FACILITATORS AND BARRIERS IN OBSTETRIC CARE IN THE IDENTIFICATION OF SEX-TRAFFICKED VICTIMS

by

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ABSTRACT

CHERYL SCOTT. Facilitators and Barriers in Obstetric Care for Sex-Trafficked Victims.
(Under the direction of DR. KATHLEEN JORDAN)

Human trafficking is an emergent public health concern that, as noted by the National Institute of Justice (2021), receives attention and support from human rights advocates and law enforcement agencies. The trafficking of women in the sex industry is a growing health concern, as most victims are often unrecognized when seeking healthcare services. Sex-trafficked women suffer adverse health effects and often present to healthcare facilities while still under the control of their traffickers (Rapoza, 2022). A review of the literature revealed a deficit in clinicians' abilities to recognize this vulnerable population. This scholarly project aimed to determine how participation in an educational intervention affects providers' and clinicians' knowledge of the facilitators and barriers to identifying and intervening with pregnant sex-trafficking victims. The intervention included the implementation of an educational intervention to enhance knowledge. A pre and posttest design was used to measure a change in confidence, knowledge, and skills. A Likert survey to assess confidence and knowledge of sex trafficking was administered before and 30 days after the educational intervention. This project aimed to demonstrate that education increased confidence, knowledge, and skills among obstetric public health providers and clinicians regarding the identification of sex-trafficked victims.

ACKNOWLEDGMENTS

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DEDICATION

Maya Rose Scott, you are my twin flame, my brilliant and beautiful daughter. You have wisdom and discernment that is beyond your years. I love and appreciate you and your support for me during this season in our lives.

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LIST OF ABBREVIATIONS

IRB	Institutional Review Board
SPSS	Statistical Package for the Social Sciences

CHAPTER 1: INTRODUCTION

Human trafficking, recognized as a global public health crisis, is a historically overlooked crime and has recently convened the attention of human rights advocates and law enforcement agencies (National Institute of Justice, 2021). The United States is the second-largest global market for this human rights violation (Lepianka & Colbert, 2020). Over 90% of human trafficking victims, disproportionately comprised of underserved women, are most often exploited in the commercial sex industry (Tracy & Macias-Konstantopoulos, 2017). Sex trafficking is a pervasive issue that often goes unrecognized and disproportionately affects marginalized populations. Survivors suffer adverse health effects and often present to healthcare facilities while still under the control of their traffickers (Rapoza, 2022). These factors make it difficult for healthcare workers to identify and assist trafficking victims. However, it is vital that they do so, and they are in a unique position to help protect the health and human rights of trafficking victims. Obstetrics professionals, in particular, are responsible for increasing their understanding of the facilitators and barriers to healthcare for sex-trafficked women. This scholarly project describes the effects of an educational intervention on providers' abilities to help victims of sex trafficking.

1.1 Background

More than one in four women become pregnant while trafficked, indicating that maternity services can offer an essential point of contact for the identification of care and resources (Bick et al., 2017). Trafficked sex workers, the population of women induced by force, fraud, or coercion (Tracy & Macias-Konstantopoulos, 2017) to exchange or sell intimate sexual services, are often unrecognized in obstetric care settings (Russo, 2017). Sex trafficking is associated with socioeconomic isolation, stigma, shame, fear of judgment, retribution by

traffickers, law enforcement encounters, and other factors that impede disclosure (Price et al., 2021). These victims also experience significant adverse health impacts, including risks of physical and emotional health issues that affect maternal and fetal outcomes (Collins & Skarparis, 2020).

Human rights advocates, law enforcement, and government agencies are committed to advocating and educating the public regarding the challenges of human trafficking. The U.S. Department of Homeland Security (DHS) investigates the bulk of sex and labor trafficking cases involving foreign nationals (Recknor et al., 2017). The Blue Campaign, a national public awareness campaign, educates the public, advocates, and partners to recognize the indicators of human trafficking and how to respond to possible cases appropriately. (US Department, 2022). National, state, and local campaigns are vital and ardent supporters of anti-trafficking policies and other efforts. Although anti-trafficking campaigns are prevalent and actively support recognition and strategies to mitigate this human rights violation, because of the covert nature of trafficking and the troublesome clinical presentations, victims, including pregnant victims, are under-identified by healthcare providers resulting in missed opportunities for specialized, comprehensive care (Scannell et al., 2018).

Advanced practice providers, registered nurses, and other healthcare personnel display a compelling lack of knowledge of the barriers victims face when seeking healthcare (Armstrong & Greenbaum, 2019). In maternity care, evidence-based practice standards are not well-defined to inform clinicians and providers on how the abuse affects pregnancy, childbirth, and the postpartum time period for sex-trafficked victims (Collins & Skarparis, 2020). Despite the risks, there is a lack of evidence-based research on maternity care for sex-trafficked victims to assist

providers in identifying and managing facilitators and barriers in obstetrics care (Bick et al., 2017).

Sex-trafficked obstetric victims are often unrecognized when they access and navigate healthcare systems. Healthcare staff do not recognize the common signs and symptoms of these victims; and, therefore, lack the awareness and insight necessary to provide evidence-based care (Raker, 2020; Sangha & Birkholz, 2021).

Healthcare providers acknowledge a deficit in having an adequate understanding of human sex trafficking; this represents a barrier that hinders efforts to identify sex-trafficked obstetric victims (Lutz, 2018). Raker (2020) asserted that educational interventions increased knowledge of human trafficking among healthcare staff. Informed nursing professionals are in ideal positions, as indispensable healthcare team members, to address this issue by identifying, treating, and referring victims of trafficking.

1.2 Problem Statement

The evidence that advanced practice providers and nurse clinicians fail to recognize common signs and symptoms of sex-trafficked victims because of a lack of experience, knowledge, or preexisting assumptions is a serious problem (Sangha & Birkholz, 2021). Bick et al. (2017) provided insight into sex-trafficked victims' needs and healthcare access, challenges, and healthcare professionals' perspectives on maternity care for sex-trafficked women. Bick et al. (2017) reported that victims sought pregnancy terminations and experienced physical, mental, and sexual abuse while in active sex-trafficking situations.

Research findings suggest that victims lacked knowledge of health resources and did not know how to access care, adversely affecting maternity services. Augmenting this knowledge deficit, most healthcare providers are unaware of or lack adequate training on the prevalence,

risk factors, and health consequences of sex trafficking (Lee et al., 2021). Obstetric healthcare staff reported more contact with potential victims of trafficking than other healthcare professionals; it is necessary to identify and include facilitators and barriers in maternity-specific guidelines and protocols for care (Costa et al., 2019). Healthcare clinicians and providers may not be aware of recommended sex-trafficking indicators and the nuances of how the victims present themselves for care (Pederson & Gerassi, 2021).

Barriers to appropriate treatment include the lack of essential skills to identify sex-trafficking victims (Richie- Zavaleta et al., 2019). Sex-trafficked victims and clinicians described the challenges, including restrictions placed on victims' movements by traffickers, the lack of knowledge to access maternity care, poor understanding of healthcare entitlements, and concerns about confidentiality (Garg et al., 2020). Additional barriers are identified by victims and obscured by the nuances of sex trafficking, including emotional reluctance, being unaware of their trafficking status, and self-minimizing the need for care as reinforced by the trafficker and peers (Garg et al., 2020). Maternity care that directly addresses pregnant women's emotional, psychological, mental, and physical care needs is an essential rendering for healthcare providers (Richie- Zavaleta et al., 2019.

Healthcare staff must work effectively to recognize and act on behalf of pregnant sex-trafficked victims when assessing for and providing care and evaluating which course of action is likely to lead to the most optimal outcomes for women (Stoklosa et al., 2016).

1.3 Purpose of the Project

The primary purpose of this scholarly project was to determine how participation in an educational intervention effects providers' and clinicians' knowledge of the facilitators and barriers to identifying and intervening with pregnant sex-trafficking victims. Addressing short-

term knowledge about pregnant sex-trafficked patients and maternity care is a gateway to long-term knowledge about the sex-trafficking experience, practice-based learning, and long-term retention of an educational intervention (Lee et al., 2021). This scholarly nursing project also addressed how public health nurses perceive sex-trafficking indicators when caring for pregnant victims.

1.4 Significance of the Project

This scholarly project fills a gap in the literature to improve the understanding of the needs of pregnant, sex-trafficked women and aims to enhance public health maternity clinic providers' and clinicians' knowledge and confidence in identifying facilitators and barriers in this vulnerable group of women.

1.5 Clinical Question

The PICO question for this DNP scholarly project is: Among clinicians and providers who care for patients in a public health obstetric clinic (P), who participate in an educational intervention (I), compared to before participating in an educational intervention (C) report increased knowledge, confidence, and skills in the identification of facilitators and barriers to the identification of pregnant sex-trafficked victims (O)?

CHAPTER 2: LITERATURE REVIEW

The literature review was conducted between September 2021 and February 2022 by accessing the databases Science Direct, PubMed, EBSCOhost, and CINAHL Plus with Full Text to locate articles relevant to the PICO question. The search terms included the project variables or combinations of the variables, i.e., *sex trafficking, human trafficking, pregnant women's access to care, maternity care and sex trafficking, health issues among trafficked individuals, sex workers, AND maternity care, healthcare providers' knowledge*, AND *trauma-informed care principles, AND facilitators* and *barriers* AND *identify human trafficking*. The search returned approximately 1500 articles; by applying inclusion criteria such as date (articles published from 2016-2022), language (articles only in English), and sex trafficking AND health (treatment AND care), the selection lessened to 202 relevant articles. After removing duplicate articles, editorials, and commentaries, the titles and abstracts of 190 studies were reviewed, and 41 studies were referenced in this review. The literature provided insight into education and training, trauma, systemic issues, implicit bias, and clinical care protocols that supported the practicality of this DNP project.

2.1 Barriers

Education and training

Current literature revealed that healthcare providers are primarily unaware of human trafficking issues and are unprepared to provide patient-centered care for trafficked and unidentified trafficked patients (Armstrong et al., 2019; Bick et al., 2017; Hemmings et al., 2016; Katsanis et al., 2019; Lee et al., 2021; Richie-Zavaleta et al., 2019). A study by Costa et al. (2019) found that healthcare providers generally agreed they lack the knowledge and confidence to competently assess for facilitators and barriers to identify sex-trafficked women; therefore, it

may be challenging to find a healthcare provider who has the experience to appropriately evaluate human sex-trafficking victims. Review results by Lepianka & Colbert (2020) revealed that an inadequate response by the health system is partly due to providers having difficulty identifying victims of sex trafficking. Pederson & Gerassi (2021) found that healthcare providers may not be aware of all recommended sex trafficking indicators and how victims and survivors present for healthcare. Hemmings et al. (2016) found there was a lack of empirical evidence to support healthcare facility providers' ability to identify and care for victims of trafficking.

Trauma

The literature review revealed that healthcare providers were unaware of trauma triggers that prevented sex-trafficked victims from accessing care. Some aspects of treatment, particularly pelvic examinations, triggered past trauma memories related to their experiences of sexual exploitation and other types of abuse (Barnert et al., 2020; Bick et al., 2017). Studies revealed other barriers for victims that healthcare providers were largely unaware of, including exploiter control and fear of unauthorized confidentiality breaches (Barnert et al., 2020; Bick et al., 2017).

Systemic Issues

The literature revealed systemic issues implicit in the healthcare system.

Macy et al. (2021) concluded in their scoping review that individuals experiencing sex trafficking may not self-identify as victims, and service providers may be unaware of guidance that could facilitate efforts to identify trafficking. As with other vulnerable and underserved populations, victims and survivors of human trafficking experience challenges accessing healthcare, both while trafficked and as survivors (Bick et al., 2017; Macias-Konstantopoulos,

2016). Pederson & Gerassi's (2021) findings also revealed that misconceptions could impact healthcare providers' knowledge and skills in identifying sex-trafficked victims.

Implicit Bias

Implicit bias emerged as another barrier to healthcare for women seeking healthcare, including obstetric services. Most healthcare providers do not intend to harm their patients; however, unconscious biases may cause harm. Training nurses and other healthcare providers about implicit bias is one step toward eradicating this bias from maternity care (Afulani et al., 2021; Russell, 2021). Findings in a systematic review by FitzGerald & Hurst (2017) highlight the need for the healthcare profession to address implicit biases' role in healthcare disparities. In addition to addressing implicit biases, it is essential to raise awareness of the potential barrier of holding explicit negative attitudes towards some patient characteristics, such as obesity, and committing to a norm to treat all patients equally. Ma & Loke (2020) revealed three major themes in their content analysis for facilitators and barriers to healthcare identification of sex-trafficked victims: (1) acceptance, stigmatizing, or against sex work; (2) reluctance, hesitation, or willingness to care for sex workers; and (3) factors affecting the care of sex workers.

Clinical Care Protocols

Bick et al. (2017) emphasized the importance of front-line maternity services to identify, support, and refer to sex-trafficked women and girls. Healthcare providers who provide front-line services require specific training to identify, treat, refer, and support trafficked women (Collins & Skarparis, 2020; Fraley et al., 2019; Garg et al., 2020; Richie-Zavaleta et al., 2019). Evidence-based informed protocols and pathways are necessary to address facilitators and barriers to care for victims and providers and to support sex-trafficked pregnant women and postpartum women and their infants (Bick et al., 2017; Collins & Skarparis, 2020). The scoping review by

Marcinkowski et al. (2022) found that most ED clinicians and staff had little or no formal training in sex trafficking victim identification, support, institutional protocols, or available local resources. The review demonstrated an absence of validated training programs, adult screening tools, and standardized institutional protocols to assist in caring for trafficked patients. Although no standardized tools are currently available to identify sex-trafficked victims, healthcare providers require reliable and valid screening tools for proper victim identification, standardized training, and protocols (Marcinkowski et al., 2022).

Maternity care professionals are more likely than other healthcare disciplines to care for women who have been sex-trafficked (Bick et al., 2017; Collins & Skarparis, 2020). Focusing on sex-trafficked women as a distinct group would facilitate identifying their specific needs and risk factors. Identifying a victim of trafficking can be complex and challenging (Collins & Skarparis, 2020). Therefore, it is essential that healthcare providers receive specific education and training in this area and remain vigilant for red flags that would raise concern for and need to assess for trafficking (Tracy & Macias-Konstantopoulos, 2017).

2.2 Conceptual/Theoretical Framework

Kurt Lewin's Theory of Planned Change is the framework that structures the planning, development, implementation, and evaluation of a specific project to change an organization's practices related to a proposed program shift (Hussain et al., 2018). Lewin's three-step change model (unfreezing, changing, and refreezing) organizes the observed project processes: the need for buy-in, the presence of resistance, and the need for primary stakeholders to sustain practices (Manchester et al., 2014). Shirey (2013) asserted that the first step of the framework, unfreezing, may be initiated with a gap analysis that contrasts differences between the current practices and a proposal for an updated plan to include, prepare and engage staff interest in learning and

implementing changes. Change, the second stage in Lewin's theory, empowers leadership personnel to engage employees by encouraging their involvement, overcoming resistance, and implementing change guidelines and practices (Hussain et al., 2018). Finally, refreezing, the third stage in Lewin's theory, is the momentum for shifting organizational change from one phase to another (Hussain et al., 2018) and locks in the pivotal higher levels of performance expectation, which are vital in the sustainability of the institutional change (Shirey, 2013).

Lewin's Theory of Planned Change is a practical approach that helps nurse leaders to advance organizational change. This theory is versatile, simple to use, and easy to understand. These attributes support using this theory as the strategic framework to mobilize the human side of change for this scholarly project (Shirey, 2013). Also, as Shirey (2013) conveys, the theory represents one of the oldest change management models. Thus, its applicability continues to be appropriate to strategically plan, execute, and sustain organizational change initiatives (Shirey, 2013). Unfreezing, change, and refreezing, the three stages of Lewin's Change Theory (Shirey, 2013), are appropriate concepts for this project because the stages necessary to implement and sustain the required actions are clearly defined, enabling a structured and organized method to create and implement a practice change. The project's planning, organization, and expected outcome was briefly described in terms of the relationship to the stages of the selected change theory.

The unfreezing process began with an assessment of current policies that address assessment, interventions, and evaluation of nursing pathways. Current policies and procedures in the women's health programs do not address human trafficking despite Family Planning/Title X annual training mandated for family planning nursing staff as a condition for receiving grant funds. The training specifies the applicability to all disciplines. Obstetric advanced providers and

clinicians do not participate in the training. The project leader met with potential stakeholders to develop a team interested in the project and willing to invest time and recommendations to plan, implement, and evaluate the project. In refreezing, permanent program changes were based on the project outcomes, beginning with small, potentially significant transformations, i.e., including, at minimum, one question on the current patient intake form to assess for signs, symptoms, and diagnoses that may prompt additional attention for human trafficking red flags. Refreezing transitioned into permanent change by implementing feedback from advanced providers and clinicians and the stakeholder team, building on each successful implementation of the staff's plan to sustain changes and continue to facilitate and develop the process for long-term learning and practice-based learning to address sex-trafficked obstetric patients. These actions set or "froze" a nursing pathway for building long-term knowledge about the sex-trafficking experience, practice-based learning, and long-term retention of educational offerings.

A decisive benefit of using Lewin's Model to structure this project was the focus it provided the project leader to implement and evaluate the change and the ability to envision the change process and its progression (Harrison et al., 2021). Lewin's Theory was also a valuable resource to mobilize staff and stakeholders to participate in organizational change initiatives (Shirey, 2013). The obstetric care clinic assessments during the unfreezing phase of this project resulted in the implementation of changes in clinic policies and procedures included in the refreezing process. One of these changes is scheduled for implementation in the fiscal year 2024; the obstetric care providers and clinicians will be required to attend the annual Family Planning/Title X annual Human Trafficking training.

CHAPTER 3: METHODOLOGY

One goal of this scholarly project was to determine how participation in an educational intervention effected providers' and clinicians' knowledge of the facilitators and barriers to identifying and intervening with pregnant sex-trafficking victims.

3.1 Project Design

This scholarly project was coordinated in two phases using a descriptive comparative design research design. The one-hour educational intervention was a PowerPoint presentation with embedded videos for presentation in a lecture-style format. The hard copy pretest and Likert-scale survey (Appendix A) contained a nine-question demographic section followed by a ten-question level of knowledge section. They concluded with a ten-question confidence and self-efficacy section. The participants completed the demographic section, pretest, and the survey. The project leader reviewed the pretest questions and provided the correct answers. The participants took a five-minute break, at which time the coded pretests and surveys were placed in a lockbox. The educational intervention was presented, followed by a posttest.

Thirty (30) days after the intervention, the project lead conducted the postintervention, the second phase of this project. The participants completed the 30-day posttest, identical to the initial postintervention posttest, to collect data to ascertain the participants' knowledge of facilitators and barriers to identifying sex-trafficked patients thirty (30) days after the intervention. The participants retook a 30-day survey to ascertain their confidence and self-efficacy 30 days after the intervention.

Sample

A convenience sample included 11 obstetric care staff assigned to the obstetric care clinic and consisted of senior public health nurses (n=10) and a Women's Health Nurse Practitioner

(n =1). All participants were female (n=11). African American participants comprised 54.44% of the sample (n = 6), twenty-seven percent were Caucasian (n = 3), and eighteen percent were Hispanic (n=2). The participants reflected the racial and gender demographics of the community within the immediate vicinity (three miles) of the public health department. The project's inclusion criteria required work assignments in the women's health program maternity clinic and direct contact with pregnant patients.

Setting

The setting for this scholarly project was a maternity clinic housed in a public health department in a large, urban city in the southeastern United States. The maternity clinic is also a clinical learning site for obstetric residents, advanced practice providers, and nursing students attending local universities. Most women and adolescents receiving care in the maternity clinic are Hispanic or African American, underinsured or uninsured, and assessed as low-risk pregnancies. Women diagnosed with high-risk pregnancies due to a physical or mental health diagnosis are transferred to a facility equipped to provide prenatal care and closely monitor these pregnancies. The clinic has large exam rooms, private breastfeeding rooms, and a small conference room that served as the site for the centering groups before the Covid-19 pandemic.

Recruitment

Recruitment occurred at staff meetings where the nursing healthcare providers listened to a description of the project and had an opportunity to ask questions. The project leader read the informed consent for the project to potential participants. The potential participant signed the consent and received a hard copy. The participant had the opportunity to ask questions before signing the consent and receiving contact information to ask questions or concerns regarding the project. Each participant received a copy of their signed consent. The project leader placed the

documents in a lock box and transferred the consent forms to a locked file drawer in a locked office designated for use during the project. Emphasis was placed on the voluntary nature of the project, and the individual's decision to accept or decline the intervention did not influence any aspect of employment in the maternity clinic or the department.

Educational Intervention

Each educational intervention offering was limited to a maximum of ten participants. The participants completed a pretest (which consisted of Likert-type questions and vignettes) of their knowledge of facilitators and barriers in the identification of sex-trafficked pregnant women and assessed their level of confidence in their ability to recognize, assess, and document facilitators and barriers to the identification of sex-trafficked pregnant women, after which they had a five-minute break. The educational intervention was then presented. After the educational intervention, the participants took the posttest, followed by a review and a discussion of the intervention and the posttest. Thirty (30) days after the intervention, the project leader followed up with a repeat posttest provided to the participants to re-assess their knowledge of facilitators and barriers to identifying sex-trafficked patients. The 30-day posttest was provided to each participant via their interoffice mailbox via the public health department's interoffice mail. The posttest and a pre-addressed return envelope were placed in a brown 8 x 11 interoffice envelope, addressed to the participants, and stamped' personal and confidential.' The project lead secured a generic interoffice mailbox (Public Health confidential mailboxes). The participants returned the posttests in the pre-addressed return envelopes sent to an interoffice address. The 30-day posttest was the same as the posttest that immediately followed the educational intervention.

Measurement Tools

The evidence-informed tool was adapted from a previously used tool (Jordan, K.S., 2014). Content reliability and validity were reviewed by expert physicians, nurses, and a nurse-research consultant. The data collection tools are modifications of tools that (Jordan, K.S., 2014) successfully used in prior studies (Jordan et al., 2014; Jordan et al., 2017; Jordan et al., 2019).

The first section contained nine multiple-choice questions focused on demographics. Data were obtained to describe the sample, including role, years of experience, the highest academic degree held, previous education regarding sex trafficking, number of sex-trafficked victims cared for in the last six months with sex trafficking, and beliefs about the necessity for sex trafficking education.

The second section contained ten multiple-choice questions to assess knowledge about human sex trafficking. These questions focused on the definition of sex trafficking, facilitators, barriers, general indicators of sex trafficking, identification of risk factors, and specific assessment and intervention questions.

The third section comprised nine statements (2 reverse-coded) to determine responses to reflect the confidence level. Each item was answered on a 4-point Likert scale: 1 *(strongly agree),* 2 *(agree),* 3 *(disagree),* and 4 (*strongly disagree).* Each item score was summed for a total score.

Data Collection Procedures

Participant identifiers were used instead of names. Participant names were collected and matched with a corresponding code placed on the pre and posttests. The participants' confidentiality remained protected from disclosure to everyone except the project leader. The information collected was used for project purposes only. The participants' contact information

was maintained in a locked cabinet in a locked office. The data was identifiable only to the project leader.

The project leader created a unique project identifier for each participant using random letters from the names combined with numbers from the telephone numbers. The project leader maintained a master list that linked participants' identities to each unique identifier. All paper data was locked in a file cabinet in a locked office. Master lists were stored and locked in a separate file cabinet from the data and destroyed after the project. Audio or video recordings were not used in this scholarly nursing project.

The 30-day posttest (posttest) and the 30-day survey (survey) were provided to each participant via their interoffice mailbox within the public health department's interoffice mail. The posttest, survey, and pre-addressed return envelopes were placed in a brown 8x11 interoffice envelope, addressed to the participants, and stamped "personal and confidential." The project lead secured a generic interoffice mailbox (Public Health 3rd Floor). The participants returned the posttests and surveys in the pre-addressed return envelopes sent to this specific interoffice address.

Data Analysis

SPSS was used to perform descriptive and inferential statistics for data analysis. Descriptive statistics and t-test analysis were used to compare participants' knowledge, confidence, and self-efficacy in identifying obstetric sex-trafficked victims. Following the educational intervention, the data was analyzed using a descriptive comparative design that included descriptive and inferential statistics (Siedlecki, 2020). The one-sample, pre, and post-intervention designs used inferential statistics (parametric and nonparametric) to examine differences between the pre-and post-intervention groups. A descriptive design option was also used because of the

implementation of a new educational intervention. Siedlecki (2020) recommended conducting a descriptive study to determine whether an issue existed and to what extent before beginning a process to address a clinical issue in a healthcare facility.

Ethical Considerations

Data stored included participant names and phone numbers, pretest and posttest results, and the 30-day posttest results. The participant's contact information was maintained in a locked cabinet in a locked office. All paper data was locked in file cabinets located in a locked office. Master lists were stored and locked in a separate file cabinet from the data. Audio or video recordings were not used in this scholarly nursing project. At the end of the project, all identifiable data was destroyed by a shredder in the project leader's office. The identifiable shredded data was placed in sealed 8x11 envelopes. The lead investigator/project lead placed the sealed envelopes in a locked, confidential data bin that a professional vendor will transport to an off-site location to destroy all the data in the container. Though not required, the non-identifiable data was also placed in the locked, confidential data bin. The vendor owns the only key to the bin; no copies were available.

The Institutional Review Board (IRB) reviewed and approved protocol IRB-22-0901 entitled "Facilitators and Barriers in Obstetric Care for Sex-Trafficked Victims." The Durham County Department of Public Health's Internal IRB reviewed and approved the Research Approval Form (Internal Research).

CHAPTER 4: RESULTS

4.1 Demographics

Eleven public health obstetric care staff participated in this scholarly project. All the participants were female. Most participants were registered nurses (91%), followed by one nurse practitioner (9%). Most of the registered nurse participants (83%) had a minimum of 16 years of nursing experience, and 36% had at least 11 years of experience as public health obstetric care nurses. The nurse practitioner recalled participating in one educational program focused on the issue of human trafficking. None of the participants suspected or confirmed caring for a sex-trafficked patient within the six months before this scholarly project. Each participant indicated on the pretests and posttests their belief that supplemental education regarding sex trafficking would benefit their nursing practice; 91% of the participants agreed with a requirement for sex-trafficking education for obstetric care clinicians and providers.

4.2 Level of Knowledge

The educational intervention assessed knowledge and self-efficacy specific to facilitators and barriers in identifying sex-trafficked pregnant patients. A 10-question pretest and posttest were administered immediately before and after the educational intervention. SPSS was used to perform descriptive and inferential statistics for data analysis. Pretest scores ranged from 40% to 80%, and the mean score was 49%. The posttest scores immediately after the educational intervention ranged from 60%-90% and the mean score was 76%. The providers and clinicians completed a 30-day posttest to assess the participants' level of knowledge specific to facilitators and barriers in identifying sex-trafficked pregnant patients after working in the public health obstetric clinic for one month. The mean score of the posttest administered 30 days after the educational intervention was 67.3%, with scores ranging between 50% and 90%.

The questions answered correctly the most frequently on the pretest and the 30-day posttest were related to adverse pregnancy outcomes (n=11). Questions that were incorrectly answered the most frequently were related to facilitators that may assist in recognizing sex-trafficked victims (n=9) and factors that may contribute to sex-trafficked victims continuing commercial sex work (n=9). Table 1 provides examples of the educational intervention test questions.

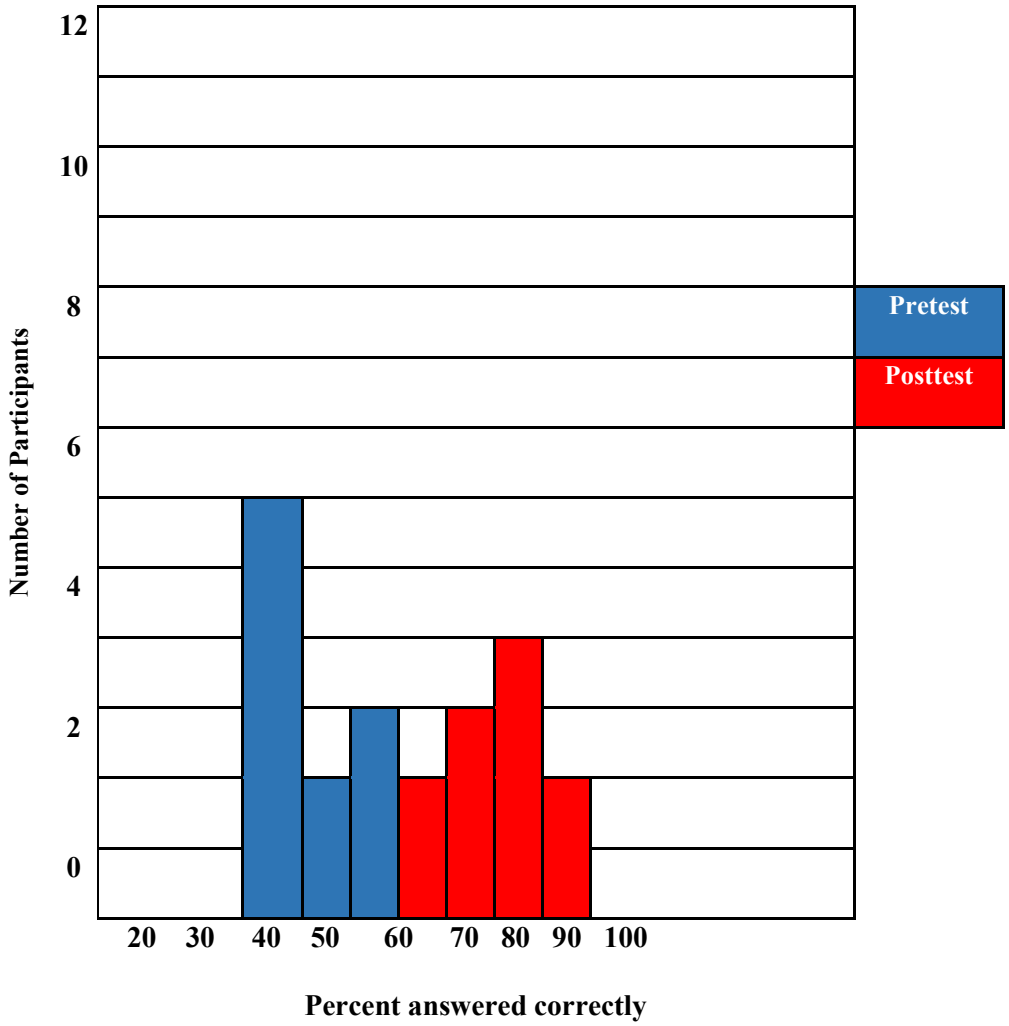
Table 1

Examples of the Educational Intervention Pretest and Posttest Questions
1. Facilitators that may assist in recognizing sex-trafficked victims include
A. Maternity-specific guidelines for sex-trafficked women
B. Knowledge and awareness of the signs of sex trafficking
C. A only
D. A and B
2. Sex-trafficked pregnant victims may continue commercial sex work because
A. The victim is afraid to leave their trafficker
B. The victim has established a trauma bond with their trafficker
C. The victim considers herself, the infant, and the trafficker a family
D. All of the above

Pretest scores ranged from 40% to 80%, and the mean score was 49.09%. The posttest scores immediately after the educational intervention ranged from 60%-90% and the mean score was 76.37%. A paired-sample t-test was conducted to compare the test scores on the pretest

administered before the educational intervention and the posttest administered immediately after the intervention. There was a significant difference in the scores in the pretest (M=49.09, SD=13.00) and posttest (M=76.37, SD=10.26); t-value = -5.45906, and the p-value = .01, which is statistically significant. These results suggest that the educational intervention increased the participants' knowledge of facilitators and barriers in identifying sex-trafficked pregnant women between the pretest and the first posttest. Figure 1 documents the frequency distribution of the pretest and posttest scores.

Figure 1 Frequency Distribution of Pretest and Posttest Scores.



The participants repeated the posttest 30 days after the educational intervention to assess the participants' knowledge specific to facilitators and barriers in identifying sex-trafficked pregnant patients after working in the public health obstetric clinic. The mean score of the posttest administered 30 days after the educational intervention was 67.3%, with scores ranging between 50% and 90%.

A paired-sample t-test was conducted to compare the test scores on the first posttest and the 30-day posttest. There was no significant difference in the scores for the first posttest (M=76.36, SD=10.26) and the 30-day posttest (M=67.27, SD=14.20), t-value = 1.72005, and the p-value = .100861. The result is not significant at $p > .05$. These results suggest that the educational intervention did not impact the knowledge in identifying facilitators and barriers in identifying sex-trafficked pregnant women during the time worked in the obstetric clinic between the two posttests.

4.3 Self-Efficacy

Confidence and self-efficacy scores were assessed using a 10-item survey with a four-point Likert scale that ranged from 1 (*strongly agree*) to 4 (*strongly disagree).* Survey responses were collected immediately before and again 30 days after the educational intervention to assess the participants' confidence and self-efficacy specific to their perceived ability to identify facilitators and barriers in sex-trafficked pregnant patients after working in the public health obstetric clinic for thirty days. Although the data obtained through a 4-point Likert Survey was qualitative data, the survey was transformed into a quantitative data set to obtain the mean and standard deviation of the responses (Siedlecki, 2020). A paired samples t-test was performed to compare the pre-intervention survey results and the 30-day post-intervention survey. There was no significant difference in the scores in the survey administered immediately before the

educational intervention (M=3.13, SD=.577) and the 30-day posttest (M=3.04, SD=.412), t-value = .40, and the p-value =. 6902. The result is not significant at p >.05. These results suggest that the educational intervention did not impact the respondents' confidence and self-efficacy in their knowledge of facilitators and barriers to the identification of sex-trafficked pregnant women between the pre-intervention survey and the 30-day day post-intervention survey.

CHAPTER 5: DISCUSSION

5.1 Summary

Public health obstetric care providers and clinicians require education and training to incorporate assessments, care, advocacy, and policies for pregnant sex-trafficked victims into their professional practices. This project's findings suggest that the public health obstetric care providers and clinicians benefited from an educational intervention regarding facilitators and barriers to the identification of sex-trafficked victims. The project's findings also suggest that the participants did not have confidence in their ability to recognize facilitators and barriers to the identification of sex-trafficked victims among their patients. These findings also support studies in the literature that suggest that providers, clinicians, and other healthcare disciplines' knowledge deficits in human trafficking education and training deter victim identification and healthcare providers' confidence to care for these victims. Ninety-one percent of the obstetric care providers and clinicians in this project reported minimal or no human-trafficking curricular offerings as part of training and continuing education for healthcare providers.

5.2 Discussion

The statistically significant results between the educational intervention's pretests and the post-intervention posttests (the paired t-test was significant at $p < .01$ (using a standard of $p < .05$) suggest that the educational intervention increased the participants' knowledge of facilitators and barriers in identifying sex-trafficked pregnant women.

The mean posttest scores were decreased on the 30-day posttest (M=67.27) compared to the posttest after the educational intervention (M=76.36). The differences in mean scores between these posttests results were not significant at a p-value = .100 (using a standard of p-value <.05). This difference suggests a decrease in test scores which may be interpreted as a

decrease in reported knowledge or a decrease in the knowledge retained during the 30 days between the administration of the two posttests.

Participants responded to Likert survey questions that specifically addressed their confidence and self-efficacy in their ability to recognize facilitators and barriers to the identification of sex-trafficked pregnant victims. The survey was administered immediately before and 30 days after the educational intervention. The responses suggested that the participants were not confident in their ability to care for sex-trafficked victims. The results were statistically significant with a p-value = .038 (using a standard of p-value < .05).

5.3 Strengths

This scholarly project successfully implemented an educational intervention that increased obstetric care providers' and clinicians' knowledge of facilitators and barriers to identifying sex-trafficked pregnant women. The statistically significant results between the educational intervention's pretests and posttests indicated one of the project's strengths.

This project's findings are similar to studies supporting the need for healthcare providers to receive evidence-based human trafficking and are another strength of the project.

Another strength of the project was the ability to adapt an evidence-informed tool, used with permission granted by Jordan et al. (2019), who used it in a similar study. The search for an evidence-based human trafficking tool did not yield results during a focused search for an appropriate measure.

5.4 Limitations

The sampling method is a limitation of this project. A convenience sample cannot be generalized as it does not represent the population.

Another limitation of the project is that the responses on the Likert survey were self-reported and prone to reporting biases. Internal validity threats (participants who do not respond truthfully) and external validity threats (differences in responses by participants who complete surveys and those who do not complete surveys) are additional project limitations.

The educational intervention was one hour in duration. Presentations that are longer with at least bi-annual updates may prove beneficial to public health obstetric care staff. Additional studies are necessary to investigate this possibility.

5.5 Implications

The results of this study bring attention to the importance of ensuring obstetric providers and clinicians are prepared to identify facilitators and barriers to identifying sex-trafficked victims and providing care, resources, and referrals to this population.

Nursing education programs should incorporate training and education specific to victims of human trafficking into their curriculums. Evidence-based protocols are necessary for healthcare providers to increase their confidence in their ability to recognize and provide optimal care for human trafficking victims.

The ability to recognize facilitators and barriers to identifying and treating these victims opens the possibility for further studies to identify patterns and clusters of adverse health outcomes and recommend, develop, and implement targeted preventative interventions (Willis et al., 2022).

Additional studies are necessary to add evidence-based studies to the body of knowledge for the care of pregnant sex-trafficked victims.

5.6 Recommendations

The development of evidence-based policies and protocols to care for sex-trafficked victims is required to standardize care for this vulnerable population.

It is crucial to ensure obstetric care and other healthcare disciplines' providers and clinicians receive ongoing evidence-based human trafficking education and training to increase self-efficacy and confidence, including sex trafficking; training is necessary to raise awareness of facilitators and barriers to identifying trafficked victims and to inform primary care providers about available treatment and support options (Costa et al., 2019).

5.7 Conclusion

Approximately one in four women become pregnant when trafficked. Studies have indicated that obstetric care is vital in identifying, providing appropriate healthcare services, supporting, and appropriately referring trafficked women and girls (Bick et al., 2017). The ability to recognize facilitators and barriers to identifying and treating these victims is a potential segway for further studies to identify sex-trafficked obstetric victims and patterns of adverse health outcomes. Opportunities may be available to recommend, develop, and implement evidence-based, targeted interventions, referrals, and resources (Willis et al., 2022).

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Appendix A: Measurement Tools-Facilitators and Barriers in Obstetric Care for Sex-Trafficked Victims

Demographic Information: Please select the appropriate answers to the following:

1. Profession
_____ Registered Nurse
_____ Nurse Practitioner

2. Specialty Certification (select all that apply)
_____ Nurse Executive
_____ Nurse Executive, Advanced
_____ Family Nurse Practitioner
_____ Clinical Nurse Specialist (please write specialty below)
_____
_____ Other(please write in below)
_____

3. Number of years as a Registered Nurse
_____Not a Registered Nurse
_____ 0-5 years
_____ 6-10 years
_____ 11-15 years
_____ 16-20 years
_____ >20 years

4. Number of years working in Public Health Obstetric Care
_____ 0-5 years
_____ 6-10 years
_____ 11-15 years
_____ 16-20 years
_____ >20 years

5. Highest level of education completed
_____ Associates Degree
_____ Diploma
_____ Baccalaureate Degree
_____ Master's degree in nursing
_____Master's degree in social work
_____ Doctorate (M.D., DNP, PhD)
_____ Other (please specify below)
_____

6. Do you recall having education in your primary or advanced (graduate) academic program on human sex trafficking?
Primary Academic Program:
_____ Yes
_____ No
_____ Do not recall

Advanced Academic Program
_____ Yes
_____ No

_____ Do not recall

7. In the past six months, how many patients have you cared for who you suspected or confirmed were sex-trafficked victims?
_____ Unsure
_____ None
_____ 0 - 5
_____ 6-10
_____ >10

8. Do you believe that supplemental education regarding sex trafficking would be of benefit to you?
_____ Yes
_____ No
_____ Undecided

9. Do you believe supplemental education regarding sex trafficking should be required for obstetric care clinicians and providers?
_____ Yes
_____ No
_____ Undecided

Pretest (Posttest): Level of Knowledge

Select one answer for each question below and circle your response.

1. Sex trafficking is defined by the National Human Trafficking Resouce Center (NHTRC) as:
   A. Women who are commercial sex workers
   B. A crime involving the exploitation of a woman for commercial sex using force, fraud, or coercion.
   C. Exposure of a person to sexual abuse
   D. None of the above

2. Barriers to sex-trafficked victims' self-identification include:
   A. Shame or guilt
   B. Fear of retaliation by the trafficker
   C. Fear of arrest
   D. All of the above

3. General indicators of sex trafficking may include:
   A. Inappropriate dress for weather or situation
   B. Malnutrition or dehydration
   C. Persistent Vomiting
   D. Illness from exposure to chemicals or unsafe water supply

4. All communication with suspected sex-trafficked victims is confidential except for the following:
   A. Information about family issues
   B. The suspected sex-trafficked victim threatens harm to self or others
   C. HIPAA-protected information
   D. Non-life-threatening health conditions

5. Initial assessments may:

A. Assess for immediate safety
B. Be conducted individually and in a safe location
C. Include only information necessary to conduct the assessment
D. All of the above

6. Facilitators that may assist in recognizing sex-trafficked victims include:
A) Maternity-specific guidelines for sex-trafficked women
B) Knowledge and awareness of the signs of sex trafficking
C) An only
D) A and B

7. Antenatal risk factors that place sex-trafficked victims at risk for poor pregnancy outcomes include:
A. Current or previous diagnosis of depression
B. Sexually transmitted infections
C. Intimate partner violence
D. All of the above

8. To prevent adverse maternal outcomes, sex-trafficked women who become pregnant are at risk of:
A. High rates of sexually transmitted infections
B. Mental health problems
C. Delaying prenatal care
D. All of the above

9. Maternity services for sex-trafficked victims are important to:
A. Identify health concerns, support healthy pregnancies and refer victims as needed
B. Avoid the Department of Social Services obtaining custody at the infant's birth
C. Assist law enforcement in prosecuting the trafficker
D. Secure funding for high-risk pregnancies

10. Sex-trafficked pregnant victims may continue commercial sex work because:
A. The victim is afraid to leave their trafficker
B. The victim has established a trauma bond with their trafficker
C. The victim considers herself, the infant, and the trafficker a family
D. All of the above

Pretest (Posttest): Confidence/Self-Efficacy

Please mark each of the following statements with an X as your response to the following statements using this 5-point Likert Scale:
1 - Strongly Agree
2 - Agree
3 – Disagree
4 – Strongly Disagree

Statement	1	2	3	4
1. I believe that I <u>have adequate knowledge and skills</u> to provide evidence-based best practices in the				

obstetric care setting care to a patient who has experienced sex trafficking.				
2. I am confident in my ability to recognize signs of sex trafficking in the obstetric care setting.				
3. I am confident asking a patient questions that pertain to sex trafficking				
4. I am confident asking a patient questions about families, caregivers, and friends that pertain to sex trafficking.				
5. I am confident in my ability to initiate interventions with members of the interprofessional team for a patient who has been sex trafficked.				
6. I am not confident that I am a valued member of the interprofessional team for a patient who has been sex trafficked.				
7. I am confident in my ability to document accurate clinical assessment findings and interventions in the medical record.				
8. I am not confident in my ability to recognize barriers to identifying sex-trafficked patients				
9. I am confident in my ability to conduct a physical assessment on a patient who has experienced sex trafficking.				
10. How well do you rate your overall confidence in the care of a patient who has been sex trafficked?				

Appendix B: Recruitment Flyer

FACILITATORS AND BARRIERS IN OBSTETRIC CARE in the IDENTIFICATION OF SEX-TRAFFICKED VICTIMS


https://www.bbc.com/news/world-europe-39755742

Are you a Maternal Health Clinic Provider or Nurse Clinician?

and

Interested in participating in a study to help understand how public health providers and clinicians perceive sex-trafficking indicators when caring for pregnant victims?

Take one of the numbers below and call for more information.

919-627-2713	919-627-2713	919-627-2713	919-627-2713	919-627-2713	919-627-2713	919-627-2713	919-627-2713	919-627-2713	919-627-2713	919-627-2713

Appendix C: Recruitment Script

Verbal Recruitment Script - Facilitators and Barriers in Obstetric Care for Sex-Trafficked Victims

- Hello. My name is Cheryl Scott. I am a doctoral nursing student at UNCC. I want to share some information about a research study I am working on and ask if you will consider participating in this study. I want to share what I learned about how confident maternity healthcare providers: advanced practice providers, and nurse clinicians, are in identifying sex-trafficked pregnant women when they are in for prenatal visits.

- According to the NC Human Trafficking Commission, NC is a hot spot for human trafficking and has consistently ranked in the 10 ten in the US for over ten years. Pregnant women are among the populations of men, women, and children trafficked for sex. Sex trafficking has significant adverse health impacts on sex-trafficked pregnant women, including risks of physical and emotional health issues associated with pregnancies that, in turn, affect maternal and fetal outcomes.

- This study aims to determine if participation in an educational intervention increases nurses' confidence in their knowledge of the facilitators and barriers to identifying sex-trafficked pregnant women.

- <u>A couple of the many reasons to participate include:</u>
    - Focusing on pregnant sex-trafficked women as a distinct group facilitates identifying their specific needs and risk factors and
    - Helping healthcare providers understand the facilitators and barriers in identifying these victims
    - Knowledge of facilitators and barriers to maternity care, especially in the first trimester, is essential.

Lastly, there are a few more details about the project that I want to share with you.

- You may benefit from the educational intervention by increasing your ability to assess and improve your awareness and knowledge of facilitators and barriers in identifying pregnant, sex-trafficked women.
- One risk is that you may feel pressure to participate in this project because we all work in public health and are coworkers. If you decide to participate and feel uncomfortable at any time during the project, you can also withdraw at any time.
- The project requires participation on two days scheduled 30 days apart. On the first day, I'm asking for approximately 1 hour and 20 minutes of your time to complete a pretest, view and discuss the educational intervention, which is a PowerPoint presentation and take a post-test.

    - In 30 days, you will complete a posttest; we will review the test and discuss the presentation again. This will take approximately an hour.

    - Do you have any questions about anything I just shared with you?

- Would you like to help?
    - Maternal Health Clinic Providers or Nurse Clinicians who work in Durham County Public Health's Maternal Health Clinic are eligible.

If you have any questions or are interested in participating in this study, take one of the phone numbers at the bottom of the flyer and call for additional information or to enroll in the study.

Thank you for helping to improve the health care for sex-trafficked pregnant women.

Appendix D: Participant Consent to Participate in a Scholarly Nursing Project

Title of the Scholarly Nursing Project: Facilitators and Barriers in Obstetric Care for Sex-Trafficked Victims
Scholarly Nursing Project Leader: Cheryl Scott, MN/MPH, RN, Doctoral Nursing Student, University of North Carolina Charlotte
Co-Leader Scholarly Nursing Project Not applicable
Study Sponsor: Not applicable

Important Information You Need to Know

The purpose of this scholarly nursing project is to determine how participation in an educational intervention affects providers' knowledge of the facilitators and barriers to the identification of pregnant sex-trafficked women.

I am asking Senior Public Health Nurses and Women's Health Nurse Practitioners who work in the Durham County Department of Public Health's Maternal Health Clinic in direct nursing practice roles to volunteer to participate in this scholarly nursing project. A signed confidentiality agreement will also confirm your enrollment in this project. Your decision to accept or decline participation in this project will not influence any aspect of employment in the Durham County Department of Public Health's Maternal Health Clinic. Each educational intervention offering will be limited to a maximum of ten participants.

What benefits might I experience?

The potential benefits of participating in this study are that you may gain additional nursing assessment skills that will contribute positively to your nursing practice. Through an educational intervention, public health nurses may increase their ability to assess and improve their awareness and knowledge of facilitators and barriers in identifying pregnant, sex-trafficked women. The educational intervention may be helpful in your work setting by helping you realize a need to learn or refresh your knowledge regarding this topic. Participation in this educational intervention may increase your confidence in identifying pregnant sex-trafficked women and help you appropriately respond to potential sex-trafficked victims regarding their trafficking experiences and healthcare concerns.

What risks might I experience?

Foreseeable risks or discomforts you may experience by participating in this project include feeling the educational intervention is unnecessary or insufficient for your job responsibilities, doubting your ability, or experiencing an inability to identify sex-trafficked victims and provide appropriate interventions. You may think human trafficking training is irrelevant to your current practice setting due to your patient population or location. You may feel discomfort in assessing pregnant sex-trafficked women or feel there is no time to assess sex-trafficked patients because of other care requirements and less time available for this assessment. You may feel embarrassed by the topic of the educational intervention. You may feel pressured or obligated to participate in this research study because you

and the scholarly project leader are co-workers. You may feel obligated to participate in the project because of perceived pressure due to a perceived position of power or influence associated with the lead investigator/project leader that could be a source of emotional and psychological discomfort. To decrease the likelihood of inferring a sense of obligation for you to participate in this study and to protect against or minimize potential risks that have been described, you will receive information regarding the study during the information session through responses to questions and answers that may be asked regarding sex-trafficked pregnant women, your right to accept or decline participation in the research study, and again during the project's consent process if you decide to participate in the scholarly project. There are opportunities to decrease or minimize your potential risks by asking questions regarding specific concerns or choosing not to participate in the project. After enrolling in the project, you may skip questions you do not want to answer or withdraw from the project at any time. Your decision to accept or decline to participate in this project will not influence any aspect of your employment.

Please read this form and ask any questions you may have before you decide whether to participate in this research study.

Why am I doing this Scholarly Nursing Project?

This scholarly nursing project aims to determine how participation in an educational intervention affects providers' knowledge of the facilitators and barriers to identifying and intervening with pregnant sex-trafficking victims.

Why are you being asked to be in this research study?

You are being asked to participate in this scholarly nursing project because you work in the Durham County Department of Public Health's Maternal Health Clinic and provide nursing care to pregnant patients.

What will happen if I take part in this study?

If you choose to participate, you will complete a pretest (which consists of Likert-type questions and vignettes) and take a five-minute break. The scholarly nursing project leader will present the educational intervention, after which the participants will take the post-test, followed by a discussion. The scholarly nursing project leader will offer you a box lunch during your attendance and participation during the intervention. Thirty (30) days after the intervention, the project lead will
follow up with a post-test for the participants to re-assess their knowledge of facilitators and barriers to identifying sex-trafficked patients.

How will my information be protected?

Your name will be collected and matched with a corresponding code placed on the pre and post-tests and surveys. Your confidentiality will remain protected from disclosure to everyone except the scholarly nursing project leader. The information collected will be used for this project's purposes only. Codes will substitute for your identifying information. All paper data will be locked in file cabinets in a locked office. Master lists will be stored

in a separate file cabinet from the data and destroyed after the project. If any electronic data is collected, files will be password protected and opened only when used by the project investigator. The data file will be closed when not in use. Your contact information will be maintained in a locked cabinet in a locked office.

How will my information be used after the scholarly nursing project is over?
After this study is complete, scholarly nursing project data may be shared with other nursing project leaders for further studies without asking for your consent or as may be needed as part of publishing our results. The data we share will NOT include information that could identify you.

Will I receive an incentive for taking part in this scholarly nursing project?
No incentive will be offered for taking part in this project.

What are my rights if I take part in this scholarly nursing project?
It is up to you to decide to be in this scholarly nursing project. Participating in this project is voluntary. Even if you choose to be part of the scholarly nursing project now, you may change your mind and stop anytime. You can answer any questions you want to answer.

Who can answer my questions about this scholarly nursing project and my rights as a participant?
For questions about this scholarly nursing project, you may contact the project leader, Cheryl Scott, MN/MPH, RN, UNCC Doctoral Nursing Student, at email: cscott91@uncc@uncc.edu, mobile phone: 919-360-3994, or the scholarly nursing project leader's faculty advisor, Dr. Katherine Jordan, email: ksjorda1@uncc.edu.

If you have questions about your rights as a research participant or wish to obtain information, ask questions, or discuss any concerns about this study with someone other than the researcher(s), please get in touch with the Office of Research Protections and Integrity at 704-687-1871 or uncc-irb@uncc.edu.

Consent to Participate

By signing this document, you agree to participate in this scholarly nursing project. Make sure you understand the scholarly nursing project before you sign this consent to participate. You will receive a copy of this document for your records. Suppose you have questions about the scholarly nursing project after signing this document. In that case, you can contact the scholarly nursing project leader or the scholarly nursing project leader's faculty advisor using the information provided above.

By signing this consent, you agree to and understand the following:

- I understand the scholarly nursing project, and my questions so far have been answered.
- I agree to take part in this study.

- A copy of this signed consent form will be given to you.
- Your signature below means that you freely agree to participate in this study.

_____
Participant Name (PRINT)

_____
Signature Date

_____
Name & Signature of the Person Obtaining Consent Date

Appendix E: Outline - Educational Intervention

DNP Scholarly Nursing Project

Facilitators and Barriers in Obstetric Care to the Identification of Sex-Trafficked Victims

Outline - Educational Intervention

(PowerPoint presentation and Discussion)

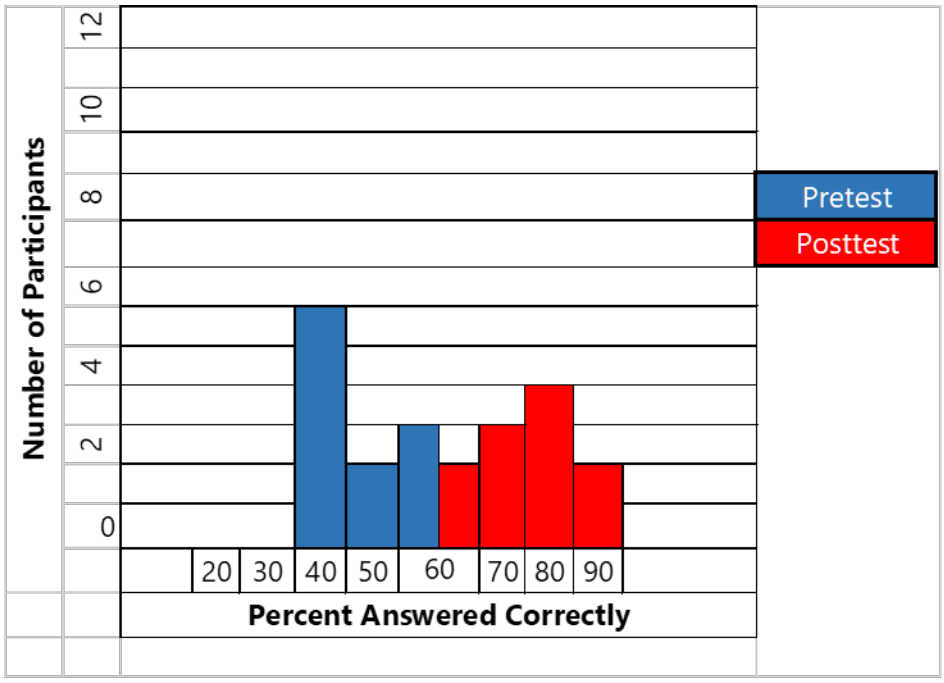
I. Introduction/Background
   A. Objective of this Educational Intervention
      1. Assess the Nurse Providers' and Clinicians' level of knowledge and confidence to identify pregnant sex-trafficked victims
   B. Overview of Educational Intervention
      1. Pre-test
   C. Definition of Human Trafficking
      1. Types of Human Trafficking
         a. Labor
         b. Sex
   D. Scope of the problem
      1. The United States and the global market
      2. Human Rights and Human Trafficking

II. Human Trafficking and its Health Impacts
   A. Sex Trafficking and Women's Health
   B. Sex Trafficking and Pregnant Women's Health
   C. Nurse Providers' and Clinicians' Maternity Care Assessments
      1. Facilitators and Barriers to the Identification of Pregnant Sex-Trafficked Victims
      2. Facilitators (examples)
      3. Barriers (examples)
      4. The rationale and importance of Nurse Providers' and Clinicians' knowledge and awareness of Facilitators and Barriers to the Identification of Pregnant Sex-Trafficked Victims
      5. Post-test
   D. Summary
      1. Review post-test
      2. Questions regarding the educational intervention

Appendix F: TABLE 1 Examples of the Educational Intervention
Pretest and Posttest Questions

APPENDIX B - Examples of the Educational Intervention Pretest and Posttest Questions
TABLE 1 Examples of the Educational Intervention Pretest and Posttest Questions
1. Facilitators that may assist in recognizing sex-trafficked victims include
A. Maternity-specific guidelines for sex-trafficked women
B. Knowledge and awareness of the signs of sex trafficking
C. A only
D. A and B
2. Sex-trafficked pregnant victims may continue commercial sex work because
A. The victim is afraid to leave their trafficker
B. The victim has established a trauma bond with their trafficker
C. The victim considers herself, the infant, and the trafficker a family
D. All of the above

Appendix G: FIGURE 1. Frequency distribution of pretest and posttest scores



Appendix H: IRB Approval

Division of Research

To:	Cheryl Scott University of North Carolina at Charlotte
From:	Office of Research Protections and Integrity
Approval Date:	15-Nov-2022
RE:	Notice of Determination of Exemption
Exemption Category:	1
Study #:	IRB-22-0901
Study Title:	Facilitators and Barriers in Obstetric Care for Sex-Trafficked Victims

This submission has been reviewed by the Office of Research Protections and Integrity (ORPI) and was determined to meet the Exempt category cited above under 45 CFR 46.104(d). This determination has no expiration or end date and is not subject to an annual continuing review. However, you are required to obtain approval for all changes to any aspect of this study before they can be implemented to comply with the Investigator Responsibilities detailed below.

Important Information:

1. Face masks are optional on UNC Charlotte's campus. This includes classrooms and other academic spaces. Researchers conducting HSR activities in other locations must continue to adhere to local and state requirements in the setting where the research is conducted.
2. Face masks are still required in healthcare settings. Researchers conducting HSR activities in these settings must continue to adhere to face coving requirements.
3. Organizations, institutions, agencies, businesses, etc. may have further site-specific requirements such as continuing to have a mask requirement, limiting access, and/or physical distancing. Researchers must adhere to all requirements mandated by the study site.

Your approved consent forms (if applicable) and other documents are available online at Submission Page.

Investigator's Responsibilities:

1. Amendments **must** be submitted for review and the amendment approved before implementing the amendment. This includes changes to study procedures, study materials, personnel, etc.
2. Data security procedures must follow procedures as described in the protocol and in accordance with OneIT Guidelines for Data Handling.

3. Promptly notify the IRB office (uncc-irb@uncc.edu) of any adverse events or unanticipated risks to participants or others.
4. Five years (5) following this approval/determination, you must complete the Admin-Check In form via Niner Research to provide a study status update.
5. Be aware that this study is included in the Office of Research Protections and Integrity (ORPI) Post-Approval Monitoring program and may be selected for post-review monitoring at some point in the future.
6. Reply to the ORPI post-review monitoring and administrative check-ins that will be conducted periodically to update ORPI as to the status of the study.
7. Complete the Closure eform via Niner Research once the study is complete.

Please be aware that approval may still be required from other relevant authorities or "gatekeepers" (e.g., school principals, facility directors, custodians of records).

Appendix I: Institutional Review Board (IRB)/Independent Ethics Committee (IEC)
Authorization Agreement

University of North Carolina Charlotte:

_____

IRB Registration #: IRB-22-0901 Federalwide Assurance (FWA) #, if any: N/A

Durham County Department of Public Health:

_____

FWA #: N/A

The Officials signing below agree that the Durham County Department of Public Health may rely on the designated IRB for review and continuing oversight of its human subjects research described below: (*check one*)

(___) This agreement applies to all human subjects research covered by the Durham County Department of Public Health may FWA.

(___) This agreement is limited to the following specific protocol(s):

Name of Research Project: _____
Name of Principal Investigator: _____
Sponsor or Funding Agency: _____ Award Number, if any: _____

(X) Other (*describe*): The scholarly project is approved as exempt by UNCC and does not include human subjects. Please see the attached IRB-22-0901 UNCC.

The review performed by the designated IRB will meet the human subject protection requirements of the Durham County Department of Public Health and may be OHRP-approved FWA. The University of North Carolina Charlotte IRB will follow written procedures for reporting its findings and actions to appropriate Durham County Department of Public Health officials. Relevant minutes of IRB meetings will be made available to the Durham County Department of Public Health upon request. The Durham County Department of Public Health remains responsible for ensuring compliance with the IRB's determinations and the Terms of its OHRP-approved FWA. This document must be kept on file by both parties and provided to OHRP upon request.

Signature of Signatory Official **University of North Carolina Charlotte**:

_____ Date: _____

Print Full Name: _____ Institutional Title: _____

***NOTE**: The IRB of the University of North Carolina Charlotte must be designated*

on the OHRP-approved FWA for the Durham County Department of Public Health.

Signature of Signatory Official **Durham County Department of Public Health**:

Signature: Rodney E Jenkins Date: 12/12/2022

Print Full Name: Rodney Ellis Jenkins Institutional Title: Public Health Director