

Human Trafficking

A Call for Heightened Awareness and Advocacy by Obstetrician–Gynecologists

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At a recent labor floor sign-out round, the resident presented a laboring patient with a complicated social history. The patient was a homeless teenager who had just arrived from Texas and was having an unplanned, undesired pregnancy. I somewhat sheepishly asked, “Any possibility of human trafficking here?” I realized that, despite having recently become educated about this topic, I still did not feel fully prepared to educate my peers about trafficking or identify and assist victims of trafficking.

As obstetrician–gynecologists (ob-gyns), we need to educate ourselves and feel empowered to help these patients. Years ago, the physician’s role in identifying and assisting victims of intimate partner violence was not recognized. After decades of advocacy and education, intimate partner violence became a topic of formal instruction in medical schools and residency programs, and the same should be true regarding human trafficking.

The extent of human trafficking is staggering. Barrows and Finger note that the “practice of slavery is alive and well around the globe.”¹ According to the U.S. Department of State, there are many kinds of human trafficking, including forced labor, bonded labor, involuntary domestic servitude, sex trafficking, forced child labor, child soldiers, and child sex trafficking.² The United Nations Office on Drugs and Crime reports that human trafficking is one of the top three most profitable crimes crossing national borders.³

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By some estimates, nearly 1 million people in the world are trafficked across international borders each year, and approximately 14,500–17,500 people are trafficked into the United States each year.⁴ According to the most recent U.S. Department of State’s Trafficking in Persons report, trafficking is widespread across this nation and the year 2010 saw an increase in the number of female, foreign-born trafficking victims receiving services in the United States.⁵ This U.S. report identifies Thailand, India, Mexico, the Philippines, Haiti, Honduras, El Salvador, and the Dominican Republic as the most common countries of origin of persons trafficked into the United States.

However, human trafficking does not require the crossing of international borders, and the aforementioned figures do not include the larger number of individuals estimated to be trafficked domestically within their own countries. According to one report, the United States is second only to Germany with regard to the rate at which women and children are trafficked into sex work.⁶ One author notes that there are currently at least 100,000 victims of domestic minor sex trafficking in the United States and that there are as many as 325,000 additional youth at risk of being trafficked.⁷ Although there are many challenges in determining accurate prevalence estimates, the United States enacted the Victims of Trafficking and Violence Prevention Act in 2000 in response to this seeming epidemic.⁸ The Act subsequently was amended and reauthorized in 2003, 2005, and 2008. Additionally, the United States ratified the United Nations’ “Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Especially Women and Children” in November 2005.⁹

Encounters with health care providers can be windows of opportunity to intervene on behalf of these victims. Given the many medical problems associated with trafficking, health care providers are uniquely positioned to identify and assist these vic-



tims. One study done by the Family Violence Prevention Fund found that 28% of trafficking survivors had been seen by a health care provider at least once during their captivity.¹⁰

The physical and mental health problems associated with sex trafficking include, but are not limited to, sexually transmitted diseases, unintended pregnancy, complications from unsafe pregnancy terminations, chronic pelvic pain and other pain syndromes, traumatic injuries, unexplained weight loss, poor oral health, anxiety, depression, posttraumatic stress disorder, and suicidal ideation.¹¹ Sexually transmitted infections are of significant concern because trafficking survivors report that those who purchase commercial sex frequently will pay more for unprotected sex.¹² One study of 200 survivors of human trafficking in Nepal found that 100% of those trafficked into commercial sex work suffered from depression, 97.7% from anxiety, 29.6% from posttraumatic stress disorder, and 29.6% were infected with human immunodeficiency virus (HIV).¹³ In contrast, victims who had been trafficked into nonsex work had rates of depression of 80.8%, 7.5% for posttraumatic stress disorder, and 0% HIV seropositivity.

Certain risk factors for trafficking have been identified. Williams et al report a wide range of individual, familial, and societal factors that increase vulnerability to sex trafficking, ranging from a history of childhood sexual abuse and family dysfunction to economic deprivation and a high demand for commercial sex.¹⁴ Homeless youth are at particular risk of becoming trafficked. Specific questions regarding school truancy or running away may be telling. Trafficking should be considered if children or adolescents are traveling with an older companion who is not a guardian, have access to material things one would doubt they could afford, or seem overly familiar with sexual terms and practices compared with their peers. Another potential indicator is a tattoo that the child or adolescent is reluctant to discuss; some traffickers may use specific tattoos to brand their victims.¹⁵ Having been intimidated with tales of jail time or deportation or both, victims also may exhibit fear and mistrust of individuals in positions of authority.

Similar to intimate partner violence, physicians should be suspicious when a patient's injury does not match her history, when she has bruises in various stages of healing, or when she has an individual accompanying her who tries to answer her questions or insists on being present at all times. The need to interview patients alone cannot be overstated. Patients may be afraid of potential repercussions to themselves or their loved ones if they were to divulge

the nature of their condition. They may be intimidated by the physical presence of their traffickers and withhold important information necessary for their care. Doctors and nurses can devise methods to screen patients alone, including sending guests to front desks with paperwork, following patients into restrooms under the guise of explaining urine sampling, and other creative strategies. Professional interpreter services should be used whenever necessary, and health care providers should avoid using family or companions as interpreters.

The U.S. Department of Health and Human Services developed sample questions that health care providers can use in taking a history regarding possible trafficking. These include:

- Can you leave your work or job situation if you want?
- When you are not working, can you come and go as you please?
- Have you been threatened with harm if you try to quit?
- Has anyone threatened your family?
- What are your working or living conditions like?
- Where do you sleep and eat?
- Do you have to ask permission to eat, sleep, or go to the bathroom?
- Is there a lock on your door or windows so you cannot get out?¹⁶

Questions specifically related to ob-gyn patient populations might also include asking if anyone is forcing or pressuring the patient to do something she does not want to do, including having sex or performing sex acts with others.

Importantly, as with intimate partner violence, interventions on behalf of an adult patient suspected or confirmed to be a victim of trafficking should be devised with the consent and input of the patient. One readily available resource is the National Human Trafficking Resource Center at 1-888-3737-888. This resource line is designed to assist the caller in determining whether a case of trafficking may exist and provide a list of local resources for further assistance. Within HIPAA privacy regulations, health care providers potentially could avail themselves of this service. In addition, the U.S. Department of Health and Human Services has a wealth of resources on their website (<http://www.acf.hhs.gov/trafficking>), including background information, tips for identifying victims, communication strategies, posters, brochures, pocket cards, and power point presentations.

Tragically, human trafficking and slavery continue to flourish in modern society. Unfortunately,



our medical literature and training programs offer little information on the prevalence, effect, identification, and potential interventions for victims. A multifaceted approach should be used to educate ob-gyns. The American Congress of Obstetricians and Gynecologists has many vehicles with which to educate providers. Similarly, the Council on Resident Education in Obstetrics and Gynecology, the American Board of Obstetrics and Gynecology, and the Residency Review Committee should incorporate this important topic in trainee curriculum. Our specialty should be knowledgeable about human trafficking and stand prepared to help these victims, who are some of the most vulnerable in our society.

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