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Research article

Systematic review of facilitators of, barriers to, and recommendations for healthcare services for child survivors of human trafficking globally

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ABSTRACT

Background: Child trafficking is associated with multiple physical and mental health problems, yet relatively little is known about the factors that facilitate or hamper delivery of high-quality health care services to trafficked children.
Objective: To summarize information about identified facilitators of, barriers to, and recommendations for medical and mental health service provision to trafficked children.
Participants and setting: A systematic review was conducted of the English-language, peer-reviewed literature on medical and mental healthcare of trafficked children published since 2010.
Methods: Inclusion criteria were: (1) the study population or focus included, wholly or in part, individuals under the age of 18 years; (2) the study focus was clearly defined as human trafficking or commercial sexual exploitation; (3) a main focus included health services or barriers to care, and (4) the article contained original data.
Results: Of the 29 articles meeting inclusion criteria, 19 included facilitators of health service provision to trafficked populations, 22 included barriers to that provision, and 25 included explicit recommendations for service improvement. 45 distinct facilitators were identified a total of 140 times, 118 distinct barriers were identified a total of 174 times, and 52 distinct recommendations were identified a total of 100 times. The majority of facilitators, barriers, and recommendations fell under the locus of the healthcare provider and healthcare organization.
Conclusions: Existing research reveals abundant areas of opportunity for healthcare professionals and healthcare administrators to improve access to, and quality of, medical and mental health care for trafficked children.

What is Known on this Subject

Human trafficking is associated with myriad adverse health consequences and trafficked persons have varied ability to access medical and mental health care worldwide. There is limited knowledge regarding the facilitators of and barriers to healthcare access

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for this vulnerable population.

What This Study Adds

This systematic review describes identified facilitators of and barriers to healthcare for trafficked children worldwide and discusses recommendations for improvement of services within the domains of individual providers, healthcare organizations, other institutions and agencies, and the larger societal/structural level.

1. Introduction

Child trafficking is a global public health problem (Chisolm-Straker & Stoklosa, 2017) and a severe violation of human rights (United Nations Human Rights & Office of the High Commissioner for Human Rights, 1990). According to the United Nations Palermo Protocol, child trafficking occurs when a person recruits, transports, transfers, harbors or receives a child less than 18 years of age for the purpose of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs (United Nations, 2000). While the United Nations (UN) definition guides signatory countries as they create their national anti-trafficking laws, countries vary in their interpretation of the definition so that a child may be considered 'trafficked' in one country and 'exploited but not trafficked' in another (Greijer, Doek, & Interagency working group on sexual exploitation of children, 2016). Reliable estimates of incidence and prevalence are difficult to obtain (Stansky & Finkelhor, 2008) given the clandestine nature of trafficking, the lack of a central database to track cases, differences in definitions and use of terms (Greijer et al., 2016), rarity of victim disclosure (Greenbaum, Crawford-Jakubiak, & Committee on Child Abuse and Neglect, 2015), under-recognition by authorities, and differences in research sampling methods. Using national surveys and other sources, the International Labour Organization (ILO) conservatively estimated that in 2016 approximately 4.5 million children around the world were victims of forced labor, which includes human trafficking (International Labour Organization, 2017).

Trafficked children may experience a plethora of adverse physical and mental health sequelae (Greenbaum, Dodd, & McCracken, 2015; Kiss et al., 2015; Silverman, 2011; Willis & Levy, 1996), including traumatic injury from sexual and physical assault, sexually transmitted infections, non-sexually transmitted infections (e.g. tuberculosis), untreated chronic medical conditions, unwanted pregnancy, chronic pain syndromes, complications of substance abuse, and malnutrition and exhaustion. Mental health consequences include depression with suicide attempts, anxiety disorder, anger control problems, dissociative disorders, post-traumatic stress disorder, and other co-morbid conditions (Hossain, Zimmerman, Abas, Light, & Watts, 2010; Ottisova, Smith, & Oram, 2018). These adverse effects are documented in victims from all over the world, emphasizing the ubiquitous harm inherent in trafficking (Kiss et al., 2015; Silverman et al., 2007). While the above study populations are restricted to children, similar findings are documented in the more common studies combining child and adult populations of trafficked persons (Decker, McCauley, Phuengsamran, Janyam, & Silverman, 2011; Zimmerman et al., 2008). Studies comparing child vs adult populations on prevalence and/or severity of health consequences are scarce. Silverman et al. compared prevalence of HIV seropositivity in sex-trafficked Nepalese girls and women, and found much higher rates of HIV in the youngest age group (60.6 % of participants 14 years of age and younger) relative to those 18 years and older (31 %) (Silverman et al., 2007). Age-related physiologic differences, less knowledge of children related to HIV risk and protection, decreased ability to negotiate condom use and work in multiple brothels were posited as potential mediators of this association.

Given the myriad physical and mental health effects of sex trafficking it is critical that survivors are offered appropriate health services, both immediately and over the long term. At the 67th World Health Assembly the World Health Organization (WHO), member states called on the Director-General to develop "a draft global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence in particular against women and girls and against children (67th World Health Assembly, 2014)". The "UN Recommended Principles and Guidelines on Human Rights and Human Trafficking" provides practical guidance for creating anti-trafficking policy, laws, prevention programs and interventions that incorporate a human rights perspective (Office of the High Commissioner for Human Rights, 2010; United National Office of the High Commissioner for Human Rights, 2010).

These guidelines and calls for action are important in highlighting the critical need for good medical and mental healthcare for trafficked persons, but they do not provide descriptions of what specific health care services are needed. While the Group of Experts on Action Against Trafficking in Human Beings (GRETA) conducts comprehensive evaluations of each party to the Council of Europe Convention on Action Against Trafficking in Human Beings (Council of Europe, 2005), assessing the implementation of Convention measures (Group of experts on action against trafficking in human beings, 2012, 2015) these country reports generally only refer peripherally to medical and mental health services for trafficked persons. Recommendations for improvement typically address all professionals and organizations interacting with exploited persons, rather than focusing specifically on healthcare providers. Other reports and recommended standards address 'mental health' and 'psychological assistance and counseling' generally, but the exact meanings of these terms are not always clear (e.g. mental health therapy vs psychosocial counseling and support) (Barath et al., 2004; ECPAT, 2011).

In an effort to assist healthcare professionals treating trafficked persons (physicians, nurses, psychologists, counselors, social workers, and others), a myriad of articles have been published (Becker & Bechtel, 2015; Chaffee & English, 2015; Hodge, 2014; Rabbitt, 2015). National guidelines, such as the one provided by the Ministry of Health in India on the medical response to sexual violence against women and children, provide additional guidance (Ministry of Health & Family Welare & Government of India, 2014). Many articles include recommendations for recognizing signs of trafficking, screening, responding in a culturally sensitive, trauma-informed manner (an approach that acknowledges trauma and demonstrates awareness of and sensitivity to its dynamics in all aspects of service delivery), and providing resources (Jimenez, Jackson, & Deye, 2015). Some include recommendations for

mental health therapy (Ijadi-Maghsoodi, Barnert, Gaboian, & Bath, 2016). Many of these guidelines and commentaries call for a trauma-focused and victim-centered (Substance Abuse & Mental Health Services Administration, 2014), rights-based (United Nations Human Rights & Office of the High Commissioner for Human Rights, 1990) approach to care. The International Organization for Migration published a general guideline for healthcare professionals caring for trafficked persons, focusing on adult patients (Zimmerman & Borland, 2009). The American Academy of Pediatrics published guidelines for the evaluation of sex trafficked youth, although this focused primarily on American-born trafficked minors exploited in the United States (US) (Greenbaum & Crawford-Jakubiak, 2015). Various frontline professionals have also published commentaries and reviews on necessary evaluation and services (Banovi & Bejelajac, 2012).

Whereas these publications are extremely helpful in providing practical guidance to clinicians, they do not necessarily reflect healthcare services actually available to survivors in many areas of the world. With the notable exception of highlighting the lack of healthcare professional training in human trafficking, these guidelines often do not address barriers to care or provide recommendations on how medical and mental health care facilities can implement policies and procedures that facilitate good healthcare delivery to trafficked persons generally, nor to children specifically.

There are a few studies that shed light on health care barriers. The International Organization for Migration (IOM) published a report on current mental health and psychosocial interventions available to trafficked adults and children in the Greater Mekong Subregion and Indonesia (Devine, 2009). While not a specific aim of the study, some significant barriers to quality mental healthcare were identified, including providers practicing without formal supervision, and lack of access to care for severe mental illness. There are a handful of qualitative studies of trafficking survivors who describe negative healthcare experiences, including bias and judgment on the part of providers, concerns about confidentiality, ineffective care and other issues (Ravi, Pfeiffer, Rosner, & Shea, 2017; Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011; Ijadi-Maghsoodi et al., 2016; Ijadi-Maghsoodi, Bath, Cook, Textor, & Barnert, 2018; Ravi, Pfeiffer, Rosner, & Shea, 2017). However, these are primarily studies conducted in the US, and often involve adults. One of these US studies involved only participants under age 18 years, and barriers identified were similar to those seen in studies with adult and mixed adult/child populations, including survivor fear, concerns about potential breaches in confidentiality, and feeling judged by staff (Ijadi-Maghsoodi et al., 2018). Youth in this study also reported strong feelings of self-reliance acting as a barrier to seeking care. Another study of key stakeholders serving trafficked youth in the US identified several barriers to health care that mirrored those that have been reported by adult survivors, including traffickers preventing access to health facilities, perceived low quality of care, geographic barriers preventing access to health facilities in particular areas, and difficulties navigating the health system (Macias Konstantopoulos, Munroe, Purcell, Tester, & Burke, 2015). While adults may also experience challenges understanding the health system, it is likely a greater problem for youth, given their age and lack of experience.

Medical and psychological services for trafficked children are poorly accessible in many areas of the world, despite economic status. Challenges exist in service availability, accessibility, acceptability, affordability and accommodation (the latter describes the extent to which the facility is organized to provide for patient needs and preferences, e.g. hours of operation) (Aberdein & Zimmerman, 2015; Devine, 2009). More information is needed about barriers and facilitators to medical and mental health service delivery worldwide in order to inform the effective response of organizations and governments. These include cultural, social, economic and practical factors, especially those that are modifiable by professionals and/or healthcare facility administrators.

The aim of this systematic review is to summarize the major facilitators of, barriers to, and recommendations for medical and mental health care of trafficked children globally, as identified in articles published since 2010 in the English language, peer-reviewed literature. To support easier and more actionable identification of opportunities to improve services to this population, we organize this information according to the primary locus of control under which it falls (e.g., utilizing more interpreters or offering telephone counseling is largely within the domain of a healthcare organization; the ability or willingness to explain medical information in an age-appropriate way is largely within the domain of an individual provider). We include all facilitators, barriers, and recommendations identified at the level of individuals (e.g., survivors and providers), organizations (e.g., the healthcare organizations serving potential survivors, and other institutions or agencies, such as nongovernmental organizations [NGOs]), and the larger societal/structural level. However, our primary interest lies in those which fall under the locus of healthcare professionals and medical/mental health organizations, as these data may be most salient to healthcare workers and organizations seeking to improve their care.

2. Methods

A review was conducted of the peer-reviewed literature on medical and mental health care of trafficked children published since 2010. The inclusion criteria were: (1) the study population or focus included, wholly or in part, children (individuals under the age of 18 years); (2) the phenomenon of focus was clearly defined as human trafficking or commercial sexual exploitation (CSEC); (3) a main focus included health services or barriers to care, and (4) the article contained original data (i.e., was not itself a systematic review or commentary). Studies that potentially included an unidentified number of trafficked persons but were focused on a larger population (e.g. “sex workers” broadly) were excluded. The process by which we identified articles for inclusion is depicted in Fig. 1, a PRISMA flow diagram. Given the variety of contexts in which children are trafficked, we first set the search criteria inclusively, using the following Boolean search terms: ((health or “healthcare” or medical or psychol*) and (access or barrier* or servic* or avail*)) and (“sex trafficking” or “sexual exploitation” or “labor trafficking” or “forced labor” or “labour trafficking” or “forced labour” or “human trafficking” or “sex work”). PubMed, CABI Global Health, PsycInfo, and the Cochrane Library were searched. PubMed returned a total of 1156 citations, CABI Global Health 252, PsychInfo 684, and Cochrane 62, for a total of 2154 citations returned. 563 duplicates were removed, leaving a total of 1591 unique citations. To determine article eligibility, a team of two

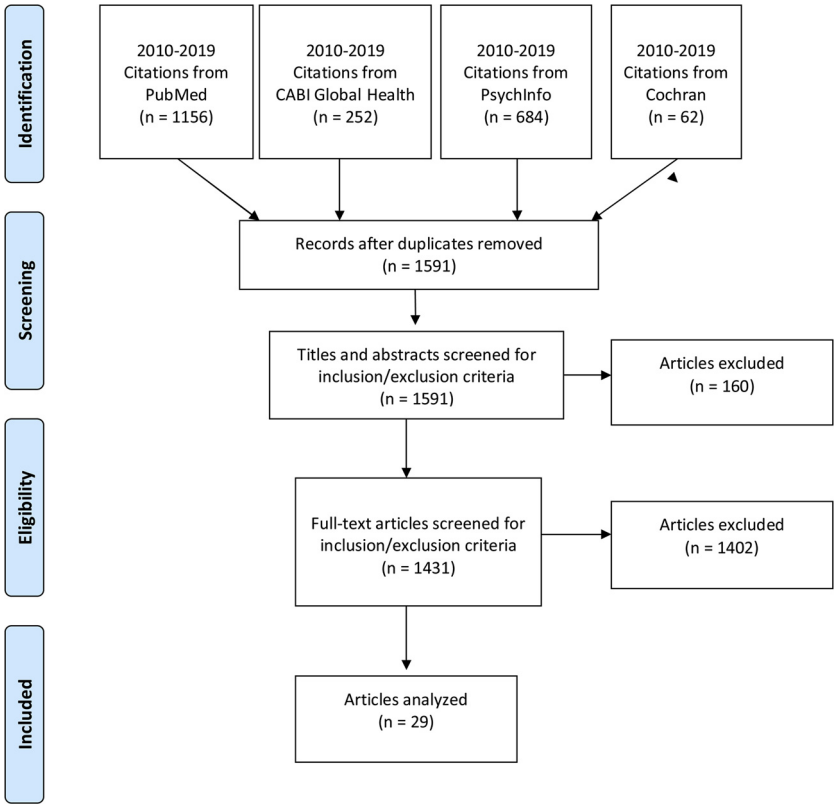

Fig. 1. PRISMA Flow Diagram of Article Selection Process.

reviewers first reviewed all titles and abstracts for the 1591 citations. If one or more of the four aforementioned inclusion criteria were met in the title or abstract, the paper was retained for full text review. Inter-reviewer reliability was established through comparison of article inclusion/exclusion on ten articles and any disagreements or questions were resolved through in-depth discussion and negotiated consensus with the entire team (Bradley, Curry, & Devers, 2007). We removed an additional 160 citations after reviewing titles and abstracts. The remaining 1431 manuscripts were then divided among three team members for comprehensive article content review to assess inclusion criteria. Reliability across reviewers was again verified through iterative comparison of inclusion/exclusion on approximately twenty articles and any disagreements or questions were resolved through in-depth discussion and negotiated consensus with the entire team. Ultimately, 1402 articles were excluded for failure to meet all four inclusion criteria, leaving 29 articles remaining for analysis (see Table 1). These 29 articles were then examined systematically. Data pertaining to facilitators of, barriers to, and recommendations for care were identified in each article and extracted into a spreadsheet. Facilitators, barriers, and recommendations data in each domain were then coded for content using established qualitative content analysis techniques, in which coding categories were derived directly from the text data (Hsieh & Shannon, 2005). Codes were derived inductively, then applied by two members of the analytic team. Inter-coder reliability was assessed through iterative comparison coding of approximately twenty articles and, again, any disagreements or questions were resolved through in-depth discussion and negotiated consensus schema with the entire team (Bradley et al., 2007). Following the completion of coding, the data were organized for presentation purposes across five domains for potential change: facilitators, barriers, and recommendations within the locus of control of survivors, of individual healthcare providers, of healthcare organizations, of other institutions or agencies, and of broader society/social structures.

3. Results

Of the 29 articles meeting the inclusion criteria (see Table 1), 19 included facilitators of health service provision to trafficked populations, 22 included barriers to that provision, and 25 included recommendations for service improvement. Facilitators were identified 140 times (range per article: 1–30; mean per article: 6.62), barriers were identified 174 times (range: 1–27; mean: 7.48), and recommendations were identified 100 times (range: 1–11; mean: 3.78). Table 2 presents the distribution of facilitators, barriers, and recommendations across the five domains for potential change: survivors, individual healthcare providers, healthcare organizations, other institutions or agencies, and broader society/social structures.

Table 1
Characteristics of Articles in Systematic Review.

Citation	Geographic Location of Study	Type of Trafficking or Exploitation	Survivor Population	Survivor Racial/Ethnic/ National Background	Study Methods	Data Collection Period	Study Participants	Sample Size	Participant Age Range	Participant Gender	Participant Racial/Ethnic/ National Background
Aberdein & Zimmerman, 2015	Cambodia	Sex and Labor trafficking, domestic violence, rape, child abuse, acid attacks	Male, female, and transgender children and adults who were sex, labor trafficked, and exploited during 2011 to 2014	Khmer, Vietnamese, Malaysian, others	Qualitative interviews exploring survivor mental health needs, access to services, and mental health issues	Data not provided	Social work, psychology, and counseling professionals	8	Data not provided	2 male, 6 females	4 Khmer, 4 expatriates
Anderson, England, & Davidson, 2017	Midwest, USA	Sex	Female adolescents	Data not provided	Qualitative interviews exploring practitioner perspectives on survivors and gender-responsivity in the juvenile justice system, case discussions about survivor needs and access to care, observation of juvenile court staff sessions	Three-month period, specifics not provided	Juvenile court practitioners (juvenile probation officers, judges, administrators, program managers, court officers, mental health personnel, etc.)	39 interview participants, 24 case discussion participants, 12 court staff meeting observations	Data not provided	38.5 % male	20.5 % nonwhite
Beck et al., 2015	Southeastern Wisconsin, USA	Sex	Children	Not applicable	Surveys assessing respondent ability to identify trafficking victims, prior training on trafficking, and knowledge gaps	Data not provided	Hospital and clinic medical providers, social workers, patient/family support providers in Southeast Wisconsin	168	Data not provided	91 % female	Data not provided
Brandt, Lind, Schreier, Sievers, & Kramer, 2018	Arkansas, USA	Sex	See “study participants” column	See “participant background” column	Feasibility pilot implementing screening of youth to identify those at high risk of trafficking, assessment trauma exposure and symptoms by UCLA PTSD index	2016-2017	Youth at risk of trafficking at Child Advocacy Centers in Arkansas	1052 participants, of which 918 were screened for trafficking	12–18 years	80.1 % female in the screened group	77.1 % Caucasian, 10.7 % African American, 4.6 % Biracial, 7.6 % Other in the screened group
Chang, Lee, Park, Sy, & Quach, 2015	Oakland, California, USA	Sex	See “study participants” column	See “participant background” column	Retrospective descriptive chart review determining prevalence of CSEC	2008-2011	Female and young adult patients at the Asian Health Services’ Teen Clinic	621	13-23 years	All female	57.5 % Asian (4.3 % Cambodian, 11.3 % Chinese, 5.5 % Filipino,

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Table 1 (*continued*)

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					and risk factors associated						1.6 % Laotian, 3.1 % Mien, 4.8 % Vietnamese, 34.6 % other Asian), 22.0 % African American, 7.6 % Hispanic, 0.8 % Native American, 1.1 % Non-Hispanic White, 9.0 % Other
Chisolm-Straker et al., 2012	USA	Sex and Labor	Children and Adults	Not applicable	Cross-sectional study utilizing a survey to assess the effectiveness of a didactic training session for service providers	Data not provided	Social workers, medical students, Emergency Medicine residents, Emergency Medicine nurses, Emergency Medicine attendings	180 pre-intervention survey participants, 104 intervention participants and post-intervention survey participants	Data not provided	Data not provided	Data not provided
Cole, 2018	USA	Sex	Male and female children and youth	96.6 % male survivors from the U.S., 92.4 % female survivors from the U.S.	Cross-sectional telephone survey including closed-ended questions assessing trafficked client needs and vulnerabilities, open-ended questions exploring participant experiences with male trafficking survivors	2012-2013	Personnel from agencies providing services to at-risk youth or crime victims throughout the state	323 survey participants, 107 participants in male/female comparison sub-analysis	Data not provided	Data not provided	Data not provided
Cole, Sprang, Lee, & Cohen, 2016	USA	Sex	See "study participants" column	Data not provided	Case control study comparing youth with history of sexual abuse/assault and youth with history of CSEC	Data not provided	Children and youth included in the National Child Traumatic Stress Network Core Data Set	43 youth with history of CSEC and 172 age-, race-, and residence-matched controls	10–20 years	CSEC group: 88.4 % female, Control group: 81.4 % female	CSEC group: 39.5 % White, 23.3 % Black, 9.3 % Other, 34.9 % Hispanic/Latino Control group: 39.5 % White, 18.0 % Black, 10.5 % Other,

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Table 1 (*continued*)

Citation	Geographic Location of Study	Type of Trafficking or Exploitation	Survivor Population	Survivor Racial/Ethnic/ National Background	Study Methods	Data Collection Period	Study Participants	Sample Size	Participant Age Range	Participant Gender	Participant Racial/Ethnic/ National Background
											44.2 % Hispanic/Latino
Domoney et al., 2015	South East London, England	Sex and Labor	See "study participants" column	See "participant background" column	Qualitative analysis of electronic medical records of trafficked patients	2006–2012	Trafficked children and adults accessing mental health care in a large case database	95 adults, 35 children	8–49 years	Adults: 80 % female, Children: 71.4 % female	Data not provided
Gibbs, Walters, Lutnick, Miller, & Kluckman, 2015	USA	Sex and Labor	See "study participants" column	See "participant background" column	Descriptive study of clients served by three programs serving trafficking survivors, qualitative key informant interviews exploring client trafficking experiences and service needs	2011-2013	Trafficked children served by three service programs, program staff	201 trafficked or at-risk children, 113 program staff	12–18 years	76 % female, 3 % transgender	65 % Black or African American, 23 % White, 22 % Hispanic/ Latino, 13 % Other
Greenbaum, Dodd, & McCracken, 2018	USA	Sex	See "study participants" column	See "participant background" column	Case control study comparing child CSEC survivors with child sexual assault/ sexual abuse survivors to identify statistical differences for a screening tool	2013-2014	Adolescents presenting to a pediatric emergency department with concerns for sexual assault/ abuse or CSEC	25 trafficked youth, 83 sexually assaulted/ abused youth	12–18 years	Trafficked youth: 100 % female, Sexually assaulted youth: 95 % female	Trafficked youth: 8 % Non-Hispanic white, 4 % Hispanic, 72 % African American, 16 % Other Sexually assaulted youth: 24 % Non-Hispanic white, 12 % Hispanic, 63 % African American, 1 % Other
Hom & Woods, 2013	USA	Sex	Women	Data not provided	Qualitative interviews exploring the experiences of trafficking and trauma-related implications of sexually exploited women	Data not provided	Service providers for commercially sexually exploited women	6	Data not provided	Data not provided	Data not provided
Ijadi-Maghsoodi et al., 2018	California, USA	Sex	See "study participants" column	See "participant background" column	Qualitative focus groups exploring trafficked participants' experiences with	2015-2016	CSEC youth residing in group homes	18	12-19 years	100 % female	69.2 % Black, 38.5 % Hispanic, 23.1 % White, 7.7 % Other

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Table 1 (*continued*)

Citation	Geographic Location of Study	Type of Trafficking or Exploitation	Survivor Population	Survivor Racial/Ethnic/ National Background	Study Methods	Data Collection Period	Study Participants	Sample Size	Participant Age Range	Participant Gender	Participant Racial/Ethnic/ National Background
					health care, barriers to access, and recommendations for improving access						
Konstantopoulos et al., 2013	Los Angeles, New York City, Salvador, Rio de Janeiro, London, Kolkata, Mumbai, Manila	Sex	Children and Adults	Data not provided	Qualitative interviews with key antitrafficking stakeholders exploring trafficking contexts, local response, barriers to health care, and opportunities for health care participation in antitrafficking efforts	2008-2009	Healthcare providers, social workers, program directors, outreach workers, government officials, law enforcement, legal personnel and others	277	Data not provided	Data not provided	18.4 % from Manila, 17.7 % from Kolkata, 14.8 % from Salvador, 13.3 % from Rio de Janeiro, 12.3 % from Mumbai, 8.3 % from NYC, 7.6 % from Los Angeles, 7.6 % from London
Landers, McGrath, Johnson, Armstrong, & Dollard, 2017	Florida, USA	Sex	See "study participants" column	See "participant background" column	Descriptive study characterizing trafficked youth using the Child and Adolescent Needs and Strengths-Commercially Sexually Exploited (CANS-CSE) assessment tool	2013-2015	Trafficked youth admitted to the Citrus Helping Adolescents Negatively Impacted by Commercial Exploitation (CHANCE) program	87	12–18 years	94.3 % female	59.3 % Black/ African American, 25.6 % White, 15.1 % Other
Lefevre, Hickle, Luckock, & Ruch, 2017	England	Sex	Children	Data not provided	Implementation study of a pilot child-centered framework for professionals working with child CSEC survivors utilizing surveys and qualitative interviews	2015	Stakeholders working with commercially sexually exploited youth (government social workers and law enforcement, health care workers)	204	35-54 years	73.4 % female	> 80 % White British, White Irish, White background, Black or Black British-Caribbean, Mixed-White, Black Caribbean
Macias Konstantopoulos et al., 2015	Boston, Massachusetts, USA	Sex	Children 13–19 years	African American, Hispanic	Qualitative interviews exploring perceptions of trafficking and local response	2011	Social service providers, health care providers, law enforcement and legal advocates	22 interviews with 25 informants	Data not provided	21 female, 3 male, 1 transgender female	Data not provided
McConkey et al., 2014	Ireland	Sex	Children and Adults	Data not provided	Systematic review of PubMed and grey literature, and	Data not provided	Health care professionals	5 interview participants	Data not provided	Data not provided	Data not provided

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Table 1 (*continued*)

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					qualitative interviews with health professionals						
Barron et al., 2016	Rhode Island, USA	Sex	Children	Not applicable	Survey of pediatricians assessing provider knowledge and comfort with identifying and managing trafficking survivors	2014-2015	Hospital staff pediatricians in various subspecialties in Rhode Island	109	Data not provided	61 % female	Data not provided
Pocock et al., 2018	Thailand, Cambodia	Labor	See "study participants" column	See "participant background" column	Cross-sectional survey assessing health symptoms, injuries, work environments, mental health and qualitative key informant interviews exploring service access and delivery barriers, and other challenges	2011-2014	Trafficked fishermen and health/service providers and fishery association staff	275 trafficked participants, 20 key informant participants	12-55 years	100 % male	78.9 % from Cambodia, 20.0 % from Myanmar, 0.7 % from Thailand, trafficked to China, Malaysia, Thailand, Indonesia, Mauritius, South Africa
Rafferty, 2016	Cambodia, India, Laos, Nepal, Thailand, and Vietnam	Sex	Children	Data not provided	Literature review and qualitative individual and group interviews exploring identification, service needs, assessments, psychosocial support, and continuing care	2013-2014	Stakeholders from governments, U.N. agencies, NGOs, and aftercare recovery programs	213	Data not provided	Data not provided	Cambodia, India, Laos, Nepal, Thailand, and Vietnam
Rafferty, 2017	Cambodia, India, Laos, Nepal, Thailand, and Vietnam	Sex	Children	Data not provided	Qualitative individual and group interviews exploring mental health needs, service availability and barriers	2014	Stakeholders from governments, U.N. agencies, NGOs, and aftercare recovery programs	213	Data not provided	Data not provided	Cambodia, India, Laos, Nepal, Thailand, and Vietnam
Ross et al., 2015	England	Sex and Labor	Children and Adults	Not applicable	Cross-sectional survey evaluating provider training and contact with trafficked patients, knowledge gaps, and training	2013-2014	Healthcare providers from emergency medicine, maternity, mental health, pediatrics, and other clinical disciplines	782	19-70 years	80.6 % female	England

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Table 1 (*continued*)

Citation	Geographic Location of Study	Type of Trafficking or Exploitation	Survivor Population	Survivor Racial/Ethnic/ National Background	Study Methods	Data Collection Period	Study Participants	Sample Size	Participant Age Range	Participant Gender	Participant Racial/Ethnic/ National Background
Spencer-Hughes, Syred, Allison, Holdsworth, & Baraitser, 2017	England	Sex	Children	Data not provided	Qualitative interviews exploring the safeguarding of children at risk of exploitation in clinic and online contexts, identification, and response	Data not provided	Local and national experts on safeguarding, youth rights, and sexual health services	14	Data not provided	Data not provided	Data not provided
Stanley et al., 2016	England	Sex and Labor	See "study participants" column	See "participant background" column	Surveys assessing trafficking survivor experiences, context, mental, and physical health, qualitative interviews exploring survivor experiences with access to care, and service professional experiences with helping survivors navigate the system	Data not provided	Trafficking survivors and health/service providers	29 trafficking survivors, 52 professionals	16-21 years	24 female, 5 male	Majority from African countries, including 10 from Nigeria, 7 Eastern European descent, including Albania and Slovakia
Twigg, 2017	USA	Sex	Male, female, and transgender trafficking survivors 11 years and older	Data not provided	Qualitative interviews exploring their client demographics, survivor mental and physical health care needs, and other long-term comprehensive needs	2011	Aftercare program founders, directors, or managers	5	> 21 years	Data not provided	Data not provided
Viergever et al., 2015	Antigua, Barbuda, Belize, Costa Rica, Egypt, El Salvador, Guyana, Jordan	Sex and Labor	Children and Adults	Not applicable	Pre- and post-training questionnaires assessing health care provider knowledge about trafficking and survivor mental and physical health issues	Data not provided	Healthcare providers, social workers, NGO and national ministry professionals	165 pre-training survey participants, 156 post-training survey participants	20–79 years	72.1 % female	Antigua, Belize, Costa Rica, Egypt, El Salvador, Guyana, Jordan
Westwood et al., 2016	England	Sex and Labor	See "study participants" column	See "participant background" column	Cross-sectional surveys assessing demographics, trafficking experiences, medical issues, and qualitative interviews exploring access to and	2013-2014	Trafficking survivors in contact with services in England	136	16 to > 26 years	67 % female	From Albania, Nigeria, Poland, Other

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Table 1 (*continued*)

Citation	Geographic Location of Study	Type of Trafficking or Exploitation	Survivor Population	Survivor Racial/Ethnic/ National Background	Study Methods	Data Collection Period	Study Participants	Sample Size	Participant Age Range	Participant Gender	Participant Racial/Ethnic/ National Background
					experiences with health care services						
Zimmerman et al., 2008	Moldova, Ukraine, Italy, United Kingdom, Bulgaria, Czech Republic, Belgium	Sex and Labor	See "study participants" column	See "participant background" column	Descriptive study measuring physical symptoms using the Miller Abuse Physical Symptoms and Injury Survey and mental health symptoms with the Brief Symptom Inventory and Harvard Trauma Questionnaire, and qualitative interviews exploring survivor experiences with abuse	2004-2005	Female adolescent and women survivors accessing aftercare services	192	15-45 years	100 % female	37.5 % from Moldova, 26.0 % from Ukraine, 26.0 % from other European countries, 6.3 % from West Africa or the Caribbean

Table 2
Distribution of Facilitators, Barriers, and Recommendations across Domains for Potential Change.

	Survivors	Healthcare Providers	Healthcare Organizations	Other Institutions/Agencies	Societal/Structural	Total
Facilitators	4	54	60	20	2	140
Barriers	35	47	50	15	27	174
Recommendations	0	24	48	10	18	100

4. Facilitators of health services to trafficked populations

Forty-five distinct facilitators of health services to trafficked populations were identified a total of 140 times in the relevant surveyed literature. As shown in Table 2, most were identified to be within the locus of control of the healthcare organization or the individual healthcare provider. Table 3 lists the 45 distinct facilitators included in the 140 identifications, organized by the five domains for potential change.

4.1. Facilitators in healthcare organizations

The most commonly identified set of facilitators within the domain of healthcare organizations involved efforts to increase the availability and accessibility of services (n = 26 identifications). Such efforts included, e.g., providing a medical van outside service organizations; offering mobile health units; having staff available to see patients at any hour; and integrating online services into the larger clinical system in order to improve accessibility and privacy of services. Another common set of facilitators involved offering specialized or tailored services to address and treat trafficking survivors (n = 8), such as by offering creative, nonverbal therapies such as dance movement therapy, music therapy, or integrated play therapy. Other common sets of facilitators focused on organizational efforts to provide nonjudgmental, confidential, safe, and reliable services (n = 8); design protocols and conduct trainings on how to recognize signs of trafficking and/or how to deliver trauma-informed therapies (n = 7); and staff and schedule thoughtfully (n = 7), such as allowing sufficient time for trafficked persons to talk with providers. Additional facilitators included actively screening to identify trafficked individuals and those at risk (n = 3); and engaging in interagency collaboration (n = 1).

4.2. Facilitators among healthcare providers

At the level of individual healthcare providers, the most common facilitator by far was the provider's interactional approach with the survivor (n = 47). This included listening to the survivor, demonstrating care and patience, building rapport and trust, and using trauma-informed principles. In addition, providers' knowledge about trafficking and its implications was identified as a facilitator (n = 4); as was the ability to communicate and explain medical information clearly, such as information about medical procedures (n = 3).

4.3. Facilitators in other institutions or agencies

Facilitators within other institutions or agencies were identified within the domain of NGOs, including local survivor service organizations. NGO facilitators included offering a full and comprehensive range of services (n = 6) to support health care access (e.g., transportation) and aftercare needs (e.g., vocational education, family counseling); and having dedicated staff who are familiar with local healthcare organizations and can help survivors navigate the health system (n = 5), including negotiating with gatekeepers (e.g., receptionists) and organizing the required documentation. Further facilitators included partnering with medical facilities (n = 4) to train volunteer interpreters and to help cover treatment costs through fee waivers and discounts; working with employers (n = 4) to emphasize the prioritization of employee health over legal concerns and facilitate investment in employee health and healthcare; and engaging in community outreach to raise awareness of available mental health services (n = 1).

4.4. Facilitators at the larger societal/structural level

At the larger societal/structural level, two facilitators were identified. These included the existence of policies that support government prioritization of and commitment to trafficking-related and mental health services (n = 1); and policies that support freer labor movement (n = 1), since those lead healthcare providers to be more welcoming of migrants.

4.5. Facilitators at the survivor level

Survivor-level factors facilitating service provision (n = 4) included knowledge of sexually transmitted infections (STIs) and the need to be tested for them; awareness of the need for condoms and, where applicable, the health facilities offering them; the desire to stay healthy; and trust in the service provider and healthcare organization.

Table 3
Facilitators of Health Services to Trafficked Populations, by Domain for Potential Change.

VICTIM	N*	PROVIDERS	N	HEALTH CARE ORGANIZATIONS	N	OTHER INSTITUTIONS/ AGENCIES	N	SOCIAL/ STRUCTURAL	N
Knowledge of STIs and the need to be tested for them	1	Using trauma-informed principles in interactions with survivors (e.g., listening, being sensitive to triggers, building trust and rapport, demonstrating support and sensitivity, allowing adequate time)	47	Making health services readily and easily available, including prompt mental health and/or substance use assessments	5	Offering a comprehensive range of services (e.g., offer clinical services at victim service organizations, incorporate long term needs like family counseling, provide assistance with financial support and transportation)	6	Policies that support government prioritization of and commitment to trafficking-related and mental health services	1
Awareness of the need for condoms and locations where they are available	1	Being knowledgeable/trained on trafficking dynamics and the health implications of trafficking	4	Offering mobile health clinics in addition to other service types	1	Using support workers to help patient navigate the system, negotiate with gatekeepers such as receptionists, organize the required documentation, and advocate for patients' health needs.	5	Policies (e.g., ASEAN Economic Community's) encouraging freer labour movement	1
Desire to stay healthy (in order to work, to protect partner from disease; to preserve mental health)	1	Ability to communicate, clarify, and explain medical information in an age-appropriate way	3	Offering medical van outside victim service organizations	1	Partnering with medical facilities to cover treatment costs through fee waivers and discounts	3		
Trust in the service provider and healthcare organization	1			Integrating online services into larger clinical system in order to improve accessibility and privacy of services	3	Training volunteer interpreters in partnership with medical facilities	1		
				Providing a continuum of case management to respond to changes in child needs	2	Emphasizing the prioritization of employee health over legal concerns and facilitate investment in employee health and healthcare (e.g. emphasize value of a healthy employee, introduce employers to drop-in centers, etc.)	4		
				Providing comprehensive, multi-disciplinary care and education for victims, including spiritual, mental, physical, psychological, vocational, economic, and legal needs	3	Engaging in community outreach to raise awareness of mental health services (e.g., through radio programs, stickers, newspaper announcements, etc.)	1		
				Offering free services, medicines, and health education	2				
				Providing health services at drop-in service centers	2				
				Having staff available to see patients at any hour (e.g., evenings, weekends)	2				
				Engagement in creative initiatives (e.g., a pilot Floating Hospital initiative, whereby short-haul fishermen were trained in basic first aid and given medicines to dispense at sea)	1				
				Thoughtfulness about payment arrangements (e.g., some private clinics with payment 'up front' may seem safer, since they ask fewer questions and survivors are less likely to risk arrest for migration issues)	1				
				Use of satellite teams to provide services to rural areas	1				

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Table 3 (*continued*)

VICTIM	N*	PROVIDERS	N	HEALTH CARE ORGANIZATIONS	N	OTHER INSTITUTIONS/ AGENCIES	N	SOCIAL/ STRUCTURAL	N
				Doing home visits, which are flattering to families and allow providers direct access to work with family	1				
				Offering telephone counselling as an option	1				
				Offering group therapy, which may provide psychoeducation about sexual exploitation	1				
				Tailoring services to individual needs of survivors	1				
				Addressing long-term care needs within the family (e.g., family counseling, safe family connections)	2				
				Offering creative, nonverbal therapies, such as dance movement therapy, music therapy, and integrated play therapy	4				
				Creating a safe, victim-centered emotional environments that allow trust to be built (services should be nonjudgmental, confidential, and reliably responsive)	5				
				Creating safe, comfortable physical environments	2				
				Giving child choices and control (e.g. right to ask for provider of specific gender)	1				
				Screening in healthcare setting can identify trafficked individuals	3				
				Providing staff training on abuse/ trafficking, recognizing and responding to suspected trafficking, trauma, assessment, child-friendly interviewing techniques and treatment strategies, cultural awareness and sensitivity and/or anti-discrimination	5				
				Developing healthcare protocols for recognizing and responding to suspected trafficking	2				
				Allowing child regular contact with same provider	1				
				Enabling continuity of staff	1				
				Providing access to staff who speak language of survivors and/or interpreters	2				
				Having diverse staff who can meet diverse needs of clients (gender, nationality, age, religion)	1				
				Scheduling so that child has sufficient time at appointment to talk to provider	2				
				Engaging in interagency collaboration	1				

* N = number of times facilitator identified in reviewed literature.

Table 4
Barriers to Providing Health Services to Trafficked Populations, by Domain for Potential Change.

VICTIM	N*	PROVIDERS	N	HEALTH CARE ORGANIZATIONS	N	OTHER INSTITUTIONS/AGENCIES	N	SOCIAL/ STRUCTURAL	N
Feels judged, stigmatized, and/or not taken seriously by providers	3	Lack of awareness of/training on trafficking, including how to identify, treat, screen, and manage victims	16	Mental health care and some primary care (e.g. immunizations) are not often integrated into reproductive health care clinics, which restricts accessibility	1	Health professional training programs do not provide education on trafficking	1	High cost of healthcare and very low/no wages of trafficked person	1
Did not want to discuss health problems in front of NGO worker	1	Difficulty responding to complex trauma of victim	1	Mental health services are often not offered/available in health care organizations	2	Many organizations place low priority on mental health, and staff may be unfamiliar with purpose and methods of counseling	2	Regulations sometimes restrict access to only certain populations (e.g., girls, those in shelters, etc.)	1
Reluctance of boys to disclose exploitation because of particular stigma	1	Not enough mental health providers trained in complex trauma and/or trafficking	1	There are often long wait lists for mental health services, even when they are offered	2	Juvenile court staff lack knowledge of community resources	1	Few services are often available for boys	1
Reluctance to disclose exploitation because of shame/stigma and/or lack of options and concerns about alternative options	2	Provider allows trafficker to interpret so s/he could control information provided, and victim was unable to fully understand the information provided to them	1	Organizations do not have enough translators/interpreters, particularly those with medical or specialist knowledge	3	Juvenile court staff regard trafficked girls as delinquents and/or offenders rather than as victims, which deters from a focus on the need for trauma-informed services	2	Few services may be available for survivors of labor trafficking	1
Concerns about confidentiality may prevent survivors from signing up for public financial support programs	1	Lack of sufficient information about procedures and tests	1	Mental health assessments are often nonexistent or, when they do exist, are often inadequate and not culturally validated	2	Ongoing police investigations inhibit mental health therapists' ability to ask victims certain questions about trafficking history, which can make therapy difficult	1	Lack of a comprehensive coordinated system to meet health needs	1
Concerns that disclosure of sensitive information would be documented and others could read it.	1	Lack of awareness that boys can be exploited	1	Western assessment instruments are often inadequate: many are not culturally validated, lack norms for local populations, present problems for language translation, and present problems for applicability of diagnostic categories; some are also very time-consuming and require high verbal ability to understand and answer questions so not appropriate for children	1	Police raids in red-light districts undermine the ability of NGOs and healthcare workers to negotiate access to brothels and provide healthcare for victims	1	Lack of recognition at systems level that trafficking is a public health issue	1
Fear (of police, of bad diagnosis, of trafficker, and of immigration)	4	Provider feels healthcare environment not safe to ask about trafficking	1	Many health facilities, particularly those that are run by governments, are understaffed and underfunded	1	Some religious NGOs may have faith-based rules that prevent access to some types of specialist care or require client to participate in religious activities in order to access services	1	Resources are constrained in overburdened systems	1
Fear of discriminatory treatment by HCP and/or that they were not entitled to or could not afford health care	2	Provider has limited knowledge of immigration laws	1	Lack of adequate and culturally sensitive mental health services	2	Many service organizations with which victims interact require verification of identity and/or age	2	Emphasis on biomedical rather than holistic approach to health in medical training	1
Fear of safety if disclosed	1	Mental health provider not adept at ascertaining patient history	1	Lack of access to care for the children of survivors	1	Lack of coordination and/or streamlined referral mechanisms between health services and social services	2	Lack of adequate mental health services generally	2

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Table 4 (*continued*)

VICTIM	N*	PROVIDERS	N	HEALTH CARE ORGANIZATIONS	N	OTHER INSTITUTIONS/AGENCIES	N	SOCIAL/ STRUCTURAL	N
Self-reliance (do not perceive need for healthcare; take care of it themselves); need to work.	1	Underqualified and undertrained mental health providers, often from varied educational backgrounds and sometimes without clinical training	2	Long wait times for any health services	1	Difficulties in communication between professions and organizations, with confusion regarding who has responsibility over what	1	Lack of ability to provide longitudinal mental health care (therapies may be time-limited because of insurance or other funding restrictions)	1
Do not see themselves as victims so don't disclose exploitation	1	Provider confusion about who is entitled to services, which may lead to denying services inappropriately	1	Restricted hours of operation at health facilities	2	Dependence on donor funding makes free health and/or social services difficult	1	No/few psychology degrees and few social work training programs in some countries	1
Lack of patient engagement in mental health care	1	Provider fear of breaching patient confidentiality	1	High patient case load	1			Limited services for those with serious mental illnesses	1
Aggressive, anti-social behavior of clients that is not well understood by providers	1	Provider fear of compromising patient safety	1	Parental permission often required to receive mental health services	1			Scarcity of human resources for mental health treatment	2
Declined therapy or did not attend appointments regularly	1	Provider fear of retribution by traffickers	1	Organizations often offer poor quality of care	1			Governments typically require identity documents and other documentation for survivors to obtain services	1
Does not want to focus on past bad experiences, but instead focus on the future; may want to forget past	2	Provider failure to use a trauma-informed approach to patient interaction and care	1	Delays in communicating test/ procedure results (or failure to communicate results at all)	1			Lack of government commitment to financing health of trafficked persons and mental health care generally	1
Language problems	1	Provider offers opinions and judgments without bothering to find out about child's life	1	Inadequate referral/resources and information when patient discloses exploitation	2			Local governments have not developed well-coordinated systems of healthcare for survivors	1
Does not understand information provided	1	Provider dismissive or insensitive	2	Lack of organizational policy/ guidelines/training about how to handle trafficked populations	7			Limited access to healthcare is available in immigration detention centers	1
Does not have internet access needed for online reproductive health services	1	Provider attitude changed when learned of trafficking status	1	When organization offers online services, patients may be treated as "faceless" and it is easier to ignore key information	1			Immigrant status and/or other issues around immigration often restrict access to mental healthcare	2
Provides inconsistent information to providers, which calls into question its accuracy and make it hard to verify identity	1	Provider hesitant and uncomfortable identifying/treating trafficking patients	2	Online services may not be able to ensure adequate safety response	1			In many cultures, there is a belief that one addresses trauma not by getting counseling but by "getting on with it"	1
Has difficulty navigating health system (how to schedule appointments, how to find a facility, how to get transportation to facility)	1	Provider not trained in trauma or trauma healing, therapeutic crisis intervention, or other emergency response measures	1	Online services may have limited knowledge of local support services, so ability to offer good referrals is reduced	1			There is often societal blame and stigma associated with trafficking	1
Undocumented victims may have erroneous impression that they cannot get healthcare without legal documentation	1	Provider views trafficked child as an immigrant first and foremost, rather than a victim with health needs	2	Complex gatekeeping systems impede or delay access to and use of health care	1			There is often societal blame and stigma associated with mental illness	1
Lack of familiarity with healthcare system	1	Gender inequalities that exist in cultural and social norms underlie providers tendency to ignore or avoid addressing problem of violence against females	1	Patient experience involves repeated requests to tell story by different stakeholders, rather than streamlined and sensitive process	1			Lack of community resources generally, particularly integrated, trauma-informed services	1

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Table 4 (*continued*)

VICTIM	N*	PROVIDERS	N	HEALTH CARE ORGANIZATIONS	N	OTHER INSTITUTIONS/AGENCIES	N	SOCIAL/ STRUCTURAL	N
Frequent disruptions related to changes in care, housing, running away, etc.	1	Providers with discriminatory attitudes toward women/girls, especially those involved in commercial sex and/or those presenting for abortion care, leading to insensitive, punitive treatment	3	Organizational age determination processes are stressful for children, erode trust, and makes children feel no one believes them	1			There is often an unequal geographic distribution of resources (not enough resources in rural areas)	1
Social instability: e.g. housing unstable and may move out of cachement area of therapist; frequent moves leads to difficulties keeping track of patient to make appointments	1	HCP lack of knowledge of resources for referrals	2	Lack of streamlined referral mechanisms to social services	1			Anti-trafficking policymaking does typically not include the participation of and input from health and other professionals	1
Stress related to lack of housing or immigration/legal issues or other social issues interferes with therapy, can cause stress-related symptoms, and at times means therapist must spend lots of time dealing with these issues	1	Provider failure to make direct referrals to specialist support services, instead relying on social work services to access those services, which causes delays	1	Organization staff may treat migrants as inferior due to racism and/or patient inability to pay	2				
Discontinuity of care because of limited time onshore	1			Institutional biases may engender lower quality healthcare for poor women/girls	2				
May be restricted to a particular health care facility due to geographic or social restrictions (e.g., can't cross gang lines; don't feel comfortable going to a facility in family's neighborhood)	1			Scheduling allows too little time for providers to practice trauma-informed care	2				
				Scheduling allows too little time for providers to screen for trafficking	2				
				Lack of coordination between health and nonhealth services leads to failure of wraparound care	2				
				Difficulties in communication between professions and organizations (lack of clarity regarding domains of responsibility)	1				
				Organization staff may experience secondary traumatic stress	1				

* N = number of times barrier identified in reviewed literature.

5. Barriers to health service provision to trafficked populations

Barriers to health service provision to trafficked populations were identified 174 times in the relevant surveyed literature. As shown in Table 2, most were identified to be either within the domain of the healthcare organization or within the domain of individual healthcare providers. Table 4 lists the 118 distinct barriers included in the 174 identifications, organized by the five domains for potential change.

5.1. Barriers in healthcare organizations

The most common set of barriers identified within the domain of healthcare organizations involved limitations in the availability and/or quality of care offered by the organization (n = 19 identifications). Such barriers included long wait lists for mental health services; lack of interpreters; lack of culturally validated assessment measures; and restricted hours of operation. Another common set of identified barriers concerned procedural problems (n = 19), such as delays in providing procedure results; inadequate referral mechanisms; lack of organizational training on or established policy on responses to human trafficking; and complex gatekeeping systems. Additional barriers included institutional biases and/or discriminatory staff attitudes toward trafficked persons (n = 4); scheduling constraints that allowed too little time for providers to screen or talk with survivors (n = 4); lack of coordination with other agencies and services (n = 3); and secondary traumatic stress in staff (n = 1).

5.2. Barriers among healthcare providers

At the level of individual healthcare providers, the most commonly identified barrier by far was providers' lack of awareness or training about trafficking and/or the appropriate protocol to address it (n = 30). Providers' poor interactional approach with patients (e.g., judgmental, insensitive, dismissive, not trauma-informed) was also a commonly identified barrier (n = 14). Providers' lack of knowledge about available resources or discomfort with referring to them was an additional identified barrier (n = 3).

5.3. Barriers in other institutions or agencies

The most common set of barriers identified within the domain of other institutions or agencies involved a lack of knowledge or training (n = 6). This included a lack of education on trafficking in heath professional training programs; unfamiliarity with purposes and methods of counseling; lack of knowledge of community resources; and a lack of understanding of the importance of regarding trafficked persons as survivors rather than delinquents. Additional barriers included procedures or regulations that interfered with or undermined the provision of healthcare (n = 5), such as police investigation constraints on the types of questions that therapists could ask about trafficking histories; religion-related rules in some faith-based NGOs that prevent access to some types of specialty care; and requirements regarding identity verification. A lack of inter-institutional coordination (n = 4) was also a significant barrier, leading to failures in accessing wrap-around care for survivors; cumbersome referral mechanisms; and lack of clear establishment of organizational roles and responsibilities.

5.4. Barriers at the larger societal/structural level

At the larger societal/structural level, barriers included a variety of systemic issues impacting the practice and delivery of healthcare (n = 8). These included the high cost of healthcare; an emphasis within the practice of medicine on a biomedical rather than holistic approach to health; a lack of recognition at a systemic level that trafficking is a public health issue; a lack of a comprehensive coordinated system to meet survivors' health needs; and the limited availability of or access to services for certain populations (e.g., services for boys and/or for those trafficked for labor are often less available than those for girls and/or those trafficked for sex, populations for which there may be more public awareness about trafficking). Additional barriers (n = 7) were identified in the provision of mental health care specifically, including a broad lack of adequate mental health services and/or qualified staff as well as funding restrictions requiring time limitations on many therapies. Another set of barriers (n = 3) involved a lack of government commitment to steps that could benefit the provision of health services to trafficked persons, including financing the health needs of trafficked persons; prioritizing mental health; and enacting policies that could make services more accessible (e.g., relaxing the requirement of identity verification documents needed to obtain services). Additional barriers (n = 3) concerned restrictions on access to health services due to immigration status, including the limited health service availability in immigration detention centers and the unlawfulness of transporting undocumented migrants in some countries, which disincentivizes employers from taking trafficked persons to a healthcare facility. Cultural stigma associated with trafficking and with mental health issues served as an additional set of identified barriers to care (n = 3), as did a lack of community resources, particularly in rural or underserved areas (n = 2) and the failure of health professionals to participate in anti-trafficking policymaking (n = 1).

5.5. Barriers at the survivor level

The most commonly identified barriers at the survivor level involved feelings of shame and stigma (n = 9) and/or fear (n = 7). Shame and stigma often caused survivors to be reluctant to disclose information about their exploitation or seek services or other forms of support, as did their fears of repercussions from police, their trafficker(s), immigration officials, and/or healthcare providers.

Table 5
Recommendations for Improving Health Service Provision to Trafficked Populations, by Domain for Potential Change.

PROVIDERS	N*	HEALTH CARE ORGANIZATIONS	N	OTHER INSTITUTIONS/ AGENCIES	N	SOCIAL/STRUCTURAL	N
Use a trauma-informed and/or strengths-based approach (e.g., nonjudgmental and accepting manner, sensitivity to potential triggers, talking with patients privately, building rapport and trust, attending to nonverbal cues, etc.)	15	Institute and/or improve training and education to providers about trafficking and/or delivering trauma-informed care to victims, including formally evaluating such training.	20	Encourage use of trusted support workers to advocate for and assist child in obtaining services (e.g. accompany to appointment, help explain the process, ask questions, normalize mental health care).	2	Conduct more research on developing reliable ways to identify child sex trafficking.	1
Have knowledge of resources for referrals and make those referrals directly, not rely on social services to do it	2	Coordinate care for trafficked patients across agencies and advocate for patients' needs	3	Include trafficking in curricula at health professional schools, postgraduate clinical training programs, and to practicing pediatricians.	2	Conduct more research to assess availability and quality of mental health care for trafficked children around the globe; assess effectiveness of mental health services, and Western as well as alternative therapies in different cultures.	1
Actively screen, especially with adolescent patients who have sexual risk factors	1	Offer services repeatedly, not just at the initial assessment	1	NGOs should offer training in both urban and rural communities to increase awareness of trafficking and improve identification.	1	Conduct more research on the use of Western assessment tools in non-Western cultures in order to establish a culturally valid tool.	1
Do not confront suspected trafficker	1	Employ a 2-phase approach: work on stabilizing housing, legal, and immigration issues before beginning mental health therapy.	1	Train juvenile justice personnel on trafficking, trauma-informed care, immediate and long-term needs of trafficked youth (including health and mental health), and local and national resources on trafficking, so they can act as effective brokers of services.	1	Conduct more research on effectiveness of online vs. on-site reproductive health services in facilitating identification of child sexual exploitation and promoting effective responses to a disclosure.	1
Partner with community and school-based educators and providers to raise public awareness of trafficking	1	Create physical environment that is perceived as safe, confidential, and non-exploitative	2	Package juvenile justice services specifically for commercially sexually exploited youth so that staff can better identify the unique needs of this population and potential treatment options.	1	Conduct more research on education and training standards for staff who provide mental health and other psychosocial services for child victims in aftercare.	1
Partner with local antitrafficking stakeholders to develop coordinated streamlined mechanisms of referral for health and nonhealth services	1	Make health facilities migrant-friendly	1	Create multidisciplinary teams including juvenile justice, law enforcement, education, child protective services, and community-based agencies to ensure care for trafficked youth.	1	Conduct more research on developing a framework for aftercare for trafficked children, and on outcomes of various aftercare programs.	1
Partner with law enforcement, child protective services, and local agencies to create community protocol on how to respond to suspected trafficking and to educate these partners on health effects of trafficking and the need for healthcare	1	Facilitate clients seeking care by having port outreach and mobile health units	1	Juvenile justice staff should consider and refer to trafficked youth as victims rather than offenders or delinquents.	2	Conduct more research on effective therapy types for trafficked populations.	1
Advocate for official recognition of trafficking as a public health issue by health professional organization and medical societies and participate in antitrafficking policymaking at local and national levels.	1	Consider telephone counseling services	1			Conduct more research on potential disparities in mental health services related to race/ethnicity.	1
Collaborate with investigators and other community organizations to educate community partners about the medical and mental health needs of trafficked youth	1	Adjust practice policies to enable victims to access treatment even when they are unable to provide proof of identity and legal status	1			Draw on lessons and successes of child abuse and domestic violence programs to inform development of prevention strategies.	1
		Offer walk-in clinics in partnership with other services for those awaiting identification documents or who wish to access care anonymously	1			Embed trafficking prevention strategies into existing disease prevention and women's health programs, especially in rural villages and other source areas, to allow for early	1

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Table 5 (*continued*)

PROVIDERS	N*	HEALTH CARE ORGANIZATIONS	N	OTHER INSTITUTIONS/ AGENCIES	N	SOCIAL/STRUCTURAL	N
						identification of, and intervention for females at risk of trafficking.	
		Embed any online services within the wider clinical or organizational structure in order to support safeguarding of children.	1			Consider offering incentives to MH professionals to practice in the provinces, and offer them training and support.	1
		Make medical and mental health diagnostic and treatment services immediately available and accessible	1			Adapt tools and treatments to fit culture.	1
		Base services for trafficked persons on good practices used for victims of domestic violence, sexual assault, and torture and for migrants and refugees	1			Utilize mental health professionals trained in the local culture to formally train and supervise upcoming mental health workers (not just on-the-job training).	1
		Use interpreters, monitor availability and uptake of interpretation services, and set aside additional time when these services are requested by patients.	5			Institute free and accessible mental health care.	1
		Facilitate staff awareness of and training on local and international resources (e.g., service agencies, helplines)	4			Create policy reforms increasing health insurance benefits to migrants, especially when they travel to different countries in fishing vessels.	1
		Employ targeted screening and event-sensitive measures to better identify trafficked patients	2			Require employers of long-haul fishermen to purchase international health insurance policies when men apply for work permits (perhaps including health insurance on the labour inspection checklist).	1
		Address secondary traumatic stress of workers (supervision, adequate time with clients, informal workplace support)	1			Increase public awareness of trauma reactions and ability to treat many of these without medications.	1
		Consider increasing awareness of MH services by using radio, news and other media networks	1			Educate professionals and public to combat stigma and discrimination related to trafficking and mental health issues.	1

* N = number of times recommendation identified in reviewed literature.

Another set of barriers involved survivors' choiceful lack of engagement in healthcare (n = 6) due to, e.g., feelings of self-reliance, a failure to see themselves as victims of exploitation, and/or a preference to forget their past. Communication problems (n = 5) such as language barriers, inadequate explanation and/or comprehension of health information, and providing changing or inconsistent information to care providers were also identified as a barrier to care at this level, as was social/geographic instability (n = 4), including changes in housing, running away, and/or moving out of the catchment area of providers, because this caused disruptions in the continuity of care. Additional factors functioning as barriers to health service provision included survivors' lack of knowledge about the healthcare system and how to navigate it (n = 3), including how to schedule an appointment, find a facility, and obtain transportation to a facility; and survivors' geographic restrictions (n = 1), such as those that might occur if the survivor did not want to cross gang lines to receive services at a particular health facility.

6. Recommendations for improving health service provision to trafficked populations

Recommendations for improving health service provision to trafficked populations were identified 100 times in the relevant surveyed literature. As shown in Table 2, the majority of those identified were directed towards healthcare organizations and individual healthcare providers. No recommendations were directed to individual survivors. Table 5 lists the 52 distinct recommendations included in the 100 identifications, organized by the five domains for potential change.

6.1. Recommendations for healthcare organizations

The most commonly identified recommendation for healthcare organizations to improve care to trafficked populations was to institute and/or improve training and education about trafficking and trauma-informed care (n = 20 identifications). Other common recommendations involved developing ways to engage trafficked persons in services (n = 8), such as assisting survivors by coordinating care across agencies and advocating for their needs; offering services repeatedly over time, not just at the initial assessment; and working to stabilize housing and other basic needs. Adjusting practices to improve access to care (n = 7) was also a common recommendation, including utilizing mobile health units; offering telephone counseling; and enabling services even when patients are unable to provide proof of identity and legal status. Additional recommendations included communicating clearly in survivors own language, using interpreters as needed (n = 5); facilitating staff awareness of resources such as service agencies and helplines (n = 4); implementing screening practices for identifying trafficking (n = 2); supporting staff members in managing secondary traumatic stress (n = 1); and increasing public awareness of the availability of health services through media and community outreach (n = 1).

6.2. Recommendations for health care providers

At the provider level, the most dominant theme among recommendations was the importance of employing a trauma-informed and/or strength-based approach when interacting with a suspected trafficked person (n = 15), including adopting a nonjudgmental and accepting manner; sensitivity to potential trauma triggers; talking with patients privately; striving to build rapport and trust; and attending to nonverbal cues. Additional recommendations (n = 4) within the context of clinical practice included personally making and following up on direct referrals to specialists; actively screening for trafficking; and not confronting the suspected trafficker if s/he is present. It was also recommended that providers engage in work beyond the immediate provision of care (n = 5). Recommendations for such work included collaborating with other providers and school-based educators to raise public awareness of trafficking and its medical and mental health effects; developing coordinated streamlined mechanisms of referral for all services with local anti-trafficking stakeholders; and working with local agencies to create community protocols on how to respond to suspected trafficking. It was also recommended that providers advocate for official recognition by professional organizations and medical societies of trafficking as a public health issue and participate in anti-trafficking policymaking at local and national levels.

6.3. Recommendations for other institutions or agencies

Recommendations for other institutions or agencies included the use of NGO support workers as advocates for trafficked persons' health needs (n = 2). Such advocates could accompany survivors on healthcare visits, help explain the medical process to them, and normalize mental health care. Health professional schools and postgraduate clinical training programs could integrate standardized training about trafficking into the curriculum (n = 2). In addition, NGOs could train communities to increase awareness of trafficking and improve identification (n = 1). Several (n = 5) other recommendations were directed specifically to the juvenile justice system, a system in which trafficked children's unique needs are often not recognized. Recommendations included that juvenile justice personnel be trained on child trafficking, trauma-informed care, the health and non-healthcare needs of trafficked youth, and available services; that services be packaged specifically for trafficked youth in order for staff to better identify potential treatment options; that juvenile justice systems partner with community-based agencies to create multidisciplinary teams that can better ensure care for trafficked youth; and that staff reconceptualize trafficked youth as survivors, rather than offenders or delinquents.

6.4. Recommendations for the larger societal/structural level

The most common recommendation at the broader societal/structural level was for more research to be conducted (n = 8).

Recognition of the need for solid evidence on mental health service strategies was particularly common, including research to assess the availability and quality of mental health care and related therapeutic techniques for trafficked persons; research on training standards for staff who provide mental health and psychosocial services for survivors; and research on racial and ethnic disparities in mental health services among this population. Also recommended was research on the use and efficacy of Western-developed assessment tools adapted for use in non-Western cultures; research on outcomes of aftercare programs; and more research to support the development of reliable ways for identifying trafficking, including research on the effectiveness of online vs. onsite health services in facilitating identification. A variety of changes to standard practices and strategies were also recommended (n = 5). These included incorporating the lessons and strategies of child abuse and domestic violence programs into prevention strategies; embedding trafficking prevention strategies into existing disease prevention and women's health programs to facilitate early identification of and intervention with persons at risk of trafficking; offering incentives to mental health professionals to practice in areas where access to care is limited; and tailoring approaches to become more culturally appropriate, such as adapting existing tools and treatments to fit the culture in which they are being used and enlisting mental health professionals trained within specific countries to formally train and supervise other mental health workers. Several recommendations also focused on policy reform (n = 4), including instituting policies enabling free and accessible mental healthcare; and increasing health insurance benefits to migrants, including long-haul fishermen. Finally, increased national and international efforts to raise awareness and combat stigma associated with human trafficking were also recommended (n = 2), including increasing public awareness of trauma reactions and trauma-informed treatment, and educating professionals and the public about trafficking and its impact on mental health.

7. Discussion

While the total number (29) of identified studies discussing facilitators and barriers to healthcare for trafficked minors is relatively small, abundant information is available to guide improvements in service delivery. Numerous barriers for trafficked children involve factors within the locus of control of health professionals and healthcare organizations.

7.1. Knowledge of human trafficking

A major barrier to high-quality healthcare cited in multiple studies involves a lack of knowledge of medical and mental health professionals regarding human trafficking. (Chisolm-Straker, Richardson, & Cossio, 2012; Cole, 2018; McConkey, Garcia, Mann, & Conroy, 2014). Again, this topic is unlikely to be covered in health professional training programs in most countries. There are increasing efforts to educate providers with webinars, online modules, journal articles, guidelines and on-site presentations (Ahn, Alpert, Purcell, Konstantopoulos, & McGahan, 2013). National medical organizations (American Medical Women's Association, 2014; Greenbaum, Bodrick, AAP Committee on Child Abuse and Neglect, & AAP Section on International Health, 2017) and others (Powell, Dickins, & Stoklosa, 2017; Stoklosa, Grace, & Littenberg, 2015) have called for training of healthcare professionals on human trafficking and HEAL Trafficking (www.healtrafficking.org), an international organization of professionals advocating for a public health approach to human trafficking, has posted a non-exhaustive compendium of available curricula for healthcare professionals. The Institute on Healthcare and Human Trafficking (www.vIHHT.org) provides links to international research, clinical guidelines, protocol toolkits and fact sheets for health professionals.

7.2. Trauma-informed care

A trauma-informed approach was viewed as a facilitator of care when present and a barrier when absent. Recommendations by trafficked persons and professionals working with them frequently suggested the practice of trauma-informed strategies to engage patients and earn trust. Trauma-informed care is a relatively recent practice (Substance Abuse & Mental Health Services Administration, 2014) and is not routinely taught in nursing and medical training programs. Altering traditional instruction on history-taking and provider-patient interaction to incorporate trauma-informed strategies involves a major shift in the clinical curricula of medical and nursing schools. Therefore, a commitment at the highest levels, by national academic accreditation agencies, health ministries and national nursing and medical organizations may be necessary. In addition, while principles of trauma-informed, rights-based and victim-centered care (transparency, empowerment, confidentiality, etc.) are essential components of a mental health practitioner's repertoire, it cannot be assumed that these skills are emphasized in training programs globally. Therefore, an active commitment to integrating trauma-informed strategies into mental health professional training will be needed.

The concepts of trauma-informed care (Fischer et al., 2019; Substance Abuse & Mental Health Services Administration, 2014) apply to any patient who has experienced or is undergoing significant trauma, including those who have suffered the loss of a significant other, experienced accidental or inflicted injury, major illness or significant medical/surgical procedures. Arguably, this approach to patient interaction is appropriate for all patients since traumatic experiences are common and providers may not know at the time of the visit whether or not the person has experienced trauma. While trauma-informed care lacks a scientific evidence base, existing studies of trafficked persons' experiences with the healthcare system provide support for this approach to patient care. Trafficked persons' complaints of lack of confidentiality, lack of provider empathy and respect, and feelings of being judged attest to the need of a trauma-sensitive approach, as do their expressions of appreciation for providers who allow sufficient time for discussion, explain medical procedures and demonstrate caring and support (Westwood et al., 2016, Barnert et al., 2019; Bick, Howard, Oram, & Zimmerman, 2017; Ijadi-Maghsoodi et al., 2016; Stanley et al., 2016). Adult and child survivors recommend trauma-informed practices, although do not refer to them as such. They call on health practitioners to listen actively, provide support, encourage a

sense of hope, and refrain from judgment and bias (Corbett, 2018; Ijadi-Maghsoodi et al., 2018; Rajaram & Tidball, 2018).

7.3. Applicability of recommendations in other patient populations

Many of the recommendations for healthcare organizations are applicable to patients without a history of trafficking, and their implementation would have far-reaching effects. Providing an environment where patients feel safe, enforcing strict measures to preserve the confidentiality of patient information, and improving efforts to identify and address secondary traumatic stress among staff members can markedly improve the healthcare experience of patients and providers, alike. The availability and use of professional interpreters, and investigation of alternative methods of providing interpretive services (e.g. use of technology) can improve care for all patients who do not speak the same language as their provider. Similarly, providing information to patients regarding tests and treatment options in a language that they can understand can improve services to all patients at a facility.

7.4. Comparison with sex worker populations

While the evidence regarding facilitators and barriers to healthcare access by trafficked persons is limited and predominantly based on studies from high-resource countries, there is a great deal of overlap in results when compared with the myriad studies of sex workers' access to reproductive healthcare and HIV testing/treatment in medium- and low-resource countries (Baleta, 2015; Binagwaho et al., 2010). Sex workers in Rwanda reported systematic discrimination by health professionals who refuse treatment based on stigma associated with prostitution (Binagwaho et al., 2010). Similarly, female sex workers in Ethiopia reported discriminatory behavior by health workers when seeking HIV counseling and treatment (Ameyan, Jeffery, Negash, Biruk, & Taegtmeyer, 2015). Migrant sex workers in Thailand faced barriers such as lack of insurance and lack of access to health information that hindered their ability to obtain healthcare (Barmania, 2013). Female sex workers living with HIV in Chennai, India reported multiple barriers to seeking care, including a lack of privacy during counseling sessions in hospitals, insensitivity and disrespect on the part of staff, discrimination based on stigma related to sex work and to HIV status, and a lack of information available regarding antiretroviral treatment (Chakrapani, Newman, Shunmugam, Kurian, & Dubrow, 2009). This overlap in study findings is not surprising, given the fact that many sex workers are trafficked, or were trafficked as minors (Goldenberg et al., 2015; McIntyre, 2009). The stigma against commercial sex is present in many cultures (Devine, 2009) and healthcare professionals may mirror the bias and discrimination demonstrated by the public.

The plethora of research studies on sex work and HIV in medium and low-resource countries offer a good opportunity to gain insight into innovative strategies to improve healthcare access among trafficked persons. For example, in Ethiopia efforts to increase awareness of HIV/AIDS have involved training a team of staff within health centers, educating health workers who visit rural homes, and facilitating community meetings at which health and HIV-related issues are discussed (Barnabas, Pegurri, Selassie, Naamara, & Zemariam, 2014). Similar efforts by clinic and hospital staff, as well as public health workers could help to prevent human trafficking by raising awareness, especially in rural areas. These initiatives could reduce harm experienced during exploitation by disseminating safety information about sexually-transmitted infections, HIV, condom use, and other issues. Healthcare workers providing care in rural villages and other regions with poor access to hospitals and clinics may be trained on human trafficking and provide follow up health care and social support to persons returning home after their period of exploitation.

7.5. Multidisciplinary collaboration

Frequently cited barriers to care for trafficked persons included a lack of coordination of referrals and service provision among health and other professionals (Beck et al., 2015; Domoney, Howard, Abas, Broadbent, & Oram, 2015). Here, again, much may be learned from efforts in fields related to human trafficking. Multidisciplinary collaboration has been maximized in the field of child abuse and neglect through implementation of the child advocacy center (CAC) model in North America and parts of Europe (Miller & Rubin, 2009; Wolfteich & Loggins, 2007), and the development of community protocols for child abuse investigations. Law enforcement, health, mental health, social service professionals and victim advocates work together to share information, collaborate on investigations and minimize re-traumatization of the child and family. Many CACs integrate medical and/or mental healthcare into the program so that the child is able to participate in the investigative interview, medical evaluation and mental health treatment at a single location, with a single group of providers. Increasingly, CACs are being used to provide services to sex trafficked children and youth in the U.S., allowing integrated services to help fulfill the vast needs of this population. Commitment to a multidisciplinary approach to human trafficking must be present at the national level, such as interagency collaboration between departments and ministries of health, child protection and justice, as well as at the local level, between organizations and individuals working directly with trafficked persons.

Central to the function of a multidisciplinary team is implementation of a community protocol for survivor identification and health and legal service provision. Health professionals can play a major role on this team, helping advocate amongst non-healthcare trained professionals for the child's healthcare needs and a trauma-sensitive approach (Greenbaum et al., 2017). This protocol should include a directory of services that reflects established community partnerships in order to facilitate streamlined referrals and comprehensive care. The directory should include specialty healthcare, primary care, mental health resources, substance abuse treatment centers (if available), and victim service organizations that can address housing, legal and immigration assistance, language assistance, education, and job training. All care should be accessible and affordable for survivors. Contact information and information about services provided, hours of operation, population served and resource capacities should also be included.

7.6. Protocols and guidelines for healthcare facilities

Healthcare facilities often have internal policies and guidelines to address specific aspects of patient care (e.g. closed head injury), staff behavior, and other major issues encountered during practice. Internal guidelines are also needed for recognizing and responding to human trafficking (Stoklosa, Dawson, Williams-Oni, & Rothman, 2016). Such a document may include an algorithm for screening and responding to suspected exploitation, as well as information on the dynamics of human trafficking, risk factors, possible indicators, the trauma-informed approach to care, and a list of community resources. Guidance is available for those developing such protocols (Dignity Health, 2017; HEAL Trafficking & Hope for Justice, 2015). Such a protocol would address multiple very important barriers to care cited in the studies we reviewed, including lack of provider knowledge of human trafficking and trauma-informed care, lack of awareness of national and community resources, and poor interagency collaboration.

7.7. Additional challenges faced by foreign-national trafficked children

While persons trafficked domestically experience numerous barriers to healthcare, it is critical to acknowledge that foreign-national trafficked persons experience additional challenges. Stigmatization associated with ethnicity and nationality; language barriers, lack of healthcare provider knowledge regarding the patient's cultural beliefs and practices; lack of translated materials and signage, and lack of professional interpreters significantly affect the access to care and health care experience. At the government level, lack of legislation and funding to provide for medical care of foreign-national trafficked persons, strict deportation policies, and limited healthcare availability in detention centers present major barriers.

7.8. Advocacy and research

Healthcare professionals, organizations, and societies can play a role in instigating change at the societal/structural level (Greenbaum et al., 2017). They may advocate for changes to policies and legislation to increase and improve services, especially for particularly vulnerable trafficked groups, such as male survivors, LGBTQI persons, and migrants (Dennis, 2008; Dank, Yahner, Madden, Banuelos, & Yu, 2015; International Centre for Migration Policy Development, 2015). Providers should advocate for increased funding and government commitment to developing a trauma-informed mental health workforce. A public health approach to human trafficking should be recommended, with adequate resources allocated to prevention and early intervention.

Prominent among the recommendations cited in our literature review is the need for an increased evidence-base. Rigorous scientific research is needed to identify incidence, prevalence, risk and resiliency factors, physical and mental health effects of trafficking, and the effectiveness of treatment interventions and public health activities aimed at prevention (American Public Health Association, 2015). This may be greatly facilitated with the adoption of specific human trafficking/exploitation codes for the World Health Organization's (WHO) International Classification of Disease system (ICD) (World Health Organization, 2018). The ICD system provides a global framework for healthcare professionals around the world to share critical information about diseases, injuries, and other diagnoses. At each medical visit, a patient is given relevant diagnoses which are documented in their medical record, along with corresponding ICD codes. The codes are accessible in a database that can be de-identified and used for research purposes. If ICD codes for trafficking are adopted, researchers will then be able to conduct large studies of trafficked persons within and between countries and regions. Currently such codes only are available in the U.S., so health professionals worldwide need to advocate for WHO adoption of global codes in its ICD-11 version (World Health Organization, 2018).

7.9. Limitations

There are several limitations to this review. We searched only peer-reviewed journals and articles written in English. Reports and studies in the non-peer reviewed, 'gray' literature were excluded and may have contained additional information, as may articles written in languages other than English. Inclusion of studies in the gray literature may have provided additional insights, although the lack of scientific peer review and the inability to systematically search the gray literature to ensure comprehensive evaluation of existing studies introduce their own limitations. Our search terms may have missed some articles in which child trafficking/exploitation was discussed but not a major focus of the study. However, we used multiple, inclusive search terms that led to a relatively large initial group of studies for review from which we identified the 29 relevant articles. This suggests that our search criteria were sufficiently broad to identify most of the pertinent studies. Another limitation involves the largely Western focus of the studies. Only seven of the 29 included articles evaluated healthcare systems outside the US and EU (2017, Aberdein & Zimmerman, 2015; Konstantopoulos, Ahn, Alpert, Cafferty, & McGahan, 2013; Pocock et al., 2018; Rafferty, 2016; Viergever, West, Borland, & Zimmerman, 2015; Zimmerman et al., 2008). Future research needs to focus on other areas of the world and compare/contrast the facilitators and barriers to healthcare experienced by trafficked children globally. Similarities and differences across countries and cultures need to be identified and 'lessons learned' need to be shared. Valuable information also may be obtained by examining cross-cultural studies involving issues related to human trafficking (e.g. commercial sex work among adults, HIV prevention, child abuse and neglect, and intimate partner violence).

8. Conclusions and implications

The peer-reviewed medical and mental health literature highlights numerous facilitators and barriers to care for trafficked

children. Training and skill building with respect to trauma-informed care as well as increasing provider knowledge of human trafficking are major recommendations for improving healthcare. Some recommendations extend the health professional's role outside of the health setting, encouraging multidisciplinary community collaboration. Many recommendations would benefit a larger patient population beyond those who have experienced trafficking, implying far-reaching implications for healthcare. Moreover, more research is necessary to further understand health care implications of trafficking and the effectiveness of current and proposed interventions.

Significant and sustained improvements in healthcare services to trafficked children requires considerable effort on the part of providers and administrators. This begins with an honest appraisal of a provider's own knowledge, attitudes and practice, as well as assessment of the services within the health facility. Identification of gaps and barriers must lead to a concerted effort to bring about appropriate social, structural and cultural change within the healthcare environment. An assessment tool for healthcare professionals and administrators has been developed to assist with such a gap analysis and is being piloted in two countries (www.icmec.org). This assessment tool is part of a comprehensive toolkit designed for use in low-, medium- and high-resource settings where trafficked persons may seek medical or mental health care. The kit also includes recommendations and resources for addressing identified gaps.

Table of contents summary

This systematic review summarizes the known facilitators of, barriers to, and recommendations for healthcare services for child survivors of human trafficking globally.

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