SCREENING PROTOCOLS FOR IDENTIFYING HUMAN TRAFFICKING VICTIMS

SCREENING PROTOCOLS FOR IDENTIFYING VICTIMS OF HUMAN TRAFFICKING IN AN ENGLISH-SPEAKING HEALTHCARE SETTING: A SCOPING REVIEW

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A Thesis Submitted to the School of Graduate Studies in Partial Fulfillment of the Requirements for the Degree Master of Science

McMaster University MASTER OF SCIENCE (2015) Hamilton, Ontario (Global Health)

Title: Screening Protocols for Identifying Victims of Human Trafficking in a Health Care Setting: A Scoping Review

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NUMBER OF PAGES: xiii, 121

Lay Abstract

Victims of trafficking sustain psychological, physical, and sexual injuries, which often lead to healthcare facility visits. Although trafficking victims do come into contact with healthcare professionals while in captivity, few victims are identified in the healthcare setting. This study, therefore, aims to uncover English human trafficking screening protocols, to compare the protocols, and to share the most effective questions for healthcare professionals when trying to identify a victim of trafficking. Previous studies have failed to address this issue globally since trafficking has traditionally been framed as a security matter rather than a health matter. Electronic databases were searched using defined keywords for screening protocol literature, revealing 29 relevant documents after review. Only one, recently developed screening tool was validated, meaning that healthcare professionals globally may be using outdated screening questions that are less effective when trying to identifying trafficking victims.

Abstract

Human trafficking is a global issue with every country being affected. Victims of human trafficking endure extreme and prolonged psychological, physical, and sexual trauma, which often lead to healthcare facility visits while in captivity. It is estimated that 28% of human trafficking victims come into contact with a healthcare professional, yet few victims are detected in the healthcare setting. The aims of this study were, therefore, to summarize and compare English screening protocol literature, disseminate the most effective screening questions in a format easily accessible to healthcare providers, and to identify gaps in the literature. Research about utilizing trafficking screening protocols in a healthcare setting is a relatively new phenomenon since trafficking has been traditionally framed as a security matter rather than a health matter. A scoping review was conducted using the five-stage Arksey and O'Malley (2005) framework with revisions from Daudt, van Mossel, and Scott (2013), and Levac, Colquhoun and O'Brien (2010). Findings were summarized thematically: 1) pre-screening, 2) screening questions, 3) post-screening, and 4) training. Twenty-nine sources were included of 325 identified with most (68.97%) being published in the United States. There was only one validated screening protocol: 94.12% of screening protocols lacked scientific reasoning for chosen questions. With limited access to evidence-based screening protocols, healthcare professionals globally may be using outdated screening questions that are less effective when trying to identify trafficking victims.

Acknowledgements

Firstly, I would like to express my deepest thanks to my supervisor Dr. Mirna Carranza for her continuous support, immense knowledge, comforting humour, and focused recommendations. Dr. Carranza helped me to make my thesis a journey on which I learned, in great detail, about myself as a researcher and as a health advocate. Besides Mirna, I would also like to thank the rest of my thesis committee: Dr. Allison Williams and Dr. Mohit Bhandari, for their insight, thoughtful recommendations, and their dedication to my progress as a human trafficking researcher. The support and love I received from friends and family kept me motivated and determined to produce a thesis that reflected my own experiences and passion.

This thesis would never have been written if not for my exposure to human trafficking while volunteering in Moldova, Thailand, and Burma. I dedicate this thesis to the women, men, and children who are not able to speak for themselves, but instead rely on the global community to fight for their right to health. I will practice medicine with all of you in mind.

"The only crime equaling inhumanity is the crime of indifference, silence and forgetting."

~James Orbinski

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List of Abbreviations

CAST	Coalition to Abolish Slavery and Trafficking
CATW	Coalition Against Trafficking in Women
CBO	Community-Based Organization
DMST	Domestic Minor Sex Trafficking
HCP	Healthcare Provider
IHRLG	International Human Rights Law Group
ILO	International Labour Organization
IMF	International Monetary Fund
IOM	International Organization for Migration
IPV	Intimate Partner Violence
LGBT	Lesbian, Gay, Bisexual, Transgender
MAPP	Movement for Abolition of Pornography and Prostitution
NGO	Non-Governmental Organization
NHTRC	National Human Trafficking Resource Center
NRM	National Referral Mechanism
SAP	Structural Adjustment Policies
STI	Sexually Transmitted Infection
TNC	Transnational Corporations
UKHTC	United Kingdom Human Trafficking Centre
UN	United Nations

UNGIFT	United Nations Global Initiative to Fight Human Trafficking
UNODC	United Nations Office on Drugs and Crime
UTI	Urinary Tract Infection
WB	World Bank

Declaration of Academic Achievement

The following is a declaration that the content of the research in this document has been completed by Emma R. S. Herrington and recognizes the contributions of Dr. Mirna Carranza, Dr. Mohit Bhandari, and Dr. Allison Williams in both the research process and the completion of the thesis. Emma R. S. Herrington contributed to the study design and was responsible for data collection, data analysis and writing of the manuscript. Dr. Carranza, Dr. Bhandari, and Dr. Allison assisted with study design, data analysis review, and manuscript review. In addition, Dr. Karen Balcom served as an external reviewer of this document and provided insightful feedback.

Introduction

Human trafficking is a heinous crime affecting all countries—no country is immune. The clandestine nature of human trafficking contributes to the difficulty of reporting evidence-based global statistics. Governments tend to cite lower numbers of trafficking victims, while non-governmental organizations (NGOs) typically cite drastically larger number of victims. Because there is no consensus on the number of victims, organizations can manipulate statistics to accommodate their own political agendas or mandates (Tyldum, 2010). While there is no undisputed victim statistic, what remains clear is that human trafficking occurs everywhere, disproportionately affecting women and girls under the age of 18, and the majority of victims are trafficked for the purpose of sexual exploitation (UNODC, 2014).

Scope of the Problem

Traditionally, human trafficking has been framed as an issue of national security. Yet, human trafficking has a lasting impact on health. Victims of human trafficking endure extensive psychological, physical and sexual abuse while in captivity. The despicably violent nature of trafficking produces a complex and unique set of symptoms amongst trafficking victims.

It has been estimated that 28% of trafficked women visit a HCP while in captivity (Barrows & Finger, 2008; Crane & Moreno, 2011). Healthcare professionals (HCPs), however, remain largely uneducated about human

trafficking. Without a consensus on the number of trafficking victims globally, the issue of human trafficking can be perceived as being unimportant, or rare, in the healthcare setting. HCPs lack confidence in their ability to identify and connect patients with support services. This is related to the fact that few HCPs receive training on the clinical representation of human trafficking, how to identify victims of trafficking, and how to support victims (Beck et al., 2015; Chisolm-Straker, Richardson, & Cossio, 2012; Cole & Sprang, 2015; Grace et al., 2014; Simmons, Lee, Simmons, & López, 2014). This lack of education has perpetuated misconceptions about human trafficking victims between HCPs. Unfortunately, for the HCPs who are aware of the issue of human trafficking, research on how to identify victims has produced a limited number of validated studies.

Research Question

Many trafficking victims do access healthcare services. Without effective screening protocols to identify potential victims of human trafficking, HCPs are missing an opportunity to intervene. This study sought to find and disseminate the most effective identification or screening tools. Our research question, therefore, was: *what screening protocols exist globally for detecting potential victims of human trafficking in an English-speaking healthcare setting?*

Study Aims

Our study had three main aims:

1. To summarize and compare the literature focused on the process of screening potential victims of human trafficking;
2. To disseminate the most effective screening protocols and ensure that information is presented in a way that facilitates the use of screening protocols and other resources in the healthcare setting; and,
3. To identify research gaps in the literature and provide recommendations for future research in the field of identifying victims of human trafficking.

Significance of this Study

While other studies have explored the identification of domestic and international trafficking victims (Macy & Graham, 2012), no study has reviewed screening protocols for all purposes of trafficking globally. Screening tools for the identification of human trafficking victims have been surfacing in the literature. For HCPs, it is imperative that the most effective screening tools are identified. This study provides HCPs with access to evidence-based screening tools and techniques, thereby encouraging patient-centered care globally for victims of human trafficking.

Literature Review

What is Human Trafficking?

Human trafficking definition. The official definition of human trafficking is outlined by the United Nations (UN) Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, herein referred to as the UN Protocol. The primary objectives of the UN Protocol are to prevent trafficking, protect victims and prosecute traffickers. The UN Protocol definition replaced the definition used in the 1949 UN Convention for the Suppression of the Traffic in Persons and of the Prostitution of Others (Skilbrei & Tveit, 2008). Few countries committed to the 1949 convention over concerns about the trafficking definition (Sullivan, 2003). Although more countries[1] did sign the UN Protocol, the most controversial aspect of the document was, once again, the definition of human trafficking. Article 3a of the UN Protocol defines trafficking in persons as:

> The recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation or the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs (UN Protocol, 2000, p.2).

Despite the fact that the document does "create [a] global language and legislation to define trafficking in persons" (Raymond, 2002, p. 491), most states and professionals remain confused about the technical definition of human

[1] There are 117 signatories and 124 parties of the UN Protocol.

trafficking (Andrees & van der Linden, 2005; Gallagher, 2001; Jordan, Patel, & Rapp, 2013; Piper, 2005; Skilbrei & Tveit, 2008). This confusion is often connected to the issue of consent, which the UN Protocol describes as being "irrelevant where any of the means set forth in [Article 3a] have been used" (UN Protocol, 2002, Article 3(b), p. 2).

Deliberations prior to the release of the UN Protocol primarily dealt with this concept of consent. For example, if a woman consents to sex work and being transported to another country, can this still be considered trafficking? The Coalition Against Trafficking in Women (CATW) and the Movement for the Abolition of Pornography and Prostitution (MAPP) were a few of many stakeholders involved in the UN Protocol deliberations (Raymond, 2002). These organizations created a coalition of 140 NGOs and advocated for the protection of all victims of trafficking, not just those who were forced. The coalition argued that demanding proof of force created two groups of victims: the deserving and undeserving (Raymond, 2002). In contrast, the Washington-based International Human Rights Law Group (IHRLG) organized a small collection of NGOs and requested that the definition of human trafficking be limited to means of force or coercion (Raymond, 2002). This argument was also common among countries that had either legalized or regulated sex work as a component of their labour sector; the IHRLG reasoned that these countries would "be required to change their domestic laws" (IHRLG, Statement, June 7, 2000), echoing the concerns of states who worried women would not be able "to migrate for sex work"

(Raymond, 2002, p. 494). The issue of consent is something that has historically plagued the international justice community in cases of human trafficking. If a woman had past experience in sex work, the courts frequently considered this to indicate consent (Raymond, 2002). For example, a 1999 case in Malawi discovered that a woman who had been taken to the Netherlands had once been a prostitute. The court required proof of force and deemed that a person already involved in sex work could not be forced into sex work elsewhere (Inter Press Service, September 10, 1999). In short, those who advocated for an inclusive definition of human trafficking were sensitive to the historical implications of a definition that placed the burden of proof on victims (Raymond, 2002).

To add further to the confusion surrounding human trafficking, the UN Protocol definition fails to address the differences between trafficking, smuggling, and sex work (Kelly, 2005). Attempts to further separate these phenomena have only lead to more uncertainty. To begin, the relationship between trafficking and smuggling is legally complex. The UN defines smuggling as:

> The procurement, in order to obtain, directly or indirectly, a financial or other material benefit, of the illegal entry[2] of a person into a State Party of which the person is not a national or permanent resident (UN General Assembly, 2000, Article 3a, p. 2).

Some studies have claimed that the distinction made between trafficking and smuggling is fictional (Kelly, 2002). Nevertheless, many of these studies fail to acknowledge that domestic trafficking (Macy & Graham, 2012), or trafficking

[2] Illegal entry is defined as "crossing borders without complying with the necessary requirements for legal entry into leaving the State" (UN General Assembly, 2000, Article 3b, p. 2).

within one's own state, does exist. For example, Kelly (2005) argues, "trafficking is a process within which, in most instances, they believe they are making an agreement to be smuggled" (p. 238). This disregards the experiences of individuals who are transported and trafficked within their state. Furthermore, the UN Protocol definition has been mistakenly interpreted as only representing cross-border trafficking in order to facilitate the comparison between trafficking and smuggling. This common misinterpretation is best demonstrated by Skilbrei and Tveit (2008) who state, "trafficking relates to border-crossing activities or other forms of transportation, like smuggling does" (p. 12). Kelly and Regan (2000) offer an explanation in an effort to distinguish between trafficking and smuggling:

> Facilitating illegal migration is usually limited to delivering the person to the country they wish to enter, at which point they are left to their own devices. Women trafficked for sexual exploitation are delivered to individuals or organizations who are party to the transportation, and who subsequently control their activity. These parties have invariably paid a fee for the 'delivery' of the women, which is then translated into a debt the women have to repay through [sex work] (Kelly & Regan, 2000, p. 3).

While this definition could be expanded to discuss other forms of exploitation and clarify that trafficking can occur within one's own state, it is unique in that it illustrates how smuggling and trafficking may exist on a continuum: a person may consent to being smuggled, but at the end point be exploited.

For those who consider smuggling and trafficking to exist on this continuum, the criminalization of smuggling is questionable. Because there is the

suggestion of consent, individuals who are smuggled are persecuted (Musto, 2009); but Skilbrei and Tveit (2008) stress that migration, often influenced by lack of opportunities, poverty, and violence, should not always be considered voluntary. It is also true that migrants who seek the support of smugglers are at risk of being trafficked. While human trafficking and smuggling both reflect "irregular forms of migration" (Aronowitz, 2001, p. 164), smuggling is illegal and human trafficking is a human rights violation (Corrin, 2005). How trafficking and smuggling are interpreted therefore influence whether or not the individual is perceived as a victim, or as a criminal.

A complex relationship also exists between human trafficking and sex work. Few definitions have provided researchers, legislators, and professionals the ability to distinguish between trafficking and sex work (Tyldum, 2010). Nawyn, Birdal and Glogower (2014) suggest that separating coercion from exploitation is central to correctly implementing the UN Protocol definition of human trafficking. Others believe that economic desperation is enough to constitute trafficking. However, this theory equates sex work with sex trafficking and implies that there is no variation in experience between the two (Nawyn, Birdal, & Glogower, 2014). By saying that sex work and trafficking are the same, the ability of women to choose sex work is removed—agency is revoked.

The UN Protocol ultimately created a broader definition of human trafficking that is inclusive of all victims, regardless of consent. Despite more countries agreeing to support the UN Protocol than the 1949 UN Convention,

applying the definition continues to be a struggle. While there are some distinctions that can be made between trafficking, smuggling and sex work, it is necessary to understand that these phenomena can interact and are often reliant on similar push factors. While there may be a global consensus that trafficking is indeed a problem, different organizations have varying understandings of why it is a problem to accommodate their own mandate or political agenda (Tyldum, 2010). These competing interests contribute to the confusion that surrounds preventing trafficking, protecting victims and prosecuting traffickers.

Purpose of human trafficking. As Article 3(a) of the UN Protocol outlines, the purpose of human trafficking is to exploit victims. The UN Protocol specifically mentions three forms of exploitation: sexual exploitation, forced labour, and the removal of organs for the organ trade (2000, p. 2).[3] The UN defines sexual exploitation as:

> ...any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another (United Nations, 2010, para. 1).

The International Labour Organization's (ILO) Forced Labour Convention defines forced or compulsory labour in Article 2(1) as "all work or service which is exacted from any person under the menace of any penalty and for which the said person has not offered himself voluntarily" (1930, No. 29). There are exceptions

[3] The UN Protocol does not state that these are the only forms of exploitation that shall be associated with human trafficking.

when the work is required due to compulsory military service, or civic obligations as a result of a conviction in a court of law,[4] in emergency or disaster situations, or for minor communal services by community members for the interest of the community.

Trafficking in organs is defined by the United Nations Global Initiative to Fight Human Trafficking (UNGIFT) as a crime comprising three primary methods of varying levels of force, coercion, and/or deception. The first method involves traffickers forcing or deceiving an individual to give an organ (UNGIFT, 2015). The second method is when a trafficker, as promised through either a formal or informal agreement, does not compensate an individual for the organ. The last method specified by UNGIFT involves traffickers removing organs from an individual who has sought medical treatment of their own volition, or as a result of a trafficker's coercion (UNGIFT, 2015).

Global statistics for human trafficking. Conflicting interpretations of the human trafficking definition directly influences how and which cases are reported within each country; as already mentioned, these interpretations are strongly related to the motivations of different parties (Anderson, 2007). Government documents have traditionally reported a lower number of victims than advocacy groups, community-based organizations (CBOs), and non-governmental

[4] The work or service should be completed under the supervision of a publically controlled authority.

organizations (reviewed in Knepper, 2013). Combined with the clandestine nature of human trafficking, a reliable estimate of the number of human trafficking victims has yet to be produced (Andrees & van der Linden, 2005; Aronowitz, 2009; Cho, 2013; Jones, Engstrom, Hilliard, & Diaz, 2007; Kelly, 2005; Lusk & Lucas, 2009; Breuil, Siegel, van Reenen, Beijer, & Roos, 2011; Piper, 2005; Raymond, 2002). In an attempt to more accurately depict human trafficking statistics, the United Nations Office on Drugs and Crime (UNODC) published the Global Report on Trafficking in Persons*,* hereafter referred to as the Global Report*,* in November of 2014. Primarily government data on human trafficking from 2010-2012 was gathered from 155 countries and analyzed. Methods of recording human trafficking cases varied extensively between countries; for example, of the 40,177 reported cases of human trafficking globally, 87% of the cases included information on age, 82% included information on gender, 79% included information on age and gender, and 56% of cases had gender reported according to the form of exploitation. Irrespective of the methodological differences between countries, the Global Report is unprecedented in that it is the first to provide a global assessment of human trafficking.

Trafficking encompasses both domestic and international flows. A flow is defined in the Global Report as a trafficking route between an origin and destination that has been used for at least five victims (UNODC, 2014). The predominant type of trafficking that affects a country is correlated to GDP: richer countries tend to be involved with more international trafficking flows, while

countries of less influence are primarily affected by domestic flows (UNODC, 2014). Developing transcontinental trafficking flows typically involves more risk, people, documentation, and funds. Therefore, it is not surprising that approximately 27% of the total number of detected victims experienced transcontinental trafficking (UNODC, 2014). Trafficking across one national border, however, occurred in 70% of detected human trafficking cases between 2010 and 2012.

The Global Report also determined that the majority of victims were sexually exploited, although trafficking for forced labour did increase over the two years. Men were typically trafficked for forced labour, while women accounted for 97% of victims trafficked for sexual exploitation (UNODC, 2014). In addition to this, 70% of all detected victims globally were women (49% women, 21% girls under the age of 18). This percentage was once even higher, but the number of young boys being trafficked increased between 2010 and 2012 (UNODC, 2014). Women and girls under the age of 18 are therefore not only overrepresented in human trafficking statistics, but are also predominantly trafficked for the purpose of sexual exploitation.

Unique to human trafficking is the involvement of women as traffickers. Women accounted for nearly 30% of all global trafficking convictions, which is approximately 20% more than for most other crimes (United Nations Surveys on Crime Trends and the Operations of Criminal Justice Systems, 2015). The involvement of women in trafficking appears to be connected to close personal

relationships: couples, mother-daughter pairs, and siblings were convicted. Previous sex work experience in the country of origin may contribute to female involvement since this experience facilitates recruitment.

What Causes Human Trafficking?

Push and pull factors. There is no uniform response to the question of 'what causes trafficking?' yet an understanding of the conditions which facilitate, and are conducive to, human trafficking can be developed. Factors that result in the migration of individuals from a country or region while making them vulnerable to trafficking are known as push factors. Push factors for human trafficking globally are broad and can assist in predicting whether or not an individual is a potential victim. For example, events resulting in the destabilization and displacement of populations, such as natural disasters or civil war, are considered to be push factors (Bales, 2007; Ejalu, 2006). More specifically, push factors include, but are not limited to: government corruption (Bales, 2007; Ejalu, 2006; Wheaton, Schauer, Galli, 2010), high national infant mortality (Bales, 2007), food production (Bales, 2007), poverty (Ejalu, 2006; Harrof-Tavel & Nasri, 2013; Moore, 1994; Nagle, 2008), urbanization and centralization of employment opportunities (Ejalu, 2006), a history of cultural subversion through colonization (Sethi, 2007), racism (Sethi, 2007; Nagle, 2008), degraded environmental conditions (Nagle, 2008), wealth disparities (Jac-Kucharski, 2012), discriminatory

labour markets (Nagle, 2008), and family disintegration due to divorce, death, or AIDS (Harrof-Tavel & Nasri, 2013; Moore, 1994).

In contrast, factors that result in the migration of individuals to a country or region while making them vulnerable to human trafficking are known as pull factors. Pull factors include: high food production, government corruption and low infant mortality (Bales, 2007; Nagle, 2008). Both food production and infant mortality are indicators of the wealth of the destination country (Bales, 2007). For destination countries there are also pull factors that contribute to the demand for trafficking victims. Pull factors that are considered to contribute to this demand are: weak or no laws against human trafficking (Nagle, 2008), a high proportion of the destination country's male population that is over the age of 60 (Bales, 2007), indifference to social conditions and morality (Nagle, 2008), weak law enforcement (Nagle, 2008), and organized crime networks (Nagle, 2008). For those hoping to resettle, the perceived level of opportunity associated with the destination country or region is a compelling pull factor (Bales, 2007; Ejalu, 2006; Vijeyarasa, 2012). Unfortunately, this perception of opportunity may be dramatized compared to the realities of the destination country or region. Inundated with images and stories of lavish lifestyles abroad, potential migrants may develop what Vijeyarasa (2012) refers to as "Cinderella Syndrome." The Cinderella Syndrome motivates individuals to take extreme risks when trying to migrate and, in the process, increases the vulnerability of being trafficked.

Risk factors. In addition to push and pull factors, there are individual risk factors that have the potential to make a person more vulnerable to human trafficking. These can include, but are certainly not limited to: a lack of education (Ejalu, 2006; Harrof-Tavel & Nasri, 2013; Moore, 1994), a history of domestic violence (Ejalu, 2006; Nagle, 2008), substance abuse (Sethi, 2007), and living in close proximity to international borders (Fong & Cardoso, 2010).

Much of the current literature focuses on the risks associated with domestic minor sex trafficking (DMST) and cannot be generalized to all populations. Childhood maltreatment and/or sexual abuse (Konstantopoulos et al., 2013) appear to contribute greatly to DMST vulnerability. Often these individuals run away from home or are thrown away from home, and become homeless (Fong & Cardoso, 2010; Kotrla, 2010). Homelessness is a major risk factor for trafficking and it is estimated that 20%-40% of homeless minors are lesbian, gay, bisexual, or transgender (LGBT) (Ray, 2006). Even for those able to seek safety off of the streets, minors in foster care, group homes, or shelters are at an increased risk for recruitment. Regardless of these risk factors, there is no single profile of a trafficking victim. For example, not all children trafficked for sexual exploitation are runaways or homeless; many are kidnapped or lured from public places (Boxill & Richardson, 2007). Thus, attempting to construct a victim profile based on the limited data on identified survivors would only oversimplify human trafficking and confirm stereotypes (Tyldum, 2010).

Globalization and trafficked women. Globalization has involved the "reconfiguration of social geography" (Scholte, 2005, p. 84) and the spread of both transplanetary and supraterritorial connections between people (Scholte, 2005). Globalization has thus reinforced and expanded capitalism by providing new opportunities for commodification and accumulation (Scholte, 2005). National and international economies have become increasingly shaped and dominated by global financial markets and the foreign involvement of transnational corporations (TNCs) (Rodriguez, 2004). TNCs were once described as having the ability to promote economic rights, along with "civil and political rights through the creation of a stable and tolerant environment" (Howard-Hassman, 2004, p. 7). Yet through global partnerships facilitated by TNCs, industries have moved from industrialized to developing countries to capitalize on inexpensive labour costs, corruption, lower tariffs, and lax environmental protection laws (Rodriguez, 2004).

With the emergence of a competitive global economy there has been an increase in the motivation to exploit populations (Lusk & Lucas, 2009) marginalized through globalization (reviewed in Jammal, 2011)—women are such a population. Many of the aforementioned push factors disproportionately affect women, including: unemployment, poverty, discriminatory markets, urbanization and centralization of employment opportunities, and wealth disparities. The overrepresentation of women in unemployment statistics (reviewed in Struensee, 2000) is perpetuated at the market, family, community and state levels; this

discrimination has resulted in a phenomenon described as the feminization of poverty (Browne & Braun, 2008; reviewed in Chuang, 2006).

Within markets women typically have limited access to the formal labour sector, since opportunities to participate are typically derived from traditional sex roles. This includes underpaid or unpaid labour such as childcare and housekeeping (reviewed in Chuang, 2006; Meyer, 2003). Gender discrimination within families promotes the preference for male children and a male privilege (reviewed in Chuang, 2006) that is further validated by community traditions or discriminatory4 state policies.

While some researchers frame globalization as a gender-neutral issue (Armstrong, 2004, reviewed in Metcalfe & Rees, 2010), other scholars believe "globalization has accelerated the negative trends of economic and social development" (Harcourt, 2001, p. 85) for impoverished women. Pyle and Ward (2003) outline several of these negative effects by exploring how the globalization of finance, trade, and production has further developed a gender-discriminatory market.

Financial globalization in developing countries is strongly linked to the involvement of the International Monetary Fund (IMF) and the World Bank (WB) (Pyle & Ward, 2003). In many of these countries, structural adjustment policies (SAPs) have been adopted in order to receive loans from these organizations. In an effort to reduce budget deficits, measures of austerity are implemented resulting in the loss of funding for social services (Chow, 2003). The negative

effects of SAPs arguably influence women on a greater scale (Hawthorne, 2004; Pyle & Ward, 2003). Women will often take on additional household responsibilities (reviewed in Harcourt, 2001) and seek minimal income-earning opportunities (Pyle & Ward, 2003) to address the shift in "public responsibilities of the state to the domestic sphere" (Chow, 2003, p. 454).

In terms of trade, women can benefit from economic globalization if they are able to work in a factory that produces goods for international trade, and if the employer remains in that community (Pyle & Ward, 2003). While some women may attempt to maintain autonomy, the export approach to trade adopted by many developing countries often forces women out of independent businesses as a result of the cheap imports produced through trade liberalization (Bee, 2000; Hawthorne, 2004; Schurman, 2001).

As previously mentioned, TNCs have largely moved production and services to developing countries. The liberalization of national economies has provided women with more opportunities for employment and helped to reduce occupational segregation in several countries (Meyer, 2003). In fact, female workers are preferred by TNCs for production; nevertheless this preference is not born out of a desire to combat gender inequality. Female labourers can receive lower wages than male labourers and are more likely to tolerate poor working conditions (Pyle & Ward, 2003). Women often consider these employment opportunities better than other available options (Meyer, 2003), despite unsafe workplaces, harassment, violence, and a lack of opportunity for career

development (Hawthorne, 2004; reviewed in Meyer, 2003; reviewed in Pyle & Ward, 2003). TNCs have also largely moved production and services to developing countries, leading to the urbanization and the centralization of employment opportunities, encouraging mass labour migration.

The wealth disparities exacerbated by globalization have increased intranational and transnational labour migration (Chuang, 2006). The economic inequalities between countries and within countries have led to the development of “survival migrants” who seek employment abroad in an effort to sustain themselves and their families (Chuang, 2006). With less access to the formal labour sector and high rates of unemployment, a large proportion of survival migrants are females searching for job opportunities (Browne & Braun, 2008; Struensee, 2000). Fewer constraints on travelling, combined with promises of higher salaries and standards of living abroad, have led to the establishment of migration routes (Chuang, 2006). Of greatest concern for these female survival migrants is the growing relationship between migration routes and violence towards women, including human trafficking (Cho, 2013; Miller, Decker, Silverman, & Raj, 2007).

Globalization has ultimately facilitated the growth of human trafficking (Jones, Engstrom, Hilliard, & Diaz, 2007) and the commodification of women on a global scale (reviewed in Hawthorne, 2004). Trafficked humans are “one of the few commodities that can be sold and then sold again” (Jones, Engstrom, Hilliard, & Diaz, 2007, p. 113), contributing to the increased power of organized

crime in today's global economy (Fukunda-Parr, 2003). Understanding trafficking as a gendered component of globalization (Limoncelli, 2009) is essential as it highlights processes that result in the overrepresentation of women in global human trafficking statistics.

How Are Health and Human Trafficking Related?

Health outcomes of human trafficking. Human trafficking has largely been problematized as a political and legal issue. This is, in part, a result of the UN Protocol. The purposes of the protocol, as stated in Article 2, are to prevent and combat trafficking in persons, to protect and assist the victims of trafficking, and to promote cooperation between states to facilitate the prevention and protection of victims (2000, p. 2). The UN Protocol also focuses on the prosecution of traffickers (Article 4) and outlines how states should develop legislature to criminalize human trafficking (Article 5). Thus, the mandate of the UN Protocol is to encourage the prevention of human trafficking, the protection of trafficking victims, and the prosecution of traffickers. Framing the global response to human trafficking using the goals of prevention, protection and prosecution has led to the phenomenon being disregarded as a health issue. Yet human trafficking results in serious mental, physical, and sexual health complications as a result of abuses directly associated with human trafficking.

Trafficking victims suffer from profound psychological abuse while in captivity (Zimmerman, Hossain, & Watts, 2011). Abuses often include intimidation

and violent threats against family and/or loved ones to foster obedience and fear. Victims are exposed to unsafe, forced, and uncontrollable events throughout their captivity while simultaneously being isolated from society. For victims, this history of violence materializes as serious and urgent mental health complications. Victims commit suicide or have a history of self-harm and suicidal ideation (Stewart & Gajic-Veljanoski, 2005; Zimmerman, Hossain, & Watts, 2011). While many victims may experience substance abuse after being trafficked, many are forced or coerced into using alcohol or illicit drugs while in captivity (Dovydaitis, 2010). Sexually exploited victims tend to show higher levels of PTSD, depression, anxiety and post-trafficking hostility than in non-sexually exploited victims (Tsutsumi, Izutsu, Poudyal, Kato, & Marui, 2008; Zimmerman, Hossain, & Watts, 2011). Victims also suffer from somatic symptoms (Stewart & Gajic-Veljanoski, 2005) in addition to immune suppression, sleep disturbances, frequent nightmares, memory loss,[5] dissociation, and cognitive problems (Dovydaitis, 2010; Oram et al., 2012).

Physical abuse is the most documented component of human trafficking (Zimmerman, Hossain, & Watts, 2011). Physical abuses endured by victims of human trafficking can include murder, torture, deprivation of sleep, food, light, or basic necessities, confinement, physical restraint, and denied access to medical care. Beatings result in injuries from chronic physical pain, including contusions,

[5] The duration of captivity has been found to be associated with the prevalence of headaches and memory loss (Oram et al., 2012).

head/neck trauma, musculoskeletal damage, dental complications, and death (Stewart & Gajic-Veljanoski, 2005; Zimmerman, Hossain, & Watts, 2011). Victims who are denied access to medical care may become disabled as a result of the deterioration of a pre-existing medical condition or nerve or bone damage (Zimmerman, Hossain, & Watts, 2011). With food or sleep denied as a component of torture, victims can become exhausted or suffer from starvation and gastrointestinal problems (Dovydaitis, 2010; Oram et al., 2012). Victims also experience a great deal of physical harm due to occupational injuries. As a result of working long hours, living and working in dangerous conditions, repetitive work motions, and extreme work-related punishments, victims may present with limb amputations, chemical burns, abrasions, or lacerations, and suffer from musculoskeletal injuries or repetitive motion syndromes (Dovydaitis, 2010; Stewart & Gajic-Veljanoski, 2005; Zimmerman, Hossain, & Watts, 2011). The unsanitary environments that victims are forced to inhabit results in bacterial and other infections, parasites, and the spread of communicable diseases. Furthermore, the physical health of victims also varies depending on the type of exploitation survived. For those who have been trafficked into forced labour, victims have reported more vision problems and a higher prevalence of back pain compared to victims trafficked for sexual exploitation (Oram et al., 2012).

With so many victims being trafficked for the purpose of sexual exploitation, the sexual and reproductive health of victims is strongly impacted. Victims are forced or coerced into having sex or engaging in pornography,

subjected to gang rape, have no control over the number of customers, are denied contraceptives and are denied appropriate medical care for abortions (Zimmerman, Hossain, & Watts, 2011). Sexual and reproductive health effects resulting from these violations include: sexually transmitted infections (STIs), HIV/AIDS, urinary tract infections (UTIs), kidney infections, pain during sex, damage to the vaginal tract or anus, infertility, and complications from unsanitary abortions (Dovydaitis, 2010; Zimmerman, Hossain, & Watts, 2011).

There is also evidence suggesting that differences in health complications depending on whether or not a victim is internationally or domestically trafficked may exist. Data analyzed by Muftić and Finn (2013) from semi-structured interviews demonstrates how the health needs of 12 internationally sex trafficked women, 18 domestically sex trafficked women, and eight non-trafficked sex workers varied.[6] American women who had been trafficked domestically presented with the poorest health outcomes. Suicide ideation and addiction were the greatest among domestically trafficked victims. However, while non-trafficked sex workers reported never being deprived of healthcare, both domestically and internationally trafficked women reported being barred from receiving medical attention (Muftić & Finn, 2013).

An effective global strategy to combat human trafficking must incorporate a medical response. For states to focus solely prevention, protection, and prosecution as mandated by the UN Protocol, effective strategies for victim

[6] Original data from Raymond & Hughes, 2002.

identification and support are left undeveloped or underfunded. Understanding the mental, physical, and sexual health of trafficking victims is vital to the creation of support services that are effective and evidence-based. Further synthesis of global literature is needed to compare how the health of trafficking victims is influenced by geography, gender, age, type of exploitation, and domestic or international travel.

The unrecognized role of healthcare professionals. HCPs are one of the few professionals to come into contact with trafficking victims still in captivity (Clawson, Dutch, Solomon, & Grace, 2009; Logan, Walker, & Hunt, 2009). In fact, 28% of trafficked women (Barrows & Finger, 2008; Crane & Moreno, 2011) and approximately 20% of DMST victims (Dovydaitis, 2010) report visiting a HCP while in captivity. Regrettably, most HCPs are unaware of their potential role in identifying, treating, and rescuing trafficking victims. The interaction between a HCP and victim of human trafficking therefore represents a missed opportunity for intervention. HCPs lack the training, confidence, and screening protocols needed to effectively identify and support victims (Crane & Moreno, 2011). Little effort has been put into developing and disseminating identification protocols and procedural guidelines for HCPs (Macy & Graham, 2012). Recent literature has focused on the role of HCPs as advocates for the prosecution of traffickers, improved service provision (Sabella, 2011), and the education of other HCPs (Cole, 2009; Sabella, 2011)

The omission of HCPs from the response to human trafficking arguably relates to the UN Protocol. Although Article 10(1) is meant to outline requirements for national information exchange and training, only “law enforcement, immigration or other relevant authorities of States Parties” (2000, p. 6) are mentioned. The training that is suggested includes becoming familiar with travel documents used to cross an international border with the intention of trafficking and familiarizing oneself with crime networks established for human trafficking. The UN Protocol does not discuss the issue of health or the training of HCPs to assist potential victims. Human trafficking victims are often hesitant to communicate with law enforcement and immigration officials due to fear of deportation or jail (Logan, Walker, & Hunt, 2009). HCPs therefore provide a practical opportunity to not only address the mental, physical and sexual health needs of victims, but to also gather information essential to the prevention of trafficking, protection of victims, and prosecution of traffickers.

Barriers for HCPs. The role of a HCP in the identification of a trafficking victim is complex and potentially dangerous for both the HCP and victim. The barriers influencing victim identification have contributed to the unrealized role of HCPs in responding to human trafficking. Barriers affecting HCPs can be categorized as either external or internal. External barriers relate to the behaviour of the potential trafficking victim, the trafficker, and available services, while internal barriers relate lack of confidence.

Fear, shame and language barriers influence victim behaviour (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011). A trafficker often accompanies victims to healthcare facilities. This limits victim interaction with HCPs, allows the trafficker to complete paperwork, and poses a safety threat to not only the victim, but also the HCPs involved (Baldwin et al., 2011). Traffickers will threaten victims with violence towards them directly or the victim's family if they do not lie while at the healthcare facility (Baldwin et al., 2011; Zimmerman & Watts, 2003). Traffickers also contribute to the fear a victim has of authority figures, including law enforcement, immigration, and HCPs (Dovydaitis, 2009; Sabella, 2011; Zimmerman & Watts, 2003). Traffickers prey on fears of being arrested or deported to create a loyal bond between the trafficker and victim (Zimmerman & Watts, 2003).

Even when traffickers do not accompany a victim to a healthcare facility, feelings of fear, shame, and a lack of understanding of their own rights will prevent victims from disclosing their situation (Baldwin et al., 2011). The fear of a family member being hurt by a trafficker because of their honesty, or the fear of being ostracized by loved ones, or their community, if their situation is revealed, motivates victims to remain unidentified (Baldwin et al., 2011; Zimmerman & Watts, 2003). A particularly prevalent external barrier faced by HCPs involved in the identification of trafficking victims is the 'victim' classification. Many trafficked persons do not identify with being a victim; they may consider their situation to be a consequence of a poor decision, an opportunity to make money temporarily, or

as not being abusive compared to their previous experiences (Baldwin et al., 2011; Zimmerman & Watts, 2003).

Of greatest concern to the HCP and the victim is the threat of violence as a result of attempted identification (Viergever, West, Borland, & Zimmerman, 2015). While it has been suggested that the "safest way to make contact with a [victim] who has been trafficked is to speak to [them] once...out of the trafficking situation" (Zimmerman & Watts, 2003, p. 8), this recommendation is not applicable to HCPs since most victims come into contact with HCPs while still in captivity. Thus, a barrier for HCPs in identifying victims is the threat of violence towards the trafficked person or involved HCPs. Conducting an interview with a trafficking victim can put a HCP in danger (reviewed in Ahn et al., 2013; Polaris Project, 2010; Zimmerman & Watts, 2003).

If a HCP is able to identify a potential victim of trafficking, the next barrier involves finding gender and culturally appropriate support services located in close proximity to the victim (Clawson & Dutch, 2008). The lack of services available to trafficking victims, along with the lack of knowledge and understanding of what is available in the community (Clawson & Dutch, 2008), results in victims being identified, but not helped. Poor service coordination and availability strongly influence the primary internal barrier affecting HCPs: confidence. A lack of training and awareness among HCPs about human trafficking has resulted in HCPs feeling unconfident in their ability to connect victims with necessary services (Beck et al., 2015; Chisolm-Straker et al., 2012;

Viergever et al., 2015). This lack of confidence undoubtedly serves as a barrier for HCPs when deciding if a patient should be screened for human trafficking.

These barriers ultimately add to the complexity of trying to discuss an extremely sensitive and traumatizing situation with a victim. For HCPs, the task of identifying victims and being able to respond appropriately is daunting without access to training, screening protocols, security, or support services.

Summary

The UN Protocol of 2000 provided a definition of human trafficking that focused on the prevention of trafficking, the protection of victims, and the prosecution of traffickers. The definition considers consent to be irrelevant, thereby alleviating the victim of the responsibility to prove innocence. While the definition has helped to create a global language surrounding human trafficking, there are many states, organizations, and service providers unsure of how to apply the definition. This confusion has developed as a result of the relationship between trafficking, smuggling, and sex work. It is important not to look at each of these as separate, finite phenomena, but as a cycle of interconnected processes. The purpose of human trafficking is exploitation and there are three predominant types of exploitation: sexual, forced labour, and organ removal. The clandestine nature of trafficking makes gathering global data difficult, providing states and organizations with the opportunity to select statistics that support their mandate. The UNODC 2014 Report, however, has been able to look at a sample of

identified trafficking victims. The Global Report highlights the overrepresentation of women not only in trafficking statistics, but also in the number of women involved in the trafficking of others. Globalization has facilitated the mass commodification of women through discriminatory markets, thereby contributing to the overrepresentation of women and girls under the age of 18 in global human trafficking statistics. While there is no specific cause of human trafficking, there is a pool of migrants made vulnerable by push and pull factors. Yet vulnerability can also be influenced by individual experiences with homelessness, violence, and sexual abuse.

The health complications resulting from trafficking are immense and severe. Mental, physical and sexual health difficulties for victims can vary based on gender, whether or not the trafficking was domestic or international and the type of sexual exploitation. Many victims either seek medical care while in captivity, or are brought to a health facility by their trafficker. Of staggering importance is the fact that 28% of trafficked women and approximately 20% of DMST victims report having come into contact with a HCP while in captivity. Despite this, HCPs are rarely provided with identification tools, safety protocols, and information on local services specific to human trafficking. The resulting lack of awareness compounded with the perceived danger of interfering with a trafficking network has led to the missed opportunity of HCPs identifying potential victims of human trafficking.

Methodological Framework

The framework used in this scoping review was modeled after Arksey and O'Malley's pivotal 2005 paper. The Arksey and O'Malley (2005) framework describes five stages of a scoping review: identifying the relevant studies; study selection; charting the data; and, collating, summarizing, and reporting the results. A sixth and optional stage, known as a consultation exercise, was not conducted as part of this project. These five stages were used with slight modifications to guide this scoping review. The following sections describe how each stage was completed in this scoping review on the screening protocols for human trafficking in a healthcare setting.

Stage 1: Identifying the Research Question

Initially planning to design an intervention to educate HCPs on human trafficking and how to identify victims, we found that victim identification or victim screening tools were not only difficult to uncover, but also lacked validation. Designing an educational workshop seemed impractical without being able to provide HCPs with a tool that could effect change. Based on our interest in providing HCPs with the most effective identification or screening tool, our research question was: *what screening protocols exist globally for detecting potential victims of human trafficking in an English-speaking healthcare setting?* We were aware that 'healthcare setting' was somewhat nonspecific and broad

but, as suggested by Arksey and O'Malley (2005), maintaining a wide approach when designing the research question allows for extensive coverage of the topic.

Arksey and O'Malley (2005) also describe four common reasons why a scoping review may be completed. Two of these were applicable to our study: to summarize and disseminate research findings; and, to identify research gaps in the existing literature. Summarizing and disseminating research findings allows for best practices in human trafficking identification to be accessible to HCPs and policy makers, while identifying research gaps highlights potential directions for future human trafficking research. These purposes were linked to the research question as suggested by Levac, Colquhoun, & O'Brien (2010) in order to provide a clear rationale for why the study was completed and to help with study selection.

Stage 2: Identifying Relevant Studies

The goal of a scoping review is to be as thorough as possible when trying to identify studies (reviewed in Arksey and O'Malley, 2005). Our method involved searching for research materials through two different sources: electronic databases and reference lists.

Electronic databases. As suggested by Arksey and O'Malley (2005), the Health Sciences Library liaison for Global Health at McMaster University assisted with identifying keywords, related keywords, and databases. All keywords were defined at the outset of the study and not altered *post hoc*. Defining the keywords

beforehand was made possible by the experience of searching for screening protocols for the previously mentioned HCP intervention. This experience allowed for a piloting of the search strategy (Arksey & O'Malley, 2005) eventually used in this project. Thus, it was known that the chosen keywords were sensitive to a variety of studies that could potentially yield screening protocols.

The research question was distilled into three levels in order to identify keywords: trafficking, screening, and healthcare. The definition used for human trafficking was from the UN Protocol (2000) and the subsequent forms of exploitation included in the search were defined using literature discussed in the "Purpose of Human Trafficking" subsection of this thesis. Screening was considered to be the use of a document that included questions specific to human trafficking in order to identify potential victims. Associated keywords for protocol and identify were based on papers found from the piloting of the search strategy. Due to the variety of HCPs who could be involved in victim identification, search terms for this component of the research question were comprehensive and designed to be sensitive to a variety of individuals involved in the maintenance or restoration of health through treatment and prevention of disease ("Healthcare", 2015). Keywords for each level included: sex trafficking OR human trafficking OR organ trafficking OR trafficking in persons OR forced labo?r; detect* OR screen* OR tool* OR identif* OR measure* OR assess* OR protocol* OR framework* OR model* OR guideline*; and, provider* OR doctor* or nurse* OR physician* OR practitioner* OR professional* OR clinician* OR health?care.

The three levels of keywords were searched together as being all part of document titles or abstracts.

A total of nine databases were searched using the above keywords. The databases searched were: the Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed, EMBASE, MEDLINE, Global Health, PsychINFO, Sociological Abstracts, Public Affairs Information Service (PAIS) International, and Applied Social Sciences Index and Abstracts (ASSIA).

All literature database searches were limited to English language articles from 2000 to the present. The year 2000 was chosen based on the fact that the UN Protocol definition of human trafficking was released in the same year. Theses, dissertations, and material from conferences were all considered to be relevant literature for this study.

Reference lists. Examining the reference lists of studies allowed for primary research to be traced. This back searching method led to the identification of research and/or policies of many NGOs, CBOs, and government departments. These documents typically would not be found in database search results, yet were the basis of several peer-reviewed articles. This process was extremely productive. With such a variety of global organizations being referenced as the authors of primary data, back searching proved to be a reproducible method of researching relevant organizations and their involvement in the field of human trafficking.

Stage 3: Study Selection

Inclusion and exclusion criteria based on the research question were defined at the outset of the project to provide consistency when reviewing studies (Arksey & O'Malley, 2005). The inclusion criteria used for this study were: articles based on primary data, articles with a primary focus on the identification of trafficking victims, and articles with specific practice recommendations for HCPs or service providers. The latter two inclusion criteria were modeled after the criteria in Macy and Graham's (2012) study reviewing human trafficking identification methods in the United States. Articles focusing on intimate partner violence (IPV), the role of law enforcement in human trafficking and sexual assault were excluded from this study. The exclusion and inclusion criteria were applied to all documents found through database searches and back searching. Abstracts were read and entire articles analyzed if initially considered to be a paper representative of the research question. If a paper's relevance was questionable after reading the abstract, the entire document was reviewed. Abstracts were never considered to be representative of the entire article (Badger, Nursten, Williams, & Woodward, 2000).

Stage 4: Charting the Data

Each paper found using databases or through back searching was assigned a unique number to help avoid confusion over papers written by the same author(s) (Daudt, van Mossel, & Scott, 2013). A narrative approach was

taken when deciding which data to record from papers fitting the inclusion criteria. This method is not focused exclusively on outcomes, but involves extracting information about processes to provide the outcomes with context (Pawson, 2002). However, a narrative approach should not result in simply a summary of articles. Within the narrative tradition there is a descriptive-analytical method. This method outlines the specific components of each paper that should be recorded while analyzed in order to facilitate comparisons once all papers are reviewed (Pawson, 2002). The descriptive-analytical method promotes distilling papers to their key components relative to one's research question. The following were chosen based on Arksey and O'Malley (2005) as the components to analyze within each paper: paper number, citation, author(s), year of publication, study location, intervention type, duration of intervention, study population(s), aim(s) of the study, important results, themes, decision to include, reason to not include, recommendations from author(s), and papers to examine from reference list.

To record all of information extracted from included articles, a chart was designed. The method of charting comes from Ritchie and Spencer (1994) and is a technique used to synthesize and organize information thematically. The components listed above were organized into an Excel Microsoft spreadsheet as column headings. Indexing, as described by Ritchie and Spencer (1994), is a process used in charting to assign each document a number correlated with a theme. Themes were developed *post hoc* after reviewing the first ten papers for

patterns in topics. Themes were organized into four main groups: pre-screening, screening questions, post-screening, and training. Pre-screening included the themes of behavioural indicators and victim interaction strategies; screening questions included the themes of comprehensive, child/youth focus, female focus, and effective; and, post-screening included the themes of HCP response and support services. A study conducted by O'Campo, Kirst, Tsamis, Chambers, & Ahmed in 2011, which reviewed methods of identifying IPV victims, influenced the screening protocol themes adopted in this project. The nine themes were enumerated and papers with corresponding topics were indexed, and then entered into the "theme" chart column. Recording the theme of each article allowed for thematic analysis of the documents once the scoping review was complete.

Stage 5: Collating, Summarizing, and Reporting the Results

Whether scoping reviews should assess quality of literature is disputed. Arksey and O'Malley (2005) do not consider quality assessment to be a feature of scoping reviews. Approximately 77% of scoping reviews do not assess quality of literature included (Pham et al., 2014), yet Daudt, van Mossel, & Scott (2013) and Levac, Colquhoun, & O'Brien (2010) believe that assessing quality as part of a scoping review is necessary. Despite this suggestion, there is no critical appraisal tool to determine quality of papers in a scoping review. For this study, no formal quality assessment was completed. As a moderate attempt to control quality, the

primary research cited in relevant articles was found and analyzed rather than the review article.

Having charted all research data, results were organized numerically and thematically. Data about the extent (search flow; publication by year), nature (type of intervention; type of document), and distribution (by country/region) of literature were organized into tables and charts. In addition, the literature was also organized thematically using the nine themes previously discussed. Of particular interest is the fact that the literature resulting from the searches revealed a set of data focused on topics complimenting screening protocols. For example, the themes of pre-screening, post-screening and training were explored extensively in the literature and provide context for the screening questions. Thus, these themes were included in the results based on the opinion that screening questions require additional information, such as how to interact with a potential victim of human trafficking, to be effective.

Applying a consistent approach to analyzing and reporting findings facilitated comparing and contrasting screening protocols. Since one reason for conducting this scoping review was to summarize and disseminate findings, screening questions were compared and summarized in tables that could easily be reviewed by HCPs or policy makers. We ultimately sought to make the screening protocols accessible to HCPs while simultaneously allowing them to understand where the research was conducted, whether or not the questions were validated, and if the questions could be used for specific victim subset.

Lastly, to identify research gaps, the recommendations from author(s) were summarized.

Results

Extent of the Literature

Searches using the previously outlined keywords resulted in: 21 papers from CINAHL; 159 papers from EMBASE, Medline, Global Health, and PsychInfo; 61 papers from Sociological Abstracts, PAIS and ASSIA; and, 51 papers from PubMed (Figure 1). Through back searching and locating the primary data cited in each of the articles, another 33 papers were identified. Of the total 325 papers identified through electronic databases and back searching, 40 studies were removed since they lacked primary data, nearly 100 papers were beyond the scope of this study, and 158 duplicates were removed (Figure 1). The remaining 29 studies were composed of 17 from CINAHL (58.62%), one (3.45%) from EMBASE, Medline, Global Health and PsychInfo combined, one from Sociological Abstracts, PAIS and ASSIA combined, and 10 (34.35%) from PubMed.

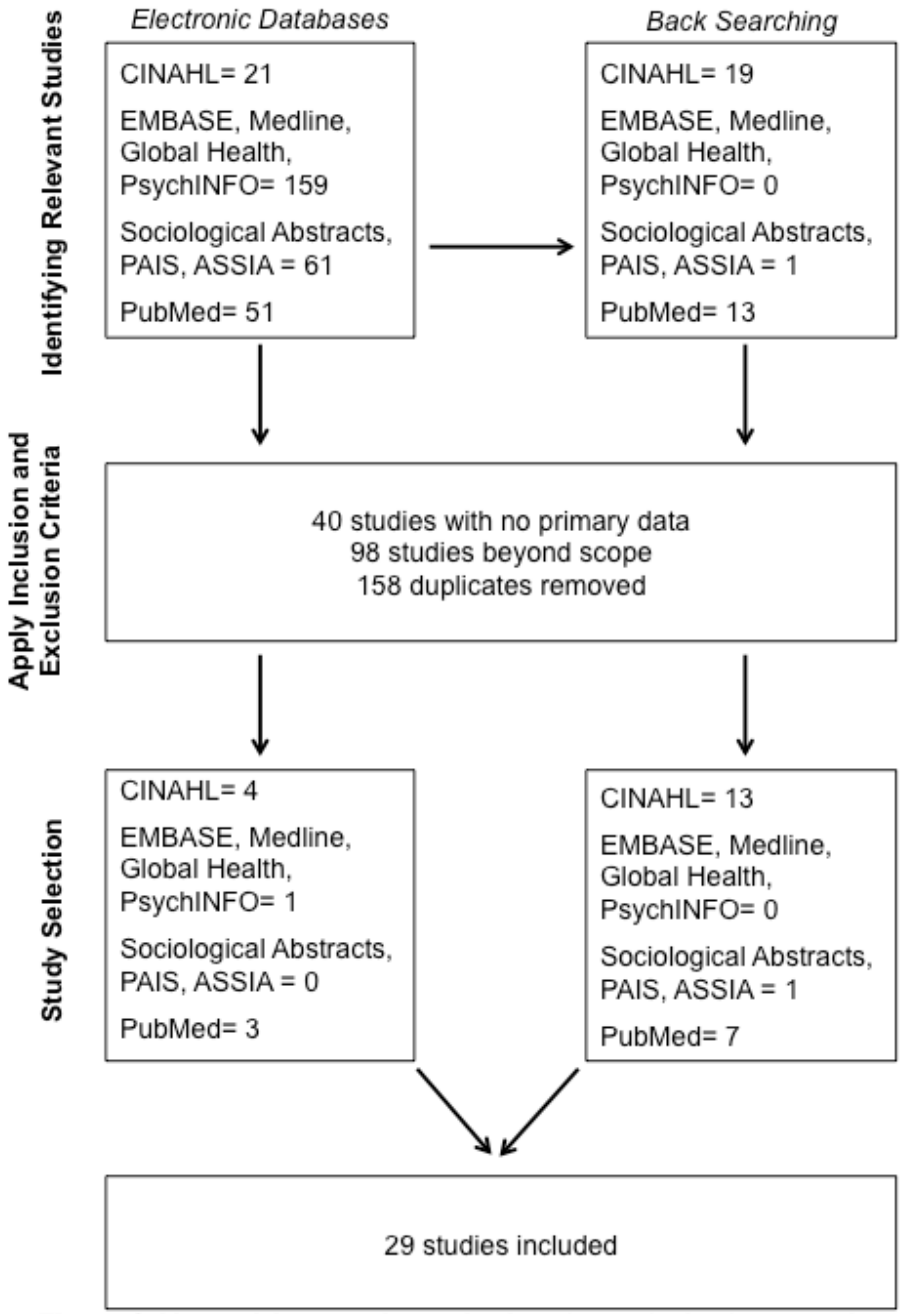

Figure 1. How articles were located using electronic databases and back searching, resulting in a total of 29 studies meeting the inclusion criteria.

All database searches were limited to English language articles from 2000 to the present. No articles from the years 2000, 2001, 2002, 2005, 2006 and

2008 met the inclusion criteria of this study (Figure 2). The majority (58.62%) of papers included in this scoping review are from 2012 to 2015. As illustrated in Figure 2, there appears to be a general increasing trend in the number of published articles focusing on human trafficking screening protocols since 2006.

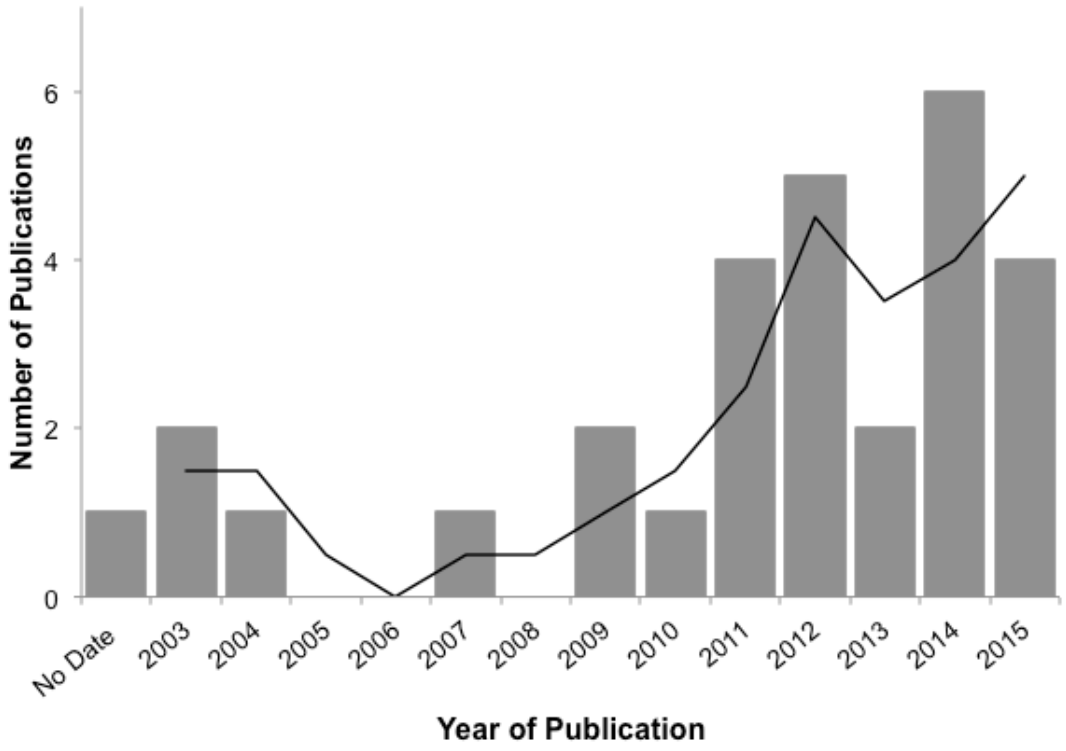

Figure 2. Extent of the literature meeting the inclusion criteria, organized by year.

Distribution of the Literature

Of the 29 articles included in this scoping review, 68.97% (20 articles) had either research conducted in the United States, or were published by American governmental or NGO organizations (Figure 3; Table 1). The three articles (10.34%) from the United Kingdom were published by the central government at the national level in London. Three papers included in this study were not related

to any one specific geographical region and were published by international organizations, such as the World Health Organization (WHO) and the International Organization for Migration (IOM) (Figure 3; Table 1). These international papers accounted for 10.34% of the literature included in this study (Figure 3). Research from Canada, Ireland and a multi-country study accounted for approximately 10.35% of this study's literature.

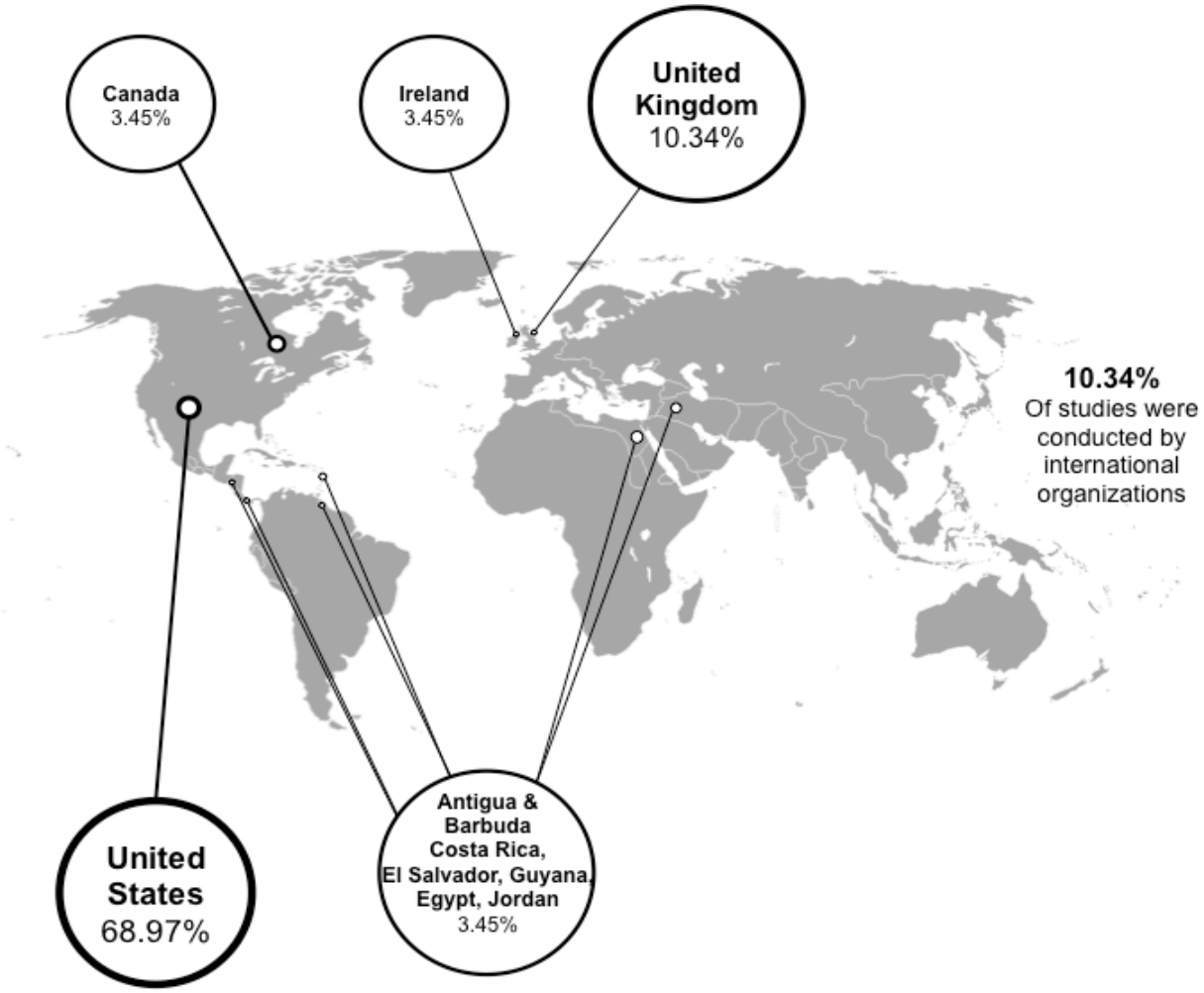

Figure 3. Distribution of the literature meeting the inclusion criteria by geographical region.

Nature of the Literature

Journal articles accounted for 41.37% of the literature included (Table 1). Screening protocols, assessment tools, and practice guidelines accounted for the remaining 58.62% of the literature. Eleven (42.31%) documents were peer-reviewed with all of them being journal articles (Table 1).

The types of interventions used in the relevant literature varied greatly and was related to whether or not the document was a journal article, or a screening or assessment tool. Other than the one validated screening tool, 94.12% of the screening protocols, assessment tools and practice guidelines did not involve any kind of intervention. Thus, only journal articles and the validated screening tool used research methods to explore their study aims. Of these 13 articles, 23.08% conducted interviews, 30.77% distributed surveys, 23.08% designed and implemented workshops, and 15.38% reviewed case studies (Table 1). The validated screening tool was the only document to conduct interviews and review case studies.

While none of the screening or assessment tools were peer-reviewed, one was a validated tool (refer to Simich, Goyen, Powell, & Mollozzi, 2014). The research involved in designing the validated screening tool, hereinafter referred to as the VERA tool, was funded by the U.S Department of Justice. The VERA tool completed 180 screening protocols with potential trafficking victims using a purposive sample selection strategy. Victim service providers from 11 partner agencies administered the screening protocol. If a victim was identified as being

a potential victim of human trafficking using the screening protocol, case files were reviewed to determine the trafficking status of the individual. If the interviewee was then confirmed as a victim of human trafficking, the survey for that individual was analyzed; this allowed for the percentage of trafficking victims accurately identified by each question to be calculated. Once the screening protocol was designed, 12 service providers and 12 trafficking victims were consulted through in-depth interviews to receive feedback on tool content.

The VERA tool defines the validity of a screening protocol as "[referring] to how well [the protocol] measures the concept that it is intended to measure" (Simich, Goyen, Powell, & Mollozzi, 2014, p. 28). While the VERA tool is not peer-reviewed, Simich, Goyen, Powell, and Mollozzi (2014) measured validity, reliability, and predictive validity. Firstly, the construct validity, convergent and discriminant validity, and criterion validity of the VERA tool were analyzed. Using a factor analysis model to explore construct validity, five distinct dimensions related to human trafficking were identified: abusive labour practices, physical harm or violence, sexual exploitation, isolation, and force, fraud, coercion. While there is convergence between some of the dimensions, such as labour and violence, there is also divergence between the different types of trafficking victimization, such as labour and sex. The criterion validity of the VERA tool was verified by comparing the victimization likelihood given to 50% of the study participants by two VERA researchers to the likelihood assigned by victim service providers administering the tool: there was a high level of agreement between the

VERA researchers and the service providers. Secondly, both the inter-rater reliability and internal consistency associated with the VERA tool were calculated. Comparing the trafficking determination assigned to study participants by two VERA researchers who each reviewed the same 50% of the completed tools revealed nearly perfect agreement between raters. Internal consistency was measured using Cronhach's alpha and every dimension, other than isolation, had a value greater than 0.7, which is typically viewed as the lowest acceptable level of internal consistency. Lastly, the predictive validity of the screening protocol was examined. Logistic regression analysis indicated that a majority of the VERA tool questions were significant predictors of trafficking in general, along with sex trafficking and labour trafficking. Simich, Goyen, Powell, and Mollozzi (2014) also developed a shortened version of the VERA screening protocol; the ability of shortened versions of the VERA tool to identify victims of human trafficking was similar to that of the longer versions.

While the tool may be validated, the VERA study itself is limited by a small sample size and a possible bias in the type of service providers involved in administering the screening protocol. In addition, the purposive sampling used in the study means that a rapport was likely built between the service provider and interviewee prior to administering the screening tool. The success of the screening tool may therefore be influenced by this existing rapport.

Table 1. Nature of the literature meeting the inclusion criteria of the study.

Reference	Type of Document	Type of Intervention	Peer-reviewed	Study Location
Asian Health Services & Banteay Srei, 2012	Screening Guildeline	N/A	No	United States
Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011	Journal Article	Semi-structured Interviews	Yes	United States
Beck et al., 2015	Journal Article	Descriptive Survey	Yes	United States
Chisolm-Straker, Richardson, & Cossio, 2012	Journal Article	Training module with Pre- and Post-Test	Yes	United States
Cole & Sprang, 2015	Journal Article	Descriptive Survey	Yes	United States
Grace et al., 2014	Journal Article	Training module with Pre- and Post-Test	Yes	United States
Greenbaum et al., 2013	Practice Guidelines	N/A	No	United States
Hughes, 2003	Assessment Guide	N/A	No	United States
IOM, 2007	Screening Form	N/A	No	International
IOM, 2009	Practice Guidelines	N/A	No	International
McConkey, Garcia, Mann, & Conroy, 2014	Journal Article	Semi-Structured Interviews	Yes	Ireland
Polaris Project, 2010	Assessment Tool	N/A	No	United States
Polaris Project, 2011	Assessment Tool	N/A	No	United States
Sabella, 2011	Journal Article	Case Studies	Yes	United States
Simich, Goyen, Powell, & Mallozzi, 2014	Screening Tool	Interviews, Case Studies	No*	United States
Simmons, Lee, Simmons, & Lopez, 2014	Journal Article	Descriptive Survey	Yes	United States

(continued)

Table 1. Continued.

Spear, 2004	Journal Article	Interviews	No	United States
State of Florida Department of Children and Families, 2009	Indicator Tool	N/A	No	United States
United Kingdom Department of Health, 2013	Identification Guidelines	N/A	No	United Kingdom
United Kingdom Visas and Immigration, 2014a	Referral Form (Child)	N/A	No	United Kingdom
United Kingdom Visas and Immigration, 2014b	Referall Form (Adult)	N/A	No	United Kingdom
United States Department of Health and Human Services, 2012a	Assessment Guide	N/A	No	United States
United States Department of Health and Human Services, 2012b	Assessment Tool	N/A	No	United States
United States Department of Health and Human Services, 2012c	Assessment Guide	N/A	No	United States
United States Department of State, n.d.	Identification Tool	N/A	No	United States
Varma, Gillespie, McCracken, & Greenbaum, 2015	Journal Article	Retrospective Case Study	Yes	United States
Viergever, West, Borland, & Zimmerman, 2015	Journal Article	Training module with Pre- and Post-Test	Yes	Antigua & Barbuda Costa Rica, El Salvador, Guyana, Egypt, Jordan
Wong, Hong, Leung, Yin, & Stewart, 2011	Journal Article	Descriptive Survey	Yes	Canada
Zimmerman & Watts, 2003	WHO Ethical Guidelines	N/A	No	International

*Note: While not peer-reveieved, the screening tool is validated.

Thematic Findings

Pre-screening. Twenty papers (68.97%) discussed the pre-screening environment (Table 2). Of these papers, 16 (55.15%) focused on indicators of human trafficking and 13 (44.83%) focused on victim interaction strategies. Papers published in the United States accounted for 70% of the articles that discussed pre-screening, while the United Kingdom and International Organizations contributed to 15% each (Table 2).

Table 2. Coverage of themes for each of the 29 sources (multiple themes possible), displayed in alphabetical order

Sources		Themes								
		Pre-Screening		Screening Questions				Post-Screening		
lead author(s) (year)	Study Location	Behavioural Indicators	Victim Interaction Strategies	Comprehensive	Child/Youth Focus	Female Focus	Validated	HCP Response	Support Services	Training
Asian Health Services & Banteay Srei, 2012	United States	✓	✓		✓			✓		
Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011	United States	✓	✓	✓				✓		
Beck et al., 2015	United States									✓
Chisolm-Straker, Richardson, & Cossio, 2012	United States									✓
Cole & Sprang, 2015	United States									✓
Grace et al., 2014	United States									✓
Greenbaum et al., 2013	United States	✓	✓		✓			✓		
Hughes, 2003	United States	✓						✓		
IOM, 2007	International	✓	✓	✓						
IOM, 2009	International	✓	✓		✓			✓		

(continued)

Table 2. Continued.

McConkey, Garcia, Mann, & Conroy, 2014	Ireland						✓	✓		
Polaris Project, 2010	United States	✓		✓			✓			
Polaris Project, 2011	United States		✓	✓						
Sabella, 2011	United States	✓	✓				✓			
Simich, Goyen, Powell, & Mallozzi, 2014	United States		✓	✓		✓	✓	✓		
Simmons, Lee, Simmons, & Lopez, 2014	United States									✓
Spear, 2004	United States	✓		✓			✓	✓		
State of Florida Department of Children and Families, 2009	United States	✓	✓		✓		✓			
United Kingdom Department of Health, 2013	United Kingdom	✓	✓				✓	✓		
United Kingdom Visas and Immigration, 2014a	United Kingdom	✓					✓			
United Kingdom Visas and Immigration, 2014b	United Kingdom	✓					✓			

(continued)

Table 2. Continued.

United States Department of Health and Human Services, 2012a	United States	✓	✓					✓		
United States Department of Health and Human Services, 2012b	United States			✓				✓		
United States Department of Health and Human Services, 2012c	United States		✓					✓		
United States Department of State, n.d.	United States	✓		✓				✓		
Varma, Gillespie, McCracken, & Greenbaum, 2015	United States	✓								
Viergever, West, Borland, & Zimmerman, 2015	Multi-country									✓
Wong, Hong, Leung, Yin, & Stewart, 2011	Canada									✓
Zimmerman & Watts, 2003	International		✓							
	N=	**16**	**13**	**8**	**4**	**0**	**1**	**18**	**4**	**7**
	%	**55.17**	**44.83**	**27.59**	**13.79**	**0**	**3.45**	**62.07**	**17.24**	**24.14**

✓' indicates that a theme is covered.

The indicators of human trafficking and the victim interaction strategies described in the literature meeting the inclusion criteria of this study are summarized in Table 3. Indicators and victim interaction strategies were occasionally specific to children or women. Thus, results were divided into three categories: children, women, and comprehensive. Five of the twenty papers (25%) focused on pre-screening discussed either indicators or victim interaction strategies specific to children; 80% of these studies were published in the United States (Table 3).

Table 3. Articles discussing the theme of pre-screening, including indicators and victim interaction strategies, organized by the victim subgroups.

Sources	**Themes**	
	Pre-Screening	
lead author(s) (year)	Behavioural Indicators	Victim Interaction Strategies
Children		
Asian Health Services & Banteay Srei, 2012	1) frequent and consistent requests for STi screening, diagnosis of STIs 2) sexually active adolescents < 13 years old with more than 2 lifetime or casual sexual partners 3) chronic truancy issues 4) not living at home or living with boyfriend 5) homelessness issues 6) more than 10 lifetime or casual partners 7) history of sexual abuse	1) do not directly ask about human trafficking, as the child may not understand that they are being trafficked
Greenbaum et al., 2013	1) signs of child being controlled, fearful, withdrawn, submissive 2) shows distrust of adults 3) presents alone or in a group of children with one adult 4) signs of physical abuse 5) signs of substance use/abuse 6) child has tattoos (evidence of branding or gang insignia) 7) child has history of living outside of home with freinds 8) child has large amount of cash, or expensive items 9) child has hotel room keys 10) child has poor school attendance 11) child gives false or changing demographic information	1) show interest 2) listen actively, carefully, and responsively 3) consider any preconceptions and prejudices that you may have 4) remain open-minded and non-judgemental 5) maintain professionalism 6) ensure child feels in control of their body and communcations (have a trusted interpreter there) 7) inform child of their right to a forensic medical exam and report 8) reassure child they are not to blame 9) establish rapport and allow time, if possible 10) treat child as someone who needs services and not as an offender 11) look for non-verbal cues 12) maintain a neutral posture and expression 13) ask open-eded questions 14) avoid assumptions, interrupting, acting like a surrogate parent, power struggles, and continous direct questions without pause

(continued)

Table 3. Continued.

State of Florida Department of Children and Families, 2009	1) evidence of physical, mental, or sexual abuse 2) cannot speak on own behalf or is non-English speaking 3) is not allowed to speak alone or is being controlled 4) doesn't have access to identity or travel documents 5) works unusually long hours and is unpaid or is paid very little 6) will not cooperate and gives incorrect information about identity or living situation 7) is not in school or has gaps in schooling 8) lives at his/her workplace or with employer and/or lives with many people in a small area 9) has a heightened sense of fear and distrust of authority 10) has engaged in prostitution or commercial sex acts	1) suspected trafficker should not be present 2) require an independent translator 3) question in an unbiased and non-judgemental way 4) be sensitive of cultural or religious differences when talking about sex or mental health 5) do not ask about immigration at the beginning of the interview
Varma, Gillespie, McCracken, & Greenbaum, 2015	1) high rates of STIs 2) physical abuse 3) history of violence with sex 4) drug/alcohol use 5) multiple instances of drug use 6) history of running away from home 7) prior involvement with child protective services and law enforcement	
United Kingdom Visas and Immigration, 2014a*	1) claims to have been exploited sexually, through labour, or domestic servitude 2) physical symptoms of exploitative abuse 3) underage marriage 4) phycial indicators of working 5) STI or unwanted pregnancy 6) coached answers 7) significantly older partner 8) claims to have been in the UK for years, but has not learned about local language 9) withdrawn and refuses to talk 10) shows signs of physical neglect 11) socially isolated 12) exhibits a maturity not expected at their age 13) low self esteem 14) sexually active 15) not registered with or attended a GP practice 16) not enrolled in shool 17) limited freedom of movement 18) unregistered private fostering arrangement 19) claims to be in debt bondage 20) receives unexplained or unidentified phone calls whilst in placement	

(continued)

Table 3. Continued.

Women		
Zimmerman & Watts, 2003		1) interviews should be conducted in a secure and private setting 2) have an open mind and listen 3) be prepared to change the subject of the conversation or close an interview if the conditions become unsafe 4) important to not leave a woman feeling ashamed and hopeless 5) be ready to provide the victim with resources 6) ensure that the woman understands that what has happened is not her fault 7) work with an interpreter or individual familiar with working with females who have experienced violence 8) do not accept unknown volunteer interpreters 9) when possible, the woman should be asked if she has a preference for interviewer gender 10) interviewer should clearly explain the reason for the interview, the subjects covered, the potential risk and benefits of the interview, and the personal nature of the questions 11) a woman's choice to respond to health concerns or situation must be respected 12) the request for help should immediately take precedence over the interview 13) before contacting authorities, make sure that this is what the woman wants
Comprehensive		
Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011	1) traffickers accompanying patients to health care facilities, completing paperwork for them, communicating with clinic staff and HCPs 2) suspicious “relatives” who accompany the potential victim	1) separate potential victim from the trafficker 2) build trust 3) educate the potential victim about their basic human rights

(continued)

Table 3. Continued.

Hughes, 2003	Indicators of force: 1) injuries from weapons 2) visible injuries or scars 3) mouth injuries from being struck 4) brands or scarring indicating ownership 5) untreated illnesses or STIs 6) general poor health and disease 7) no english language skills 8) kept under surveillance when taken to the doctor, hospital, or clinic for treatment Indicators of coercion: 1) victim is not in possession of identity or travel documents 2) women victim is fearful of police 4) signs of threats made by the accompanying trafficker Indicators of fraud: 1) victim was lied to about aspects of their travel, employment, or living conditions 2) victim does not know how identity or travel documents were obtained 3) someone else made travel arrangements 4) victim was coached on what to say to officials 5) woman had to pay a fee to someone to arrange tavel and transportation 6) woman was smuggled across borders	
IOM, 2007	1) mistrust of others 2) memory loss 3) no identity documents 4) moved from an area/location that is associated with trafficking (brothel, sweatshop) 5) signs of prolonged physical and psychological abuse 6) withdrawn or fearful 7) uninhibited anger without apparent reason	1) ensure that the victim understands the interview is voluntary 2) be aware of the effects of culture on the beliefs and behaviours of others 3) be aware of one's own cultural attributes and biases and their impact on patients 4) show patience in relation to memory problems 5) have respect for patient privacy and modesty 6) do not disregard patient if they are angry or dismissive 7) explain things in a manner that is easy to understand 8) do not pursue or press for details when it appears that they have shared all of their information 9) keep the atmosphere informal and simple

(continued)

Table 3. Continued.

IOM, 2009	1) migrated locally or internationally for work commonly associated with trafficking 2) trauma symptoms 3) injuries associated with abuse 4) injuries or illnesses associated with unprotected labour or poor/exploitative working or living conditions 5) presence of a minder 6) fearful or untrusting 7) doesn't speak local language	1) treat all contact with trafficked persons as a potential step towards improving their health 2) prioritize the safety of trafficked persons 3) provide respectful, equitable care 4) be prepared with referral information and contact details for trusted support persons 5) collaborate with other support services 6) ensure confidentiality and privacy 7) conduct private interviews 8) obtain voluntary informed consent; be prepared to discuss informed consent 9) maintain non-judgemental manner 10) show patience 11) ask only relevant questions 12) avoid repeated requests for the same information 13) avoid calling authorities, such as police or immigration services 14) assess the individual's literacy level 15) explore the patient's own understanding of their illness 16) accommodate wishes for a same sex provider or translator when possible 17) ask your questions in relation to patient's health and in the simplest way possible
Polaris Project, 2010	1) patient is reluctant to explain or has inconsistencies when asked about his/her injury 2) patient is not aware of his/her location 3) patient has someone speaking for him/her 4) patient shows signs of physical or sexual abuse, medical neglect, untreated STIs, and/or torture 5) patient exhibits fear, anxiety, depression, submission, tension, nervousness, or avoids eye contact 6) patient is under 18 and is engaging in commerical sex or trading sex for something of value 7) patient has an unusually high number of sexual partners for his/her age	
Polaris Project, 2011		1) conduct the assessment in a comfortable and safe environment 2) provide the individual with space when speaking with them 3) be relaxed and use an approachable tone, demeanor, and body language 4) use emphatic listening 5) maintain good eye contact with the victim 6) try not to take notes and instead engage in active listening 7) if you must take notes, inform the victim of why and for what purpose 8) be clear about your role and goals 9) be conscious of the language that you use when speaking with a potential victim and mirror the language that the potential victim uses

(continued)

Table 3. Continued.

Sabella, 2011	1) the person does not speak English 2) someone is speaking for him or her 3) the person doesn't seem to know where she or he is 4) the person doesn't have any identification or travel documents 5) the person has no spending money 6) the person appears to be under the control and supervision of someone 7) there are signs of malnutrition, dehydration, drug use or addiction, poor general health, or poor personal hygiene 8) signs of physical abuse or nelect (scars, bruises, unusual bald patches, tattoos that raise suspicion) 9) the person's story about what he or she does in the country doesn't make sense 10) the person lives with an employer or at the place of business 11) people who brought in the person for treatment will not let you speak with the person alone 12) the person appears depressed, frightened, anxious and otherwise distressed	1) talk to the person alone 2) have a translator brought in that is not affiliated with the trafficker
Simich, Goyen, Powell, & Mallozzi, 2014		1) fulfill the basic needs of food, clothing, medical care, and shelter 2) hold the interview in a non-threatening location 3) provide the victim with food and drink 4) talk to the victim in private 5) maintain a professional, but friendly attitude 6) be honest about the purpose of the screening 7) describe the victim's rights, the screening process, and your role 8) employ competent, trustworthy interpreters 9) be aware of gender issues 10) when possible, the victim's preference for an interpreter of a specific gender or culture should be accommodated 11) allow the victim to relay their fears 12) do not imply that the victim was responsible for their own abuse and exploitation 13) allow the victim to tell their own story 14) be aware of cultural differences that may make some topics uncomfortable to discuss 15) express sorrow, but do not appear judgmental 16) convey that you are there to help, that you can be trusted, that safety is your priority, and that they have the right to live without being abused

(continued)

Table 3. Continued.

Spear, 2004	1) injury that does not match explanation 2) reluctant to give information about self, injury, home, or work environment 3) fearful of authority figures 4) person accompanying the woman does not allow the woman to be seen alone 5) signs of physical abuse (sexual, burns, signs of torture, malnourishment) 6) signs of psychological abuse (fearful, intimidated, or fearful of employer) 7) the individual is isolated (not allowed to leave home or work without knowledge of employer or sponsor) 8) long working hours with no breaks and unhealthy working conditions	
United Kingdom Department of Health, 2013	1) a person accompanied by someone who appears controlling and who insists on giving information and coming to see the health worker 2) the person is withdrawn and submissive 3) the person seems to be afraid to speak to a person in authority 4) the person gives a vague and inconsistent explanation of where they live, their employment, or schooling 5) the person has old or serious injuries left untreated and has delayed presentation and is vague and reluctant to explain how the injury occured or to give medical history 6) the person is not registered with a GP, nursery, or school 7) the person has experienced being moved locally, regionally, nationally, or internationally and appears to be moving location frequently 8) the person's appearance suggests general physical neglect 9) the person may struggle to speak English	1) try to find out more about the situation 2) speak to the person in private 3) reassure the person that it is safe to speak 4) do not make promises that you cannot keep 5) ask only non-judgemental, relevant questions 6) allow the person time to tell their experience 7) do not let concerns you have about challenging cultural beliefs prevent you from making an informed assessment 8) do not raise trafficking concerns with anyone accompanying the person 9) ensure that you address the health needs of the person 10) ensure that the person knows that the health facility is a safe place 11) react in a sensitive way that ensures the person's safety 12) think about support and referrals
United Kingdom Visas and Immigration, 2014b*	General indicators: 1) distrustful of authorities 2) expression of fear or anxiety 3) lack of access to medical care 4) perception of being bonded by debt 5) money is deducted from salary for food Indicators of forced labour: 1) poor or non-existent health and safety 2) excessive wage reductions 3) imposed place of accommodation 4) no or limited access to earnings 5) dependent on employer for a number of services Indicators of domestic servitude: 1) living with and working for a family 2) not eating with the rest of the family 3) no private space 4) no proper sleeping place 5) never leaving the house without employer Indicators of sexual exploitation: 1) sleeping on work premises 2) movement of individuals between brothels 3) only able to speak sexual words in local language or client language 4) substance misuse 5) person subjected to crimes such as abduction, assault or rape	

(continued)

Table 3. Continued.

United States Department of Health and Human Services, 2012a	1) evidence of being controlled 2) evidence of an inability to move or leave job 3) bruises or other signs of battering 4) fear or depression 5) non-English speaking 6) recently brought to the country from Eastern Europe, Asia, Latin America, Canada, Africa, or India 7) lack of passport or identity documents 8) lack of immigration documents	1) work in a safe and confidential environment 2) separate any controlling individuals from the potential victim 3) screen interpreters to ensure that they do not know the victim or the traffickers and do not have a conflict of interest
United States Department of Health and Human Services, 2012c		1) convey that you are there to help and that safety is your priority 2) convey that you will provide medical care, that you will find the victim a safe place to stay, and that they victim has a right to live without being abused 3) explain that the victim deserves the right to become self-sufficient and independent 4) if able, share that you could protect the victim's family 5) explain that the victim can receive help to build a life safely in the United States
United States Department of State, n.d.	1) living with employer 2) poor living conditions 3) inability to speak to individual alone 4) answers appear to be rehearsed and scripted 5) employer holds identity documents 6) signs of abuse 7) submissive or very fearful 8) unpaid or paid very little 9) under 18 and in sex work	

*Referral form for both children and adults at: https://www.gov.uk/government/publications/human-trafficking-victims-referral-and-assessment-forms. Note that these forms are extensive; they contain 63 and 52 indicators, respectively.

Several child indicators of trafficking were mentioned by more than one of the sources (Table 3). These indicators were: not living at home (Asian Health Services & Banteay Srei, 2012; Greenbaum et al., 2013; Varma, Gillespie, McCracken, & Greenbaum; 2015); giving false information (Greenbaum et al., 2015; State of Florida Department of Children and Families, 2009); poor school attendance (Greenbaum et al., 2015; State of Florida Department of Children and Families, 2009; UK Visas and Immigration, 2014a); fearful and distrusting of authority (Greenbaum et al., 2015; State of Florida Department of Children and Families, 2009); STIs (Asian Health Services & Banteay Srei, 2012; UK Visas and Immigration, 2014a; Varma, Gillespie, McCracken, & Greenbaum, 2015); drug use (Greenbaum et al., 2015; Varma, Gillespie, McCracken, & Greenbaum, 2015); history of truancy issues (Varma, Gillespie, McCracken, & Greenbaum, 2015; Asian Health Services & Banteay Srei, 2012); signs of prolonged physical abuse (Greenbaum et al., 2015; State of Florida Department of Children and Families, 2009; Varma, Gillespie, McCracken, & Greenbaum, 2015; UK Visas and Immigration, 2014a); and, evidence of being controlled by a trafficker (Greenbaum et al., 2015; State of Florida Department of Children and Families, 2009; UK Visas and Immigration, 2014a). The United Kingdom source for behavioural indicators included a potential 63 indicators of child trafficking (Table 3). Many of the indictors listed by the United Kingdom Visas and Immigration (2014a) were not mentioned by any other source. These unique behavioural indicators for child trafficking included: underage marriage, a significantly older

partner, more mature than expected for their age, an unregistered private fostering arrangement, receiving unexplained or unidentified phone calls, and not registered with a family physician (Table 3; United Kingdom Visas and Immigration, 2014a).

Only three of the five articles that discussed pre-screening themes mentioned victim interaction strategies for children (Table 3). The most commonly reported interaction strategies included: remaining unbiased and non-judgmental (Greenbaum et al., 2015; State of Florida Department of Children and Families, 2009), and not asking directly about immigration or human trafficking (Asian Health Services & Banteay Srei, 2012; State of Florida Department of Children and Families, 2009).

One source that met the inclusion criteria of this study discussed pre-screening methods specific to women (Table 3; Zimmerman & Watts, 2003); the WHO published this article. The source focused largely on victim interaction strategies and not behavioural indicators.

In contrast, 14 papers (70%) took a comprehensive approach when discussing pre-screening methods (Table 3). Of these papers, 78.75% of them specifically mention behavioural indicators of human trafficking, while 64.39% mention victim interaction strategies. As with the child-specific papers for the theme of pre-screening, the majority of sources were published in the United States (71.43%). Several comprehensive indicators of trafficking were mentioned by more than one of the sources (Table 3). These indicators were: trafficker

accompanying the potential victim (Baldwin et al., 2011; Hughes, 2003; IOM, 2009; Polaris Project, 2010; Sabella, 2011; Spear, 2004; United Kingdom Department of Health, 2013; United States Department of Health and Human Services, 2012a; United States Department of State, n.d.); potential victim does not have access to identity and/or travel documents (Hughes, 2003; IOM, 2007; Sabella, 2011; United States Department of Health and Human Services, 2012a; United States Department of State, n.d.); limited English language skills (Hughes, 2003; IOM, 2009; Sabella, 2011; United Kingdom Department of Health, 2013; United Kingdom Visas and Immigration, 2014b; United States Department of Health and Human Services, 2012a); fearful and distrusting of authority (Hughes, 2003; IOM, 2007; IOM, 2009; Polaris Project, 2010; Sabella, 2011, Spear, 2004; United Kingdom Department of Health, 2013; United Kingdom Visas and Immigration, 2014b; United States Department of Health and Human Services, 2012a; United States Department of State, n.d.); signs of abuse (Hughes, 2003; IOM, 2007; IOM, 2009; Polaris Project, 2010; Sabella, 2011; Spear, 2004; United Kingdom Department of Health, 2013; United Kingdom Visas and Immigration, 2014b; United States Department of Health and Human Services, 2012a; United States Department of State, n.d.). In addition to these frequently referenced behavioural indicators, memory loss (IOM, 2007), uninhibited anger without apparent reason (IOM, 2007), and an injury that does not match explanation (Spear, 2004) were all unique and referenced by one source.

Suggested comprehensive victim interaction strategies were abundant and many of the sources shared similar strategies. These shared strategies included: separating the victim from the potential trafficker (Baldwin et al., 2011; IOM, 2009; Sabella, 2011; Simich et al., 2014; United Kingdom Department of Health, 2013; United States Department of Health and Human Services, 2012a); screening interpreters (Sabella, 2011; Simich et al., 2014; United States Department of Health and Human Services, 2012a); explaining to the victim that safety is your priority (IOM, 2009; Polaris Project, 2011; Simich et al., 2014; United States Department of Health and Human Services, 2012c), explaining your role in their safety and health (Polaris Project, 2011; Simich et al., 2014; United States Department of Health and Human Services, 2012c); remaining non-judgmental (IOM, 2009; Simich et al., 2014; United Kingdom Department of Health, 2013); being sensitive to culture and gender (IOM, 2007; IOM, 2009; United Kingdom Department of Health, 2013; Simich et al., 2014).

Between the groups of children, women, and comprehensive there were many similar behavioural indicators and victim interaction strategies. For behavioural indicators, sources specific to children and comprehensive sources referenced fearful and distrusting of authorities, signs of prolonged physical abuse, and the presence of a controlling potential trafficker. While only one article included in this study addressed victim interaction strategies specific to potentially trafficked women, suggested strategies were similar across all groups. Sources focusing on children, women, and comprehensive victim interaction strategies all

mentioned the importance of being non-judgmental and screening interpreters (Table 3).

Screening questions. Twelve sources (41.38%) focused on screening questions for identifying potential victims of human trafficking (Table 2). Of these sources, 8 (66.67%) had comprehensive screening questions, 4 were child/youth specific (33.33%), zero were specific to women (0%), and one was a validated screening tool (8.33%). Papers published in the United States accounted for 83.33% of the articles that discussed screening questions.

The VERA tool created by Simich et al. (2014) was the only validated tool, as previously discussed, found in the literature. As such, the screening questions from all other tools, practice guides, and assessment forms were compared to the VERA tool (Table 4). After comparing all of the other screening tools with the VERA tool, it was determined that the Polaris Project (2011) shared the most questions. In fact, the Polaris Project (2011) shared 45.24% (19 questions) of the VERA tool questions (total of 42 questions). In comparison, the United States Department of Health and Human Services assessment tool (2012b) shared 11.90% of the VERA questions, and the United States Department of State (n.d.) identification tool shared 14.29% of the VERA questions (Table 4). The most commonly shared VERA tool questions were:

1. Did anyone where you worked [or did other activities] ever harm/threaten to harm people close to you, like family or friends?

2. Did anyone ever take and keep your identification/documentation, for example your passport or driver's license?
3. Did anyone you ever worked [or did other activities] for or lived with control how much food you could get?
4. Have you ever felt you could not leave the place where you worked [or did other activities]?
5. Did you ever have sex for things of value (for example, money, housing, food, gifts, or favours)? Were you pressured to do this? Were you under the age of 18 when this occurred?

These questions were determined to detect 31.2%, 48.9%, 46.3%, 75%, and 38.9% of trafficking victims, respectively (Simich et al., 2014).

Table 4. The VERA long tool with comparisons to other screening questions from different sources

VERA Screening Questions	References Sharing this Question
Personal Background	
What is your date of birth?	
If you don't know your date of birth, approximately how old are you?	
How many years of schooling have you completed?	
What country were you born in?	IOM, 2009; Spear, 2004; State of Florida Department of Children and Families, 2009
Are you a citizen of any other countries besides where you were born?	
Migration	
Can you tell me why you left your country?	
What country did you live in for at least 3 months before you came to [insert country's name]?	
In what year was your most recent arrival to [insert country's name]?	IOM, 2009
Did anyone arrange your travel to [insert country's name]?	IOM, 2007
Did the people or person who arranged your travel pressure you to do anything (for example, did anyone ask you to carry something across the border)?	
Can you tell me the total cost (approximately) of your migration?	IOM, 2007
Did you (or your family) borrow or owe money, or something else, to anyone who helped you come to [insert country's name]?	Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011; IOM, 2007; Polaris Project, 2011
If you did borrow or owe money, have you ever been pressured to do anything you didn't want to do to pay it back?	
Work	
How have you supported yourself while in [insert country's name]?	Spear, 2004
Have you worked for someone or done any other activities for which you thought you would be paid?	Spear, 2004
Have you ever worked [or done other activities] without getting payment you thought you would get?	Polaris Project, 2011; State of Florida Department of Children and Families, 2009
Did someone ever: withhold payment/money from you, give your payment/money to someone else, control the payment/money that you should have been paid?	IOM, 2007; Polaris Project, 2011

(continued)

Table 4. Continued.

Were you ever made to sign a document without fully understanding what it stated, for instance, a work contract?	Polaris Project, 2011
Have you ever worked [or done other activities] that were different from what you were promised or told?	Polaris Project, 2010; Polaris Project, 2011
Did anyone where you worked [or did other activities] ever make you feel scared or unsafe?	
Did anyone where you worked [or did other activities] ever hurt you or threaten to hurt you?	United States Department of Health and Human Services, 2012b
Did anyone where you worked [or did other activities] ever harm or threaten to harm people close to you, like family or friends?	Polaris Project, 2010; Polaris Project, 2011; Spear, 2004; State of Florida Department of Children and Families, 2009; United States Department of Health and Human Services, 2012b; United States Department of State, n.d.
Were you ever allowed to take breaks where you worked [or did other activities], for example, to eat, use the telephone, or use the bathroom?	
Were you ever injured or did you ever get sick in a place where you worked [or did other activities]?	IOM, 2009
Living and/or Working Conditions	
When you were in that situation, were you living [or do you currently live] there?	
Do you live, or have you ever lived, in the same place where you work?	Polaris Project, 2011; Spear, 2004; United States Department of State, n.d.
Have you ever felt you could not leave the place where you worked [or did other activities]?	Greenbaum et al., 2013 ;Polaris Project, 2011; Spear, 2004; United States Department of State, n.d.
Have you ever worked [or did other activities] or lived somewhere where there were locks on the doors or windows or anything else that stopped you from leaving?	IOM, 2009; Polaris Project, 2011; United States Department of Health and Human Services, 2012b
Did anyone at the place where you lived or worked [or did other activities] monitor you or stop you from contacting your family, friends, or others?	Polaris Project, 2011
Did anyone ever take and keep your identification, for example, your passport or driver's license?	Polaris Project, 2010; Polaris Project, 2011; Spear, 2004; United States Department of Health and Human Services, 2012b; United States Department of State, n.d.
Did anyone ever force you to get or use false identification or documentation, for example, a fake [green card/visa/etc.]?	IOM, 2007

(continued)

Table 4. Continued.

Did anyone where you worked [or did activities] ever tell you to lie about your age or what you did?	
Did anyone you ever worked [or did activities] for or lived with threaten to report you to the police or other authorities?	Polaris Project, 2010
Did you ever see anyone else at the place where you lived or worked [or did other activities] harmed, or threatened with harm?	Polaris Project, 2011
Did anyone where you worked [or did other activities] ever trick or pressure you into doing anything you did not want to do?	Polaris Project, 2010; Polaris Project, 2011
Did anyone pressure you to touch someone or have any unwanted physical [or sexual] contact with another person?	Asian Health Services & Banteay Srei, 2012; Greenbaum et al., 2013; Polaris Project, 2011
Did anyone ever take a photo of you that you were uncomfortable with? What did they plan to do with the photo, if you know?	Polaris Project, 2011
Did you ever have sex for things of value (for example, money, housing, food, gifts, or favours)? Were you pressured to do this? Were you under the age of 18 when this occurred?	Asian Health Services & Banteay Srei, 2012; Polaris Project, 2010; Polaris Project, 2011; State of Florida Department of Children and Families, 2009
Did anyone you ever worked [or did other activities] for or lived with control how much food you could get?	Greenbaum et al., 2013; IOM, 2009; Polaris Project, 2011; United States Department of Health and Human Services, 2012b; United States Department of State, n.d.
Did anyone where you worked [or did other activities] ever take your money for things, for example, for transportation, food, or rent?	Polaris Project, 2011
Did anyone you ever worked [or did other activities] for or lived with control when you should sleep?	Polaris Project, 2011; State of Florida Department of Children and Families, 2009; United States Department of State, n.d.
In this situation, did language difficulties ever prevent you from seeking help when you needed it?	

The VERA tool also offers a short version (Table 5) of the original screening tool (Table 4). By adding the percentages of 'yes responses' to questions from identified victims of trafficking and non-trafficking victims, the VERA tool is distilled to its most effective questions (Table 5). The five most effective questions for identifying a victim of human trafficking, as determined by Simich et al. (2014) are:

1. Did anyone arrange your travel to [insert country's name]?
2. Did anyone where you worked [or did other activities] ever make you feel scared or unsafe?
3. Have you ever felt you could not leave the place where you worked [or did other activities]?
4. Did anyone where you worked [or did other activities] ever trick or pressure you into doing anything you didn't want to do?
5. Were you allowed to take breaks where you worked [or did other activities], for example, to eat, use the telephone, or use the bathroom?

Table 5. VERA short tool with the percentage of yes responses for each question.

VERA Screening Questions	Yes Responses (%)	
	Trafficking Victims	Non-Trafficking Victims
Personal Background		
What is your date of birth?	56.3% between ages 25-39	39.3% between ages 25-39
How many years of schooling have you completed?	63.2% had 7-12 years	53.6% 7-12 years
What country were you born in?	26.0% Mexico 17.7% Philippines 10.4% USA	24.1% China 20.5% Latin America 16.9% Honduras
Migration		
In what year was your most recent arrival to [insert country's name]?	44.2% for 5-10 years	26.2% for 1-2 years; 26.2% for 5-10 years
Did anyone arrange your travel to [insert country's name]?	89.5%***	61.9%
Did you (or your family) borrow or owe money, or something else, to anyone who helped you come to [insert country's name]?	50%*	31.3%
If you did borrow or owe money, have you ever been pressured to do anything you didn't want to do to pay it back?	64.1%***	8.0%
Living and/or Work Conditions		
Have you ever worked [or done other activities] without getting payment you thought you would get?	74.2%	19.1%
Did someone ever (check all that apply): withhold payment/money from you, give your payment/money to someone else, control the payment/money that you should have been paid?	Withhold payment: 65.2%*** Give payment: 19.6%** Control money: 51.1%**	Withhold payment:18.5% Give payment: 4.6% Control money:4.6%

(continued)

Table 5. Continued.

Have you ever worked [or done other activities] that were different from what you were promised or told?	58.5%***	10.4%
Did anyone where you worked [or did other activities] ever make you feel scared or unsafe?	75.5%***	19.7%
Did anyone where you worked [or did other activities] ever hurt you or threaten to hurt you?	60.6%***	12.3%
Were you allowed to take breaks where you worked [or did other activities], for example, to eat, use the telephone, or use the bathroom?	62.4%***	15.2%
Were you ever injured or did you ever get sick in a place where you worked [or did other activities]?	47.3%***	10.6%
Have you ever felt you could not leave the place where you worked [or did other activities]?	75%***	15.0%
Did anyone where you worked [or did other activities] tell you to lie about your age or what you did?	37.2%***	3.8%
Did anyone where you worked [or did other activities] ever trick or presure you into doing anything you did not want to do?	71.6%***	9.9%
Did anyone pressure you to touch someone or have any unwanted physical [or sexual] contact with another person?	42.1%***	7.6%
Did anyone ever take a photo of you that you were uncomfortable with? What did they plan to do with the photo, if you know?	15.6%**	3.7%
Did you ever have sex for things of value (for example money, housing, food, gifts, or favours)? Were you pressured to do this? Were you under the age of 18 when this occurred?	38.9% ***	4.9%
Did anyone ever take and keep your identification, for example, your passport or driver's license?	48.9%***	11.3%
Did anyone where you worked [or did other activities] ever take your money for things, for example, for transportation, food, or rent?	60.6%***	11.0%

Note: *** $p \leq 0.001$, ** $p \leq 0.01$, *$p \leq 0.05$.

Post-screening. Eighteen sources (62.07%) focused on post-screening methods (Table 6). Of these sources, all 18 (100%) discussed a potential HCP response after identifying a potential victim of human trafficking and three (5.56%) discussed support services HCPs could suggest to a potential victim. Papers published in the United States accounted for 72.22% of the post-screening literature.

HCP responses following victim identification and support services for HCPs to suggest to victims are summarized in Table 6. HCP responses and support services were specific to the country in which the paper was published. Thus, results were divided into four groups: International, Ireland, United Kingdom, and United States.

Table 6. Post-screening strategies organized by geographical region.

Sources	Themes	
	Post-Screening	
lead author(s) (year)	HCP Response	Support Services
International		
IOM, 2009	1) Offers a referral mapping form, refer to Table 7	
Ireland		
McConkey, Garcia, Mann, & Conroy, 2014	National Referral Mechanism: 1) An Garda Síochána Human Trafficking Investigation and Coordination Unit 01-6669192 2) HSE Anti-Human Trafficking Team Responsible for CARE PLAN 0860220160 012680578	NGOs: 1) Practical Support for Victims Ruhama (Confidential) 018360292/0863813783- 24 hour 2) Legal/Immigration Asssistance for Victims (Confidential) ICI Immigration Council Ireland 016740202 3) Irish Refugee Council 01 7645854 4) HSE Women's Health Service Confidential Medical Screening 016699515 5) Doras Luimni (LIMERICK) 061310328 6) Sexual Violence Centre Cork 0214505577 1800496 496 - free phone
United Kingdom		
United Kingdom Department of Health, 2013	Children: 1) speak with designated Child Protective Lead Adults: 1) salvation Army 03003038151	
United Kingdom Visas and Immigration, 2014a	1) United Kingdom Human Trafficking Centre (UKHTC) 08447782406	
United Kingdom Visas and Immigration, 2014b	1) UKHTC 08447782406	
United States		
Asian Health Services & Banteay Srei, 2012	1) complete referral form and contact the referral agency 2) let the patient know that the agency will follow up with them to make an appointment to discuss resources 3) if under 18, fill out a Child Protective Services report form, call, and fax in	
Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011	1) National Human Trafficking Resource Center (NHTRC) 18883737888 2) The Coalition to Abolish Slavery and Trafficking (CAST) 1888KEY2FRE(EDOM)	

(continued)

Table 6. Continued.

Greenbaum et al., 2013	1) NHTRC 2) U.S. Immigration and Customs Enforcement (ICE) Victim Assistance Program 8668724973	
Hughes, 2003	1) Trafficking in Persons and Worker Exploitation Task Force Complaint Line 8884287581 (weekdays only)	
Polaris Project, 2010	1) NHTRC	
Sabella, 2011	1) NHTRC	
Simich, Goyen, Powell, & Mallozzi, 2014	1) American Gateways Austin, TX 15124780546 ext. 200 2) CAST	1) City Bar Justice Center New York, NY 2123826600 2) Girls Education and Mentoring Services (GEMS) New York City, NY 2129268089 3) International Institute of Buffalo Buffalo, NY 7168831900 4) My Sisters' Place Westchester, NY 8004615419 5) Northwest Immigrant Rights Project WA Number varies based on location in Washington State 6) Refugee and Immigrant Center for Educational and Legal Services San Antonio, TX 2102267722 7) Rocky Mountain Immigrant Advocacy Network Westminster, Colorado 3034332812 8) Sanctuary for Families New York, NY 2123496009 9) Workers Justice Center of NY Rochester, NY
Spear, 2004	1) Trafficking in Persons and Worker Exploitation Task Force Complaint Line 18884287581 (weekdays only)	1) Boat People S.O.S., Inc Falls Church, VA 2) Mosaic Family Services Dallas, TX 2148210810 3) ECPAT-USA Brooklyn, NY 4) Florida Coalition Against Domestic Violence Tallahassee, FL 8504252749 5) Heartland Alliance Chicago, IL 3126601351 6) Immigrant and Refugee Community Organization Portland, OR 5032341514 7) Safe Horizon, Inc. Family/Clinical Programs Division New York, NY 7188991233 ext 102 8) SAGE Project San Francisco, CA 4159055050 9) Survivors' Empowerment and Advocacy (SEA) Project Portland, OR 5034457792

(continued)

Table 6. Continued.

State of Florida Department of Children and Families, 2009	1) Florida Abuse Hotline and report human trafficking 80096ABUSE 2) Trafficking in Persons and Worker Exploitation Task Force Complaint Line 18884287581 (weekdays only)
United States Department of Health and Human Services, 2012a	1) NHTRC 2) U.S. Immigration and Customs Enforcement (ICE) Victim
United States Department of Health and Human Services, 2012b	1) NHTRC
United States Department of Health and Human Services, 2012c	1) NHTRC
United States Department of State, n.d.	1) NHTRC 2) Trafficking in Persons and Worker Exploitation Task Force Complaint Line 18884287581 (weekdays only)

The international source that met the inclusion criteria (IOM, 2009) included a referral mapping form. This form has been modified for effectively screening and supporting potential victims of human trafficking (Table 7). While only one source from Ireland was identified for this study, McConkey, García, Mann, & Conroy (2014) offer response options for physicians at the national level. The list of NGOs provided for Irish physicians covers a variety of services, including clinical, legal and social (Table 6). The United Kingdom sources did not contain information on support services for patients. Instead, sources focused on educating HCPs on how to report a potential victim to the National Referral Mechanism (NRM) using the United Kingdom Human Trafficking Centre (UKHTC) help line.

With 13 sources published in the United States, more information regarding HCP response and support services was available compared to the

other included countries (Table 6). The National Human Trafficking Resource Center (NHTRC), similar to the UKHTC, was the most commonly cited option for HCP response in the United States with 61.54% of sources referencing its hotline for human trafficking (Table 6). Other popular hotlines included the Trafficking in Persons and Worker Exploitation Task Force Complaints with 30.77% of sources referencing the hotline. In addition to a few other hotlines specific to regions of the United States (Table 6), the Coalition to Abolish Slavery and Trafficking's (CAST) hotline was also cited as a potential response for healthcare professionals by 15.38% of sources. Two sources included in this study had information on support services for HCPs to suggest to potential trafficking victims in the United States; thus, 15.38% of the American post-screening literature discussed support services for HCPs to share with potential trafficking victims. Of the 18 suggested support services, 44.44% were located in New York State, 11.11% in Oregon, 11.11% in Texas, and 5.56% in Washington State, Colorado, Florida, Illinois, and California.

Table 7. Referral map adapted from IOM, 2009 for HCPs to facilitate appropriate victim support.

Service	Contact Details
Local counter-trafficking organizations	
Telephone hotlines	
Counter-trafficking hotline	
Family violence hotline	
Child serivces hotline	
Suicide hotline	
Missing persons hotline	
Shelters and Housing Services	
Counter-trafficking shelter	
Children & adolescent shelter	
Migrant & refugee shelter	
Shelters run by CBOs	
NGOs and CBOs	
Counter-trafficking	
Rights Organizations (human, women's or children's, labour)	
Refugee or immigrant services	
Religious Organizations	
Other CBOs	
Legal Services	
Independent Lawyers	
Community legal aid services	

(continued)

Table 7. Continued.

Local Government Contacts
National Anti-Trafficking Centre
Children's offices or services
Women's offices or services
Immigration services
Housing and social services
Embassy and Consular Offices
(fill in for most common migrant or trafficked populations)
International Organizations
International Organization for Migration
International Labour Organization
Office of the High Commissioner for Refugees
Office for the High Commissioner for Human Rights
United Nations Children's Fund
United Nations Office on Drugs and Crime
United Nations Population Fund
World Health Organizatoin
Other
Accessible Interpreters
List likely languages required

Training. Seven papers (24.14%) focused on the role of training HCPs in identifying victims of human trafficking (Table 8). Papers published in the United States accounted for 71.43% of the training literature, while one multi-country study and a study from Canada both accounted for 14.29% each. Of the seven papers focused on training, 57.14% were descriptive surveys and 42.86% designed a training module and assessed any self-reported changes in knowledge using pre- and post-tests (Table 8). All of the journal articles discussing training were published between 2011 and 2015. In addition, all seven articles shared the aim of assessing the knowledge of either HCPs or medical students. Another aim shared by three papers was to determine if self-reported knowledge of human trafficking could be improved using a training module (Table 8). All seven papers discussed how few HCPs had received training specific to human trafficking. If HCPs were trained, they were typically from urban centers (Beck et al., 2015; Cole & Sprang, 2015). The lack of training has resulted in a lack of confidence among HCPs not only when identifying victims of human trafficking, but also when referring potential victims to support services (Beck et al., 2015; Chisolm-Straker et al., 2012; Simmons et al., 2014; Viergever et al., 2015). Furthermore, several articles that met the inclusion criteria also commented on how the HCPs thought that it would be unlikely to encounter a victim of human trafficking (Chisolm-Straker et al., 2012; Cole & Sprang, 2015; Wong, Hong, Leung, Yin, & Stewart, 2011). Training modules of moderate length were found to improve self-report knowledge of human trafficking and confidence

in dealing with potential victims of human trafficking (Beck et al., 2015; Chisolm-Straker et al., 2012; Viergever et al., 2015).

Table 8. Knowledge that HCPs have of human trafficking and the effects of training modules on HCP knowledge, organized alphabetically by author.

Sources		Type of Intervention	Study Aim(s)	Study Population(s)	Theme
lead author(s) (year)	Study Location				Training
Beck et al., 2015	United States	Descriptive Survey	1) evaluate knowledge gaps and training needs of medical providers 2) demonstrate the importance of provider training to meet the needs of pediatric sex trafficking victims 3) highlight barriers that influence victim identification	physicians, nurses, nurse practitioners, physician assistants, social workers, patient and family advocates	1) respondents who had more training were more likely to identify victims in training case studies 2) 37% of participants had received training specific to human trafficking 3) those with training were more likely to be from an urban centre 4) many HCPs were not confident in their abiliity to connect patients with necessary support services 5) those with training were more likely to think that human trafficking was an issue locally, were more likely to have encountered a victim in their practice, and reported more confidence in ability to identify victims
Chisolm-Straker, Richardson, & Cossio, 2012	United States	Training module with Pre- and Post-Test	1) determine knowledge and comfort levels of emergency department providers in identifying and treating victims of HT before and after exposure to an educational workshop	emergency medicine residents, emergency department attendings, emergency department nurses, and hospital social workers	1) 97.8% of participants reported never receiving formal training on the clinical presentation of trafficking victims 2) 95% reported never receiving formal training on the appropriate treatment of human trafficking victims 3) 59.4% were unsure if trafficking affected their area 4) many reported being hesitant or not confident in their ability to identify a victim 5) before training, 4.8% before were confident in their ability to identify a victim; this increased to 53.8 after training 6) 93.3% reported that the training session was useful

(continued)

Table 8. Continued.

Cole & Sprang, 2015	United States	Descriptive Survey	1) examine professionals' awareness, knowledge, protocols, and experiences working with individuals who were trafficked as minors in commercial sex to better understand how trafficking of minors occurs 2) compare professionals' awareness, knowledge, and experiences by type of community in which they worked to examine similarities and differences in how sex trafficking and community agencies respond to victims	juvenile court workers, juvenile justice, victim services, agencies that serve at-risk youth, behavioural health providers, (health care/ law enfircement, public defenders, school)	1) significantly more respondents in metropolitan communities perceived child sex traffickingas being a fairly or very serious problem in the state 2) significantly more respondents in metropolitan communities stated they were fairly or very fairly familiar with state and federal statutes on human trafficking than respondents in micropolitan and rural areas 3) significantly fewer professionals working in micropolitan communities had experience working with victims of sex trafficking with minors compared to respondents who worked in the other settings
Grace et al., 2014	United States	Training module with Pre- and Post-Test	1) determine whether an educational presentation increases emergency department providers' recognition of trafficking victims and knowledge of trafficking resources	emergency department physicians, nurses, and social workers	1) self rated knowledge increased after a training workshop on trafficking 2) the proportion of those who suspected that a patient of theirs was a victim of trafficking doubled after the workshop

(continued)

Table 8. Continued.

Simmons, Lee, Simmons, & Lopez, 2014	United States	Descriptive Survey	1) assess the knowledge and attitudes of HCPs in the state of florida regarding sex trafficking	female nurses from across the state of florida	1) 14.9% indicated that they had received training relating to identification and treatment of sex trafficking vitims 2) only two participants (2.7%) reported ever having knowingly assessed or treated a victim of human trafficking 3) many participants reported low self-efficacy, which many further underline the need for specialized training
Viergever, West, Borland, & Zimmerman, 2015	Antigua and Barbuda, Costa Rica, Egypt, El Salvador, Guyana, Jordan	Training module with Pre- and Post-Test	1) determine what healthcare providers know of trafficking 2) evaluate a human trafficking training program	nurse, social worker, doctor, psychologist, policy maker, NGO project manager, health educator, counselor, researcher, hospital manager, detective or inspector, administrative support worker, lawyer, interpreter, physiotherapist, volunteer	1) many participants incorrectly speculated that: trafficking must involve movement across an international border; trafficking does not include exploitation of children by relatives in domestic work; and that trafficking only happens to people with little education 2) 22% stated that they did not feel confident when referring a potential victim 3) reasons for feeling less confident included: feeling that the workplace was not safe enough to discuss human trafficking, time limitations, and a lack of knowledge of support services
Wong, Hong, Leung, Yin, & Stewart, 2011	Canada	Descriptive Survey	1) asses pre-clerkship medical students' awareness of trafficking 2) assess attitudes towards learning about trafficking hte medical curriculum at Canada's largest medical school	pre-clerkship medical students at the University of Toronto	1) 88.9% of participants weren't faimilar with signs and symptoms of HT victims 2) 76% thought that trafficking was important to learn about 3) 93.9% though that it would be unlikely or only somewhat likely to encounter or identify a trafficked person in a Canadian clinical setting

Recommendations from Literature

Twelve journal articles (41.38%) included recommendations for future research (Table 9). Recommendations could be separated into five different groups, highlighting the need for: national victim databases, HCP training, a medical school curriculum that incorporates human trafficking, more victim support services, and evidence-based screening protocols for detecting victims of human trafficking. Papers published in the United States accounted for 83.33% of the sources with recommendations. Recommendations also came from two other articles: one from Ireland (McConkey et al., 2014) and the other from Canada (Wong et al., 2011) (Table 9). The need for HCP training was discussed in 75% of the journal articles; the need for a national victim database, a medical school curriculum that is inclusive of human trafficking, and evidence-based screening tools each accounted for 16.67% of the recommendations made. In addition, one article mentioned the need for further developed support services for victims (Table 9). Several papers made multiple recommendations (Beck et al., 2015; Chisolm-Straker et al., 2012; Grace et al., 2014; Sabella, 2011).

Table 9. Recommendations from the literature included in this study, organized alphabetically by author.

Sources	Recommendations				
lead author(s) (year)	National Victim Database	HCP Training	Medical School Trafficking Curriculum	More Support Services for Victims	Evidence-Based Screening Tools
Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011		✓			
Beck et al., 2015	✓	✓			
Chisolm-Straker, Richardson, & Cossio, 2012	✓	✓			
Cole & Sprang, 2015		✓			
Grace et al., 2014		✓	✓		
Greenbaum et al., 2013					✓
McConkey, Garcia, Mann, & Conroy, 2014		✓			
Sabella, 2011		✓		✓	
Simmons, Lee, Simmons, & Lopez, 2014		✓			
Varma, Gillespie, McCracken, & Greenbaum, 2015					✓
Viergever, West, Borland, & Zimmerman, 2015		✓			
Wong, Hong, Leung, Yin, & Stewart, 2011			✓		
***N*=**	**2**	**9**	**2**	**1**	**2**
%	**16.67**	**75.00**	**16.67**	**8.33**	**16.67**

✓' indicates that the recommendation was made within the specified paper.

Conclusion

Implications for Future Research

The need for global involvement in human trafficking research. With 68.97% of the literature that met the inclusion criteria of this study originating from the United States (Figure 3; Table 1), research on screening victims of human trafficking may be specific to the American setting (Table 4; Table 5). Of the pre-screening literature thematically identified in this study, 70% were published in the United States (Table 3); 83.33% of the literature focused on screening questions was from the United States (Table 2); and, 72.22% of the literature discussing post-screening strategies was from the United States (Table 8). With a patient-centered model, care for trafficking victims must be culturally appropriate and individualized.

Culture has been defined as a "collective programming of the mind" (Hofstede, 2011, p. 3) that allows for groups or categories of individuals to distinguish between each other. Within culture, shared values and practices influence how individuals experience illness, process and adapt to trauma, and respond to care. Trafficking victims are likely to have diverse cultural, social, economic, ethnic, and sexual differences (IOM, 2009), contributing to the complexities surrounding their identification.

Complicating issues further is the fact that every country has a different trafficking profile: the origins of trafficking victims within each country vary. Domestic trafficking dominates in North America, Central America, the

Caribbean, Europe, South America, Sub-Saharan Africa, Central Asia, South Asia, East Asia, and the Pacific (UNODC, 2014). The VERA tool (Table 4; Table 5), along with the research on pre-screening and post-screening strategies, is extremely specific to the United States environment. Further research is necessary to ensure that screening protocols are both culturally and locally sensitive. By taking the VERA tool and conducting a similar study using trafficking victims in a different country, the percentage of 'yes responses' (Table 5) could be compared to determine how the VERA tool can be adapted to accommodate cultural nuances prominent in certain geographical regions.

The need for individualized victim identification research. The majority of literature focusing on pre-screening (Table 3), screening questions (Table 2), and post-screening strategies (Table 6) in this study were inclusive of all genders. Comprehensive indicators, victim interaction strategies, referral charts, and screening questions are not uncommon in the field of human trafficking research (Barrows & Finger, 2008). How groups of different individuals experience and respond to trafficking is, however, different. Furthermore, how trafficking manifests itself symptomatically can be incorrectly assumed to be the same as sexual or physical abuse; this could be related to confusion over the UN Protocol's definition of human trafficking and/or a lack of awareness of human trafficking.

Evidence-based research focused specifically on child trafficking is very limited (Godziak, 2008; Greenbaum et al., 2013). For example, no screening protocol, including the VERA tool, included information on sexual orientation despite the increased vulnerability of being trafficking among LGBT youth in particular. Often studies include both adolescents and young adults in samples and/or focus on a restricted population, limiting the generalizability of the results (Cochran et al., 2002; reviewed in Varma, Gillespie, McCracken, & Greenbaum, 2015). A recent study by in Varma, Gillespie, McCracken, & Greenbaum (2015) has revealed specific differences in how child sex trafficking victims and child victims of sexual abuse/assault present in the Emergency Department. Child sex trafficking victims had higher rates of STIs, experience more physical abuse, were more likely to have a history of violence with sex, abuse drugs or alcohol, have a history of running away from home, and have prior involvement with both child protective services and law enforcement (Varma, Gillespie, McCracken, & Greenbaum, 2015). These variables have not only the potential to serve as behavioural indicators for HCPs, but also could be developed into child-specific screening questions.

In addition to limited research on child-specific pre-screening techniques, screening questions, and post-screening strategies, no male-specific studies were found in the 325 articles reviewed. While approximately 70% of all detected human trafficking victims globally are women and girls under the age of 18, the

number of men being trafficked for forced labour has been increasing (UNODC, 2014).

Results from this study did reveal that literature with a comprehensive approach to behavioural indicators and victim interaction strategies share similarities with gender-specific studies (Table 3). If a HCP only has access to literature with a comprehensive approach to identifying victims of human trafficking, it is probable that the HCP will be ably to identify victims of all genders. However, having an understanding of the indicators, questions, and referrals that are specific to all genders ensures that victims are identified and appropriately supported. Future research should aim to establish if there are differences, if any, specific to victim gender, the purpose of trafficking, and whether or not the victim was domestically or internationally trafficked. Future research should aim to establish how gender, the purpose of trafficking, and if being domestically or internationally trafficked, influences pre-screening, screening questions, and post-screening.

The need for validated screening tools. Although 12 articles were identified as having screening questions, 94.12% of the documents were not validated (Table 2). Many of these documents lacked information on how the screening questions were developed. Of greatest concern is the fact that these articles represent the primary data being referenced in human trafficking victim identification literature.

By demonstrating that so few of the referenced screening protocols had questions similar to the validated VERA tool (Table 4), these concerns are logical. Commonly referenced screening questions from the United States Department of Health and Human Services (2012b) and the United States Department of State (n.d.) shared only 11.90% and 14.29%, respectively, of questions from the long version of the VERA tool (Table 4) Future research must focus on developing and disseminating evidence-based screening tools through peer-reviewed journals in order to facilitate HCP access (Table 9; Greenbaum et al., 2013; Varma, Gillespie, McCracken, & Greenbaum, 2015).

The need for more victim support services. All of the literature included in this study discussed potential HCP responses if a patient is suspected of being a victim of human trafficking (Table 6). In comparison, only 5.56% of the post-screening articles discussed support services that could be suggested by a HCP. These articles were specific to either Ireland (McConkey et al., 2014) or the United States (Simich, Goyen, Powell, & Mallozzi, 2014; Spear, 2004). For the suggested support services in the United States, 44.44% of the organizations were located in New York State. More residential treatment facilities, mental health services, and direct services are needed for trafficking victims (Sabella, 2011). Without appropriate support services for trafficking victims, it is difficult to encourage the integration of screening protocols into the healthcare system: if a HCP is unable to offer support to a victim locally, why would a HCP feel

comfortable screening for human trafficking? Further research could explore the distribution of victim support services, the gaps in services, and if HCPs are aware of local trafficking services.

The need for trained HCPs. There is an extensive body of literature advocating for the education and training (Table 8) of HCPs and medical students on the issue of human trafficking (Baldwin et al., 2011; Beck et al., 2015; Chisolm-Straker et al., 2012; Cole & Sprang, 2015; Grace et al., 2014; McConkey et al., 2014; Sabella, 2011; Simmons et al., 2014; Viergever et al., 2015; Wong et al., 2011). Through brief training modules, several studies have recently been able to demonstrate that self-reported HCP knowledge of trafficking identification techniques can improve drastically (Chisolm-Straker et al., 2012; Grace et al., 2014, Viergever et al., 2015). As with the screening protocols, many training modules are being developed, but few are being compared and disseminated. Standardizing training could help to improve awareness of trafficking, increase collaboration between HCPs and trafficking-specific support services, and encourage HCPs to screen for trafficking.

HCPs' perceptions of how important or relevant the issue of human trafficking are often negative prior to training. The clandestine nature of human trafficking allows for HCPs to categorize victims as rare. A study conducted by Wong et al. (2011) at Canada's largest medical school shockingly demonstrated how prevalent this misconception is amongst pre-clerkship medical students.

Approximately 94% of the surveyed students thought that it would be unlikely or only somewhat likely to encounter or identify a trafficked person in a Canadian clinical setting (Wong et al., 2011). Surveyed medical residents and other HCPs in the United States shared similar perceptions to the Canadian pre-clerkship medical students (Chisolm-Straker et al., 2012; Cole & Sprang, 2015).

Future research should focus on examining and comparing validated human trafficking training modules currently available for HCPs. Disseminating the most effective training modules would help to ensure that new, less effective training programs are utilized by HCPs. Lastly, research could focus on surveying how HCPs and medical students comprehend human trafficking globally. This data could potentially provide insight into how culture affects the perceived importance and relevance of human trafficking in the healthcare setting.

Implications for HCPs

Learning about behavioural indicators and victim interaction strategies. The pre-screening indicators and techniques discussed in this study are primarily based on papers from the United States (Table 3). HCPs are confronted with the issue of not having access to a great deal of literature focused on gender-specific behavioural indicators and victim interaction strategies. Using documents that have a comprehensive approach to pre-screening methods, however, does share some similarities with gender-specific literature. The indicators of being fearful and distrusting of authorities, signs of

prolonged physical abuse, and the presence of a controlling trafficker appear in literature specific to children and women, and comprehensive literature. Sources focusing on children, women and comprehensive victim interaction strategies all discussed the importance of being non-judgmental and screening interpreters (Table 3). Table 3 can easily be printed and utilized by HCPs as a reminder of trafficking indicators and helpful victim interaction strategies, both of which affect the success of the screening process.

The most exhaustive lists of child and adult trafficking indicators were created in the United Kingdom as part of their National Referral Mechanism (NRM) (United Kingdom Visas and Immigration 2014a; United Kingdom Visas and Immigration, 2014b). The NRM was established in 2009 by the UK government to identify, support and protect victims. The lists of indicators exist as part of two referral documents that are submitted by a designated first responder to the UKHTC. The UKHTC then determines if the individual interviewed is a victim of human trafficking based on this completed referral form. HCPs are not considered to be first responders, thus, this form with an exhaustive list of trafficking indicators is not used in the healthcare setting. The forms are easily accessible online however, and could be modified by HCPs globally.

Recognizing the importance of validated screening tools. As previously mentioned, the majority of screening protocols for human trafficking victim identification lack scientific rigour. The only validated screening protocol

identified in this study was the VERA tool. The complete version of the tool can be found in Table 4. In a clinical setting, however, the shorter VERA tool (Table 5) may be more appropriate. While the long version of the VERA tool accurately identified 100% of trafficking victims, the short version identified 88% of trafficking victims (Simich, Goyen, Powell, & Mallozzi, 2014). For HCPs who feel that the short version of the VERA tool is still too arduous, or unrealistic under time constraints associated with a clinical setting, Table 5 contains the percentage of 'yes responses' for each question included in the short version; asking the most effective questions from this document is an option. Encouraging the use of the VERA tool globally helps to determine if the questions are applicable outside of the United States. Moreover, disseminating the VERA tool supports the standardization of victim identification.

Dealing with the lack of victim support services. Both the lack of victim identification and the clandestine nature of human trafficking have affected the number of support services for victims. For many physicians, feeling apprehensive when referring a potential victim of trafficking leads to a lack of interest in screening patients (Viergever et al., 2015). The only way for HCPs to address this is to become familiar with local anti-trafficking organizations. Adapted from a referral map by the IOM (2009), Table 7 has been designed for HCPs to print and complete. By gathering information on the available services

that may benefit potential trafficking victims, the anxiety of being unsure of how to support a victim is ameliorated.

For HCPs in Ireland, the United Kingdom, and the United States, Table 6 summarizes the commonly cited trafficking hotlines and support services. Having this information accessible facilitates a standardized and more efficient patient-centered care approach to reporting victims of human trafficking.

HCPs must receive education and training about human trafficking. It has been reported that 28% of trafficking victims come into contact with a HCP while still in captivity (Barrows & Finger, 2008; Crane & Moreno, 2011). This represents a missed opportunity to improve the health and safety of trafficking victims globally. However, many HCPs consider interactions with human trafficking victims as unlikely (Table 8; Chisolm-Straker et al., 2012; Cole & Sprang, 2015). A study conducted in New York City, NY, United States by Chisolm-Straker et al., (2012) with emergency department medical residents, nurses, and attendings found that 97.8% of participants had never received formal training on human trafficking. This trend is not uncommon (Beck et al., 2015; Cole & Sprang, 2015; Grace et al., 2014; Simmons et al., 2014) and has led to the recommendation that HCPs and medical students be educated about human trafficking (Table 9).

Limitations of this Study

Non-English articles were excluded from this study due to constraints surrounding translation. As reported in Table 1, literature included in this study was primarily from the United States, the United Kingdom, or from international organizations. The language limitations may have contributed to the overrepresentation of American literature in this study (Table 1).

Arksey and O'Malley (2005) do not consider quality assessment to be a component of scoping studies. Other researchers have described a need for quality assessments in scoping studies (Daudt, van Mossel, & Scott, 2014; Levac, Colquhoun, & O'Brien, 2010). There is no critical appraisal tool to determine the quality of literature included in a scoping review. Thus, a limitation of this scoping review is that no formal quality assessment of the included literature was completed. However, in an attempt to screen literature for quality, primary articles were identified. In addition, screening questions were compared to the validated VERA tool in an attempt to compare the predictive power of varying screening tools (Table 4).

Arksey and O'Malley (2005) also discuss an additional, optional stage of a scoping review known as a consultation exercise. The consultation stage has been described as being essential to the scoping review methodology (Daudt, van Mossel, & Scott, 2014; Levac, Colquhoun, & O'Brien, 2010). Future research could focus on consulting with HCPs on a global scale about the VERA tool. This

consultation stage could provide a strategy on how to adapt the VERA tool to be culturally sensitive.

A Canadian Perspective on Human Trafficking

The Royal Canadian Mounted Police (RCMP) created the Human Trafficking National Coordination Centre (HTNCC) at the RCMP headquarters in Ottawa, Ontario, Canada. The HTNCC collects Canadian statistics on human trafficking, has a hotline, and has developed online toolkits to educate about human trafficking for law enforcement, youth, and the general public.

The profile of trafficking victims in Canada is diverse. Non-Canadian victims of human trafficking are typically brought to Canada from Asia, Thailand, Cambodia, Malaysia, Vietnam, and Eastern Europe. Organized crime networks with Eastern Europe have facilitated the entry of women from post-communist states into Canada primarily for the purpose of sexual exploitation as escorts in the Greater Toronto Area and Montreal, Quebec. Major Canadian cities with established Asian organized crime networks typically are destinations for sexually exploited women from Asia (RCMP, 2010). Forced labour has been detected primarily in Alberta and Ontario, with male and female workers being trafficked from the Philippines, India, Poland, China, Ethiopia, Mexico, Thailand, and Hungary (RCMP, 2010). Victims of domestic trafficking typically are Caucasian women between the ages of 14 and 22 (RCMP, 2013). Convicted offenders of

domestic human trafficking have been affiliated with street gangs. Aboriginal women are overrepresented in Canada's domestic trafficking statistics. While Aboriginal youth make up only 3-5% of the Canadian population, in some cities they account for up to 90% of those involved in sex work (reviewed in Salvation Army, 2014). Indigenous people of Canada are disproportionately affected by sexual and physical abuse during childhood (Native Women's Association of Canada, 2014). The legacies of residential schools, family violence, lack of education, migration, substance addiction, homelessness, and discrimination have led to unhealthy environments that make Aboriginal women particularly vulnerable to being trafficked (Kingsley & Mark, 2001; Native Women's Association of Canada, 2014). Aboriginal women are specifically targeted for trafficking for purposes of sexual exploitation (Kaye, Winterdyk, & Quarterman, 2014).

No Canadian literature focused on screening protocols surfaced through the electronic databases or back searching. Regardless, forensic nurses with Fraser Health have recently developed a training module in the province of British Columbia. The goal of the *Human Trafficking: Help Don't Hinder* learning module is to educate HCPs on how to identify and respond to potential human trafficking victims who may present in the emergency department (Falkenberg, Wilkie, & Dodd, 2014). The public is now able to access to online training module.[7] The *Help Don't Hinder* online course was partially funded by the Canadian Women's

[7] Please refer to 'references' for the module link.

Federation, Fraser Health, and the British Columbia Ministry of Justice and serves as an educational credit for HCPs in British Columbia. The module is designed to be interactive and incorporates pre-screening methods, screening questions, and post-screening strategies. Through case studies, the various clinical representations of human trafficking are explored.

While the VERA tool provides HCPs with a screening tool, the *Help Don't Hinder* learning module is designed specifically to support emergency HCPs with screening and assisting potential victims of human trafficking who present in the hospital emergency department. The training module incorporates literature included in the VERA tool. For example, the module shares similar screening questions with the VERA tool:

1. Can you leave your job or situation if you want to?
2. Is anyone forcing you to do anything that you don't want to do?
3. Do you have to ask for permission to eat, sleep, or go to the washroom?
4. Have you been physically harmed in any way?
5. Has your identification or documentation been taken away from you?

These questions identified 75%, 71.6%, 62.4%, 60.6%, and 48.9% of trafficking victims accurately when asked as part of the short VERA tool (Table 5). While the VERA tool focuses largely on providing validated screening questions, the Fraser Health learning modules represents an attempt to apply those questions in a healthcare setting. The *Help Don't Hinder* module also addresses the issue of screening protocol length and practicality: HCPs in emergency departments often

lack time to build the rapport necessary to ask such probing questions of a potential victim. Having trained forensic nurses who can be contacted if a HCP recognizes potential indicators of trafficking is arguably a more realistic method of screening and assisting victims.

Human trafficking research has consistently found that assistance to trafficking victims in Canada has been limited and uncoordinated (Oxman-Martínez, Lacroix, & Hanley, 2005). As previously discussed, this is a barrier for HCPs who may wish to screen for potential trafficking. A lack of willingness to acknowledge that human trafficking is an issue within the Canadian healthcare system has negatively affected victim identification and research development. The role of Canadian HCPs in the identification of victims is largely unrealized. Nevertheless, with the help of innovative programs like the *Help Don't Hinder* learning module, Canada will be able to begin framing human trafficking as a health issue and provide victims of trafficking with the opportunity to escape captivity and receive healthcare.

Effectively Implementing Human Trafficking Screening Protocols

While human trafficking resources such as the VERA tool and the *Help Don't Hinder* learning module may exist, disseminating this knowledge and implementing it effectively is a challenge. Examining how other screening protocols have been successfully implemented globally provides guidance when developing human trafficking victim identification guidelines and practices.

A systematic review of the successful implementation of IPV screening protocols by O'Campo, Kirst, Tsamis, Chambers, and Ahmad (2011) offers insight into the potential process of integrating human trafficking screening protocols within healthcare systems. For example, providing HCPs with information on community resources for individuals experiencing IPV increased support and reinforced the necessity of screening; in addition, the increased support helped to develop an overall environment of IPV awareness and developed an understanding of the interconnectedness between IPV and health among HCPs (McCaw, Berman, Syme, & Hunkeler, 2001; Short, Hadley, & Bates, 2002). Furthermore, partnerships with emergency departments and community-based IPV committees allowed screening guidelines, documentation procedures, and funding to be coordinated (O'Campo et al., 2011). Clear guidelines on how to respond to an identified victim, combined with mandatory training sessions increased the level of HCP comfort with IPV screening and referrals. In addition to the involvement of community organizations in developing practice procedures and guidelines, support from provincial and national HCP organizations would ensure that standardized practices are enforced within Canada. For example, the Royal College of Physicians and Surgeons of Canada offers certificates in areas of focused competencies after completing specific training and practice experiences; training HCPs to screen potential victims of human trafficking is certainly an opportunity for a new focused competency. Programs that provided immediate, on-site access to victim services or a case

manager showed the most improvement in IPV screening rates (Short, Hadley, & Bates, 2002).

The involvement of community organizations, clear suggestions for referral, ongoing training of HCPs, and the presence of an on-site case manager have largely been addressed Fraser Health and the *Help Don't Hinder* learning module. Fraser Health's response to human trafficking could consequently serve as a model for other human trafficking identification and support programs across Canada. Implementing the VERA tool and training modules such as the *Help Don't Hinder* program requires community, institutional, and HCP involvement. With the institutional support of ongoing training based on validated screening protocols, such as the VERA tool, and access to either on-site or community support services, HCPs can develop high self-efficacy for screening potential victims of human trafficking (O'Campo et al., 2011).

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