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A Quality Improvement Project to Facilitate a Human Trafficking Screening Protocol at a Maternal Resource Center

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A QUALITY IMPROVEMENT PROJECT TO FACILITATE A HUMAN TRAFFICKING SCREENING PROTOCOL AT A MATERNAL RESOURCE CENTER

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Abstract

Human trafficking is a global, criminal industry that negatively impacts the health of victims. Most U. S. victims of human trafficking are young females. Many female sex trafficking victims will seek health care services for unplanned pregnancies and sexually transmitted infections. Healthcare professionals fail to identify human trafficking victims due to lack of standardized screening. The aim of the project was to initiate a sustainable, standardized human trafficking screening protocol at a Maternal Resource Center (MRC) in order to improve human trafficking identification.

This 10-week quality improvement project provided the staff and volunteers at the MRC with the necessary tools to implement evidence-based practices for human trafficking screening. Prior to this project there was no active, standardized screening to identify victims at the MRC. Objectives included addition of a human trafficking screening tool into routine clinic processes, formulation and distribution of a human trafficking resource packet for staff and qualifying clients, creation and display of a confidential human trafficking tear-off flyer, education for staff and volunteers, and the delineation of human trafficking protocol steps to facilitate safe decision-making. Of the 304 clients screened, 14 (4.6%) clients gave positive answers to human trafficking screening questions. The 14 clients included five (35.7%) victims who confirmed being trafficked, six (42.9%) clients displaying risk factors but denied being trafficked, and three (21.4%) clients with prior/current abusive relationships.

Keywords: human trafficking, quality improvement, healthcare, sex trafficking, pregnancy, screening

A Quality Improvement Project to Facilitate a Human Trafficking Screening Protocol at a Maternal Resource Center

Human trafficking is a criminal industry that affects approximately 40 million people globally (International Labour Organization [ILO], 2017). Human trafficking is the act of recruitment, movement, or harboring of vulnerable people through the means of force, fraud, coercion, or abuse with the purpose of exploitation (United Nations Office on Drugs and Crime [UNODC], 2018a). Human trafficking thrives separately from mainstream society, as this lucrative industry secretly exchanges people's basic human rights for profit (United States Department of Homeland Security, n.d.). Since human trafficking victims are denied free will and exploited for profit, the ILO refers to this industry as modern slavery (ILO, 2017). There are 25 versions of human trafficking reported, some examples include forced prostitution, pornography, marriage, military service, organ donation, and escort services (Polaris, 2017). Most human trafficking falls under the category of labor trafficking or sex trafficking (Polaris, 2017). International statistics reveal that 71% of trafficking victims are female and 25% of all trafficking victims are under the age of 18 years old (ILO, 2017). Although victims are not exclusive to a specific sex or age, human trafficking mostly affects young females.

The United States is not immune to the crime of human exploitation. The number of reported human trafficking cases are increasing in all 50 states (Polaris, 2019a). In response to this epidemic, the U.S. government granted $47 million to both government and non-profit programs and organizations to combat human trafficking and provide resources for victims (United States Department of Justice [USDOJ], 2017). An additional $2 million was given to the Research and Evaluation on Trafficking in Persons program in hopes of fostering human trafficking awareness and instigating change in societal practices (USDOJ, 2017). The recent surge of human trafficking research has greatly impacted health care by increasing human

trafficking awareness and screening recommendations for healthcare professionals (USDOJ, 2017). Numerous descriptive, retroactive studies of former human trafficking victims demonstrate health care professionals encounter victims of human trafficking; however, health care professionals are often unaware of the client's victimization (Polaris, 2019b). In order to address this disparity in victim identification, evidence-based recommendations advocate for a clinical human trafficking assessment fostered by a standardized protocol.

Statement of the Problem

Human trafficking victims are subject to physical trauma, illness, infections, unplanned pregnancies, malnutrition, post-traumatic stress disorder, psychological manipulation, and other outcomes of abuse and neglect (Ottisova et al., 2016; Pascual-Leone et al., 2016). The trafficker's abuse and display of power ensures victims feel physically and emotionally bound to the trafficker. This sense of bondage to the trafficker prevents victims from leaving their situation. By physically and mentally controlling their victims, traffickers have a stable source of revenue. In one reported case, two traffickers generated a total of $422,822 in one year by exploiting a total of seven women for sex (Human Rights First, 2017). This large source of income relies on the victims' abilities to perform duties. If victims are too ill, sustain too much abuse, or are injured from working conditions, then the traffickers have lost their source of income. Because of the prevalence of physical, sexual, and emotional trauma, most traffickers will eventually have to take their victims to a healthcare facility (Ottisova et al., 2016). This clinical encounter with a healthcare professional may be the only time a victim is interacting with mainstream society (Chisolm-Straker et al., 2016). Unfortunately, healthcare workers often miss this rare opportunity to save a life.

There is a lack of victim identification and assistance in healthcare settings (Polaris, 2019b). Chisolm-Straker et al. (2016) identified that 68% of the former victims reported seeing a

healthcare provider during their period of captivity. Of the human trafficking victims interviewed, 44% of them were seen in primary care settings. However, of all the victims who sought healthcare from a provider, 57% of the victims were not identified and returned to captivity (Chisolm-Straker et al., 2016). The victim's fear of trafficker retaliation, lack of self-awareness to identity as a victim, and feelings of hopelessness, coupled with the healthcare professionals' lack of human trafficking awareness and sensitivity contribute to this healthcare disparity (Bick et al., 2017; Lederer & Wetzel, 2014; Pascual-Leone et al., 2016). Evidence-based recommendations inspired this quality improvement project. The MRC located in San Antonio, Texas serves as an ideal location for implementing human trafficking screening as the MRC provides free services to women experiencing unplanned pregnancy or STI infection. The project objectives delineated strategies to increase human trafficking staff awareness, screening, and provision of resources.

Background and Significance

Human trafficking affects males and females of all ages. However, this crime largely impacts females and youth. In North America, 85% of victims are female, 20% of which are female children (UNODC, 2018a). Sexual exploitation makes up 71% of North America's trafficking industry (UNODC, 2018a). Of the 23,078 victim survivors identified in the U.S. last year, approximately 15,000 were females used for sex trafficking (Polaris, 2019a). Child runaways are also at risk for becoming a sex trafficking victim. The National Center for Missing and Exploited Children (NCMEC, 2019) reported 23,500 runaways in 2018. About 86% of homeless children who became human trafficking victims were previously in the care of social services or foster care (Polaris, 2016). One study estimated that one in seven child runaways became victims of sex trafficking (NCMEC, 2019).

Survivors of human trafficking report physical, mental, and emotional abuse (Hemmings et al., 2016; Lederer & Wetzel, 2014; Macias-Konstantopoulos, 2016; Ottisova et al., 2016). Victims of sexual exploitation also report STIs and unintended pregnancies (Tracy & Macias-Konstantopoulos, 2017). Traffickers often seek quick, affordable treatment options so victims can be treated by unsuspicious providers. Traffickers typically desire providers who have no relationship with the victim. This allows the victim to be quickly returned to exploitation with minimal suspicions raised by healthcare workers (Judge et al., 2018).

From 2015 to 2019, Texas has ranked second for reported cases of human trafficking in the United States (Polaris, 2019c). Texas creates an ideal location for human trafficking due to its shared border with Mexico, presence of major roadways like the Interstate-10 corridor, and the five Texas cities with populations greater than 675,000 people, including Dallas, Austin, San Antonio, El Paso, and Houston (U.S. Census Bureau, 2018b). Transportation plays a large role in human trafficking as victims and traffickers travel to buyers. In one national survey of survivors, 63% (n = 127) of the participants stated they often used public transportation including taxis, buses, subways, and rideshares (Polaris, 2018). In a survey of 104 survivors, other modes of transportation listed were airplanes, moving trucks, cruise ships, rental vehicles, and trains (Polaris, 2018). The most common method of transportation was the trafficker's vehicle. The large Texas cities, shoreline, and interstates allow accessibility to consumers and swift transportation of victims (Santana, 2018). Texas may not be the destination for victims, but transportation through Texas is feasible due to the multiple transportation possibilities. For this reason, the Texas Attorney General estimates 313,000 human trafficking victims are in Texas at any given time (Busch-Armendariz at al., 2016).

Illegal immigration across the Mexico-U.S. border is still considered a large contributor to human trafficking (Busch-Armendariz at al., 2016; Department of Health and Human Services [USDHHS], 2018). In one study by Polaris (2018), the results indicated the majority of survivors (77%, *n* = 127) were U.S. citizens or legal residents. However, this could be due to underreporting. From 2015 to 2018, Polaris (2020) stated that an estimated 17,000 victims failed to report their immigration status. Of the 3,871 victims who identified their immigration status, 56.6% (*n* = 2,191) were from Mexico and 11.5% (n = 466) were from Guatemala (Polaris, 2020).

The Mexican-American border is an ideal setting for traffickers to exploit vulnerable immigrants. Traffickers lure desperate immigrants to the United States under false pretenses. Once smuggled across the border, victims are threatened by their traffickers. Traffickers prey upon the immigrant's fears and threaten to reveal their illegal status to authorities as a manipulation tactic (Busch-Armendariz at al., 2016). This power display by the trafficker sets the foundation for a human trafficking dynamic and greatly impacts the state of Texas. Texas abuts a significant portion of the Mexican American border. In 2019, Texas had 1,080 total reported cases of human trafficking, of which 933 (86.4%) were female and 261 (24.2%) were minors. Of the total Texas cases reported, 805 (74.5%) involved sex trafficking (Polaris, 2019c). With such a large human trafficking presence in Texas, changes need to be made in order to combat human trafficking.

Setting

The non-profit MRC serves San Antonio and surrounding areas by providing free services including pregnancy resource assistance, counseling, and some medical services. San Antonio is one of the largest cities in Texas with a population of more than 1.5 million people. Located in Bexar County, more than 18% of San Antonio's population lives in poverty (US

Census Bureau, 2018a). In 2016, 15 zip codes in Bexar County had a teen pregnancy rate two to four times the U.S. rate (San Antonio Metropolitan Health District, 2016). In 2016, there were about 39 births a week to mothers who were between the ages of 10 and 19 years old (San Antonio Metropolitan Health District, 2016). Therefore, the MRC is ideal for sex trafficking victims to visit due to affordability and location.

Contrary to the assumption that numerous human trafficking victims would be identified, MRC staff has only reported two clients who were human trafficking victims in the history of the MRC. Staff stated a middle-aged woman brought two young girls on separate occasions for testing. Despite the vast age gap, the middle-aged woman consistently said that each girl she brought in was her cousin. Both girls confirmed they were trafficked but did not want to be rescued (Milli, E., personal communication, September 16, 2019). Despite these encounters at the MRC, there is no active, standardized screening for victims at the MRC. This report of trafficked victims provided the MRC's human trafficking victim baseline.

Assessment

The MRC is a faith-based, non-profit organization which focuses on a client's well-being and access to resources during an unplanned pregnancy. The facility's location is close to a family planning clinic and the county hospital. Volunteers, patrons, and donors provide 100% of funding through monetary gifts, donation of supplies for mothers and babies, and services. The clinic provides transabdominal and transvaginal ultrasounds, sexually transmitted infection (STI) testing for gonorrhea and chlamydia, pregnancy tests, counseling services, parenting classes, and baby supplies. It does not serve as a replacement for prenatal care, but serves as a launching pad for improving women's health and healthy pregnancies. Staff keep client information

confidential unless the client is a danger to herself or others. Staff document in an electronic charting program and paper charts, which are then filed by staff and trained volunteers.

Clients

In August and September 2019, there were 1,036 total appointments at the MRC for 632 clients. Each client fills out an initial assessment intake form which includes demographic questions. The majority of the clients seen at the MRC were young women of ethnic minorities with low annual income and lower educational attainment (Table 1).

Pregnant clients at the MRC are categorized as either likely to carry (LTC), abortion-minded (AM), or abortion-vulnerable (AV). Services and education provided are tailored to their category and pregnancy test results. The MRC receives no government funding. Private donores provide all the MRC revenue. The Center costs approximately $350,000 to function for 6 months (S. Coots, personal communication, September 16, 2019). The cost of daily services and supplies are monitored by the office manager.

Providers, Staff, and Volunteers

Since January 2020, the staff included three full-time employees and seven part-time employees. The nurse manager and ultrasound technician are key healthcare professional employees at the MRC. The ultrasound technician conducts most ultrasounds and ensures all scans are sent to the volunteer radiologist for interpretation. The nurse manager addresses all health-related questions, performs birth control and STI counseling, performs quality checks in the laboratory, and ensures the STI specimens are correctly processed. The rest of the MRC staff has public health or mental health career backgrounds. The MRC relies on volunteers for additional support. Nurses, doctors, ultrasound technicians, counselors, doulas, and public health professionals make up the majority of volunteers.

Table 1

Demographics of MRC Clients Seen From August to September 2019

Demographics	Clients	
	n	%
Sex		
Female	632	100.0
Race		
White	91	14.4
African American	75	10.3
Asian	19	3.0
Multi-Racial	41	6.5
Middle Eastern	6	1.0
East Indian	3	0.5
Native American	4	0.6
Other	4	0.6
Not Indicated	102	16.1
Ethnicity		
Hispanic	297	47.0
Non-Hispanic	233	36.9
Not indicated	102	16.1
Age (years)		
<15	1	0.2
15-19	77	12.2
20-24	191	30.2
25-29	196	31.0
30-34	101	16.0
35+	52	8.2
Not indicated	14	2.2
Annual income		
$0-14,000	336	53.4
$15,000-29,000	96	15.2
$30,000-44,000	41	6.5
$45,000-59,000	11	1.7
$60,000+	8	1.3
Not Indicated	140	22.2
Education Level		
Less than high school	45	7.1
High school/GED	256	40.5
Trade school	34	5.4
Some college	72	11.4
College graduate	105	16.6
Graduate degree	4	0.6
Not Indicated	116	18.4
Student status		
High school	27	4.3
College or trade school	93	14.5
Not a student	388	61.4
Not indicated	124	19.6

Note. This table data was collected retroactively from the electronic health records.

[a] This statistic includes unemployed clients as well as clients who were completely dependent on others for income.

Processes

All clients who wish to receive any MRC services must first complete a free pregnancy test appointment (Appendix A). These initial appointments determine whether the clients are eligible for additional free services (such as ultrasounds, parenting classes, and material gifts). At the initial pregnancy test, the client's intention for the pregnancy, medical and educational needs, sexual health, and emotional well-being are assessed. Clients with a positive pregnancy test who are at least six weeks gestation are eligible for an ultrasound. Clients who are abortion-minded or abortion-vulnerable are eligible for STI testing for chlamydia and gonorrhea, whereas likely-to-carry clients will receive STI testing once they establish prenatal care with a provider. The nurse manager performs the STI testing, counseling, and documentation.

Project Identification

A pre-intervention assessment of the facility, staff, and clients was conducted from August 30, 2019 to December 19, 2019. The assessment revealed no standardized human trafficking screening process. Research supports the need for human trafficking screening, especially in healthcare settings.

Bick et al. (2017) state that maternity services are a first-line defense in identifying victims and supporting women and girls who had been trafficked. The MRC sees approximately 20 clients daily and is an ideal location to screen for human trafficking victims. Lederer and Wetzel (2014) discovered the majority of pregnant sex trafficking victims (67.6%) wanted an abortion and sought care in a clinic. Many women who are seeking an abortion or prenatal care come to the MRC to receive a free pregnancy test, STI testing, and ultrasound. These results are then taken to a women's health or abortion clinic and can reduce the cost of a medical appointment. The low cost can be appealing to vulnerable populations, especially human trafficking victims.

Purpose

The purpose of this project was to initiate a sustainable human trafficking screening and intervention protocol at the MRC. Through staff education and standardized screening, the project was designed to identify human trafficking victims and provide human trafficking specific resources.

Goals and Objectives

This quality improvement project centered on five goals. These goals and objectives provided direction and ensured appropriate implementation. The goals focused on client safety, stakeholders' adherence, education, and sustainability (Table 2).

The first goal stated that the human trafficking screening questions would be incorporated into the routine clinic processes. The objectives concern client and staff adherence to the incorporation of human trafficking screening questions. The first goal is for 100% of clients to receive the screening questions, and 98% of all clients to respond to all five questions.

Human trafficking questions were created and incorporated into the confidential client assessment questionnaire. The anticipated result was that all clients would answer the five human trafficking questions. This adherence would allow for standardized screening. If the client answered positively to any of the screening questions related to human trafficking, then the staff would be prompted to conduct further client evaluation and follow the protocol steps.

The second goal was for 100% of staff and 50% of volunteers to attend a human trafficking education session conducted by the project leader. The education included human trafficking information, the impact trafficking has on the MRC, and the successful implementation of the new human trafficking protocol**.** Through human trafficking education, the project leader planned to increase human trafficking knowledge, provide the participants with

the tools necessary to implement the protocol, and to foster staff and volunteer confidence. Since the staff are consistently present and volunteers' schedules fluctuate, the goal of educating all staff was a necessity for promoting project sustainability. In contrast, the goal to obtain at least 50% of volunteers was established to facilitate a pool of volunteers who were able to assist staff in implementation. Every session, participants responded to a post-education evaluation and submitted it to the project leader.

The third goal was the development of a flowchart to clearly delineate the human trafficking victim screening and referral process. A flowchart was created, discussed in all educational sessions, and placed in available locations throughout the MRC. The locations were determined based on their accessibility to staff and volunteers and included the front desk, workstations, offices of leadership, and the human trafficking education binder. The flowchart included human trafficking indicators and risk factors which are applicable to the MRC client population and referral steps.

The fourth goal addressed the accessibility of human trafficking resources and centered on two avenues for resource distribution. The first method was for the project leader to compile a resource packet to be available to all MRC staff and volunteers to review with clients who answered any screening questions with a positive answer. The second method of resource distribution was through a confidential tear-off flyer. The tear-off flyer included the National Human Trafficking Hotline information and was to be placed in the women's restrooms and changing rooms. The clients would be able to confidentially take the National Human Trafficking Hotline information. Whether confidentially or through discussion, the intention was that the receipt of human trafficking resources would empower victims to seek assistance and leave a dire situation.

Table 2

Project Goals, Objectives, & Aims

Goals	Objectives	Aims
Human trafficking screening is incorporated into the routine clinic processes by adding human trafficking screening questions agreed upon by content experts into the confidential client assessment questionnaire which is provided to 100% of clients and answered by 98% of clients.	Human trafficking questions are adapted for the MRC population and agreed upon by an expert panel. Adapted human trafficking questions are incorporated into the confidential client assessment questionnaire which is provided to 100% of clients. Clients are encouraged to answer the full questionnaire including the human trafficking questions.	Human trafficking questions are approved by a panel of experts. Human trafficking questions are incorporated into the confidential client assessment. 98% of clients answer all five human trafficking specific questions.
Education designed and led by the project leader for staff and volunteers incorporates critical elements required for each role prior to project implementation for 100% of staff and 50% of healthcare volunteers.	Project leader designs and presents five educational sessions incorporating indicators of human trafficking, relevance to the center, roles in the screening process implementation, and process for referrals based on literature. All participants fill out education evaluation after session and give to project leader.	100% of staff and at least 50% of volunteers will attend an education session. 100% of educational session participants will indicate that they have learned about human trafficking screening and their role.
A flowchart of the new human trafficking screening process is created and placed in accessible locations for the MRC staff and volunteers.	Flowchart created by project leader and approved by MRC leadership and clinical mentor.	Approved flowchart designed by the project leader will remain available and accessible to all staff and volunteers.
Human trafficking resources are compiled and accessible to all MRC staff, volunteers, and clients. Human trafficking resources will be offered to all clients who screen positive for human trafficking.	Resource packets are developed and distributed in counseling rooms, resources areas, nurse manager's office, and ultrasound rooms. Tear-off flyers providing emergency contact information for trafficked victims are placed in women's changing areas in the sonogram rooms and in the bathroom where the pregnancy test is performed.	100% of clients who answer positively to questions will be offered resource information. Weekly, the project leader will assess the flyers' presence and determine whether any tear-offs are missing.

	MRC workers who have clients with positive screenings document in electronic chart regarding all human trafficking resources provided.	All clients who screen positive will receive a human trafficking resource.
	Clients seeking abortion options are provided with the abortion booklet which contains the National Human Trafficking Hotline number.	All clients considering abortion receive National Human Trafficking Hotline contact information.
The human trafficking screening protocol is sustained by the nurse manager after implementation period.	Nurse manager will verbally confirm confidence in her ability to conduct human trafficking training.	Nurse manager will participate in training of new orientee alongside project leader.
	Training binder of materials to educate new staff and volunteers are kept in nurse manager's office and center director's office.	Binder containing human trafficking training for new staff and volunteers is held in nurse manager's office.
	Human trafficking education is added to the orientation checklist for all new employees and volunteers.	Human trafficking education incorporated into the orientation checklist for all new employees and volunteers.

The last goal addresses project sustainability. The human trafficking screening process must be sustained beyond the project manager's involvement in order to diligently serve the community. The human trafficking education was designed to be mandatory for all new volunteers and employees. The education documentation was to be incorporated into the MRC orientation checklist. After being provided with materials and an opportunity to observe the education, the nurse manager would be able to conduct the defined human trafficking education for each new employee and volunteer. A binder containing all education material, process steps, and post-tests was created by the project manager and designed to be stored in the nurse manager's office for future use. The nurse manager would use this binder for future employees and volunteers.

Summary and Strength of Evidence

The project objectives were based on evidence-based recommendations tailored to the MRC setting. These recommendations primarily came from researchers who retroactively collected data from past victims and healthcare professionals. The results gathered from these studies inspired human trafficking-specific healthcare recommendations, education, and interventions. In the last decade, multiple health care organizations declared or updated their human trafficking position statements. The World Health Organization ([WHO], 2012), the U.S. Department of Health and Human Services ([USDHHS], 2018), the American College of Obstetricians and Gynecologists (Gillispie, Russo, & Shah Arora, 2019), and the Association of Women's Health, Obstetric, and Neonatal Nurses ([AWHONN], 2016) supports diligent client assessments, recognition of warning signs, education of health care staff, and the provision of resources. This evidence and national recommendations provided the foundation for the human trafficking protocol project at the MRC.

Negative Health Outcomes

Female sex trafficking victims experience negative reproductive health outcomes. Of the 70 studies systematically analyzed by Cannon et al. (2016), each study confirmed that human trafficking drastically impacts a victim's health. A study of 106 former sex trafficking female victims revealed that after being trafficked, most of the women experienced STIs (67.3%), gynecological problems other than STIs (63.8%), physical health problems (99.1%), psychological problems (98.1%), and post-traumatic stress disorder (41.5%) (Lederer & Wetzel, 2014). According to Tracy & Macias-Kostantopoulos (2017) victims of sex trafficking often experience an STI infection as well as an unplanned pregnancy. Bick et al. (2017) explored the stories of 98 adult, female trafficked victims who sought maternity care while in captivity. Of the

98 women, 28 (28.6%) became pregnant during captivity at least once, 9 (9.2%) women contracted an STI, 25 (25.5%) had a mental health disorder after captivity, 12 (42.8%) had at least one abortion, and 28 (28.6%) were physically or sexually abused before being trafficked (Bick et al., 2017). Of those who were pregnant, sex workers and forced brides 12 (34.5%) reported the greatest number of pregnancies per person in the study (Bick et al., 2017). Furthermore, the pregnant women were significantly more likely to have experienced sexual violence than the non-pregnant women. Lederer and Wetzel (2014) also revealed 71.2% of victims reported at least one pregnancy during captivity, while 21.2% reported at least five pregnancies. The results revealed chlamydia (39.4%), gonorrhea (26.9%) and hepatitis C (15.4%) were the most popular STIs reported (Lederer & Wetzel, 2014).

Aspects of health, beyond reproductive health, are also affected by the victimization of human trafficking. Ottisova et al. (2016) completed a systematic review of 37 articles identifying major health issues female victims of sex trafficking experience. In addition to the sexual infections and violence, chronic somatic pain is a common physical problem after human trafficking experiences. This chronic pain includes headaches, back pain, and stomach pain (Ottisova et al., 2016). Lederer and Wetzel (2014) described issues beyond reproductive health consequences including damage to other organ systems, substance abuse, and mental health issues. Of 106 former victims interviewed by Lederer and Wetzel (2014), 104 (98.1%) victims reported having a mental health problem while being trafficked and 83 (96.4%) reported still having a mental health problem after trafficking. Neurological problems, such as sleep disturbances, headaches, memory loss, and poor concentration, were reported by 97 (91.5%) of the women. Lederer and Wetzel also found nutritional problems were an issue for 75 (71.4%) former victims who reported severe weight loss, malnutrition, loss of appetite, and/or an eating

disorder. Furthermore, of the 102 who answered the relevant questions, 86 (84.3%) reported substance abuse. Finally, 105 out of 106 trafficking survivors (99.1%) reported at least one other physical health problem in dental, gastrointestinal, cardiovascular, and respiratory systems, injuries, or general health areas (Lederer & Wetzel, 2014). Human trafficking victimization negatively affects the health of victims and risks damaging the health of others as sexual contact spreads diseases like HIV (Cannon et al., 2016). Due to the plethora of negative health outcomes, healthcare professionals should view human trafficking as a public health issue. This viewpoint focuses on disease prevention, early education and identification, and policy changes (Le et al., 2017). If human trafficking must be viewed as a public health issue, then healthcare professionals need to emerge as public health leaders and be present for these vulnerable victims.

Interaction with Healthcare Professionals

Facilities that provide maternal services offer a valuable point of contact for victim identification (Bick et al., 2017; Lederer & Wetzel, 2014). In one mixed-methods study by Lederer and Wetzel (2014), 86 (87.8%) of the 98 former female sex trafficking victims had contact with a healthcare provider during captivity. Almost half of the 98 human trafficking victims (49.0%, $n = 48$) sought women's services, especially Planned Parenthood (29.6%, $n = 29$). All healthcare professionals need to be mindful of human trafficking victims so these vulnerable patients can be identified by any staff member.

Risk Factors for Human Trafficking

Human trafficking risk factors are elements that might lead someone to become a victim of human trafficking. These include poverty, illegal immigration, runaways, foster care, homelessness, LGBTQ populations, addiction, childhood trauma and abuse, and political upheaval (Dank et al., 2017; Schwarz et al., 2016). Although these elements are not specific

indicators of human trafficking, they do contribute to physical, mental, and financial vulnerability. This vulnerability can negatively impact health and put someone at risk for being trafficked or at risk for returning to human trafficking (Collins & Skarparis, 2020; Schwarz et al., 2016).

Health care professionals should strive for human trafficking prevention and treatment. Human trafficking prevention begins by looking at root causes (Le et al., 2017). Human trafficking tends to occur when a compilation of risk factors and environmental influences makes a vulnerable person exploitable. These risk factors for human trafficking should be noted by healthcare professionals so human trafficking prevention and education can begin immediately (Le et al., 2017).

Indicators of Human Trafficking

Indicators, or red flags, often include frequent physical injuries and infections, clients being accompanied by an overbearing person, clients who are unsure of their location and are lacking documents, those with severe depression and suicidal ideation, as well as substance abuse (Bick et al., 2017; Lederer & Wetzel, 2014; Schwarz et al., 2016). Additional signs include jaw or neck problems, debris or cotton in the vagina or rectum, or pseudo-seizures (AWHONN, 2016; Egyud et al., 2017). Children who do not live with relatives, have access to large amounts of money and resources, have inconsistent stories, or who are not currently attending school are also indicators of human trafficking (Hemmings et al., 2016). Furthermore, some human trafficking victims are amateurly tattooed (AWHONN, 2016; Farly et al., 2019). The tattooed victims may be branded to show they are owned by the trafficker. These tattoos usually have images such as dollar signs, crowns, or a prominently placed name or initials of someone (Farly et al., 2019). Suspicious signs of human trafficking include inadequate working or living

conditions, poor mental health and abnormal behavior, poor physical health, lack of autonomy, inconsistent stories, and confusion regarding time and location (National Human Trafficking Hotline, n.d.).

Bick et al. (2017) asked nine maternal healthcare workers to identify trafficking warning signs they noticed in their clinical experiences. The clinicians revealed that receiving late maternity care, inability to read or speak English, and limited knowledge about the area surrounding their home were associated with trafficking. Several victims interviewed also confirmed they used a false address in order to register for maternity care. Another sign was the refusal of case worker assistance or translation services. If the victim was accompanied with another person, he or she may be referred to as "aunty" or "uncle" (Bick et al., 2017). Finally, one of the greatest barriers to receiving proper specialty care (such as psychiatric or obstetrics) was the inability to see a primary care provider. For this reason, many victims started receiving prenatal care late in pregnancy (Bick et al., 2017).

In addition to signs of forced sex and being kicked, punched, or beaten, other red flags for sex trafficking include multiple abortions and repetitive treatment for STIs (Lederer & Wetzel, 2014). One victim reported no medical follow up after multiple abortions. Her lack of post-procedural care resulted in sepsis and having a radical hysterectomy. Another victim reported 17 abortions, some of which were forced upon her (Lederer & Wetzel, 2014).

Overlap of Signs of Domestic Abuse and Human Trafficking

Domestic abuse signs and human trafficking red flags can overlap. Due to similarities, DHHS (2018) incorporated several domestic abuse screening questionnaires into the human trafficking toolkit. The first similarity is the manipulative control the traffickers and domestic abusers use in order to coerce their victims; techniques that often lead the victims to view their

abusers as intimate partners (Walsh, 2016). Stockholm syndrome, which is a psychological phenomenon that makes the victims grateful to their abusers, is common in many abused, trafficked, or prostituted women (Walsh, 2016). Victims of both crimes fail to recognize their position and do not see themselves as helpless victims, but rather the victims view themselves as willing participants or blame themselves for their position (Walsh, 2016). Finally, despite their lack of empowerment, their experience with psychological and physical abuse, and their lack of rights and informed consent, victims are often blamed for staying with their abuser (Walsh, 2016). Since sexual assault nurse examiners (SANEs) are trained to recognize signs of domestic violence and human trafficking, these nurses serve as valuable assets to the healthcare team treating these vulnerable patients (Schwarz et al., 2016)

Screening

One of the greatest challenges with human trafficking is the lack of victim identification (AWHONN, 2016). According to Lederer and Wetzel (2014), of the 81 female human trafficking victims interviewed 51.9% (42) stated they believed their doctor knew they were “on the street”, but only 58 (43.1%) said their doctor asked them about their situation. Healthcare professionals should ask appropriate questions and screen patients for human trafficking (Berishaj, Buch, & Glembocki, 2019). Validated, brief standardized tools, and process flowcharts can assist healthcare professionals with the screening process (AWHONN, 2016).

Although there are numerous human trafficking tools, only a few tools are validated and their validation is not specific to the women’s health environment. DHHS (2018) compiled a holistic toolkit to assist with implementing a human trafficking screening tool. These steps include education, creation of a referral network, and appropriately administering a screening tool with cultural, ethical, and safety issues in mind (DHHS, 2018). DHHS (2018) heavily

stresses the importance of establishing rapport with the client before screening for trafficking. The DHHS (2018) toolkit includes 20 human trafficking tools while addressing their limitations. Most of the tools in the kit targeted a specific setting or specific population and are not currently validated. Secondly, the average length of the tools was 40 questions, which is too long for the healthcare environment and can cause further traumatization of the victim (DHHS, 2018). The DHHS (2018) screening tool, which is not currently validated, is for adult victims and aims to address the three aspects of human trafficking which include transportation, force, and exploitation.

One of the largest barriers to appropriate screening tool use was a lack of training and preparedness (DHHS, 2018). The DHHS (2018) recommends training on how to use a human trafficking screening tool and to establish a plan once someone screens positive for human trafficking. Flowcharts can assist by clearly delineating a screening and referral process. The Medical Assessment flowchart developed by Polaris (2010a) and DHHS (2018) begins with the recognition of signs and red flags. Both stress the importance of confidentially speaking with the patient, assessing safety and security, and providing the victim with resources. Hemmings et al. (2016) systematically reviewed 37 databases for human trafficking literature and developed recommendations. Five studies reviewed by Hemmings et al. (2016) revealed that victims had sought health services but were constantly in the presence of their traffickers. This lack of privacy meant the victim might not have the opportunity to be honest with the healthcare professional. In the same study, 10 of the articles stressed the importance of screening suspected victims privately, regardless of what the accompanying party says (Hemmings et al., 2016). This relationship dynamic of separating a suspected abuser/trafficker from the victim can create trepidation in healthcare staff and can best be addressed through education and clearly defined

processes (Berisah et al., 2016). However, healthcare professionals need to be prepared for emergency intervention and be familiar with referral information (WHO, 2012). Referrals include local resources such as free health services, housing, social services, legal aid, immigration services, local churches, English classes, and other community support organizations (AWHONN, 2016). Healthcare workers who refer to community resources are engaging multiple local stakeholders and emphasizing the fact that human trafficking is a public health issue (Le et al., 2017). By increasing the community's involvement and the number of stakeholders, the healthcare leader promotes human trafficking prevention and awareness (Le et al., 2017).

Stakeholders can be community leaders but should also include healthcare leaders. Schwarz et al. (2016) collaborated with a SANE team, ED providers, public health graduate students, and medical-legal professionals and developed an intervention tool, flowchart, and human trafficking screening process. This interprofessional teamwork led to the development of a flowchart specific to the facility and community which was based on the Polaris Medical Assessment Tool (Polaris, 2010a; Schwarz et al., 2016). Since many victims of human trafficking may not speak the local language, Schwarz et al. (2016) recommends having a medical interpreter who also understands the cultural and psychological viewpoint of the victim (Hemming et al., 2016; Walsh, 2016). Hemming et al. (2016) reviewed 16 articles which supported the use of medical interpreters who were culturally sensitive in order to build trust and disclose the traumatic experiences and cautioned against a family member or friend interpreting. AWHONN (2016) asserts that the use of interpreters for human trafficking victims unable to speak the language of the healthcare team is imperative.

DHHS (2018) recommends the creation of a referral network for those treating human trafficking victims. Ultimately, healthcare professionals should collaborate with administrators and local community stakeholders in order to successfully implement anti-trafficking protocols and screening, regardless of the medical setting (Schwarz et al., 2016). Due to the social, physical, and mental effects human trafficking has on victims, trafficking protocols should include access to resources to meet victims' immediate needs such as shelter and safety, as well as long-term needs including psychological therapy and support (Berishaj et al., 2019).

Education

Education can empower healthcare workers and assist in effective implementation of human trafficking protocols (Berishaj et al., 2019). The literature supports clinician education and increased trafficking awareness, however there is a lack of trafficking education among health care professionals (Cannon et al., 2016). In their review of 70 human trafficking studies, Cannon et al. (2016) found few studies that addressed prevention of and intervention for human trafficking. Titchen et al. (2017) surveyed physicians and medical students which revealed the majority of participants thought trafficking training was relevant, but admittedly lacked basic knowledge and had received no training regarding human trafficking (Titchen et al., 2017). Among nurse practitioner students in a study of 73 nurse practitioner students, there was no history of human trafficking education for 94.5% (n = 69) of the participants (Lutz, 2018). When the Bick et al. (2017) researchers interviewed nine maternity care clinicians, the results indicated that none had received human trafficking-specific education.

Healthcare professionals who receive human trafficking screening education can greatly impact patient care and community health. Human trafficking training needs to include identification of victims, recognition of victim needs, and knowledge of available resources,

followed by an evaluation of the training (Berishaj et al., 2019; Bick et al., 2017; DHHS, 2018; Macias-Konstantopoulos, 2016). The literature consistently supports the role of the nurse as one of the few people who interact with trafficked women and children (AWHONN, 2016). Berishaj et al. (2019) developed a nursing education program that included the human trafficking indicators (red flags), screening tool use, and available resources for long-term health, safety, and legal needs. There was an evaluation to determine if the educational intervention impacted the nurses' perspectives on human trafficking, confidence, and knowledge. After the education, the surveys revealed an increase in nurse confidence (from 4.8% to 53.8%) in identifying victims. Schwarz et al. (2016) provided education to Emergency Department (ED) staff regarding human trafficking red flags and how to interview victims. The ED was also given copies of the red flags and instructed to call the SANE team if they had a suspected victim. In both studies, nurses reported feeling significantly more confident regarding identification, recognition of indicators, available resources, and strategies. Although this study addresses nurse education, the study supports the same intervention for other healthcare professionals and professionals who are responsible for human trafficking victim screening (Berishaj et al., 2019).

Human trafficking education can also help healthcare professionals avoid harmful, judgmental reactions during patient interviews. The response of the healthcare professional to the trafficker and the victim is an essential part of the patient interview. An interview approach that empowers victims, promotes safety, and avoids pressuring victims to discuss past details is called trauma-informed care (Hemmings et al., 2016; Pascual-Leone et al., 2016). Objective and supportive comments help establish rapport between the patient and nurse while maintaining professional boundaries and safety (AWHONN, 2016). Young, female victims often feel love for their trafficker (Walsh, 2016). This unhealthy, emotional connection can be a barrier to open,

honest conversation if the provider criticizes their trafficker (Walsh, 2016). Several trafficking survivors interviewed by Bick et al. (2017), stated that providers would often chastise victims for not receiving earlier prenatal care, rather than asking the reasoning for the delay. Victims felt discouraged to open up to their provider after being chastised. Bick et al. (2017) also interviewed nine health care providers in the maternity setting who treated human trafficking victims previously. Through their experience, these healthcare providers recognized that human trafficking victims usually sought out late prenatal care due to physical, financial, and emotional barriers. These providers took a proactive approach to these patients rather than a reproachful one. Human trafficking victims should receive trauma-informed care (Hemmings et al., 2016). Education for healthcare professionals addressing trauma-informed care should encourage healthcare professionals to shift their perspective from judgement and disdain to sympathy and deeper understanding.

Legal aspects of human trafficking are essential to include in education. AWHONN (2016) states that education should include the topics of anonymity, confidentiality, and informed consent with regards to human trafficking. An adult victim who refuses assistance cannot be forced to receive help. Authorities can only be informed in Texas if the victim offers consent or if the victim is a minor (Hemmings et al., 2016; Texas Law Help, 2020a, 2020b). Instead, the victim can be informed of the resources available whenever she decides to leave her situation. Confidentiality is a large factor in honest communication between a health care professional and a victim. Victims reported a lack of sensitivity and confidentiality once they explained their situation to a healthcare professional. Healthcare workers should avoid asking sensitive questions in front of other staff and patients so the victim can feel valued and safe (Collins & Skarparis, 2020). By receiving thorough trafficking education, healthcare

professionals can better consider legal and ethical guidelines when intervening with patients (Berishaj et al., 2019).

Resources and Referrals

Bick and colleagues (2017) support clear referral options to ensure quality maternity care that promotes confidentiality and safety. Referrals to appropriate legal agencies, safe houses, material assistance, immigration services, and the National Human Trafficking Hotline is essential so victims can be safely rescued from their situation (DHHS, 2018; Polaris, 2016). Hemmings et al. (2016) conducted a systematic review addressing human trafficking and reported the importance of comprehensive assessments of victims. A comprehensive assessment will help the healthcare professional assess the patient's physical, mental, security, and safety needs and help direct the healthcare professional toward specific resources. Since victims of human trafficking tend to experience long-term complications, a thorough needs assessment is vital (Hemmings et al., 2016). There are a larger number of child victim resources than there are for adults. Despite this challenge, health care professionals should clearly delineate referral pathways (Hemmings et al., 2016). Ideally, all human trafficking resources would share one location (Hemmings et al., 2016). Finally, delay in resource attainment could risk danger to the victim by her trafficker and therefore swift referral is imperative (Berishaj et al., 2019).

Methods

Project interventions included the selection and creation of screening questions; design and provision of education for staff and volunteers; revision of a flowchart delineating clinic processes (Appendix B) with the incorporation of human trafficking screening and resources (Appendix C); and the identification of resources and development of a human trafficking resource list to share with clients who screen positive for human trafficking. The final

intervention was to implement processes to assure that the project is sustained without the presence of the project leader.

Screening Questions

Screening questions were incorporated into the confidential client questionnaires and included a redesign of the form to allow efficient and effective flow. The project leader led the redesign of the form and the selection of the five screening questions and their preamble. The questions were inspired by the Polaris Medical Assessment Tool (2010a) and the USDHHS Adult Human Trafficking Toolkit (2018). The questions were shortened and simplified in order to lower them to a 5.8 reading level without changing the intent. The questions were reviewed by a panel of content experts and a past human trafficking survivor to verify appropriate wording and readability. MRC leadership approved of the addition of the questions to the MRC's confidential questionnaire with the leading preamble. A new questionnaire format was edited by the project manager to allow for additional space for the screening questions. For example, the original format included a question inquiring about the client's doctor and the following question asked about an obstetrician. These two questions were consolidated into one question asking about the client's healthcare provider. The new format was approved by MRC leadership and printed for distribution.

The clients answered the questionnaire alone in the appointment room. Clients provided written responses to the questions while the MRC worker prepared the bathroom and pregnancy test. Each question addresses an aspect of human trafficking (Figure 1). A response of "yes" or a "?" were considered positive responses for human trafficking and prompted further evaluation by the MRC staff.

Figure 1

Human Trafficking Screening Questions

Sometimes a person is put in a difficult situation:	
Have you ever been told to lie about the work you do?	Yes ? No
Do you have the freedom to go wherever you like and spend time with loved ones?	Yes ? No
Have you ever been forced to have sex or work for free to pay off a debt?	Yes ? No
Has anyone ever threatened to harm you or a loved one if you did not do as they wanted?	Yes ? No
Has anyone ever taken your personal identification documents and refused to return them?	Yes ? No

*Note***.** Screening questions were incorporated into the confidential questionnaires.

Education

The project leader designed and hosted educational sessions at the MRC for all staff and eligible volunteers. The sessions included three main sections. The first section centered on awareness. Key points in this section included the definition of human trafficking, national and local statistics, the lack of victim identification in healthcare, the deficiencies in human trafficking literature, and victim demographics and experiences. The second section addressed how human trafficking is relevant to the MRC. This component compared known victim demographics and experiences to the client demographics and services offered at the MRC. The comparison showed significant similarities and encouraged the implementation of a human trafficking screening protocol. The last section of the educational training addressed the steps of the new protocol. The project leader went through the process in sequential order following the flowchart steps. The resource packets, flowcharts, and binder were provided to the participants. At the end of each session, there was an opportunity for questions and discussion. After the presentation, participants completed education evaluations. For eligible volunteers and staff who

could not physically attend an in-person presentation, a virtual Zoom meeting was hosted by the project leader. Training evaluations were filled out verbally by zoom participants and recorded by the project leader.

The project leader recruited staff and volunteers for educational training. Flyers regarding educational trainings were placed in prominent MRC locations. Incentives for attendance included an interactive session and food. Sign-up sheets were placed at the front desk. Staff quickly signed up for their preferred session time. Volunteers required more recruitment efforts.

Any volunteer who successfully completes an orientation is permanently placed on the MRC volunteer list. This created an overly robust volunteer list of 93 volunteers. However, not all of the listed volunteers were currently active. Inclusion criteria for the education sessions established that invitations to participate should be extended to appropriate volunteers. Inclusion criteria included volunteers who lived in the surrounding areas and had either volunteered in the last two months or were scheduled to volunteer in the next two months. The project leader referenced the MRC's posted schedule and discussed volunteer involvement with leadership to assure that all volunteers eligible for education were included. Volunteers who were interested in attending, but failed to meet the inclusion criteria, were not prevented from participating in the education.

Flowchart

A flowchart was developed to delineate safe decision processes applicable to the maternal health setting (Appendix B). The flowchart format was inspired by the Polaris Medical Assessment Tool (2010a). Human trafficking indicators incorporated into the flowchart came from established lists and literature (National Human Trafficking Hotline, n.d.; Polaris, 2010a, 2010b). Signs were not included if they addressed men, primarily addressed labor trafficking, or

they did not apply to the client demographics. Indicators listed were only those pertinent to the MRC setting.

Resources and Referrals

A resource and referral packet including local and national resources was created by the project leader. The packet was printed, laminated, and distributed at the MRC. The resource packet's accessibility was key so that staff and volunteers could easily reference resources. Although the MRC had a thorough list of resources and referrals, they were not specific to the needs of human trafficking victims. In order to create the human trafficking resource packet (Appendix C), the project leader called local and national agencies and verified contact information. Each resource listed includes the contact information, services offered, requirements for receiving services, and relevant miscellaneous information.

There were two alternative methods to ensure a client received human trafficking resources. The first is for the MRC worker to verbally discuss available resources and draw attention to the National Human Trafficking Hotline number that is discretely listed in the abortion booklet. The second method included a tear-off flyer that provided the National Human Trafficking Hotline's contact information. The flyer was placed in all changing rooms and women's restrooms accessible only to clients. The women's restroom located near the common area accessible to both clients and accompanying individuals, which may include traffickers, was excluded. This strategic placement ensured that only clients would be seeing the flyers and be able to remove a slip of the flyer containing the Hotline information.

Ethical Considerations

Victims of human trafficking victims and women who are pregnant are both vulnerable populations. The project implementation required sensitivity and diligence. Confidentiality is a

major fear and concern for victims of human trafficking. All documents containing information on human trafficking screening results or referrals are part of the client record and accessible only by staff and approved volunteers. Volunteers are only approved after passing through a rigorous application process. All staff and volunteers abide by Health Insurance Portability and Accountability Act (HIPAA) laws. In addition, staff and volunteers receive training in the educational sessions regarding client rights, legal factors, and safety concerns. The DNP project was submitted to the University of the Incarnate Word IRB and was determined to not be research and did not require full institutional review board review.

Hemmings et al. (2016) strongly enforces the importance of victim autonomy. If the client is an adult, she has the right to refuse assistance and rescue support. The project leader advocated for the safe distribution of resources. In Texas, authorities can be notified of a human trafficking case if the adult client consents, however minor victims must be reported by professionals within 48 hours regardless of the child's consent (Texas Law Help, 2020a, 2020b). Many victims, especially individuals in the country without proper documentation, may be fearful of involving authorities. A victim who is an undocumented immigrant may avoid prosecution under the Trafficking Victims Protection Act. The act adopted as a federal law in 2000, protects undocumented victims of human trafficking. The latest edition of the act, adopted in 2015, added more protective policies regarding minor victims (Busch-Armendariz at al., 2016).

Barriers and Facilitators to Implementation

There were several facilitators and barriers for project implementation. In Bick et al. (2017), former female victims of human trafficking who sought out maternity care while still being trafficking identified specific barriers to receiving care. These included cost, shame, lack

of documentation of identity, distrust of confidentiality, or their fear of punishment by the trafficker for revealing the crime (Bick et al., 2017). The MRC does not require official documentation of identity and does not require payment. The MRC strives to create a welcoming environment and accepts clients without regard to religion, race, ethnicity, age, and income.

Although the MRC welcomes all people, the MRC personnel may refuse to provide services for individuals if they need medical attention or there is a communication barrier. The center is not a replacement for prenatal care. Clients who are currently bleeding or have other major health concerns are given the information to go to a nearby hospital. One of the potential indicators of human trafficking is an individual that does not speak English (Polaris, 2017). Clients who speak Spanish are common in the San Antonio community and the language they speak may not be the strongest warning sign of human trafficking. However, the MRC is often unable to see non-English speaking clients due to the lack of medical translation services. Clients who do not speak English will not be seen for an ultrasound, but sometimes will be seen for a pregnancy test appointment if family members can translate. Clients who are Spanish-speaking are typically seen on days when a volunteer who is Spanish-speaking is available. Due to this, a language barrier was not listed in the *Human Trafficking Screening* flowchart as a possible indicator of human trafficking. Although the MRC leaders are investigating purchasing a translation service for ultrasound appointments, this has yet to be implemented and there are no current plans in place. Despite this process, the use of interpretation services for translation is recommended for human trafficking clients (Hemmings et al., 2016). This communication issue may prevent the identification of some human trafficking victims.

In the initial implementation period, the project manager executed additional methods in response to the barrier of lack of documentation. Human trafficking tabs were created in the

electronic chart which allowed the project manager and MRC leadership to track human trafficking resource allocation as well as the presence of positive screenings. Reminder posters were created and placed at all workstations, and individual counseling with staff members was executed by the project manager. The staff eagerness made this a transient barrier. These early interventions accompanied with the staff eagerness to change, made the lack of documentation a transient barrier to the methods.

Results

During the 10-week implementation period, the project leader maintained consistent dialogue with MRC staff, volunteers, and leadership, performed weekly chart reviews, collected data, and analyzed results. The human trafficking screening and data collection implementation period began on February 10, 2020 and ended on April 20, 2020.

Goal 1: Human Trafficking Screening Questions

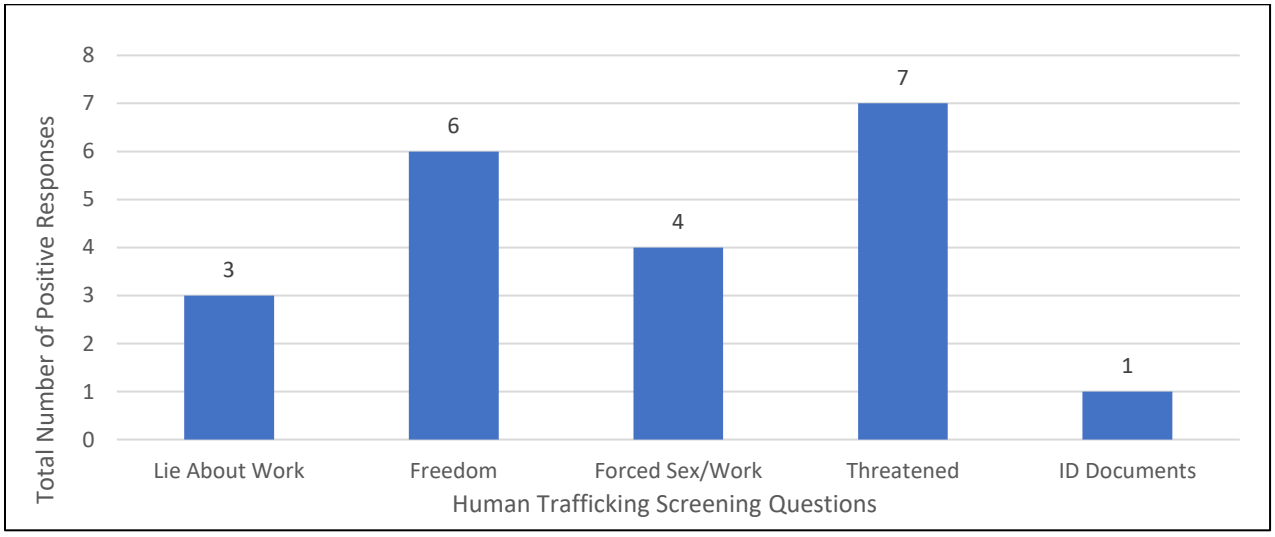
During the implementation period all clients (N = 309, 100%) received the new version of the confidential questionnaire and 98.4% (n = 304) completed all five screening questions. Of the responsive clients, 18 (5.9%) clients screened positive. However, upon further evaluation by MRC staff, only 14 (4.6%) clients were considered to have positive screenings. The four excluded responses were based on the clients' interpretations of the questions. One client stated she replied "yes" to the fifth question because someone stole her wallet once, and therefore withheld her personal documents. Another client replied positively to the first question because she worked in government intelligence and was asked to lie about the work she did. The other two responses came from teenagers who stated they did not have freedom because they did not have personal transportation and had to live under the rules of their parents. All four

interpretations were not incorrect but were deemed by the project leader as irrelevant to human trafficking screening.

There was a total of five questions for the human trafficking screening questionnaire (Figure 1). The analysis of the 14 client responses revealed that clients responded positively to some questions more than others. The fourth question received the most positive responses. The fourth question asked about the receipt of threats. Half of the clients with positive responses answered positively to the fourth question. In contrast, the fifth question ranked last with only one positive response. The fifth question addressed personal identity documentation. The second question received the second most responses, followed by the third question. The second question asked the client about personal freedom. The third question asked about forced sex and work. The first question ranked fourth in number of positive responses and addressed lying about work (Figure 2).

Figure 2

Human Trafficking Question Positive Responses



Note. Responses collected from February 10, 2020 to April 20, 2020.

The 14 clients with positive answers to screening questions were then categorized as either a victim of human trafficking, a person displaying human trafficking risk factors, or a client who experienced an abusive relationship. Of the 14 clients, five (35.7%) were confirmed as victims of human trafficking. These clients' past or current experiences met the definition of human trafficking based on verbal statements. There were three (21.4%) of the clients who divulged an abusive relationship with their current or past partner in which the relationship experience resulted in positive responses to one or more of the screening questions.

The at-risk category was based on accompanying risk factors, indicators, and positive questionnaire responses; however, clients were placed in this category if they exhibited these characteristics, while also denying any abuse or human trafficking experiences. Six (42.9%) of the clients fell into this category based on MRC staff assessments and documentation. The risk factors exhibited by these clients included the inability to speak English, drug abuse, homelessness, nightlife entertainment occupation, forced abortion, incorrect contact information, suspicious actions by their accompanying guest, conflicting stories, and noncompliance with appointments. Most of these clients (66.7%, $n = 4$) answered positively for the second question regarding personal freedom. One of the clients answered positively to the fourth question because she worked as a nightclub dancer for her occupation. Another client had a boyfriend who wore a hood and sunglasses and refused to speak during the visit. She mentioned that her boyfriend had multiple children from other women. This client screened positively because she answered yes to the first question which addressed lying about work. When probed by the advocate, she quickly denied her written response and changed her answer. The suspicious behavior of the boyfriend accompanied with the client's changing of her answer kept her on the positive screening list.

Table 3

Characteristics of Clients With Positive Responses to Human Trafficking Screening Questions

Demographic Characteristics	Abusive relationship		Trafficking risk factors		Human trafficking victim	
	n	%	n	%	n	%
Age (years)						
<15	0	0.0	0	0.0	0	0.0
15-19	1	33.3	2	33.3	0	0.0
20-24	2	66.7	0	0.0	4	80.0
25-29	0	0.0	2	33.3	0	0.0
30-34	0	0.0	1	16.7	1	20.0
35+	0	0.0	1	16.7	0	0.0
Annual income						
$0-14,000	1	33.3	5	83.3	5	100.0
$15-29,000	1	33.3	1	16.7	0	0.0
$30-44,000	1	33.3	0	0.0	0	0.0
Educational Attainment						
High school or less	1	33.3	3	50.0	2	40.0
Some college	0	0.0	2	33.3	1	20.0
College graduate	2	66.7	0	0.0	0	0.0
Unknown school	0	0.0	1	16.7	2	20.0
Ethnicity						
Caucasian	0	0.0	1	16.7	2	40.0
Hispanic	2	66.7	1	16.7	2	40.0
African American	0	0.0	2	33.3	0	0.0
Asian	0	0.0	2	33.3	0	0.0
Middle Eastern	0	0.0	0	0.0	1	20.0
Native American	1	33.3	0	0.0	0	0.0
Human trafficking resources						
Received packet	0	0.0	0	0.0	2	40.0
Received hotline information	3	100.0	6	100.0	5	100.0

Note. $N = 14$ responses (positive responses to human trafficking risk factors/screening questions from 4.6% of the 305 clients screened). Results based on client written responses and electronic chart documentation.

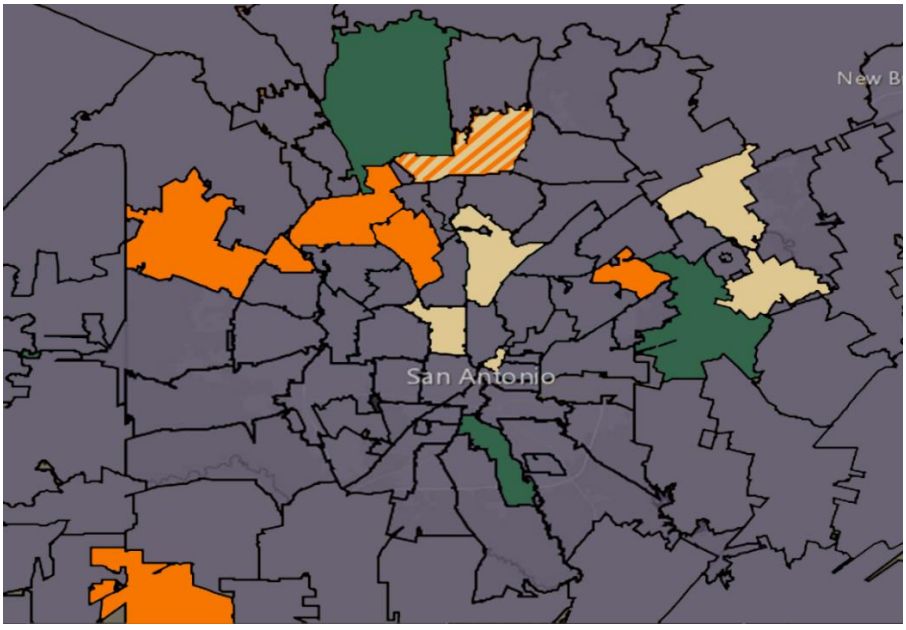
After the clients were grouped by human trafficking screening questions and life status, the client demographics were collected and analyzed (Table 3). The 14 MRC clients with positive responses to human trafficking screening questions were predominantly Hispanic (42.9%, $n = 6$), in the 20s age group (57.1%, $n = 8$), made less than $14,000 annually (78.6%, *n*

= 11), seeking STI testing (57.1%, *n* = 8), had experienced an unplanned pregnancy (85.7%, *n* = 12), and had a high school education or less (42.9%, *n* = 6).

The project leader collected zip codes of residences from clients with positive screenings. Out of the 14 responses, only two of the women shared the same zip code. There was no zip code that emerged as being a significant area for human trafficking. Client zip codes were subsequently mapped (Figure 3). Orange indicates clients with human trafficking risk factors (*n* = 6), yellow indicates victims of human trafficking (*n* = 5), and green indicates clients with an abusive relationship (*n* = 3). The orange and yellow striped zip code indicates two clients each with a different human trafficking status (one with risk factors, the other with confirmed victimization).

Figure 3

Zip Codes of Clients With Positive Human Trafficking Screenings



Note. *N* = 14 positive responses to human trafficking risk factors/screening questions from 4.6% of the 304 clients screened. Results based on client written responses.

Since the MRC serves pregnant women, maternal health data was collected from the 14 clients with positive screening responses. This included the result of their qualitative pregnancy test, whether they desired sexually transmitted infection (STI) testing, and their intention for the pregnancy (Table 4). The majority of the 14 clients were pregnant with 85.7% (n = 12) receiving a positive qualitative pregnancy result. Despite the high pregnancy rate, only 57.1% (n = 8) agreed to STI testing. Of the 12 eligible women, none of them had definitively decided to carry to term. Instead, 41.7% (n = 5) of the pregnant women sought an abortion and the remaining 58.3% (n = 7) were undecided in their pregnancy decision.

Table 4

Maternal Health Factors of Clients With Positive Responses to Screening Questions

Maternal Health Factors	Abusive relationship		Trafficking risk factors		Human trafficking victim	
	n	%	n	%	n	%
Pregnancy test result [a]						
Pregnant	3	100.0	6	100.0	3	60.0
Not pregnant	0	0.0	0	0.0	2	40.0
STI testing received [b]						
Yes	1	33.3	4	66.7	3	60.0
No	2	66.7	2	33.3	2	40.0
Pregnancy decision						
Abortion	0	0.0	3	50.0	2	40.0
Likely to carry	0	0.0	0	0.0	0	0.0
Undecided	3	100.0	3	50.0	1	20.0
Not applicable	0	0.0	0	0.0	2	40.0

Note. N = 14 responses (positive responses to human trafficking risk factors/screening questions from 4.6% of the 305 clients screened). Results based on client written responses.

1 Based on qualitative pregnancy test performed at Maternal Resource Center

b STI testing includes Chlamydia and Gonorrhea testing

Goal 2: Human Trafficking Education

The project leader recruited staff and volunteers for human trafficking educational sessions. Recruitment methods included flyers, sign-up sheets, phone calls, text messages, and

on-site recruitment. Ten staff and eight volunteers met the inclusion criteria for education sessions. There were five education sessions in total, including four at the MRC and one virtual presentation. A total of 15 out of the 18 eligible participants (83.3%) received the training. All staff attended the educational training (100%, n =10), which took place in the conference room over the course of two weeks. For the volunteers meeting the inclusion criteria, 62.5% (n = 5) received the training.

Each attendee responded to an education evaluation at the end of session. All participants (N = 15) responded "Yes" when asked whether they had learned something about human trafficking. Of the 15 participants, 66.7% (n = 10) stated they learned about the statistics of human trafficking, while 20% (n = 3) stated they learned how to talk to victims, and 13.3% (n = 2) listed resources as a topic they learned. Before the educational training, 60.0% (n = 9) of participants ranked their knowledge of human trafficking as "Very little" while 40.0% (n = 6) ranked themselves as "Moderately knowledgeable" about human trafficking. After the training, 93.3% (n = 14) participants stated they were confident in their ability to follow the human trafficking protocol. Only 6.7% (n = 1) said they were uncomfortable with the concept, but would try their best to follow the protocol. The staff and volunteers exhibited an eagerness to learn and participate in training. All participants came to the education sessions with basic human trafficking knowledge. The training sessions focused on how to apply human trafficking knowledge at the MRC.

Goal 3: Human Trafficking Screening Flowchart

The creation and implementation of the flowchart provided a visual representation of the protocol and serves as a guide for decision-making. The flowchart was created by the project leader and inserted into the human trafficking resource packets. The packets were then placed at

all the workstations and leadership offices. The flowchart remained present and accessible to all employees and volunteers throughout implementation period.

Goal 4: Human Trafficking Resources

Human trafficking resources needed to be available to MRC workers and clients. The compiled resource packet was placed at all MRC workstations and leadership offices. The resource packets were given to 14.3% (n = 2) of the positive clients. After discussions with their clients, the advocates deemed these women to be safely secure from their traffickers. All clients considering an abortion received a booklet containing the National Human Trafficking Hotline's contact information. Since all clients considered abortion as a potential pregnancy solution and received an abortion booklet, 100% (n = 14) were documented by the MRC workers as receiving a human trafficking resource.

Another method for resource distribution included the tear-off flyer. This was a confidential way to provide clients with the Hotline's information. In April, one person removed a tear-off slip from a flyer. The location of the flyer was the women's restroom specifically utilized for pregnancy tests. Due to the confidentiality, none of the MRC staff or project leader could identify the client who tore the information.

Goal 5: Human Trafficking Screening Sustainability

A human trafficking training binder was created by the project leader, provided to the nurse manager, and incorporated into the future worker orientations. The human trafficking training followed a similar format as the MRC's safety training, both of which the nurse manager conducts. The binder's printed pages included the educational sessions, project leader notes, post-tests, and copies of the resource packet, flowchart, tear-off flyer, new confidential questionnaires, letter of appreciation, and acknowledgement. The binder is meant to be read like

a narrative, following the pages in numerical order. The nurse manager will grade the post-test and review any questions or thoughts with the trainee. The nurse manager observed one new employee being trained and stated she felt confident in conducting the training for future MRC workers.

Another intervention to assist with project sustainability included electronic health record updates. The option titled "human trafficking resources" was added under client referrals. Furthermore, a "human trafficking" selection was added under topics discussed. By adding these options to electronic documentation, the MRC leadership can continue to create client reports and collect data on human trafficking victims seen at the MRC.

Evaluation

Evaluation of goals determines project implementation success. Table 5 delineates goal attainment. Each goal was met during the 10-week implementation period.

Table 5

Project Goal Evaluation

Goals	Evaluation
Human trafficking screening is incorporated into the routine clinic processes by adding human trafficking screening questions agreed upon by content experts into the confidential client assessment questionnaire which is provided to 100% of clients and answered by 98% of clients.	Goal met. A chart review found 100% of the clients received a confidential questionnaire. 98.4% of the total 304 clients answered all five human trafficking questions.
Education designed and led by the project leader for staff and volunteers incorporates critical elements required for each role prior to project implementation for 100% of staff and 50% of healthcare volunteers.	Goal met. 100% of all 10 staff attended an education session and 62.5% of eight eligible volunteers attended an education session. 100% of participants responded "yes" on their education evaluation when asked if they learned something about human trafficking
A flowchart of the new human trafficking screening process is created and placed in accessible locations for the MRC staff and volunteers.	Goal met. The flowchart was created, presented at all trainings, and was available at all workstations and staff offices. Leadership and the nurse manager verbalized the location of the flowchart.

Human trafficking resources are compiled and accessible to all MRC staff, volunteers, and clients. Human trafficking resources will be offered to all clients who screen positive for human trafficking.	Goal met. Human trafficking resources were compiled and accessible to all MRC staff, volunteers, and clients. 100% of clients who screened positive for human trafficking received, as a minimum, the National Human Trafficking Hotline contact information. One tear-off slip was removed during the implementation period
The human trafficking screening protocol is sustained by the nurse manager after implementation period.	Goal met. The nurse manager observed the training of a new orientee alongside the project leader using the education binder. Nurse manager verbalized she was willing and able to perform human trafficking training. The binder was created and placed in the nurse manager's and clinic director's office. Human trafficking training was added to the orientation checklist.

Discussion

The project goals centered on the delineation and creation of improved, sustainable MRC processes. The project was intentionally focused to encourage standardized screening and victim preparedness. According to staff reports, few human trafficking victims came to the MRC prior to implementation. MRC staff were doubtful of victim identification during a limited, 10-week implementation timeframe. The results exceeded expectations with fourteen screenings with positive findings, five of which were confirmed human trafficking victims. The nine unconfirmed clients were still included in the data collection and analysis for two reasons. First, personal fear and shame could have been a barrier to one's human trafficking confirmation and pursuit for assistance. Secondly, the women exhibited risk factors for human trafficking and could be victimized in the future. The project results indicate that human trafficking victims do come to the MRC more frequently than anticipated. These outcomes also lead to the postulation that many human trafficking victims came to the MRC before a screening protocol was initiated,but were not identified.

In the initial implementation period, staff and employees struggled to document the human trafficking victim interaction in the electronic chart. This lack of documentation

prevented the project leader from identifying the steps taken for some clients with positive responses to screening questions. In response, the project leader intervened to identify and assist in the creation of needed changes to the electronic documentation program to include human trafficking options; to create and place reminder posters at all workstations to promote documentation; and to provide individual counseling for staff on electronic documentation of human trafficking victim interaction.

The responses from clients were both anticipated and unexpected. Figure 2 shows the volume distribution of positive screening responses by question. Two of the questions were broader in language and could be applicable to current or past abusive relationships as well as human trafficking experiences. Unsurprisingly, these two received the greatest number of positive responses because they were the least esoteric. Despite efforts toward inclusive writing, the author did exclude four clients. One of these clients responded positively to question five because her wallet was recently stolen. Another client responded yes to question one because she worked in government intelligence. The two other clients were teenagers and still living at home and considered themselves to have no autonomy. Both answered no to one of the questions due to a lack of personal transportation and parental dependence. Another surprising trend was the trend among the five human trafficking victims. These clients did not answer the education question, despite answering all the other demographic questions. The education question is in the middle of the form and failure to answer the question is probably not due to fatigue with answering questions or distractions. The reason for this omission is unclear, but could suggest an association between personal educational shame in attainment or a shame in being a victim despite education. Finally, five clients did not provide any answers to the human trafficking screening questions. Employees were interviewed by the project leader if they conducted an

appointment with an unresponsive client to determine the cause for the omission. Limitations of literacy and language were seen. Although, the screening questions ranked at a 5.8 reading level, two women were unable to read or understand the questions when they were read to them despite speaking English. Three clients did not speak English and were unable to read the questions in English and a medical interpreter was not available.

Of the clients with positive screenings, the demographics and maternal health factors data showed trends consistent with national human trafficking victim demographics. Lower socio-economic status, Hispanic ethnicity, concern about STI exposure, unplanned pregnancy, and young age range are trends among human trafficking victims (Polaris, 2020; Tracy & Macias-Kostantopoulos, 2017). These trends also applied to MRC clients. Of the 13 zip codes collected, the data did not suggest an area in the city that is more prone to human trafficking. This serves as a reminder that human trafficking victims are not clustered in one particular area of a city.

The project leader emphasized an approach focused on human trafficking prevention. Although five women were confirmed as victims of human trafficking and nine were not, all clients with positive responses ($N = 14$) should be offered applicable resources. This strategy was due to the fact that a client in an abusive relationship or exhibiting trafficking risk factors does not possess guaranteed immunity from victimization through trafficking. Since many traffickers use vulnerability and manipulation to obtain victims, human trafficking should still be viewed as a potential threat to women with positive responses to screening questions. In response, the project leader encouraged MRC workers to share human trafficking information with all clients whose responses to screening questions were positive. Furthermore, due to the extreme negative health outcomes of human trafficking victimization, connecting clients who were past victims of human trafficking with resources could be beneficial to psychological

empowerment and physical healing (Pascual-Leone et al., 2016). Not all clients were provided resources at their initial visit. After intervention by the project leader, some clients with positive answers to screening questions received resources during their follow up visit. In addition to human trafficking resources, the MRC staff provided information about self-actualization counseling, government assistance programs, educational assistance, and relationship dynamics. Not only do these interactions create human trafficking awareness, but it also solidifies the MRC as a safe location that provides tools and empowers women in difficult situations.

Limitations

Factors negatively impacting the implementation process included operational changes, a global pandemic, the absence of medical translation services, and a shortage of current, relevant research studies. Operational changes included MRC personnel changes. From August 2019 to December 2019, there were 15 employees, three (20%) of whom were full-time. By January 2020, five (33.3%) of the staff members left for reasons including maternity, health issues, and/or career changes. These staff positions were then filled by volunteers. In addition to this staffing change, the number of active volunteers dwindled due to relocation, educational pursuits, job transfers, illness, and scheduling. However, on March 16, 2020, volunteer involvement was halted completely in response to the Covid-19 pandemic. Prior to Covid-19, the MRC had a consistent influx of new volunteers. After the pandemic, only the project leader and paid staff were permitted to work at the MRC. This change in staff and volunteers affected recruitment for educational sessions and project investment. Before the banning of volunteers at the MRC, virtual educational sessions were held to reach volunteers. After March 16, 2020 volunteer investment was low and recruitment for education no longer necessary. With the new

staff changes occurring immediately before the implementation period, the project leader had to quickly build rapport with new employees in order to foster project support.

The eruption of the Covid-19 pandemic also impacted MRC processes. The MRC decided to make changes based on the new Covid-19 regulations. This meant the MRC could no longer accept walk-in appointments, allow clients to be accompanied (excluding children), or permit anyone in the waiting area. Instead, clients waited in their cars and were then called into the MRC. Since traffickers are often fearful of leaving their victim alone, it is suspected the MRC process changes might have prevented current trafficking victims from seeking services. Although the results proved victim identification occurred, the process changes in response to Covid-19 may have impacted the total number of victims identified at the MRC. These changes began during the sixth week of project implementation.

Recommendations

Language can provide a barrier to quality care. Three women did not speak English and relied on their husbands for translation. Although the MRC tries to see all clients, the language barrier negated the effectiveness of the confidential screening questions. These women could also not be provided with an ultrasound or STI testing due to legal reasons regarding medical interpretation. This prevented follow-up appointments and client assessment opportunities. The investment of certified medical interpreters would improve care for clients who do not speak English.

The healthcare literature addressing human trafficking client care has flourished in the last decade; however this is still a new area of research. The first literature review addressing maternal health and human trafficking was just published by British midwives (Collins & Skarparis, 2020). The number of human trafficking articles published by European authors has

exceeded U.S. studies, particularly with regards to maternal health (Collins & Skarparis, 2020). American human trafficking studies are not as proliferative as Europeans and are also becoming outdated. Healthcare professionals, particularly doctorally-prepared nurses should continue to research and publish human trafficking studies which apply to the U.S. healthcare system.

Human trafficking screening tools are not standardized and largely address children. Numerous screening tools are inappropriate for the MRC due to length or intended audience. The project leader created a new screening tool that was inspired by human trafficking literature and that could be incorporated into the MRC processes. However, national standardization of a screening tool would ensure all healthcare facilities are screening their patients for human trafficking and could prevent missed opportunities.

Implications for Practice

The recent surge of human trafficking literature reveals a national push for awareness in healthcare. Nurse researchers as well as policy makers recognize human trafficking awareness as vital for the effective practice of healthcare professionals. The Texas Criminal Justice Coalition passed several bills concerning human trafficking. One of these bills includes mandatory human trafficking education for health care practitioners. Starting on September 1, 2020, physicians and nurses in Texas will be expected to complete a human trafficking prevention course for their license renewals (Texas HB2059, 2019). The next step needed is to translate the staff human trafficking education and awareness into tangible interventions in the healthcare setting. Screening processes like the one used in this project, provide the foundation for standardized human trafficking screening in women's health clinics as well as other healthcare settings.

In March 2020, the world became focused on a pandemic threatening the lives of thousands of people. This tragedy impacted healthcare workers and clients, leaving many people

in vulnerable situations. Traffickers recruit victims during vulnerable times (Collins & Skarparis, 2020). The recent global disease outbreak could be an impetus for a flourishing human trafficking industry this year. For this reason, human trafficking prevention policies should be included in national and local disease outbreak and disaster protocols. As healthcare adapts to societal changes, healthcare leaders need to respond though preparation, advocacy, and diligent screening.

Nurse practitioners serve as leaders in the community and healthcare. By stepping into the leadership role, healthcare leaders like nurse practitioners can lead the implementation of human trafficking screening processes. A doctorate-prepared nurse practitioner is the ideal professional for bridging the fields of research and practice. A nurse practitioner with a Doctor of Nursing Practice can take the implementation further by not only assessing the gaps in client care, but synthesizing knowledge from the research, and potentially developing new research and human trafficking protocols.

Summary

This quality improvement project is one of the first projects addressing human trafficking screening implementation in this health setting. Due to this challenge, the project leader had to synthesize information from human trafficking literature, create new strategies, and adapt the recommendations to the MRC population. Human trafficking screening typically takes place in emergency departments while addressing human trafficking awareness, practice recommendations, and human trafficking education of healthcare professionals. A miniscule number of articles show the application of a screening tool with results. This project shows ingenuity in the adaptation of strategies, applies the literature recommendations in a community health setting, and provides the results.

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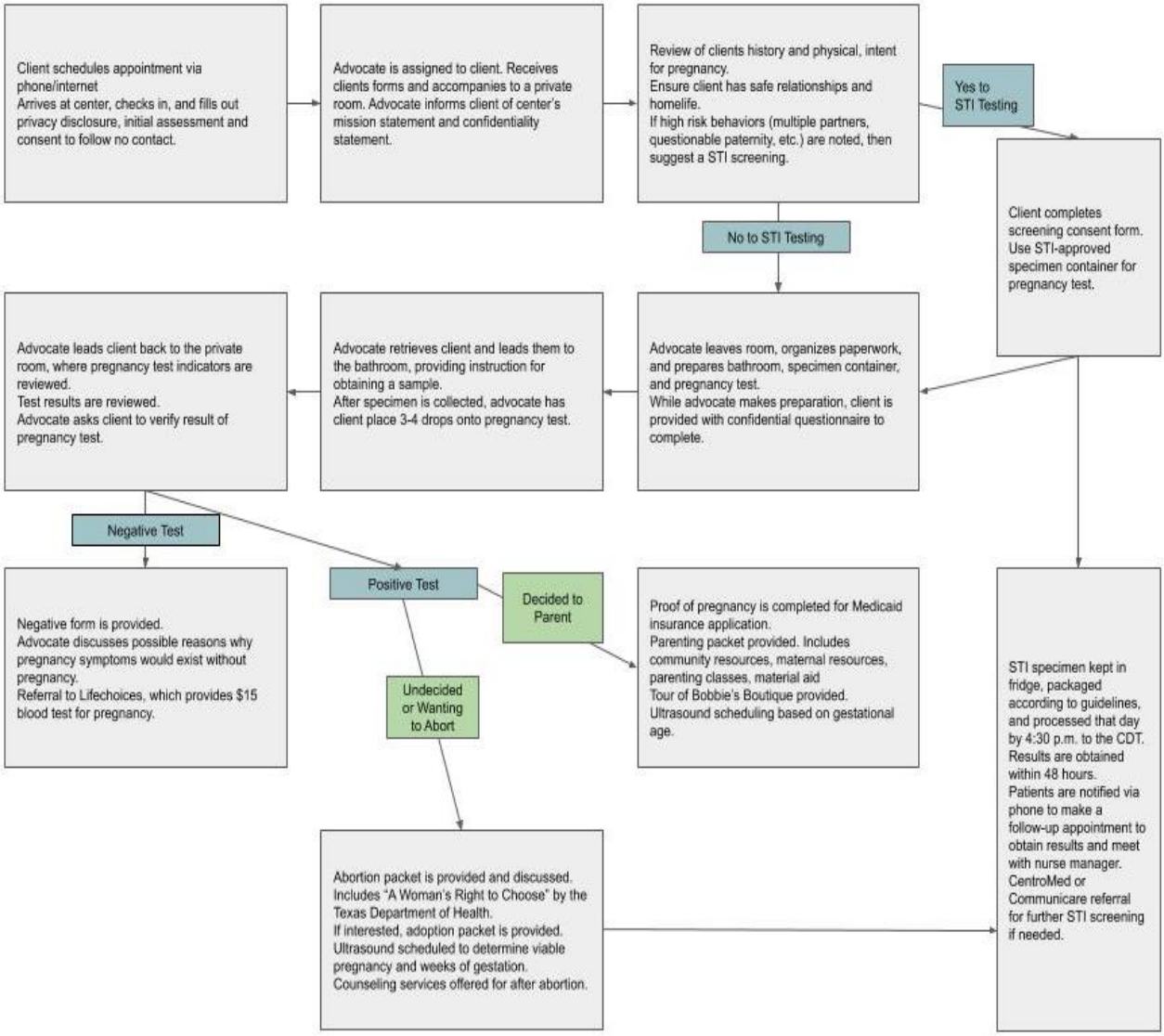
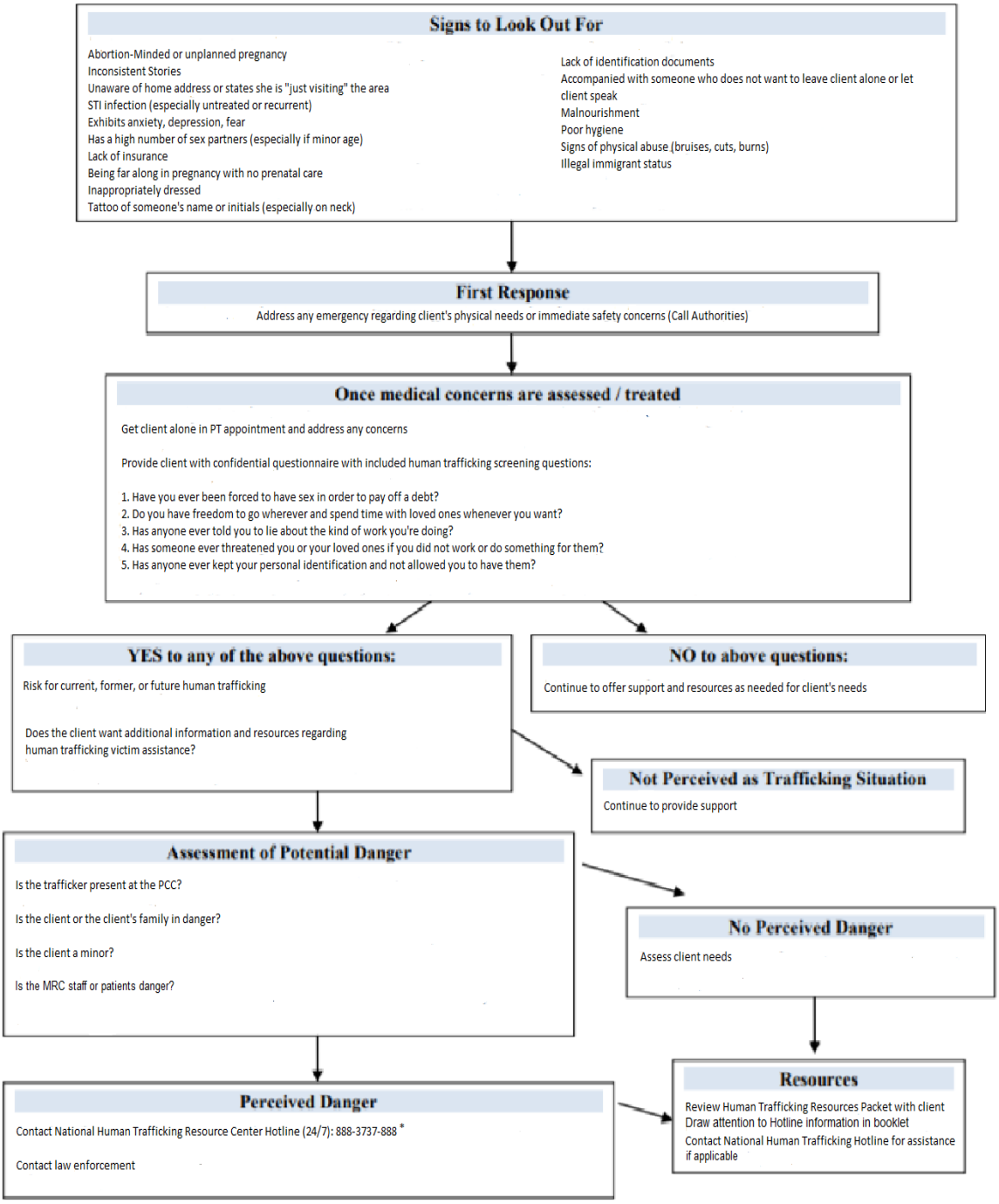
Appendix A

Maternal Resource Center (MRC) Processes



Appendix B

Human Trafficking Screening Flowchart



* If the client is highly suspicious for human trafficking or if they answer yes to any of the questions, the National Human Trafficking Hotline can be contacted at any point during the flowchart process if necessary to assist in the steps of obtaining resources and ensuring safety

Appendix C Human Trafficking Referrals and Resources

Name	Contact	Services Provided	Demographics	Comments
BCFS Health and Human Services-Common Thread	888-884-7323 (24/7) Commonthread@bcfs.net www.Commonthread.net	Immediate dispatch of an advocate (victim survivor), emergency shelter, transportation, case management, training of professionals	Anyone under age 25 English, Spanish and Translation Services	Sex trafficking only San Antonio, Houston, Waco, Killeen, Harlingen, McAllen, Del Rio, & Laredo, TX Potential source of training for MRC staff
Roy Maas Youth Alternatives	24/7 hotline 210-340-8090 Centroseguro@rmya.org www.rmya.org	Primarily for youth and victims of child sex trafficking, counseling, shelter, drop-in center, case management, inpatient and outpatient mental health services	Minors and their families Emergency shelter for ages 5-17 only Transitional housing ages 18-21 English, Spanish, and Translation services	Sex and Labor trafficking Bexar County, Kendall County Potential source of training for MRC staff
Texas RioGrande Legal Aid	512-374-2773 Hours: Mon-Fri 9-5	Comprehensive legal services to survivors of human trafficking Specializes in LGBTQI, immigration law, civil litigation, and family.	Anyone who is a human trafficking survivor English, Spanish, and Translation services	Free to low income, vulnerable populations

The Rape Crisis Center	Crisis: 210-349-7273 (24/7) Main business line: 210-521-7273 slowry@rapecrisis.com www.rapecrisis.com	Case management, Crisis services with hospitals, law enforcement, and legal services, free mental health counseling, support groups, play and art therapy, free services, transportation provided	Adult and Minors of all genders and nationalities Deny services to offenders or suspected offenders English, Spanish, Korean, and translation services	Sex and Labor Trafficking Provides community training
Catholic Charities	210-226-6178	English classes, citizenship courses, food, clothes	Adult identification needed or name and birthdate Ages 18 and up	Not specific to human trafficking but may prove beneficial
National Human Trafficking Hotline	888-3737-888 24/7 www.humantraffickinghotline.org Text 233733	Assists victims in step by step process of leaving their situation	All victims of all types of trafficking English, Spanish, and 200 languages	First step for assistance and reporting agency for trafficking
National Runaway Hotline	Text 66008 1-800-Runaway (24/7) www.1800runaway.org	Provides resources, free Greyhound bus ride to family, relay messages to guardian for the youth who is not ready to speak with family yet	Teenagers Spanish and English	Runaways are at a large risk for human trafficking
Texas Health and Human Services Commission	211 (if Texas number) 877-541-7905 (24/7)	One stop for all referrals and information regarding resources in Texas	The goal is to connect Texas citizens and residents with the services they need	Supplemental information

Salvation Army	210-352-2020	Women's shelter, family shelter, men's shelter, social services, food and utility, case management	Women's shelter- 18 or older, No ID or social required, for full-time employed women may be required to pay $12.50 a night. Families at the family shelter Emergency shelter- 7 day limit	Salvation Army takes a firm stance against human trafficking
San Antonio Sex Crimes Unit	PDSexCrimes.Unit@sanantonio.gov 210-207-2313 (Mon-Fri 7:45-5:45) After hours: 210-207-7389	Call if know or suspect someone is a victim of human trafficking	Local authorities for any human trafficking victim	Non-life-threatening emergency call 210-207-7273
No Strings Attached	www.nsagirls.org Call or text 210-517-8256 Email: info@nsagirls.org	Mentorship, support groups, certified trauma-informed therapist, single-mom support, resources,	Adult women only	Participants and leaders are former sex trafficking victims