

Nebraska Medicine

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Human Trafficking

How health care providers in Nebraska can identify and assist victims



Nebraska
Medical
Association

Advocating for Physicians and the Health of all Nebraskans

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ADDITIONAL RESOURCES:

- Human Trafficking: Guidebook on Identification, Assessment, and Response in the Health Care Setting, Massachusetts Medical Society and Massachusetts General Hospital's Human Trafficking Initiative - <http://www.massmed.org/Patient-Care/Health-Topics/Violence-Prevention-and-Intervention/Human-Trafficking-%28pdf%29/> Or, Google search Massachusetts Medical Society Human Trafficking
 - PATH, Physicians Against the Trafficking of Humans - <http://www.doc-path.org/path>
 - Information for emergency health care providers - <http://www.humantrafficking-ed.com/>
 - Health Needs of Human Trafficking Victims, U.S. Dept. of Health and Human Services - <http://aspe.hhs.gov/hsp/07/HumanTrafficking/Symposium/ib.shtml>
 - Stanford School of Medicine Human Trafficking - <http://humantraffickingmed.stanford.edu/>
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FOREWORD

by Dale Michels, MD
NMA Past President

Growing up in a small northeast Nebraska town, trafficking to me meant the many trucks and cars driving the busy highway between our home and the rest of town. College, medical school and 40 years of practice along with exposure to the rest of the world have brought me to realize that human trafficking is much different and takes many forms. Unfortunately, being in the middle of America does not exempt us from the scourge of this world-wide problem. And, as you will see, it's not just the I-80 corridor where this can occur.

Have I missed patients caught in this tangled web of abuse and exploitation? Probably so, but not intentionally. As you read the information that follows, I encourage you to think about the patients in your practice, the resources of your community and the need to be alert and aware of the possibility of trafficking. Only by being aware can we have the opportunity to stop this abuse of other humans and lessen the world-wide problem. We must start in our community and then spread our influence to our state and eventually the world. □

Health Care and Human Trafficking

by Jeffrey Barrows, D.O., M.A.
Director, U.S. Training Hope for Justice

The issue of human trafficking is in the news with increasing frequency, but what is often not mentioned is the connection between human trafficking and health care. Human trafficking is the legal term describing the criminal activity of human exploitation, usually either in the form of sexual or labor exploitation. It is far more common than most people realize, and it's happening all around us...even in Nebraska.

Congress first defined human trafficking in legislation passed in 2000 entitled "The Trafficking Victims Protection Act" or TVPA. In this landmark legislation, human trafficking was defined as the recruiting, harboring, transporting, obtaining, or exploiting of one human being by another through force, fraud,

or coercion into some form of exploitation. Within the United States, the two most common forms of exploitation are either sexual exploitation in some form of commercial sex, or various forms of labor exploitation.

With sexual exploitation of adults, the TVPA requires proof that force, fraud, or coercion were utilized because the law recognizes that adults can give consent to commercial sex. However, as they worked through the definition of sexual exploitation of minors under the age of 18, Congress came to the opinion that they did not believe a minor could give consent to commercial sex. Therefore, they removed any requirement to prove force, fraud or coercion when dealing with a minor in commercial sex. This means that in the view of the federal government, any minor involved in commercial sex such as stripping, pornography, or prostitution is

a victim, not a criminal.

Human trafficking is defined under Nebraska State Statutes §§28-830 and 28-831 in a manner very similar to the federal statutes. Under Nebraska law, the use of force, fraud, or coercion are not required to classify a minor involved in commercial sex as a victim. However, there is provision for an increased penalty against the trafficker if force is used on a minor in sexual exploitation.

Due to the criminal nature of human trafficking, it's very difficult to obtain accurate figures regarding the actual number of victims in the U.S and across the world. The International Labor Organization, part of the United Nations, estimates that there are approximately 21 million people worldwide entrapped in

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some form of forced labor.¹ That same report estimates that approximately 471,000 of those entrapped victims live within the U.S.

In 2014, the NGO The Walk Free Foundation released its Global Slavery Index estimating that almost 36 million people worldwide are enslaved.² Their estimate for the number of human trafficking victims within the United States was 60,100, far less than the ILO report. This wide disparity shows the difficulty in obtaining accurate estimates of the number of human trafficking victims. In conclusion, most experts agree that there are many thousands of people within the U.S. that are in some form of human trafficking. Health care plays a critical role in finding and freeing these victims. Recent reports have documented that between 50-88% of human trafficking victims encounter some type of health care professional *while they are being trafficked*.^{3,4} The most common health care setting for these patients to present is the emergency room.

Unfortunately, when victims of human trafficking enter the health care system, the vast majority leave that encounter without being recognized.

This failure of recognition occurs for several reasons. The first is the lack of training on human trafficking among health care professionals. One study showed less than 3% of emergency room personnel had ever received any formal training on human trafficking.⁵ Another barrier to recognition of human trafficking victims within the health care setting is a misconception of the driving factors in sexual exploitation. Unfortunately, even many healthcare professionals believe that men and women voluntarily

Indicators of Human Trafficking in the Healthcare Setting

Adapted from 1, 2

Indicators of Control

- The Person is accompanied by another person who seems controlling
 - Insists on giving health information for the patient
 - Corrects the patient
 - Exhibits non-verbal control over patient
 - Revealed by signs of fear and/or submission in patient
 - Person refuses to leave
- Unaccompanied patient that receives frequent texts or phone calls during the exam
 - Patient unable to ignore texts or phone calls
 - Patient may appear to be unusually rushed
 - Patient may appear to be unusually anxious

Red Flag Indicators

- Fake identification
- Inability to produce proper ID documents
- Clothing inconsistent with weather
- Stated age older than appearance
- Patient doesn't know physical address
- Patient doesn't know what city he/she is in
- Patient is a very poor historian
- Discrepancy between stated history and clinical presentation
- In possession of large amounts of cash
- Delayed presentation for medical care

Physical Indicators

- Signs of physical trauma
- Signs of sexual trauma
- Dental trauma
- Multiple STI's
- Signs of malnutrition and/or dehydration
- Tattoos that indicate ownership by someone else
- Evidence of substance abuse
- Unusual infections such as TB
- Immunizeable infection
- Physical indicators of stress such as somatic symptoms

1) Barrows J, Finger R. Human trafficking and the healthcare professional. *South Med J*. 2008; 101(5):521-524.

2) Alpert EJ, Ahn R, Albright E, Purcell G, Burke TF, Macias-Konstantopoulos WL. *Human Trafficking: Guidebook on Identification, Assessment, and Response in the Health Care Setting*. MGH Human Trafficking Initiative, Division of Global Health and Human Rights, Department of Emergency Medicine, Massachusetts General Hospital, Boston, MA and Committee on Violence Intervention and Prevention, Massachusetts Medical Society, Waltham, MA. September 2014.

choose to be involved in commercial sex rather than correctly viewing that involvement as a form of sexual exploitation by another person. In surveys of women working in prostitution, Melissa Farley has found that 92% of those in prostitution want to get out.⁶

A final barrier to the identification of minors in sexual exploitation is that many healthcare professionals do not realize that family caregivers frequently traffick the minors under their care. A study out of New York found that over

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Health Care and Human Trafficking *(continued)*

one-third of traffickers of children were immediate family members.⁷

There are 3 major categories of indicators for human trafficking victims within the healthcare setting and these are detailed in chart 1. The 3 major categories of indicators are indicators of control, red flag indicators, and physical indicators.

By definition, victims of human trafficking are under the control of another person through either psychological or physical means. With proper training, that control can be recognized within the healthcare setting.

Red flag indicators are the inconsistencies that often accompany human trafficking such as the inability to give an address, or a fake ID when dealing with a minor or a person from another country.

Finally, there are certain physical indicators that can be found on physical examination or through laboratory evaluation. Most commonly these include physical indications of trauma and abuse such as cigarette burns or extensive bruising. Laboratory confirmation of multiple sexually transmitted infections should raise the possibility of sexual exploitation.

In order to safely and effectively respond to victims of human trafficking encountered within the healthcare

setting, it is critical for each healthcare institution to develop a response protocol designed specifically for their facility. Victims of human trafficking are among the most traumatized group of people within our society and their needs are highly complex, requiring a multidisciplinary response. This multidisciplinary response should include trained representatives from various law enforcement agencies, the judicial system, child protective services, and social service organizations that provide the services needed by these victims.

Because of their highly traumatized condition, these patients do best when interviewed and treated by trauma-informed staff who understand the physiological effects of trauma on a person. Some common trauma-informed staff within health care include SANE/SAFE nurses or trauma trained hospital social workers.

Just as most large emergency rooms and clinics have protocols in place to respond to victims of child abuse, sexual assault, or domestic violence, they should also take the step of developing a protocol to respond to victims of human trafficking. Further educational resources on human trafficking designed specifically for the healthcare professional

can be found at: www.cmda.org/tip.

Other resources on human trafficking for healthcare professionals are available at: <http://hopeforjustice.org/professionals/>. Assistance on the process of developing a response protocol for victims of human trafficking encountered in the healthcare setting can be obtained by emailing the author at jeff.barrows@hopeforjustice.org. □

- 1) ILO "ILO Global Estimate of Forced Labor". (2012). Available online at: http://www.ilo.org/sapfl/Informationresources/ILOPublications/WCMS_182004/lang-en/index.htm
- 2) The Walk Free Foundation. "2014 Global Slavery Index Report". Available online at: http://d3mj66ag90b5fy.cloudfront.net/wp-content/uploads/2014/11/Global_Slavery_Index_2014_final_lowres.pdf
- 3) Baldwin, SB, Eisenman DP, Sayles JN et al. "Identification of Human Trafficking Victims in Healthcare Settings". *Health and Human Rights* (2011) (13) 1:1-14.
- 4) Lederer, L. and Wetzel, C.A. "The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities". (2014) *The Annals of Health Law* 23:1. 61-91.
- 5) Chisholm-Straker, M., Richardson, LD., and Cosio, T. "Combating Slavery in the 21st century: The role of emergency medicine." (2012) *J Healthcare for Poor and Underserved* 23:980-987.
- 6) Farley, M., Baral, I., Kiremire, M. and Sezgin, U. (1998). Prostitution in five countries: Violence and post-traumatic stress disorder, *Feminism in Psychology*, 8(4), 405-426.
- 7) "Homelessness, Survival Sex and Human Trafficking: As Experienced by the Youth of Covenant House" New York. (2013). Available online at: <http://www.covenanthouse.org/sites/default/files/attachments/Covenant-House-trafficking-study.pdf>

The Reality of Human Trafficking in Nebraska

by *The Hon. Douglas J. Peterson,*
Attorney General

How many?

The tragedy of human trafficking is global in scope but is not foreign to Nebraska.



There is “a flourishing sex trade in Nebraska”¹ according to the report issued by the Task Force appointed by Governor Dave Heineman to study, identify and recommend solutions for combating human trafficking. The full extent of human trafficking in Nebraska, however, has not definitively been quantified by a single organization. The 20-member panel wrote it was concerned there was little data measuring the extent of the problem.

“Unless you are out really looking for it or are attuned to it, you may not realize it’s happening right in front of you,” said Anna Brewer, a special agent with the Omaha office of the Federal Bureau of Investigation.

The National Human Trafficking Resource Center (NHTRC) began maintaining state specific data in 2007. NHTRC compiles aggregated information including phone calls, emails and online tips reported to the hotline. The NHTRC reported 115 contacts and 12 reports of trafficking cases in Nebraska for 2014.²

The Polaris Project, a respected national organization, analyzes and tracks human trafficking statistics and evaluates state laws. Several of Polaris’ recommendations for Nebraska are being implemented in LB294, the bill proposed by my office and sponsored by Senator Jim Scheer from Norfolk and Senator Patty

Pansing Brooks from Lincoln.

Recognize and report

Victims will ultimately interface with the medical system, legal system and social system during their lifetimes either while they are being trafficked or after being victimized.

The victims experience the loss of their most basic dignity as human beings and suffer immediate and ongoing issues of sexually transmitted diseases, disfigurement, depression and suicide.

In a 2014 U.S. HHS study^{12 13}, almost 88 percent of interviewed survivors of domestic sex trafficking had encountered one or more health care professionals some time during the period in which they were being trafficked, yet none were identified as a victim during these encounters.

As physicians, you will potentially find yourself in the position of first line of defense in the battle to protect young victims from being trafficked. By equipping yourself with the understanding of identifying victims and being armed with the necessary resources to provide support and referrals to victims and their families you may literally become a lifeline to allow escape from the horrors of this devastating exploitation.

According to Dr. Jeffrey Barrows “indicators of a possible victim include someone under control of another, physically and/or psychologically; inconsistencies in what is being told to care givers when a potential victim arrives at an Emergency Department; and physical signs of trauma.”⁴ These physical indicators could include bruises, broken teeth, malnutrition, poor hygiene and evidence of neglected health.

One national physicians’ network,

Christian Medical and Dental Association (CMDA), has created an educational course that provides medical providers with training to identify and care for victims. This specifically targeted, continuing educational resource is available online.⁵

It is only in more recent years that the issue of human trafficking is coming into greater understanding and being identified as a horrendous “mainstream” activity associated with nationally hosted events and sporting events.

Anna Brewer leads “Innocence Lost,” a Nebraska-based effort investigating human trafficking cases. The effort combines the resources of several law enforcement agencies in the state. The group compiled plenty of evidence on the darker side of high-profile events like the College World Series, Nebraska football weekends, and the annual Berkshire Hathaway shareholder’s meeting hosted by Warren Buffett.

This year an estimated 35,000 people attended the Berkshire event. Police set up a sting in one west Omaha hotel. Brewer described the near non-stop traffic as being like “a revolving door” ending with 23 arrests in eight hours. Half were prostitutes and half were would-be customers. “I think that’s very significant,” Brewer said.⁶

Do you know my name?

As a father and now a grandfather, it is not trite for me to say a single case is one case too many. Each young person in our state is a gift to their family and uniquely created to serve with the gifts they have been given. For any other human being to strip another of their endowed dignity and to treat them as a

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Trafficking in Rural Nebraska

by *Tori Moser, B.S.*
Abolitionist, I AM for Freedom
Resource Specialist, Faith Regional Health
Services

When we hear a statistic such as “there are an estimated 35.8 million¹ people enslaved in the world today” it’s easy to allow ourselves to detach from the enormity and humanity of the issue. What could someone from Nebraska possibly do to save all of those people in third world countries? You might feel compelled to make a donation to an organization and then never think about it again. But slavery is not just happening “over there.” It’s right here, in America, in Nebraska and likely in your hometown. Each one of the “enslaved” has their own story. And each one deserves to be identified, rescued, vindicated and restored to a life of freedom. Everyone needs to play a role in the battle to end slavery and health care providers have a unique opportunity to intervene on behalf of trafficking victims.²

Human trafficking exists because the world demands it. It is the classic supply and demand business model. Consumerism and the demand for cheap products and services and commercial sex have ignited the human trafficking world, making it the second leading criminal industry behind the drug trade and it boasts the fastest growth rate, generating an estimated \$150.2 Billion per year.³ Traffickers perceive high profits with low-risk making this criminal industry a very attractive

career option. Additionally, a human victim can be sold multiple times per day, seven days per week; unlike drugs or guns. A victim with a daily quota of \$1000 can earn his/her trafficker over \$365,000 per year and the trafficker or pimp will often have several victims in his/her “stable.”⁴

Does It Really Happen In Nebraska?

Due to the hidden nature of human trafficking, collecting accurate data is very difficult. Victims do not self-identify, are vulnerable and isolated and often live in fear of violence or death imposed by their trafficker. Nebraska, as a state, lacks awareness in identifying victims and currently has no systematic method of re-

porting contact with a trafficking victim. Therefore, very little data currently exists on the true extent of trafficking in our state.

The National Human Trafficking Resource Center operates a 24/7 national hotline and collects

statistics about the calls. Since December 2007 the number of calls to the hotline have increased 259% and the hotline has received calls from all 50 states. It has been contacted 90,480 times resulting in 18,645 potential cases nationwide. There have been 312 calls from Nebraska during that time resulting in 61 potential cases.⁵

In July of 2013, the Governor’s Task Force on Human Trafficking submitted a report that examined the prevalence of human trafficking in Nebraska, the current prevention efforts and the available

services to victims. There is “a flourishing sex trade in Nebraska” according to a statement in the report.⁶ Interviews conducted by the task force revealed the following information:

- There is a misconception that prostitution is a profession. While it may appear the victim is willingly engaging, behind the scenes is a violent pimp and a nightly quota expectation, a drug addiction, or the need to just survive.
- The I-80/I-29 Interstate corridor coupled with internet advertising makes Nebraska vulnerable to trafficking.
- Runaway youth and youth in the foster care system are extremely vulnerable to sexual exploitation and several hundred are known to exist in the state.
- The U.S. Attorney for Nebraska office has investigated cases involving adults, minors and immigrants including cases related to child pornography whose consumers are highly likely to prey on minors if provided the opportunity.
- A study of the website *Backpage.com* identified over 1500 advertisements for over 300 women for sale in the Lincoln area with 17 identified as possible minors. Contact numbers listed were from 61 area codes in 29 states.
- Escort owners report violence in the industry and having knowledge of women in the sex trade who mysteriously disappear.
- Escort owners report an increase in calls during big events such as Husker football games or any other event that comes to Lincoln/Omaha; truck stops are also a focus for escort companies.
- Many of the escort agencies advertise



“Human trafficking is a violation of the human body, mind and spirit. For this vile practice to be taking place in a country that the world looks to as a beacon of freedom... is a terrible irony and an utter tragedy.”

- Former Attorney General
 Alberto Gonzales³²

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Trafficking in Rural Nebraska *(continued)*

they will travel outside of the Lincoln and Omaha areas.

Cases of Human Trafficking in Nebraska

There have been several cases of human trafficking in Nebraska in recent years. This list was prepared to show the diverse characteristics of human trafficking incidents. It should be noted that although the victims in the sampling of cases have all survived, a much larger percentage of victims are never identified and rescued.

- Rachel Davis-Pointer of Omaha was six years old when she was first trafficked by her neighbors. She would sneak out of her house after bedtime, be driven around the city to service clients and sneak back in before morning to attend school. Her victimization continued until she was 16. Her perpetrators have never been brought to justice. Rachel now serves as an anti-trafficking advocate in the state of Nebraska.⁷
- Jessica from Lincoln, whose mother suffered a mental illness and was addicted to drugs, was raped repeatedly starting at age 11. She was placed in foster care and she married at age 17 to get out of the system. At age 19 she began escorting and by age 21 she was recruiting other girls to work for her.⁸
- Ashley graduated from a Lincoln high school and attended Southeast Community College for music. She was lured into prostitution by a "Romeo pimp" who promised her a music career and record deal. He sold her on multiple

escort sites and threatened her mother if she left him.⁹

- Leticia Montoya-Bonifas, Executive Director of Central Nebraska Human Trafficking & Immigration Outreach in Lexington, reported she had over 1,000 calls to her hotline in 2014. Calls ranged from tips to requests for services, information, education and/or training. Of the victim-related calls, she estimates 80% were related to sex trafficking and 20% to labor trafficking. She is actively working on multiple cases to assist victims.¹⁰
- Eviana Saunders, Columbus, was adopted out of Chile by a Nebraska family. She and her family have recently learned the true story behind her illegal adoption. Her birth mother was a victim of sex slavery, forced to become pregnant and give up her children to be adopted by American families who are willing to pay more for a child. Evie was located by a Chilean investigative reporter through Facebook.¹¹
- Jane was lured from her abusive home in Africa by a man who tricked her by pretending to be in love with her. He smuggled her back to Nebraska, locked her in a basement and sold her for sex to other men. She did not speak English, but managed to escape. She has not been able to identify her captor and is now working to rebuild her life.¹²
- Michelle Randall, Upland, sentenced in January 2013 for prostituting out her 14- and 7-year old daughters through an advertisement on Craigslist.¹³
- Tammy Schuck, Omaha, was convicted

of operating a prostitution enterprise out of three "spas." Clients paid a door fee to have sessions with her workers and negotiated separate tips in exchange for sex acts.¹⁴

- In 2007, an undercover female Lincoln police officer was "claimed" by a pimp in a neighborhood near the Capitol building. Within minutes he had arranged a sex act with a client for \$20.¹⁵
- Polly was a young girl from a small town in Nebraska. She was kicked out of her impoverished, abusive home at age 12 and lived on the streets of Omaha. She ran with a group of other homeless youth and survived by having sex with men to get money.¹⁶
- Mary Crane Horton, Nate Horton, Ramon Heredia and Katherine Heredia were convicted in Omaha in 2011 on counts related to a sex trafficking ring. Between 2007 and 2010 they trafficked six women including two minors. Katherine Heredia was also victimized during this time and was not charged on all counts.¹⁷
- Leonard Russell was convicted in Iowa of trafficking two Nebraska girls ages 15 and 16 who ran away from a group home in Fremont. He picked them up and told them they had to earn money by "getting dates" (i.e. perform commercial sex acts) in exchange for food, shelter, transportation and clothing. The 15-year old was eventually recovered by police in Washington, D.C.¹⁸
- The Franklin Scandal of the 1980s involved wealthy state residents and high-level government officials who were part of an elite child sexual abuse ring in Nebraska.¹⁹

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Trafficking in Rural Nebraska *(continued)*

Combating Human Trafficking in Nebraska

Prevention, protection, prosecution and partnerships are the fundamental foundation being used worldwide and are written into the United States' Trafficking Victims Protection Act (TVPA). Individual states must also respond with a planned approach to fight trafficking through increased awareness and prevention efforts, increasing penalties for traffickers, pimps and johns and protecting and providing services to those who have been victimized.

The legal experts at Shared Hope International have evaluated each state on its ability to effectively respond to the crime of domestic minor sex trafficking (DMST). In the study, known as "The Protected Innocence Challenge," Nebraska is currently receiving a grade of "D" with a score of 69.5 out of 102.5 points placing Husker Nation 35th in the national rankings. Neighboring states Iowa and Missouri (B, 85.5) have advanced far ahead in their efforts to fight trafficking.²⁰

Fighting human trafficking is one of the priorities of newly elected Nebraska Attorney General Doug Peterson who, along with Senator Jim Scheer of Norfolk, introduced LB294 during the 2015 legislative session. The bill addresses multiple aspects in the fight against trafficking and would be a big step forward for the state.

As previously stated, health care can play a critical role in identifying victims of human trafficking. In a 2012 study of survivors from across the nation, 87.8% reported contact with the healthcare system at some point during their victimization. The most commonly reported site was the hospital emergency room. Other

locations included Planned Parenthood, regular doctors, urgent care clinics and women's health clinics. Pimps and traffickers exercise complete control over their victims and these points of contact represent rare opportunities for identification and intervention.²¹ A recent article in *Pediatrics* addresses the specific needs of child victims of sex trafficking.²²

Intervention can be a very delicate situation and proper education, training, protocols and resources are highly recommended before attempting to intercede. There are several resources available for training providers and staff members who could come in contact with a potential victim.

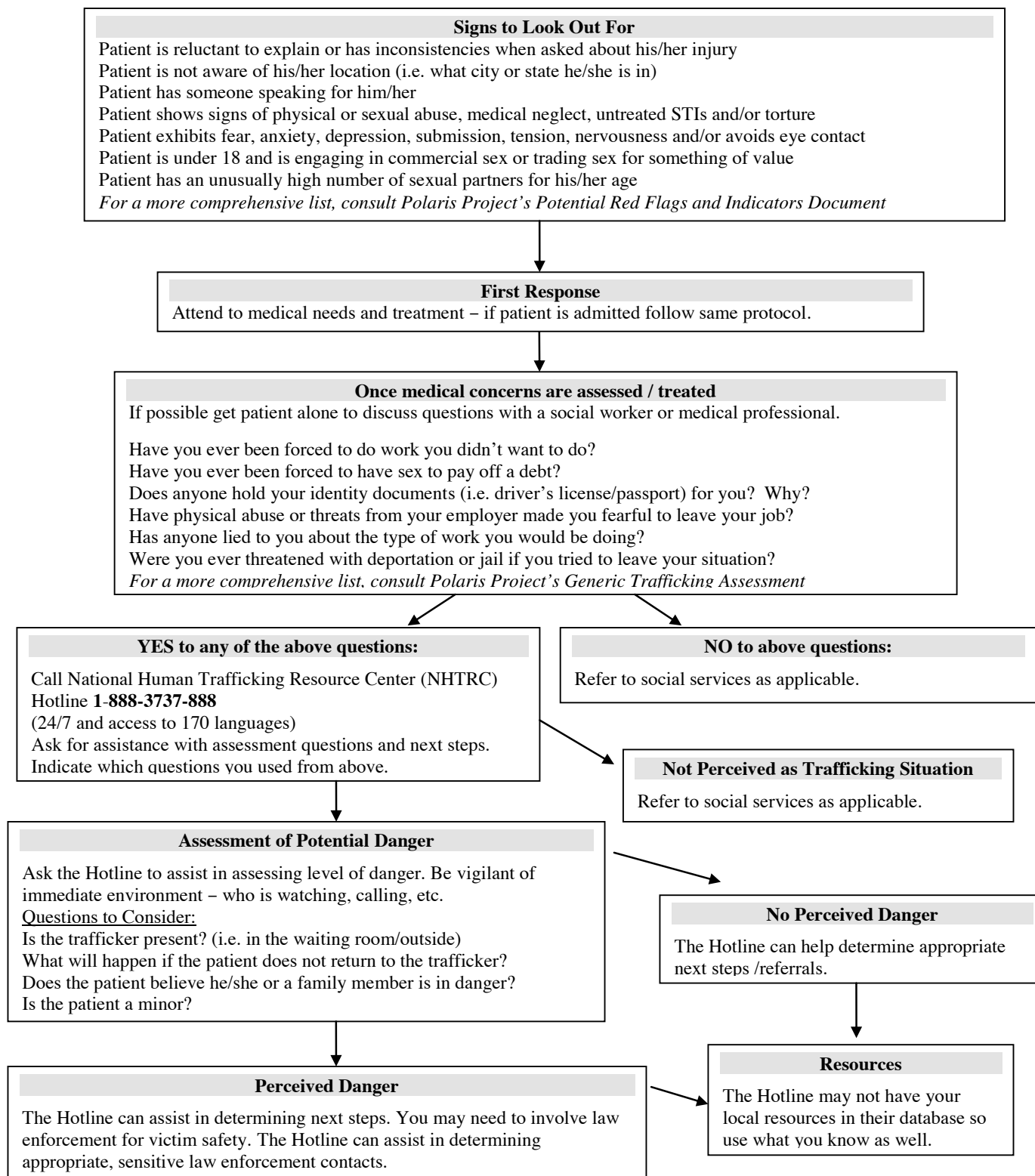
- "Human Trafficking in Rural Communities", online training video²³
- "Medical Assessment Tool" by Polaris Project, (found on page 10)²⁴
- "Identifying Victims of Human Trafficking: What to Look for During a Medical Exam/Consultation"; by Polaris Project; available for download.²⁵
- "Federal Strategic Action Plan on Services for Victims of Human Trafficking in the United States", available for download²⁶
- SOAR to Health & Wellness Training for Human Trafficking²⁷
- "Recognizing and Responding to Human Trafficking in a Healthcare Context" by Polaris Project; online training video²⁸
- Rescue & Restore Tool Kits (Look Beneath the Surface), videos and print materials available²⁹
- National Center for Missing & Exploited Children Fact Sheets³⁰
- National Human Trafficking Resource Center Hotline; 1-888-3737-888³¹

Human Trafficking is an enormous, complex issue not to be solved by any one person, organization, agency, government or country. But we cannot afford to become complacent, overwhelmed or discouraged by the task at hand. We must commit and fight for those who are unable to fight for themselves. To advocate for the voiceless. To bring justice on behalf of the victims. We must all choose to do something rather than nothing. □

- 1) 2014 Global Slavery Index; report by the Walk Free Foundation; <http://www.globalslaveryindex.org/>, accessed 2/28/2015
- 2) "The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities"; Laura J. Lederer and Christopher A. Wetzel; *The Annals of Health Law*; (2014) Vol. 23: Issue 1; (Available for download at <http://traffickingresourcecenter.org/sites/default/files/The-Health-Consequences-of-Sex-Trafficking%20-.pdf>) accessed 3/1/2015
- 3) Profits and Poverty: The Economics of Forced Labour; International Labour Office; Geneva, Switzerland; 2014 http://www.ilo.org/wcmsp5/groups/public/---ed_norm/---declaration/documents/publication/wcms_243391.pdf, accessed 2/28/2015
- 4) Stable is the street-term used to describe the group of victims who work for a particular pimp/trafficker. Brewer, Anna; *Human Trafficking 101*; Training on July 30, 2013; Northeast Community College; Norfolk, Nebraska.
- 5) National Human Trafficking Resource Center Hotline Statistics; <http://traffickingresourcecenter.org/states>; <http://traffickingresourcecenter.org/state/nebraska>; accessed 2/28/2015; A full report of the 2007-12 trends can be downloaded at <http://traffickingresourcecenter.org/sites/default/files/Human%20Trafficking%20Trends%20in%20the%20US%2007-2012.pdf>
- 6) July 9, 2013 Report submitted by the Governor's Task Force on Human Trafficking <http://www.ncc.nebraska.gov/pdf/others/2013HumanTraffickingReport.pdf>, accessed 2/28/2015
- 7) "Passion for Freedom: Kill me, or let me go"; Natasha Rausch; *Norfolk Daily News*; *Norfolk Daily News*; August 11, 2014
- 8) "Jessica"; Panel Discussion; UNL Human Trafficking Summit; April 22, 2013
- 9) Riskowski, Al; Nebraska Family Alliance; Presentation on Human Trafficking; Evangelical Free Church; Norfolk NE; October 23, 2013
- 10) Personal Interview conducted on January 11, 2015; Lincoln, NE
- 11) "Black Market Baby Finds Mother After 25 Years"; Elizabeth Anna Valla; *Columbus Telegram*, October 16, 2014; <http://columbustelegram.com/news/>

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Medical Assessment Tool | Polaris Project



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Trafficking in Rural Nebraska *(continued)*

- local/black-market-baby-finds-mother-after-years/article_d6463b6f-c4db-5f38-86e2-5ad4f93fb32.html
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The Reality of Human Trafficking in Nebraska *(continued)*

commodity is simply reprehensible and deserves our united indignation and significant response in eradicating this crime and protecting and restoring its victims.

One former victim tells of the night that her perpetrator asked her trafficker, "What is her name?" Her trafficker said, "She doesn't have a name."

In our state, each one of our citizens has a name, a uniquely given and called name and we should join our voices in calling out their names, calling them out of being traded like property, used like a commodity and harmed by strangers.

Please join me in caring deeply for those who may be vulnerable and abused. Please engage in a new way of educating

yourself and knowing more today and tomorrow than you might have about this tragedy of trafficking.

A Sampling of Nebraska Resources:

- Wellspring Program: (402) 898-5900
- The Women's Center for Advancement: (402) 345-6555
- Heartland Family Service: 402-553-3000
- I've Got a Name: <http://ivegotaname.com/contact/>
- Christ Community Church: 402.330.3360
- Nebraska Alliance of Child Advocacy Centers: 402.650.5883

<http://www.nebraskacacs.com> □

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- 5) <http://www.cmda.org/resources/publication/human-trafficking-continuing-education>
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Human Trafficking: The Who, What and Then What?

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Imagine that a patient with chest pain from myocardial infarction presents to an emergency room. However, the responding clinician has never heard of a heart attack, nor a STEMI, and does not know what questions to ask, what diagnostic tests to order, nor what treatment plan to offer. It seems ludicrous to consider the possibility that an emergency medicine clinician went through years of training without learning an approach to a patient with chest pain. Arguably human trafficking is as grave as a heart attack; and yet, health providers receive no standardized training in its recognition or care.

Human trafficking victims are slipping through our doors unrecognized. The other articles in this edition review how to identify a victim of trafficking and how to connect them with the resources they need. Remember, in addition to being a resource for victims, the National Human Trafficking Resource Center is available 24-7 to answer health professional questions on trafficking: 1 (888) 373-7888.

As an emergency medicine physician, I see the care for trafficking persons in the United States health care system as ad hoc. It is time for this to change and the critical piece in this "pre-awareness" stage is educating our clinical workforce.

There are three important points that

must be considered in educating our health workforce nationally about human trafficking. The considerations are 1. Who? 2. What? 3. Then what?

The existing research on human trafficking has shown us that up to 88% of human trafficking survivors interface with health care, that they present to a range of health care settings, and suffer from a myriad of mental and physical health problems. Yet, most health providers are not aware of the presence human trafficking victims within their clinics, emergency departments, and hospitals.

Who? First, the full gamut of health providers must be trained. As patients, survivors will interact with a variety of clinicians throughout their care. These include emergency medical service providers, physicians, advanced practice clinicians, nurses, dentists, psychologists, counselors, and clinical social workers, across various medical specialties. We need to ensure that this training is integrated at the initial health professional training as well as certification and re-certification stages. For example, emergency physicians, such as myself, should be trained in human trafficking victim care while in medical school, and this training should be reinforced through subsequent medical licensing exams and board certification processes.

What? Secondly, the cornerstone of trainings should be an evidence-based, trauma-informed approach. Survivors of trafficking are living in a reality of complex trauma, yet health providers often have no specific training in a trauma-informed approach. Our health settings see survivors of violence across

the lifespan, including child abuse, sexual abuse, intimate partner violence, gang violence, elder abuse, and human trafficking. Many patients are victims of one or more types violence, but without trauma-informed training, well-meaning clinicians and clinics may inadvertently re-traumatize these survivors, missing critical opportunities for intervention. To properly care for this population, the development of trainings and identification- and treatment-protocols must be based on evidence; to that end, research aimed at expanding our knowledge-base is also imperative.

Then what? Third, we need more resources for survivor referral. Survivor care does not end the point of identification, but involves a long-term healing process. Training health providers in victim identification and care must be done in concert with enhancing options for referral. The current state of referral options for survivors of trafficking, especially male and labor trafficking survivors, is inadequate. When we train medical providers, more victims will be identified, and there will be an increased demand for survivor services. We need a robust network of resources including long-term mental health provision, housing, and legal services to care for survivors of trafficking after their initial interface with health care. The clinician's voice is integral in advocating for these survivor resources.

Furthermore, we must enhance our evidence base on human trafficking and health, including our understanding of less understood populations of adult, male, transgender and labor trafficking

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Human Trafficking: The Who, What and Then What?

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victims. We must study the impact of health care protocols and educational tools for this vulnerable population, ensuring our approach is evidence based and impactful.

Health providers are on the frontlines of human trafficking victim identification and care, but without empowering clinicians with awareness of the problem or an action plan, victims of trafficking will continue to go through our health facility doors undetected.

In summary, who should we train? We must train all health care providers. What should every training include? All providers must be trained in a trauma-informed approach. Where will providers refer victims? We need to galvanize, increase and improve referral resources for survivors, as current options for referral are quite limited.

I am an emergency physician at Brigham and Women's Hospital and faculty at the Harvard Medical School, as well as co-founder of the international organization, HEAL (Health, Education, Advocacy, and Linkages) Trafficking. HEAL Trafficking was founded in the fall of 2013 and our vision is a world healed of trafficking. HEAL unifies and mobilizes interdisciplinary professionals combating human trafficking through a

health care lens and serves as a centralized resource on health for the broader anti-trafficking community. Our working groups tackle issues at the crux of health and trafficking, including Education and Training, Protocols, Research, Direct Service, Prevention, Advocacy, Media and Technology, Legal, and International Linkages. You can learn more at our website, HEALtrafficking.org.

The opinions and conclusions expressed in this article are the author's alone and should not be interpreted as representing those of Brigham and Women's Hospital or Harvard Medical School. □

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Recognizing and Screening for Victims of Human Trafficking: A Foreign Concept in Health Care

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A misconception concerning human trafficking is that it occurs in foreign countries, distant shores, and in large metropolitan cities. However, the reality of human trafficking is that it is present in every state, large metropolitan city, medium size town, and small, rural community across the United States (Belles, 2012). Human trafficking assessment is a term and concept foreign to health care professionals at all levels of practice. The importance of identifying telltale signs of human trafficking is just beginning to break the surface in the health care sector in addition to understanding the significance human trafficking assessments have for the victim (CdeBaca, 2014). Never before has health care been asked to embark upon a mission of assessing for red flags of human trafficking victims until now (Isaac, 2011, March 15). The growing understanding and awareness about the plight of human trafficking victims is just beginning to be addressed at all levels of health care professions. Health care providers especially, are in a unique position to perform screening assessments on patients who they suspect to be victims (Tracy & Konstantopoulos, 2012). Before providers can identify possible victims,

they need the tools to identify what the red flags are when assessing these patients. Providers need to know what to look for, what kinds of questions to ask when human trafficking is suspected, and what resources to contact in order to ensure their patient's safety (Belles, 2012; Straker, 2012). The provider-patient encounter may be a missed opportunity if providers are untrained in warning signs and symptoms of human trafficking, and sadly this may be the only opportunity the victim has for disclosing their story of human slavery in the 21st century (Wilkie, February, 2011; Belles, 2012).

Recognizing and Screening for Victims of Human Trafficking: A Foreign Concept in Health Care

As stated earlier in this issue, human trafficking is defined by the 2014 United Nations Office of Drugs and Crimes as: The recruitment, transportation, transfer, harbouring 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 of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs (Article 3, para (a) of *Protocol to Prevent, Suppress and Punish Trafficking in Persons*, United Nations Office on Drugs and Crimes, 2014).

Types of human trafficking most commonly seen are sex and labor trafficking or a combination of both. This involves men, women and children, with women, children and sex trafficking compiling the largest group of victims. Human trafficking is victimization at many levels. It is a global public health problem. Trafficking can be international or domestic (home grown). The United States is one of the largest markets and destination locations for victims of trafficking, followed by Asia, Latin America, Eastern Europe and Africa. Every year there are over 27 million victims of trafficking with greater than five million being girls and women who are bought and sold for sexual exploitation, slavery, and mail order brides. They suffer unspeakable human rights violations as commodities of trade. Statistics show 80% of sexually exploited victims are women and children; 17% are trafficked for forced labor in the agricultural arena, garment industry, restaurants, construction, hospitals, and home care. Human trafficking brings in an annual income of \$150 billion dollars, second only to weapons and drug deals (Warria, March, 2010; Polaris Project, 2014). The cost that a trafficker spends to procure a single victim usually averages \$90, and then sells the victim for many times that. When a person becomes a victim of trafficking there is a 1:100 chance of rescue and the life expectancy of a child victim is seven years (Polaris Project 2014).

Traffickers are creative and take advantage of many situations that health care providers are not aware of, such as natural or man made disasters, armed

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Recognizing and Screening for Victims of Human Trafficking: A Foreign Concept in Health Care *(continued)*

conflicts, when parents and children become separated, and at large sporting events such as the Super Bowl, World Series, World Cup Soccer, and yes even the Olympic Games (United States, 2014). They are now even using fabricated orphanages to buy, sell and transport children. So for clients who are using “newly formed” orphanages as their choice for adoption, make sure it is a long-standing and trusted facility. Many other creative methods traffickers use include the promise of a *better life*, which is often used with parents who live in poverty and \$90 can mean a year’s worth of food for their family, so parents give up a child to the trafficker thinking at least one of their children will have a better life. Promises of a fabulous modelling career, college degree so they can send money back home to their family, singing career, and nice clothes are just some of the ploys used to disguise trafficking. With promises like these, many unknown victims go willingly, only to end up in a nightmare that never stops. Victims are seen as a commodity that can be sold over and over with immense profit. Many traffickers have turned to becoming brokers for organ sales. A broker pays \$250 to a victim to donate a kidney, which on the black market brings upwards of \$500,000. However, many donors aren’t as lucky as others, especially when there is a heart or liver that is taken. Organ broking occurs in all countries and with all ages. In fact some countries are specifically selling live infants for spare parts (Epstein, 2013; Iturbe, 2008).

Over 300,000 American children are victims of trafficking annually. The Na-

tional Center for Missing and Exploited Children (NCMEC) states that 98.8% of children on the missing or runaway list from 2004-2010 are *confirmed* victims of human trafficking (Polaris Project, 2010). Gangs in the U.S. are active in using the social network for identifying potential victims (Betz, 2012; FBI, 2012). This is why it is so important to become educated on the topic of human trafficking; this could be a child any provider may see at any given time (Abu-Ali & Al-Bahar, 2011; Miller, 2011, March 15).

Assessment screening tools for health care providers at all levels should be conducted while the patient is alone; traffickers or handlers of a trafficker normally accompany their victims to clinics or hospitals. They may identify themselves as a family member, friend, or interpreter. Interviewing and assessing a suspected victim alone can be accomplished by saying it is hospital policy or confidentiality policy that patients must be alone with their health care provider during the assessment. Never directly confront a suspected trafficker or handler for your own safety and the safety of your patient (Belles, 2012). Red flags to watch for are:

- 1) Is the patient allowed to answer your questions?
- 2) Is the patient in charge of his or her own documents (passport, ID, etc)?
- 3) Does the patient know what city, state, or town they are in?
- 4) Does the patient make eye contact?
- 5) Have you seen this patient repeatedly for treatment of STIs or requested pregnancy terminations?
- 6) Can the patient state their home address and if there are locks on their

windows/doors to prevent them from leaving?

- 7) Are there unusual scars on the patient (organ donations, beatings, etc.)
- 8) Are there unusual tattoos or brandings that would signify who owns them (Thomas, 2011; Belles, 2012; Polaris Project, 2011; Polaris Project, 2014; Barrows, 2008, May).

Questions of this type can be a starting point. For more specific questions and assessment tools please query *DCF Human Trafficking Tool Kit* on your search engine. This is a wonderful assessment tool developed by an APRN for the Department of Juvenile Justice. There are also many useful tools for health care professionals on the Polaris Project web site at the following

www.polarisproject.org. Additional helpful resources are:

- http://www.acf.hhs.gov/sites/default/files/ort/traffickingservices_0.pdf
- <http://traffickingresourcecenter.org/resources/recognizing-and-responding-human-trafficking-healthcare-context>
- <http://www.traffickingresourcecenter.org/state/nebraska>, which has Nebraska’s statistics on human trafficking.

Also on the Polaris web site you can find states that have laws on human trafficking.

Remember, if you suspect a patient to be the victim of human trafficking the patient may be unwilling to report for various reasons; they may not know there is a word for what is happening to them, threats of harm to their families if they disclose, and fear of harm to themselves

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Recognizing and Screening for Victims of Human Trafficking: A Foreign Concept in Health Care *(continued)*

by their trafficker (Adams, 2012; Belles, 2012; Betz, 2012; Canadian Nurse, 2011; Patel, 2011; NIJ 2014; Patel et al, 2010; Polaris, 2010, 2014; nursetogether.com, nd; Sabella, 2011; DOJ, 2014; DOS, 2014).

The best thing to do is make a safety plan with the patient until they are willing to report. Contact the local law enforcement with your suspicions and this is where the link can become broken because many law enforcement agencies have yet to become educated about human trafficking just like many other service providers, including all levels of health care (Eastern Missouri & Restore Consortium, nd). Service providers may not understand your concern (Adams, 2012; Belles, 2012; Betz, 2012). So contact the *National Human Trafficking Resource Center Hotline 1-888-373-7888* and they will direct you with more specifics of how to proceed.

Health care providers should also inquire at the facility where they work to see if a specific human trafficking policy and procedure is on file; in most facilities this is non-existent and badly needed. Also find out what your facility is doing to educate health care providers on identifying victims of human trafficking. Please do not let a missed opportunity for help happen to victims of human trafficking. □

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The Mystery of Return: Why some trafficked survivors go back

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Human trafficking

The term human trafficking is relatively new, introduced in this century to define modern day slavery. By now most of us have some awareness, albeit vague, about this travesty ensnaring an estimated 27 million. According to The National Human Trafficking Resource Center, trafficking of persons has now exceeded weapons and drugs as the most lucrative business globally generating an estimated 32 billion dollars annually, half coming from industrialized countries. There are several varying definitions of human trafficking, as codified by the United Nations, the U.S. federal government and most state governments. Since the definition of trafficking is addressed in a previous article, I will not delve into that here. All definitions refer to the *use of force, fraud or coercion* for the purpose of commercial exploitation of another. Although human trafficking can be for sex, labor or harvesting of human organs, I will focus on sex trafficking.

Before “human trafficking”

In the mid-late 1970s, I had the privilege of working in a juvenile justice system as a probation officer and State Youth Authority Representative. It was then that I worked with teens classified as delinquents, that is, they committed offenses which would be crimes for adults. A number of teen girls, often runaways, were charged with prostitution. As such, they were referred to as “prostitutes” or worse. It was commonly accepted that these girls, typically runaways but in reality “throw-

aways,” were prostituting as a matter of personal choice. They were often viewed with pity, disdain and/or ridicule; marginalized in the male dominated systems of justice and corrections. However, as defined today, these delinquents, “bad girls,” would now be considered victims by their status as minors—even if they willfully participated.

Later in the 1980s, I served as the director of a group home for pregnant and parenting young women, ranging from age 11 to 22. Several of these young ladies had various experiences with prostitution resulting in pregnancy. Typically a family member, even a mother, boyfriend or husband, benefitted from the prostitution of these young women. One eleven-year-old mother had both a mother and grandmother involved in prostitution. For her, getting to “have sex with her older boyfriend” was a reward for good behavior. Another older teen’s boyfriend arranged “dates” for her as a fast way to earn money so they could get married and have their dream home. Still another young woman in the early twenties told me that her husband had her prostituting, walking the streets. Tragically, he had convinced her, verbally or otherwise, that if she loved him, she would “turn tricks” to support them. While this concept was foreign and abhorrent to me she defended him, stating that he demonstrated his love by giving her a cell phone so she could call him if things went bad. Why would a victim of trafficking consider this as an act of love? I pondered why someone who was in reality a perpetrator, a trafficker—typically controlling, abusive and perhaps even brutal—was viewed so differently by the very person being repeatedly “sold”

and exploited.

In 1993, I realized a childhood dream of traveling to Africa, Nigeria to be precise, with medical doctors and nurses on a short-term medical mission trip. That was my first foray into international humanitarian work, which has become a personal passion. Over the years, I have traveled to over 20 countries working in various venues, often with women who have been traumatized by violence, poverty, sexual exploitation and trafficking. Many were victims of human trafficking, although that specific vernacular did not come to prominence until 2000 when President George W. Bush spearheaded the legislation aimed to address international trafficking to the U.S. I will not focus here on my international experiences, but rather on the domestic human trafficking that is endemic in our country. While we might expect such occurrences in countries wrought by economic instability, violence and abject poverty, many of my contemporaries have a hard time acknowledging the realities of trafficking in the U.S.

Human Trafficking Defined and Codified

“The **Trafficking Victims Protection Act (TVPA) of 2000** was the first comprehensive federal law to address trafficking in persons. The law provides a three-pronged approach that includes prevention, protection, and prosecution; targeting international trafficking. The TVPA was reauthorized through the Trafficking Victims Protection Reauthorization Act (TVPRA) of 2003, 2005,

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The Mystery of Return: Why some trafficked survivors go back *(continued)*

2008, and 2013.” [The National Human Trafficking Resource Center]. The first legislation focused specifically on people who were trafficked from one country to another to be used for commercial sex and/or labor. However, as victim services developed, it became profoundly clear that domestic trafficking was, in fact, a bigger national problem. That realization led to broadening the target population to include all trafficked persons, foreign or domestic, in subsequent reauthorizations of TVPRA legislation.

The Challenges of Fighting Human Trafficking

There are numerous factors and challenges involved with addressing human trafficking: the demand/supply equation, profitability and poverty, sophisticated multinational and interstate organized crime, use of the internet, legal and jurisdictional issues, coordination of interstate/federal law enforcement, coordination and lack of victim services, cultural/language barriers, a woeful lack of data or system for collecting data on trafficking--the list goes on and on. But, for the purposes of this article, I will focus on the challenge of engaging and successfully treating those who have been rescued from or escaped prostitution and/or survived sex trafficking.

As the chief administrator of social services operated by The Salvation Army, I have the privilege of overseeing a broad array of programs addressing human needs. One of those programs is the Wellspring program, which was conceived in the 1980s by local citizens with a heart for those entrapped by prostitution. Other programs include housing for homeless individuals and families, behavioral health services, older adult and family services. In

these diverse programs I have seen a common thread of vulnerable, marginalized youth and adults who have been ensnared in an ugly underbelly of our civic society. While we may live in the same state, their worlds have been light years away from mine.

Through our Wellspring program, we work with women, men and occasionally transgender individuals who have all been involved in prostitution. Our staff is specifically trained in providing “trauma informed care,” also referred to as “trauma sensitive” as well as trained in treating co-occurring symptoms. We provide case management, support, advocacy, therapy, and material assistance to survivors of trafficking and have met with varying degrees of success. Because of the insidious nature of the dark subculture of the sex industry, our goals are built on small, incremental behavioral changes. For some, that may be keeping an appointment or asking for help in accessing services. Over the years, there have been profound, inspiring examples of restoration and healing. Those who were trapped in the nightmare of prostitution and addiction have gone on to complete their educations, reunite with family, marry and even graduate with college degrees. For others, success may be not engaging in prostitution and maintaining sobriety. A unique aspect of Wellspring is the strong bonds participants form with each other. The peer support group is a key component of treatment. Some have even gone on to form a “thrivers” group; they see themselves beyond just surviving but living lives they never thought possible.

In spite of caring, credentialed professionals trained in “trauma informed care”

utilizing a holistic, nurturing approach, there are some who relapse and return to their trafficker or back into a similar lifestyle. This is a difficult reality for service providers who expend themselves on behalf of trafficked persons and are invested in their freedom.

Overwhelmingly, our Wellspring participants have histories of early and ongoing sexual abuse, family dysfunction/disintegration, substance addiction and undiagnosed/untreated mental illness. While often they deny that they were victims of trafficking, according to self-report, an estimated 80% or more have been under the control of a pimp at some point. Generally when they came into the program they have experienced numerous incarcerations, loss of custody of children and breakdown of support systems. Although Wellspring provides professional counseling, nurturing, safety, peer support and a multitude of other services while being “open ended,” some choose to return to their trafficker and/or destructive lifestyle. They are always welcome to return. Frequently, staff report that those in the program may relapse and disappear - sometimes coming back months and years later. The focus of the remainder of this article will delve into this dilemma. If a trafficked person is “rescued” or has left the control of the trafficker, why would they return to that person or situation? The answer to this question is complex, varied and enigmatic.

Why do they return?

For those of us who work with victims or survivors (as many prefer to be called) of sex trafficking, a source of bewilderment and frustration accompanies our

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The Mystery of Return:

Why some trafficked survivors go back (continued)

best efforts. Why, after months of making progress in a safe, secure environment with basic needs, social supports and proper treatment, would someone leave and return to the “streets” or a trafficker? For some, the pull of a substance addiction and need to use drives them back. Others may miss the danger and hyper vigilant state of arousal. I have heard some say that the daily routine of “normal” life did not have the thrill. Often trafficking survivors have Post Traumatic Stress Disorder similar to military personnel who have experienced combat duty. Still others find it difficult to gain employment, housing and basic assistance because of past criminal history. The lack of ability to secure a livelihood through legal means may be insurmountable; only the very determined and fortified survivor can press forward through the multitude of barriers they face in society.

There is another powerful factor which often thwarts and intercepts the recovery process for survivors of sex trafficking. Initially, once trafficked, victims often go through a “breaking” or conditioning process which includes isolation, deprivation, beatings, rape, forced drug use, etc. “Thereafter, captivity, which brings the victim into prolonged contact with the perpetrator, creates a special type of relationship, one of coercive control. The goal of the perpetrator is to instill in his victim not only fear of death but also gratitude for being allowed to live.” [Judith Herman, *Trauma and Recovery*, 1992]

It is a phenomenon referred to as “traumatic bonding.” One common definition of traumatic bonding is: “a strong emotional attachment between an abused person and his or her abuser, formed as a

result of the cycle of violence.” [Wendy Austin; Mary Ann Boyd. *Psychiatric and Mental Health Nursing for Canadian Practice*, 2010]. There is a wealth of study and professional writings surrounding this condition including the work of Dr. Patrick Carnes who developed the term to describe “the misuse of fear, excitement, sexual feelings, and sexual physiology to entangle another person.” [Patrick Carnes, Ph.D., *The Betrayal Bond: Breaking Free of Exploitive Relationships*, 2010]. Traumatic bonding has been long acknowledged in situations of domestic violence. Thus, domestic violence treatment models have often been successfully applied to treating

survivors of trafficking. For those working with survivors of trafficking, they would do well to understand the power of traumatic bonding.

One schema which I have referred to often is *Biderman's Chart of Coercion*. This tool was developed to explain the methods used to break the will or brainwash a prisoner of war. Domestic violence experts believe that batterers use these same techniques. More recently, it has also helped explain the relationship between a trafficker and his/her victim.

Refer to the chart below.

[https://niastories.files.wordpress.com/.../bidermans_chart_of_coercion.pdf]

BIDERMAN'S CHART OF COERCION

General Method	Effects and Purposes
Isolation	Deprives victim of all social support (for the) ability to resist Allows victim to be present at all times to keep home environment stable and non-threatening Makes victim dependent upon abuser
Control or Distortion	Fixes attention upon immediate predicament; fosters introspection Eliminates information that is not in agreement with the abuser's message Punishes actions or responses that demonstrate independence or resistance Abuser manipulates by being charming, seductive, etc., to get what is wanted from victim and becomes hostile when demands are not met
Humiliation or Degradation	Wakens mental and physical ability to resist Heightens feelings of incompetence Induces mental and physical exhaustion
Threats	Creates anxiety and despair Outlines abuser's expectations and consequences for noncompliance
Demonstrating Omnipotence or Superiority or Power	Demonstrates to victim that resistance is futile
Enforcing Trivial Demands	Demands are often trivial, contradictory and non-achievable Reinforces who has power and control
Exhaustion	The abuser uses sleep deprivation to keep victim in a state of confusion
Occasional Indulgences	Provides positive motivation for conforming to abuser's demands Victim works to “earn” these indulgences in an effort to increase self esteem

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Human Trafficking in Nepal and Our Fight to End It

by Michael O'Hara, MD
Board chair of Tiny Hands International
Internist at Providence Portland Medical
Center in Portland Oregon

We landed in Kathmandu on a warm September day in 2002. There were five of us—young and enthusiastic recent college graduates who decided to travel together to Nepal for six months. We didn't know exactly why we were going, but we knew we wanted to volunteer, and we knew we wanted to trek deep into the Himalayas.



When we arrived, we were immediately struck by the plight of children living and working on the streets of Kathmandu. Their struggle was apparent, impossible to ignore. Suddenly, we were conscious of a reality we had never fully known or experienced. We wanted to do something in response. A year later we raised enough money back in the states to start Peace Children's Home with a Nepali couple willing to serve as house parents. Two years later a new non-profit, Tiny Hands International, was born.

While we had heard of human trafficking in our early years in Nepal, it wasn't until 2006 that we began to learn more about the horrifying reality that Nepali girls faced. Thousands of them were trafficked annually south across the border to the large urban cities of New Delhi, Kolkata, and Mumbai. Unlike the struggle of street children, which is hard to ignore when walking the streets of Kathmandu, there is no easy way to "experience" the reality of human trafficking. It is a hidden, hideous reality that is gain-

ing worldwide notoriety at the same time as the vile industry is gaining worldwide momentum.

Like most people who first hear the grisly details of human trafficking, we were angry. The idea of children being sold into lives of sexual slavery is appalling. Similar to our enlightenment about street children, we were suddenly conscious of an industry described by many as one of the greatest injustices of our day. It seemed obvious to join the fight, and as members of an organization working in Nepal and able to raise funds, we were well positioned to do so. Tiny Hands International president John Molineux suggested that we begin work at the India-Nepal border where several, albeit not enough, organizations were working to stop traffickers before they brought their unknowing victims across into India. Later in 2006, we opened our first border monitoring station in Janakpur, Nepal.

Nepal is primarily considered a source country for human trafficking, meaning that victims are taken from Nepal and trafficked to other countries. The most prominent and well-documented form of trafficking from Nepal is sex trafficking; traffickers take victims by force, fraud, or coercion and sell them into brothels or other forms of sexually exploitative situations. India and the countries on the Persian Gulf are the primary *destination* countries on the other side of the transaction.

A typical story goes something like this: a newcomer visits an impoverished, mountainous village in Nepal. He approaches a 14-year-old girl (some are as

young as 7); she's from a poor family. He has money, nice clothes, and he tells stories about the wonderful opportunities that abound across the border. He offers the family an opportunity they can't pass up—he'll bring their daughter to Mumbai to have her work for his friend. She'll escape the cycle of poverty, and they'll have one less dowry to pay. It's a win-win ... at least until she arrives in Mumbai when a brothel owner gives her the crushing news—she has been sold and must work until she pays off her "debt." She may initially refuse to do the work they demand, but she eventually gives in. Girls are often subject to beatings, gang rape, and have their families threatened to bring about compliance. They are locked inside or held in cages until they are no longer a flight risk.

Eventually this young girl will be required to serve 30-40 clients a night. The repeated trauma slowly kills her physically and emotionally. After years of enslavement she learns that she has contracted HIV and is tossed out by her captor. Her only option is to return to her poor Nepali village, where she is ostracized by friends and family for what has happened to her. This is an all-too-common story for Nepali (and Bangladeshi, Burmese, Thai, Vietnamese, Indian, etc.) girls.

While human trafficking estimates are notoriously unreliable, the number of women and girls trafficked from Nepal to India and other countries is thought to be somewhere between 10,000-20,000 a year. As a result, an estimated 100,000-200,000 trafficking victims, mostly woman and children, are held in India today¹.

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Human Trafficking in Nepal and Our Fight to End It *(continued)*

Whether along the I-80 corridor, on 82nd Street here in Portland, Oregon, or along the trafficking routes from Nepal to India, human trafficking has many commonalities. Traffickers target the young, uneducated, naive, and innocent. They sell a story of hope, leverage their deception to gain control, and then maintain control through threats or acts of violence.

The majority of the worldwide anti-trafficking work can roughly be divided into pre-trafficking interventions (e.g. awareness and poverty alleviation) and post-trafficking interventions (e.g. rescue and rehabilitation). In Nepal, Tiny Hands has helped develop a transit-monitoring model, in which trained staff, strategically placed at high-traffic transit points, are trained to identify and disrupt trafficking as it occurs. Data gathered from suspected trafficking victims are analyzed and used to inform an intelligence-led investigation strategy, which targets the organized crime rings that perpetuate trafficking. Since 2009, through a learn-as-you-go development process, Tiny Hands has intercepted over 8,000 suspected trafficking victims. We've since expanded this model to northern India and Bangladesh, and are planning on initiating work in Thailand in the next year.

In medicine, the amount of published research outpaces the most committed clinician's ability to keep up. Conversely, the government and non-governmental organizations involved in anti-trafficking work are only beginning to collect, analyze, and disseminate information to further our collective understanding of the trafficking industry and how best to fight it. Opportunities for innovation abound.


As one of the five college graduates who stepped off the plane in Nepal in 2002, I had no idea where the journey on which we were embarking would lead. While it's a start, organizations like Tiny Hands are still losing the battle for the lives of women and children who are desperate to escape the cycle of poverty in the rural developing world. Nevertheless, the darkness that long-concealed the realities of human trafficking is lifting. More and more organizations and individuals have had their awakening and are joining the fight. □


1) Mukherji KK, Muherjee S. Girls and women in prostitution in India. Department of Women and Child Development, New Delhi, India; 2007.

The Mystery of Return: *(continued)*

In working with trafficked survivors, I have found this chart helpful as I have been challenged to break down barriers and build relationships leading to healing and wholeness. I have also included this schema as I have conducted training for both law enforcement and service providers. It provides a context for understanding the complexities of trafficking, especially in prolonged relationships. Understanding the inherent coercive nature and attachment issues is critical to effectively serve survivors as they disentangle themselves and move toward lasting freedom. For readers who treat survivors of trafficking, I would encourage further study on this topic. □

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Bond Investing-Proceed with Caution

by Ross Polking

Provided by the Foster Group

The landscape of the bond market has undergone massive changes over the years. What was once a plain-vanilla way to create steady income is now replete with variety as well as risk.

First, the basics. Bonds are a form of debt, a loan to a borrower with the promise of future payback of the loan amount, plus interest. The credit-worthiness of the borrower and the amount of time until the loan is repaid directly impact the interest rate offered. The more risk you accept when loaning your money, the higher the interest rate should be as compensation.

Prevailing interest rates affect bond prices, and they are inversely related. Rising interest rates cause bond prices to fall as new bonds, issued at the higher rate, cause bonds with lower rates to be less valuable. A bond held until maturity will return its initial investment amount provided the issuer doesn't default. If you need to sell your bond prior to maturity, though, you may get back less (or more) than your original investment.

Bond mutual funds function a bit differently than individual bonds. Bond funds do not have a specific maturity date and they invest across a variety, sometimes hundreds or even thousands, of individual bonds. For the individual investor, building a diversified portfolio of individual bonds can be difficult and expensive. Bond funds provide an efficient way to achieve broad, inexpensive diversification.

For many investors, bonds are an important portfolio component. Low interest rates over the past few years have sent many investors on a quest for higher yield and the acceptance, sometimes unwittingly, of significantly more risk. Consider these principles as you review your bond strategy in this low-interest environment:

How Markets Work

Current bond values reflect everything the market knows and anticipates about economic conditions, inflation, and monetary policy.

Have a Plan

Understand the overall portfolio allocation (equities vs. bonds) that's appropriate for you. Don't confuse the distinct roles stocks and bonds play in your investment strategy.

Know What You Own

Be educated about your portfolio, especially if an advisor manages your assets. Don't assume your plan and their philosophy align - verify.

Risk vs. Reward

There are two primary ways to potentially increase bond returns: lengthen maturity and reduce credit quality. Pursuing higher income generally means accepting more risk, increasing the likelihood of losing value if interest rates rise or the issuer defaulting.

Don't ignore costs

Investment costs can be large relative to a bond portfolio's return; minimizing these costs is critical.

Diversify

A broadly-diversified portfolio of bonds issued by governments and companies around the world reduces risk.

Summary

Many investors have anticipated an upward interest rate move for several years. Those seeking higher yields should understand the elevated risks. Your best solution remains the same: establish your plan...seek needed return primarily from equities...use bond funds to dampen volatility of your overall investment strategy...and stay diversified.

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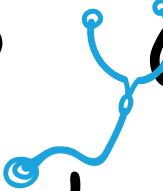
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