Beyond Sex Trafficking: Responding to Commercial Sexual Exploitation and the Role of Healthcare Systems

Kalie R. McNelly

Northwest University

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Names and identifying details in this thesis have been changed to protect the privacy of individuals.

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Introduction

It was early summer 2017, the beginning of my fieldwork for my Masters in International Community Development (MAICD). As a women's health nurse for the last ten years with a strong passion for those involved in the global sex trade, I wanted to better understand the role of healthcare in identifying and providing services for these victims. In most healthcare institutions, there are usually two or three admission questions to assess whether patients feel safe in their living situation, and/or if they struggle with depression and suicidal ideation. I recently made the decision to ask every patient that came into my care the same admission questions whether or not I believed they fit the criteria. From my experience, I can ascertain that most healthcare providers answer these questions themselves based on their initial perceptions while clicking the boxes on the computer, usually with their backs turned toward the patient. There are several reasons why these patients go unidentified: stigma, shame, mistrust in people and systems that have failed them in the past, the presence of their abuser and the inability to be honest, etc. These reasons along with the discomfort of the provider in asking such personal questions are why so many patients are discharged without the real help they need apart from the physical ailment which brought them into the healthcare facility.

It was a busy afternoon on labor and delivery when Maria appeared on the unit complaining of contractions that had begun earlier that morning. The 24-year-old was having her first baby, and because she was preterm at only 30 weeks gestation, I hurried her into our evaluation room and quickly put her on the monitor. Maria was a lovely, quiet young woman; nice clothes, good hygiene, and from our initial conversation, seemingly educated. Maria came alone making it that much easier to inquire about intimate details. As I went about my nursing duties, I asked her the basic admission questions about her overall health and pregnancy. I then

sat on a stool looking her in the eyes as I continued with more specific questions regarding any drug and alcohol use, living situation, or history of depression and suicide. The only thing of note that Maria divulged was regarding depression in the past, but she insinuated that it was no longer an issue. As I was nearing the end of my assessment, my impression of Maria was lining up with her oral history. While gathering the last of my things before walking out the door to give the doctor a call, I turned back toward her and explained that, "I don't know what caused your depression in the past, but if there is anything we do or say here in the hospital that triggers you, do not be afraid to speak up or ask for help." That was all it took for the tears to begin falling down her cheeks.

Maria shared that she was nervous to come to the hospital that day because of her last experience in a birthing center almost eight years earlier when she was just 16 years old. Maria's mother was a meth addict and her father had been both verbally and physically abusive. In and out of different homes as a small girl, Maria ended up meeting her boyfriend shortly after running away from an abusive foster home. As he was much older than her, Maria felt comfortable with him because it was the first time she remembers being "taken care of." Unfortunately, it didn't take long for this feeling to fade, and after almost a year together she moved to Mexico with him. That was the beginning of what she described as her "hell."

Over the next year, Maria was forced to have sex with multiple men in a given day. She was not allowed to go outside or use the phone. She was drugged, beaten, and starved. At some point, Maria found herself pregnant. Once her boyfriend found out, he forced her to swallow a bunch of pills that were unknown to her. She also remembers him shoving these same pills up her vagina and using a wire coat hanger to try to abort the baby. The procedure did abort the baby, a little girl she recalls. It also left her hemorrhaging and begging for him to bring her to the

hospital. He finally did, and all Maria remembers from the experience was how judged she felt by the hospital staff. No one asked her how this happened to her or if she felt safe with her partner. The only things she received were quick judgements and condescending remarks after her drug test came back positive. As miserable as she was under the control of her abusive boyfriend, a part of her could not wait to be released from the hospital. For most individuals, healthcare is generally regarded as being a place where people feel safe and cared for. Unfortunately for Maria and many victims alike, it can also be the place of further stigmatization, neglect, and exploitation.

Shock, utter disgust, and deep sadness washed over me as I sat with Maria that afternoon, listening to her every word. Through my own tears, all I could say was that it was not her fault. I told her I did not judge her, and that as a nurse, I was sorry that the nurses and doctors who took care of her that day did not help her in the way she needed most. I told her I was currently working hard to change that. Maria's story is horrific, but unfortunately not unique.

How is this happening in our world today? How is healthcare missing what is often times so blatant? Healthcare is just one of the many systems that let Maria down in her early life, but it's her story that solidified my personal and professional mission to help educate and enable these systems to better care for our most vulnerable youth. Sex trafficking and commercial sexual exploitation (CSE) are long-standing social issues that require a coordinated community response. Because most trafficked and prostituted individuals seek medical services during the period of their exploitation, healthcare workers have the opportunity and responsibility to not only identify victims, but to understand how the demand for sex fuels the global sex trade. Within a multi-sector approach, educating healthcare becomes a vital component in ending the victimization that occurs in the form of human trafficking and commercial sexual exploitation. In

future sections of this thesis, the reader will develop a deeper understanding of the inner workings of the sex trade with discussion on: factors that make an individual vulnerable to exploitation, the inherent harm experienced by those involved in the sex trade, the demand that drives the global sex trade, and the importance of a holistic and sustainable response for those working in healthcare.

Most, if not all existing education for healthcare focuses solely on victim identification in a trafficking situation. Although an important first step, I have determined through fieldwork research, through my ten-year career as a women's health RN, and through my involvement educating healthcare on this issue, that victim identification alone is insufficient. Healthcare will never be adequately prepared to offer appropriate acute nor long-term care and services for these patients without addressing the demand, shining a light on the buyers, or recognizing the systems in place that create equal harm to individuals who are sexually exploited regardless of the presence of a third-party trafficker. In an effort to bridge these crucial gaps, I will offer a comprehensive summit in May 2018 to empower healthcare professionals how to address issues of commercial sexual exploitation on both a global and local scale (See Appendix 1).

Research Methodology

From early on, I knew that I wanted to focus my research on the personal insights and perspectives of those who had experienced commercial sexual exploitation, particularly in their interactions with healthcare. To do this, I utilized a variety of qualitative methods to include: phenomenology, grounded theory, case studies, and both practical and critical action research. Arguably the most useful framework for my topic was action research which not only "guided my interest in enlightening healthcare practitioners so they can act more wisely and prudently," but also my interest in "emancipating people and groups from injustice" (Merriam and Tisdell

54). During my research I conducted interviews and engaged in participant observation with healthcare professionals, survivors of sex trafficking and prostitution, anti-trafficking organizations, and direct victim service organizations in the Seattle area. Additionally, I conducted research through surveys and research literature to help guide intellectual progression on this topic.

During one of my interviews with Peter Qualliotine, co-founder of Organization for Prostitution Survivors (OPS) and Stopping Sexual Exploitation (SSE): An Accountability Program for Men led me to where I am today. Through my interviews with Peter, I learned that OPS is an active stakeholder in the Ending Exploitation Collaborative (EEC), a groundbreaking multi-sector partnership in the Pacific Northwest to end commercial sexual exploitation (CSE). The EEC unites survivors, NGOs, businesses, and government officials to carry out a comprehensive strategy based on the Nordic Model which shines the spotlight on the demand while simultaneously providing exit services to victims. The Nordic Model is based on research that promotes shifting away from past practices which solely focused on prosecuting prostituted individuals, instead on those who cause the harm, the buyers. Combating sexual exploitation requires a holistic method that targets not one, but multiple systems that both directly and indirectly impact CSE. The EEC's new approach engages multiple sectors of society to reduce harm and holds exploiters accountable. These systems include: education, technology, media, business, government, criminal justice, and healthcare. Peter Qualliotine happens to be the chair of the Ending Exploitative Collaborative's healthcare sector, and after hearing my story and understanding my interest in this topic, he extended an invitation to join their work.

The Demand

On December 10, 1948, the United Nations General Assembly adopted the universal "Declaration of Human Rights," which lays out the basic principle that all human beings are born free and equal, and that every human has the right to life, liberty, and security of person (UNGA). This agreement leads us to the first step in understanding the global sex trade which is to acknowledge it as a fundamental human rights issue, one that is governed largely by and for the benefit and profit of men who represent the grand majority of the buyers of commercial sex. Those who create the demand for the sale of women and children do not always match society's stereotypes, nor are they treated like the criminals they really are. They are doctors, teachers, lawyers, businessmen, coaches, and police officers. They are our family, friends, and co-workers who do not appear evil, rather frequently resemble model citizens. While addressing the executive committee of the Tom Lantos Human Rights Commission, Congressman Randy Hultgren said that, "We could end this overnight if men stop buying sex" (TLHRC3:33-3:45). Sounds simple enough, but unfortunately, despite the recent attention being paid to this nefarious global enterprise that depends on the supply and demand of human beings, we have a long road ahead in order to end the business that preys on the most vulnerable: those who lack the freedom or ability to walk away.

Although it is men who undoubtedly stoke the global sex trade, we cannot point to patriarchy alone as the overwhelming culprit. I have witnessed too many brave men, currently dedicating their lives on behalf of the rights of women and children. Yes, male power and privilege throughout history can help explain the link between violence against women and sexual exploitation, but the thread of all forms of power throughout multiple systems, generations, and genders is why the exploitation of others continues to prevail. It is also

important to note that though most men do not buy sex, the small percentage that does, when quantified, causes an incredible amount of damage. The minority of men who purchase sex are not only supported by those who make a profit by supplying victims to meet the demand such as traffickers, pimps, brothel owners, and corrupt officials, but also by our society whose culture normalizes, glamorizes, and romanticizes prostitution as a victimless crime.

Many still hold the belief that prostitution and sex trafficking are separate issues, and that trafficking is only seen in corrupt, poverty-stricken economies such as South-East Asia, Latin America, and Eastern Europe. As we consider the woman on the internet who offers her children for sex, and the man, a business executive, eager to pay the price, we cannot ignore the fact that this issue also exists in the most affluent of neighborhoods in the United States. It is easy to put these criminals on the other side of the line from us, finding comfort in the fact that they are different or far away. But we cannot cast this issue out of sight, somewhere else unseen, for then we ignore those ensnared in its trap who may need our help.

The Men Who Create the Demand

Language and Labels

Because of the hidden nature of the crime, no NGO, the UN, nor the United States State Department know exactly how many people are trafficked around the world for both labor and sex trafficking. There is however overwhelming agreement; first, that 70-80% of trafficked persons are women and children, and second, that the economic equations of supply and demand are applicable to this multi-billion-dollar illegal market (Soroptimist 2). Each year, depending on the source (numbers range from 4 to 27 million), millions of women and children around the world fall victim to the global sex trade (TLHRC 7:47-8:08). They are tricked, recruited, bought, and sold into prostitution, often by means of force, fraud, or coercion; the three official factors

that have become consistent in human trafficking definitions worldwide. Sex trafficking, prostitution, and exploitation of all kinds are far from new. The failing systems that sustain the steady flow of supply and demand is largely supported by society's role in defending prostitution as the "oldest profession." The primary actors who influence the demand are the men who purchase sex. Without them, prostitution would not exist. Throughout the literature around prostitution, these men are often referred to as, "customers," "clients," "consumers," or "Johns" which tend to add a normalizing tone to the language. For the purpose of this thesis and future work around this issue, I will refer to these men as they are, "those who purchase sex," or "sex buyers."

Common Beliefs

According to the "Best Practices to Address the Demand Side of Trafficking" published by the University of Rhode Island, "For any woman to be considered a victim of sex trafficking by most legal criteria, she must perform commercial sex acts as a result of force, fraud, or coercion" (Hughes et al. 7). The only exception is in the presence of commercial sexually exploited children (CSEC), which always falls under the trafficking definition. After nearly 18 months studying this issue, I now realize that regardless of a man's preferences and criteria for purchasing sex, the fact that a woman or child is trafficked by legal definition or not becomes irrelevant and mostly impossible to distinguish. This single truth is largely what influenced the topic of this thesis. Most individuals (including those in healthcare) view sex trafficking as a horrendous human rights violation worth fighting for, while those experiencing sexual exploitation or prostitution without the presence of a third-party trafficker are viewed as empowered "sex workers" who freely choose this work regardless of their age. If there is one thing the reader will take away from this thesis, I hope it is this: The acceptance of prostitution is

a harmful view that justifies and encourages gender-based violence and men's belief that they are entitled to sexual access of women's bodies. In future sections of this thesis, we will explore how prostitution is inherently harmful, dehumanizing, and fuels the supply and demand for trafficking victims.

In Our Own Backyard

During the summer of 2017, Seattle residents were left in disbelief as they read one of the top stories in the *Seattle Times* which uncovered the truth behind a popular prostitution review board. The 23,000 members, all of which were men, not only admitted to paying for sex, but boasted about it as they wrote detailed online reviews of their encounters (Thompson). While some claim that websites like "The Review Board" keep women in prostitution safe by giving the buyers an identity, survivors who were once advertised on the site beg to disagree after sharing stories of rape and violence (Thompson). According to Melissa Farley, American psychologist, researcher, and anti-prostitution activist, "There is a vast power differential between a buyer of sex and the woman he buys in terms of poverty, social status, abuse history, and often immigration status" (Macleod et al. 30). The relationships between the men who buy sex and the women they buy are far from equal. This was evident in the recent Seattle bust where the men were mostly affluent professionals while the women by contrast, "were typically young, non-English speaking, isolated in a foreign country, traveling with little more than a suitcase full of clothes, maybe overstaying a tourist visa or brought to the U.S. with forged documents" (Thompson). These instances occur every second of every day around the globe. While the majority of citizens see through the lens of legally consenting adults working as empowered "sex workers", they ignore the blaring truth where long histories of childhood abuse, racism, gender-based violence, and huge economic power disparities are hidden. When the paradigm shifts, it is

harder to make the argument for consent, especially after money is exchanged. It becomes harder to rationalize consent after it is bought for a monetary value.

The Internet

Information gathering and communication have drastically changed with the rise of globalization. Where there was once real human interaction, we now have the, "World Wide Web which has allowed people to gain access to information anywhere at any time," without ever having to encounter another human being (Wooldridge and Micklethwait 16). In their book *Globalization, Technology, and Philosophy*, Koivukoski and Tabachnik explain that, "Technology is the independent variable of globalization," both of which create increasing avenues for the exploitation of people and places around the world (61). While both the internet and technology have allowed us to create many amazing things in the last few decades, it has also introduced a new advancement for crimes against humans, more specifically children.

Lechner and Boli help describe some of these recent challenges in their book *The Globalization Reader* as they explain how:

> As economic globalization has increased, and as technology and technical systems have become more encompassing and complex, global problems like pollution, *trafficking,* and terrorism have also become global. The adequacy of states to cope with the rapidly integrating world has increasingly been called into question (229).

This is evident by the shift of all forms of trafficking and prostitution from the streets to the internet. In many sex trafficking cases, offenders use social media and online job boards to recruit many young victims by gaining trust, professing admiration and love, and promising a better life or to make the victim a star.

Today, traffickers use the internet and dark web (a portion of the internet which is intentionally hidden and inaccessible through standard web browsers), to buy, sell, and rent human beings. According to Anne-Marie Slaughter in *The Globalization Reader*, "Traffickers of women and children, and the modern-day pirates of intellectual property all operate through global networks" (Slaughter 283). Whether it be for sex or labor, there is an increasing number of illegal activity happening out of plain sight from most of humanity, which is why it comes as a complete surprise to many that there are more slaves in the world today than ever before in human history with an estimated 27 million worldwide (Johnson 00:32).

Pornography

There is no sense in talking about how technology has become the catalyst for many human traffickers and buyers worldwide without discussing the link to online pornography. Many people do not like to discuss the relationship between pornography and human trafficking because although most would agree that human trafficking is harmful and illegal, the same people are likely to argue that porn use is not. Today, 96% of men and over 50% of women surveyed admit to viewing online pornography, mostly on their smartphones and while at work (Johnson 3:38-3:41). Simply put, pornography is just pictures of prostitution (Qualliotine). To understand it's magnitude, we can look at the work, or at least the intentions of Dr. Simon Lajeunesse at the University of Montreal who started a research study seeking men in their twenties who had never viewed online pornography to learn more about the effects on the brain. The study was canceled because there simply were not enough people who had not viewed online porn to constitute a control group to study its effects ("Get the Facts"). Buying and selling people can now be done from the privacy of your own home, office, or hotel room. While

moving it from the streets to the internet, the risk for those buying and selling goes down, while the risk for those being bought and sold goes up.

The Link Between Pornography and Human Trafficking

In the United States of America, we have managed to legislate sex. We have outlawed rape, statutory rape, and pedophilia. Laws are consistent in the fact that sex should only occur between consenting adults who understand the risks and responsibilities, such as pregnancy and diseases that come with it. But what about sex in exchange for money? Forced sex for money is illegal and is what most of the world acknowledges as sex trafficking. There are a myriad of reasons as to why referring to prostitution as consensual sex is incorrect, and all fifty states except for two counties in Nevada have managed to agree that this type of exchange should be labeled illegal.

Legislation is persistent regarding sex as a, "legally, significant act with physical, relational, and psychological consequences which should only occur between consenting adults," (Johnson 2:26-2:29). If money is exchanged for sex, a crime is committed, but if someone films the sex and distributes it on the worldwide web, this is called hardcore pornography which is labeled as freedom of speech. It is encouraged and normalized. It is a rite of passage for young boys, an inspiration for couples, and a recreational pastime which is becoming an addiction for many. The discrepancy that most fail to recognize is that people are still getting paid to have sex. This legally significant act with all its many consequences still occurs. Megan Johnson in her TEDx talk linking pornography and human trafficking describes this as the, "commodification of human beings for the pleasure of paying consumers for an estimated 14 billion dollars a year" (Johnson 2:40-2:45). Just like tobacco companies that denied any relation between tobacco and

cancer for many years, we are just now beginning to recognize how the pornography industry undeniably both drives and supplies the demand for sex slaves.

Current Laws and Legislation

In 2012, most owners of a computer or smartphone remember the online viral video produced by the Invisible Children exposing the horrific actions of war criminal Joseph Kony. Their slogan, "Kony 2012" had college campuses, youth groups, and entire communities in the U.S. and around the world outraged at Kony for his hand in using child soldiers to fight for his regime. Both the Invisible Children and Kony became household names, and just like that, not even a decade later, we have moved on while Joseph Kony continues using children to fight. Every social movement has its moment in the spotlight: domestic violence, the environment, elder abuse, child soldiers, female genital mutilation, etc. The problem lies in the fact, that though society and the media decide to move on to the next topic, it doesn't mean that the previous one has disappeared. One hot topic today in 2018 is human trafficking. Human trafficking is undeniably an important social issue that has been around for a very long time and is likely not going anywhere soon. The attention being paid to this issue is long overdue, but I fear this movement will also pass without ever addressing the deeper-rooted issues such as, gender-based violence, race, the demand, and systems that induce poverty which keep trafficking alive and well. We need to be able to address the continuum of these foundational issues of which commercial sexual exploitation is just one component.

There is no other industry in the world that targets those who have been victims of childhood sexual abuse or that preys on the most vulnerable people in our communities (Lloyd 12:19). As a society, we have a difficult time recognizing prostitution as a form of violence and power over those who suffer from acute vulnerabilities such as homelessness, childhood sexual

abuse, and racial inequalities. The concept is even difficult for other human rights organizations such as Amnesty International, who propose to decriminalize pimps, brothel owners, and buyers of sex as a means to protect the exploited. Even as the tides of social issues turn, one way to create sustainable long-term outcomes are to change laws which invariably influence societal changes.

Human Trafficking in the U.S.

Historically, the U.S. has done a poor job at protecting victims of human trafficking and sexual exploitation, especially those who are from this country. The global sex trade as we know it today began with the deep-rooted tradition of conquering women of color, a result of European and American colonization worldwide. In his book *Resisting Global Toxics,* David Pellow argues that, "though rapid cultural transformations are indeed taking place, they are reflective of both old and new hegemonies that have maintained the subjugated position of indigenous, poor, and ethnic populations around the globe much more than they have elevated them" (40). This is evident in the irony that the Global North who currently leads much of the efforts that address human trafficking, was built on the continued tradition of colonization and exploitation of land and people by means they now profess to condemn.

National progress was made in 2000 when congress passed The Trafficking of Victims Protection Act (TVPA) to end human trafficking. The TVPA includes an evaluation tool that rates nations based on their adoption of the "4 Ps" approach: Prevention of human trafficking, Protection of victims, Prosecution of trafficking offenders, and Partnership (OJJDP 2). The most important principle of the TVPA is to ensure that the trafficking of persons is a federal crime, regardless of citizenship. Though some states continue to prosecute minors for prostitution,

under the TVPA, any minor who is exploited for sex is considered a victim of human trafficking which brings us to the creation of the Safe Harbor law of 2008 (CCWC46).

State Laws

Although prostitution remained widely illegal, it was not a crime to purchase sex from a minor in all 50 states before 2008. What we saw was the arrest of 12, 13, and 14-year-old prostituted kids while the much older adult sex buyer was given a slap on the wrist as he was handed back his money. Despite the current laws that deem it illegal at both the state and federal level, it is still rare in most states for police and prosecutors to pursue the men who pay to exploit children. The fact that most buyers of sex will never be held accountable or charged is yet another injustice which adds to our culture of impunity (Swarens). Thanks to the hard work of trafficking survivor and well-known activist Rachel Lloyd, New York was the first state in the country to protect, not prosecute, children who have been sexually exploited and trafficked (Lloyd 10:23). The Safe Harbor law was introduced to protect children who were victims of sexual exploitation which states that any child under eighteen that is coerced into providing commercial sex is a victim of trafficking and must be treated as such (Polaris 1). Though it may seem like an obvious and imperative human rights law to enact, as of 2015, 16 states in the U.S. had still yet to adopt "Safe Harbor" laws (Polaris).

International Laws

Legislation that protects victims of trafficking is fairly recent as evidenced by the international communities first collaborative action on the issue in 1996 at the First World Congress Against Commercial Sexual Exploitation of Children in Stockholm, Sweden (CCWC 53). On the agenda was the first agreement signed by 160 countries, (including the U.S.) to protect children from commercial sexual exploitation (CCWC 53). Since then, the United

Nations Office on Drugs and Crime (UNODC) has taken the lead in creating and sustaining international law's ability to combat human trafficking. To further support these efforts, the UNODC established the United Nations Global Initiative to Fight Human Trafficking (UN.GIFT) in 2007 from which the Palermo Protocol was created. The primary objectives of the Palermo Protocol are to prevent trafficking, to protect victims, and to punish those responsible (OJJDP 2).

Existing Obstacles

Despite the enormous progress that has been made in protecting sexually exploited children, we still have a lot of legal work to do to protect victims of all genders and ages. With the normalization of internet pornography, the consumer demand for sex has never been higher. Many websites that sell human beings and children for sex are protected by section 230 of the Communications Decency Act (CDA) passed by congress in 1996. This section of the CDA was fashioned to protect websites from liability when they host content from third parties (Leary). Even though legislative intentions for the CDA were to promote economic growth and business, it has nevertheless become a platform for illegal commercial sexual transactions as in the case of Backpage.com where most American victims of human trafficking are bought and sold. I cannot imagine this is what congress had in mind circa 1996, but that does not negate their responsibility to fix their mistake.

In his book *Unclean,* Richard Beck explains that, "the great moral temptation in scapegoating is that it often feels justified and righteous" (95). The fact that we live in a society that has largely stood behind the men who pay for sex while punishing, blaming, and scapegoating the victims is a very disturbing reality that we must face. Without shining a light on those who stoke the demand for sex, cycles of abuse and gender inequality will continue. Peter

Qualliotine, co-founder of the Organization for Prostitution Survivors in Seattle, WA told once told me that he believes the primary problem with the demand for sex is not that it causes sex trafficking, but that men feel entitled to purchase sex. The day women become equal to men will be the day prostitution will cease to exist (Broadly 19:19-19:25).

Many educated, academic, and even feminist activists argue otherwise claiming that women "enjoy this," are "free to do this," and are "empowered through the sex work they choose," all of which could not be farther from the truth. The global sex trade is built on the exploitation of women by men, and according to activist and author Julie Bindel, "it could not exist without the institutionalized oppressions of gender, race, and class" (Bindel xix). Prostitution is a human rights violation against women and children, but unfortunately, not everyone shares this understanding. Those that support the "sex work" position; the same who continue to fight to legalize and decriminalize, believe that prostitution is a valid form of labor that it is not inherently harmful to women (Mathieson et al. 368). In the end, the theoretical debate about what we should call the problem is irrelevant. What is relevant is that people are being sold for sex (WuDunn and Kristoff 26).

Legalize or Decriminalize?

Both legalization and decriminalization support the belief that prostitution is a personal choice, an indication of women's empowerment, and is a business agreement made between consenting adults with equal power (Mathieson et al. 378). In legalization, the government takes control through labor laws, taxes, even promoting the sex businesses as seen in tourist promotions for countries like Germany and the Netherlands. This creates enormous profit for the sex industry while creating tax revenue for the government; revenue generated by exploiting vulnerable women. Decriminalization on the other hand simply removes all laws and penalties

that are associated with the prostitution industry which means no regulations and no arrests (Qualliotine). What unites the two is that neither result in either a reduction or an end to the sex trade, and both confirm the belief that prostitution is an inevitable, age old profession. When we hear certain policy proposals by well-intentioned individuals and organizations about decriminalization and legalization, it is important to ask who would be impacted? Considering prostitution is illegal nationwide (except for two counties in Nevada) changing the laws to allow the selling and purchasing of sex would mean more buyers and more importantly, more vulnerable children and adults falling victim to sexual exploitation in order to satiate the demand.

The Nordic Model, a Way Forward

The Neoliberal perspective that defines women in prostitution as free agents working and responding to a market demand for sex was met with abrupt resistance in 1999 when the Nordic Model was first adopted by Sweden. In contrast to the two previous models, the Nordic Model is based on the understanding that women's equity and equality depend on improving structural barriers that prohibit women's full economic, social, and political inclusion (Mathieson et al. 371). The Nordic Model is based on human rights principles which address the demand for sex, regard exploitation in the sex trade as gender-based violence and discrimination, and punish those who purchase and sell human beings for sexual acts. Multiple reports from the Nordic Model founding countries, (Sweden and Norway), show that targeting the demand for prostitution reduces the level of sex trafficking compared to neighboring countries yet to adopt such laws (TLHRC 11:08-11:25). The Nordic Model has since been adopted in Norway, Iceland, Northern Ireland, the Republic of Ireland, and France. Though U.S. legislation has yet to adopt the Nordic Model, much of the way we are operating is through Nordic Model principles.

Local Progress

Seattle has become been a leader in following the Nordic Model as evidenced by the adoption of new policies that prohibit prosecutors from filing prostitution-related charges until a person has been offered services to get out of the sex industry and refused (Merfendereski). In an interview with King5 News, King County Prosecuting Attorney Val Richey states that, "Our goal is to address the long history of violence against people in prostitution. We want to send a message to people in positions of vulnerability that they can come forward, feel comfortable, and be assured" (Merfendereski). Since 2009, these policies have dramatically decreased the amount of prostitute arrests while more attention is drawn to the buyers. The root of the problem will always stem from those who create the demand, and the Nordic Model has proven effective by focusing on that demand.

Addressing the Men

A mere 1% of research on prostitution addresses the men who buy sex, thus contributing to the discrete nature of those who create the demand (Farley et al. "Comparing" 7). Additionally, individuals or programs that work directly with sex buyers to prevent, educate, and rehabilitate this population are far from common. Peter Qualliotine of OPS says that, "According to the evaluations from our classes, most of the men who buy sex do not want to." These evaluations are consistent with Melissa Farley's research based on interviews with over 700 sex buyers where, "men's feelings after buying sex were generally more negative and less positive and were far more frequently described as: "glad it's over," "weird," "regretful," "guilty," or "dirty" (Farley et al. "Comparing" 27). Programs like SSE are different in that they are not shame based. They are designed to help men understand their behavior and promote their own decisions to not buy sex (Qualliotine). Peter is convinced that the best opportunity for combating and hopefully eradicating sexual exploitation and gender-based violence is to work alongside the

men while restoring their relational capacity to love (Jarvis). This class is the first of its kind worldwide, and there are many eyes on the Pacific Northwest as SSE attempts to dismantle the sex trade by changing the lives of the men who perpetrate it.

A More Holistic Approach

Unfortunately, despite the Nordic Model's paradigm shift and programs like SSE, addressing the men after the fact could be considered too little too late. What we desperately need is a holistic approach that begs for more prevention programs for at risk boys and men, better parenting, more social and emotional learning in schools, and more programs that promote healthy sexuality and relationships, all of which need to happen simultaneously in order to impact individual men (Qualliotine). Even when setting the human rights issue aside, the sex that men learn about in both pornography and prostitution is disconnected and unemotional. It is the opposite of what most women are interested in. Lastly, to halt the demand, we need a society that stands behind the vulnerable and unites against the practice of renting or purchasing people for the benefit and pleasure of those who hold more power.

Why Healthcare Should Acknowledge the Demand

It takes time to change societal beliefs. Measuring long-term results or attitudinal changes in the social sector is complicated and usually unfold over decades (Bornstein and Davis 63). There is no exception when it comes to women's equality which remains globally omnipresent. We cannot deny the progress we've made on a global scale as women are now allowed and encouraged to vote, are allowed the same educational opportunities, and have more access to economic options seen through microcredit systems. In the U.S., we now enforce laws that protect women and prohibit domestic violence such as the 1993 Supreme Court decision to outlaw spousal rape in all 50 states (Polisi 2009). However, to claim that women are seen and

treated as equal to men in the U.S. would be untrue. We still live in a society that largely believes prostitution is an economic opportunity based on choice, and sadly healthcare is a part of that society. To truly help those who are being trafficked and those who want to exit the life of commercial sexual exploitation, we must recognize that as long as women's bodies are rented, bought, and sold, gender equity and equality cannot exist. Healthcare has the power to influence society and stand in alliance with these victims, but the first step is to acknowledge the demand as the root of the problem. For the project portion of my thesis, I have partnered with the Ending Exploitation Collaborative's Healthcare Sector to host an event for healthcare professionals which will include education on the demand which fuels the global sex trade (See Appendix 1).

The men who buy sex matter too, and they need relationships where they are not trying to fill relational needs with non-relational sex. Men matter because they are the only ones who hold the power to eliminate the global sex trade. By educating the full spectrum of healthcare systems including: medical, community, psychological, therapeutic, and behavioral, we can begin changing a culture whose practices, laws, and social norms say that buying sex is an acceptable practice.

The Exploited

It should be taken into consideration that I am addressing this issue from a position of privilege. I have white skin, have had access to private education my entire life, and have been given immense economic opportunity. I grew up without the presence of childhood trauma and have lived in a supportive family unit with two parents who encouraged and loved me into adulthood. Even amidst what most would consider "ideal" conditions, I feel connected to this issue for the simple fact that I am a woman. I may have never been sexually exploited, but I have experienced sexual harassment and have been made to feel that my body is what gives me value.

I may never have been in a relationship where I experienced intimate partner violence, but I am a millennial; a woman in my thirties who has only been intimate with men who have learned about sex solely through internet pornography.

This issue is not separated from society. It is woven so cunningly through every aspect of our daily lives that its influence is barely recognizable, especially to those who hold power and privilege. The last few years of media and political scandals have exposed the ugly truth that, "For too long, women have not been heard or believed if they dare speak the truth to the power of those men" ("Oprah"). This is evidenced by the recent Larry Nassar indictment, the former Michigan State doctor who molested over 150 young gymnasts over the course of 30 years. Because of Nassar's high-profile status as a respected doctor who ironically developed the policies and procedures to protect the innocent from crimes he was guilty of, no one believed the girls who did speak up, not even their own parents. Society has become so accustomed to misogyny that we've even elected a president who blatantly contributes to gender inequity by publicly shaming women for breastfeeding, menstruating, and by being overweight. Sadly, the stories do not stop there. Over the past 18 months of research on this topic and many more stories alike, I have concluded that the exploitation of women and children, (along with the men who fuel it), is and should be everyone's problem.

How the Social Construct of Gender Perpetuates Gender-Based Violence and the Exploitation of Women and Children

Those who prefer to substitute the word "feminist" for "human rights activist" fail to acknowledge that the problem is not being human, rather being female (Adichi 41). According to Moe-Lobeda in her book *Resisting Structural Evil,* "Feminist theorists have explored ways in which women have gained the right to vote without gaining equal political influence" (223).

Although women in the Global North have made progress in earning the right to vote, own property, and hold positions of authority, blatant inequalities still exist. The proliferate sex industry is evidence of this fact. These small victories have created a veil over the eyes of many who continue to dismiss the present injustice. The veil is beginning to lift as recent headlines flood our news sources with sexual abuse accusations against politicians, celebrities, and high profile medical providers. Today, we watch aghast as women all over the world begin to feel empowered enough to speak up and share their personal stories. Oprah's unforgettable speech at the 2018 Golden Globes celebrated these women as she shone light on those who for far too long have not been heard or believed. "This year," she says, "women have become the story" ("Oprah"). Powerful blinders have kept us from seeing the reality of women's existence and time is up for the structural violence that has silenced a whole gender (Moe-Lobeda 108). It is my honor to add to this conversation by voicing a perspective from those who have largely remained invisible: the women and children commercially exploited for sex.

To fully conceptualize all forms of human trafficking and sexual exploitation, we must begin by understanding how the social construct of gender perpetuates and sustains inequality. Abraham Lincoln once said, "Although volume upon volume is written to prove slavery [prostitution] a very good thing, we never hear of the man who wishes to take the good of it, by being a slave [prostitute] himself" (qtd. in WuDunn and Kristoff 23). When a human being is reduced to a body for the purpose of sexually satisfying another, regardless of consent, an undeniable violation has taken place. Beyond the individual harm that is experienced by those who are sexually exploited, there is a social impact that turns a blind eye to gender-based violence and damages the perception of every woman on a global scale. For example: In South Africa a woman is killed by an intimate partner every six hours. An estimated 140 million

women and girls around the world have experienced female genital mutilation. In Papua New Guinea, 40% of men report having raped a stranger, and 80% of those trafficked annually are women and girls (Calkins 2013). There is absolutely no conceivable way for women to evade these social consequences or even establish equality with the continuation of a prolific sex industry and the normalization of prostitution and pornography.

Act Like a Man

To illustrate the *normalcy* of prostitution, we must begin by understanding how society's gender norms shape men. When boys are small, the message is consistent that "men are tough," "men don't cry," and when you feel vulnerable or emotional you should instead "act like a man." These boys eventually become teenagers who do not always understand or know how to process their emotions. Those who do, often receive labels by their peers such as, "sissy, girl, fag, gay, etc." It is during these teenage years where young men learn about sex largely through online pornography that depicts women and girls not as real people, rather as sex objects who exist for men's pleasure and consumption. Some social scientists defend the behaviors of men who buy sex as "normal" saying that it is simply a part of our human nature; a "boys will be boys" mentality (Farley 5).

My friend Kate recently shared her experience with me after spending an afternoon with her boyfriend and his close friends (all who were male). At one point during the night, someone told a story about his college experience using prostitutes as if it were normal; something that every man partook in. After returning home, she asked her boyfriend if he had ever had sex with a prostitute, to which he promptly denied. He further explained that neither had most of the men who were there that night. Kate explained that the most disturbing part of this experience was not that this one individual used prostitutes in college, but that no one spoke up against his behavior,

thus validating the message that prostitution is normal and acceptable (Kate). Even though most men do not buy sex, the acceptance and normalizing behavior of objectifying women has become present in every system of society. Indystar columnist Tim Swarens explains that, "Sex buyers are shielded by the same cultural attitudes and biases that men are entitled to sex and that victims are somehow to blame. These attitudes have protected powerful men who harass and assault women in the workplace and other settings" (Swarens).

Beyond the challenge of fighting these normalizing stereotypes, even more difficult is that prostitution has been proposed as a development strategy for industrializing and developing countries. The Netherlands for example includes profits from the sex industry into their economic activity which accounts for 5% of their GDP (Farley 4). In her article "Bad for the Body, Bad for the Heart," Farley explains that, "these stereotypes about men not only normalize and trivialize prostitution, but are also good business strategies, relieving 'Johns' of any doubts regarding the social acceptability of their sexual predation while at the same time inviting them to spend their money" (Farley 4).

Glamorizing Prostitution

When I was around nine years old, my family lived with our good friends for a few months while my parents were both unemployed. These friends had two older girls who my sister and I shared a bedroom with. One evening, the youngest of the two girls who must have been around twelve, snuck a movie up to the bedroom for us to watch late one night. Before that night I had never heard of *Pretty Woman* nor Julia Roberts, but after watching the film and for years to come, the movie made me feel more envy towards Roberts than empathy. Our society's common perception and numbness to the realities of "sex work" by glamorizing prostitution is clear in the first scene when Roberts is sexually assaulted by a stranger next to a dumpster

holding a dead prostitute. Hollywood has carried on this injustice in our society by helping encourage gender-based violence, toxic masculinity, and gender socialization, while completely disregarding the context in which individuals become vulnerable in the first place. Whether directly or through implicit bias, most of us have been conditioned to think of those involved in the sex trade as less than human; individuals who are almost always women.

Even after Hollywood's successful attempt to glamorize an industry built on the exploitation of others, the movie did capture a few rare moments that are all too common for those in prostitution. There were a few scenes where Robert's character was denied service at a high-end retail store and another where she was assaulted by her boyfriend's business partner. Both stigma and shame are what lead to secret lives that are most often lied about and hidden. The presence of stigma and shame are also what prevent those in prostitution to seek medical care or report crimes against them in fear of judgment, humiliation, and further stigmatization, thus pushing them farther and farther into isolation. We live in a society that values men's power and privilege over women, and worse, a society that values everyone's power and privilege over "prostitutes." In prostitution there is always a power imbalance, one that excludes any mutuality of power or privilege (Farley et al. "Prostitution" 34). Ghandi said, "it is time we stop confusing what is habitual with what is normal" (qtd. in Maine). Just because we have ignored the habitual harm experienced by those involved in the global sex trade, does not mean it is normal. It is time to develop relationships that challenge our world-views and expand our empathy and understanding for others (Bornstein and Davis 72-73).

And Boys, Too

Before gaining any more ground, I want to make it clear that even though we know the majority of individuals trafficked and exploited for sex are women and girls, little notice is given

to the victims and survivors who are boys. Responses from service providers indicate that the scope of commercial sexual exploitation (CSE) of boys is significantly under reported mostly due to three important factors:

1) Boys are less willing to self-identify as being trafficked or exploited due to the shame and stigma about being perceived as gay by friends, family, and the community at large.
2) Insufficient screening tools by law enforcement and social service organizations who fail to recognize that boys too are victims of CSE.
3) Limited outreach by service providers to tracks, venues, and areas known for male prostitution (Willis 5).

The risk for the sexual exploitation of boys begins much like it does for girls. Strong links such as: poverty, unstable housing, and early childhood abuse all contribute to the vulnerability of all children regardless of biological gender, gender identity, or sexual orientation. For boys however, there is a strong correlation between meeting basic needs and their sexual orientation or identity. For these reasons, many boys are kicked out of the house or rejected by family after opening up about being gay, bi-sexual, or transgendered (Willis 7). While it is important to acknowledge the high numbers of sexually exploited LGBTQ youth, we must remember that not all boys who are trafficked and exploited for sex identify as such, and regardless, the buyers are still men.

Distinguishing the Differences and Acknowledging the Similarities Between Human Trafficking and Commercial Sexual Exploitation

Language and Labels

Earlier we looked at some of the common names society has given men who purchase sex. We learned that when referring to men as anything but "sex buyer," it can have a normalizing, even invisible effect. In the same vein, women and children in prostitution have been given names that downplay the abuse that is occurring: "sex worker," "prostitute," even "child prostitute" have been assigned to these individuals, completely masking the physical, psychological, and sexual violence they experience. Referring to prostitution as "work" ignores the fact that so many are trafficked into it. For this dialogue and beyond, (unless used in a citation or quotation marks), I will only refer to these individuals as "prostituted women," "prostituted children," or "exploited persons," which remove the underlying tones of stigma and blame. Language matters, and it is the first step on the road to recognizing and changing erroneous beliefs. Lastly, as you read throughout this paper, please note that the term "prostitution" and "commercial sexual exploitation (CSE)" will be used interchangeably.

Consent

Our culture has managed to surmise that there is a definitive separation between victims of sex trafficking and those involved in prostitution. On one side we have an image of a young girl, tied to a bed who is forced to perform sex acts with no freedom or ability to leave. She is what most people think of when they hear the term "modern day slavery." On the other side of the spectrum we have the glorified adult sex worker who "chooses" her "job" as an empowered feminist and simply enjoys having a lot of sex. Do both scenarios exist? Probably, but that is not the point. People, more importantly men who buy sex, want to believe that those who they are soliciting sex from enjoy and choose their job. They pay for the illusion of consent. They pay for

the fantasy that the person whose body they are renting is over 18, is not being trafficked, and enjoys this "work." Sure, maybe somewhere there exists those where all the above are true, but the point is this: There is no way to know the truth about someone's situation. Whether it be trafficking or "sex work" by definition, we lose sight of the fact that coercing people with money to pretend they want to be with you is problematic (Qualliotine).

Definitions

According to the Trafficking Victims Protection Act (TVPA) of 2000, sex trafficking is defined as the:

> The recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not obtained 18 years of age (Raphael et al. 5).

Prostitution is defined as trading sex acts for anything of value: money, shelter, food, clothes, etc. (Raphael et al. 5). Because of the magnitude of the commercial sex industry, there are many systems in which one could be sexually exploited: street prostitution, brothels, massage parlors, escort services, strip clubs, phone sex, and adult and child pornography (Farley et al. "Prostitution" 34).

Many advocacy groups and social service providers are quick to spout off statistics on the prevalence of both trafficking and prostitution, but the truth is that due to the illegal nature of the issue, reliable data is hard to come by. I only intend to share what we do know about both, and where it is applicable, will be honest about that which we do not. For example, before the Safe Harbor Law was introduced in 2009, King County was able to identify the number of children

under 18 arrested for "prostitution," making it much easier to understand the magnitude of the problem. Because this area is currently operating under Nordic Model principles, we now target the men who buy sex instead of those being prostituted. This leaves us guessing as to how many are being victimized, and also makes it harder to offer services to those who are.

Most of us can assume that harm exists in the presence of sex trafficking. I have yet to hear a position arguing otherwise. What is less often acknowledged however, is the same harm and violence which permeate the lives of those involved in prostitution; most often as children before they enter the life of commercial sexual exploitation (CSE). Prolonged and repeated trauma precedes entry into prostitution as anywhere from 55%-90% report histories of childhood sexual abuse, and 59% physical abuse (Farley et al 35). In her article, *Bad for the Body, Bad for the Heart: Prostitution Harms Women Even if Legalized or Decriminalized,* Melissa Farley shows us that throughout history, "regardless of its legal status, prostitution has had a devastating impact on women's health" (1097). Prostitution in itself is a form of violence, one that results in economic profit for those who sell women and children. Though other kinds of gender-based violence such as intimate or domestic violence are rampant, they do not generate income as is the case for those in prostitution (Farley et al. "Prostitution" 35). In future sections of this thesis we will explore the factors that make individuals vulnerable to CSE, but first let us take a closer look at the physical and psychological damage these individuals face.

Physical Harm

According to Soroptimist International, "For the vast majority of prostituted women, prostitution is the experience of being hunted, dominated, harassed, assaulted and battered" (1). Prostitution is sexual terrorism against women at the hands of men and there is very little being done to stop it. Indeed, in "no other so-called profession are so many women murdered each

year" (Soroptimist 1). Most people in the workforce are aware of the specific occupational hazards they face. In the nursing profession there are many: chemical spills, back-related injuries, exposure to blood borne illness etc. Nursing students spend hours learning about ways to avoid said hazards and within each hospital system there are those with paid positions who provide continued, mandatory education on how to reduce these risks to keep us safe. Occupational hazards exist in the realm of CSE, but are obviously less valued. Risks such as sexually transmitted infections, gynecological conditions, unwanted pregnancies, exposure to substance use, physical violence, and a multitude of psychological damage all occur at high rates among those in prostitution (Greiner 10). No one should be forced to work a job where they are exposed to these inevitable threats.

In a 30-year study with nearly 2,000 prostituted individuals in the United States, "the most common causes of death were homicide, suicide, drug and alcohol-related problems, HIV infection, suicide, and accidents" (Soroptimist 7). Other reported physical consequences include high rates of: exhaustion, frequent viral illness, stomachaches, eating disorders, back aches, sleeplessness, headaches, traumatic brain injuries (TBI), cervical cancer, and chronic Hepatitis (Farley 12). Although most of the physical harm experienced by those in prostitution is caused by acts of violence as seen in the above examples, 30 % still report "poor general health" (Farley et al. "Prostitution" 53). Unlike the nursing profession where supervisors demand compliance with policies that protect staff from experiencing harm; those who claim responsibility for those in prostitution accept these hazards as part of the job. This is evidenced by a comment from an anonymous pimp where he refers to the "brief shelf life" of a girl in prostitution (Farley 12).

In my research I had the opportunity to conduct interviews with prostitution and trafficking survivors at a drop-in center downtown Seattle. My original intentions were to ask

these individuals about their experiences with healthcare during the time of their exploitation, but what resulted turned out to be much more than what I expected. Immediately after finding out that I am a nurse, multiple women came up to me asking me if I would look at their physical injuries, all of which were inflicted on them by their traffickers, pimps, or the men who bought them for sex. One woman who recently moved from Nevada had second degree burns on the bottoms of her feet from being forced to walk outside barefoot on the cement in 107-degree heat. Another had just returned from the hospital after being stabbed in the neck by a, "John who tried to slit [her] throat" (Steph). Irony tells us that I happened to be there by chance that night, but my heart tells me that the physical harm I witnessed is the norm for prostituted women.

Psychological Harm

When a survivor exists the life of prostitution, though it may take time and effort, recovering from physical ailments is possible. This is far less likely the case when it comes to the emotional wounds caused by years, often decades of psychological turmoil and abuse. The findings from countless studies over the last 100 years overwhelmingly agree on the numerous mental and psychological conditions seen in survivors of trafficking for sexual exploitation. These include:

- Depression (88.7%)
- Anxiety (76.4%)
- Nightmares (73.6%)
- Flashbacks (68%)
- Feelings of shame or guilt (82.1%)
- PTSD (54.7%)
- Suicide attempts (41.5%) (Raphael et al. 37-38)

You cannot separate physical violence and abuse from psychological. Our minds and bodies are connected in ways we still do not fully understand. What is important to comprehend is the prevalence of physical, psychological, and psychosomatic symptoms among trafficked and prostituted individuals compared to the general population (Greiner 17). Humiliation, racism, verbal abuse, manipulation, harassment, neglect, blackmail, being lied to, being trafficked and kidnapped are only some of the examples that contribute to their distress (Farley et al. "Prostitution" 53).

According to the American Psychological Association, PTSD or post-traumatic stress disorder is an anxiety problem that can develop after experiencing:

> extremely traumatic events, such as combat, crime, an accident or natural disaster. People with PTSD may relive the event via intrusive memories, flashbacks and nightmares; avoid anything that reminds them of the trauma; and have anxious feelings they didn't have before that are so intense their lives are disrupted (APA).

Combat military personnel are generally regarded as having the highest rates of PTSD among any other population. It is surprising to most who learn that victims and survivors of prostitution suffer higher rates of PTSD over those who have been weathered in combat. After interviewing more than 500 women in prostitution around the world, Dr. Melissa Farley and her team of researchers discovered that two-thirds of the women suffered from PTSD, a condition that is found in less than 5% of the general population (Farley et al. "Prostitution" 56) In contrast, studies looking at the rates of PTSD among Vietnam vets found diagnoses in 20-30% of the population (Zuger). Farley's study, *Prostitution and Trafficking in Nine Countries: An Update of Violence and Post-Traumatic Stress Disorder* was published in 1998 and revised again in 2003. Interestingly, the frequency of PTSD among the women in prostitution was found to be unrelated

to their nationality, race, or place of employment (Farley et al. "Prostitution" 37). Therefore, Farley's work helps us conclude that we need to view prostitution itself as a traumatic stressor for every woman and child around the globe.

Violence

In no other system outside of prostitution would we be able to find a wider array of violence that is so intrinsically traumatizing. The existence of prostitution and sex trafficking alone is synonymous with a form of sexual violence that result in profit for those who sell them. Beyond economic gain, gender violence, intimate partner violence, and physical violence are frequently the norm for those in prostitution, and multiple studies reveal just how commonplace they are (Farley et al. "Prostitution" 35):

1) In a 2004 study among 107 survivors of trafficking ages 14-60 from eleven major U.S. cities, 92.2% reported being the victim of at least one of 10 forms of physical violence: threatened with a weapon, shot, strangled, burned, kicked, punched, beaten, stabbed, raped or penetrated with a foreign object. Most of the survivors suffered more than half of these experiences as respondents reported an average of 6.25 of the 12 forms of violence (Raphael et al. 37).
2) In 2007 study out of Chicago, 100 girls ages 25 and below who were currently under the control of a pimp or trafficker were interviewed. 43% reported inability to leave without threats of physical harm, 48% had been punched, 43% had been kicked, and 47% had been raped by their trafficker. Weapons used were fists (71%), guns (38%), and burns via matches or cigarettes (38%) (Raphael et al. 35).

3) A 1997 study out of Portland OR discovered women in prostitution were raped on an average of once per week. In Minneapolis 85% had been raped in prostitution (Farley et al. "Prostitution" 35).
4) In the Netherlands where prostitution is legal, 60% of prostituted women experienced physical assault, 70% verbal assault, 40% sexual violence, and 40% reported being forced into prostitution by someone they knew (Vanwesenbeeck 508).
5) In a sample of 43 women on the streets 18 years and older, 72% relayed incidents of severe abuse suffered at the hands of their partners, clients, and/or pimps. Many reported having been beaten with objects, threatened with weapons, and abandoned in remote regions (Dalla et al. 1379).
6) 70% of those interviewed in a 1983 study reported the influence of early sexual abuse on their entry into prostitution (Silbert and Pines 286).

Defining "Choice"

Moe-Lobeda reminds us that as global citizens, "It is our obligation to understand how we have become inheritors of previous acts and how our collective acts influence and shape the coming generations" (63). Apart from blatant oppressive acts such as gender-based violence and human trafficking, we all naively contribute to many patterns of structural injustice that have been passed on to us. The limited lens in which we all view the world, each from a different perspective, makes it challenging to peel away from a society built on social injustice and in this case, the exploitation of others. This societal amnesia is what leads many to believe that prostitution:

- Is a choice

- Is a job just like any other
- Is about sexual freedom between two consenting adults
- Is different from trafficking and should be legalized (European Women's Lobby).

The truth is that most people in prostitution are being exploited by variables unseen to those of us who hold power and privilege. There is no voluntary prostitution. Instead, it is a choice made by those who have no choice (Soroptimist 2) While most individuals are forced into prostitution by way of gender discrimination, racism, poverty, lack of education, childhood trauma, neglect, and an inability to make a living wage, the men who buy sex are always the ones making a choice. No one has a gun to their head and they aren't doing it to put food on the table. Acknowledging the victimization from the inside is imperative before we can understand prostitution as a multidimensional issue that affects people at every level of their existence.

Gender

While both men and women may be victims of trafficking and sexual exploitation, the largest group of victims worldwide are women and girls (Stop the Violence 2010). International and domestic statistics align that adult women make up the largest group of sex trafficking victims, followed by girls under 18, then men and boys (King County CSEC Task Force). Research from the Bridge Collaborative in Seattle between 2014 and 2017 shows that females made up the majority of referrals and those who sought services ranging from 84% to 96%. Boys and men consisted of 4% to 13% while unknown, transgender, and gender non-conforming made up 1% to 2% (Bridge Collaborative). Women are disproportionately targeted because of their vulnerabilities such as gender discrimination, poverty, and access to employment and education. Arguably the strongest factor pulling women into the sex trade is economic instability

as women are often exploited or trafficked when they seek employment. Traffickers know this when they prey on their desperate circumstances through deceit and false promises.

Race

What may be the most disturbing truth about the global sex trade, is that it is a manmade disaster that can and should be prevented. The global sex trade as we know it today began with a long tradition of conquering women of color, a result of European and American colonization worldwide. Women of all ethnicities and socioeconomic backgrounds have fallen victim to sexual exploitation, but according to the federal government's crime statistics, American Indian and Alaska Native women suffer from the highest rates of sexual violence and oppression, more than any other ethnic group in the United States (Deer). Human trafficking is a crime of racism and poverty that has been largely ignored since those responsible for creating the demand are of predominate races and ethnicities.

David Pellow reminds us that until we identify and understand the "racial privilege" that freely gives us our freedom, citizenship, jobs, political power, housing, education, and prestige, we will never be able to address oppression, the denial of equal access to all of the above based on racial designation (49). In the U.S., people of color are disproportionately affected by commercial sexual exploitation. According to King County's CSEC task force statistics, 52% of those who are exploited for sex in Seattle and surrounding areas are African American who make up just 7% of the population (King County). A prostitution survivor and current advocate for the black community says, "You know why they (white men) choose us, right? It's because we don't look like their daughters" (King County). Although difficult to acknowledge for those of us who hold power and privilege, the deafening silence of racism experienced by those in prostitution is

nothing new. Since the first world domination of minorities, women of color continue to deal with the oppressions that arise from being black in a white-dominant culture.

Poverty, Unstable Housing, and the Welfare System

Recent technological advances have provided new ways of connecting with some of the most remote places on earth. With this new perspective we are confronted with shocking realities that portray massive poverty and obscene inequalities of our time. The vast distance between the rich and the poor is explored further in the book *Globalization, Spirituality, and Justice,* where Daniel Groody explains how the lack of opportunities and resources diminishes people's freedom. By means of survival, they are forced to work multiple or undesirable jobs which diminish their hope for a better life and reduce their capacity for their human development (10). Every problem in our society begins with disorders of the human heart causing us to make poor choices that unravel relationships. "Justice then," says Groody, "is about fidelity to the demands of these relationships" (27). As children, we rely on our parents to love and keep us safe. Even in the first few months of life, the love we receive from our parents greatly affects our ability to love as adults. Sadly, not every child experiences the stability and safety they deserve.

Several studies have found that survivors of trafficking and sexual exploitation have experienced one or more of the following:

- History of childhood abuse and neglect (85-89% in New York)
- History of sexual abuse by family members (40% in Ohio)
- Placement in foster care (50-75% in New York, 28% in San Diego)
- Homelessness (55% in San Diego)
- Having run away from home at least once (63% in Ohio) (Raphael et al. 37).

Unstable housing for kids involved in the welfare and foster care systems can serve as a pipeline into prostitution. Multiple placements, attachment instability, and the presence of continued abuse all contribute to making these kids vulnerable to exploitation. Consider this:

- In 2013, 60% of the child sex trafficking victims recovered as part of a FBI nationwide raid from over 70 cities were children from foster care or group homes (Post 2015).
- In 2012, Connecticut reported 88 child victims of sex trafficking. Eighty-six were child welfare involved, and most reported abuse while in foster care or residential placement (Post 2015).
- In 2013, 85% of trafficking victims in New York had prior child welfare involvement (Raphael et al. 43).

T. Ortiz, child sex trafficking survivor who was born into the foster care system and trafficked from 10 to 17 years old shares her story:

> Foster care in many ways was a perfect training ground for a life of trafficking because it was in foster care throughout 14 placements that I was introduced to the concept of being both cared for and raped by my foster family. And it was in foster care where I first internalized the notion that I was tied to an income, a source of income for my foster family. These two realities made it a seamless transition into a life of trafficking with a pimp who both cared for me, abused me, and profited off me (King County).

Age

Children in the U.S. are bought and sold for sex every day. Research consistently supports the fact that many trafficked and sexually exploited adults first become exploited as

children (Raphael et al. 36). Even though runaway and unstably housed youth make up the majority of sex trafficking victims, children from all different family backgrounds are vulnerable to the manipulative tactics of traffickers. Kidnapping is generally not a point of entry into prostitution for teenagers since they typically become prostituted after running away, being kicked out, or being "seduced" away from their home (Ports et al. 314). For children who have not yet entered puberty, they are most often trafficked by one or both parents, caregivers, or foster parents (CAS Research and Education 2015).

Under the TVPA, anyone who is sexually exploited under the age of 18 is considered a sex-trafficking victim. But what happens the day he/she turns 18? Do the factors that first ushered them into prostitution suddenly disappear? Are we magically left with an empowered adult who "chooses" to engage in "sex work?" Farley argues that, "the 14-year-old in prostitution who suddenly turns 18 has not suddenly made a new vocational choice. The abuse and reenactment of the abuse simply continue" (Farley 36). It is easy to become outraged at the thought of children being sexually abused and sold for sex. It is easy to raise money for nonprofits whose mission is to fight child pornography, child sex trafficking, and the commercial sexual exploitation of children. But let us not forget that the majority of these kids who are never identified or offered services will all become adults. Even though the laws that protect our youth may disappear once they turn 18, their needs and desire for escape do not.

Power Imbalance

Prostitution and trafficking are built on multiple systems of power imbalance that exclude any mutuality of privilege or pleasure. Prostitution is an extension of every woman's struggle throughout history to control her own body, but for those of us who belong to a dominant group with structural privilege, it will rarely cross our minds that the more we have the less we will

need to fight for it (Moe-Lobeda 62). This paradox which helps hide oppression also explains why sexual violence is a reality for 80% of indigenous women in this country (Erdrich 2013). Even in the confines of the United States, "land of the free," the lack of action on behalf of these victims is not only directly related to their gender, but socioeconomic status and race/ethnicity as well. Author Diane Williams supports this truth in chapter 6 of her book, *Race, Ethnicity and Crime: Alternate Perspectives* when she asks a hypothetical question, "If a rash of wealthy American or European women were suddenly trafficked, would the international community take more immediate and forceful action" (177)?

Though the power distance between indigenous women and European colonists during the 16th century may represent one of our most blatant examples, we continue battling inequality on many fronts, even in America. On December 18, 2018 at the Stolen Youth Town Hall on "Child Sex Trafficking: The Impacts of Race, Gender, and Economic Inequality," Peter Qualliotine shared some thoughts on this power imbalance:

> I think that all of these things are the same thing. So yes, we're talking about men's violence—against women, against children, against one another—and there's linkages between all of these things. The link is toxic masculinity, for lack of a better term. It's about dominance, rather than mutuality. It is about owning, about controlling, rather than about engaging. It's not relational. It values "power over" rather than "shared power," "power with" (King County).

Apart from more apparent oppressive acts such as gender-based violence and human trafficking, we all naively contribute to many patterns of structural injustice that have been passed on to us. Our limited lens in which we all see the world from a different perspective

makes it that much harder to peel away from a society built on social injustice and in this case, the exploitation of others.

Healthcare's Response

The last day of 2017 I spent the night ringing in the New Year with friends and family in Oregon. It was still early in the evening, and just as I was about to refill my champagne glass, my cell phone rang. It was work calling. I answered almost certain that they were calling to ask if I would be willing to come in and help due to staffing needs, but I soon found out it was much more serious than that. On the other line was my good friend and long-time co-worker, Leah, who was asking for advice about a patient who she suspected was being trafficked. This patient claimed to be 18, but had no documentation. The father of the baby was supposedly outside of the country and she was accompanied by three older women who were answering all questions for her. The patient did not have any prenatal care and presented to the hospital with an active sexually transmitted infection (STI). During her vaginal exams she sunk into the bed like a corpse showing no signs of discomfort or pain. The more I listened to Leah explain the grave situation, the clearer it became that she was calling me on my day off because she believed I was the only one who would know how to respond. Partly because of the topic of this research and partly because of personal interest, I have become known as the "human trafficking nurse" at work who everyone comes to for guidance on the issue.

After I gave Leah some advice and resources, I hung up further affirmed that our healthcare system is failing trafficked and prostituted women and children. Not only in the institution where I work which happens to be the largest labor and delivery unit in the Pacific Northwest, but in the majority of healthcare systems nationwide. It is not sustainable for a single nurse who happens to be passionate about this issue to bear the responsibility for identifying and

providing interventions for an entire group of people. We are clearly seeing these patients, but are woefully unprepared to identify them due to lack of education and awareness around the issue. In Leah's case, there were enough red flags to identify this victim which is a great start, but what she lacked was the ability to respond. For those who are being exploited, points of contact with healthcare represent rare opportunities for victim identification and intervention (Lederer 78). But without mandatory education about strategies and preparation for how to address potential sex trafficking and prostitution cases, these victims may never feel empowered to freely escape.

Why is this Issue Important for Healthcare?

Despite repeated healthcare reform efforts, the current market-based system in the United States deprives 32 million people annually from receiving basic healthcare (NESRI). This crisis is a result of the privatization of a healthcare system which disproportionately affects vulnerable groups and under-resourced communities such as, those living in poverty, people of color, immigrants, and the LGBTQ community. One group in particular that remains largely affected yet invisible to many systems of society are the victims and survivors of human trafficking and commercial sexual exploitation (CSE). Human trafficking and CSE are global issues that affect men, women, and children in all 50 states of the U.S. In 2016, 553 calls were made to the National Human Trafficking Resource Center (NHTRC) from Washington state; most of which were to report sex trafficking cases (Polaris 2016). Unfortunately, factors that make a person vulnerable to trafficking are the same factors that create barriers to healthcare. These barriers together with the harmful behaviors and abuses these individuals face cause them to suffer from a wide range of untreated health-related issues throughout their lifespan.

In 2003, Washington State was the first to pass a law that criminalizes human trafficking. Under chapter RCW 9A.40.100, it is a felony to, "recruit, harbor, transport, or obtain any person for labor or services using force, fraud or coercion. That includes sex trafficking and other forms of forced labor, from domestic servitude to sweatshop work" (WSOAG). Sadly, by 2008 no charges were filed under the law. This was not because there were no trafficking cases, but rather victims were not being recognized. Title RI.2.150 of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) states that, "Patients have the right to be free from mental, physical, sexual, and verbal abuse, neglect, and exploitation" (JCAHO). If the organization responsible for the accreditation of hospital systems nationwide prioritizes patients that fall under this definition, there is no excuse for the majority of healthcare personnel to remain ill prepared to address this issue.

A 2014 study published by the *Annals of Health Law* found that 88% of sex trafficking victims sought some form of healthcare during the period of their exploitation (Dignity Health 4). Similarly, a 2017 report from the Coalition to Abolish Slavery & Trafficking (CAST) found that over half of the labor and sex trafficking victims they interviewed had accessed healthcare at least once while being trafficked. Sadly, 97% of these individuals were never offered help or provided with human trafficking information and resources (Dignity Health 4). Both of these studies highlight the reality that healthcare professionals and institutions are repeatedly unprepared to identify and respond to victims of human trafficking and CSE. Just as trafficked and exploited individuals face barriers to healthcare, the healthcare system faces barriers which prevent them from providing comprehensive care to this population, which include:

- Loose federal and state laws
- A lack of understanding and common misperceptions on the issue

- Absence of institutional policies and protocols
- Absence of training mandates from a governing body

While the last ten years have expanded our recognition of human trafficking as a public health issue, we have not determined how to transfer that awareness into our healthcare settings or practices successfully. We also fail to recognize that all women and children involved in the sex trade, regardless if they are being trafficked or feel they are making the decision by personal choice, have the most acute and complicated medical needs in the community (Geynisman). This may be the single most difficult concept for healthcare and society overall to grasp. It is also what sets my thesis apart from traditional human trafficking resources for healthcare. Society (including healthcare systems) continue to frame the issue in a very black and white manner. The common belief is that on one end of the spectrum lies a victim of human trafficking who is forced and beaten to perform sex acts for money against his/her will, while the other side generally portrays an adult "sex worker" with free agency who happily "chooses" her vocation. Survivors of the sex trade and those working in and around this issue will tell you that these two groups are not inherently separate.

The truth is that systematic oppression and poverty have restricted options, pathways, and choices for marginalized groups (Briner and Roberts). The vast majority of women in prostitution (89%) do not want to be there, do not seek it out, and are desperate to leave (Farley 34). Finally, regardless of the presence of a third-party trafficker, this population lacks preventive healthcare due to absence of insurance and a fear of healthcare systems. Ironically, this came up not long ago as I was reviewing the agenda for the summit I am hosting in May as part of my thesis project (See Appendix 1). One of the continuing education representatives (also a nurse) commented that she thinks it would be best if I focused the summit on human trafficking

and not "sex workers." This goes to show the common misperception that healthcare has about the sex trade and explains why this population has become disregarded by society. In his book *Exclusion and Embrace,* Miroslav Volf quotes James McClendon who explains how "Our common task is not so much discovering a truth hiding among contrary viewpoints as it is coming to possess a selfhood that no longer evades and eludes the truth with which it is importunately confronted" (256).

The way we deliver healthcare in this country to victims of human trafficking and CSE needs to change. Healthcare providers are among the few professionals that will come into contact with trafficked and exploited individuals, thus bearing the responsibility of recognizing and responding, "in a victim-centered, culturally appropriate, trauma-informed manner" (Greenbaum 241). In their book *Social Entrepreneurship,* Bornstein and Davis remind us that, "In order for change to happen, new institutions with new spheres of power need to be created" (10). The time is now for healthcare to take the lead in designing lasting solutions that prioritize some of our society's most vulnerable.

Healthcare Systems as a Barrier to Accessing Care

No community is immune from human trafficking and CSE as it affects people of every age, gender, race, sexual orientation, and socioeconomic status. Although anyone can be at risk for victimization, people who suffer the highest risk are women and girls, those living in extreme poverty, those with minimal education, those who have histories of abuse, and those who are vulnerable in other ways such as, immigration status or unstable housing (Alpert et al. 8). Those involved in the sex trade suffer a wide-range of health effects that are largely dependent on individual situations. Numerous negative health outcomes include, "violence-related injuries, occupational injuries, sexually transmitted infections and diseases, unplanned pregnancy,

malnutrition, substance use disorders, psychological trauma and neglect of chronic medical conditions" (Mass General Freedom Clinic). Because of the nature of their situation, victims typically seek out healthcare when their condition becomes serious thus utilizing emergency rooms and urgent care settings, most often with no health insurance. Although over 80% of victims report having contact with healthcare during their exploitation, only 5% of emergency room personnel are trained to treat these victims (Chisolm-Straker 980). This is a blatant result of system failure that must be repaired and healthcare institutions are in a perfect position to do so. Healthcare systems have an obligation to uphold rights of victims and decry exploitation by decreasing barriers, setting up internal human trafficking protocols, and partnering with survivor services. Beyond healthcare's inherent responsibility to serve these patients, we need legislation to mandate the ongoing education of healthcare workers. To date, few states have done so and most operate under loose bills that are underfunded and under resourced.

At some point during my research I learned of a bill which required all healthcare providers to be trained on human trafficking in Washington State. I inquired about this to Cynthia Wolf, an ER doctor in Olympia who has spent the last ten years educating healthcare about human trafficking through her own interest and passion on the subject matter. She mentioned that there is a "loose mandate" that requires the public health department to help healthcare agencies educate their providers, but the requirement is likely being fulfilled by posters or signs that hang on bulletin boards in break rooms or doctor's lounges which is clearly not enough information to reach anyone (Wolfe). After interviewing more healthcare providers from organizations around Seattle, I found that there is no systematic approach to how we educate about human trafficking. This hot topic is clearly on the forefront of conversation, yet many have not received any substantial mandatory or optional training. The degree of education

and training offered to workers is dependent on each healthcare organization or educator. In my ten years as a nurse, I was offered my first training a few months ago through my employer; And though I could receive continuing education credit (CME) for taking the class, it was completely optional. I find this astonishing considering the fact that in order to renew our yearly nursing license, every RN must complete six hours of suicide prevention training regardless of the field of nursing where you work. It was at this time when I began to realize how much policy is involved even in regard to basic human rights issues.

Barriers to Disclosure in a Healthcare Setting

Interactions between healthcare personnel and those involved in the sex trade are almost always delicate situations that require a baseline knowledge of those being exploited, trust building, patience, and cultural sensitivity on the part of the provider. Beginning with sensitive, open-ended questions with few interruptions is a good place to start in order to begin building trust. Asking directly whether a patient is a "prostitute" or "trafficking victim" may prove meaningless since most victims do not identify with this terminology. Another consideration is that many victims of trafficking and exploitation are often accompanied by their trafficker. If possible, separation should happen discreetly in order to provide a safe place to talk. When this is not possible, prioritizing the patient's safety should always come first. Confronting a possible trafficker is always ill-advised and can increase safety risk for both the patient and provider. Where a translator is needed, care needs to be taken when identifying the right person to avoid collusion with a trafficker. Finding a translator who is unconnected to the patient is critical.

Even when provided a safe, empathetic, and supportive environment to disclose, many trafficked and prostituted individuals will not be ready to do so. Traditionally, these individuals have been let down time and time again throughout the course of their life and they have learned

to guard their trust. Many have been hurt, betrayed, or even trafficked by friends, family, teachers, law enforcement, and even those within the healthcare system. Some victims may not fully understand the concept of the coercive control they are under or recognize that they are being trafficked. Regardless if they identify as being trafficked or not, some may be so fearful of being harmed that they will decide to remain in an unsafe situation for the sake of predictability. Lastly, some victims may have been manipulated into believing that they are in relationship with, or are important business partners to their traffickers, thus bearing responsibility for helping pay the bills or recruiting other victims. Many additional factors influence victims from disclosing to healthcare providers. Some of these challenges include:

- Prior unsuccessful attempts
- Fear of threat from trafficker
- Fear of judgement, stigma, and shame about the realities of their situation
- Physical or mental disabilities
- Substance addiction
- Distrust of authority figures including healthcare
- Fear of deportation
- Prior criminal record (Alpert et al. 12).

Most often, multiple barriers exist simultaneously for those who desire to leave their trafficker or the life of prostitution making it extremely difficult to exit. Judge et al. explain that:

> Persons exiting trafficking often lack physical, psychological, and physiologic safety and stability. Food, housing, clothing, financial support, safety and protection, transportation, and acute substance withdrawal treatment are

> immediate needs that often are unmet. In one program for sex trafficked minors, creative and persistent efforts to meet these needs frequently take precedence over addressing the exploitation itself, because sex trafficking too often represents "the least bad" solution to meeting fundamental needs (Judge et al. 1).

For victims who do wish to escape and are ready to disclose, it is not uncommon for them to make deliberate choices about where, who, and when to disclose. Similar to intimate partner violence, trafficked persons may prefer to disclose to a provider of a specific gender, age, or ethnicity. Some may want to test whether a particular provider or healthcare setting is trustworthy by making frequent visits until they feel safe disclosing. During my fieldwork this summer I interviewed a variety of healthcare professionals about their experiences with those involved in the sex trade. One provider, a midwife, told me about her experience with one individual who she said came to see her seven times before disclosing that she was being prostituted by her boyfriend. These decisions which may appear to delay disclosure, are important steps towards "healthy decision making, exiting exploitation, and moving towards independence" (Alpert et al. 11).

What is Being Done? Current Research and Protocols Within Healthcare Systems

Few healthcare institutions in the U.S. provide or require human trafficking training for their employees. Because of this, the DOJ reports that less than 1% of victims who seek healthcare will ever be identified (Egyud 527). Though we have a long way to go to ensure every doctor, nurse, lab tech, social worker etc. is able to recognize red flags and intervene appropriately, there are some wonderful examples of success from which we can learn. In 2014, Massachusetts General Hospital (MGH) was awarded a $600,000 government grant to establish the first human trafficking centered clinic in the state, named Freedom Clinic (Salahi). The clinic

not only offers free primary and preventative care for victims and survivors of human trafficking who are 13 and older, but also partners with both local and regional social service providers to help survivors rebuild their lives (MGH). Similar to the Freedom Clinic in Boston, The Purple Clinic in Lower Manhattan also offers specialized healthcare for those who have experienced sexual exploitation, trafficking, domestic violence, and selling sex to survive (The Institute for Family Health).Over the last few years, more clinics similar to these have popped up around the country to include: the Hope Through Health Clinic in Austin, TX., The Pacific Survivor Clinic in HI., the entire Dignity Health hospital system in CA., and the Thrive Clinic in Miami, FL.

Apart from these human trafficking clinics, only a few other hospital systems such as PeaceHealth in Bellingham, WA and the University of Vermont Medical Center in Burlington, VT have managed to implement human trafficking protocols into their facilities for the purpose of establishing a standardized process of caring for these patients. Washington's Task Force Against Trafficking of Persons reports that the international freeway spanning Mexico to Canada, along with its multiple ports and international airport make Seattle a hotbed for human trafficking (WSOAG). Despite Washington State having one of the highest rates of trafficking, to date, Seattle has only one hospital working on a protocol, Seattle Children's. To say that it is past time for Seattle to step up to the plate is an understatement.

Because healthcare systems in the United States have successfully adopted screening protocols and response tools that address issues like domestic violence, child, and elder abuse, I believe the same can be done with trafficking. Although some hospitals in the U.S. have implemented protocols or have offered sporadic trainings to their staff, few have taken on the issue of human trafficking at a system-wide level. When looking for an example of system-wide implementation, Dignity Health of California leads the way. Their program is set up to educate

every staff member how to both identify and work with victims. They have in place internal protocols, in-person trainings, and education/resource algorithms for staff and the community on how to handle a patient who is identified as at-risk or a victim of human trafficking. To date, no healthcare institution in the Seattle area has made human trafficking prevention and identification a system-wide priority. Swedish Medical Center in Seattle has taken action regarding this issue by allowing me the opportunity to host a summit for their employees and take the first steps toward a human trafficking task force (See Appendix 1).

Survivor's Voices: Experiences with the Healthcare System

People who work on the front lines, such as those in the medical field, have an important responsibility to help victims of trafficking and CSE. For some victims, it may be the only time that they are away from their trafficker. Unfortunately for most involved in the sex trade, healthcare providers are not viewed as allies, rather outsiders who feed the traditions of power imbalance. Out of the dozens of interviews I conducted this summer with survivors of the sex trade, not one had a positive thing to say about their experiences with healthcare. Individuals reported feeling "judged, stigmatized, ashamed, and looked down upon" (Kara). The following is an account of one woman's experience after ending up in the hospital one evening:

> The nurses and doctors just treat you like a drug addict. They had no idea I was being raped a minimum of ten times a day. They had no idea that my pimp was shooting meth in my ass to keep me awake. All they saw was this junkie and they treated me like one. The healthcare system is made up of people who don't know what to look for because they've never had to see it. When you are little you're taught that nurses and doctors are there to take care of you. I remember wanting to be a nurse when I grew up. But after my experience, you realize that you are alone (Jenn).

Unless trained otherwise, most healthcare providers are often unaware of the grave realities their patients face, and do not make the appropriate effort to investigate inconsistencies or red flags. They operate by their own assumptions about juvenile delinquency, prostitution, homelessness, and substance abuse. Holly Smith, a survivor of child sex trafficking and Human Trafficking Program Director at Dignity Health, said this of her experience as a 14-year-old in the emergency room:

> I remember feeling like the healthcare staff wanted to talk to me, but I could tell that nobody knew what to say to me. I remember sitting in that hospital room feeling like no one was talking to me; like everyone was judging me. I think what was missing from that moment was human kindness. I was still just a 14-year-old kid, I wasn't a prostitute or a criminal. And I wasn't an adult; I needed compassion. I want to make sure that staff who are working with victims today know what these kids are thinking (Smith 2016).

I truly believe that if healthcare providers knew more about this issue, the response would be different. There is a reason why healthcare systems are just now implementing human trafficking education into their facilities in the 21st century. It is not because this is a new phenomenon, but because most healthcare professionals have never had to look at this issue head on. We are educated, privileged, and naïve. One survivor of child sex trafficking explained it this way:

> It is not their problem. No one asked why this 12-year-old had a tattoo on her neck. They just assumed I was a bad kid or something. That's how law enforcement sees it. That's how everyone sees it. I wasn't the community's problem. I wasn't their daughter (Oree).

Trauma-Informed Care

Because of the coercive, exploitive, and dehumanizing nature of trafficking and prostitution, routine practices in healthcare that are automatic for most patients can frequently be triggering and anxiety producing for survivors of trauma. Routine procedures such as, asking a patient to undress, checking vital signs, or performing a gynecological exam can cause interactions with healthcare providers to become frightening experiences that elicit fear, shame, or loss of control. All healthcare professionals should utilize a trauma-informed approach not only with victims of trafficking or CSE, but with all patients to increase safety, communication effectiveness, and to avoid re-traumatization. Although trauma can result from a single event, i.e., experiencing a violent act, witnessing the death of a loved one, or living through a natural disaster, victims of trafficking and CSE generally experience a culmination of many traumatic experiences throughout their lifetime. According to the Office for Victims of Crime:

> A trauma-informed individual or organization realizes the widespread impact of trauma on victims and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by integrating knowledge about trauma into policies, procedures, practices, and settings (Office for Victims of Crime).

The ultimate goals of using a trauma-informed approach with victims of trafficking and CSE are to utilize strengths and resilience, promote healing and recovery, and to help create short and long-term coping mechanisms for past trauma (Alpert et al. 18).

Providers who utilize a trauma-informed approach assume that all patients in a medical setting have experienced some level of trauma in their lives and understand that these

experiences often influence the way they feel and behave. By involving patients into decisions about their care, including when or if to contact law enforcement or outside services, healthcare is prone to decrease re-traumatization and build trust.

Relationship is the Intervention

When I began researching this topic, my intended goal was to simply help educate medical professionals how to "rescue" victims of human trafficking when they appeared in our healthcare settings. I had no understanding of commercial sexual exploitation or its intersection with sex trafficking, i.e., how most people in prostitution are trafficked into it. I believed the only thing missing was awareness around the issue which could be solved with mandatory education and system-wide protocols. However, after diving into this work, I now realize that much more is needed beyond recognizing the red flags. Failure to identify stems both from victims who are resistant to disclose and more importantly, providers who profoundly lack understanding about the sex trade. During one of the trainings I attended, "Responding to the Sexual Exploitation and Trafficking of Youth" through the King Country CSEC Task Force, the speaker reminded us that relationship and rapport building may be our best bet for intervention. Are human trafficking policies, protocols, and screening tools necessary? Yes! But they only get us so far. If we are unable to build trust, utilize trauma-informed care, or maintain a compassionate and non-judgmental attitude at all times, we will never be successful at empowering these individuals to advocate for themselves. When we solely focus on the "rescue" we miss the fact that often recovery is a very involved process that takes time, which is why building a relationship is the most important intervention that healthcare can make.

My preconceived notion that I was going to walk in and simply teach healthcare how to identify and rescue every sex trafficking victim was not realistic. What is realistic, is that exiting

prostitution and trafficking is a long process which takes time through transformational development. For victims, "rescue" is only the beginning of a lifelong road to recovery. When describing what "getting out" realistically looks like, Mangiaracina said that, "Relationship is the intervention" (Mangiaracina). To better, "understand the meanings people have constructed, and how people make sense of their world and the experiences they have in the world," is to be vulnerable with them, not to attach a number and/or symbol to them (Merriam and Tisdell 15). The impetus for an individual responding to an offer for help can only come from a trusting relationship. This is why educated nurses and healthcare professionals are in the perfect position to provide care and resources to those who are ready to get out.

Conclusion

Let me be clear, this work is not mandatory. We can choose to block our own perception of the light and live in darkness.

John Lewis, American politician and notable civil rights leader

Throughout history we have witnessed in almost every culture around the world the oppression of others in some way. Despite efforts to enforce gender equality worldwide, there are still millions of women and children missing, sold into sex slavery, sold as child brides, denied education, excluded in political decisions, and dying in childbirth. Though these extremes are believed to exist primarily in developing nations, the exploitation of others exists everywhere, even in the United States as seen in the form of sex trafficking and commercial sexual exploitation (Duflo 1054). Sexual exploitation, regardless of the presence of a third-party trafficker, is violence towards women and children. When we narrow our focus solely on victims of human trafficking, we miss an entire population of vulnerable individuals who begin their

lives as targets for abuse; abuse for which they are later blamed and punished by systems, societies normalized beliefs, even their own families.

Early on in my research, after recognizing the amount of literature already written on the intersection between human trafficking and healthcare, I began to feel as though I had chosen a superfluous topic. During one of my interviews with King County Task Force Coordinator, Kelly Mangiaracina, she reminded me that though there is no lack of current research on the issue, there remains a major gap in transferring said research into our healthcare systems (Mangiaracina). Dawn St. Aubyn, Clinical Social Work Supervisor at Swedish Medical Center reiterated this point when she shared how she believes the reason we have not connected the dots in healthcare yet, is because, "we do not want to believe that these things are really happening to our patients in our communities and in our healthcare settings" (St Aubyn). People have a hard time understanding the issue because they think of it as this horrible problem that is unconnected to the world they move through every day. Stolen Youth's slogan, "Not in My Backyard," attempts to raise awareness that this is happening in our communities in Seattle, but there is still much work to be done.

In healthcare, we are generally not well trained to address the physical, sexual, and psychological abuse of our patients. Many healthcare professionals do not ask their patients about abuse or coercion because they have not been trained how, or they are unaware of where to refer them if they admit to needing or wanting help. Sometimes they do not ask because they simply do not have time due to an inequitable healthcare system that does not allow us to provide vulnerable patients with the help they need. If we truly wish to address sex trafficking and other forms of violence among our patients, we must transform medical settings into places that optimize our ability to establish rapport and trust with people who are suffering in isolation. For

many victims of all forms of trafficking and abuse, their encounter with healthcare may be their only window to connect with support and tools they need to escape their situations. It is sobering to acknowledge that in medicine and public health we will rarely see the outcomes of our efforts to assist patients who we suspect or know are being trafficked, exploited, or abused. Rather, we are opening doors for them, planting seeds of hope for a life free from force, fraud, or coercion.

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Appendix 1: Thesis Project

Background

In recent years, the increased number of reported human trafficking cases in the United States indicates a steady growth among victims. Though exact numbers are hard to come by, the most likely explanation for this jump is not that more people are being trafficked, but that more victims are being identified. The need for victim identification by means of education traverses many community systems to include: criminal justice, education, technology, media, business, government, and healthcare. Victim identification is the first step in the empowerment of healthcare to assist this vulnerable group of individuals, but unfortunately this is where most of the educational materials and curricula for healthcare cease to exist. When we solely pay attention to victim identification, we fail to address three very significant constituents: the demand that fuels the sex trade, the buyer, and the vast number of individuals who don't fall under the definition of trafficking victim, but experience equal exploitation and abuse in the trade. Including these components when educating healthcare professionals is imperative if we want to offer every patient a clear, supportive path toward rehabilitation and a healthy safe future.

The responsibility to abolish the global sex trade does not lie solely in the hands of healthcare, however, it is healthcare who has a great opportunity simply because of the access to victims and buyers alike. Multiple studies confirm that upwards of 80-100% of trafficked and commercial sexually exploited individuals will come into contact with a healthcare professional during the time of their exploitation. This serves to emphasize the need for urgency regarding proper education and understanding around this deeply rooted systemic human rights violation that has survived far too long (Dignity Healthy 4). Sex trafficking and commercial sexual

exploitation (CSE) are part of wider gender-based violence against women and children, and as long as prostitution is seen as any other job, gender equality will never be attained and those who truly hold the choice (men) will continue to treat women's bodies as a commodity. Power and profit are what have driven the business of buying and selling human beings for sex, making trafficking and prostitution one of the most misunderstood human rights violations our world has ever faced. The millions of women and children who fall victim need more than a nonprofit to offer resources, they need a society to stand behind them declaring their value and equality. They should not need to have sex as a condition of their employment or to work a "job" where occupational hazards include sexually transmitted infections (STIs), AIDS, and death. We have a lot of work to do in convincing society of this, but I believe healthcare is a powerful place to start.

Swedish Summit

Established in 1910, Swedish Medical Center, (within Providence), is the largest nonprofit healthcare provider in the Greater Seattle area. I have been an employee of Swedish for ten years, and it is where I plan to implement the project portion of my thesis. I have partnered with the Ending Exploitation Collaborative Healthcare Center to provide a seven-hour summit on May 15, 2018 titled: Beyond Sex Trafficking: Responding to Commercial Sexual Exploitation and the Role of Healthcare Systems. The summit will be open to all Swedish employees; however, attendance is encouraged for those working in departments that this population frequents: ED, L&D, Primary Care Clinics.

The primary objective of the event will be to educate healthcare to identify and respond to human trafficking, commercial sexual exploitation, and the demand that drives both in our community. Summit goals are as follows:

1. Develop a comprehensive understanding on the intersection of sex trafficking and commercial sexual exploitation (CSE)
2. Understand and identify the health impacts of sex trafficking and commercial sexual exploitation (CSE)
3. Gain skills and knowledge to provide trauma informed care in responding to sex trafficking and commercial sexual exploitation (CSE)
4. Consider personal beliefs and biases about people in the sex trade
5. Empower Swedish to take a leading role in addressing sex trafficking and CSE in our community

Learning Outcomes

1. Participants will learn to define sex trafficking and CSE.

2. Participants will learn when and how to report sex trafficking

3. Participants will learn how to identify victims and at-risk individuals of sex trafficking and CSE.

4. Participants will understand the scope of the problem on an international and local level.

5. Participants will learn to identify risk factors for becoming a victim of sex trafficking or CSE

6. Participants will be able to identify the healthcare needs of trafficked persons in the short-, medium-, and long-term

7. Participants will learn best practices in providing services to victims of human trafficking and CSE

8. Participants will gain a better understanding about the demand that fuels the global sex trade

9. Participants will learn how to identify a buyer of sex and their healthcare specific needs

10. Participants will learn the different legislative approaches to combating human trafficking and CSE

11. Participants will be able to recognize the importance of the continuum of care and the essential role played by the healthcare provider

The agenda for the event will provide a holistic account by subject matter experts who work with both survivors of sex trafficking and commercial sex as well as those who run programs that promote healthy sexuality and relationships to buyers of sex. There will be education about federal and state definitions of human trafficking, current laws that protect victims, and local statistics. We will explore current research and protocols that few healthcare systems have implemented and will hear from those institution representatives. We will discuss the cultural landscape beyond trafficking, the socialization of gender, gender-based violence, and what fuels the demand for sex. Lastly, we will hear from survivors of the sex trade about their experiences with healthcare and why they believe it is important to implement education into our healthcare systems.

For evaluation purposes, we will provide both pre/post surveys to the approximately 120 healthcare providers attending the summit. The pre-survey will be issued during the online registration, and the post-survey will be given in paper format at the end of the event. We will be creating the survey based on previous evaluative measures, such as the "Human Trafficking General Knowledge Instrument" that will utilize both qualitative and quantitative measures. The

survey will assess pre and post knowledge and perceptions about covered topics as well as include questions regarding satisfaction of the presenters and overall summit.

The idea for the summit came after partnering with the Ending Exploitation Collaborative's Healthcare Sector as part of my fieldwork in the summer of 2017. Because of my experience as a nurse along and interest in the topic, organizational chair, Peter Qualliotine invited me to join their work. Other members of the summit planning committee include:

1. Peter Qualliotine, Co-Founder of Organization for Prostitution Survivors (OPS) and Director of Men's Accountability and Community Education
2. Lewissa Swanson, MPA, Public Health Advisor for the US Department of Health & Human Services Office of the Assistant Secretary for Health Region X
3. Kelly Mangiaracina, JD, King County CSEC Task Force Coordinator
4. Kelly Martin-Vegue, RN, MSW, Project Coordinator Center for Children & Youth Justice
5. Allison Jurkovich, MSW, Director of CSE Advocacy Services at Organization for Prostitution Survivors
6. Nicole Canete, University of Washington MSW intern
7. Emily Goldstein, University of Washington MSW intern

From November 2017 to present, this team has been meeting bi-monthly to discuss and plan for the upcoming summit. Our original idea was to host an event open to any healthcare provider around Seattle, but we agreed that concentrating on one healthcare system at a time could provide added benefit by creating system-wide momentum on this issue. The Swedish Continuing Education Director, Renne Rassilyer agreed to host the event which includes event space, food, printed materials, and free continuing education units (CEUs)

In conjunction with of this event, I am creating a business proposal for Swedish to create a Human Trafficking Task Force and to open their own Survivor Clinic for victims of human trafficking and CSE. Accepting the proposal would not only validate their mission of, "Improving the health and well-being of each person we serve," but it would set Swedish apart in the Seattle community as the first hospital system to prioritize this population (Swedish).

The primary goal of the Swedish Survivor Clinic will be to provide comprehensive, trauma informed, and victim-centered care to victims and survivors of human trafficking and CSE regardless of their age, gender, insurance, or documentation status. Because health and healing from the effects of trafficking and exploitation move beyond the physical body, partnering with subspecialists within the Swedish system and the community will be essential in order to optimize holistic care for these patients. Reforming a hospital system at this level will be both a challenging and worthwhile undertaking. Given the difficulties, it is easy to understand why few hospital systems have yet to do so. But if more hospitals like Swedish dare to embody their patient-centered values, they will not be deterred. Instead, they will, "envision new possibilities, appreciate their meaning, and recognize how they can be broken down into doable steps that build momentum for change" (Bornstein and Davis 25). After all, sometimes the richest opportunities for change come from approaching challenges that derive from a basic human need.

Appendix 2: Summit Agenda

SWEDISH
Extraordinary care. Extraordinary caring.℠

Beyond Sex Trafficking:

Responding to Commercial Sexual Exploitation and the Role of Healthcare Systems

May 15, 2018 0845-1600

Glaser Auditorium, First Hill Campus

Objectives:

1. Develop a comprehensive understanding of the intersection of sex trafficking, commercial sexual exploitation (CSE) and healthcare.

2. Gain skills and knowledge to provide trauma-informed care in responding to sex trafficking and commercial sexual exploitation in a healthcare setting.

3. Learn current laws and mandatory reporting requirements for minors and community resources for adult survivors.

4. Learn the importance of healthcare's role in understanding gender-based violence and the demand for sex which fuels the global sex trade.

Course Description:

A comprehensive summit to better understand and provide care for victims and survivors of sex trafficking and commercial sexual exploitation in our community.

AGENDA

Time		Topic	Presenter(s)
0845-0900	15 min	Arrival, Check-in, Coffee and Tea	
0900-0910	10 min	Welcome & Introduction	Kalie McNelly Swedish RN MAICD
0910-1010	60 min	Sex Trafficking Overview, Intersection with Healthcare, Trauma-Informed Care and Advocacy, Case Study. Sex Trafficking and Youth, Mandatory Reporting	Josephine Ensign BA, MSN, DrPH Dae Shogren, MPA LGBTQ, Disproportionality, Commercially Sexually Exploited Children (CSEC) program manager for DSHS Children's Administration
1015-1115	60 min	Current Sex Trafficking Legislation Overall issue of the Socialization of Gender, Gender-Based Violence, and the Demand	Peter Qualliotine, co-founder of Organization for Prostitution Survivors (OPS) and Director of Men's Accountability and Community Education
1115-1130	15 min	Break	
1130-1230	60 min	"Life Story" video Commercial Sexual Exploitation Advocate and Survivors Voice	Peter Qualliotine Alisa Bernard, Survivor Advocacy Coordinator OPS
1230-1300	30 min	Lunch	

1300-1330	30 min	Local Statistics and Research	Josephine Ensign BA, MSN, DrPH
1330-1420	50 min	Service Provider/Community Advocate Panel	Kelly Mangiaracina King County CSEC Mullane Harrington PeaceHealth Bellingham Erik Gray, REST Outreach Coordinator Kyra Doubek, KYFS CSEC Behavioral Health Specialist
1420-1435	15 min	Break	
1435-1455	20 min	Intersection of Healthcare and the Demand	James Olson, LMHC Pacific Behavior Health
1500-1530	30 min	Demand Prevention, Education, and Intervention	Peter Qualliotine
1530-1535	5 min	Closing	Kalie McNelly, RN
1535-1600	25 min	Please visit the Community Resource Tables in the FH Glaser Auditorium Foyer	

Appendix 3: Post Summit Results

Over the last 18 months as part of my research for my masters in International Community Development, I have been working with the Organization for Prostitution Survivors (OPS) and the Ending Exploitation Collaborative's healthcare sector to create an all-day summit for healthcare called:

Beyond Sex Trafficking: Responding to Commercial Sexual Exploitation and the Role of Healthcare Systems.

The summit was held at Swedish Medical Center on May 15, 2018 with the primary objective to educate healthcare to both identify and respond to sex trafficking, commercial sexual exploitation, and the demand that drives both in our community. There were 120 Swedish employees in attendance, 5 presenters, 4 panelists, and 8 community organizations represented at the event. The agenda gave a holistic account by subject matter experts who work with both survivors of sex trafficking and commercial sex as well as from those who run programs that promote healthy sexuality and relationships to buyers of sex. There was education about federal and state definitions of human trafficking, current laws that protect victims, and local statistics. We explored current research and protocols that few healthcare systems have implemented and heard from those institution representatives. We discussed the cultural landscape "beyond trafficking," the socialization of gender, gender-based violence, and what fuels the demand for sex. Lastly, we heard from survivors of the sex trade about their experiences with healthcare and why they believe it is important to implement education and trauma informed care into our healthcare systems. Packets of local resources were given to each participant and representatives from organizations working on this issue in our community were present to provide more information.

Both pre- and post-evaluations were collected at the end of the event, and results are still being processed. Some preliminary comments are as follows:

- Thank you! This is the first step of educating myself, getting more involved in my community, and enhancing my role as an RN.
- I hope to adjust my parenting style to avoid/prevent feelings of inequality between men and women and to promote emotional equality.
- I am going to organize my notes and put what I learned into practice.
- The presentation today was truly life changing!
- Most of my post evaluation responses are still marked lower because I know I still have so much to learn.
- This should be mandatory for all Swedish employees, please offer it annually.
- I now understand the importance of recognizing victims as well as sex buyers in order to break the cycle of violence towards women and children.