CONVERGENCE OF MODERN-DAY SLAVERY WITH
POVERTY, DRUGS, AND CONFLICT IN VULNERABLE POPULATIONS:
TRAINING RURAL PUBLIC HEALTH WORKERS TO PROMOTE
HUMAN TRAFFICKING AWARENESS

by

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ABSTRACT

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In spite of mass media attention and implementation of international laws in the last two decades, modern-day slavery is still active in communities across the globe. Individuals trapped in forced labor situations endure devastating physical and mental illnesses, with dire consequences that extend into families and neighborhoods. The call has been made for every citizen to join in the anti-human trafficking movement. Lawmakers, police, and border patrol officers are on alert in each major U.S. city. Yet, training some of the most valuable stakeholders who work among some of the most vulnerable populations has been largely overlooked.

Rural public health workers, specifically promotoras, serving in Texas-Mexico border communities are a key component to activate in the anti-trafficking awareness and prevention efforts in this region. The current research examined the geographic and socioeconomic situation of the colonias in the Rio Grande Valley and the effect of the drug cartel conflict directly across the border. Through an online survey, this study assessed rural public health workers’ knowledge and awareness of human trafficking and educational needs on human trafficking issues.

Results of this research indicate that limited education and training of rural public health workers on the topic of human trafficking contribute to the low rate of
victim identification in the rural clinic and community settings. Recommendations for immediate training of this strategic population located on our southernmost U.S. border is proposed along with future research.
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Chapter I
INTRODUCTION

This is an inferno of sexual exploitation for thousands and thousands of women ... we will all be obliged to act, and no authority can say, “It’s not my responsibility,” or turn a blind eye to the terrible crime of human trafficking.
—Mexican President Felipe Calderón

Yes, it is the 21st century. Gripping headlines, horrific documentaries, and disturbing Hollywood films seem to indicate otherwise. More than 2,000 years after Joseph was sold by his brothers as a slave to Potiphar in Egypt and hundreds of years after human beings were forced to toil on North American plantations, we must face the grim reality that slavery still exists in the modern world.

The term human trafficking refers to a group of certain connected activities that include migration, prostitution, and acts that violate human rights. It is synonymous with human beings being moved across international borders or within their own countries (Protection Project, 2009). The United Nations defines human trafficking as

the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. (United Nations Office on Drugs and Crime [UNODC], 2013)

Surprising to most, human trafficking takes place not just in backwoods, primitive villages or in dark, seedy inner-city brothels, but also in every country of the world and is a growing problem (Attorney’s General Annual Report to Congress, 2012). This global industry generates an estimated $150 billion of profit annually (International Labor
Organization, 2017). According to the United States State Department, yearly an estimated 18,000 individuals are forced into hard labor or commercial sex work in the United States (United States State Department, 2009), although more recently the Polaris Project (2017) estimated that the total number of victims actually reaches into the hundreds of thousands.

In response to increases in human trafficking, President George W. Bush passed the Trafficking Victims Protection Act (TVPA) in 2000 and renewed it in 2003 (United States Department of State, 2011). Synonymous to the phrase human trafficking, the term trafficking in persons refers to the movement of individuals from their homes to places of forced servitude whether across international borders or within a state or country. The goals of the TVPA are to prevent human trafficking overseas; to protect victims and help them rebuild their lives in the United States with federal and state support; and to prosecute traffickers of persons under stiff federal penalties (US Department of Health and Human Services, 2011). As well, the US Department of Homeland Security launched a program called Blue Campaign, which encompasses a wide range of public outreach tools and resources for the antitrafficking movement (US Department of Homeland Security, 2010). As the designated federal agency in charge of assisting victims of trafficking, the Department of Health and Human Services runs the Rescue and Restore Victims of Human Trafficking campaign (US Department of Health and Human Services, 2010). In the public health arena, the American Public Health Association (APHA, 2010) at its 138th Annual Meeting in Denver in November 2010 dedicated several sessions to discussion of the topic of human trafficking.

After the TVPA was passed, numerous nongovernmental organizations (NGOs) across the United States were created or began allocating time and funds to antitrafficking measures. The National Human Trafficking Resource Center (NHTRC) lists 18 major organizations working against modern-day slavery, and other websites have links to scores of others (Polaris Project, 2017). Outreach includes the rescue of
victims, restoration, state task forces, research and policy initiatives, and education and awareness campaigns (Protection Project, 2012; Shared Hope International, 2012).

Some researchers have argued that the estimated number of trafficking victims is overinflated (O’Brien, 2012), whereas others maintain it is actually undercalculated (Sisken & Wyler, 2013). Whether or not the numbers are being reported accurately, the facts remain that there have been thousands of documented human trafficking cases, there are real people still suffering, and there is a conglomerate of factors that, when viewed collectively, produce a fertile breeding ground for human slavery to thrive. To date, the majority of antitrafficking efforts by the government and various NGOs (EPCAT International, Rescue & Restore campaign, Shared Hope) have targeted large, metropolitan cities; smaller communities have been left out. The current study focuses on examining awareness of that issue among those who provide rural health care for the largely overlooked inhabitants of the Rio Grande Valley in an effort to improve health outcomes and knowledge of human trafficking and with the potential for creating positive social change beyond the border region.

**Background**

For the past 15 years, advocates for trafficking victims have published accounts of survivors’ experiences. The following is a “typical” scenario that sheds light on how and why human trafficking exists.

- Recruiters come to a poor village, promising people jobs as housekeepers, teachers, and waitresses in the U.S. Young women and men, eager for the chance to help their families monetarily, agree to go. In another scenario, a guy befriends a vulnerable gal by lavishing her with gifts and promises of marriage until she agrees to run away with him. A third commonly used recruiting method involves picking up runaway kids from bus stations, malls, and parks.
• When the job seekers cross the border into Texas, or reach their final destination, the “bosses” confiscate their false travel documents and warn them that they will be arrested as illegal immigrants if they ever ran away.

• To repay the debt for crossing them into the U.S., the individuals are forced to labor. There are numerous accounts of being forced to pay their transportation fees through prostitution, 12 hours a day, 6 days a week with guards posted at the doors. Attempted escapes are reportedly punished with severe beatings and even death.

For decades, criminal organizations such as gangs, smuggling and trafficking groups, and illegal-drug cartels have been implicated in a wide range of criminal activity in Texas, including murder, kidnapping, assault, drug trafficking, weapon smuggling, and money laundering (Texas Department of Public Safety [TXDPS], 2013). Trafficking in Texas especially thrives because of three key factors: proximity, demographics, and the large immigrant labor force (Children at Risk, 2013). The Department of Health and Human Services reports that 25% of all international victims and 30% of phone calls to the National Human Trafficking Hotline are from Texas (Polaris Project, 2013). The geography and layout of Texas lend themselves to the state’s naturally becoming an epicenter for international trafficking. Not only does it share a border with Mexico, where illegal entry into the United States can be accomplished without documents, but also it has many busy interstate highways and bus stations, international airports, and several seaports. As well, the I-10 corridor, which runs through the heart of Texas, was identified by the Department of Justice as one of the major routes for human trafficking (Walker-Rodriguez & Hill, 2011). Even more alarming, the Texas–Mexico border has been named the primary supply site for children in labor and sex trafficking in North America (Children at Risk, 2013).
In recent years, the most significant organized crime threat to Texas has been the Mexican cartels (Knowles, 2008; TXDPS, 2013). Of the eight top cartels, the Texas Department of Public Safety (2013) reports that six have command and control networks operating in the state and using it as a transshipment center for the movement of marijuana, cocaine, methamphetamine, heroin, and people into and throughout Texas and the nation, and transporting bulk cash, weapons, and stolen vehicles back to Mexico.

It is estimated that in Latin America, 20% of the 1.3 million people in an indentured-servant type of situation are actually trafficking victims (International Labor Organization [ILO], 2012). Criminal gangs from Mexico, Central America, and other countries that are smuggling people across the United States–Mexico border have greatly increased in number in recent years (Bilateral Safety Coalition, 2013).

The combination of these trends—increasing violence and northward expansion—has increased the threat of violence and other crimes associated with Mexican cartels taking place in the United States. Within this context, the threat to Texas is significant due to the prevalence of lucrative trafficking routes and smuggling networks throughout the state, as well as the state’s proximity to cities and towns steeped in cartel violence and influence just across the border in Mexico. (TXDPS, 2012)

A 2009 study estimated that each year, around 10,000 women are trafficked and forced to work in the sex industry from the southern and central part of Mexico to the northern border (Acharya, 2009), and recent reports have not changed that estimation significantly. Scores of newspaper articles and police statements continually report that this crime is only expanding.

The smuggling of immigrants produces an environment of vulnerability to labor exploitation. Many immigrants do not have legal visa status to be in the United States, so they are vulnerable to exploitation, which leads them to work long hours in hazardous conditions (Reynolds & McKee, 2010). Teresa Ulloa, regional director of the Coalition Against Trafficking in Women in Latin America and the Caribbean, summarized from
her experience that human trafficking is growing because of poverty, because the cartels
have gotten involved, and because no one is telling them no (O’Connor, 2011).

The increasing number of illegal aliens in Texas augments the already large
population of possible susceptible victims. From 2006 to 2012, the US Border Patrol
reported 1,338,541 illegal alien apprehensions in Texas sectors, with an increase of 40%
from 2010 to 2012; Texas accounted for 50% of all apprehensions along the border in
2012, up from 28% in 2010 (TXDPS, 2013).

After border crossings into Texas, another series of problems presents. Smugglers
and traffickers customarily “store” illegal aliens in stash houses. In the Rio Grande
Valley alone, law enforcement responded to 237 stash houses, where they apprehended
4,752 illegal aliens in 2012, up from 178 stash houses with 1,945 illegal aliens in 2011
(TXDPS, 2013). Physical harm, starvation, forced labor, rape, unsanitary conditions, and
even death have been associated with stash houses (US Department of Homeland
Security, 2010).

Thousands of children are subject to violence, extortion, forced labor, sexual
assault, or prostitution each year by prostitution rings; manufacturers and viewers of child
pornography; sexual predators; and other criminals (End Child Prostitution in Asian
Tourism [ECPAT], 2017; Protection Project, 2013; TXDPS, 2013). In the United States,
girls in the greatest danger of exploitation by pimps are runaways from home, including
group homes, foster homes, and treatment centers (Clawson, Dutch, Solomon, & Grace,
2009). Unaccompanied alien children are at even more risk. Since 2010, there have been
33,474 apprehensions of unaccompanied alien children along the Texas-Mexico border,
an increase of 81% from 2010 to 2012 (TXDPS, 2013).

While criminals are gaining wealth from exploiting human beings, the victims are
enduring unspeakably adverse physical and psychological health effects. Because of the
nature of keeping a person in bondage, labor and sex slaves suffer from physical trauma,
reproductive and genitourinary problems, infectious diseases, and a plethora of mental
health issues (Chacham, Diniz, Maia, Galati, A., & Mirim, 2007; Cohen & Mannarino, 2008; Farley, 2003; Isaac, Solak, & Giardino, 2011; Zimmerman, 2007). Human-trafficking victims may contract HIV/AIDS from drug abuse and from spread through sexual contact and needle sharing. Violence is often used for keeping victims submissive, causing physical and psychological harm. Frequently moving victims around results in isolation that keeps them completely dependent on traffickers. And posttraumatic stress disorder, stigma, shame, depression, and continued drug addiction often persist after rescue (Gupta, Raj, Decker, Reed, & Silverman, 2009; Tsutsumi, Izutsu, Poudyal, Kato, & Marui, 2008; Ward & Day, 2006; Zimmerman et al., 2007). Silverman et al. (2007) reported that the risk of contracting HIV rose 3 or 4% for every month a girl worked in a brothel. Not just unwilling victims but also johns are at risk of contracting HIV and TB, which can spread to their families and communities (Dharmakhikari, Gupta, Decker, Raj, & Silverman, 2009). A study by the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2010) found that in some locales, the partners of clients of female sex workers have more cases of HIV than do the clients; the study also gave account of the devastating effects sexually transmitted diseases (STDs) have on a community, including infertility.

Although many points of intersection are apparent, the diverse relationships between human trafficking and illegal drugs has not been studied in depth in the literature (Shelley, 2012). Established drug routes are easily used, and sometimes simultaneously, to move humans (Bosco, Cortemiglia, & Serojitdinov, 2009). The United Nations recognizes that those areas of established drug networks have progressively become more significant growth areas for human trafficking (UNODC, 2010). Drug traffickers have found a commodity in the trafficking of humans because humans can be exploited repeatedly for labor, pornography, and the sex trade—unlike drugs, which are sold only once (Shelley, 2012). In addition, a 2010 study found that recent increases in Latin American drug cartel’s moving into the business of human trafficking have been caused
by the lure of low risk as well as existing demand (Llana, 2010). DEA (Drug Enforcement Agency) reported that the Mexican drug cartels had infiltrated over 200 cities across the United States in 2008 and increased to more than 1,200 communities in 2011; they active in every region, making them the most pervasive organizational threat to the United States, where they recruit United States minions to carry out assassinations and other violent crimes (Tarm, 2013).

Researchers and analysts are cognizant of the dangers of human trafficking, but there is a knowledge gap with regard to ways of raising culturally sensitive human trafficking awareness in rural US communities with established drug and smuggling routes coursing through them. This study is critical to an understanding of what knowledge exists and what situations have been experienced, so that pertinent and effective continuing education can be implemented in training rural public health workers to reach small communities in Texas border towns.

**Statement of the Problem**

In 2008, the American Public Health Association (APHA) succinctly summarized the human trafficking problem as follows:

 Trafficking denies women, children and men basic freedom. Trafficking robs communities of potentially productive members of society, and exposes victims to violence, injury, disease and death. Trafficking is a detriment to public health, both economically and in the potential for widespread health issues (APHA, 2008).

A review of data from governments and NGOs found that persons are getting trafficked into multiple and diverse forms of exploitation, including domestic labor, agricultural labor, begging, and sex work. There are certain individual factors that other studies have found that contribute to human trafficking- most of these are prominent in the Rio Grande Valley (Healthy Border 2010, 2013; Texas Department of Health and
Human Services, 2013), including poverty, unemployment, illiteracy, history of physical or sexual abuse, homelessness, illegal-drug use, and gang membership (Seelke, 2016).

In Texas, officials say most of the human trafficking routes and networks are controlled by Mexican drug cartels. Investigative studies and reports have found that such trafficking networks on the border region are varied in type. In some circumstances, cartel members have direct organizational involvement in and responsibility for human-smuggling and human-trafficking operations; in other cases, human-smuggling organizations are forced to pay the cartels for operating their networks and routes in their territories (TXDPS, 2013).

For many years, 3 of the 10 poorest counties in the U.S. have been determined to be in the Texas-Mexico border region (Census Bureau, 2016). In fact, in a survey of America’s poorest cities, the McAllen, Texas, region was named number one, and Brownsville–Harlingen came in at number two (Cohen, 2013). Residents of colonias (poor Texas communities near the Mexican border) specifically have consistently been described as one of the most disadvantaged, hardest-to-reach minority groups in the U.S.

![Image of a map showing the U.S.-Mexico border and the Lower Rio Grande Valley, 2014.](http://quod.lib.umich.edu/m/mjs/12333712.0002.010?view=text;rgn=main)

(Barton, Blum, Marquez, & Perlmeter, 2015; Mier et al., 2008). The top situational or circumstantial factors are high demand for workers in agriculture, factories and domestic and sex work; unrest on the political, social, or economic scene; discrimination against women; public-servant corruption; limited economic opportunities for women; and the existence of established trafficking networks with sophisticated recruitment methods (Seelke, 2016).

Texas colonias, first established in the 1950s for migrant workers, are the homes of half a million people; 2,294 colonias are found in Texas, of which 1,836 are located 62 miles from the border, with an estimated 384,761 residents (Barton et al., 2015; Texas Department of Health and Human Services, 2013). Colonia dwellers on the border suffer from especially high rates of certain diseases and conditions such as diabetes, chronic liver disease, cirrhosis and tuberculosis (United States-Mexico Border Health Commission, 2014), as well as a multitude of public health problems that affect their quality of life, including lack of access to medical care, language barriers, unfamiliarity with government services, high unemployment rates, and poverty (Coppock, 1995; Texas Department of Health and Human Services, 2013). One study of Texas colonias found that poor education and long-term residency in colonias were predictors of poorer physical health and poorer mental health among women living in a colonia for a long time, as well as high comorbidity status, and issues with access to health care associated with poorer mental health status (Mier et al., 2008).

As organized crime and globalization have increased in Mexico—particularly near the northern border region—drug cartels have moved into the area of human trafficking, preying especially on immigrant women (O’Connor, 2011). Organized crime in itself generates a disease burden and has been called a neglected contributor to avoidable illness (Reynolds and McKee, 2010; Shelley, 2012).
Most of the adults living in colonias are Mexican immigrants (Dutton, 2000).

Hispanics experiencing high rates of poverty often suffer from healthcare-access inequality and disparities in health (Texas Department of Health and Human Services,
A European landmark study on the health consequences of trafficking found that trends toward anti-immigrant sentiment have implications for health (Zimmerman, 2003), which contributes to the complexity of services to this population. When cultural barriers and goals are not understood by healthcare providers and clients, cultural sensitivity is difficult to achieve (Du Pre, 2000). To improve the health of poor and vulnerable populations and to reduce healthcare disparities, it is critical to understand the influences on health-related quality of life because these populations can be driven underground, resulting in serious public health consequences if health communicators do not provide culturally competent care (Mier et al., 2008).

The data and the research describe that a problem exists, but there is a gap in healthcare providers’ knowledge and awareness of human trafficking (Beck, Lineer, Melzer-Lange, Simpson, Nugent, and Rabbitt 2014) given that there is no mention of the training of rural public health workers to be key players in the fight. The current literature describes neither how to provide training for rural public health care workers in awareness and prevention of human trafficking nor the need to reach smaller, ethnic communities in the rural United States. Human trafficking researcher Zimmerman of the London School of Hygiene and Tropical Medicine contends that trafficking-related abuses have been well documented in such fields as immigration and law enforcement, but the subject of health has been largely neglected in antitrafficking work (Zimmerman, Hossain, & Watts, 2011).

**Purpose and Objectives**

This study is the first research conducted on the topic of human trafficking among rural health workers in this region. It used an online survey that was sent to rural public health workers on the Texas–Mexico border to obtain preliminary data on their
knowledge of, attitudes toward, and prior education in the issue of human trafficking. The study objectives were:

- To assess rural public health workers’ knowledge and awareness of human trafficking
- To assess rural public health workers’ educational needs in human trafficking issues
- To discuss the implications for rural public health workers’ education in human trafficking and their development as promoters, community leaders, and researchers in the antitrafficking movement

A questionnaire was created by using a survey developed by researchers at the University of Toronto’s Faculty of Medicine to measure medical students’ knowledge of human trafficking (Wong, Hong, Leung, Yin, & Stewart, 2011). The questionnaire was deemed appropriate for assessing healthcare workers’ perceived awareness and attitudes about human trafficking. Details about subject selection and survey administration are provided in the methods section of this dissertation. The purpose of this research was to obtain baseline information and provide a descriptive analyses on which to build future studies upon so multivariate analyses were not implemented. Data were analyzed using the Qualtrics survey tool and SPSS software version 2.0 to address the following research questions.

**Research Questions**

1. What knowledge level of human-trafficking issues do rural public health workers possess?
2. Has this group of healthcare workers received training in awareness and prevention of human trafficking?
3. Do these healthcare workers feel it is important to be offered educational training in prevention and identification of human-trafficking victims?

4. What do health leaders on the Texas-Mexico border region feel are important issues to address concerning human trafficking in that region?

**Definition of Terms**

*Colonias (in Texas):* Located along the United States–Mexico international border, unincorporated, impoverished settlements located within or beyond the extraterritorial jurisdiction of cities in which many people live in trailers or self-built houses that lack basic services such as drainage, paving, and street lighting (Davidhizar & Bechtel, 1999).

*Domestic human trafficking of minors:* The recruitment, transportation, or receipt of children through deception or coercion for the purposes of prostitution, other sexual exploitation, or forced labor within their own country only (Trafficking Victims Protection Act [TVPA], 2000).

*Domestic minor sex-trafficking:* A term coined by Shared Hope International to identify the form of commercial sexual exploitation of children—namely, prostitution—who are victims younger than 18 years of age and either US citizens or lawful permanent residents and to clarify that those victims are children or adolescents (TVPA, 2000).

*Health education:* Any combination of learning experiences designed to help individuals and communities improve their health by increasing their knowledge or influencing their attitudes (World Health Organization [WHO], 2016).

*Healthy People 2020:* Provides science-based, 10-year national objectives for improving the health of all Americans by establishing benchmarks and monitored progress over time in order to encourage collaborations across communities and sectors, empower individuals to make informed health decisions, and measure the impact of prevention activities.
**Human trafficking, trafficking in persons**: The transportation, harboring, or sale of persons within national borders or across international borders through coercion, force, kidnapping, deception, or fraud for purposes of placing persons in situations of forced labor or such services as forced prostitution, domestic servitude, debt bondage, or other slavery-like practices (US Department of Homeland Security, 2010).

**International human trafficking of minors**: The recruitment, transportation, or receipt of children through deception or coercion for the purposes of prostitution, other sexual exploitation, or forced labor across international boundaries (International Labor Organization [ILO], 2012).

**Modern-day slaves**: The status or condition of persons over whom others have power attaching to the right of ownership or control that gets exercised by means of exploitation through involuntary servitude, forced labor, child labor, debt bondage, bonded labor, serfdom, peonage, trafficking in persons for labor or for sexual exploitation (including child sex tourism and child pornography), forced marriage, or other, similar means (Shared Hope International, 2012).

**Sex industry/sex trade**: The group of legal and illegal businesses and single-party and multiparty operations that profit from the sexual exploitation of women, children, and men in trafficking, organized prostitution, and or pornography by way of brothels, massage parlors, bars, strip clubs, mail-order-bride agencies, prostitution tour agencies, so-called adult entertainment and adult bookstores, and pornographic Web sites (Polaris Project, 2013).

**Smuggling**: The procurement of illegal entry of a person—into a nation of which the person is not a national—with the objective of the smugglers’ making a profit; distinguished from trafficking in that smuggling of aliens involves the provision of a service, albeit illegal, for people who knowingly buy the service in order to get into a foreign country (United Nations Office on Drugs and Crime, 2014).
Significance and Rationale

In spite of the emergence of human trafficking as a global hot topic during the past decade, the fact is that many communities remain ignorant of the reality and gravity of the subject. This study provides insight that supports providing education in trafficking in persons for rural public health workers and stresses urgency in the development of evidence-based, culturally appropriate educational and preventive services tailored specifically to the unique needs of subpopulations in the United States—namely, Hispanic immigrants on the United States-Mexican border.

The Texas Department of State Health Services highlights the critical need for healthcare services in general for southern Texas (Texas Department of Health and Human Services, 2013). Research studies and government data consistently cite the Rio Grande Valley (RGV) as high ranking in poverty, infectious diseases, and difficult access to healthcare services, as well as lower education and lower socioeconomic status compared with Texas and the rest of the United States (Centers for Disease Control and Prevention [CDC], 2009; Dutton, 2000; Franzini & Fernandez-Eshcer, 2006; Mier et al., 2008; Ortiz, Arizmendi, & Cornelius, 2004) Rodriguez-Saldana, 2005; United States-Mexico Border Commission, 2014).

The Texas border colonias are in an especially precarious position. Free or low-cost health care is available to children in the region, but problems of the uninsured continue to persist at higher levels than anywhere else in the country (Warner & Jake, 2003). Colonias along the United States-Mexican border have been described for decades as reflective of Third World communities, with their limited infrastructures, lack of basic educational and work opportunities, and prevalence of diseases that are controlled in most parts of the world but are epidemic within these communities (Davidhizar & Bechtel, 1999). This plight has been recognized by the Texas government, which recently supported an initiative to assist needy Texans living in colonias. The initiative would
provide better roads, bring water, and build wastewater infrastructures for areas that lack those basic services and would improve quality of life for colonia dwellers (Texas Border and Mexican Affairs Division, 2013).

Figure 3. Map of health concerns in Lower Rio Grande Valley colonias. “Health risk” represents the combined effects of several factors, including wastewater disposal (as indicated by the presence of cesspools), potable water supply, road surface, flood susceptibility by lot and roads, and whether lots have been legally subdivided (platted). Retrieved 10/3/16 from http://quod.lib.umich.edu/m/mjs/12333712.0002.010?view=text;rgn=main.

Public health workers in rural Hispanic communities are locally known as promotoras. They work full- or part-time and are typically bilingual (Spanish and English), Hispanic, and from the colonia they work in. Promotoras play unique roles because not only do they wear the various official hats of educators, social workers, counselors, and health promoters, but they also serve in many other capacities such as translators, liaisons, and trusted friends of colonia dwellers (CDC, 2009; Texas A&M, 2012). A Texas A&M University director of the school’s Colonias Program said that in 2012, there were over 2,333 colonias along the border—homes to half a million people
(Texas A&M, 2012). Many immigrants avoid any type of official person and are leery of going to authorities for health services or even of simply reporting problems. Therefore, many of the injustices and abuses experienced by that population remain hidden due to shame or fear, but promotoras try to bridge that gap. These rural public health workers already have open lines of communication with colonia residents, know the culture and customs, and coordinate services with community leaders. They play a pivotal role in helping colonia residents enhance their quality of life while reducing the prevalence of disabling health issues (Davidhizar & Bechtel, 1999).

The Centers for Disease Control and Prevention (Balcazar et al., 2012) recognized this essential group of workers as representing a best-practice model for purposes of effecting individual and community-wide behavior changes. There have been success stories and positive health outcomes in different studies that used promotoras to promote health in their own neighborhoods (Balcazar et al., 2012; Ramos et al., 2009). However, an APHA meeting in 2010 that focused on community power and the promoter emphasized the current need to train promotoras to address the root cause of health disparities (APHA, 2010).

Three objectives of Healthy People 2020—STD reduction, HIV reduction, and implementation of rural public health and education programs—form part of the foundation of this research. In addition, several of the Healthy Border 2020 initiative’s health objectives are addressed, including increased access to health care, reduction in the incidence of infectious diseases, and improvements in mental health and maternal and child health (United States-Mexico Border Health Commission, 2014). This study is significant because it affects national health issues such as women’s health, sexual health, improvements in quality of life, decreasing of inequities, and prevention of violence and injury.

After more than a decade of examining patterns and trends in trafficking in persons, I concur with researchers that there are indeed conditions in which human
trafficking thrives—namely, poverty, lack of economic opportunity, and gender discrimination—in addition to factors prevalent in Latin America such as gang affiliations, drug abuse, and teen parenthood (Coffey, 2004). The Rio Grande Valley in general—and the colonias in particular—meet all of those criteria (Texas Department of Health and Human Services, 2013). The present study both focused on the complexity of the RGV region—with its blending of two cultures, two languages, ongoing drug cartel wars, and low socioeconomic status—and examined the need for health workers and community involvement in raising levels of awareness of human trafficking.

This study also has great significance on a personal level. My work has allowed me to live among and serve those living in abject poverty, suffering acute inequalities, and lacking basic resources—with no hope of finding a way out of their circumstances. I have been involved in the anti trafficking movement for more than 20 years on the medical and social level on the Rio Grande border as well as in cities worldwide. While serving local communities on both sides of the border as a physician, public health practitioner, educator, and NGO outreach worker, I have witnessed firsthand the harrowing effects of human trafficking on individuals, families, and communities. I also have experienced the advantageous position health personnel are in to detect and intervene in victims’ lives. It has been my passion and desire to engage public health workers in the fight against modern day slavery and bring attention to this region of the U.S.

Rural public health workers, and more specifically on the border, promotoras, have a unique advantage because they can reach hidden and often forgotten segments of the population. This investigation sought to identify the knowledge gaps and educational needs of rural healthcare workers with regard to human trafficking awareness. The study has important significance because the ability to educate depends on awareness of and meeting the specific needs of the audience. The findings of this study support the increase of community awareness of human trafficking and the strengthening of knowledge of and access to local trafficking services, which will lead to improved health-seeking behavior
in situations of abuse. The results will help design better resource tools to reach not only rural public health workers but communities at large.

**Conceptual Framework**

Researchers at the University of London created a conceptual model of the phases of human trafficking to explain the stages of the human-trafficking process (Zimmerman, Hossain and Watts, 2011). Trafficking is illustrated as a sequence of incident-related stages during which many dangers and intervention opportunities may occur:

- Recruitment
- Travel and transit
- Detention, exploitation, and/or re-trafficking
- Integration or reintegration (Zimmerman, Hossain and Watts, 2011)

This study targeted rural public health workers who may encounter trafficking victims during their travel and transit to a destination or during the actual exploitation or integration phase.

**Delimitations of the Study**

The current study was delimited to include only public health workers, leaders, and volunteers involved in primary care, medical assisting, nutrition and health counseling, and community health promotion (e.g., promotoras, social workers). Only online survey methods were used. The survey was written only in English and was distributed through a listserv of rural public health workers. This approach allowed for participation by those fluent in English, who were on the e-mail listserv and who had access to a computer.
Summary

This chapter has discussed the significance the current study has with regard to addressing several of the Healthy People 2020 goals and with regard to impact on health education. The detrimental health and social consequences of trafficking in persons is significant worldwide, affecting millions annually; it is the second-largest illegal industry globally after the weapons and drug trade. The role of the public health worker in raising awareness and educating the community is pivotal—thus the need to understand gaps in their knowledge and attitudes toward human trafficking. This online-survey study of rural public health workers generated data that supports the need for the development of culturally sensitive health worker education and community awareness directed at preventing and recognizing human trafficking. Chapter II provides an in-depth review of the current literature on international trafficking in persons, trafficking in persons in the United States and Latin America, trafficking and migration, organized crime and trafficking, trafficking in conflict zones, the health consequences of trafficking, public health workers’ roles in combating trafficking, and challenges in human trafficking research.
Chapter II
LITERATURE REVIEW

This chapter presents a review of current literature related to the present study. It specifically covers literature on the topics of (1) international trafficking in persons, (2) trafficking in persons in the United States, (3) trafficking in persons in Latin America, (4) trafficking and migration, (5) organized crime, drug cartels, and trafficking, (6) trafficking in conflict zones, (7) health consequences to trafficked victims, (8) public health workers’ role in combating trafficking, and (9) challenges in trafficking-in-persons research.

**International Trafficking in Persons**

Even though several countries addressed the so-called white slave trade in the early nineteen hundreds by agreeing to suppress the exploitation of women for prostitution (Irwin, 1996), the topic of human trafficking did not receive noticeable attention in the international political arena until the 1990s. Following passage of the Trafficking Victims Protection Act in 2000, trafficking became the focal point of many studies, conferences, academic courses, newspaper stories, and journal articles.

Today the term *trafficking in persons*, which refers to the forced labor of individuals outside their home, is commonly referred to as modern-day slavery (US State Department, 2016). Because of the illegal and invisible nature of forced labor and discrepancies in how it is identified, consistent data is tough to acquire (Oram, Stockl,
Busza, Howard, & Zimmerman, 2012). Hence, at the international and even local levels, accurate trafficking statistics continue to be vague because the pertinent population remains hidden (Tyldum & Brunovskis, 2005; Weitzer, 2015). Even so, the International Labor Organization reports that trafficking agents garner massive revenue worldwide through the trade of the trafficking of human beings (US Department of Health and Human Services, 2011). One study estimated profits from commercial sexual trafficking alone generated $27.8 billion globally from 1995 to 2004 (Belser, 2005). The figures have risen dramatically since then with some estimates as high as $150 billion (International Labor Organization, 2017).

Cases of the illegal trafficking of humans have been described in every country of the world as either places of origin, recruitment, transit, or destination (US Department of State [USDOS], 2011).

- A **country of origin** is one whose residents are recruited and exploited for forced labor (International Organization on Migration [IOM], 2017). Generally, economic hardship in one’s country, in addition to poverty and conflict, often prompt individuals to seek employment in other countries with greater prospects for success. Such job seekers then become easy targets for traffickers, who make phony pledges of respectable work in foreign lands (TVPA, 2000).

- The nation through which victims of trafficking are transferred or smuggled is the **transit country**. “Traffickers are often transported from their home communities to unfamiliar destinations, including foreign countries away from family and friends, religious institutions, and other sources of protection and support, leaving the victims defenseless and vulnerable” (TVPA, 2000).

- A **destination country** is where victims are transported to and forced into labor (TVPA, 2000). The fuel that feeds trafficking in such nations is the demand for inexpensive labor. That demand is met by exploiting humans through illegal

Women and children are more likely to be forced into the sex industry or domestic servitude (Tsutsumi et al., 2008). Cases have been reported of women being expected to service as many as 35 clients a night in brothels, strip clubs, massage parlors, and hotel rooms. Men and boys are frequently trafficked for different types of manual labor (International Labor Organization, 2012). Depending on the area, men may be forced to toil long hours in work in mining, fishing, construction, cleaning, manufacturing, and agriculture; in addition, both adults and children are trafficked into serving as beggars and soldiers, and women as “wives” (Shared Hope International, 2012).

**Trafficking in Persons in the United States**

The United States has been a leading force in the fight against worldwide human trafficking, yet sadly enough, there are new cases of human trafficking within its own borders each year. A study of media headlines of trafficking incidents and reports from 54 US newspapers from 2000 to 2010 found that the occurrence of human trafficking increased substantially (Burnette, 2010), with the numbers continuing to climb in more-recent reports (Polaris Project, 2013). Trafficking for both sexual exploitation and labor is present in across the United States, with the top state hotline calls coming from California, Texas, and Florida (National Human Trafficking Resource Center [NHTRC], 2016).

The top labor-trafficking incidents in the United States usually get reported as forces work in agriculture, restaurants, and domestic servitude, as well as in factories, begging, and the hospitality industry (Feingold, 2005; NHTRC, 2016). Even though both legal and illegal residents work in such jobs and are paid and treated fairly, cases of abuse keep surfacing. A situation becomes labor trafficking for the purpose of agriculture/
factory work or domestic servitude when the employer uses force, fraud and/or coercion to maintain control over the worker, as well as when the worker is led to believe that he or she has no other choice but to continue working for the employer (Polaris Project, 2013).

Trafficking of men, women, and families for seasonal farmwork; for harvesting crops, tending orchards, and raising animals; and working in restaurants has been found in states all across America. The Polaris Project (2011, 2016) cites the following situations.

- Since passage of the Trafficking Victims Protection Act, numerous cases of slavery have emerged in agriculture.
- The Department of Justice issued an indictment in 2010 alleging that Global Horizons, a labor recruiting company, recruited more than 400 Thai workers and forced them to work in agriculture in at least 13 states by confiscating their passports and visas, by ensuring the workers accrued substantial debts, and by deporting workers who didn’t cooperate with the company’s demands.
- Cases of human trafficking in restaurants have been investigated in multiple states—including Florida, Texas, Massachusetts, New York, Wisconsin, and Minnesota—and the prevalence of labor trafficking in restaurants has been commonly cited by human-trafficking investigators and service providers as an area of concern.

Domestic workers are usually female; they work in an employer’s household, performing cleaning, cooking, and child care (International Labor Organization, 2017). The Polaris Project (2011, 2016) also cites statistics on domestic servitude labor trafficking in the United States.

- In one report, the Government Accountability Office identified 42 domestic workers with A-3 and G-5 visas who alleged abuse by foreign diplomats from 2000 through 2008. Ten of the 42 cases resulted in federal human-trafficking investigations. The study concluded that the total number of incidents is likely higher.
- Domestic Workers United estimated more than 200,000 domestic workers are in New York. According to its report, 76% are foreign nationals, 95% are people of color, and 93% are women. The report further found that 41% of the workers who participated in the study earned low wages and that an additional 26% earned below minimum wage. Half of the workers interviewed worked
overtime, often more than 50 or 60 hours a week. Sixty-seven percent of workers reported not receiving overtime pay for overtime hours worked.

- Domestic Workers United in California found that many respondents experienced various labor violations or mistreatment. Respondents reported working more hours than initially agreed upon with their employers (31%), being paid less than agreed upon with their employers (22%), or not being paid at all (16%). Many domestic workers also reported being insulted or threatened by their employers (20%), being sexually harassed (9%), or experiencing physical assault or violence (9%). The study also noted an unusually high rate of nonresponse to these particular questions, suggesting that workers were uncomfortable with the questions or feared responding.

- The National Human Trafficking Resource Center received reports of 25,696 trafficking cases from December 2007 through December 2015, referencing potential labor trafficking of domestic workers. In 2015, the NHTRC received 21,947 calls, 1,535 Webforms, and 1,275 e-mails. The most-common locations referenced in those contacts, in descending order, were California, New York, Maryland, Virginia, and Washington, D.C. The most-common nationalities of potential victims referenced in the contacts, in descending order, were Filipino, Ethiopian, Indian, Guatemalan, and Mexican.

**Trafficking in Persons in Latin America**

Compared with Asia and eastern Europe, less information has been published about trafficking in Latin America. However, estimates during the past 20 years are consistent that thousands of women and girls are being trafficked each year in Latin America (Polaris Project, 2016; Langberg, 2005). It is a staggering figure—and does not include men and boys. The Coalition Against Trafficking in Women (CATW, 2016) and the International Organization on Migration (IOM, 2015) have collected detailed data and analyses of trafficking in Latin America and the Caribbean, in which Mexico is listed as a source, transit, and destination country, with the Mexican–United States border believed to be one of the largest sources of human trafficking across international borders (Cicero-Dominguez, 2005; Gozdziak & Collett, 2005; TXDPS, 2015).

The US State Department (2009) reports together with many other reports have found that great numbers of women and children are trafficked to the border for sex
tourism. The danger of trafficking for sex is especially high along that border because of high unemployment rates and the fact that thousands of US citizens cross the border every day to buy prostituted Mexican youth (Ugarte, Zarate, & Farley, 2004. As in many Third World countries, cultural norms such as machismo engender discrimination against women, restrict economic opportunities, and allow males to exert decision-making authority. In Mexico, social acceptance of gender-based inequity has led to violence against women, including vulnerability to trafficking (Langberg, 2005; Seelke, 2016). Newspaper articles that document trafficking include the trafficking of girls from eastern Europe and Russia into Mexico en route to the United States (Landesman, 2004).

Because news from the RGV portion of the Texas-Mexico border rarely makes the national news syndicates, many erroneously assume things have calmed down. But combing through news reports on human trafficking activity in the Rio Grande Valley reveals the opposite. Those of us who live near the border face a reality very different from the one that officials present. Violence, drugs, and smuggling have been the norm for years, but with human trafficking on the rise, feelings of unrest and danger have escalated. Interviews with border residents describe gunfights and destruction of personal property as illegals run through backyards and hide in people’s sheds and cars in an attempt to escape border.

On both sides of the border, illegal aliens are commonly held, many times against their will, in stash houses, where they await transport to another city and are often extorted for more money, violated, and even murdered (TXDPS, 2015). In Texas, those stash houses, which may be hotels, mobile homes, apartments, ranches, and the like, are usually not equipped to hold large numbers of people and are found to be in deplorable condition. Law enforcement in the Rio Grande Valley apprehended 4,752 illegal aliens in 2012 from 237 stash houses—up from 1,945 illegal aliens in 178 stash houses in 2011 (TXDPS, 2015).
Trafficking and Migration

Among the various theories of migration, trafficking in persons has been identified as the phenomenon of illegal migration (Friebel & Guriev, 2004). There is much discussion—and there is much confusion about terms—when it comes to migration and trafficking. Migrants enter the United States willingly either by obtaining a visa or paying a “coyote” (smuggler) to smuggle them across the border illegally. The relationship of illegal migration to human trafficking occurs when smuggling becomes trafficking. Many people who agree to pay for assistance to enter the United States find that after they cross the border, they are forced to provide additional funds, labor, or services for the smugglers (Walters & Davis, 2011). The results are migrants now caught in forced-labor situations.

Much of the literature focuses on abuses of migrating women and girls and does not adequately consider abuses of men and boys (Alvarez & Alessi, 2012). Males are just as vulnerable as females to falling prey. In 2013, 16% of tips sent to the National Human Trafficking Resource Center involved male victims of human trafficking (NHTRC, 2016). In Central America and Mexico, males are used for illegal-drug production and transportation, exploited as drug mules, and trafficked into various forced-labor situations such as agricultural, industrial, and construction jobs (UNODC, 2013).

Labor trafficking is usually overlooked, as it sits in the shadows of harrowing reports of sex trafficking, yet it is just as prevalent in the United States (TXDPS, 2015). Illegal migrant women are recruited the majority of the time to work as domestic servants, prostitutes, waitresses, or dancers in clubs. While awaiting border crossings, women experience an apparent increase in vulnerability to sex trafficking. Several studies, including a large USAID literature review (Coffey, 2004), cited that occurrence at several Latin American borders—notably, the United States-Mexico border, the Guatemala–Mexico border, and the triborder region of Paraguay, Argentina, and Brazil
(Azola, 2000; Guinn & Steglich, 2003), With the stricter immigration policies of recent years have come arguments that an unintended consequence is an increase in labor trafficking along the border as traffickers pose as labor recruiters. And that merging of organized crime networks of humans with drug, weapons, and pornography trafficking is promoting a rise in gang violence in Texas border cities (TXDPS, 2015).

The International Organization for Migration has been collecting data on individuals utilizing IOM’s antitrafficking programs since 1999. Researchers studying IOM data from 5,513 households derived from five countries in the Balkans found that individuals living in migrant families, living in migration areas, or who are parts of large migrant networks are a great deal more likely to become victims of trafficking (Mahmoud & Trebesch, 2010).

A study of interrelationships between migration and human trafficking offers an economic analysis of the way that insufficient opportunities for legal migration combined with strong demand for cheap labor in the United States have encouraged illegal migration and trafficking (Anti-Slavery International, 2003). It is known that hundreds of migrants try to cross the border illegally in search of work, but it is surprising to learn that an estimated 10 million to 13 million illegal migrants are working without documentation in the United States every year (Anti-Slavery International, 2003; IOM, 2013).

The latest humanitarian crisis in immigration on the Texas-Mexico border has sparked national outrage as large influxes of unaccompanied minors continue to cross the border. In October and November 2015, the US government reported more than 10,500 children crossed the border by themselves (Markon & Partlow, 2015). Personally witnessing that phenomenon can be shocking. The needs of literally thousands of children have overwhelmed RGV outreach centers, churches, and makeshift shelters set up to care for them (Hennessy-Fiske & Carcamo, 2014). Amidst the chaos, that surge in vulnerable, unaccompanied minors—attributed to drug-related violence in southern
Mexico and Central America—contributes to the border’s ripe breeding ground for human trafficking.

**Organized Crime, Drug Cartels, and Trafficking**

Who profits from the exploitation of human beings? Some argue that evidence is lacking to link large-scale organized crime to trafficking (Bruckert & Parent, 2002; Feingold, 2005; Salt, 2000), but others find a close relation between the two (Claramunt, 2002; ILO, 2012; Lederer, 2011). Regardless of the scope, law enforcement asserts that criminal groups are increasingly entering into the business of trafficking humans at some level (Smith & Miller-de la Cuesta, 2011). The high-profit/low-risk nature of the industry and the fact that people can be used over and over again—unlike sales of drugs and weapons—make human trafficking a lucrative business.

Human-trafficking law enforcement busts involving large organized crime rings have been increasingly reported in the past two decades. In 1997, a thousand Mexican deaf and mute adults selling trinkets on New York subways and buses represented one of many reports that caught government officials’ attention to the existence of modern-day slavery in the United States (Bales & Lize, 2005). In addition, federal cases involving agricultural slave labor, such as the prosecutions of Miguel Flores in 1997 and Abel Cuello in 1999 (Bales & Lize, 2005), have been tried. Studies dating back for the past two decades have consistently found that to smuggle women for forced prostitution, traffickers in Latin America use routes similar to those they use to smuggle illegal aliens (IOM, 2015).
Figure 4. Drug routes in Texas through the Rio Grande Valley. Texas shares a 1,254-mile border with Mexico that follows the course of the Rio Grande River. This border area, a large portion of which is open and incapable of being continuously monitored by border enforcement agencies, is extensively used by drug trafficking organizations (DTOs) to smuggle illicit drugs into the United States. Significant quantities of methamphetamine, cocaine, heroin, and marijuana are smuggled from Mexico into Texas. Federal-wide Drug Seizure System (FDSS) data indicate that the quantity of drugs seized by federal law enforcement officers in Texas, most of which is seized at or near the U.S.-Mexico border, consistently exceeds that of any other state in the nation. From National Drug Intelligence Center. October 2003. Retrieved on November 5, 2015 from https://www.justice.gov/archive/ndic/pubs5/5624/overview.htm.

Recent research confirms the trend of the organized crime-trafficking connection. The UN’s *Global Report on Trafficking in Persons* analyzed different patterns and flows
of trafficking and found that international trafficking is more organized than and has different characteristics and challenges from domestic trafficking, which can be organized or nonorganized (UNODC, 2013). The Rio Grande border is unique in that both small-scale, independent traffickers and larger, organized networks are at work simultaneously. The coinciding statistics related to the intensifying drug cartel war on the northern Mexican border and to flooding reports describing the increase in human trafficking are especially noteworthy (USDHHS, 2013).

Currently, total illegal-alien apprehensions along the United States-Mexico border are at historically elevated levels, with the Rio Grande Valley section reporting the highest activity in 2013, which is a noteworthy change from previous years (TXDPS, 2015). That surge in illegals coincides with drug cartels’ engagement in human trafficking and with increased infiltration of US communities by the Gulf Cartel, the Juárez Cartel, and Los Zetas along the border, and the Barrio Azteca, Black Gangster Disciples, Bloods, Crips, Mara Salvatrucha, Sureños, and Tango Blast in Texas (UNODC, 2013). The White House drug czar (director of the Office of National Drug Control Policy) confirmed in one report that the Mexican drug cartels are found in more than 200 US cities (Jessup, 2011).

**Trafficking in Conflict Zones**

For decades, research has been conducted in war-torn nations, documenting the devastating consequences of conflict. Sadly, political and economic changes often produce mass migration and poverty, from which corruption, organized crime, and trafficking of humans emerge (Nelson, Guthrie, & Coffey, 2004). The sexual exploitation faced by women and girls intensifies considerably during those periods (Ugarte et al., 2003).
Forced migration due to conflict—and aggravated by scarcity of economic resources—places affected community members at greater risk of abuse. And the border region of Mexico is not exempt. Mexicans from the southern state of Chiapas, where the Zapatista war has devastated entire villages, have been trafficked to the border and into the United States via larger Mexican cities (Acharya, 2005). Not only does conflict destroy homes and normal life, but also many parents even reach the point of selling their daughters in their desperation to escape the fighting and poverty (Not For Sale Campaign, 2013).

**Health Consequences to Trafficked Victims**

The trafficking of humans for labor or sex work produces a vast array of both mental and physical pain, which tends to leave permanent scars on its victims.

The majority of studies on human trafficking and health have focused on sex trafficking. The health consequences of trafficking in women for sex work have been researched in a handful of areas such as Moldova, Nepal, Thailand, and Europe (Beyer, C. & Stachowiak, J., 2003; Decker, McCauley, Phuengsamran, Janyam, & Silverman, 2011; Ostrovschi et al., 2011; Tsutsumi et al., 2008; Zimmerman, 2007). Zimmerman and researchers at the Imperial College London School of Public Health found that women, men, and children survivors suffered not only from physical and mental abuse but also from forced use of drugs, mental and emotional manipulation, insurmountable debt, and isolation (Zimmerman, 2003; Zimmerman et al., 2011). Of 200 women interviewed at several European sites, the majority (95%) reported high levels of physical and sexual abuse, with the most common physical health symptoms reported as back pain, fatigue, headaches, weight loss, and sexual and reproductive issues (Zimmerman, 2007). In reviewing the literature on reports about the mental states of trafficked persons, the studies that used screening tools to identify mental distress found
high levels of anxiety, depression, and posttraumatic stress disorder (Oram et al., 2012). An early Zimmerman study also found that the majority of trafficked women reported symptoms consistent with posttraumatic stress disorder (Zimmerman, Yun, Shvab, Watts, & Trappolin, 2003).

Two of the gravest public health consequences of sex trafficking are sexually transmitted infections and HIV/AIDS (Gupta, Raj, Decker, Reed & Silverman, 2009; Shannon et al., 2008; Silverman, 2006; Stein, 2010). Risk factors and social and environmental influences on vulnerability to human trafficking and HIV include gender inequality, prostitution laws, immigration policies, and poor quality of life (Farmer, 2010; Garcia-Moreno & Watts, 2000; Ramos et al., 2009). Another morbid communicable disease in this population is tuberculosis (TB). Due to unhygienic and crowded working and living conditions, sex-trafficking victims as well as those trafficked into forced labor often contract TB and spread it to coworkers and communities (Dharmadhikari et al., 2009).

A leading researcher on understanding and preventing gender-based violence against adolescent and adult women, Jay Silverman, led groundbreaking studies of sex trafficking in South Asia and Southeast Asia, reporting high HIV prevalence among trafficked girls in India and Nepal (Silverman et al., 2007). His 2009 study for the United Nations found high prevalence of sexually transmitted infection among trafficked females working in the sex industry in Cambodia, Thailand, and Indonesia (Silverman, Decker, McCauley & Mack, 2009). The study researchers emphasized the need for primary prevention of trafficking to become prioritized by increasing dialogue across the spectrum of responses to sex trafficking and HIV within sex work and including advocates for the rights of both sex workers and children, advocates for the prevention of trafficking, law enforcement policy makers and practitioners, and those leading public health efforts to reduce HIV in the context of sex work, concluding that, “only through such efforts we may develop effective and sustainable solutions to address the health,
well-being and human dignity of sex-trafficked women and girls” (Silverman, Decker, McCauley & Mack, 2009). University of California, San Diego researcher Shira Goldberg (2011) conducts research on social and structural factors that shape the risks of HIV and sexually transmitted infection among mobile, vulnerable populations. Studying the relationship between the mobility, trafficking, and HIV risk of sex workers on the United States-Mexico border, she proposed that the structural factors influencing both health outcomes and human rights violations offer opportunities to identify common targets for HIV and trafficking prevention.

Oram et al. (2012), in conducting a systematic review of 16 studies on health and trafficking, found only two that included data on labor-trafficking victims. Although the literature has more heavily emphasized sex trafficking, the health consequences of labor trafficking are also harsh. Reports of injury are frequent when victims are discovered hidden in cargo ships, bunkers, or cages while in transit to their destinations and exposed to severe heat or cold, unclean conditions, and deficiencies of food and water (Gushulak & MacPherson, 2000). These individuals’ lives are also at risk due to perils along the way by exposure to toxic waste, crushing of their bodies, or suffocation (Bales & Lize, 2004).

Depending on the form of labor they get trafficked into, victims become vulnerable to a wide range of occupational health risks in addition to mental abuse upon reaching the work site (Abas, Ostrovschi, Prince, Gorceag, Trigub, & Oram (2013); Gushulak & MacPherson, 2000; Macy & Johns, 2011). King’s College London researcher Siam Oram (2011) lists the top illnesses among trafficked individuals in factory work as chronic coughs, respiratory problems, severe headaches, allergies, skin infections and irritations, eye strain, back pain and general body pain, and work-related injuries. Her interviews with NGOs found that the unsanitary and generally inhumane living and working conditions of labor trafficking victims may also pose additional health risks such as infectious and communicable diseases, fatigue, weight loss, undernutrition, injuries, and
poor mental health (Oram, 2011). A study by Bales and Soodalter (2009) also found forced-labor victims suffering from malnutrition, damaged teeth, stab wounds, head injuries, bruises, and broken bones.

Evidence indicates that very few victims actually reach services offered by antitrafficking reintegration programs (Dovydaitis, 2010; GAATW, 2007; Human Trafficking Task Force of Greater Milwaukee, 2013; Wisconsin Office of Justice Assistance, 2008). Unfortunately then, survivors often endure continual symptoms and risks—in addition to posttraumatic stress disorder and depression—for months and years after release from bondage (Dovydaitis, 2010; Yakushko, 2009). The risk of becoming retrafficked is high whether a victim returns home or remains in the destination country (Jobe, 2010). Those who do return home often face the same hardships that caused them to seek better lives elsewhere—but now with the added burdens of health problems and stigma (Dovydaitis, 2010).

**Public Health Workers’ Role in Combating Trafficking**

The health consequences of human trafficking are exceedingly negative for victims, with effects extending to families and communities. Individuals in both labor and sex trafficking are typically forced to work in filthy and squalid conditions, leaving them susceptible to infectious diseases and sexually transmitted diseases. Men in the community who are serviced by woman sex workers return to their houses and spread disease to their spouses and/or next sexual partners (Bennetts et al., 1999; Beyrer & Stachowiak, 2003).

The US Congress included in the TVPA that human trafficking is a violation of labor, public health, and human rights standards worldwide (TVPA, 2000). Georgia State University professor of law Jonathan Todres (2011) called attention to the benefits of a
public health approach to human trafficking and explained how the traditional four areas emphasized by public health would strengthen antitrafficking efforts:

- Reliance on evidence-based research
- Focus on prevention
- Correction of behaviors that increase risk of disease or harm
- Seeking to engage all stakeholders in a population who can tackle a health issue

Research demonstrates that medical personnel have a great opportunity to recognize victims. In a recent survey of sex-trafficking victims, 28 to 50% said they had been seen by a healthcare worker while being trafficked but were not recognized (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011; Beck, Lineer, Melzer-Lange, Simpson, Nugent, & Rabbitt, 2015). A Wisconsin study found the main barrier to identification is lack of human-trafficking awareness by and training of medical providers in awareness and prevention of human trafficking (Beck, Lineer, Melzer-Lange, Simpson, Nugent, & Rabbitt, 2015). A survey in Milwaukee found that human trafficking victims may not be connecting to services in their communities and that healthcare workers have reported not feeling confident about knowing how to connect victims to services (Human Trafficking Task Force of Greater Milwaukee, 2013).

Promotoras are in a position to incorporate public health’s four epidemiological processes. Todres (2011) emphasized how public health workers’ use of epidemiological methods could help authorities implement successful procedures to fight human trafficking, including:

- Public health surveillance
- Identification of group at risk
- Examination of risk factors
- Implementation and evaluation of programs
Challenges in Trafficking-in-Persons Research

Despite widespread public sympathy for victims, despite the distribution of federal funds to antitrafficking programs, and despite enactments of new policies to punish perpetrators, many challenges remain in human trafficking research. Constant criticisms by researchers analyzing the antitrafficking discourse are that it is not evidence based (Weitzer, 2015), that empirical studies are scarce, and not much systematic research has been conducted (Gozdziak & Bump, 2008; Sanghera, 2005).

Another criticism has been that research on trafficking is skewed to serve a particular political or moral agenda (Smith & Miller-de la Cuesta, 2010; Weitzer, 2005). Feminist researchers argue that antitrafficking crusaders simply want to use the modern-day slavery problem to shut down, criminalize, or regulate the business of prostitution (Masenior & Beyrer, 2007; Zimmerman, 2011).

Furthermore, there is a problem with the statistics. Describing the unobserved presents many challenges for researchers. Understandably then, calculating the number of trafficked individuals is extremely difficult (UNODC, 2014). The range of estimated persons trafficked is from 4 million to 27 million (United States State Department, 2007, 2016). Several researchers have pointed out the gap in the literature and recommended improved methodologies to correct those numerical discrepancies (Gozdziak & Collett, 2005; Smith & Miller-de la Cuesta, 2011; Tyldum & Brunovskis, 2005).
Chapter III

METHODS

This chapter describes the methods of study in the forms of research design, description of survey instrument, description of study participants and setting, and data collection and analysis. The study protocol was approved by the Columbia University Teachers College Institutional Review Board (IRB) and assigned protocol number 15-011 (Appendix A).

Research Design

This study utilized a single-administration, cross-sectional online survey design to determine human trafficking knowledge and attitudes of rural healthcare workers. Studies aimed at improving preventive care services as well as enhanced delivery of clinical services have found that surveying knowledge and attitudes help researchers gain an understanding of the educational needs of healthcare personnel (Gaspard & Yang, 2016; Hicks & Hennessy, 2012; Nichol & Zimmerman, 2012).

Description of Survey Instrument

An anonymous questionnaire was designed combining two surveys that had been used previously in health professional and trafficking studies: a survey by Wong et al. (2011) administered to evaluate Canadian students’ trafficking awareness and attitudes
and a survey administered to emergency physicians to study their role in human trafficking (Chisolm-Straker et al., 2007. The survey was presented in English and contained topics that described the participant’s practice setting, knowledge of human trafficking, perception of trafficking on the border, perceived competence in recognizing a victim of human trafficking, and prior training received in human trafficking awareness and prevention. The simple questionnaire was completed online, with respondents’ answering questions such as: Have you heard of human trafficking? Do you think human trafficking occurs on the border? Do you feel you could identify a victim of human trafficking? Have you ever received formal training in the awareness, identification, and/or treatment of victims of human trafficking? Demographic information included gender, age, job description, city of employment, and place of birth. The items were phrased as statements consistent with Texas Department of State Health Services (DSHS, 2013) guidelines for adult healthcare workers’ training, the CDC (2012) community health worker guide to community health services, and associated recommendations for a successful promotora program. The questionnaire also asked respondents whether they would find a workshop on awareness, clinical presentation, and treatment of victims of human trafficking useful. Estimated time for survey completion was 20 minutes (Appendix C).

**Description of Study Participants and Setting**

The study participants were rural healthcare workers, including promotoras, community health workers, public health workers, social workers, and others who currently provide and/or direct rural healthcare services along the border in Cameron and Hidalgo counties, Texas. The survey was e-mailed to a listserv of approximately 150 rural public health personnel, including promotoras, leaders, organizations, public and private rural healthcare services, and volunteer health outreach missions. Inclusion
criteria included being able to read English, age 18 years or older, and serving in some capacity in health outreach services on the Rio Grande border.

The setting was on the Texas Rio Grande border, more commonly known as the Valley, an area with an estimated population of 1,305,782. The Valley is located in the southernmost tip of South Texas, along the northern bank of the Rio Grande, which separates Texas and Mexico. The central region of the Valley is made up of four counties: Cameron, Hidalgo, Starr, and Willacy. According to the US Census Bureau, 86% of the population of Cameron County, 90% of Hidalgo County, 97% of Starr County, and 86% of Willacy County are Hispanic.

**Data Collection and Analysis**

In an in-depth interview several years ago with a leader in the Texas Department of State Health Services, interest was expressed in this study and the impact it would have in the region. When the design of the study was being formed I emailed the director who agreed to send out the survey to her private listserv containing various health personnel serving colonias on the Rio Grande border. Invitations to participate in the study were delivered via e-mail to the listserv of approximately 150 rural health workers. Each invitation included an informed-consent statement approved by Columbia University Teachers College that described the purpose of the research, the associated risks and benefits of participation, and data storage methods that protect confidentiality (Appendix C).

The e-mail sent to the prospective study population consisted of an introduction to the researcher, a statement of purpose of the study, a process for consenting to the study, and a survey URL (Appendix D). Individuals were encouraged to respond by the e-mail’s emphasis on the importance of contributing to local health topics, and an optional Best Buy $50 gift card drawing was offered as a token of appreciation for participation. It was
clearly stated that each person could opt to complete the survey without participating in the gift card drawing or after completing the survey they could continue on to a separate section and enter their email for the gift card drawing.

After the initial survey was emailed, two survey reminders were subsequently sent a month apart to invite those who had not participated to do so before the survey closed. A month after the last reminder was sent, the survey was closed. The anonymous survey data was collected and housed by the Qualtrics survey program and transferred to the principal investigator for initial qualitative analysis. SPSS software version 20.0 was used for statistical analyses of questions 1, 2, 3, 7, 8, 9, and 10 of the survey and question 4 of the demographic information to elucidate correlations and trends in the survey results. A chi-square test and Fisher’s exact test were used to examine categorical data. Nonparametric tests were also utilized. To determine if there were significant differences in respondents’ familiarity with signs and symptoms of human trafficking based on having contact with a human trafficking victim, a Kruskal Wallis test was conducted (see Table 18). A Kruskal Wallis test was utilized in lieu of a one-way ANOVA because the dependent variable (familiarity) was measured on an ordinal scale. Hence, the dependent variable did not meet the ANOVA assumption of being on an interval or ratio scale.

Also, to determine if there were significant differences in respondents familiarity with signs and symptoms of human trafficking and knowledge of human trafficking based on whether the respondent had attended a training, two Mann Whitney tests were conducted (see Table 19). Moreover, to determine if there were significant differences in respondents familiarity with signs and symptoms of human trafficking based on whether the respondent had come in contact with a human trafficking victim, a Mann Whitney test was also conducted (see Table 19). Mann Whitney tests were utilized in lieu of an independent samples t-tests because the dependent variables (familiarity and knowledge) were measured on an ordinal scale. Hence, the dependent variable did not meet the t-test assumption of being on an interval or ratio scale.
A significance level of \( p < 0.01 \) was employed. Analytic summaries were written up by the researcher based on key findings from the survey. All data were stored under password in the principal investigator’s private laptop.

A descriptive study design to characterize the data, and statistical analyses were used for exploring factors associated with training in human-trafficking awareness and prevention, human-trafficking knowledge, and identification of victims. The data analysis focused on providing a description of the dominant categories and themes captured by the survey in four major content areas: rural healthcare workers’ knowledge level and experience in human trafficking, availability of training material and resources in the community, educational priorities with regard to health issues and identification of victims in the community, and need for training of rural healthcare workers in awareness and prevention of human trafficking.

**Summary**

This chapter has presented the research design, a description of the survey instrument and study participants, and the data collection and analysis methods. A single-administration survey design was used for determining the educational needs of rural health workers through an assessment of knowledge and attitudes about human trafficking. The study sample was drawn from a listserv of approximately 150 rural public health workers and leaders who currently serve families living along the Rio Grande border. The survey was developed based on a review of the literature of previous surveys of healthcare students and personnel. Data were collected by Qualtrics, analyzed by SPSS version 2.0, and applied to the research questions.
Chapter IV

RESULTS

This section presents the results of the human-trafficking survey as related to four of the major content areas of this study. Those areas are rural public health workers’ knowledge level and experience in human trafficking, availability of training material and resources in the community, educational priorities with regard to health issues and identification of victims in the community, and need for training of rural health care workers in awareness and prevention of human trafficking. The first section describes the study sample.

Response Rates

One hundred fourteen individuals started the survey. However, 11 individuals did not respond to any questions. These responses were excluded from the dataset using case-wise deletion. An additional 8 respondents provided incomplete responses (had 85% or more missing responses on questions of interest). Of these 8 individuals, only 6 provided demographic information. This information reflects that these individuals were all women (n = 6). These non-responders varied in age, place of birth, and profession. Therefore, the estimated response rate is approximately 67% for demographic and background data (non-response rate: 33%) and approximately 64% (non-response rate: 36%) for the rest of the survey.
Demographic Findings

Demographic characteristics of the 102 study participants are summarized in Tables 1–4. Of those who completed the survey, women accounted for the majority (see Table 1).

Table 1. Response Rates by Gender (N=99)

<table>
<thead>
<tr>
<th>Gender</th>
<th>%</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>14.14%</td>
<td>14</td>
</tr>
<tr>
<td>Female</td>
<td>85.86%</td>
<td>85</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>99</td>
</tr>
</tbody>
</table>

The respondents varied in age; 1% were younger than 20 years old; 12% were 20-29 years old; 22% were 30-39 years old; 27% were 40-49 years old; 20% were 50-59 years old; and 19% were 60 years old or older (see Table 2).

Table 2. Age Range of Respondents (N=101)

<table>
<thead>
<tr>
<th>Age</th>
<th>%</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20 years old</td>
<td>0.99%</td>
<td>1</td>
</tr>
<tr>
<td>20-29 years</td>
<td>11.88%</td>
<td>12</td>
</tr>
<tr>
<td>30-39 years</td>
<td>21.78%</td>
<td>22</td>
</tr>
<tr>
<td>40-49 years</td>
<td>26.73%</td>
<td>27</td>
</tr>
<tr>
<td>50-59 years</td>
<td>19.80%</td>
<td>20</td>
</tr>
<tr>
<td>&gt;60 years</td>
<td>18.81%</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>101</td>
</tr>
</tbody>
</table>

Percentages do not total 100 because of rounding.

Within the sample, 70% reported being born in Texas, 15% in Mexico, and 17% in another country or the United States. All of the survey respondents worked in either Cameron County or Hidalgo County, Texas (see Table 3).
Table 3. Location of Birth (N=102)

<table>
<thead>
<tr>
<th>Birth location</th>
<th>%</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas</td>
<td>68.63%</td>
<td>70</td>
</tr>
<tr>
<td>Mexico</td>
<td>14.71%</td>
<td>15</td>
</tr>
<tr>
<td>Other</td>
<td>16.67%</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>102</td>
</tr>
</tbody>
</table>

With regard to employment, 40% of respondents indicated they worked in the community as health workers or promotoras; 3% were in healthcare leadership; 10% were in government healthcare agencies; 8% were in community health organizations; 6% were social workers; 6% were clergypersons; 4% were doctor/nurse/med students; 2% were teachers; and 22% were working in a health-related capacities, such as therapists, emergency medical technicians, counselors, victim advocates, and behavioral health coordinators (see Table 4).

Table 4. Job Description of Respondents (N=101)

<table>
<thead>
<tr>
<th>Job description</th>
<th>%</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health worker/ Promotora</td>
<td>39.60%</td>
<td>40</td>
</tr>
<tr>
<td>Other: please specify</td>
<td>21.78%</td>
<td>22</td>
</tr>
<tr>
<td>State or Government Agency</td>
<td>9.90%</td>
<td>10</td>
</tr>
<tr>
<td>Community organization</td>
<td>7.92%</td>
<td>8</td>
</tr>
<tr>
<td>Social worker</td>
<td>5.94%</td>
<td>6</td>
</tr>
<tr>
<td>Clergy/Church staff</td>
<td>5.94%</td>
<td>6</td>
</tr>
<tr>
<td>Doctor/Nurse/Medical student</td>
<td>3.96%</td>
<td>4</td>
</tr>
<tr>
<td>Director or Leader in Health</td>
<td>2.97%</td>
<td>3</td>
</tr>
<tr>
<td>Teacher/Professor</td>
<td>1.98%</td>
<td>2</td>
</tr>
<tr>
<td>NGO/ Volunteer in health services</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>101</td>
</tr>
</tbody>
</table>
Knowledge Level and Experience in Human Trafficking

The first major content area examined in this study was rural public health worker’s level of knowledge and experience. The intent of this section was to collect background information on the sample’s familiarity with and understanding of human trafficking. All had heard of human trafficking (see Table 5). The majority of the sample (52%) reported hearing about human trafficking from the news; 23% from working in health care; 18% from working in the community; 7% from a friend or family member; 1% had never heard of human trafficking.

Table 5. Sources of Learning about Human Trafficking (N=95)

<table>
<thead>
<tr>
<th>Sources</th>
<th>%</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never heard about human trafficking</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Heard about human trafficking in my community</td>
<td>17.89%</td>
<td>17</td>
</tr>
<tr>
<td>Heard about human trafficking from the news</td>
<td>51.58%</td>
<td>49</td>
</tr>
<tr>
<td>Heard about human trafficking from a friend or family member</td>
<td>7.37%</td>
<td>7</td>
</tr>
<tr>
<td>Heard about human trafficking during my work in the health care arena</td>
<td>23.16%</td>
<td>22</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>95</td>
</tr>
</tbody>
</table>

Within the sample, most respondents indicated having only some knowledge of human trafficking. The highest percentage (66%) reported feeling somewhat knowledgeable of human trafficking, and some (7%) indicated not being knowledgeable at all. Only a small percentage (3%) indicated being very knowledgeable, and of the remaining participants, 23% expressed being knowledgeable (see Table 6).
Table 6. Degree of Knowledge of Human Trafficking (N=95)

<table>
<thead>
<tr>
<th>Degree of Knowledge</th>
<th>%</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not knowledgeable</td>
<td>7.37%</td>
<td>7</td>
</tr>
<tr>
<td>Somewhat knowledgeable</td>
<td>66.32%</td>
<td>63</td>
</tr>
<tr>
<td>Knowledgeable</td>
<td>23.16%</td>
<td>22</td>
</tr>
<tr>
<td>Very knowledgeable</td>
<td>3.16%</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>95</td>
</tr>
</tbody>
</table>

Almost all of the respondents (94%) said human trafficking occurs in the Texas Rio Grande Valley; a few (5%) were not sure whether it occurred; only 1 respondent (1%) said it did not occur (see Table 7).

Table 7. Perception of Occurrence of Human Trafficking in the Texas Rio Grande Valley (N=96)

<table>
<thead>
<tr>
<th>Human Trafficking in the Rio Grande Valley</th>
<th>%</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>93.75%</td>
<td>90</td>
</tr>
<tr>
<td>No</td>
<td>1.04%</td>
<td>1</td>
</tr>
<tr>
<td>Not sure</td>
<td>5.21%</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>96</td>
</tr>
</tbody>
</table>

Very few participants (1%) reported being very familiar or familiar (12%) with the signs and symptoms of a human-trafficking victim. Most of the respondents said they did not feel well-informed about such indicators. Some (32%) reported being somewhat familiar; and most (48%) not familiar at all with the topic of human trafficking (see Table 8).
Table 8. Familiarity with the Signs and Symptoms of a Human Trafficking Victim (N=93)

<table>
<thead>
<tr>
<th>Familiarity</th>
<th>%</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very familiar</td>
<td>1.08%</td>
<td>1</td>
</tr>
<tr>
<td>Somewhat familiar</td>
<td>34.41%</td>
<td>32</td>
</tr>
<tr>
<td>Not familiar</td>
<td>51.61%</td>
<td>48</td>
</tr>
<tr>
<td>Familiar</td>
<td>12.90%</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>93</td>
</tr>
</tbody>
</table>

Within the sample, 19% reported they had come in contact with an individual they suspected of being trafficked; 64% said they had not; 17% were not sure (see Table 9).

Table 9. Contact with a Person in the Valley Suspected of Being Trafficked (N=95)

<table>
<thead>
<tr>
<th>Contact with Suspected Victim</th>
<th>%</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>18.95%</td>
<td>18</td>
</tr>
<tr>
<td>Not sure</td>
<td>16.84%</td>
<td>16</td>
</tr>
<tr>
<td>No</td>
<td>64.21%</td>
<td>61</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>95</td>
</tr>
</tbody>
</table>

A very high percentage of respondents (84%) said they had never knowingly come in contact with a victim of human trafficking in the Valley; a few (16%) reported having had contact with a victim (see Table 10).

Table 10. Contact with a Known Victim of Human Trafficking in the Valley (N=95)

<table>
<thead>
<tr>
<th>Contact with a Known Victim</th>
<th>%</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>15.79%</td>
<td>15</td>
</tr>
<tr>
<td>No</td>
<td>84.21%</td>
<td>80</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>95</td>
</tr>
</tbody>
</table>
In summary, all of the participants had heard of human trafficking, the majority learning about it from the news; over half of the respondents reported having little knowledge of human trafficking nor had not come in contact with a suspected or known victim of human trafficking; almost half reported being somewhat familiar with signs and symptoms of trafficking, felt only somewhat likely a victim would be identified in a social service setting and were unsure if resources existed in the community to help victims of human trafficking. Over half of respondents have never attended a training event.

**Training and Community Resources**

In terms of training, a majority (66%) of survey participants said they had never attended a training event on human-trafficking awareness and victim identification; some (34%) said they had attended an event (see Table 11).

<table>
<thead>
<tr>
<th>Training Attendance</th>
<th>%</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>34.04%</td>
<td>32</td>
</tr>
<tr>
<td>No</td>
<td>65.96%</td>
<td>62</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>94</td>
</tr>
</tbody>
</table>

In assessing whether a victim of human trafficking on the Texas border would be correctly identified in a social service or clinical setting, 34% said it was unlikely such a person would be identified; 48% said it was somewhat likely; 15% said it was likely; and only 3% said it was very likely the person would be identified (see Table 12).
Table 12. Likelihood of a Victim of Human Trafficking to be Identified in a Social Service or Clinical Setting in the Rio Grande Valley (N=95)

<table>
<thead>
<tr>
<th>Likelihood of victim being identified in the Valley</th>
<th>%</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unlikely</td>
<td>33.68%</td>
<td>32</td>
</tr>
<tr>
<td>Somewhat Likely</td>
<td>48.42%</td>
<td>46</td>
</tr>
<tr>
<td>Likely</td>
<td>14.74%</td>
<td>14</td>
</tr>
<tr>
<td>Very Likely</td>
<td>3.16%</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
<td><strong>95</strong></td>
</tr>
</tbody>
</table>

Within the sample, 45% of respondents said there are resources and services in the Rio Grande Valley to help victims of trafficking; 13% said there were no resources or services; 42% were not sure whether resources and services exist.

Table 13. Perceived Availability of Resources and Services in the Valley to Help Victims of Human Trafficking (N=95)

<table>
<thead>
<tr>
<th>Available Resources</th>
<th>%</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>45.26%</td>
<td>43</td>
</tr>
<tr>
<td>Not sure</td>
<td>42.11%</td>
<td>40</td>
</tr>
<tr>
<td>No</td>
<td>12.63%</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
<td><strong>95</strong></td>
</tr>
</tbody>
</table>

Educational Priorities for Health Issues and Prevention and Identification of Victims

Given a list of eight community issues to rank in order of importance for community members to be educated on, human-trafficking education was rated the fourth-most-important topic. Ranked from greatest importance to least, the mean values were for child abuse (3.89), elder abuse (3.82), domestic violence (3.81), human
trafficking (3.79), homelessness (3.74), poverty (3.72), gender disparities (3.53), and racial disparities (3.52).

Table 14. Community Health Topics Ranked in Order of Importance for Community Members to be Educated on (N=96)

<table>
<thead>
<tr>
<th>Topic</th>
<th>Not Important</th>
<th>Somewhat Important</th>
<th>Important</th>
<th>Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Child abuse</td>
<td>0.00%</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Elder abuse</td>
<td>0.00%</td>
<td>0</td>
<td>1.05%</td>
<td>1</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>0.00%</td>
<td>0</td>
<td>1.05%</td>
<td>1</td>
</tr>
<tr>
<td>Human trafficking</td>
<td>0.00%</td>
<td>0</td>
<td>2.08%</td>
<td>2</td>
</tr>
<tr>
<td>Homelessness</td>
<td>0.00%</td>
<td>0</td>
<td>3.16%</td>
<td>3</td>
</tr>
<tr>
<td>Poverty</td>
<td>0.00%</td>
<td>0</td>
<td>2.11%</td>
<td>2</td>
</tr>
<tr>
<td>Racial disparities</td>
<td>1.05%</td>
<td>1</td>
<td>8.42%</td>
<td>8</td>
</tr>
<tr>
<td>Gender disparities</td>
<td>1.05%</td>
<td>1</td>
<td>7.37%</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Topic</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std Deviation</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child abuse</td>
<td>3.00</td>
<td>4.00</td>
<td>3.89</td>
<td>0.31</td>
<td>0.09</td>
</tr>
<tr>
<td>Elder abuse</td>
<td>2.00</td>
<td>4.00</td>
<td>3.82</td>
<td>0.41</td>
<td>0.17</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>2.00</td>
<td>4.00</td>
<td>3.81</td>
<td>0.42</td>
<td>0.17</td>
</tr>
<tr>
<td>Human trafficking</td>
<td>2.00</td>
<td>4.00</td>
<td>3.79</td>
<td>0.45</td>
<td>0.21</td>
</tr>
<tr>
<td>Homelessness</td>
<td>2.00</td>
<td>4.00</td>
<td>3.74</td>
<td>0.51</td>
<td>0.26</td>
</tr>
<tr>
<td>Poverty</td>
<td>2.00</td>
<td>4.00</td>
<td>3.72</td>
<td>0.50</td>
<td>0.25</td>
</tr>
<tr>
<td>Gender disparities</td>
<td>1.00</td>
<td>4.00</td>
<td>3.53</td>
<td>0.68</td>
<td>0.46</td>
</tr>
<tr>
<td>Racial disparities</td>
<td>1.00</td>
<td>4.00</td>
<td>3.52</td>
<td>0.69</td>
<td>0.48</td>
</tr>
</tbody>
</table>

When asked to rank the most-important aspects of human trafficking that should be addressed in a public health leaders’ seminar on human trafficking, the following means were obtained: identification of victims (3.79), health needs of victims (3.74), community
and social services (3.69), legal and immigration issues (3.62), and lobbying and advocacy (3.53).

Table 15. Human Trafficking Topics Ranked in Order of Importance to be Taught in a Community Health Leader’s Continuing Education Course (N=95)

<table>
<thead>
<tr>
<th>Topic</th>
<th>Not Important</th>
<th>Somewhat Important</th>
<th>Important</th>
<th>Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Identifying trafficking victims</td>
<td>0.00%</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Health needs of trafficking victims</td>
<td>0.00%</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Community and social services</td>
<td>0.00%</td>
<td>0</td>
<td>3.16%</td>
<td>3</td>
</tr>
<tr>
<td>Legal and Immigration issues</td>
<td>1.05%</td>
<td>1</td>
<td>3.16%</td>
<td>3</td>
</tr>
</tbody>
</table>

Need for Training of Rural Healthcare Workers in Human-Trafficking Awareness and Prevention

Given a list of eight community health issues to rank in order of importance for healthcare workers to be educated on, human trafficking was ranked the second-most-important topic. Ranked from greatest importance to least, the mean values were health effects of child abuse (3.81), health effects of human trafficking (3.77), health effects of domestic violence (3.73), health effects of elder abuse (3.72), health effects of poverty (3.66), health effects of homelessness (3.65), health effects of racial disparities (3.45), and health effects of gender disparities (3.45).
Table 16. Community Health Topics Ranked in Order of Importance in the Continuing Education of Healthcare Workers (Scale = 1-5) (N=95)

<table>
<thead>
<tr>
<th>Health Topic</th>
<th>Not Important</th>
<th>Somewhat Important</th>
<th>Important</th>
<th>Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health effects of child abuse</td>
<td>0.00%</td>
<td>0</td>
<td>18.95%</td>
<td>81.05%</td>
</tr>
<tr>
<td>Health effects of human trafficking</td>
<td>0.00%</td>
<td>0</td>
<td>23.16%</td>
<td>76.84%</td>
</tr>
<tr>
<td>Health effects of elder abuse</td>
<td>1.05%</td>
<td>1</td>
<td>23.16%</td>
<td>74.74%</td>
</tr>
<tr>
<td>Health effects of domestic violence</td>
<td>0.00%</td>
<td>1</td>
<td>25.26%</td>
<td>73.68%</td>
</tr>
<tr>
<td>Health effects of poverty</td>
<td>0.00%</td>
<td>2.11%</td>
<td>29.47%</td>
<td>68.42%</td>
</tr>
<tr>
<td>Health effects of homelessness</td>
<td>0.00%</td>
<td>3.16%</td>
<td>28.42%</td>
<td>68.42%</td>
</tr>
<tr>
<td>Health effects of gender disparities</td>
<td>1.05%</td>
<td>8.42%</td>
<td>34.74%</td>
<td>55.79%</td>
</tr>
<tr>
<td>Health effects of racial disparities</td>
<td>1.05%</td>
<td>7.37%</td>
<td>36.84%</td>
<td>54.74%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Topic</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std Deviation</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health effects of child abuse</td>
<td>3.00</td>
<td>4.00</td>
<td>3.81</td>
<td>0.39</td>
<td>0.15</td>
</tr>
<tr>
<td>Health effects of human trafficking</td>
<td>3.00</td>
<td>4.00</td>
<td>3.77</td>
<td>0.42</td>
<td>0.18</td>
</tr>
<tr>
<td>Health Effects of domestic violence</td>
<td>2.00</td>
<td>4.00</td>
<td>3.73</td>
<td>0.47</td>
<td>0.22</td>
</tr>
<tr>
<td>Health effects of elder abuse</td>
<td>1.00</td>
<td>4.00</td>
<td>3.72</td>
<td>0.54</td>
<td>0.29</td>
</tr>
<tr>
<td>Health Effects of poverty</td>
<td>2.00</td>
<td>4.00</td>
<td>3.66</td>
<td>0.52</td>
<td>0.27</td>
</tr>
<tr>
<td>Health effects of homelessness</td>
<td>2.00</td>
<td>4.00</td>
<td>3.65</td>
<td>0.54</td>
<td>0.29</td>
</tr>
<tr>
<td>Health effects of racial disparities</td>
<td>1.00</td>
<td>4.00</td>
<td>3.45</td>
<td>0.68</td>
<td>0.46</td>
</tr>
<tr>
<td>Health effects of gender disparities</td>
<td>1.00</td>
<td>4.00</td>
<td>3.45</td>
<td>0.69</td>
<td>0.48</td>
</tr>
</tbody>
</table>

The great majority of respondents (98%) said a training event on human-trafficking awareness and victim identification should be offered to rural healthcare workers in the Rio Grande Valley; only 1% said such training is not needed; 1% were not sure.
Table 17. Need for a Training Event on Human Trafficking Awareness and Victim Identification in the Valley (N=93)

<table>
<thead>
<tr>
<th>Need for training</th>
<th>%</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, this training is needed.</td>
<td>97.85%</td>
<td>91</td>
</tr>
<tr>
<td>No, this training is not necessary in our community.</td>
<td>1.08%</td>
<td>1</td>
</tr>
<tr>
<td>I am not sure.</td>
<td>1.08%</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>93</td>
</tr>
</tbody>
</table>

Inferential Statistical Analyses of Training Received, Knowledge, and Victim Identification

First, to determine if there were significant differences in respondents’ familiarity with signs and symptoms of human trafficking based on having contact with a human trafficking victim, a Kruskal Wallis test was conducted (see Table 18).

The results showed that there are significant differences in familiarity with signs and symptoms of human trafficking based on whether a participant had contact with a person the participant suspected of being trafficked, $\chi^2 = 16.16 \ p < .001$. Those who reported that they suspected they had come in contact with a person who was trafficked had a higher mean rank sum of self-reported familiarity with signs and symptoms (mean rank = 67.75) compared with those who said they had not come in contact with a suspected human-trafficking victim (mean rank = 41.65) and those who said they were not sure (mean rank = 43.38) if they came in contact with a suspected human trafficking victim.
Table 18. Kruskal Wallis Results of Differences in Familiarity with Signs and Symptoms of Human Trafficking Based on Contact with a Suspected Human Trafficking Victim (n = 93)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean Rank</th>
<th>$\chi^2$</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact with person suspected of being trafficked</td>
<td>18</td>
<td>67.75</td>
<td>16.16</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Never had contact with person suspected of being trafficked</td>
<td>59</td>
<td>41.65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not sure if had contact with person suspected of being trafficked</td>
<td>16</td>
<td>43.38</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Second, to determine if there were significant differences in respondents’ familiarity with signs and symptoms of human trafficking and knowledge of human trafficking based on whether the respondent had attended a training, two Mann Whitney tests were conducted (see Table 19). Moreover, to determine if there were significant differences in respondents’ familiarity with signs and symptoms of human trafficking based on whether the respondent had come in contact with a human trafficking victim, a Mann Whitney test was also conducted (see Table 19).

The results showed that there were significant differences in familiarity with signs and symptoms of human trafficking based on whether a respondent attended a training, $\chi^2 = 403.00$, $p < .001$. Those who attended a training had a higher mean rank of familiarity with signs/symptoms (mean rank = 63.91) than those who did not attend a training (mean rank = 37.22).

Additionally, there were significant differences in self-reported knowledge of human trafficking, based on whether a participant attended a training, $\chi^2 = 484.00$, $p < .001$. Those who attended a training had a higher mean rank of self-reported knowledge of human trafficking (mean rank = 63.38) than those who did not attend a training (mean rank = 39.31).
Finally, aligning with the results of the Kruskal Wallis analysis, there were significant differences in familiarity of signs and symptoms of human trafficking based on whether a participant had contact with a victim of human trafficking, $\chi^2 = 282.00$, $p < .001$. Those who have come in contact with a human trafficking victim had a higher mean rank sum of self-reported familiarity with signs/symptoms (mean rank = 67.20) compared to those who had not come in contact with a victim (mean rank = 43.12).

Table 19. Mann-Whitney Test Results of Differences in Familiarity with Signs and Symptoms of Human Trafficking and Knowledge of Human Trafficking Based on Training and Contact with a Human Trafficking Victim

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean Rank</th>
<th>U</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Familiarity with Signs &amp; Symptoms of HT</td>
<td>403.00</td>
<td>&lt; .001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attended Training</td>
<td>32</td>
<td>63.91</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not attend Training</td>
<td>60</td>
<td>37.22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge of HT</td>
<td>484.00</td>
<td>&lt; .001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attended Training</td>
<td>32</td>
<td>63.38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not attend Training</td>
<td>62</td>
<td>39.31</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Familiarity with Signs &amp; Symptoms of HT</td>
<td>282.00</td>
<td>&lt; .001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact with a HT victim</td>
<td>15</td>
<td>67.20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No contact with a HT victim</td>
<td>78</td>
<td>43.12</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Next, chi square tests of independence were conducted to determine if there were significant differences in having had contact with a victim of human trafficking and having had contact with a person suspected of being trafficked based on the respondent’s profession (see Table 20). Respondent’s profession was dichotomized into community/public health workers (1) and other (0) for these analyses. The results showed that there were no differences in respondents having had contact with a person he/she suspected of being trafficked based on profession, $\chi^2(2) = 0.20$, $p = .905$. Likewise, there were no differences in respondents having had contact with a victim of human trafficking based on profession, $\chi^2(1) = 2.97$, $p = .085$. 
A cross-tabulation is not presented due to the lack of statistically significant results.

Table 20. Chi Square Test of Independence Results of Contact with Human Trafficking Victim Based on Respondent’s Profession (n = 95)

<table>
<thead>
<tr>
<th>Contact with a person suspected of being trafficked</th>
<th>χ²</th>
<th>df</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.20</td>
<td></td>
<td>2</td>
<td>.905</td>
</tr>
<tr>
<td>Contact with a victim of human trafficking</td>
<td>2.97</td>
<td>1</td>
<td>.085</td>
</tr>
</tbody>
</table>

Finally, chi square tests of independence were conducted to determine if there were significant differences in attending a training on human trafficking and knowledge of resources based on the respondent’s age (see Table 21). Respondent’s age was dichotomized into those aged less than 40 years and those 40 years and older for these analyses. The results showed that there were significant differences in respondents having had attended a training on human trafficking based on age, χ²(1) = 10.38, p = .001. Almost all of those younger than 40 reported not having attended a training (87.5%) while a little more than half (54.1%) of those 40 and older reported not having attended such a training.

Likewise, there were significant differences in respondents knowledge of resources and services to help human trafficking victims based on age, χ²(2) = 6.21, p = .045. A little over half (53.2%) of those aged 40 and older reported having knowledge of resources and services to help human trafficking victims compared to less than one-third (28.1%) of those younger than 40. Nearly equal amounts of both age groups reported not having knowledge of resources and services to help human trafficking victims (12.5% and 12.9%). Over half (59.4%) of those younger than 40 years of age reported not being sure of having knowledge of resources and services to help human trafficking victims, compared to about one-third of those 40 and older (33.9%).
Table 21. Cross-tabulation of Human Trafficking Training Attendance and Knowledge of Resources by Age

<table>
<thead>
<tr>
<th></th>
<th>Age &lt; 20 to 39 yrs</th>
<th>Age 40 + yrs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever attended a training event on human trafficking awareness and victim identification (N = 93), $\chi^2 = 10.38, p &lt; .01$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>$N$</td>
<td>4</td>
<td>28</td>
</tr>
<tr>
<td>% within age</td>
<td>12.5%</td>
<td>45.9%</td>
<td>34.4%</td>
</tr>
<tr>
<td>No</td>
<td>$N$</td>
<td>28</td>
<td>33</td>
</tr>
<tr>
<td>% within age</td>
<td>87.5%</td>
<td>54.1%</td>
<td>65.6%</td>
</tr>
<tr>
<td>Knowledge of resources and services in the Valley to help victims of human trafficking (N = 94), $\chi^2 = 6.21, p &lt; .05$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>$N$</td>
<td>9</td>
<td>33</td>
</tr>
<tr>
<td>% within age</td>
<td>28.1%</td>
<td>53.2%</td>
<td>44.7%</td>
</tr>
<tr>
<td>No</td>
<td>$N$</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>% within age</td>
<td>12.5%</td>
<td>12.9%</td>
<td>12.8%</td>
</tr>
<tr>
<td>Not sure</td>
<td>$N$</td>
<td>19</td>
<td>21</td>
</tr>
<tr>
<td>% within age</td>
<td>59.4%</td>
<td>33.9%</td>
<td>42.6%</td>
</tr>
</tbody>
</table>

**Summary**

This chapter reported the survey results. The majority of the present sample was between 30-49 years old (49%) with a range of 18 to >60 years. Women accounted for 86% of the sample. Within the sample, 70% reported being born in Texas and 40% worked as a rural public health worker/promotora. Other health professionals who completed the survey included rural health leaders and directors, community health organization leaders, social workers and clergy involved in providing health care services.

Over half of the respondents reported hearing about human trafficking from the news (52%) followed by from working in health care (23%). Overall, 66% of the sample indicated having just a little knowledge of human trafficking, but almost all (94%) believed human trafficking occurs in Texas. Some (32%) of the participants reported being only somewhat familiar with signs and symptoms of human trafficking and most (48%) not familiar at all.
Overall, 64% of respondents felt they had not come in contact with a suspected victim of human trafficking and 84% said they had never come in contact with a known victim. Over half of the participants (66%) reported never attending a training event on human trafficking. The majority of respondents (48%) felt it was only somewhat likely that a victim would be identified in a social service setting on the Texas border, and 34% said it was unlikely they would be identified. About half of the sample (42%) was unsure if resources exist in the community to help victims of human trafficking.

Human trafficking was ranked fourth (mean value 3.79) in a list of eight community issues that the community members should be educated on. The health effects of human trafficking ranked second most important topic (3.77) to educate health workers on. Identification of victims was ranked as the most important topic (3.79) to be addressed in a health leaders’ seminar on human trafficking.

Almost all of the respondents (98%) said a training event on human trafficking awareness and victim identification should be offered to rural health care workers in the Rio Grande Valley.

Statistical analyses showed that there are significant differences in familiarity with signs and symptoms of human trafficking based on whether a participant had contact with a person the participant suspected of being trafficked, $\chi^2 = 16.16, p < .001$. Those who reported that they suspected they had come in contact with a person who was trafficked had a higher mean rank sum of self-reported familiarity with signs and symptoms (mean rank = 67.75) compared with those who said they had not come in contact with a suspected human-trafficking victim (mean rank = 41.65) and those who said they were not sure (mean rank = 43.38) if they came in contact with a suspected human trafficking victim.

The results showed that there were significant differences in familiarity with signs and symptoms of human trafficking based on whether a respondent attended a training, $\chi^2 = 403.00, p < .001$. Those who attended a training had a higher mean rank of
familiarity with signs/symptoms (mean rank = 63.91) than those who did not attend a training (mean rank = 37.22).

Additionally, there were significant differences in self-reported knowledge of human trafficking, based on whether a participant attended a training, $\chi^2 = 484.00$, $p < .001$. Those who attended a training had a higher mean rank of self-reported knowledge (mean rank = 63.38) than those who did not attend a training (mean rank = 39.31).

There were significant differences in familiarity of signs and symptoms of human trafficking based on whether a participant has had contact with a victim of human trafficking, $\chi^2 = 282.00$, $p < .001$. Those who have come in contact with a human trafficking victim have a higher mean rank sum of self-reported familiarity with signs/symptoms (mean rank = 67.20) compared to those who have not come in contact with a victim (mean rank = 43.12).

Finally, there were significant differences in respondents having had attended a training on human trafficking based on age, $\chi^2(1) = 10.38$, $p = .001$. Almost all of those younger than 40 reported not having attended a training (87.5%) while a little more than half (54.1%) of those 40 and older reported not having attended such a training. Likewise, there were significant differences in respondents knowledge of resources and services to help human trafficking victims based on age, $\chi^2(2) = 6.21$, $p = .045$. A little over half (53.2%) of those aged 40 and older reported having knowledge of resources and services to help human trafficking victims compared to less than one-third (28.1%) of those younger than 40.

The next chapter discusses the findings of this study and, combined with community statistics and research on human trafficking, provides insight into the perceived knowledge, experience and educational needs of health care workers in the Rio Grande Valley and offers further action recommendations.
Chapter V
DISCUSSION AND RECOMMENDATIONS

The current research was constructed as a preliminary study to assess Rio Grande Valley rural public healthcare workers’ awareness, knowledge, and experience of human trafficking. This chapter discusses the major study findings and recommendations for improving rural public healthcare workers’ awareness and knowledge about trafficking in persons on the Rio Grande border. The demographic characteristics of participants and four major content areas are examined with regard to human trafficking and rural public health workers, as follows.

- Knowledge level of rural public health workers and their experience with human trafficking
- Training received in the area of human trafficking awareness and prevention
- Educational priorities for health issues and identification of victims
- Importance of offering rural public health-worker training in human trafficking awareness and prevention

Demographic Characteristics

The present study sample (N=102) came from a typical Texas-Mexico border. Traditionally, it is women who have worked under the specific title of promotoras in the South Texas colonias, and in general, females dominate the rural health care service scene in Latin American rural communities. The survey participants were more than
three-fourths female. The average age range of survey participants (30-49 years) is similar to the average age of public healthcare workers in previous studies in the literature (Health Resources and Services Administration [HRSA], 2007; Ingram, Sabo, Rothers, Wennerstrom, & Guernsey de Zapien, 2008).

The majority of respondents were born on one side of the border or the other (Texas or Mexico). This is consistent with the promotora ideology that health care workers serving in the local rural communities are well trusted because they are native to or live in the communities they serve. All of the survey participants worked on the border in either Hidalgo or Cameron County, Texas.

Rural public health workers made up 40% of the study sample. The remaining participants worked in various rural health-related capacities such as being a director of a health organization, a social worker, a victim’s advocate, or government health agency worker (<10% each). Survey respondents were likely to be key informants and to realistically reflect the situation of rural health care personnel’s experiences with trafficking.

**Discussion of Content Areas**

Although human trafficking is very common, especially along international borders, it was surprising that this study found healthcare providers had limited knowledge of trafficking, unfamiliarity in identifying victims, and lack of formal training. Those factors appear to contribute to the failure of trafficking victims’ being recognized in the rural healthcare setting. Training in trafficking awareness, prevention, and resource options is crucial for rural healthcare workers because the health consequences of trafficking such as physical trauma, reproductive and genitourinary problems, infectious disease, and mental health issues affect not only victims, but their families and the community at large. It is hence vitally important for health workers to be aware of the
far-reaching consequences of human trafficking such as the spread of STDs, HIV, and TB; drug addiction; and infertility (Gupta et al., 2009; Tsutsumi et al., 2008; Ward & Day, 2006; Zimmerman et al., 2007).

Rural Healthcare Workers’ Knowledge Levels and Experience in Human Trafficking

All of the survey respondents, with one exception, said they had heard of human trafficking; and more than half said they had learned of it from newspapers and newscasts. In spite of that awareness, though, only a small percentage reported feeling knowledgeable when asked to rate their level of knowledge of human trafficking. The majority reported having little or no knowledge at all, and that’s not surprising, because the literature shows that individuals in the health arena do commonly self-report a lack of knowledge of human trafficking when surveyed. However, the fact that the current study found that almost all of the rural healthcare workers said they did not feel knowledgeable is alarming. Given the nature of the trafficking business, which operates clandestinely in the shadows, those who are out in the field—such as law enforcement officers, border patrols, and community workers—must stay alert. That finding is therefore critical to understanding the educational needs of health workers in this population: in order to bring trafficking awareness to the communities they serve, health workers must first build a foundation of knowledge, which can then be expanded upon to develop intervention strategies.

The source of learning about human trafficking is particularly important in designing awareness campaigns. Statistical tests showed no difference in health profession and source of learning about human trafficking, nor was there a difference in age of participants and source of learning about human trafficking. Because a large portion of the sample said they first heard about trafficking from various news services, the use of television and media as outreach tools could potentially reach a significant percentage of healthcare workers, not to mention the community at large. Although not
the highest-rated source of learning, it is also a key finding that almost half of the sample said they first heard about human trafficking at their job or by working in the community. That suggests the effectiveness of aiming awareness programs at healthcare workers through on-the-job seminars.

A critical finding that emerged from this study is that even though most of the survey sample said they believed human trafficking occurs in the Rio Grande Valley, only a few (13%) respondents reported being familiar with the signs and symptoms of a trafficking victim. The majority said they were not confident in that respect, and almost half reported not being familiar at all with identification of victims. A key finding is that those who had previously attended training seminars had higher self-reported knowledge of human trafficking, and those who attended a training seminar were also more familiar with the signs and symptoms of trafficking than were those who had not been trained.

In light of the aforementioned finding, it is expected that only a small percentage of participants would report having come in contact with either a known or suspected victim of human trafficking. More specifically, of those working as promotoras, very few (8%) reported having had contact with a victim. That is not a surprising outcome if participants possess only baseline knowledge that the problem exists, if they are not confident they can identify a victim, and if they have not received further training. Even though there was no difference in the various jobs in the rural healthcare field and the reporting of contact with a victim, participants who were familiar with the signs and symptoms of human trafficking had a higher chance of coming in contact with a human trafficking victim.

Previous research on healthcare personnel and human trafficking has consistently found that trafficked persons present to hospital and clinics; one study found 28% of victims came in contact with the healthcare system at least one time during captivity (Family Violence Prevention Fund, 2005). Combined with the fact that local law enforcement statistics confirm trafficking flow in and through the Rio Grande Valley, it is
possible then that the reported lack of contact by rural healthcare workers on the border suggests that victims are not always being recognized in the healthcare community or are presenting to hospitals where promotoras do not actively work.

**Training Received in Trafficking-in-Persons Awareness and Prevention**

More than half of the survey participants said they had never attended a training event on human trafficking awareness and victim identification. That report is likely the primary reason most of the respondents reported not being familiar with human trafficking signs and symptoms. It is understandable, then, why study participants were uncertain of being able to identify a victim if a victim presented for care at a social service or clinical setting on the Texas border; very few said victims would be recognized. The finding that a majority of respondents said they did not feel confident that a trafficking victim could be readily identified implies that presentation by trafficked persons is possibly quite low at rural health outreach centers, or victims try to hide their plight, or both. Persons being held against their will exhibit characteristic behaviors, answers, and markers when they are in a public setting, and a trained eye can pick up on them. Often, a person who is a victim will let an “aunt” or “uncle” do all the talking, won’t make eye contact, appears nervous, gives little information about personal life either on the chart or verbally, has unexplained marks of abuse, and/or is positive for infections consistent with constant sexual activity. Human-trafficking-victim identification classes, then, are critical for the various professions working in rural health care on the Rio Grande border.

Study respondents categorized education on the identification of signs and symptoms as the number one topic to be taught, followed by victims’ health needs, if a training conference on trafficking in persons were offered. Rural health workers are intrinsically aware of and advocate for basic human rights needs in the communities they serve, especially the needs of immigrants and children. In tackling unmet needs such as
poor living standards, limited or no access to health care, and unemployment, it is imperative that those workers be able to identify victims of trafficking in persons and understand how trafficking affects both individuals and communities.

The findings of this study confirm previous research findings that trafficked persons are not being identified—in part because of ignorance of how victims would present themselves. There also exists among persons caught in trafficking situations an inherent lack of trust in authority. Such persons have been deceived and taken advantage of by either a boss, a loved one, or the police and then threatened with harm to their lives or their family’s lives if they confide in anyone the true nature of their captivity. Therefore, victims do not readily open up to health workers or teachers or law enforcement if questioned. A trained eye and an alert ear, however, can many times pick up even the subtlest signs displayed by a trafficked individual.

Almost half of respondents said they felt that community resources to help victims existed, but almost half reported feeling unsure whether such resources were available. That finding is significant because first responders who identify human trafficking activity must be prepared to handle the situation if it exists. Knowing whom to contact, what law enforcement will do, and what kinds of housing and counseling and legal services are available are crucial elements in getting physical and mental health help for victims. The literature stresses the importance of collaboration between all agencies in the antitrafficking movement (Bale & Lize, 2004; Wilson & Dalton, 2008). Collaboration between law enforcement, the healthcare system, service providers, and NGOs is the only effective method for responding to the crime of human trafficking. The present research shows that as unique field agents, rural health workers on the border should be trained and equipped to identify—and respond optimally when they come in contact with—trafficking victims.
Educational Priorities for Health Issues and Identification of Victims

To obtain insight into which subjects in the field of human trafficking should be emphasized in the education of community members, survey participants were asked to prioritize eight different public health topics. The top three rated issues were child abuse, elder abuse, and domestic violence; human trafficking ranked fourth. That ranking shows the gravity of the topic of human trafficking. Next, to determine topics to include in the context of continuing health education seminars, study participants were asked to prioritize the same topics to be addressed to healthcare workers. Of the eight well-known health issues, the health effects of child abuse was rated number one; health effects of human trafficking ranked number two; and health effects of domestic violence ranked number three. The fact that participants place trafficking close to abuse confirms the literature as well as my own experience in the field.

Such prioritization sheds light on how weighty the subject of human trafficking is in the public health arena. The devastating effects of the abuse of children, elders, and domestic partners have long been established. The fact that participants placed trafficking close to those top three abuses in importance confirms the significance of providing human trafficking education for rural healthcare workers on the Texas-Mexico border.

Indeed, almost all of the survey participants (98%) indicated the need for rural healthcare workers to receive training in human trafficking awareness and victim identification. That consensus is this study’s major finding.

Study Limitations

This study has several limitations. It did not use a random sample but was based on a convenience sample, so those who were sampled might not be representative of other rural healthcare workers serving in other parts of the state or the country. Because a listserv was used for recruitment of participants, healthcare workers not on the listerv
might have differed in their perspectives of human trafficking from those who were sampled. Language, too, could be a limitation. It might have made a difference if the survey had been offered in Spanish for healthcare workers who felt uncomfortable reading English. The survey responses may not have revealed the same outcomes as face-to-face interviews would have. The researcher originally wanted to conduct individual interviews, but IRB issues did not allow for that research method. Finally, the response rate was lower than anticipated and therefore, those who responded may have differed from those who did not. Based on those limitations, it is recommended that the study findings be used as a basis for further investigation of the subject matter.

**Recommendations**

In the past decade, national and local governments across the globe have increasingly prioritized the combating of human trafficking by enacting laws, funding awareness campaigns, and developing task forces (humantrafficking.org). As a result, both NGOs and political agencies that focus on antitrafficking measures have provided critical information that serves as a foundation on which prevention strategies can be developed. However, this study coincides with recent literature indicating that although there has been an increase in awareness of the problem, gaps remain with regard to ways of effectively reaching minority migrant populations working in the United States and the complex issues intertwined therein.

As the Mexican drug cartel war continues moving northward toward the Texas border and into the United States, violence and human trafficking are infiltrating cities across the United States (National Drug Intelligence Center, 2012; Shelley, 2012). The United States-Mexico border is believed to be one of the largest sources of human trafficking in the world. Texas law enforcement statistics continue to report high numbers of persons being trafficked through the Rio Grande Valley each year—some of them
living on the border for various lengths of time in stash houses while awaiting transit, and others staying on the border in forced labor (Children at Risk, 2013; TXDPS, 2013; Walker-Rodriguez & Hill, 2011).

The majority of participants in this study concur that human trafficking is a phenomenon in the Rio Grande Valley. Knowledge of the problem, however, has to move forward into action. The literature shows numerous cases of trafficking victims who were seen by healthcare personnel while being abused (Barrows & Finger, 2008), yet the data from this study’s survey found that very few abused victims are getting identified as trafficked persons by rural health workers on the border. Although that under-identification could indicate that victims are not presenting in healthcare facilities where rural healthcare workers serve, it is more probable that it is lack of training in human trafficking awareness and unfamiliarity with the signs and symptoms of human trafficking that accounts for the perceived low percentage of victim encounters.

Having worked in colonias for more than 20 years, I can attest that rural public health workers are urgently needed in border communities to serve as guides and leaders in the antitrafficking movement so they can bring together various key members of the community. The literature shows that preventing and combating trafficking must be a joint effort, not just an effort by the border patrol, police forces, and lawmakers. That principle is so critical that in an effort to combine forces, the US Department of Health and Human Services held a symposium of more than 150 experts and professionals from a variety of fields—including directors of national medical associations, program directors of hospitals, medical personnel working in clinics, organizations serving victims of human trafficking, executive directors of antitrafficking organizations, and various government officials—to discuss the importance of educating the broader public, including people in other professions who may encounter this population (Williamson, Dutch and Clawson, 2008). As in the current study, that symposium emphasized the problem of social service professionals’ coming into contact with people from all walks
of life who may have witnessed instances of human trafficking but lacked proper information or the resources to recognize them and who, coinciding with the current research, expressed the need for further and ongoing public education and awareness building to successfully address human trafficking (Williamson, Dutch and Clawson, 2008).

The results from this study add to the body of literature successfully documenting the educational gaps of hard-to-reach populations. In addition to my own field experiences, the survey responses confirm that immediate action must be taken to address those unmet needs. Teaching rural public health workers to apply a public health model approach to confront the human-trafficking issue would be a useful strategy. Public health epidemiological methods such as surveillance, identification of groups at risk, examination of risk factors, and creation of programs would assist rural public health workers in implementing successful procedures to fight trafficking in their communities (Todres, 2011). Based on this study, an adapted, four-step antitrafficking model for promotoras is presented here, which includes human trafficking surveillance, identification, examination, and implementation.

• Increase public health surveillance for the signs and symptoms of trafficking in colonias and rural communities through awareness campaigns and educational seminars.

• Identify border groups at risk—such as undocumented workers, illegal border crossers, single mothers, and teenagers—with the aims of distributing prevention material and dedicating resources to reach those specific groups in clinics for women, infants, and children; at bus stations; in food pantries; at churches; and in migrant worker camps.

• Examine risk factors on the Rio Grande Valley border, such as poverty, fear of authorities, illegal-alien status, and ties to cartels. List those barriers and develop strategies to overcome them.
• Implement and periodically reevaluate programs such as awareness campaigns, resource utilization, and empowerment seminars for individuals at risk such as young girls living in colonias and undocumented teenage boys.

Public health workers have become increasingly recognized as serving as a best practice model for influencing individual and -wide behavior change (CDC, 2012; Kerstin et al., 2006; Ramos et al., 2010). By fighting for the human rights of those in forced labor, the current study has responded to public health experts’ challenge to train public health workers so they can both address the root causes of health disparities and include a social justice perspective (Guidinio, APHA, 2010). Based on the study findings, it is paramount that promotora and rural public health care personnel education classes in human trafficking be implemented to increase awareness in order to prevent or alleviate the health consequences of trafficking in persons. Following are summary recommendations for rural public health worker training in human trafficking awareness and prevention, task force membership, and liaison recognition.

Rural Public Health Worker Training

The results of this study suggest that offering training in awareness and prevention of human trafficking to rural health workers in the Rio Grande Valley may increase levels of awareness, improve the identification of victims, and alleviate the health consequences of trafficking in persons in the community. Interestingly, among the group of participants, those who are more educated in human trafficking are more confident in their knowledge (63%) and more likely to detect victims (67%). Rural healthcare workers on the border who report lack of competence in recognizing victim signs and symptoms rated having such competence of great importance in training in this area.

The data also showed that almost all of the sample younger than 40 years old had not attended a training and the majority of this age group also reported being unsure of or
not having knowledge of community human trafficking resources. These results suggest a need for training in younger rural public health workers.

There is an urgent need therefore that an educational class on trafficking in persons be provided at RGV promotora association meetings, with a follow-up seminar offered for those who wish to get more involved. As well, to address the younger, and perhaps newer health care workers, education in human trafficking and victim identification should be incorporated in the newly hired health worker training program so they are informed from the start of their career.

Over the years, I have found successful training in awareness, prevention and victim identification through the use of PowerPoint presentations introducing the topic, short films depicting real life trafficking situations and bringing in various experts in the field to address specific trafficking topics. One day seminars are extremely effective. As well, I recommend public health worker’s required attendance at local human trafficking conferences and, at a minimum, yearly update seminars tailored specifically to them.

Having a promotora representative actively involved in the RGV human trafficking task force that meets once a month would ensure that pertinent updates, new information, and case updates would be shared with the rest of the promotoras. Trafficking-in-persons training materials written for general healthcare personnel, such as those by the US Department of State and Shared Hope International (Shared Hope, 2017; USDOS, 2017) should be used as templates and adapted as needed to educate promotoras working in border colonias.

Based on the literature, results of this survey and my own experience in the past two decades, I believe an effective curriculum design would emphasize the training of healthcare workers to become competent in human trafficking identification by recognizing the signs and symptoms of trafficking victims residing in or passing through the border. My rudimentary attempt to educate community volunteers several years ago included a PowerPoint presentation of human-trafficking facts and identification basics
that seemed beneficial, so those same slides could be used in creating a curriculum that would ideally consist of the PowerPoint presentation; a fact sheet that listed local phone numbers, hotlines, and community resources; and a brochure outlining key points based on resources available at the government webpage, trafficking.org, and leading antitrafficking NGO Shared Hope. Important points to incorporate into the presentation to healthcare workers on the border include detecting who in the community is at risk of being trafficked and where geographically the victims might be working and possibly presenting at clinics.

**Awareness and Prevention**

Rural public health workers in this study highly prioritized raising community awareness of trafficking in persons. Culturally competent communication is imperative in this setting. And providing educational interventions and prevention strategies for those at risk in the community such as teens and unwed mothers is key to adequately equip rural public health workers to take the lead in engaging colonias in the fight against trafficking. Based on the results of this study and the literature of successful public health campaigns, culturally sensitive preventive and educational services such as bilingual flyers, posters, and public service announcements on human trafficking must be developed for colonias. Currently, antitrafficking messages on billboards, flyers, or posters are nonexistent in the study region.

This study is similar to a recent trafficking in persons report that explains how public awareness campaigns represent one piece of an effective prevention strategy, but to empower vulnerable populations and foster a vigilant general public, knowledge about the risks of trafficking is just as important (United States State Department, 2017). Due to the unique family structures of RGV border residents, with most families having extended and even immediate family members living in Mexico, an awareness campaign addressing the tactics traffickers use to snare victims would be of great value if conducted
in the colonias. Awareness is a key component in prevention. Although history shows that many migrating individuals will take the risk with a trafficker in spite of knowing the danger and that many get deceived into a trafficking situation in spite of the red flags, based on current successful human trafficking campaign stories and my years of working with this population it remains a worthy goal of public health officials to empower those at risk with information and resources.

Rural public health workers were studied because it was believed they should be consulted to help develop targeted prevention strategies and because they understand more than anyone else working with this population the unique vulnerabilities of colonia dwellers. Based on their feedback and in order to convey the reality of the crime, it is crucial that awareness campaigns accurately describe the characteristics of human trafficking—that is, what its victims and its perpetrators really look like. Women have indeed been rescued by police from being chained up and beaten by a cruel gang member or pimp, but that is not the scenario of what the general public or community members will likely encounter. It is important to recognize that girls of all ages as well as boys and men who willingly migrate to the Texas-Mexico border or farther north of Texas to find work by way of a familiar face or a coyote could very well be the trafficking picture colonia dwellers will witness or experience. Therefore, to move beyond awareness and into prevention, it is imperative for health workers in these small communities on the border to recognize and teach the unique characteristics of human trafficking in their region because trafficking lies on a continuum of irregular migration and is an issue intertwined with migration and policy matters.

**Task Force Membership**

This study is the first of its kind to advocate that United States-Mexico border promotoras be considered integral components of the antitrafficking task force. In the Rio Grande Valley, a few anti-human-trafficking task forces have organized in recent years.
They include members of police forces, immigration officials, clergy, border patrols, and social service organizations. To date, there is no representative from the promotora arena. It is vital that rural public health workers collaborate with other local agencies to stay current on the issue and to maximize their effectiveness in the field. If a campaign is to be successful in the fight against trafficking in the Rio Grande Valley, specific research, information sharing, and “bilateral, regional, and international cooperation from both sides of the border is essential to provide insight into the various points where individuals come in contact with potential traffickers” (United States State Department, 2017).

**Liaison Recognition**

Rural public health workers have filled roles as health educators, promotors, and counselors for many years in the border colonias. In countless situations, they are the only bridges linking colonia dwellers to community social services. County health departments and antitrafficking task forces, therefore, have to recognize that role and provide rural public health workers on the border with local resource information so they can connect trafficking victims with services and interventions. For example, the Rio Grande Valley currently has no safe house specifically for trafficking victims, but a battered-women’s shelter in Harlingen, Texas, is helping care for females rescued from sex or labor trafficking. There are also many churches that offer temporary assistance for those in emergency situations, and free legal help is available to migrants, including human trafficking victims, through Texas RioGrande Legal Aid. It is vital that promotoras be aware of and in communication with those services in order to connect victims and members of the community to them when necessary.

**Recommendations for Further Studies**

After a training has been offered to rural public health workers, it would be of great value for researchers to evaluate the training’s impact on victim identification on the RGV border. A more in-depth evaluation should also be conducted to calculate what
kinds of resources could spread awareness and offer those resources to victims in the community. To date, it is unclear whether a community fund has been allocated for prevention and victim services. As well, further research, led by promotoras, should assess the most effective means of reaching colonia dwellers with human-trafficking awareness.

**Conclusion**

Human trafficking is a truly international public health issue; the trend of ignoring health concerns until they become critical or life threatening must be stopped (APHA, 2008). Public health workers, especially those serving rural areas that lack resources and projects common in larger cities, “can be instrumental in coordinating services in partnership with community members to enhance health and social service programs” (Davidhizar & Bechtel, 1999). Rural public health workers in this study demonstrated lack of confidence in their knowledge about human trafficking, which correlates with their limited training. There is an urgent need to educate and train rural public health workers on the Mexican border so they can take their places in the antitrafficking movement. Using the findings from this study, the Texas–Mexico border can initiate a Valley-wide awareness campaign, implement an effective educational program for health workers, obtain better understanding of patterns of human trafficking, migration, and improve surveillance of human-trafficking victims.

This researcher agrees with the view of Chris Beyrer (2004) of Johns Hopkins Bloomberg School of Public Health, who said, “The healthcare community must become more engaged in increasing the recognition of trafficked women and girls in healthcare settings, in provision of appropriate services, and in helping shape public policy to address what is one of the most disturbing health issues of our time” (p. 564).
The activities recommended in this study would potentially enhance understanding of human trafficking in and throughout the Rio Grande Valley and advise evidence-based intervention strategies. The training of rural public health workers in the areas of awareness, intervention, and prevention strategies would not only reduce the effects of disease and ill health associated with trafficking but also improve the ability to reach vulnerable communities on the southern border.
REFERENCES


Appendix A

IRB Approval of Protocol

To: Sharmayne Brooks
From: Karen Froud, IRB Chair
Subject: IRB Approval: 15-011 Protocol
Date: 12/18/2014

Dear Sharmayne,

Thank you for submitting your study entitled, "CONVERGENCE OF MODERN DAY SLAVERY WITH POVERTY, DRUGS AND CONFLICT IN VULNERABLE POPULATIONS: TRAINING RURAL PUBLIC HEALTH WORKERS TO PROMOTE HUMAN TRAFFICKING AWARENESS & PREVENTION ALONG THE TEXAS-MEXICO BORDER," the IRB has determined that your study is Exempt from committee review (Category 2).

Please keep in mind that the IRB Committee must be contacted if there are any changes to your research protocol. The number assigned to your protocol is 15-011. Feel free to contact the IRB Office by using the "Messages" option in the electronic Mentor IRB system if you have any questions about this protocol.

Please note that your IRB protocol number must appear on all research materials. You can retrieve a PDF copy of this approval letter from the Mentor site.

Best wishes for your research work.

Sincerely,

Karen Froud, Ph.D.
Associate Professor of Neuroscience & Education
IRB Chair

Attachments:
  • Brooks_Approved Consent.pdf
Appendix B

Informed-Consent Forms

Teachers College, Columbia University
525 West 120th Street
New York NY 10027
212 678 3000
www.tc.edu

INFORMED CONSENT

DESCRIPTION OF THE RESEARCH: You are invited to participate in a research study on community health care workers and those associated with health care in the Rio Grande Valley’s awareness of human trafficking in the community. You will be asked to complete an online survey that assesses your knowledge, attitudes, and prior education of human trafficking. The goal of this study is to ascertain the level of current knowledge and training on human trafficking that health care workers and related leaders in the valley have been exposed to, as well as what resources you are aware of that are available in the community. The answers to the survey questions will be used to determine if there is a need in the Valley for training and teaching on the issues surrounding the fight against human trafficking in the public health care arena.

Your participation in this survey is completely voluntary. This study is being conducted by Sharrayne Brooks, a doctoral student at Teachers College, Columbia University. To participate, you must be at least 18 years old.

RISKS AND BENEFITS: The research has the same amount of risk as a survey of another sensitive topic, e.g. child abuse or domestic violence, would have. You will be asked general questions about your awareness of human trafficking services in your area and your knowledge of the problem and victim identification. If you or someone you know has been involved or affected by the human trafficking movement, this survey might stir up undesirable thoughts and memories. There is no direct benefit to participants in this study. Being a part of research that affects your community as well as adding your experience and opinion to a study aimed to improve education, awareness, and services in the area of human trafficking in the Valley may provide participants a feeling of well-being for contributing.

PAYMENTS: For your participation, your email will be put in a drawing for a $100 Best Buy gift card. The odds of winning are 1/300 or 0.33% based on one winner out of 300 participants. Actual odds could be higher or lower based on actual survey response rates at the end of the study.

DATA STORAGE TO PROTECT CONFIDENTIALITY: The answers you provide on the survey are anonymous. Neither your name nor email address will ever be linked to the survey. Survey responses will be stored and coded by an online survey program, Qualtrics. All data materials will be stored through Qualtrics, which has advanced technology for internet security. Only the Principal Investigator and her faculty sponsor will have access to the data through a password known only to them.

TIME INVOLVEMENT: Your participation will take approximately 15 minutes.

HOW WILL RESULTS BE USED: The results of the study will be used for a doctoral dissertation and for an article to be published in a peer-reviewed journal. As well, the results of this study

TEACHERS COLLEGE, COLUMBIA UNIVERSITY
INSTITUTIONAL REVIEW BOARD
Protocol # 15-011
Consent form approved until 5/16
IRB Signature: SH
could be used to help create and implement procedures, policy and educational training on this issue in the Valley.

PARTICIPANT'S RIGHTS

Principal Investigator: Sharmayne Brooks

Research Title: CONVERGENCE OF MODERN DAY SLAVERY WITH POVERTY, DRUGS AND CONFLICT IN VULNERABLE POPULATIONS: TRAINING RURAL PUBLIC HEALTH WORKERS TO PROMOTE HUMAN TRAFFICKING AWARENESS & PREVENTION ALONG THE TEXAS-MEXICO BORDER

- I have read the Research Description.
- My participation in research is voluntary. I may refuse to participate or withdraw from participation at any time without jeopardy to future medical care, employment, student status or other entitlements.
- Answers to the survey questions are anonymous. Neither my name nor email address will be linked to the survey. Should I choose to enter the gift card drawing, my email will be entered in the drawing, separate from the survey.
- If at any time I have any questions regarding the research or my participation, I can contact the investigator, who will answer my questions. The investigator's phone number is (956)536-7052.
- If at any time I have comments, or concerns regarding the conduct of the research or questions about my rights as a research subject, I should contact the Teachers College, Columbia University Institutional Review Board / IRB. The phone number for the IRB is (212) 678-4105. Or, I can write to the IRB at Teachers College, Columbia University, 525 W. 120th Street, New York, NY, 10027, Box 151.
- I should print a copy of the Research Description and this Participant's Rights document.

- Please check one of the following:

☐ Yes, I agree to participate in the study (though I can stop and exit the survey at any time).

☐ No, I do not agree to participate in the study.
Appendix C

Rural Public Health Leaders’ Perceptions of Human-Trafficking Survey

Introduction

According to the United Nations, human trafficking is the process of recruiting, transferring, harbouring, or receiving persons by using means like threat, force, deceit or abuse of power for the purpose of exploitation. Exploitation of persons includes forced labor, forced prostitution, and other forms of slavery.

Note that this is different from smuggling which is assisting illegal aliens enter the country without proper documentation.

Survey Instructions

Please read and respond to the questions by checking the appropriate boxes.

Your Demographic Information

1. Sex:  Male  Female

2. Age range:  Less than 20 years  20–29 years  30–39 years  40–49 years  50 years or older

3. Place of birth:  Texas  Mexico  Other place

4. Your job description
   - Community health worker/promotora
   - Director or leader of community health workers
   - Social worker
   - NGO volunteer in providing health care services
   - Other community organization
   - Teacher or professor
   - Doctor/nurse/medical student
   - Church staff
   - State or government agency
   - Other (Please specify) _____________________________

5. City or community you work in or serve: _____________________________
Introduction

According to the United Nations, human trafficking is the process of recruiting, transferring, harbouring, or receiving persons by using means like threat, force, deceit or abuse of power for the purpose of exploitation. Exploitation of persons includes forced labor, forced prostitution, and other forms of slavery.

Note that this is different from smuggling which is assisting illegal aliens enter the country without proper documentation.

Survey Instructions

Please read and respond to the questions by checking the appropriate boxes.

1. Have you heard about human trafficking?
   - Never heard about human trafficking.
   - Heard about human trafficking from a family member or friend.
   - Heard about human trafficking in my community.
   - Heard about human trafficking during my work in the healthcare arena.
   - Heard about human trafficking from the news.

2. How would you rate your knowledge of human trafficking? Please select one.
   - Not knowledgeable
   - Somewhat knowledgeable
   - Knowledgeable
   - Very knowledgeable

3. Have you ever attended a training event on human-trafficking awareness and victim identification?
   - Yes
   - No

Do you think a training event on human-trafficking awareness and victim identification should be offered to community health workers in the Valley?

4. Do you think human trafficking occurs in the Texas Rio Grande Valley?
   - Yes
   - No
   - Not sure
5. If human trafficking were to occur on the Texas border, how likely do you think victims of human trafficking would be identified in a social service or clinical setting in your community? Please select one.

   Unlikely
   Somewhat likely
   Likely
   Very likely

6. To your knowledge are there resources and services in the Valley to help victims of human trafficking should any be identified in Valley communities?

   Yes
   No
   Not sure

7. How familiar are you with the signs and symptoms that might help you identify a victim of human trafficking? Please select one.

   Not familiar
   Somewhat familiar
   Familiar
   Very familiar

8. Have you ever come in contact with a person you suspected was being trafficked?

   Yes
   No
   Not sure

9. Have you ever come in contact with a victim of human trafficking in the Valley?

   Yes
   No
   Not sure
10. For each of the following community health topics please indicate how important the topic is to the continuing education of healthcare service personnel/staff/workers in your community.

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<th>Important</th>
<th>Very important</th>
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<tr>
<td>Health effects of poverty</td>
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<td>Health effects of racial disparities</td>
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<td>Health effects of child abuse</td>
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<td>Health effects of gender disparities</td>
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<td>Health effects of elder abuse</td>
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<td>Health effects of homelessness</td>
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</tbody>
</table>
11. For each of the following community health topics, please indicate how important you feel the topic is for members of your community to be educated on.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Not important</th>
<th>Somewhat important</th>
<th>Important</th>
<th>Very important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic violence</td>
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<td>Human trafficking</td>
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<tr>
<td>Poverty</td>
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<td>Racial disparities</td>
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<td>Child abuse</td>
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<td>Gender disparities</td>
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<tr>
<td>Homelessness</td>
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</table>

12. Do you think a training event on human-trafficking awareness and victim identification should be offered to community health workers in the Valley?

__ Yes the training is needed.
__ I am not sure.
__ No, such training is not necessary in our community.
13. If the issue of human trafficking were taught in community leader’s continuing education, various aspects of the issue could be addressed. For each of the following topics related to human trafficking, please indicate how important the topic is to continuing education.

<table>
<thead>
<tr>
<th></th>
<th>Not important</th>
<th>Somewhat important</th>
<th>Important</th>
<th>Very important</th>
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<tbody>
<tr>
<td>Identifying trafficking victims</td>
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<td>Legal and immigration issues</td>
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<tr>
<td>Health needs of trafficking victims</td>
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<td>Community and social services</td>
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<td>Lobbying and advocacy</td>
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Appendix D

Recruitment Script

I am Sharmayne Brooks, public health practitioner and local humanitarian aid worker in the Rio Grande Valley and graduate student at Columbia University Teachers College. I am doing research for my doctoral dissertation. My study is on the engagement of health workers in the fight against human trafficking. I would greatly value your opinion and comments on this important issue.

I invite you to participate in the study. You will be asked to complete an online survey that will assess your awareness and knowledge of trafficking in the Valley as well as training you have received in that area. The estimated time to complete the survey is 15 minutes.

As most of us are well aware, there has been an intense surge in drug trafficking along the Mexican border because of cartel wars that have escalated during the past few years and with that, an increase in smuggling and trafficking of humans. It is my desire to work with local groups and organizations to join forces to fight the horrific practice of forcing human beings to work without their consent—basically, as modern-day slaves. But first, it is essential to learn the needs and the levels of awareness and knowledge that exist in the community.

If you are willing to participate in the survey, please read and electronically sign the participant’s rights and consent forms. At the end of the participant’s rights form, check the box at the bottom, whereby you agree to participate. You will then be directed to begin the survey. Neither your name nor your e-mail address will be linked to the survey answers; your participation is completely anonymous. If you have further questions or concerns, please e-mail me.

Thank you for your time. Your participation is greatly appreciated! As a thank-you for your help, upon completion of the survey you will be invited to enter your e-mail address into a drawing for a $100 Best Buy gift certificate if you so desire. The drawing for the gift card is optional and separate from the survey; it will not link the survey to your e-mail. Odds of winning are 1 in 300, or 0.33% based on the participation of 300 people.

Sincerely,

Sharmayne Brooks
956-536-7052
brooks712@gmail.com