Identifying Health Experiences of Domestically Sex-Trafficked Women in the USA: A Qualitative Study in Rikers Island Jail

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Abstract While sex trafficking in the USA is a significant medical and public health issue, there is sparse data on the healthcare needs of and access for this population. This study was designed to identify experiences of domestically sex-trafficked women regarding healthcare access, reproductive health, and infectious diseases while trafficked. Trafficking survivors incarcerated in New York City’s Rikers Island women’s jail participated in audio-recorded interviews between July and September 2015. Recordings were transcribed, and a content analysis was completed to identify health-related themes. Twenty-one women ranging from 19 to 60 years old were included in this study. Reasons for accessing care included sexually transmitted infections (STIs) and HIV testing, unintended pregnancies, traumas, and chronic diseases. Emergency departments, Planned Parenthoods, and jails were common care sites. Traffickers and substance use impeded care and access to follow-up. Unintended pregnancy and STIs resulted in trafficker-perpetrated violence. Condoms, the most common form of contraception and HIV prevention, were inconsistently negotiated due to financial and violent consequences. These findings demonstrate that domestic sex trafficking survivors experienced chronic and acute health issues while trafficked and multiple barriers to care. Substance use and financial vulnerabilities furthered

unintended pregnancy and infection risk. These findings can inform future research regarding healthcare access and practices for domestically trafficked women.

Keywords Sex trafficking · Access to care · Women · Condoms · HIV · Reproductive health

Introduction

Sex trafficking, “the recruitment, harboring, transportation, provision or obtaining of a person for the purpose of a commercial sex act” [1] is increasingly recognized as a significant medical and public health issue in the USA [1–4]. Involving the sale of sex due to force, fraud, or coercion, sex trafficking may be perpetrated by traffickers (e.g., relatives, acquaintances, partners, strangers) who exploit victims for profit [5]. Domestic sex trafficking, referred to as trafficking within the USA, involves US citizens, lawful permanent residents, and undocumented immigrants, and is often disproportionately perpetrated against vulnerable women and children [3, 6, 7].

Health conditions associated with sex trafficking include forced pregnancies and abortions, substance abuse, sexual violence, suicide attempts, HIV, and sexually transmitted infections (STIs) [8–11]. However, there is sparse data on the healthcare needs and access of this population in the USA, due in part to challenges in identifying trafficking survivors [12, 13].

Laws and law enforcement practices have resulted in the criminalization of domestic sex trafficking survivors

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[14]. For example, in New York City (NYC), reasons for arrest among women who are later identified as trafficked include charges associated with drugs (forced drug use by traffickers to maintain control over victims), weapon possession (for protection from potentially violent buyers), various types of fraud including using a false identity (created by the trafficker), and theft or robbery (through force by the trafficker or buyer) [15 (L. Latimer (Staff Attorney, Legal Aid Society- Exploitation Intervention Project), personal communication, November 5, 2014)]. Consequently, jails are a setting where trafficking survivors' health needs may be elicited directly from survivors whose experiences may not yet be reflected in the growing field of health and human trafficking research. Our study aimed to identify health experiences of domestically sex-trafficked women incarcerated on Rikers Island with regard to healthcare access, reproductive health, and infectious diseases while trafficked.

Methods

Study Setting

The Rikers Island Prison Complex in NYC consists of ten jails, including one facility for incarcerated women: The Rose M. Singer Center (RMSC). RMSC contains a substance use housing area with dedicated counseling and therapeutic programming. Our study was conducted from July to September 2015. Following study recruitment, interviews were conducted by A.R. and M.R.P. in private office spaces on the unit. All interviews were audio recorded.

Study Participants

Eligibility criteria were limited to women age 18 and older who were comfortable completing interviews in English. Potential participants were informed of the study by (1) announcements made during health education programs run weekly by one of the investigators (A.R.) through volunteer work with Correctional Health Services, or (2) therapeutic programming coordinators, who were aware of the study and informed the study team if they encountered potential participants who were interested in learning more about the study. Interested persons were screened for eligibility by being asked: "Were you ever forced into prostitution or made to turn tricks by family members, boyfriends, friends,

pimps, or other people you met?" Those who answered "yes" participated in full interviews. Participants were compensated for their participation with a jail-approved package of undergarments. The Institutional Review Boards of the NYC Department of Health and Mental Hygiene and the University of Pennsylvania approved this study. We aimed to recruit approximately 30 participants to achieve thematic saturation. Participants were asked to choose a name other than their own to facilitate anonymity. Of note, the study team did not inquire about the reason for a participant's current incarceration prior to recruitment, as it was not related to our study.

Interview Content

Primary areas of focus in the interview guide included healthcare access, reproductive health, and infectious diseases. The script was piloted with volunteers meeting the study inclusion criteria for feedback prior to utilization.

Data Analysis

Interview recordings were transcribed by an independent transcription agency and reviewed for accuracy. Transcripts were then reviewed to determine whether participants ultimately shared narratives that fit the legal definition of sex trafficking. Those that did not were not included in analysis. Content analysis was used to identify themes addressing the study's purposes. Members of the research team (A.R., M.R.P., J.A.S.) independently read through a subset of transcripts to identify interview themes, after which a coding scheme was created and applied to subsequent transcripts with iterative revisions until a separate final coding scheme was developed for interviews. The data set was then divided, and all interviews were (re)coded by two authors (A.R., M.R.P.). Seven of 26 transcripts were coded by both of these authors for quality assurance. Discrepancies were resolved through discussion until consensus was achieved. Qualitative data analysis software, NVivo version 11 (QSR International, Doncaster, Victoria, Australia), was used to assist in this process.

Results

Twenty-six participants answered "yes" to the screening question and completed the interviews. Five participants were later excluded from the analysis as the narratives

they shared did not ultimately meet the legal definition of sex trafficking. Participant ages ranged from 19 to 60 years, with an average age of 35.5 years (Table 1). With regard to their race and ethnicity, participants self-identified as African American or Caribbean American 42.9% ($n=9$), White 28.6% ($n=6$), Hispanic 23.8% ($n=5$), and one person identified as mixed White-Hispanic 3.8% ($n=1$). Participants varied in the types of trafficker they had, the most common being exploiters who ran trafficking rings that involved groups of trafficked women (42.9%, $n=9$). Other traffickers included drug dealers (23.8%, $n=5$), mothers (9.5%, $n=2$), and intimate partners (9.5%, $n=2$). Two participants without traffickers met the definition of being trafficked by default because they sold sex as minors (9.5%, $n=2$), and one participant described two incidents of being kidnapped by a stranger, forced to sell sex to the buyer and his friends, after which she was immediately released (4.8%, $n=1$). Of note, all participants used illicit substances such as cocaine or heroin while trafficked.

Table 1 Study participant characteristics among domestically sex-trafficked women incarcerated in Rikers Island Jail, New York City, July 2015–September 2015

Characteristic	$N=21$	Percentage
Age range (years)	19–60	
Average age (years)	37.7	
Race		
White	6	28.6
African/Caribbean American	9	42.9
Hispanic	5	23.8
Mixed	1	4.8
Education		
Some middle school	2	9.5
Some high school (HS)	10	47.6
HS graduate/GED	5	23.8
Some college	3	14.3
College completed	1	4.8
Primary trafficker		
Drug dealer	5	23.8
Exploiter running trafficking ring	9	42.9
Intimate partner	2	9.5
Mother	2	9.5
No trafficker but sold sex under the age of 18	2	9.5
Stranger—single interaction via kidnapping, limited to less than 24 hours	1	4.8

Results are organized around the major research questions of experiences related to healthcare access, reproductive health, and infectious diseases. Prevalent themes are presented in italics with examples of representative quotations presented in Table 2.

Healthcare Access

Survivors discussed their reasons for and barriers to accessing healthcare and described experiences with receiving diagnoses and treatments. The most commonly discussed reasons for seeking healthcare included STI and HIV testing, unintended pregnancies, acute, violence-related issues (such as rape, traumatic injury, and suicide attempts), and chronic disease management (such as hypothyroidism or asthma). With regard to payment for services, survivors who experienced trafficking-ring-related sexual exploitation more often referenced paying for healthcare and prescriptions out of pocket due to inactive Medicaid, while those who did not experience trafficking rings tended to use Medicaid for care.

Care Locations

The most *common locations* of healthcare provision while being trafficked were emergency departments (EDs), jails, women's health clinics such as Planned Parenthood and free or Department of Health clinics. Survivors who did not experience trafficking-ring-related sexual exploitation more commonly referenced utilizing private outpatient primary care or gynecologic clinics as well. Lack of personal identification (ID) documents and insurance were primary drivers in avoiding healthcare utilization or choosing the ED instead of primary or urgent care clinics.

For some survivors, *jail was the only place* where they interfaced with formal medical care when trafficked. Because health screenings can be a routine part of initial entry into jail, several participants mentioned learning of new diagnoses through this process, including gonorrhea, chlamydia, Human papillomavirus-positive pap smears, and Hepatitis C, that they had been unaware of prior to incarceration.

Trafficker-Related Factors

Some participants stated that healthcare access was limited by their traffickers due to concern that survivors

Table 2 Illustrative quotes of themes with regard to healthcare access, reproductive health and infectious disease related experiences among domestically sex-trafficked women incarcerated in Rikers Island Jail, New York City, July 2015–September 2015

Healthcare access

Care locations

Common locations

“I had several experiences at emergency rooms...more than a couple of times. I would go to a house or something, and I never got robbed or anything, but I got beaten up a couple of times. And I always managed to get away, but...more than once. I got raped twice, and I got beaten up maybe like five or six times...So every time I would go – I would go the emergency room. I never called the ambulance – just go to the emergency room.” - Participant 18

“...I would always go to clinics. Didn’t go to hospitals. Very rare. I can count on my hand. Four times I’ve been to the hospital, but mostly clinics, because they were so private and so cool.” - Participant 24

Jail as the only place of care

“It would only be when I got arrested most of the time that I came...here, do a pap smear, do blood, do all of that. Get my HIV test...That’s how I found out I had the trichomoniasis, from here. I never really went to a clinic. Well, I know that’s bad, but I used to get arrested a lot. I have a lot of – over the years too. So I mean, that was basically the doctor...” - Participant 17

“One time I came in here...I had chlamydia again and...I didn’t know I had it. And it was really bad...But I didn’t know I had it out there. And thank God that I came here. Because I would not have known I had it.”

- Participant 12

Trafficker-related factors

Financial impact

“... 98.8 percent of the time, I used protection. But that little bit of 1 percent and some change is a big risk and weighs heavily on someone’s mind, especially a woman inside the life, when you can’t just ask your pimp, can I go to the doctor? And they’re like, no, you haven’t made enough money yet today, we don’t have time to take you out to go to the hospital or go to the doctor.” - Participant 2

Fear of retaliation

“I went to the emergency room once for an asthma attack...It was one of the days where I wasn’t with him so I just went and I was released...like six hours later, so he didn’t really know. And it was better that way in my opinion because I don’t know how he would have reacted to me saying I went to the emergency room, even if it was for something like my asthma. And I don’t know how he would have reacted to that maybe thinking that I was lying or that I’m snitching on him or something like that. So, yeah, no. He didn’t know about it.” - Participant 14

Non-trafficker-related factors

Prioritizing substance use

“...I would just go douche {if a condom broke}...I had Medicaid at that time, and I just didn’t have time, or I didn’t know what to do either...it was like a weird situation where it was just like you don’t have time. You’re too busy trying to get high. You’re too busy trying to please my mom, trying to please. So it was just a weird situation.” - Participant 10

Criminal justice-related fears

“... we don’t wanna go to the hospitals because we feel like they’re gonna check there. Or we go to the hospital, our names are ran. And the cops come and they take us. And that has happened a lot.” - Participant 5

Follow-up care

Test results

“Well, they had my mom’s number and stuff, but I usually was a runaway, so I didn’t have time...I didn’t go to appointments and stuff like that. Because I was just rebellious. I was just running away and stuff. I didn’t care about anything. Just about hanging out. That’s what I cared about.” - Participant 20

Reproductive health

Menstruation

Stuffing

“It sounds crazy, but I would put tissue in there, and I would try to stop the bleeding...Yes, it is embarrassing. Yes, it is disgusting. It is not a tampon and not medically...approved” - Participant 25

Pregnancy

Stresses associated with the potential for pregnancy

“...it was always something I was worried about. And even if my period was like three days late, I would start freaking out and crying...because the last thing I wanted was to get pregnant, because that would affect my boss, how he would treat me. Like he would probably beat the shit out of me more because I wasn’t able to work because I was like a big belly or something like that, and I also wouldn’t have the money to get an abortion, or like the little things like that really scared me...” - Participant 14

“...another girl...he beat her up really bad. She was pregnant and he beat her up really, really, really, really, really bad and he put her into a full body cast. And she went into the hospital. But she didn’t tell on him. She just told that a guy beat her up or whatever.” - Participant 12

Contraception

“...if I didn’t make money, then, sometimes I would have to wait for my prescriptions for days before I could, yeah....You can take it {emergency contraception} up to 72 hours. So...I would try and go right

Table 2 (continued)

	away. Sometimes, I would take it at the last minute. I've had so many abortions because it was too late to take it..." - Participant 26
<i>Abortion</i>	"I went there {Planned Parenthood} to have an abortion...he told me to go get it...I took a pregnancy test. I missed my period for a few months. And I went and bought a test from the store and took it...He told me I should probably get an abortion. And we waited a few months...It was more or less getting together the money and just getting up the strength to go to it. Because I wouldn't do it before...No {he did not help pay}...I had sex with people." - Participant 4
<i>Prenatal Care</i>	"...when I did get pregnant...and still smoking, he was locking me in closets in the room...with guns and stuff like that...Because he didn't want me to go out...I was pregnant with his baby...I did break out a couple of times and went to hotels and got high." - Participant 7
Infectious diseases	
Condoms	
<i>Access</i>	"...{the trafficker} always supplied the condoms. He would get them from the clinics. He would get them from the clinics, packets of them. Women's lubricant, all types of stuff, he would give us the packets. But he would get them. We wouldn't be able to." - Participant 12 "...The hotels have them sometimes. Sometimes they sell them. But yeah, they gave them to me for free because I made enough money. I paid them...I paid them when I make good money, so when I don't have money, I can get in and make money...So it's investing in yourself...It's business." - Participant 9
<i>Trafficker expectations</i>	"...that's my first STD* – I caught an STD from a pimp...that was his choice not to use a condom. He told me that I couldn't use a condom with him, but I had to use it with the johns." - Participant 20
<i>Financial losses</i>	"Well, I've always carried condoms with me. But there were men that didn't wanna use condoms. And if I refused, it was – my pimps were gonna find out. Because I would come back, lose a trick, lose a date, and lose money. And then my type of people would beat us." - Participant 5
<i>Violence perpetrated by buyers</i>	"I mean, it's – basically there is no negotiation. It's either happening, or I'm going to leave. Actually, one of the times that I got beat up was because I didn't want to use a condom...I refused to not use a condom. Yeah, and he wanted to not use one, so." - Participant 18
<i>Oral sex</i>	"Very rarely {used condoms}. There were times where the guy just didn't look clean enough or smell clean enough...pull back foreskin and I'm seeing this like fucking beige cheese around it and shit. I don't know. I don't want my mouth on that. But I was so naïve again. Safety first did not exist." -Participant 24
<i>Practices to decrease infection risk</i>	"I would drink a lot of alcoholic stuff, and I'd buy off-the-counter antibiotics, which in my neighborhood, there's a lot of those. And I used to buy off-the-counter antibiotics and just drink them for a few days." - Participant 22 "I was really nervous. Wow, my heart's racing. When condoms used to break...I would carry baby wipes and I would scoop as much as I can out. Even though didn't make a difference but I did. I would try to urinate it out. And wash up is pretty much it." - Participant 5
HIV	
<i>Testing</i>	"Because my doctor wanted to know why I keep wanting an HIV test. I just took one. It'd be a month and I just went...I told her because my condom broke...I says I have more than one partner, and my condoms – it broke, so I got terrified, so I came back in. And she's like it's not even three months and you're coming back for another test; we can't keep giving you tests. So I told her the truth, I'm at risk, I'm having sex every day with at least 20 different men, and sometimes the condom breaks. So I get scared. She said...we can't find out if you have AIDS just from right now...you have to let some time go by...I didn't like that she said I had to wait...Why can't we know right now from her taking my blood right now. I told her to take blood from my arm...I thought that if you take blood from your arm, you can find out right away." - Participant 1 "I would tell them that I had sex with somebody...that I believed that was HIV-positive...I would say...I need to be tested...I used to make up stories...I feel like I have lesions on my skin. ...I made up stories to be tested." - Participant 7

STD *sexually transmitted disease

would attempt to run away from or report the trafficker if allowed to seek care. Traffickers also weighed the *financial impact* of survivors taking time to seek medical care instead of seeing buyers. Trafficking-ring survivors described instances where the trafficker would

attempt to treat survivors' injuries by purchasing medical supplies at the pharmacy or arranging for a private contact (who survivors assumed to be a doctor) to see the survivor at the location they were held. Others recalled being forced to mask their injuries in order to

continue seeing buyers. For example, one survivor stated that she wore sunglasses to mask bruising after being hit so that her appearance would not impact “business.” Participants’ *fear of retaliation* by a trafficker for certain diagnoses such as pregnancy and infection also limited or altogether prevented access to healthcare. For example, one HIV-positive participant did not receive treatment while trafficked due to fear of violence perpetrated by the trafficker if he learned of the diagnosis, as it was expected that all of his “girls” were “healthy.” In cases where traffickers permitted healthcare visits, some participants described that either the trafficker or another trafficked woman would accompany the survivor to the appointment for intimidation and control purposes.

Non-Trafficker-Related Factors

Non-trafficker-related considerations also factored into decisions to seek medical care. For example, some survivors described *prioritizing substance use* over their healthcare needs, influencing their decision not to seek care. Others also expressed *criminal justice-related fears* associated with seeking care, such as not wanting to be arrested in the ED if they had open warrants due to fear of arrest for substance use and prostitution.

Follow-up Care

Logistical circumstances related to being trafficked hindered follow-up for *test results* and treatments. Some participants described barriers to receiving test results such as having inconsistent access to a stable telephone number or mailing address to receive results, or being unable to return for a scheduled follow-up visit due to the trafficker and non-trafficker-related barriers noted above. For example, one survivor said that because she did not have permanent housing or routine telephone access while trafficked, she listed her mother’s address in her ED paperwork. Six months later, when collecting her mail from her mother’s home, she learned she had been diagnosed with syphilis. Some participants also discussed different strategies they would use during visit registration, such as using a fake name or listing a fake address to facilitate receiving acute care if they were without ID, which also complicated follow-up.

Challenges in following up with new medication recommendations also emerged as a theme. For example, being prescribed a vaginal antibiotic suppository for nightly use or being counseled to not have sex for 7 days

following STI treatment, though standards of care, were not feasible plans for trafficked persons expected to see multiple buyers nightly. Consequently, some women did not use the prescribed medication or chose to follow-up at a different clinic if they anticipated needing re-treatment. For prescriptions that needed to be filled in a pharmacy, medication cost was another barrier, at times resulting in survivors needing to see a higher volume of buyers to facilitate payment.

Reproductive Health

Menstruation

Participants were asked how menses impacted their trafficking experiences. While some women did not see buyers during this time, others described “stuffing,” whereby absorbent objects such as baby wipes or make-up sponges were inserted into the vagina so that the traffickers’ expected income quotas could continue to be met. Others described offering oral or anal sex instead or engaging in “thigh sex” (whereby women would hold their thighs together during intercourse, resulting in non-penetrative sex) if buyers were simultaneously using drugs and less likely to notice that they were not engaging in vaginal sex.

Pregnancy

Many participants discussed *stresses associated with the potential for pregnancy* while trafficked, due in part to fear of increased trafficker-perpetrated violence, since unintended pregnancies risked financial loss for the trafficker.

The most common form of *contraception* was condoms, while a few participants also discussed clinic visits for depot medroxyprogesterone acetate injections. All three participants who noted having an intrauterine device in place while trafficked also had removal procedures during that time due to associated pain. Emergency contraception was rarely used.

Trafficking survivors who became pregnant while trafficked described varying experiences in *abortion* access and *prenatal care*. Transportation and cost-related barriers sometimes led to later-term procedures due to resulting delays. One survivor described these circumstances and additional complexities when she was forced to move to a different state with a trafficking ring after day one of a 2-day abortion procedure,

recounting her desperation to find money and transportation to return to the clinic and complete the procedure. Prenatal care access varied, as some survivors connected with care, while others did not. One survivor recounted that during her pregnancy, she reconnected with her mother, who assisted in paying for prenatal care, and remained substance-free during that time, while another recounted being unable to seek care due to her trafficker.

Infectious Diseases

Condoms

Condom *access* varied depending on involvement with a trafficking ring. Free condoms from hospitals, clinics, or needle exchange programs were more commonly accessed by survivors who were not in trafficking rings, while those who were in trafficking rings typically accessed condoms from their traffickers or purchased them at pharmacies or the hotels in which they saw buyers. Some participants also shared concerns regarding the free condoms they had access to. For example, one survivor noted that she had a latex allergy and found it challenging to find free condoms that did not have latex. Participants also described concerns that the NYC Department of Health and Mental Hygiene-manufactured condoms broke easily, which caused some to use two condoms at a time in an effort to prevent breakage.

Condom use negotiation with a buyer involved multiple considerations. *Trafficker expectations* sometimes included that survivors use condoms with all buyers and no condoms when engaging in intercourse with the trafficker himself (meaning that any STI diagnoses would be interpreted as condom non-use with buyers). However, survivors also faced violent consequences for *financial losses* incurred for turning away buyers who only desired sex without a condom. While some said that they insisted on condom use with every encounter, others said that if they had regular buyers or buyers without signs of genital infection, they would ultimately discontinue condom use. A few participants described *violence perpetrated by buyers* if steadfastly insisting on condoms, while others found that the potential for increased payment from a buyer for intercourse without a condom often outweighed health-related concerns. Some participants also described having decreased negotiating ability due to co-occurring substance use impacting their mental state. Condoms for vaginal sex

were used more often than condoms for *oral sex* or anal sex.

If condoms were not used or if condoms broke during sex, participants described various *practices to decrease infection risk sex*, such as frequently gargling mouthwash, sitting in a tub of bleach, douching, and using over the counter antiseptics. Others described simply changing condoms if a condom broke or making an appointment for a pap smear afterwards.

HIV

Several participants cited HIV infection as their greatest health-related fear while being trafficked, sometimes because they had relatives with the disease. Although some participants attempted to have routine *HIV testing*, they noted that the current testing protocols were not helpful for their circumstances. That is, because rapid HIV tests are not sensitive in detecting the virus for potential exposure in 3 months prior to testing, some survivors would attempt to have direct viral load testing through venous blood draws (a more accurate test but infrequently offered due to cost) [16], through various means, including fabricating HIV-related symptoms.

HIV-positive-related themes were also discussed with regard to trafficking survivors and buyers. Two participants discussed fear of disclosing their HIV-positive status to traffickers or buyers and reflected on worries they had about potentially exposing buyers to the virus if condoms broke or were not used. Similarly, some women expressed fear that out of revenge, other exploiters or women engaging in prostitution would intentionally arrange for the survivor to have intercourse with an HIV-positive buyer as a means of infecting them.

Discussion

At a time when there is increasing investment in identifying and addressing the health of human trafficking survivors in the USA, our study provides necessary insight into healthcare experiences of a subset of domestically sex-trafficked women in the USA: those who are justice involved. While studies have shown that trafficking survivors frequently interface with the healthcare system, this work provides a contextual understanding of both the factors impacting sex trafficking survivors' access to medical care, as well as their

reproductive health and infectious-diseases-related experiences [3, 12].

Our findings provide insight into the ways in which traffickers' "business model" approach to sexual exploitation is detrimental to the health of victims. Reproductive coercion, limiting healthcare visits, perpetrating violence for unmet financial quotas, and incentivizing money over safe sex were examples of traffickers' tactics to maximize profits. Awareness of these practices and their harmful impact on victims' health are essential for clinicians and researchers to consider when addressing healthcare and its delivery for this population.

Also highlighted in our results was that jail was the site of many first STI diagnoses, emphasizing the importance of expanding survivors' access to care both inside and outside of the criminal justice system. A qualitative study regarding jail-based contraception among incarcerated women on Rikers Island found that participants supported such services because incarceration was the only point of access for needed medical care, findings that echo the circumstances of the trafficked population in our study [17]. Furthermore, quantitative studies of the risk factors and health issues associated with incarcerated women with histories of sex exchange (of which trafficking survivors are a potential subset) suggest that identifying this history at the time of incarceration can be critical in coordinating appropriate care and post-release services for these populations [18, 19].

Given these findings, one potential way to connect this population of trafficking survivors with additional healthcare services outside of the ED or jail may be through Human Trafficking Intervention Court (HTIC). HTIC is a jail-diversion program that was started in New York State to assist criminalized trafficking survivors in vacating their charges, which typically mandates four to six sessions with a counselor [14]. As HTIC is implemented in more states, incorporating the *option* of health visits as a way to fulfill mandated sessions may facilitate healthcare access for survivors seeking these services.

This study also reflects the need for healthcare providers to consider social determinants of health, such as housing and economic stability, when developing follow-up plans with patients. Recognizing the ways in which these factors impact basic parts of healthcare by proactively asking patients their preferred method of receiving test results and whether treatment suggestions are feasible for their life circumstances can help improve care delivery for trafficked persons.

Public Health Implications

HIV and STI prevention efforts must acknowledge and address the financial disincentives of condom use that trafficked women face. Unlike harm reduction strategies with intravenous drug users, where there is no financial gain in the use of a "dirty needle," the financial incentives associated with sex without a condom exploit persons in already vulnerable socioeconomic positions. As a result, to truly achieve public health goals such as New York State's "AIDS-FREE NY 2020" campaign to end the state's epidemic in the next 4 years, public health efforts must go beyond condom distribution and rapid HIV testing for this population [20]. For example, expanded efforts to connect trafficked persons with pre-exposure HIV prophylaxis access medications or affordable venous HIV testing may facilitate earlier diagnosis and medication initiation while also curbing risk of spreading infection [21].

Reliance on condoms as a primary form of birth control in this population also carries significant public health implications. For example, outbreaks such as Zika virus, which highlight risks for pregnant and reproductive age women, tout messaging campaigns of protecting oneself by using condoms or not having sex [22]. However, guidelines such as these overlook circumstances of some trafficked women, as they do not address the financial and violent consequences of refraining from sex and negotiating condom use for this population, or offer viable alternatives (such as improving access to reliable forms of birth control or distributing emergency contraception with condoms). Our findings emphasize the need to account for this population of women for not only common public health issues but also in the setting of emergent epidemics, where trafficking victims may be among the most vulnerable.

Limitations

While our goal was to only elicit participants' trafficking-related health and healthcare experiences, due to the nature of the study design and the potentially fluid oscillation between trafficking- and non-trafficking related prostitution that survivors experienced, our study is subject to recall bias. In addition, the incarcerated subset of sex trafficked women may have experienced prior trauma and medical conditions unrelated to being trafficked, which may influence their health needs and interactions with the healthcare system. However, given the limited

existing information in this field of study, any insight into the health needs of this population will serve in designing essential follow-up studies.

Conclusion

This qualitative study of incarcerated domestically sex-trafficked women was conducted to convey health-related experiences of those who may not otherwise be represented in current health and human trafficking literature. The findings of our study can be used to design future research regarding trafficked person-centered healthcare access and practices to optimize service for this population.

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