Educating Pre-Clerkship Canadian Medical Students About Human Trafficking

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March 19th, 2016

Executive Summary

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 (HCPs) while in captivity, few victims are identified in the healthcare setting. Several researchers have suggested that this problem stems from a lack of education of HCPs and medical students in Canada about human trafficking. In fact, many HCPs and medical students perceive human trafficking to be irrelevant for practicing physicians in Canada. Thus, we are advocating for the inclusion of human trafficking education in the pre-clerkship curricula of Canadian medical students across the country.

The medical curricula in Canada currently fail to highlight the role HCPs could have in identifying and supporting victims of human trafficking. The lack of education provided to medical students and HCPs about trafficking has negatively affected victim identification and the development of victim support services. Simple education initiatives that work to disseminate screening tools and highlight behavioural indicators through learning modules have been able to drastically improve self-reported HCP knowledge of trafficking identification techniques in the United States. Furthermore, the number of potential human trafficking victims identified by Canadian HCPs increased drastically with the introduction of these learning modules.

We are advocating for a three-tiered approach to the education of Canadian medical students: the human trafficking curricula should incorporate elements of raising awareness, providing validated screening protocols, and teaching how to identify and counsel different populations. Medical students should also be educated about populations vulnerable to being trafficked, including First Nations, Métis and Inuit, and LGBTQ youth.

Background

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 (1-2). It is estimated that 28% of human trafficking victims come into contact with a HCP (1). However, few victims are detected in the healthcare setting due to the fact that HCPs remain largely uneducated about human trafficking. There is an extensive body of literature advocating for the education and training of HCPs and medical students on the issue of human trafficking (3-12). Currently, medical students in Canada lack not only the skills to deal with patients who are potential victims of human trafficking, but also lack basic information about the phenomenon of trafficking. We are therefore advocating for the inclusion of human trafficking education in the pre-clerkship curricula of Canadian medical students across the nation. By both describing the profile of human trafficking in Canada and by illustrating the current intersection between health and trafficking, the importance of educating Canadian medical students about this issue will become apparent.

Human Trafficking Globally and in Canada

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 (13). The primary objectives of the UN Protocol are to prevent trafficking, protect victims and prosecute traffickers (Appendix 1). The UN Protocol ultimately created a broad definition of human trafficking that is inclusive of all victims, regardless of consent. The UN Protocol specifically mentions three forms of exploitation: sexual exploitation, forced labour, and the removal of organs for the organ trade. We recommend that medical students be educated about these three forms.

A complex relationship exists between human trafficking and sex work. Few definitions have provided researchers, legislators, and professionals the ability to distinguish between trafficking and sex work (14). Nawyn, Birdal and Glogower (2014) suggest that separating coercion from exploitation is central to correctly implementing the UN Protocol definition of human trafficking (17). 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 (17). By saying that sex work and trafficking are the same, the ability of women to choose sex work is removed—agency is revoked. We, therefore, do not support an anti-sex work approach to educating Canadian medical students about 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, hosts a hotline, and has developed online toolkits to educate about human trafficking for law enforcement, youth, and the general public. Based on their reports (18), the profile of trafficking victims in Canada is diverse and dominated by domestically trafficked victims. 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. Major Canadian cities with established Asian organized crime networks typically are destinations for sexually exploited women from Asia (18). 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 (18). 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 (19). Indigenous people of Canada are disproportionately affected by sexual and physical abuse during childhood (20). 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 (20-21). Aboriginal women are specifically targeted for trafficking for purposes of sexual exploitation (22).

Human Trafficking and Health

Human trafficking results in serious mental, physical, and sexual health complications. Trafficking victims suffer from profound psychological abuse while in captivity (23). 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 often commit suicide or have a history of self-harm and suicidal ideation (15, 23). While many victims may experience substance abuse after being trafficked, many are forced or coerced into using alcohol or illicit drugs while in captivity as a way to ensure their subjugation and control (25). Sexually exploited victims tend to show higher levels of PTSD, depression, anxiety and post-trafficking hostility than in non-sexually exploited victims (23-24). Victims also suffer from somatic symptom disorder (15) in addition to immune suppression, sleep disturbances, frequent nightmares, memory loss, dissociation, and cognitive problems (25-26).

Physical abuse is the most documented component of human trafficking (23). 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, head/neck trauma, musculoskeletal damage, dental complications, and death (15,23). Victims who are denied access to medical care may become disabled as a result of the deterioration of a pre-existing medical condition, nerve or bone damage (23). With food or sleep deprivation as a component of torture, victims can become exhausted or suffer from starvation and gastrointestinal problems (25-26). 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 (15,23,25). The unsanitary environments that victims are forced to inhabit result 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 (26).

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, engaging in pornography, or subjected to gang rape. They have no control over the number of customers, are denied contraceptives, and are not provided with appropriate medical care for abortions (23). Sexual and reproductive health effects resulting from these violations include: sexually transmitted infections (STIs), HIV/AIDS, urinary tract infections (UTIs), pyelonephritis, dyspareunia, damage to the vaginal tract or anus, infertility, and complications from unsanitary abortions (23,25). The overwhelming health complications associated with human trafficking highlight the need for an effective global strategy that incorporates the involvement of HCPs and medical students.

HCPs are one of the few professionals to come into contact with trafficking victims still in captivity (27-28). In fact, 28% of trafficked women (1) and approximately 20% of domestic minor sex trafficking victims (25) 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 (2). Little effort has been put into developing and disseminating identification protocols and procedural guidelines for HCPs (29).

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 and medical students in the identification of victims is largely unrealized. Future HCPs' perceptions of how important or relevant the issue of human trafficking is are often negative prior to training, partly due to the fact that the clandestine nature of human trafficking allows for HCPs to categorize victims as rare. For instance, a study conducted by Wong et al. (2011) at the University of Toronto's medical school shockingly demonstrated how prevalent this misconception is amongst pre-clerkship medical students. Approximately 94% of the surveyed students thought that they would be unlikely or only somewhat likely to encounter or identify a trafficked person in a Canadian clinical setting (12). Surveyed medical residents and other HCPs in the United States shared similar misconceptions to the Canadian pre-clerkship medical students (5-6). 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 (4, 6-7) and, both in the United States and in Canada has led to the recommendation that HCPs and medical students be educated about human trafficking. Through brief training modules, several studies have recently been able to demonstrate that self-reported HCP knowledge of trafficking identification techniques can improve drastically (5, 7, 11). In Canada, the number of identified potential victims of human trafficking increased by 7% just one month after a learning module was provided to HCPs in British Columbia (30). Simply providing access to human trafficking information and screening protocols is therefore an effective method of educating HCPs. As with the screening protocols, many training modules are also 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.

Principles

1. Human trafficking is a relevant concern for Canadian HCPs.
2. HCPs are some of the only professionals to come into contact with victims who are still in captivity.
3. Human trafficking has severe effects on the health of victims.
4. Assistance to human trafficking victims by Canadian HCPs is limited and uncoordinated.
5. Canadian medical students and HCPs are currently not being trained to identify victims of human trafficking and are not being educated about human trafficking.
6. Researchers have extensively advocated for medical students be educated on the topic of human trafficking.
7. Human trafficking disproportionately affects First Nations, Métis, and Inuit communities in Canada.
8. Providing medical students with training will increase HCPs' confidence while working with potential victims of human trafficking and increase the likelihood of screening, recognizing, and helping these potential victims.
9. HCPs benefit from short, effective training sessions on human trafficking.
10. Human trafficking relates to four of the core competencies outlined by the CFMS Global Health Program:
    a. *Health implications of travel, migration and displacement:* victims of human trafficking are displaced from their communities;
    b. *Social and economic determinants of health:* populations are made more vulnerable to human trafficking through poverty, racism, urbanization, and discriminatory markets in a competitive global economy;

c. *Globalization of health and healthcare:* the spread of both transplanetary and supraterritorial connections has created a global medical community in which human trafficking poses unique clinical challenges; and,

d. *Human rights in healthcare:* victims of human trafficking endure extreme and prolonged psychological, physical, and sexual trauma.

Recommendations

1. **The Canadian medical school curricula on human trafficking should incorporate:**
   a. **Elements of raising awareness:** Medical students should be taught about the definition of human trafficking (13), the relationship between human trafficking and sex work (14), and both global (16) and Canadian human trafficking statistics (18).
   b. **Providing validated screening protocols:** Medical students should be provided with potential screening questions for victims of human trafficking from validated screening protocols (Appendix 2; 52).
   c. **Teaching how to identify and counsel different vulnerable populations:** Training modules have been developed within Canada to educate HCPs about the potential clinical presentation associated with victims of human trafficking. Forensic nurses with Fraser Health in British Columbia have recently developed a training module called *Human Trafficking: Help Don't Hinder*. The module is meant to educate HCPs on how to identify and respond to potential human trafficking victims who may present to the emergency department (Appendix 3; 30). Medical students could complete these learning modules and potentially receive certification.

2. **The human trafficking curriculum should not be anti-sex work.**
   Human trafficking education should focus on all forms of human trafficking, not just sexual exploitation. Furthermore, students should be encouraged to engage in discussions about the differences between sex work and human trafficking (14) and the role of consent (32). Analyzing human trafficking through an anti-sex worker lens oppresses groups vulnerable to being trafficked.

3. **Human trafficking should be incorporated as part of Aboriginal health lectures.**
   Aboriginal women are overrepresented in Canada's domestic trafficking statistics. Legacies of residential schools, violence, substance addiction and discrimination have created unhealthy environments that make Aboriginal women particularly vulnerable to being trafficked (20-21). Integrating Aboriginal health and human trafficking provides an opportunity to expose Canadian medical students to the concept of trafficking. Potential methods of incorporating human trafficking into Aboriginal health lectures include: sharing statistics on the number of trafficked women in Canada who are Aboriginal and providing students with the definition of human trafficking.

4. **Human trafficking should be incorporated as part of LGBTQ health and homelessness lectures.**
   Homelessness is a major risk factor for trafficking and it is estimated that 20%-40% of homeless minors are lesbian, gay, bisexual, transgender, or queer (LGBTQ) (31). 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. Integrating LGBTQ health and human trafficking provides an opportunity to expose Canadian medical students to the concept of trafficking. Potential

methods of incorporating human trafficking into homelessness and LGBTQ lectures include: explaining how homeless and LGBTQ populations are at an increased risk of being trafficked and providing students with the definition of human trafficking.

5. **Human trafficking should be incorporated as part of violence against women lectures.**

   Women accounted for 97% of victims trafficked for sexual exploitation between 2010 and 2012 (16). In addition to this, 70% of all detected victims globally were women (49% women, 21% girls under the age of 18). 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. Potential methods of incorporating human trafficking into violence against women lectures include: sharing the above statistics about human trafficking and women, and providing students with the definition of human trafficking.

6. **Human trafficking should be incorporated as part of refugee health lectures.**

   Refugees represent a population vulnerable to being trafficked. Economic inequalities between and within countries, natural disasters, and conflict have led to the development of survival migrants who seek employment and safety abroad in an effort to sustain themselves and their families (33). There is a growing relationship between migration routes and violence, including human trafficking (34). Potential methods of incorporating human trafficking into refugee health lectures include: explaining the definition of human trafficking, discussing smuggling in comparison to trafficking, and exploring why refugees are at an increased risk of being trafficked.

7. **Experts in human trafficking should be consulted as the human trafficking curriculum for medical students is designed.**

   Letters of support for this initiative have been collected from across Canada (Appendix 4). In these letters, HCPs and researchers have offered to either provide information for the curriculum or offered to act as consultants throughout the curriculum development process. In addition, both the Medical Students' Society of McGill University and the Global Health Committee of McMaster have endorsed this initiative. We recommend that CFMS' VP Education, CFMS' Global Health Officers, CFMS' Government Affairs, Canadian human trafficking researchers and organizations, and curriculum-planning committees from every school be involved in the curriculum development process.

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Appendix

1. 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 (13).

2. Curriculum Design

Tier 1: Raising Awareness and Sharing Information

Goal	Potential Resources
Teach medical students what human trafficking means	UN Protocol, 2000
Introduce medical students to the concept of human smuggling and sex work and how they relate to human trafficking	Tyldum, 2010; Kelly, 2005
Introduce medical students to the different purposes for human trafficking	UNGIFT, 2015; UN Protocol, 2000
Share Canadian statistics on human trafficking	RCMP, 2010
Highlight the relationship between Aboriginal Health and human trafficking	Kaye, Winterdyk, & Quarterman, 2014; Kingsley & Mark, 2001; Native Women's Association of Canada, 2014
Highlight the relationship between LGBTQ Health and human trafficking	Ray, 2006

Tier 2: Providing Validated Screening Protocols

Goal	Potential Resources
Provide medical students with effective questions for identifying potential victims of human trafficking	Simich, Goyen, Powell, & Mollozzi, 2014*; Falkenberg, Wilkie, & Dodd, 2014

The five most effective questions for identifying a victim of human trafficking as determined by Simich et al. (2014) are:

1. Did anyone arrange you 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?

**Note: Refer to Appendix 3 if looking for more information about the validated VERA screening tool.*

Tier 3: How to Identify Victims and Counsel Potential Victims

Goal	Potential Resources
Introduce medical students to the clinical presentation of a potential victim of human trafficking; introduce health outcomes	Dovydaitis, 2010; Oram et al., 2012; Stewart & Gajic-Veljanoski, 2005; Tsutsumi, Izutsu, Poudyal, Kato, & Marui, 2008; Zimmerman, Hossain, & Watts, 2011
Provide medical students with information on behavioural indicators of human trafficking and victim interaction strategies (Table 1)	Asian Health Services & Banteay Srei, 2012; Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011; Falkenberg, Wilkie, & Dodd, 2014; Greenbaum et al., 2013; Hughes, 2003; IOM, 2007; IOM, 2009; Polaris Project 2010; Polaris Project 2011; Sabella, 2011; Simich, Goyen, Powell, & Mallozzi, 2014; Spear 2004; State Department of Florida Department of Children and Families, 2009; United Kingdom Department of Health, 2013; United Kingdom Visas and Immigration, 2014a; United Kingdom Visas and Immigration, 2014b; United States Department of Health and Human Services, 2012a; United States Department of Health and Human Services, 2012b; United States Department of State, n.d. Varma, Gillespie, McCracken, & Greenbaum, 2015; Zimmerman & Watts, 2003
Provide medical students with a referral mapping form (Table 2)	IOM, 2009
Highlight the relationship between Aboriginal Health and human trafficking	Kaye, Winterdyk, & Quarterman, 2014; Kingsley & Mark, 2001; Native Women's Association of Canada, 2014
Highlight the relationship between LGBTQ Health and human trafficking	Ray, 2006

Table 1. 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 1. 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 1. 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 1. 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 1. 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 1. 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 1. 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 Eng;ish	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 1. 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.

Table 2. 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 2. 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

3. The VERA tool is one validated screening tool developed in June of 2014 (52); screening questions from this tool could be adapted to the Canadian context. The research involved in designing the validated screening 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" (52, 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 (Table 3). 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 3). The five most effective questions for identifying a victim of human trafficking, as determined by Simich et al. (2014) are:

   a. Did anyone arrange your travel to [insert country's name]?

   b. Did anyone where you worked [or did other activities] ever make you feel scared or unsafe?

   c. Have you ever felt you could not leave the place where you worked [or did other activities]?

d. Did anyone where you worked [or did other activities] ever trick or pressure you into doing anything you didn't want to do?

e. Were you allowed to take breaks where you worked [or did other activities], for example, to eat, use the telephone, or use the bathroom?

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

4. The *Human Trafficking: Help Don't Hinder* learning module can be accessed at: https://learninghub.phsa.ca/Courses/6427/human-trafficking-help-donthinder. The online course was partially funded by the Canadian Women's Foundation (who have also supported this initiative), Fraser Health, and the British Columbia Ministry of Justice and Services as an educational credit for HCPs in British Columbia. The module is designed to be interactive and incorporates human trafficking statistics, the clinical presentation of potential trafficking victims, and strategies for interacting with these patients (30). The training module incorporates literature included in the VERA tool. For example, the module shares similar screening questions with the VERA tool:

    a. Can you leave your job or situation if you want to?

    b. Is anyone forcing you to do anything that you don't want to do?

    c. Do you have to ask for permission to eat, sleep, or go to the washroom?

    d. Have you been physically harmed in any way?

    e. 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 3). 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.

5. Please refer to the attached letters of support from medical school interest groups, researchers, and organizations across Canada. Below is a list of those who have provided support for this initiative *(Note: Letter pending from the Native Women's Association of Canada)*:
    -Action Coalition on Human Trafficking, *Karen McCrae*
    -Canadian Federation of Medical Students, *Anuradha Dugal*
    -Fraser Health Forensic Nursing Service Human Trafficking Team, *Tara Wilkie*
    -Harriet Tubman Institute and Alliance Against Modern Slavery, *Karlee Sapoznik*
    -Native Women's Association of Canada, *Gail Gallagher*
    -South House, Dalhousie University's Gender and Sexual Response Centre, *Marietta Wildt*
    -HCP and Researcher, *Donna E. Stewart*
    -HCP and Researcher, *Harriet MacMillan*
    -McMaster MD Global Health Committee, *Anthony Sandre*
    -Medical Student's Society of McGill University, *Doulia Hamad*