such as the Centers for Disease Control and Prevention's National Center for Health Statistics to gather and categorize epidemiological data pertinent to population health and clinical treatments (Macias-Konstantopoulos, 2018). Using the ICD standard, data generated at each patient encounter with the healthcare system are entered into administrative health databases as codes (Otero Varela et al., 2021). Clinicians enter the ICD codes along with its corresponding clinical diagnosis (Zhou, Cheng, Ou, & Huang, 2020). Medical record coders also enter codes based on the diagnosis that the clinician documents (Zhou et al., 2020). This coding system is critical to monitoring disease incidence, assessing treatment modalities, estimating the financial cost of care, quality and safety, and to ultimately improve population health (Greenbaum & Stoklosa, 2019; Hoyle, 2017; Macias-Konstantopoulos, 2018; Otero Varela et al., 2021). Due to the reimbursement and compliance requirements, diagnosis codes are quality assured and very rich in details, presenting a holistic picture of a patient (Nguyen, D. et al., 2018). When a system such as the ICD coding system is used normatively for budgeting, then those qualitative boundaries affect the behaviors of those involved in maintaining their coding system at work, whether it be clinicians, coders, or administrators (Hoyle, 2017). Although other data collection and tracking tools exist, ICD is the coding system required under the United States legislation (Macias-Konstantopoulos, 2018).

The International Classification of Diseases has been the cornerstone in monitoring global health trends and mortality statistics since WHO was entrusted with the ICD in 1948 (Doctor, Rashidian, Hajjeh, & Al-Mandhari, 2021). The system provides an internationally harmonized language that allows health professionals to share health information across the world (Greenbaum & Stoklosa, 2019). The global ICD system, created by the World Health Organization (WHO), is used by more than 100 countries (Greenbaum & Stoklosa, 2019; Zhou et al., 2020). The 10th version (ICD-10) is the most frequently used (Otero Varela et al., 2021). To enhance the comparability impact of health data and the generalizability of

observed findings, WHO released an updated version, the 11th version for Mortality and Morbidity Statistics (ICD-11 MMS) (Otero Varela et al., 2021).

International Classification of Diseases (ICD) for Human Trafficking

Since 2018, the United States added diagnostic codes for forced labor and sexual exploitation in the American ICD system (Greenbaum & Stoklosa, 2019). However, in the global ICD-10 system, there are no codes for sex or labor trafficking (Greenbaum & Stoklosa, 2019). Yet, in the same global ICD version, sexual assault, intimate partner violence, and even the rare event of “being hit by a spacecraft” are listed (Greenbaum & Stoklosa, 2019). As a result, codes for documenting general abuse have failed to capture the exploitative nature of human trafficking and the varied degrees of physical, sexual, and psychological trauma experienced by trafficked persons (Macias-Konstantopoulos, 2018). The exploitative experience and the needs of the trafficked population are extensive and merits an ICD code structure of its own for more robust data collection on both forced labor and sexual exploitation (Macias-Konstantopoulos, 2018). Such information is needed to tailor the best response to survivors’ broad spectrum of needs that require abundant resources (Macias-Konstantopoulos, 2018). Thus, the addition of human trafficking diagnostic codes at WHO level is critical to enhance international public health efforts in ending trafficking (Greenbaum & Stoklosa, 2019).

A proposal for new ICD-11 codes on human trafficking was submitted to WHO in 2014 by the International Centre for Missing and Exploited Children (ICMEC). Although it was supported by multiple organizations around the world, WHO rejected the proposal without an explanation (Greenbaum & Stoklosa, 2019); and in June 2018, WHO published the 11th edition of ICD (Krawczyk & Święcicki, 2020). New information on mental health disorders and several non-existent categories were added to the global ICD-11 system (Krawczyk & Święcicki, 2020). However, there were still no codes for human trafficking, sex or labor trafficking/exploitation (Greenbaum & Stoklosa, 2019). A healthcare provider practicing outside of the U.S. has no explicit ability to code for labor exploitation, and instead must use the codes for “sexual abuse” or “sexual assault” in cases of trafficking (Greenbaum & Stoklosa, 2019). The problem with such categorization is that not all trafficking involves sexual violence, and critical information on significant characteristics of labor and sex trafficking is lost or inaccessible (Greenbaum & Stoklosa, 2019). Since the inclusion of diagnostic codes at WHO level is critical to harmonizing international public health efforts to end trafficking, it is important for WHO to include human trafficking among the ICD-11 codes, which will take effect in 2022 (Greenbaum & Stoklosa, 2019).

Although implementation of ICD codes for human trafficking carries major benefits, documenting ICD codes has the potential to risk patient privacy and safety (Greenbaum et al., 2021). Therefore, it is crucial that care providers take steps to (1) protect patient privacy and confidentiality through disciplined and consistent maintenance of a secure electronic health record (EHR) (Greenbaum et al., 2021).

Consequences of Reporting Human Trafficking

In several states, trafficked victims may be prosecuted for crimes they committed during their captivity (Tiller & Reynolds, 2020). In certain states, healthcare providers are mandated to report to legal authorities, when children under the age of 18 are suspected victims of human trafficking (Chisolm & Dr Kline, 2018; Tiller & Reynolds, 2020). Although mandatory reporting laws are designed to protect these victims, the laws can potentially create further harm to the victims (Boswell et al., 2019). Victims may end up being treated as criminals instead of victims (Boswell et al., 2019). Entering minors into the juvenile justice system decreases their chances of getting the appropriate help and protection that they need, increasing the risk of further victimization (Boswell et al., 2019). A health care provider should consult with, not only local law enforcement, but also child protective services and other relevant agencies to prevent further harm to the child (Boswell et al., 2019).

Unless legally mandated, involving the police without the adult patient's permission may violate HIPAA, breach the patient-clinician trust, and result in unintended legal ramifications (Tiller & Reynolds, 2020). If disclosure of suspected human trafficking is not mandated by law, the care provider must obtain the patient's consent prior to speaking with anti-human trafficking service providers or trying to access legal, housing, and law enforcement resources for the victim (Chisolm & Dr Kline, 2018; Powell et al., 2018). Once consent has been obtained, the patient should be encouraged to speak with National Human Trafficking Hotline directly so that the case can be discussed in detail, since the hotline can provide assistance with community human trafficking resources (Powell et al., 2018). The patient's consent, whether written or verbal, should be documented in the medical record (Powell et al., 2018).

Amendment of *mandatory reporting laws for child abuse* to include both sex and labor trafficking could result in significant benefits (English, 2017). The risks of mandatory reporting could be mitigated and the benefits realized (English, 2017). Such benefits would include provisions to ensure that the victims are connected to services to meet their needs

(English, 2017). The federal Child Abuse Prevention and Treatment Act of 1974 (CAPTA) requires states to have child abuse reporting laws as a condition of receiving federal funds for child abuse and neglect prevention and treatment programs (English, 2017). The 2010 reauthorization of CAPTA includes important definitions (English, 2017). For example, the definition of "sexual abuse" does not explicitly include the term trafficking but encompasses conduct involved in trafficking (English, 2017).

Relevant Health Care Policies

The health system has a duty of care to trafficked victims and those managing the complexity of trafficked patient (Testa, 2020). WHO's role involves supporting countries to develop efficient systems to monitor health risks and determinants; track health status and outcomes, including mortality and morbidity (Doctor et al., 2021). In 2008, the Secretary of the United States Department of Health and Human Services noted that it was still difficult to address the needs of human trafficking victims (Lemke, 2019). Since then, the federal, state, local government health and education agencies, associations, and medical societies' policies and guidelines have included efforts to monitor and combat trafficking by increasing community awareness and training health care professionals (Lemke, 2019; Preble et al., 2019). The global ICD system that was created by the World Health Organization (WHO), allows for the global monitoring of disease incidence and assessment of treatment modalities (Greenbaum & Stoklosa, 2019). In the new ICD-11 version, sexual assault and intimate partner violence are included (Greenbaum & Stoklosa, 2019). However, sex trafficking or labor trafficking are not included, and health care professionals do not have the ability to code sex or labor trafficking (Greenbaum & Stoklosa, 2019). Exclusion of such diagnostic codes precludes the requisite global public health efforts to monitor, diagnose, and end worldwide labor and sex trafficking (Greenbaum & Stoklosa, 2019). Greenbaum & Stoklosa (2019) has called on WHO to include human trafficking, namely sex and labor trafficking, among the new ICD-11 codes. Finally, further research is needed in the area of existing health care policies that could empower world health leaders with the tools to help end human trafficking (Leslie, 2018).

Methodology and Procedures

Methodology

There was only one method to be employed for this paper. The method was developmental.

Procedures

Search Procedures

The author commenced the research by reviewing literature pertaining to the two research questions. Regarding the first research question, an initial review of the significant literature related to identifying human trafficking victims was conducted. A more thorough review of human trafficking victim identification within the healthcare settings was conducted. Each article was reviewed for its significance in victim identification. The search was then narrowed to reviewing the human trafficking identification protocols used in hospitals. Regarding the second research question, an initial review of literature on the International Classification of Diseases (ICD) system was conducted. The author focused on ICD coding and its significance. The review was then narrowed to International Classification of Diseases for Human Trafficking. The author focused on global ICD coding and its significance to human trafficking. The following topics were highlighted by the review: definition of human trafficking, the nature of human trafficking, incidence of human trafficking, history, cause and risk factors of human trafficking, types of human trafficking, significance of identifying a trafficked victim, warning signs and health consequences of a trafficked individual, barriers to identifying human trafficking, International Classification of Diseases for human trafficking, relevant health care policies, and recommendations.

Libraries Used. There were only three libraries used to search for the initial sources for this project. The Alvin Sherman Library and Health Professions Library at Nova Southeastern University; and the University of Central Florida library were used for this project.

Search Engines and Databases Used. The following databases from the library were used to search for the sources for this project. The databases were Academic Search Premier, ProQuest, Medline, and CINAHL Complete.

Search Terms. Several search terms were used to identify sources for this project. The search terms included human trafficking, health care, emergency department, identification tools, barriers to identification, sex trafficking, labor trafficking, health consequences of

human trafficking, screening tools, sex trafficking health policies, validated screening tools, World Health Organization (WHO), United Nations (UN), Health Insurance Portability and Accountability Act (HIPAA), National Human Trafficking Hotline (NHTH), National Human Trafficking Resource Center (NHTRC), International Classification of Diseases (ICD), and Mandatory Reporting.

Boolean Strings. Boolean strings were considered for the literature search. The Boolean strings used were human trafficking AND health care, human trafficking AND emergency department, human trafficking AND health consequences, human trafficking AND identification tools, sex trafficking AND barriers to identification, labor trafficking AND health care, human trafficking AND screening tools, sex trafficking AND health policies, human trafficking AND validated screening tools, human trafficking AND World Health Organization (WHO), human trafficking AND United Nations (UN), human trafficking AND Health Insurance Portability and Accountability Act (HIPAA), sex trafficking AND National Human Trafficking Hotline (NHTH), human trafficking AND mandatory reporting, and human trafficking AND International Classification of Diseases (ICD).

Age of the Sources. The significant literature has been reviewed. Sources from the last 5 years ranging from 2016 to 2021 have been considered for inclusion in the review of literature. Pertinent historical or seminal articles older than 5 years have also been considered.

Inclusion Criteria. There were three inclusion criteria. Inclusion criteria included (a) literature published since 2016, except historical sources; (b) English-language text; and (c) peer-reviewed articles.

Exclusion Criteria. There were three exclusion criteria. The exclusion criteria included (a) literature published before 2016, except historical sources; (b) text not published in English; and (c) articles not peer reviewed.

Research Modalities. Multiple research modalities, including descriptive, qualitative, and survey designs, were available in the literature. Research studies regarding the identification of human trafficking victims and the International Classification of Diseases system were common and were examined. Descriptive articles were featured that emphasized the importance of the topic. Studies that included various aspects of identifying human trafficking victims and the International Classification of Diseases system were used in the review of literature.

Assumption

There is an assumption that the review of literature is the most currently available.

Limitations

The paper is limited to world leaders, health institutions, healthcare educators, care providers, and professional clinicians. This author is limited by the absence of input from a world health legislator or the Secretary of the United Nations who has the power to recommend governmental policies relevant to the implementation of global International Classification of Diseases for human trafficking. The paper was developed using secondary data.

Delimitation

The paper includes the identification of human trafficking victims and the International Classification of Diseases system.

Results

The following question drove the research of the literature. What were the necessary strategies in identifying human trafficking victims within healthcare settings; and how could implementation of the global International Classification of Diseases coding system help to combat human trafficking?

From the search conducted and the review of articles, twenty of the articles listed the screening and physical examination that is necessary to identify the victim. Thirteen of the articles listed the International Classification of Diseases (ICD) coding system and mandatory reporting of human trafficking. The remaining articles focused on the complexity of the social dynamics among the victims, and the needed change in the behavior of clinicians to help in the victim identification process.

Stoklosa, Dawson, Williams-Oni, & Rothman (2017) reviewed U.S. healthcare institution protocols for the identification and treatment of victims of human trafficking. That evidence-based study looked at human-trafficking identification, along with treatment and referral protocols of U.S. healthcare service provider institutions. 30 protocols from 19 states and 2 national organizations were reviewed. 70% of the protocols listed the most common assessment indicator of HT victimization as: patient history of physical or sexual abuse, at least one medical-symptom of physical trauma such as, bruises, scars, frequent injuries; at least one indicator based on a patient's apparent dependence on another person, such as, patient not in control of personal identification; and at least one indicator related to how the

patient communicates, such as, inconsistencies in the patient's story about his or her medical condition. A smaller proportion of protocols included indicators of HT that pertained to housing (60%), the patient's appearance (47%), the patient's mental health (63%), sexual history (63%), or technology-related indicators such as the patient possessing explicit digital photos of himself or herself with another person (20%). Stoklosa, Dawson, Williams-Oni, & Rothman (2017) proposes that the ideal protocol might be one that uses an evidence-based and practice-informed comprehensive list of potential indicators, and includes information about approaches to screening, including trauma-informed care (Stoklosa, Dawson, Williams-Oni, & Rothman, 2017).

Stevens & Berishaj (2016) and (Peters, 2013) examined the roles of clinicians, particularly emergency department clinicians, in screening and identifying those at risk of human trafficking. Stevens & Berishaj (2016) further reviewed the clinical practice screening and identification tools and guidelines that may be used for human trafficking victims, and outlines the recommendations for the use of a specific screening tool. Stevens & Berishaj (2016) recommends that a specific screening tool be incorporated as follows: (a) Within the regular assessment process during healthcare visits; (b) On an individual case-by-case basis; and (c) after rapport is established (Stevens & Berishaj, 2016).

Shandro et al (2016) focuses on human trafficking identification in the emergency department. Shandro et al (2016) believes that evaluation of possible trafficking victims in the emergency room is challenging for the clinician because patients who have been exploited rarely self-identify. Shandro et al (2016) recommends that emergency clinicians maintain a high level of suspicion and assess for specific indicators of trafficking, when evaluating patients who appear to be at risk for abuse and violence, and that potential victims should be evaluated with a multidisciplinary and patient-centered technique.

Schwarz, Unruh, Cronin, Evans-Simpson, Britton, & Ramaswamy (2016) focused on identification to assist victims of labor trafficking as well as sex trafficking, and offer a framework to anti-trafficking efforts that addresses the practical challenges of human trafficking victim identification.

According to Orme & Ross-Sherif (2015)'s research study, assessment for child victims of sex trafficking should be done at the individual, family, and community levels. At the individual level, social workers can assess for risk factors that could lead to increased vulnerability to sex trafficking (Orme & Ross-Sherif, 2015).

Nguyen, Coverdale, & Gordon (2017) focused on human trafficking identification and treatment in the psychiatric department. In the study, Nguyen et al (2017) notes that on their own inpatient psychiatric unit, the number of patients that screened positive for human trafficking increased substantially with routine screening. According to Nguyen et al (2017), one primary reason why human trafficking victims are not identified is because they may present with acute or decompensated mental health conditions that prevent them from accurately reporting their trafficking history and status. Nguyen et al (2017) adds that patients may be acutely psychotic, manic, agitated, or delirious, and suggests that healthcare providers go beyond the initial human trafficking assessment point and rescreen patients when their mental status improves. Nguyen et al (2017)'s study further recommends that in addition to educating staff about human trafficking, a trauma-informed and patient-centered care model on a multidisciplinary unit is needed to allow for a safe, confidential, and an integrated care approach therapeutic environment.

Hodge (2014) examined the role that social workers can play in identifying victims in settings such as hospital emergency rooms and health clinics. According to Hodge (2014), some physical or emotional symptoms among others, are indicators that suggest the presence of trafficking, and be classified into three categories: situational, story, and demeanor. Situational indicators are HT victim markers that may include: the absence of documentation (or documentation held by another person); the constant presence of another individual, such as a pimp; signs of physical abuse, such as, scars, cigarette bums, HIV/AIDS, damage to vagina or anus, complications from forced or unsafe abortions; a large number of people living together in a private residence; and frequent changes of address or physical location (Hodge, 2014). Story indicators in the health setting, refer to the patient's presenting complaint or story that suggest the presence of trafficking (Hodge, 2014). For example, a patient's story that indicates that the patient is being controlled, does not have the freedom to move or change employment, or is forced to provide sex may indicate the existence of trafficking (Hodge, 2014). A patient's emotional demeanor such as, signs of fear, depression, or a tendency to answer questions evasively, can also be an important indicator of trafficking (Hodge, 2014). If upon initial screening, situational, story, and emotional indicators are present, further exploration of the patient's story and emotional demeanor may be justified (Hodge, 2014).

Hachey & Phillippi (2017) addresses the gap in knowledge barriers to human trafficking identification, and outlines the above warning signs, screening, and physical examination to

be applied in identifying a potential human trafficking victim. According to Hachey & Phillippi (2017), a major barrier to human trafficking identification is the patient's deterrence to disclosing the situation. The reasons why patients tend not to disclose their situation, include: fear of further abuse by the trafficker, since traffickers often threaten and condition victims to conceal the trafficking situation; fear of being reported to immigration, inability to pay for services, shame and stigma, prior criminal record, and judgmental or discriminatory treatment by healthcare worker (Hachey & Phillippi, 2017). Hence, Hachey & Phillippi (2017) recommends that a patient-centered, trauma-informed approach can provide a safe environment to sensitively screen patients for human trafficking.

Edwards & Mika (2017) examined the intersection of sex trafficking and social work and found that many social workers do not realize how often they have the opportunity to identify and help human trafficking victims escape. According to Edwards & Mika (2017), sex trafficking victims avoid seeking help because of the stigma, emotional and psychological manipulation that is involved; and is more likely to present with a different issue, leaving the social worker to use professional judgment to reach out to the suspected victim. Because of this, Edwards & Mika (2017) calls on social workers to increase its efforts to combat sex trafficking by preparing themselves with the ability to identify and assess potential victims of sex trafficking. Edwards & Mika (2017) believes that the social work profession is mandated to serve vulnerable populations, and suggests that todays' social workers be called to the same standard as its traditional profession that fought for abolition, human rights, and equality.

Doctor, Rashidian, Hajjeh, & Al-Mandhari (2021)'s editorial letter serves as a reminder that in 2015, the United Nations (UN) General Assembly committed to transforming our world with the 2030 Agenda for Sustainable Development. Among the 17 Sustainable Development Goals (SDGs), Doctor et al (2021) focused on the health-related targets under SDG 3 and other SDG goals that require careful measurement and monitoring in order to track progress and success in policy implementation, in light of the fact that many countries rely heavily on international estimates by WHO. Doctor et al (2021) emphasizes the need for accurate and timely reporting of diseases and risk factors; and the significant role of the International Classification of Diseases (ICD) in strengthening health information systems.

Nguyen, Luo, Venkatesh, & Phung (2018)'s evidence-based study involved the use of coding for the identification of patients with similar conditions. Nguyen, Luo, Venkatesh, & Phung (2018) placed emphasis on the need in the medical field to often find patients with similar

care needs. Nguyen, Luo, Venkatesh, & Phung (2018) presented a coding method that captured the clinical similarity among patients with multiple comorbidities and complex care needs; demonstrating the significance of the ICD coding system to capture specific patient care needs and resources.

Greenbaum & Stoklosa (2019) highlights the rationale for the critical necessity of the implementation of specific ICD codes for HT in ICD-11; the most important being that critical gaps in knowledge may be addressed; codes will support research on risk and resilience factors, monitor trends in incidence of health adversities associated with HT, support development of treatment and other services, and drive the creation of new prevention strategies.

Macias-Konstantopoulos (2018) presented the case for ICD diagnosis codes for human trafficking. According to Macias-Konstantopoulos (2018), until October 1, 2018, the ICD trafficking-specific abuse codes were non-existent, and general abuse codes available for documenting child and partner abuse failed to capture the exploitative nature of human trafficking, and hence, the varied and extensive degree of psychological, emotional, physical, and sexual trauma that trafficked persons' experience. Macias-Konstantopoulos (2018) argued that although child sex trafficking is a form of abuse, and commercial exploitation also falls along the continuum of abuse and violence, the abuse component combined with the commercial exploitation that is involved in human trafficking places trafficking into a category of its own. Macias-Konstantopoulos (2018) explained that trafficking entails stripping individuals of their autonomy and inherent human rights and can lead to severe psychological trauma as seen in torture survivors. Macias-Konstantopoulos (2018) emphasized that the extensive needs of the trafficked patient population due to the profound health sequelae for survivors and the experience of trafficking warrants a code structure of its own for a more vigorous data collection on both labor and sexual exploitation.

Discussion

Analysis

Although Stoklosa, Dawson, Williams-Oni, & Rothman (2017) is an evidence-based study, its proposal appears to be contradictory in nature with a different study conducted by Stoklosa and three other authors. Stoklosa, Dawson, Williams-Oni, & Rothman (2017) proposes that an ideal protocol would be a practice-informed comprehensive list of potential indicators. However, Stoklosa, Showalter, Melnick, & Rothman (2017) concludes that the

wide variation in what is included on human trafficking healthcare protocols make it difficult to hold up any particular protocol as a national model. A true comprehensive list of indicators as proposed by Stoklosa, Dawson, Williams-Oni, & Rothman (2017) would be inclusive of the wide variation of indicators on human trafficking healthcare protocols that according to Stoklosa, Showalter, Melnick, & Rothman (2017) would be difficult to hold up as a national model. Therefore, the proposal by Stoklosa, Dawson, Williams-Oni, & Rothman (2017) negates the effect of what the federal human trafficking laws are trying to achieve.

According to Hachey & Phillippi (2017), a major barrier to human trafficking identification is the patient's deterrence to disclose the situation, noting the patient's fear of further abuse by the trafficker, fear of being reported to immigration, inability to pay for services, shame and stigma, prior criminal record, and judgmental or discriminatory treatment by healthcare worker. Hence, Hachey & Phillippi (2017) recommends that a patient-centered, trauma-informed approach can provide a safe environment to sensitively screen patients for human trafficking. Based on Hachey & Phillippi (2017)'s above reasons for patients not disclosing relevant information, Hachey & Phillippi (2017)'s recommendation for a patient-centered, trauma-informed approach, by itself, is inadequate to provide a safe environment and avoid the deterrence because Hachey & Phillippi (2017) does not specify how to address the victim's expected fears.

Edwards & Mika (2017) believes that the social work profession is mandated to serve vulnerable populations, and placed an analogous call to action on the profession of social work to increase its efforts to combat sex trafficking. However, Edwards & Mika (2017) does not address the interdisciplinary dynamics that must collaborate to effect this needed change.

In addition to observing for all of the human trafficking warning signs of both sex and labor trafficking mentioned above, NHTRC (n.d.) recommends to first take the following actions: Allow the patient to decide if they would feel more comfortable speaking with a male or female practitioner, utilize professional interpreters who are unrelated to the patient or situation, find a time and place to speak with the patient privately; if the patient is accompanied by others, take time or find someone else on staff to build rapport with potential victims; ensure that the patient understands confidentiality policies and practices, including mandatory reporting laws; use multidisciplinary resources, such as social workers; refer to existing institutional protocols for victims of abuse/sexual abuse; and contact NHTRC (n.d.) hotline for assistance in conducting an assessment and determining next steps in the absence of a protocol to respond to victims of human trafficking. This is unlike Hachey & Phillippi

(2017) that notes the victim's fears as barriers to human trafficking identification, yet the study does not specify how to address the expected fears of the victim.

Conclusion and Recommendations

Conclusion

Victims of human trafficking often seek medical care. Since about 88% of victims are seen by a healthcare provider while under the control of their trafficker, it is significant that healthcare professionals know how to identify victims of sex trafficking amongst their patients. After reviewing the healthcare protocols for human trafficking victim identification, a list of the screening and physical examination, as well as the change in behavior of clinicians that is needed to help identify a victim, it is clear that there is no effective standardized national protocol for the identification of the human trafficking victim within the healthcare setting. It is also apparent that world leaders and health institutions have failed to combat trafficking. Despite interventions by international and local governmental health and education efforts in community awareness and health care professionals' training, care providers still lack the requisite tools that are needed to assess and rescue trafficked victims. Even the World Health Organization (WHO) International Classification of Diseases (ICD) 11th version system excludes the diagnostic codes for sex trafficking and labor trafficking, preventing health care professionals around the world from being able to code sex or labor trafficking. Such exclusion hinders the requisite global public health efforts to research, monitor, and diagnose labor and sex trafficking. The World Health Organization can do more to combat human trafficking by including sex and labor trafficking among the new ICD-11 codes to be effective in 2022.

Recommendations

Based on the author's experience as a researcher and provider in the healthcare system, the care of acutely ill patients is prioritized over patients who appear to be victims of human trafficking. In the absence of an effective national protocol to identify victims, NHTRC's method of screening should be used to identify human trafficking victims within the healthcare setting. In addition, the World Health Organization should include human trafficking, namely sex and labor trafficking, among the new ICD-11 codes to take effect in 2022. Finally, mandatory reporting laws for child abuse should be amended to include both sex and labor trafficking. Such laws should help to mitigate the risks and realize the benefits

of mandatory reporting. Most importantly, the benefits should include provisions to ensure that the victims are connected to services to meet their needs.

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