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Human Trafficking Education Module for Healthcare Providers: Reviewed and Informed by Survivors of Sex Trafficking

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Abstract

Human trafficking (HT) is an epidemic within the United States, resulting in what could be deemed a public health crisis. HT remains concealed due to the criminal, secretive nature of the enterprise, in addition to inconsistent definitions, historically perpetuated biases, and stigmas, in addition to an overall lack of education, knowledge, and awareness. Data around HT are also minimal due to these same barriers. The majority of HT victims report accessing the emergency department and hospital during their time of trafficking, placing healthcare professionals in a unique position to recognize and assist victims. Studies indicate that few healthcare professionals have general knowledge of HT and no healthcare professionals report having formal education or training around HT. No standardized education or training exists for healthcare professionals concerning HT, and no standardized screening tool has been created to identify HT victims. Screening tools currently utilized have not been tested for sensitivity, specificity, or positive outcomes. The implementation and testing of an education and training system for healthcare professionals, and a screening tool for identifying HT victims, is imperative in affecting change within the United States to assist HT victims in advocating for their safety and ultimate freedom.

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The Global Slavery Index (GSI) estimates more than 400,000 people, or 1.3 people per thousand people, in the United States were enduring conditions of which have been equated to modern-day slavery (Washington State Department of Health, 2018). These conditions refer to the global epidemic of human trafficking (HT), where the United States has been identified to have one of the largest, most prominent HT markets globally, with HT being the fastest growing criminal industry in the world. The Department of Justice estimates that profits generated from trafficking are $150 billion per year (Long & Dowdell, 2018). The United Nations defines HT as:

> "The recruitment, transportation, transfer, harboring or receipt of persons, employing the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or a position of vulnerability or the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude, or the removal of organs (World Health Organization [WHO], 2012, para. 2)."

Human trafficking is divided into two subcategories of labor trafficking (LT) and sex trafficking (ST), with ST being significantly more prevalent than LT (WHO, 2012). HT is not isolated to large cities but transcends all state lines and infiltrates all communities. Victims are men, women, and children of all socioeconomic statuses, education levels, backgrounds, nationalities,

religions, and professions (OVC TTAC, 2017). While ST disproportionately affects disadvantaged populations, the one thing all victims share is the loss of their freedom.

Lab-Susca and Clements (2018) describe sex trafficking as a term to include commercial sex work such as prostitution, pornography, exotic dancing, strip shows, live sex shows, mail-order brides, modeling, military prostitution, and sexual tourism, with the majority of victims being women and children. HT in North America closely resembles that of developing countries, as economically disadvantaged or socially marginalized individuals are most often targeted, with runaway children from America making the bulk of those exploited in Northern America (Reid, 2012). HT's criminal and underground nature diminishes the ability to obtain quality evidence and data around ST, and exploitation is primarily understudied, despite being acknowledged as an epidemic (Institute of Medicine & National Research Council, 2014). Further, the definition of HT and ST alike varies among different entities and countries, creating a lack of clarity and understanding of who qualifies as a victim or what qualifies as HT (Jansson, 2014). No international laws addressing HT exist; only national laws are present and enforced (McKee, 2016). While HT remains an epidemic within the United States, the hospital- and healthcare-related costs resulting from HT are uncertain but estimated to be exceedingly high (Gerassi, 2015).

Many adverse consequences are associated with an individual experiencing ST, both immediate and long-term, that affect the victim, their families, and the overall community. Victims of ST report high incidences of physical and psychological impairments due to their exploitation, which can be barriers to victims re-entering society and obtaining the stability required to remain free from exploitation. Rates of PTSD, depression, anxiety, STIs, substance abuse, rape, and physical abuse suffered are exceptionally high in groups of HT survivors

(Lederer & Wetzel, 2014). The criminalization of ST victims perpetuates a cycle where victims' criminal records inhibit their ability to obtain gainful employment or housing, creating additional structural barriers in the path of victims attempting to escape exploitation and further bars them from living healthy, productive lives (Nichols, 2016). Preventative measures around ST are mainly absent in the United States despite being acknowledged as essential in addressing the issue. Subsequently, HT remains unchecked and rampant in communities across the United States, claiming victims and causing insurmountable pain and lasting damage (Nichols, 2016).

Background and Significance:

Sex work was identified as a form of slavery within the United States in the early 1900s. The Trafficking Victims Protection Act (TVPA) was enacted in 2000, which aimed to prevent HT, protect the victims of HT and prosecute the HT victim's trafficker, establishing HT and related offenses as a federal crime (US Department of State, 2019). Countries were subsequently placed in tiers to indicate their compliance with minimal standards created to enforce the elimination of trafficking. Currently, the United States is in the first tier with other countries that are fully compliant with these minimal standards (Lamb-Susca & Clements, 2018). Despite complying with the current requirements of the TVPA, little progress has been made concerning the eradication of HT, and the United States remains one of the largest HT markets in the world, only second to Germany (Lamb-Susca & Clements, 2018). The TVPA focuses primarily on The Three P's, representing strengthened efforts to prosecute traffickers, increased HT prevention measures, and increased government effort to protect trafficked foreign victims (US Department of State, 2015). When analyzing the United States' response to HT, the penalties for trafficking humans for sexual exploitation are minimal compared to criminal activities like drug and gun

trafficking, and law enforcement agencies are not aware of the danger and the horrific nature of the problem (McKee, 2016).

The TVPA Reauthorization Act (TVPRA) was passed in 2003, 2005, 2008, 2013, and again in 2019. Each version has included additional provisions to attempt to address HT as an epidemic (Polaris Project, 2019). The 2019 TVPRA expanded the funding of grants and authorized government expenditures allocated for HT in addition to provisions for additional training for law enforcement in DOJ, DHS, and at the state, local, and tribal authority levels (Polaris Project, 2019). These provisions are often vague and loosely enforced. In 2003, Washington and Texas became the first states to enact anti-trafficking legislation, with many states passing legislation in the subsequent decade (Butler, 2015). Laws between states differ concerning definitions of what constitutes a victim, what constitutes an HT crime, and the focus of the states' response to trafficking as a recognized problem (Farrell et al., 2012). The United States Department of Justice determined that minors who were victims of ST were frequently misidentified as criminals within Texas despite meeting the TVPRA's definition as victims. Many states maintain legal provisions that conflict over whether prostituted minors are victims or criminals (Butler, 2016).

In addition to the various TVPRA's enacted over time, Washington State's current legislation called the Commercial Sexual Abuse of a Minor (CSAM) provides additional protection to victims. The Revised Code of Washington (RCW) 9.68A.100 adds that the consent of a minor to partake in a sex act does not suffice as a defense for the buyer or trafficker (Washington State Legislature, 2017). Washington shares an international border and has both sea- and airports, making it an especially ideal location for traffickers. A study conducted in Seattle estimated that on any given day there are approximately 300 to 500 minors involved with

ST in the Seattle area (Bower, 2008). This same study found that law enforcement reports likely underreport minors involved with ST, in addition to the study indicating that children engaged in ST are often arrested for unrelated charges with their ST history going identified. Female minors of color were disproportionately represented as ST victims in relation to Seattle's general demographics (Boyer, 2008). Seattle has little infrastructure to support ST victims, including a lack of specialized housing, case management, and recovery services. Ultimately, the minor ST victims were significantly underserved and unrecognized, in addition to having high recidivism rates and frequently being involved with criminal behavior (Boyer, 2008).

The Urban Institute Study of Underground Prostitution studied 8 major United States cities to better understand the nature of ST, with one of the cities being Seattle. The study found that Seattle's ST included street prostitution, online prostitution, massage parlors, brothels, escort services, gang-related prostitution, and independent or voluntary prostitution. Home brothels derive from Asian culture and are relatively unique to Seattle compared to the 7 other major cities studied. Traffickers in Seattle had an average of two to three girls working for them and often required each girl to make a daily quota for the amount earned. Quotas typically ranged between $400 to $1000 per day, per girl, and frequently the victims were physically abused or even tortured if they did not meet their designated quota. A local trafficking circuit that ST victims and their traffickers frequent runs between Everett, Seattle, and Tacoma, while a larger circuit extends from Seattle, Washington to Portland, Oregon, then to San Francisco, California, and finally to Las Vegas, Nevada (Dank et al., 2014). The transient nature of ST works to increase the difficulty in intervening and enacting meaningful change. The study found that 71% of the traffickers reported working in more than one city and cited their reasons for traveling, including recruitment of ST victims, police crackdowns, special events, and tragedy. Traffickers

reported increasing rates of internet utilization for ST and maintaining lucrative relationships with businesses such as hotels, clubs, photographers, retail shops, and car dealerships. Relationships with law enforcement were identified by the traffickers as well, indicating law enforcement officers were regular buyers of ST victims (Dank et al., 2014).

One complication in addressing HT is the use of differing language and terminology. Varying definitions of HT terms work to create confusion and controversy within academic and legal work, contributing to the shortage of available statistics and data. Differences in terminology make educating healthcare providers increasingly problematic by contributing to the difficulty in identifying victims and inhibiting the efforts to assist victims in exiting exploitation. Conflicting definitions and understandings also work to prevent effective criminal investigations and successful prosecutions, as well as the inhibited delivery of effective victim services (Reid, 2010).

Washington State has been considered a leader among the states in addressing trafficking (Washington State Department of Commerce, 2017); however, HT is rampant in Washington State, with no adequate solutions at this time. In 2018, there was not a single criminal defendant charged for HT in Washington State (Currier et al., 2018). Most of the public is largely unaware that HT is in their own backyard, re-enforcing HT's transient and hidden nature through lack of education and awareness.

The Misconceptions and Myths of Sex Trafficking

Many misconceptions and myths around HT and ST alike work to conceal the prevalence of this epidemic, including the secretive nature of HT overall, making it difficult to compile statistics and data around the topic. While healthcare workers have education and training on domestic violence and child abuse issues, HT is lesser-known or understood, creating a

knowledge gap for victims to fall through. Many myths surrounding HT create biases that prevent a victim from being identified.

A stereotypical image of an ST victim is a woman engaging with street prostitution, despite street prostitution only accounting for approximately 10% to 20% of the environments in which sex is traded. More popular ST locations include massage parlors, brothels, escort services, and independent call girls or "sugar babies," emphasizing that ST victims are frequently stereotyped based on a small percentage of the victim population (Lucas, 1995). These stigmas work against the proper recognition and understanding of ST, further hindering any addressing of the issue. Cunningham and Cromer (2014) explain that myths around ST work to justify the exploitation of women while simultaneously minimizing the perception of risk of harm. Ideologies that individuals involved with ST gain monetary wealth and enjoy having sexual intercourse with "Johns," and the individual chose to be involved with ST, or that the individuals engaged in ST cannot be raped or even deserve rape. Studies also showed that men were less likely to believe that a given situation constituted sex trafficking and more likely to blame the victim for being in that given situation. Men additionally were more likely to believe myths regarding human trafficking than women (Cunningham & Cromer, 2014). These differences were hypothesized to be due to gender differences in the experience of sexual victimization being higher in women than men, as well as women's greater likelihood to believe disclosures of abuse in contrast to men, but also to an overall lack of education, awareness, and understanding of ST as a whole. The label of prostitute often refers to the perception that a woman chooses to sell her body for sex versus being identified as a victim of ST; however, the definition of HT by the United Nations identifies that the "giving or receiving" of anything constitutes HT – including, but not limited to, currency (WHO, 2012). Using prostitution as terminology for an ST

victim has reinforced a bias or misconception that the individual is willing or wants to have sex, despite the interaction being illegal no matter the individual's label (Cunningham & Cromer, 2014).

Historically, prostitution was criminalized with anyone buying or selling sex-related services facing arrest and subsequent potential incarceration with a prohibition model. The prohibition model has created a stigma around ST, often resulting in the misidentification of victims as criminals. Criminalization has further contributed to additional barriers in re-entering society after exploitation, as criminal charges related to prostitution make obtaining employment substantially more difficult (Nichols, 2016). In a study of 163 police departments across the United States, only 12% of police officers believed ST was a significant issue within their departments. Further, 92% of these police offers had not received any training concerning ST, and 98% reported no specific policies or protocols in place to address ST (Nichols & Heil, 2014). The criminalization of victims ultimately prevents victims from seeking out law enforcement when in need of their assistance, for fear of their illegal employment placing them in jail or with heavy monetary fines. Research shows that victims are disproportionately arrested, charged, and fined compared to the buyers of sex services or traffickers of victims (Nichols, 2016). ST victims who are not minors are less likely to be seen or viewed as victims by law enforcement and more likely to be assumed to be voluntary sex work (Heil, 2012). Victims face significant barriers in exiting exploitation, such as fear of repercussions from a trafficker, the potential for the victim themselves to not self-identify as an ST victim, a general belief that service providers alike will not take their claims seriously as well as the fear and barrier of being criminalized and incarcerated for the trauma they have endured (Heil, 2012; Nichols & Heil, 2014; Reid, 2010).

One study identified that myths could hinder the identification of victims if professionals are misinformed about the nature and characteristics of trafficking and its victims (Menaker & Franklin, 2013). Cunningham and Cromer (2014) explain the victims of sex trafficking in the media are portrayed as very young, innocent, and vulnerable children, in contrast to seemingly hardened, promiscuous youth who are viewed as willful sex workers making it less likely that victims who do not match a given stereotype will be identified. Through a study done concerning perceptions of ST, it was found that without accurate knowledge and education around ST, an individual's perception of a victim may be skewed by the awareness of economic exchange, increasing the victim's responsibility for their present circumstances and subsequent victimization (Cunningham & Cromer, 2014). These stereotypes, biases, and myths create a culture where victims lived experiences are denied, justified, or misinterpreted. When victims doubt that their story will be believed, they are also less likely to disclose, further decreasing the likelihood that they will receive the necessary safety, treatment, and support required to exit their life of recurrent abuse (Ullman & Filipas, 2001). Healthcare providers are uniquely poised to identify and positively impact a suspected or confirmed victim of HT; however, they must have the knowledge to overcome societal myths and misconceptions of HT to do so.

The Most Disadvantaged are at the Greatest Risk

While people of all genders, sexual orientations, socioeconomic class, race, religion, and education level may be victims of ST, disadvantaged or marginalized individuals are at the most significant risk of being victims. The average age of entry into ST is 12 to 15 years old; however, some data indicate that the average may be decreasing to 10 and 11 years old (Friedman, 2005). Many ST victims continue to attend school despite their entry into ST, although attendance is often sporadic, despite victims rarely being identified within their school or other frequented

environments (Grace et al., 2012). A study in Boston, Massachusetts, revealed that 68% of women incarcerated or arrested for prostitution-related charges experienced childhood sexual abuse, with nearly half of the women having been raped before 10-years-old, indicating that childhood sexual abuse may be correlated to an increased risk of future ST involvement (Grace et al., 2012). A study of a juvenile justice facility in Texas that works with commercially sexually exploited child (CSEC) victims found that 93% to 95% reported a history of physical or sexual abuse (Grace et al., 2012). Homes with domestic violence or family dysfunction are also prevalent in ST victims (Barnert et al., 2017). In 2016, one out of every six endangered runaway children were likely victims of ST, with 86% of those runaways residing in the care of social services or foster care when they ran away (Polaris Project, 2016). Children are young, innocent, and ultimately vulnerable targets for buyers and traffickers that deserve protection.

Women of color, specifically Black women, are disproportionately represented within ST victims. Black women are more likely to be ST victims before 18-years-old compared to White women. Black women were also more likely to be involved in street prostitution than their White counterparts, where street prostitution is identified to be increasingly dangerous (Fedina et al., 2019). The Bureau of Justice Statistics found that between 2008 and 2010, children of color accounted for 358 of the 460 cases of child ST investigated by the United States Department of Justice, with the majority of the children being Black and Latino (Banks & Kyckelhahn, 2011). American Indians are believed to be disproportionately trafficked, however, very few studies have focused on the American Indian population specifically (Gerassi, 2015). In a report to the Minnesota State Legislature, it was identified that 24 to 57 American Indian women and girls from just Minnesota were missing in any given month from 2012 to 2020 (MartinRogers & Pendleton, 2020). Racial discrimination is a critical component in the disproportionate

representation of people of color in HT and works to disadvantage minority populations. Low socioeconomic status is frequently found in HT victims, extending to victims reporting higher rates of gang involvement, poverty, under-resourced schools, and high crime neighborhoods (Barnert et al., 2017). Minority populations are more likely to be of low socioeconomic status, adding additional high-risk factors to people already most disadvantaged. Institutionalized racism and discrimination contribute to a person's risk of being victimized.

Gerassi (2015) explains that mental health, substance abuse, and housing instability issues place an individual at an increased risk of being a victim of exploitation, in addition to becoming a comorbid condition resulting from being a victim of exploitation. Among homeless minors, there are comparable numbers of males and females who disclose being victims of ST (ECPAT USA, 2013). As acknowledged, childhood sexual abuse increases the likelihood of ST involvement. Childhood sexual abuse is also closely linked to increased rates of running away and homelessness, which simultaneously increases ST victimization risk. Running away has been indicated to be the strongest predictor for a minor becoming an ST victim in the United States (Fedina et al., 2019). National Incidence Studies of Missing, Abducted, Runaway, and Throwaway Children estimate that 450,000 children run away from home each year in the United States, with one out of every three minors on the streets likely to experience an attempt to be insnared in prostitution within 48 hours (Friedman, 2005). Involvement in the child welfare system is also associated with an increased risk of HT involvement. The most significant risk associated with the child welfare system lies in children being placed outside their homes, including youth shelters, foster homes, and group homes. Two-thirds of prostituted women had previously been involved with child welfare, and 78% of those women had lived in foster care or group homes (Gerassi, 2015). Individuals who identify as lesbian, gay, bisexual, transgender,

queer, or questioning (LGBTQ) are also at an increased risk of ST victimization. One study found that nearly one-third of ST victims identified as LGBTQ+ (Fedina et al., 2019). Substance use or involvement with the juvenile or criminal justice systems is correlated to a higher risk for victimization (Barnert et al., 2017).

Preventative Measures

The preventative measures are sparingly implemented and not aimed at the high-risk populations disproportionately represented within ST. Black, American Indian, and Latina women and girls show the highest risk of being victims of ST; however, government efforts to combat sex trafficking are most often not directed to these populations (Nichols, 2016). Other high-risk people include runaway youth, individuals lacking a high school education, and those who are experiencing homelessness; however, communities with the most significant number of high-risk individuals are frequently not the target of adequate federal funding to support prevention efforts relative to areas associated with lower risk (Nichols, 2016). Prevention is currently lacking in the United States, and while no standardized protocol or training to identify and respond to a suspected victim now exists, efforts are emerging. These efforts are often under-supported, insufficient, uncoordinated, and not evaluated for sensitivity, specificity, or positive outcomes associated (IOM and NRC, 2013).

Ultimately, addressing the HT epidemic in the United States from the healthcare perspective originates in the spread of consistent education, knowledge, and awareness across all healthcare workers and all fields. Specific attention should be paid to emergency departments and hospitals, as most victims identify these to be the primary healthcare access points victims frequent (Lederer & Wetzel, 2014). Education should be aimed at signs, symptoms, and red flags to be aware of when assessing a patient, how to best treat a patient who is a victim of HT (i.e.,

trauma-informed care, complex-trauma understanding), and resources to provide this patient. The development and subsequent validation of a screening tool for HT are imperative to aid healthcare providers in recognizing a suspected victim. Victims of HT can vary significantly in their lived experiences and subsequent signs and symptoms a healthcare provider may identify; however, common high-risk variables can help alert a provider to investigate more thoroughly (Varma, et al., 2014). Standardization of a screening tool will better assist providers in proper identification and management, although it is recognized that the ability to test for sensitivity and specificity will be a lengthy process, and the tool will likely change as time, knowledge, awareness, and understanding progresses forward (IOM and NRC, 2013). Finally, minor additions to emergency departments and hospital spaces, such as the previously mentioned silent-notification system, offer easy ways to allow a victim the ability to reach out for help without putting themselves at risk with their potential perpetrator (Egyud et al., 2017). Placing silent safety signs and instructions not only benefits victims of HT but potentially that of domestic violence or abuse of any kind and is a low-cost solution for hospitals to integrate swiftly feasibly.

HT demands the world's attention and immediate action. Lives are at risk, and the current level of education, prevention, and intervention to address and diminish HT is unacceptable and ultimately immoral. Healthcare personnel alike are uniquely positioned to intervene and advocate for those most disadvantaged and enact change where currently stagnant. In this way, healthcare personnel can better position themselves to enact change and provide hope for the victims and survivors who deserve a chance at freedom.

Theoretical Framework

Kurt Lewin created the Change Theory of Nursing in the early 20th century. Lewin theorized a three-stage model of change that requires an individual's prior learning to be rejected and replaced, describing human behavior as a dynamic balance of forces working in opposing directions (Petiprin, 2020). This three-stage model is often referred to as the unfreezing-change-refreeze model.

Unfreezing refers to the process in which a person(s) abandons an old pattern or belief that is no longer beneficial (Petiprin, 2020). In the context of HT, lack of education and awareness among healthcare providers has contributed to myths and misunderstandings regarding ST and its victims. These myths and misconceptions work to conceal victims despite their proximity to healthcare providers, reinforcing the perpetuated cycle of violence that HT victims endure. Working to unfreeze healthcare providers, correct the myths and misconceptions around HT, and reframe their definition and understanding of HT is the first step in diverting from the status quo of how HT is addressed within healthcare presently. For effective change to be achieved, change must be implemented at both the individual and organizational levels. Thus, unfreezing must occur at both levels, in which both individuals and organizations abandon their current knowledge and understanding of HT, making space for updated, more accurate information regarding HT. The lack of a standardized HT education or protocol, let alone HT survivor-led education and protocols, create the opportunity for vast amounts of incorrect or potentially harmful misinformation to circulate on behalf of an already traumatized and vulnerable population. Space must be created and prioritized to abandon current practices and make space for new, survivor-created, and survivor-led, standardized education and protocols for HT.

The change stage represents the change in thought, feelings, or behaviors that is in some capacity a more positive or beneficial change for a person(s). This stage is also referred to as "moving to a new level" or "movement", as a person(s) change is a move in a good direction. To address HT within the healthcare setting, the thoughts, feelings, and behaviors must change concerning the understanding and intervention on behalf of HT victims. Unfreezing makes the space for the change stage, and because the change stage does involve movement, it is recognized that the change stage consists of a process of growth over time. The change stage cannot conclude until a new status quo replaces the previously abandoned status quo.

The third and final stage of Change Theory is refreezing may officially establish the positive, beneficial change as the new status quo (Petiprin, 2020). Prior to the status quo being established, it is very easy to revert to the old, comfortable, easy status quo during the quest for lasting change. Implementing a new standard provides the framework for a habit, for repetition, for continuity – for lasting change. This ongoing change is then refrozen, and the abandoned status quo is replaced with an improved version. Ideally, this would reflect HT education and protocols led by HT survivors, standardized and implemented across all healthcare workers, healthcare organizations, and healthcare systems. For this reason, Change Theory was felt to be the ideal framework for which to base this project, as the current status quo concerning HT must be abandoned, changed, and replaced to achieve the wide-scale change warranted by the epidemic that is HT.

Project Aims

This project aims to evaluate and improve upon the established human trafficking education module called Human Trafficking 101, currently utilized by a multi-site healthcare delivery system working in a specific location out of the greater Seattle area. The specific aims

include (1) completing a cohort project with sex trafficking survivors to identify gaps in knowledge or information that survivors feel is important for healthcare provider knowledge; (2) use the information ascertained from the cohort study to expand upon and improve the established human trafficking training currently utilized; (3) and to later disseminate the updated human trafficking training to healthcare providers within emergency departments and urgent care settings in the greater Seattle area.

Integrating sex trafficking survivors' lived experiences into healthcare workers' education is imperative in reflecting trafficking victims accurately in healthcare provider training. The accuracy of these provider training modules is essential to impart real change. Then dissemination of this improved education module to healthcare workers in the future, specifically in the greater Seattle area, will hopefully be a first step in creating the knowledge and awareness needed to combat trafficking more effectively.

Review of Literature

Sex Trafficking and the Medical Field

Lack of education and awareness around HT and ST contributes to structural and societal barriers that limit victims from escaping trafficking and exploitation. Standardized training or protocols regarding HT and ST within healthcare are not used. It is estimated that 87.8% of ST survivors accessed medical care during their exploitation, with 66.3% entering an emergency department (ED) or hospital setting (Lederer & Wetzel, 2014). An additional study conducted in New York found that 82% of ST victims sought medical care during their time of captivity (Barnert et al., 2017). A qualitative study aimed at nurses' perceptions of HT victims. Themes related to nurses' perceptions of HT victims included that victims are often assumed to be young, female, and foreign and difficult or tough (Long & Dowdell, 2018). The nurses identified that

none had received formal education on HT and would not know how to identify an HT victim or treat them as their patient (Long & Dowdell, 2018). Statistics indicate that most ST victims access healthcare during their exploitation, which offers an invaluable opportunity for healthcare providers to intervene in a victim's traumatic life of abuse and provide victims the necessary means to exit exploitation, provided healthcare personnel has the necessary education and tools.

Donahue et al. (2019) instituted an HT training module for ED personnel, including physicians, nurse practitioners, physician assistants, nurses, registration staff, and technicians. The training module included a pre-and post-education survey, assessing confidence in identifying and treating a victim of human trafficking. They determined that 89% of the ED personnel had never received training regarding HT. After the training, the average confidence level for identifying an HT victim increased from 4/10 to 7/10, and the average confidence level in treating an HT victim increased from 4/10 to 8/10 (Donahue, 2019). Similarly, Chisolm-Straker et al. (2012) implemented a 20-minute educational intervention for emergency medicine residence, emergency department attendings, nurses, and hospital social workers. Confidence in the ability to identify an HT victim increased from 4.8% to 53.8%, and confidence in the ability to treat rose from 7.7% to 56.7% (2012). A web-based 20-minute training increased healthcare personnel's knowledge of HT significantly, indicating that training for healthcare providers does not need to be overwhelmingly lengthy or costly to make a difference. An additional study demonstrated that ST was perceived to be more prevalent in metropolitan areas versus *micropolitan or rural areas. Consequently, healthcare professionals in metropolitan areas reported having more knowledge and experience with ST victims than healthcare professionals in micropolitan or rural areas, with 54.7% of participants who resided in metropolitan communities reporting they had encountered a suspected or definite victim of ST. In comparison,

29.8% of participants who live in micropolitan or rural communities reported working with a suspected or definite victim of sex trafficking. Half of the professionals who work with at-risk youth and crime victim offenders had direct experience working with a suspected or definite victim of sex trafficking, and micropolitan and rural areas were found to have substantially less infrastructure in place to support the needs of trafficking victims (Cole & Sprang, 2015).

Varma et al. (2015) completed a retrospective study to identify if characteristics of a child sexual assault (CSA) victim differed from that of a CSEC victim. Individuals in the CSEC group had higher rates of prior sexually transmitted infections (53%), physical abuse (44%), history of violence with sex (31%), drug and/or alcohol use (70%), multiple drug use (50%), history of running away from home (81%), prior involvement with child protective services (47%) and with law enforcement (75%) than the CSA group. CSEC patients also recently reported visiting their medical provider, 46% having an appointment in the last two months and 75% over the previous 6 months. Healthcare workers are well-positioned to interact and engage with victims of ST, and education can assist with the specific identification of an ST victim. Assessment and identification of these high-risk variables in a child may assist a healthcare provider in recognition and intervention, simply through screening and proper interpretation of what these high-risk variables may correlate to. Acknowledged in the study, if the patient is determined not to be a CSEC victim, the provider is now more equipped to offer more proper referrals, patient education, and necessary guidance to meet this patient's needs regardless. Goldberg et al. completed a similar study concerning minor ST patients trafficked in the United States, which found certain high-risk variables to be associated with increased risk of ST victimization. These high-risk variables included a history of sexual assault (57%), parental substance abuse (60%), sexually transmitted infections (32%), acute suicidality (20%),

psychiatric admission (46%), and substance use (88%). Runaway rates (63%) and group-home placement (42%) were also exceptionally high (2017). ST victims under the age of 18 in this study reported that 81% had seen their medical providers in the year before being referred as a suspected victims of ST (Goldberg et al., 2017). Exhibiting signs and indications of ST involvement remained relatively consistent between these two independent studies, indicating that signs and symptoms may often be present that healthcare professionals lack the education to connect to ST.

HT is a public health crisis in the United States and destroys the lives of those victims. A mixed-methods literature review identified that 99.1% of survivors report physical health problems related to their exploitation. 95.1% were victims of violence or abuse, 81.6% were forced to have sex, and 68.9% were beaten (see table 1) (Lederer & Wetzel, 2014). Many survivors experience physical and mental health conditions that can affect them for the rest of their lives, indicating the extensive damage victims endure. ST frequently results in clinical disorders and diseases requiring treatment, including fractures, gastrointestinal disorders, infections, malnutrition, pregnancy, and gynecological disorders. While lack of data surrounding HT and ST alike impairs the ability to get an actual estimate of the hospital- and healthcare-related costs of HT, the annual cost for a woman with a history of abuse is 19% greater than that of a woman without abuse (Gerassi, 2015). The extensive consequences of ST as a public health crisis are largely unacknowledged. Many ailments that occur during trafficking indicate the specific need for healthcare workers to be educated and trained around ST, including victim recognition and treatment protocols, in addition to the importance of trauma-informed care and complex trauma.

Table 1

Negative Health Consequence Suffered by Victims of ST

Negative Health Consequence	Percentage of Victims (%)
Physical Health Problems	99.1
Psychological and Mental Conditions	98.1
Depression	88.7
Anxiety	76.4
Flashbacks	68
Attempted Suicide (at least once)	41.5
PTSD	54.7
Contracted STI	67.3
Substance Abuse (during exploitation)	84.3

A 2017 study implemented mandatory education for emergency department (ED) personnel, including nursing staff, physicians, laboratory staff, social services, radiology, registration, security, and transport. The education was completed using live training, with supplemental informational binders available throughout the hospital, including tip sheets for nurses to keep on hand and a treatment algorithm that all employees would have regular access to in the future. Education focused primarily on screening tools, medical red flags to look for in HT victims, and plans of which organizations or agencies to notify in the case of a suspected or confirmed victim. Ultimately, the study implemented a screening process that began at the ED's registration and continued throughout a patient's ED visit. This screening process included nurse-completed screenings, silent visual notification tools in patient-accessible areas (i.e., the bathroom in case a victim's perpetrator is present with them, instructing the victim how to secretly alert staff of their danger), and a protocol of how to assist the victim. Five months after

implementation, 38 patients were identified as potential HT victims, 20 of whom were identified through the screening process, and 18 self-identified through the silent notification system. Before implementing this education and protocol, no victims had been identified in this ED (Egyud et al., 2017). Through education and simple screening techniques, ED personnel were not only able to identify suspected and confirmed HT victims but were able to offer them substantial resources to assist them. However, despite this study's relative success, no standardized education or screening tools specifically for the ED or other healthcare-related departments remain. Further, the sensitivity and specificity of this study in identifying and assisting victims are yet to be determined. These questions still impair an adequate response to HT and ST alike in the United States.

HT and ST remain in the shadows of society, and high-quality literature remains marginal at best. The Institute of Internal Medicine completed a study assessing the publications on HT and the quality of evidence those publications possessed. Over 700 sources were identified concerning HT; however, 218 of those were found to be journal articles. Only 39 articles, or 16%, were empirical research, with only 36 articles having been peer-reviewed. Eight of these articles deal with HT concerning the medical field, but only three are explicitly aimed at the medical community. The 3 articles authored for the medical community focus solely on HIV/AIDS and written by the same researcher (Gozdiak & Bump, 2008). Despite the apparent acknowledgment of the importance of HT awareness among healthcare personnel, very little quality data and statistics are available. A slightly more recent study completed in 2013 analyzed keyword search of peer-reviewed and gray* literature to determine resources and tools available to healthcare professionals concerning human trafficking. Subsequently, the authors identified 27 resources that varied in length, scope, and range of target audiences, with some being very

*Gray literature is defined as literature that is not formally published, including government reports, conference proceedings, graduate dissertations, unpublished clinical trials, etc. Gray literature will not be found in books or journal articles (Higgin et al., 2021)

specific and others being more general. General themes addressed in these resources include definition and scope of HT, health consequences, victim identification, medical treatment, referral to sources, legal issues, security, and prevention. Only four resources directly acknowledged prevention. Most resources were found in the gray literature rather than the peer-reviewed, with gray literature (Ahn, et al., 2013). With the pediatric population being an exceptionally vulnerable population with HT, published research on medical best practices concerning HT and the pediatric population is minimal (Barnert et al., 2017). While some progress in data and knowledge around HT can be identified over the last decade, acknowledging HT as an epidemic without the academic work to support and propel the change required to eradicate it is irresponsible and liability to everyone.

The education module chosen for this project is stated to be developed with a group of multidisciplinary professionals with the partnership of a leading organization in the anti-HT movement (Common Spirit, 2021). No additional information was provided concerning what professions were represented within this forming group, nor was it mentioned whether the group comprised any HT survivors. The organization, as mentioned above, that serves as one of the leaders within the anti-HT movement additionally reviewed the educational module, cosigning their approval by providing a link to this module on their website with the notation that the organization's consultancy team has reviewed it. This consultancy team is stated to assist in providing training and technical assistance to improve the healthcare response to HT around the world. Members of their consultancy team have at least 7 years of experience “working in their field” and may or may not have lived experience of HT (HEAL Trafficking, 2021). No additional detail is provided regarding what fields of work team members have previous experience in, nor is any clarity given concerning whether an HT survivor would be represented

on this team. In this way, there is little insight into the authors and voices behind this education module. Further, without HT survivors being at the forefront of education, awareness, and understanding efforts, the risk of inaccurate or misleading information perpetuating increases. Placing survivors as the drivers of all education and protocols related to HT is paramount, as their knowledge derived from their lived experience cannot be equated.

Methods

Design

This project is a cohort prospective process quality improvement project through the lens of change theory and the utilization of practice topic dissemination. In this project, ST survivors will review and offer suggestions for an established human trafficking education module to better inform healthcare providers in the greater Seattle area about the best practices for assessing, identifying, treating, and managing the care of a possible or confirmed trafficking victim.

This project is that of a qualitative descriptive design. The qualitative descriptive design allows for exploring a population, situation or phenomenon, and often works to acquire the information needed to complete additional research in the future. Due to the lack of available data related to HT survivors' assessments of HT education materials, utilizing a qualitative descriptive design allows this project to explore what improvements can be made while still allowing the derived themes to reflect the participants' lived experiences. Margarete Sandelowski (2000) explains this further, stating that qualitative descriptive studies are instrumental when wanting to know the who, what, and where that correlates to a specific phenomenon. Due to its hidden, criminal nature, it is paramount to establish the who, what, and

wheres of HT accurately to better equip healthcare providers with the knowledge and tools required to create impact and change for victims.

Setting

A small non-profit organization (NPO) in a micropolitan area outside the greater Seattle area works to help victims of sex trafficking and sexual exploitation. This NPO was the location of participant recruitment as well as data collection. The NPO provides holistic survivorship care to their survivors through outreach and case management services to women victims of sex trafficking. Their comprehensive services include intensive case management, mentoring, life-skill building, and support in helping clients attain their own established individualized goals.

Data collection took place at the NPO's office. All participant Zoom interviews were conducted at the NPO's Office to ensure a private, safe, and comfortable place for participants to complete the semi-structured interview that participants were already familiar with. Completing the participant interviews in the NPO's Office also ensured participants had access to and could be supported by the NPO's Staff before, during, and after the Zoom interview, if wanted or needed.

Recruitment of Subjects

Women over the age of 18 and engaged with the NPO's Case Management Program for victims of sex trafficking were invited to participate in this project. Before entry into the NPO's Case Management Program, each individual is screened and thoroughly assessed to ascertain their status as a victim of sex trafficking. Only individuals meeting the definition of sex trafficking are admitted into the Case Management Program. The NPO currently does not serve men; thus, only women were included in this project. To participate, potential participants must have accessed healthcare during their time of exploitation as a means to reflect on their past

experiences and interactions with healthcare while being a victim of ST and how healthcare can work to improve its response to HT. Individuals who are not eighteen or older at the time of the interview or who did not access healthcare during their time of exploitation were not included in this project.

The NPO's current and former case managers and program directors assisted in communicating with participants, including notification of this project, its purpose, and potential participants' rights and privacy. All current Case Management Program participants who met this project's inclusion criteria were invited to participate, as well as previous Case Management participants and graduates who still had contact with current or former NPO staff. Potential participants were all informed that participation was entirely voluntary. A participant was told that they may discontinue their participation in this project any time without consequence, and involvement in the project would not affect the individual's current or future standing in the NPO's Programs.

Consent for participation in this project was obtained verbally at the beginning of each Zoom interview, where each Zoom interview consisted of strictly audio without any video functioning. The interviewer verbally explained the project over Zoom, answered any questions the participant may have had, and provided a written consent copy for program participants' records if they desired. The consent included consent for audio-recording of the semi-structured Zoom interviews. No video recording was utilized during the Zoom interviews. The consent forms included project contact information for the author of this project and the chair of this project, Dr. Benjamin Miller, and the reader of this project, Dr. Diane Switzer. The consent forms also reflected that the interviewer's Seattle University faculty advisers have access to all

data and information obtained during the project. Consent forms were provided in the English language. All participants were English speaking and literate in the English language.

Human subjects review and approval for this project were obtained from the Seattle University Institutional Review Board.

The project's subject matter had the potential to require participants to discuss difficult topics and potentially sensitive information during their interviews. Due to the problematic nature of the issues at hand, participants were supported by the NPO with resources and assistance if desired. Participants were reminded they may discontinue the interview at any time.

Intervention

Existing Education Module

The education module utilized for this project consists of a 28-slide presentation with an associated voiceover presenter. The presentation slides are titled with overarching subject matter related to HT, such as Risk Factors, Three Victim Populations, and Watch for Red Flags. The education module consists of definitions related to HT, including that of force, fraud, coercion, and some HT survivor stories. The module is self-paced at the learner's discretion. Red flag signs the module covered are included in Table 2.

Table 2

Red Flags Included in Education Module

Red Flags Signs to Watch for
Clinical Presentation and oral history don't match up
Oral history is scripted, memorized, or mechanical
Someone with the patient exerts an unusual amount of control over the visit

The patient appears fearful, anxious, depressed, submissive, hyper-vigilant, or paranoid
The patient is concerned about being arrested or jailed
The patient is concerned for his/her family's safety
Evidence that care has been lacking for prior or existing conditions
Tattoos or insignia's indicative of ownership
Occupational-type injuries or physical ailments linked to their work
Sexually Transmitted Infections

Data collection occurred via Zoom due to COVID-19 health and safety concerns. Participants were auditorily recorded during a semi-structured Zoom interview with the researcher. The participants were provided a quiet counseling room area in which to complete the interview via Zoom. Via a provided laptop, participants were logged into a Zoom account in which their true identity was hidden and replaced by their given pseudonym. Participant consent was obtained verbally at the beginning of the Zoom interview. The Zoom interview was audio recorded for later transcription. Video recording was turned off during all of the Zoom interviews. For added safety, the provided laptop's camera lens was covered with a security device during all of the Zoom interviews.

First and last names, addresses, phone numbers, and other direct subject identifiers were not obtained for this project. Indirect identifiers obtained include race, ethnicity, current age, and age(s) when an individual was trafficked.

Participants were provided a printout copy of the education module and pen and paper for any note-taking. A print-out copy of the education module's stated learning objectives was also provided to the participants for their reference and consideration (see Appendix B).

Participants viewed the 20- to 30-minute self-paced educational module at their own pace with the option to make any comments or notations regarding their thoughts or opinions of the education module as the training progressed. Upon completing the education module, the participants were asked several open-ended questions in a semi-structured interview to elicit additional insight into participants' opinions regarding the education module's strengths and weaknesses concerning their lived experiences and knowledge as survivors. These auditorily recorded Zoom interviews were then transcribed verbatim using the NVivo Transcription Application. These transcriptions were then reviewed and revised as necessary for any potential mistakes identified in the transcripts. The final transcripts were then uploaded into the NVivo Application and assessed for commonalities or themes within participants' interview responses. All audio recording files were password-protected, in a file that was also password-protected, on a computer with password protection.

Results

Demographic Characteristics

Fourteen potential participants responded with interest in participating in this project. All 14 potential participants scheduled interviews, with 7 either canceling or not completing the entire interview process. Six participants (N = 6) completed the whole interview process. Project participants ranged from 20 to 42 years of age at the interview, with a mean age of 29 years old. Five of the six participants identified themselves as White, 1 participant identified themselves as African American. All 6 participants accessed healthcare during their time of exploitation in various settings. These settings included primary care, urgent care, and emergency department settings. The ages of which these six participants experienced ST ranged from 16 to 31 years old.

During project interviews, three participants disclosed entering the healthcare setting with their abuser. The other participants did not disclose, deny, nor were they asked if an abuser was present with them during their previous encounters with healthcare. Interviews ranged from 43 to 109 minutes in length. Four themes were identified from participant interviews.

Table 3

Demographic Characteristics of Project Participants

Demographics	**N = 6**
Race	
White	5
Black	1
Age	
Mean	29
Age ST Experienced	
Minimum	16
Maximum	31

Findings

Participants in this project were asked to complete the self-paced education module and note any comments regarding the module and its content. Participants shared their reflections regarding the module in relation to their lived experiences as previous HT victims. All six participants noted areas where the module needed to be added to or improved upon throughout the module. One-half of the participants identified portions of the module they indicated as having been done well and identified the Red Flags section provided in the education module to

be valuable and critical points for healthcare providers. *Violet* noted the Red Flag section of the education module to be accurate in her experience:

> "There's a lot of times where I have gone to the doctors for things that are red-flagged in the module that we went over, and I wasn't, I wasn't helped. And I really wish that I was."

All three of these participants expressed that the red flags were accurate and depicted actual signs that healthcare providers should look for in patients. Two of these 3 participants added that the red flags should be expanded upon more greatly, with possible examples that healthcare providers may see in the clinic setting. Two participants who did not identify components of the education module they felt were done well criticized the lack of red flags concerning toddlers or children. They emphasized how vulnerable of a population children are specifically.

Participants noted multiple environments they felt should at least be addressed or mentioned in the education module as places where HT may occur (see Table 2).

Table 3

Environments Identified to be Associated with HT

Locations HT Occurs Informed by Participant Interviews
Malls
Bus Stops
Only Fans
Public Schools
Colleges
Bikini Barista Expresso Stands
Religious Settings

Theme I: Real Victims, Real Examples

During participant interviews, commonalities emerged regarding the various information pieces that participants felt were missing or included within an education module for healthcare providers related to HT. Commentary related to improvements that should be considered for this education module was the most discussed topic by participants. Many participants noted subject matter or language that may be confusing or incomplete. All participants acknowledged that additional real-life examples would benefit the module and healthcare providers' understanding of HT. *Violet* explains that:

> "I feel like it could use a little bit more of personal experience or examples in some type of way. Like it, it gives examples, but this module is specifically towards health care workers. I believe that it should be using a couple of health care examples like "this so-and-so walked into the medical office, and this is what she looked like, and she left… it's a very basic training module".
>
> "Real-life examples that clinicians can kind of go off of is super powerful because I think we can know all the definitions. But unless we have real-life examples of, like how to connect these cases to how it looks in real life, it's really hard to synthesize the information."

Violet continues by offering her experience with healthcare as a victim of ST as a real-life example she wants healthcare providers to consider in their everyday work.

> "… like the example of [my abuser] dropping me off a doctor's office and me going inside as a young child. Like trying to find somebody to get me help, but no one

recognizing me as a victim, and me leaving and continuing to be trafficked. It is really important."

Janet also noted that additional real-life examples in the module would be helpful, commenting that she felt as though the education module had failed in adequately teaching healthcare providers how to identify vulnerable populations and high-risk industries, two of the stated objectives of the education module. She stated:

"I think that what would be even more helpful is, like, hey, you come from a community that has these kinds of industries. People who are exploited in these industries have previously shown these kinds of things. That can help give clues to their potential exploitation".

"…pulling other previous data about people who reported being trafficked and that data from those people who have been trafficked and what those health reports look like to help give more clinical setting examples of like what it presents as like".

"… if there's not enough stories in the world of healthcare, people will continue to not understand".

Three participants noted that the examples provided in the education module were primarily centered around individuals who were not from the U.S., with all 3 participants reporting this to contradict the education module's stated purpose of awareness around HT in the U.S. *Tara* expressed her frustration with the lack of U.S.-based examples when illustrating HT:

"HT in other countries is important for us to understand and know about. But if we only focus on HT in other countries, then we are turning our back on our own people and immigrants within our country that are being trafficked here. I've seen organ trafficking in our country, and that's shocking to a lot of people. I've seen child trafficking, you

> know, as young as 3 years old here in our country. A lot of people are shocked by that, too, right? We shouldn't be shocked by that. Medical practitioners should never be shocked by that. No, if we are, then we don't screen, and we don't do the things that we have to do. I've literally had kiddos that [healthcare providers] refuse screening [for] because they couldn't disclose their abuse. They're three years old. They can't speak anyway".
>
> "I think kind of giving more examples, that make these makes sense to people who don't understand the intricacies."

Crystal also expressed frustration that the examples provided in the education module were limited and primarily foreign-based. Having been a victim of trafficking at only 16-years-old in her local community, *Crystal* believes more examples of real-life situations and victims are necessary to help healthcare providers identify victims in the community. She explains that HT victims are often overlooked or unidentified because they do not fit an over-dramatized or stereotyped image of an HT victim often sensationalized. She wants healthcare providers to know that the 16-year-old teenager in a primary care office could just as likely be a victim:

> "They are talking so much about undocumented immigrants and not domestic trafficking victims, which I think is tragic. And the reality is there are domestic people, tons of domestic people, that are a vulnerable population. These examples don't help the 11-year-old girl who is sold by her family be identified; it doesn't help the 19-year-old guy who is forced to use sex to survive be identified. I need them to know it happens to anyone, and that person doesn't always look how you think they're going to look".

Both *Laura* and *Violet* also felt healthcare providers should be educated further that victims of HT often appear "normal" to the outside world. *Violet* noted that since escaping her

exploitation, she's met numerous individuals who have fallen victim to HT, explaining that most people would never know, and never guess, that an individual is a victim of HT. *Laura* expands on this, stating:

> "Some of the most "normal" seeming people that I know have been victims of trafficking, of exploitation. And I just don't think that sometimes health care providers realize how common it is in the community and that they're likely every day interacting with someone who's experienced trafficking".

It was further identified during participant interviews that in addition to a need for the module to have more real-life examples and stories to illustrate to healthcare providers what HT and its victims may look like in the community, the training must also invoke a call to action for providers to engage with HT. Four participants felt a lack of humanizing components to the education module, noting they felt no "call to action" for healthcare providers in addressing HT after completing the education module. *Laura* explained:

> "Victims are just like, just according to this, they're just like a faceless community, right, of people that don't speak English and that do not belong to our country. They're not necessarily your neighbor, they're not the 13-year-old girl that's coming into your ER, and that ran away. There's always another. This training gave no humanity to victims at all. Like, I didn't feel a heartbeat. I don't remember a face. I don't remember stories. I wasn't turned to action at all."

Theme II: Language Matters

Participants made a note of the language used throughout various portions of the education module. Participants did not all comment on the same portions of the education module; however, a common theme of misaligning terminology was found. Some terms were

noted as outdated or never used among survivors themselves, such as “Romeo pimp” and “sales crew.” *Tara* expanded upon how the use of incorrect or obsolete language can be a barrier in establishing rapport with a suspected victim of ST:

> “The term Romeo pimp isn't even around anymore, and it was never used by anybody in the sex trade. Ever, ever, ever. So, if a doctor asks me because this is what they learned, then I'm going to think that they're not trustworthy and that they're stupid and that I am lost.”

In reference to the term “branding” used in the education module, 2 participants stopped to ask for clarification of the term’s meaning. Upon explanation, *Krystal* indicated she had never seen any branding occur in her experience; however, *Janet* explained she had seen branding happen before, and she believes greater explanation for the learner is warranted:

> “… [it] means ownership, I would think it would be helpful to have some examples of what that is and what that means. Because sometimes people are like, well, doesn’t everybody have [a Famous Cartoon Animal] playing [a game] without a weird interpretation? No”.

Participants noted a lack of instruction regarding what language to use with victims, identifying this as a weakness in the education module. The education module addresses that victims do not always self-identify that they are, in fact, victims. However, *Laura* questions the lack of direction the education module provided in navigating this as a healthcare provider:

> “I also don't think that they gave any language around how to help a victim maybe identify or what language to look for and what a patient or individual might say so that we could identify that they are a victim. If victims don't self-identify as victims, then how do providers identify that they are victims?”.

Similarly, *Tara* acknowledges concern for lack of instruction or tools healthcare providers can utilize from this education module regarding the language used in speaking with victims:

> "And there was nothing that talked about a process or policy of like gendered interviewing, or questioning, and being able to differentiate, because it's not always obvious. They didn't talk about asking questions or like how to think about those kinds of things. There's no, like, practical tools, really".
>
> "You don't understand that you're being devalued. You don't understand that you're being objectified. You don't understand that you're being dehumanized. Those aren't words you have for this".

Theme III: Lack of Confidence Post-Module

Participants reflected on the education module in relation to their lived experiences with HT. All participants expressed a lack of confidence in healthcare providers' knowledge of HT if the viewed education module were their healthcare provider's information source. Many participants noted the education module as basic, acknowledging a lack of helpful information and examples that would have been bettered the module. Some participants believed that the content in this module would not have assisted a healthcare provider in identifying them as victims during their exploitation. *Tara* shared the following:

> "If I were a survivor, that was which I am met by somebody that only had this training, they would never have identified me… they wouldn't have been helpful to me at all. And I was in the hospital all the time with [my abuser]".

When asked what level of confidence *Tara* would have regarding a healthcare provider's knowledge of HT after watching this module, *Tara* continued:

> "None, zero. I've trained people on better material than that, and they still don't know what they're doing. They still refuse to [do anything] because there's no policy to back it up. Because there's no accountability. Because there's no one putting it into action. There're no repercussions if you do it wrong. It's just kind of a free for all. Like, yeah, here's the info. And you have to hope, pray that someone enacts it in the correct ways."

> "… I just think it's really general, and to me, this feels like a training that people did to say that they did it but to not actually be any more helpful to anybody, and that is disappointing".

Laura mirrors the same sentiment when noting:

> "I would have very little to no confidence in the health care providers' knowledge based on this module. I understand it's supposed to be basic, but I think it misses a lot of foundational points that are needed in order to help a health care provider actually recognize a human trafficking victim and actually be able to intervene on their behalf without further traumatizing or causing more harm than help. I think this training did not really meet that level of effectiveness."

Theme IV: Healthcare Providers May, or May Not, be Ideal Interventionists

Regarding the module's stated objectives of preparing healthcare providers to be able to "take action to prevent trafficking and respond to victims appropriately" participant, *Laura,* expressed concern that this module may give healthcare providers a false sense of confidence in their ability to interact with HT victims (Common Spirit, 2021):

> "And it's a little scary to think that providers have no training and then maybe get this one quick 20-minute training or whatever and then go and think that they are ready to interact

with a possible or confirmed, or whatever survivors, because they're not. This isn't enough information."

Despite participants expressing a lack of confidence in the ability of this module to educate healthcare providers regarding HT adequately, the participants reported that healthcare providers are uniquely poised to intervene on behalf of victims. However, half of the participants noted a caveat that healthcare providers are only well-positioned to intervene on behalf of a suspected HT victim if they have the correct knowledge and understanding regarding HT. *Violet* explains how she believes healthcare providers could be good interventionist on behalf of HT victims:

"I feel like it's because doctors are where people tend to feel a bit more comfortable because doctors are supposed to know everything about what's going on with their bodies and, like, they have the answers. And some people would rely on that."

"I feel like health care providers have a really, really big impact on stopping sex trafficking. Not that, not completely, but like at least, discovering it more in health care if health care providers were a little bit more educated about it being in their office."

Similarly, when asked if *Abbie* believed that healthcare providers are good intervention points on behalf of suspected victims, she agreed, but with the caveat that healthcare providers must be adequately trained in HT:

"You should be trained in every aspect of life because, again, you are there to help us with whatever health, mental, physical issues that we are having. That's why we come to the health, to the hospitals or see our doctors. So you should be trained in every possible aspect that life can throw out at people."

Most participants paralleled a similar concern that healthcare providers are in an excellent position to intervene on behalf of a suspected HT victim, depending upon their knowledge, understanding, and outlook of HT. Participants expressed concern that some healthcare providers hold judgment against HT victims and that without the correct information, HT victims are often stereotyped and misunderstood by healthcare providers. *Abbie* noted this concern when asked if healthcare providers would make good interventionist on behalf of HT victims:

> "Depending on that person and how they see sex trafficking and the people who are in it, because some are like, "oh, yeah, well, you know, they chose this life" and others are like, "no, they didn't choose this life." So, it really depends on who the person is and who the doctor is."

Abbie further acknowledged that she does believe healthcare providers can change their views regarding HT, noting that if any individual wants to change and better themselves, they can – but that regarding individuals working in the field of healthcare, it should be their objective to continue to learn and better themselves as healers and care providers in their communities. *Abbie* was not alone in her concern regarding whether a healthcare provider is, or is not, a safe or desired intervention point on behalf of victims, depending upon their view of HT. *Laura* noted:

> "You know, I think that providers who believe that trafficking is a thing and understand that no one chooses to be in those situations and that sometimes life makes us make choices that we're not proud of, that we are not happy about, but that we have to do in order to make ends meet just like anyone else. Sometimes life gives us a hard deal. And I just think that if providers don't understand that, then they're probably not equipped, or ready, or the one that should be taking care of a victim when we already have been

victims, and we don't need to be a victim to a health care provider who doesn't believe us or thinks that we're we deserved it or that we chose this or that it or that it's not real."

Table 4

Themes Identified from Participant Interviews and Associated Recommendations

Theme	**Recommendations**
Real Victims, Real Examples	Inclusion of more real-life examples of HT victims within the education module Examples of U.S.-born HT victims Examples of less obvious HT victims More accurate representation of victims
Language Matters	Inclusion of accurate terminology and definitions Module reviewed by HT survivors for accuracy Inclusion of up-to-date terminology Clear definitions Standardization of language and terms
Lack of Confidence Post-Module	Improved module and educational training Include more real-life examples of HT Ensure accuracy and up-to-date terminology Expand upon the basics of the education module Continued review of a module with survivors for updates
Healthcare Providers May, or May Not, be Ideal Interventionists	Improved education and training among healthcare providers Mandatory education and training for healthcare providers regarding HT Standardization of education, training, and protocol related to HT Correct misconceptions healthcare providers may hold regarding HT and its victims

Discussion

Four prominent themes were derived from the 6 completed participant interviews. Each theme represents a slightly different component related to common HT-misunderstandings or

myths, exemplifying the shortcomings of these education modules in their applicability. In assessing some of the

All participants identified the need for more real-life examples and stories within the education module. Sentiments included that without additional examples for healthcare providers to relate to, many healthcare providers would be unprepared to truly recognize a possible HT victim. Some participants noted that based on this education module alone, it is unlikely they would have been identified. This further exemplifies the importance of including HT survivors in the creation of HT-related materials, as the inclusion of their lived experience and real-life examples is recognized as a hallmark to healthcare providers' understanding of HT. As previously discussed, incorrect or misleading characterizations of victims have been a long-standing barrier in victims being correctly identified; thus, the widely recognized need for more examples that offer greater representation for what an HT victim from the U.S. might look like indicates this education module is lacking the correct imaging survivors feel would be most helpful to healthcare providers. In many ways, the education modules' focus on examples of foreign-born individuals may contribute to unhelpful stereotyping of victims, primarily if no instances of U.S.-born HT victims are represented within the examples provided.

Many participants made note that victims of HT are more common and frequent than healthcare providers likely realize. Participants referenced that individuals they have known to be involved with HT are sometimes people that may be least expected, indicating they often appear "normal" to others. In many ways, participants' request that the education module is more humanizing of victims mirrors the feeling that the commonality of HT victims is lost within the education module itself. When acknowledging that HT is much more common-place than many might know or recognize, it must also be addressed that the victims of HT are also not an

isolated sector of society with a marked identity. Victims of HT could be found in the primary care office any healthcare provider works in on any given day. Ensuring education modules represent just how seemingly "normal" a victim of HT may present is imperative in conveying to learners how the learners' own biases may contribute to the lack of victim recognition. Concerning Theme IV, how a healthcare provider views HT may dictate if that healthcare provider is an ideal interventionist on behalf of victims. To emphasize to learners that victims of HT can come from all walks of life, all situations, and look all sorts of ways is to relay to the learner that victims of HT are no different than any other patients. Thus HT should be considered by all healthcare providers with all patients, as any other standardized screening might be. The inclusion of examples that model this - such as *Violet,* who shared how her abuser took her to her doctor's office and despite displaying multiple red flags the education module did cover, *Violet* as still only a child was not identified by anyone at that office – are necessary for conveying to healthcare providers that a possible victim who needs help may be in their office today. *Tara* also mirrored this when she referenced that she was taken to the emergency department multiple times after being beaten by her abuser, however, she was not recognized as a victim despite red flags being present. Both participants model how everyday patients can be overlooked if healthcare providers are not adequately educated and trained in recognizing victims that may be more subtle or seemingly not fit the stereotypes that healthcare providers may associate with victims of HT. Creating examples representing survivors of HT from local communities may offer healthcare providers a more profound understanding and greater clarification of how to identify potential victims of HT that may otherwise remain unidentified.

The language that surrounds HT is varied and inconsistent. Participants exemplified the need for standardization of language and terminology around HT, as incorrect or outdated

language could create distrust or interrupt rapport with a victim of HT. Ensuring that language used in the education module reflects the language healthcare providers should use with patients is imperative. Some terms in the education module were noted to be outdated or never actually used by survivors themselves, strengthening the need for education modules to be survivor-led to guarantee that the language and terminology are accurate. While slang evolves over time, updates would be necessary, and language may slightly differ by region. Nonetheless, the importance of correct language use is imperative for healthcare providers working with possible victims of HT.

Participants also noted the need for additional terms to be included concerning environments in which a person may experience trafficking. Some of these included things like "Only Fans" and "bikini baristas." Due to the many avenues and environments in which HT can occur, additional examples that identify common phrases or wording that may be associated with HT may offer greater understanding to healthcare providers on who or what to be looking for. Creating space for survivors to be the leader in creating education modules allows these accurate environments and their associated terminology to be included and reflected appropriately. The lived experience and inside understanding of HT that only survivors possess is invaluable in combatting HT. Utilizing survivor-driven education whenever possible should be considered of significant benefit to the learner and subsequently victims of HT, who in turn have a potentially greater likelihood of being identified. See Appendix A for some common HT terms.

Post-module, all participants expressed a lack of confidence in the knowledge a healthcare provider would have regarding HT if this module were their source of education. In the context of Theme IV, participants acknowledge that without proper training and accurate understanding of HT, some healthcare providers may not be ideal sources of intervention on

behalf of victims. This creates concern for victim-blaming, possible re-traumatization and further reverberates the need for more healthcare providers to be appropriately trained regarding HT.

Many participants felt the training was too basic and foundational, especially concerning the education module's stated learning objectives (see Appendix B). Concern for healthcare providers having misguided confidence in their knowledge of HT was acknowledged, with many participants recognizing that a negative interaction with healthcare can compound the shame, distrust, and fear that victims may already have around accessing healthcare. Ultimately, lack of confidence in the knowledge this education module would give healthcare providers acknowledges that improvements can and should be made. In acknowledging that participants did not feel enough real-life examples of HT and its victims were present in the module and the sentiment that language within the module must be improved upon, ways to improve the education module were implicated. In creating an education module that better reflects the participants, as well as the many victims and survivors which they represent, the inclusion of HT survivors voices in the creation of examples for an education module by which accurate language and terminology are also used, may increase the confidence participants and HT survivors have in the effectiveness of this education module. In turn, considering the concern for misguided healthcare provider confidence having the potential to result in the re-traumatization of victims, the inclusion of survivor-led improvements to this education module is imperative in preventing additional mistrust and further harm to HT victims in healthcare settings.

Considering an individual healthcare provider's views regarding HT was a significant concern for participants concerning whether a healthcare provider is a good intervention point on behalf of HT victims. All participants agreed that healthcare providers are good interventionists – if they understand and are educated in HT. However, if a healthcare provider does not

understand or has not been educated in HT, participants note more significant concern about being shamed or their stories not believed.

In tandem, the concern that participants have little to no confidence in healthcare providers' knowledge of HT after this education module is that participants would want healthcare providers to be educated more thoroughly and accurately. Basic education, or supplying healthcare providers with a bare minimum, does not instill confidence in participants that healthcare providers will be well-educated regarding HT; thus, this education would not instill confidence that healthcare providers who received this training would be ideal interventionists on behalf of victims. As previously mentioned, Theme I and II provide some basis for areas of improvement that may be expanded upon, as an improved education module may increase the confidence HT survivors have in the healthcare providers who receive it, in turn creating a greater number of healthcare providers who are viewed as safe and ideal interventionists by victims of HT.

The lack of education to healthcare providers regarding the realities of HT is a failure on healthcare systems and organizations at large. The lack of HT education to correct the biases and stereotypes that are pervasive in the U.S. only works to perpetuate and protect the exploitation of victims. Participants alike realize that healthcare providers are not trained regularly in HT. *Tara* shared about how through the numerous times she was taken to the emergency department by her abuser, after being beaten by her abuser, one nurse identified that she needed help, one time. *Tara* explained that the nurse had been a victim of domestic violence herself, which is why *Tara* believes the nurse recognized she needed help at that moment. She elaborated that she felt like the nurse realized that she was a victim because the nurse had also been a victim. While all healthcare providers will not be victims, giving them the proper education and knowledge to

serve as tools to recognize victims, in the same way that a victim can recognize another victim, creates the opening for positive, healthy intervention points. Without accurate education modules and accurately informed healthcare providers, HT victims can still not access healthcare and be confident they will interact with a healthcare provider who understands or knows HT. This creates a lack of trust that victims have for healthcare providers and the healthcare systems at large, as victims risk shame and retraumatization. Due to a general lack of knowledge and training around HT, victims may be less likely to trust, disclose, or access help in the healthcare setting, despite victims commonly accessing healthcare during their victimization. To end this cycle of mistrust, accurate and adequate education must be provided to healthcare providers across the U.S.

A lack of consistency in training healthcare providers on HT will continue to contribute to a cycle of mistrust and concern that HT victims have in accessing healthcare. While various systems and organizations may set their individual education and training requirements, HT is frequently not mandatory, let alone a topic of discussion. Without creating a standard in which most systems and organizations have an expectation of which healthcare providers are educated and trained regarding HT, victims of HT may never be able to confidently access healthcare for fear of false stereotypes and misconceptions. Inconsistency in the education of healthcare providers at large contributes to victims' uncertainty regarding whether a healthcare provider is an ideal person to disclose to. A lack of accountability for learning this knowledge and information will result in little change to addressing HT within healthcare settings. It is simply inadequate to create an education module without any requirement or standardization that employees complete it. Without changing how HT is viewed within healthcare, misconceptions

and biases may continue to blind healthcare providers to the victims in their care and contribute to a cycle of mistrust that victims have with the healthcare providers.

Ultimately, a lack of standardization of healthcares' view of and response to HT will forever plague efforts in effectively combatting HT. Without standard education modules and protocols to reliably inform healthcare providers, myths and misconceptions may persist. Without standardization in the requirement of healthcare providers to be educated and trained regarding HT, victims will continue to question and lack confidence in whether the healthcare provider will be prepared to help them in the ways they need or who might shame or stereotype them. Without standardization of the inclusion of survivors in the creation and review of all HT-related materials, the potential for outdated or misguided information to perpetuate to healthcare providers increases, further increasing the risk of losing trust or rapport with a possible victim.

Limitations

This project relied on a non-randomized sampling technique to recruit potential participants from a singular NPO limiting, the ability to generalize this project's results. Findings derived from this project may not represent HT survivors' at large due to the non-randomized sampling in addition to the small sample size of participants. Five of six participants identified themselves as white, with 1 participant identifying themselves as African American. No participants in this project identified as American Native, Asian, Hispanic, or any other race. Due to the NPO's current ability to only serve women in their Case Management Program, only women were interviewed for this project. Additionally, ST survivors were represented, however, the voices of LT survivors were not and should be considered and included when assessing all HT-related materials.

Due to the COVID-19 pandemic, participant interviews were completed via Zoom out of an abundance of caution for the health and safety of everyone. It is possible that conducting the interviews in an in-person format would create a more comfortable and open environment for participants to offer more commentary and insight. Additionally, the pandemic has resulted in many individuals across the country being affected by various changes in life. Of the 14 potential participants who expressed interest in participating, 8 potential participants who either canceled or did not complete the whole interview process all had life events, and circumstances related to the pandemic inhibited their ability or capacity to participate.

Implications

The results of this project create a foundation for the changes and improvements that must be made to HT-education materials to represent the actualities of HT best and empower healthcare providers with the most accurate information possible to truly understand and address HT. Understanding these 4 themes allows a basis for greater insight into what ST survivors believe is helpful and necessary for healthcare providers to know and understand HT in a way that is effective for assisting victims. Further, this project establishes that the utilization of HT survivors to critique and assess HT-related resources is feasible and, whenever possible, should be employed. Of note, special consideration and care should always be taken when working with survivors due to the difficult and potentially triggering nature of the topics at hand.

Considerations

If repeated, this project would preferably be completed as an in-person interview versus the Zoom interview format utilized due to COVID-19. Additionally, more participants would be included to include a more diverse demographic representation and the inclusion and

representation of mens' perspectives. Ideally, an incentive would be provided to participants for their time and assistance as it is invaluable in improving all HT-related materials.

Since the creation of this project, an additional educational module has been released by the same authors and creators of the education module utilized in this project. If repeated, the assessment of both modules in tandem with one another would be beneficial, as they cover differing HT topics from one another.

Future Recommendations

Additional research is required to determine the accuracy and legitimacy of HT education modules that are being produced and distributed concerning the lived experiences of HT survivors at large. The creation of an education module that accurately depicts the knowledge and information required to intervene on behalf of HT victims successfully is imperative in giving healthcare providers the tools needed to be successful in assisting suspected victims. Utilizing the voices and experiences of HT survivors to lead the development of these training modules is necessary to ensure accurate information is being depicted and that the information being presented will be of benefit to helping victims.

This project provides some general foundational themes that should continue to be explored for generalizability and broader application. Utilizing these results, future projects may focus on eliciting more specific information related to the 4 themes identified to allow for the identification of more detailed information. For example, further information and understanding related to the language used regarding trafficking are needed, in addition to specific real-life examples that can be understood and applied to a standardized audience of healthcare providers. Standardization of education modules, protocols, and language related to HT is paramount, and

HT survivors' voices should be leading the knowledge, creation, and understanding of each individual component to ensure accuracy and broad applicability.

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Appendix A

Terminology and Definitions

- **Prostitution:** The United States Department of Justice (2012) defines prostitution as (1) the unlawful promotion of or participation in sexual activities for profit, including attempts or the solicitation of customers or transport of persons for prostitution purposes, (2) the ownership, management, or operation of a dwelling or other establishment to provide a place where prostitution is performed, or (3) the assisting or promoting of prostitution. The United States currently criminalizes prostitution (Gerassi, 2015). Prostitution is an action, not an identity.
- **Sex Work:** Sex work refers to exchanging sexual acts, services, performances, or products for compensation. Sex work includes direct physical contact and indirect sexual stimulation, such as pornography (Gerassi, 2015). Advocates frequently use sex work as a term to justify that it provides more dignity and professionalism in comparison to "prostitution." However, it also has been acknowledged to normalize an act of abuse, as an individual is still trading a commodity for something of a sexual nature (Gerassi, 2015; Scarlet ROAD, 2018).

- **Sexual Exploitation:** Sexual exploitation is used uniquely in the United States to refer to minors specifically. However, the United Nations (2017) defines sexual exploitation as "any actual or attempted abuse of position of vulnerability, differential power or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another" (p. 4), without distinction of age.

- **Commercial Sexual Exploitation of Children:** Commonly denoted by the abbreviation of CSEC, commercial sexual exploitation of children maintains the United Nation's definition of sexual exploitation (defined above) but is specific to minors. This includes child sexual abuse; however, it differs from sexual abuse in the component of being for economic gain. "Put plainly, CSEC is the buying and selling of children" (Grace et al., 2012, p. xx).

- **Minor:** Any person under the age of 18 years old, regardless of the age of consent locally. Minor, child, and youth are frequently used interchangeably (United Nations, 2017).

- **Force:** Force includes causing, or threatening to cause, serious harm to another person or physically restraining or threatening to physically restrain another person, sexual restraint,

monitoring of an individual, physical or sexual abuse, or forced confinement. Monitoring and confinement are often used to control victims, especially in the early stages of victimization. Force works to break the victim's resistance down over time (Child Welfare Information Gateway, 2016; Office on Trafficking in Persons [OTIP], 2017).

- **Fraud:** This includes, but is not limited to, false offers of employment, wages, working conditions, marriage, security, a better life, or lying about laws. Further, "over time, there may be unexpected changes in work conditions, compensation or debt agreements, or nature of the relationship" that are often unexpected (OTIP, 2017).

- **Coercion:** Coercion is a broad list of tactics meant to establish a power dynamic in which one individual ultimately is forced to do what the other demands. These tactics include, but are not limited to, threats (threats of physical harm, threats to family, threats of being turned in to law enforcement, etc.), debt-bondage, psychological abuse, document confiscation, withholding of personal property, extortion, financial harm, the threat of sharing information or pictures of an individual, or the facilitation or controlling of another person's access to a controlled substance (Child Welfare Information, Gateway).

Appendix B

Training Module Objectives Provided to Parcipants: “This course was developed in partnership with HEAL Trafficking, a united group of multidisciplinary professionals dedicated to ending human trafficking and supporting its survivors from a public health perspective. It covers basic information about human trafficking, including potential red flags in health care settings. Following this course, providers should be able to define human trafficking, recognize misconceptions often associated with this type of violence, identify vulnerable populations and high-risk industries, and take action to prevent trafficking and respond to victims appropriately. It includes a quiz you must pass in order to print results for completing the course” (Common Spirit, 2021).