Title

Midwives' experiences and perceptions in treating victims of sex trafficking: a qualitative study

Abstract

Aim: To explore the perceptions and experiences of midwives in the treatment of sex trafficking victims.

Design: The study was qualitative with a hermeneutic-phenomenological approach, using semi-structured interviews and focus groups.

Methods: Two focus groups and six interviews were carried out on fourteen midwives in primary care, delivery and emergency rooms. Data was collected in three hospitals in Spain in June 2021. ATLAS.ti 9 software was used to conduct a content analysis of the focus group and interview data.

Results: The results revealed two primary themes and six subthemes. The two primary themes were (i) sex trafficking: a camouflaged reality on the invisible spectrum, and (ii) a thirst for attention in the aftermath of violence. Representative quotations were used to illustrate both the main themes and the subthemes.

Conclusions: This study provides new insight into midwives' experiences treating sex trafficking victims. Professionals view this type of violence as a silent issue that negatively impacts victims' health and livelihood. However, a number of different factors stand in the way of correctly identifying and treating victims. Therefore, healthcare workers must be provided with practical tools and continuous professional development on this topic.

Impact: This study indicates the importance of the midwives' key role in identifying and assisting victims of sex. Not only do measures in the healthcare setting, such as on-going specific-related content training or up-to-date protocols, need to be implemented to ensure proper care for those affected by sexual exploitation, but focusing on suspicious

characteristics and reducing obstacles to patient communication will help bring the true situation to light and better respond to patients' priority needs.

Keywords: midwives; nursing; qualitive research; sex trafficking

INTRODUCTION

Human trafficking is defined as the capture, transportation, or receipt of people using threats, force, coercion, fraud, abuse of power or vulnerable situations with the aim of exploiting the victim, either sexually, or through forced labor, slavery or organ extraction (Baird et al., 2020; Tracy & MacIas-Konstantopoulos, 2017; United Nations Office on Drugs and Crime, 2014). Sexual exploitation continues to be one of the most common types of trafficking (Ottisova et al., 2016), constituting a public health problem that has considerable effects on the health and well-being of its victims, which also violates various fundamental rights such as the right to life, physical and moral integrity, sexual freedom and human dignity (Lepianka & Colbert, 2020; Talbott et al., 2020).

It is estimated that 25 million people are subjected to forced manual labor or sex work around the world, of which, 4.9 million are victims of sexual exploitation (International Labour Office, 2017). In Western and Southern European countries, sexual exploitation remains the form of trafficking detected most often (44%), where the majority of victims are adult women (37%) who are most commonly from countries in Central and Southeast Europe (32%) and Sub-Saharan Africa (11%) (United Nations Office on Drugs and Crime, 2020).

BACKGROUND

Several studies have confirmed the many negative effects of sex trafficking on victims' physical, mental, sexual and reproductive health (Fazio et al., 2021; Le et al., 2018; Rothman et al., 2017; Williamson et al., 2020). Healthcare services are one of the resources most frequently accessed by people involved in this crime, which might have also negative consequences on the psychological and emotional health of professionals who are frequently confronted with such situations (Horvath et al., 2020; Kliner & Stroud, 2012). Health care providers play a key role in detection and identification of victims (Chisolm-Straker et al., 2016; Gibbons & Stoklosa, 2016); however, many victims have

difficulty accessing adequate care, or when they seek care, are not correctly identified as true victims of sex trafficking (Lederer & Wetzel, 2014; McDow & Dols, 2021).

The relationship between sex trafficking, its impact on victims' health and the role of healthcare professionals has been studied by different researchers over the years (Chisolm-Straker et al., 2016; Gibbons & Stoklosa, 2016; Le et al., 2018; Lederer & Wetzel, 2014; McDow & Dols, 2021). Researchers have attempted to reveal both the perspectives of those directly involved in this type of violence and their perceptions of the care they receive from medical personnel (Baldwin et al., 2011; Bick et al., 2017; Westwood et al., 2016), as well as the experiences of both healthcare and other professionals with trafficking and the practical approach they take to address it (Beck et al., 2015; Gerassi & Pederson, 2021; Testa, 2020).

However, the figure of the midwife deserves more research attention, a medical professional who is likely to be in contact with possible victims, despite the fact that gynecology and obstetrics, as well as emergency services and primary care, are the healthcare services most often utilized by sex trafficking victims (Chisolm-Straker et al., 2016). Most of the available research on this topic, moreover, focuses on the study of general human trafficking on a global scale, without an emphasis on sex trafficking. Thus, this research would allow us to explore midwives' perspective on sexual exploitation to increase the quality of care and to provide guidance for the development of preventive interventions and strategies.

THE STUDY

Aim

The aim of this study is to explore the perceptions and experiences of midwives in the care of victims of sex trafficking.

Design

In June 2021, a qualitative study using a phenomenological approach was conducted to answer the following research question: how do midwives perceive and understand care for victims of sex trafficking? The research was conducted with the understanding that

sex trafficking is a construct that requires comprehensive study based on the experiences of patients or professionals and that could only be understood through deep inquiry. To achieve this, Gadamer's hermeneutic approach was used, according to which, neither human experience nor phenomena can be understood separate from language, but rather, must be evaluated through dialogue with others, in a fusion of horizons. Dialogue with others and understanding of their narratives allows meaning to emerge (Gadamer, 2007; Hermanus-Demon, 2013).

Participants

The study sample consisted of midwives who performed their work in different clinical areas (Emergency, Labor & Delivery, and Primary Care departments) (Table 1). Convenience sampling was used, with the following inclusion criteria: (i) having at least 5 years of experience as a midwife, (ii) having participated in the care of sex trafficking victims, and (iii) submitting a signed informed consent to participate in the study. No exclusion criteria were established.

[INSERT TABLE 1 AROUND HERE]

Data collection

Data collection took place in June 2021, through semi-structured in-depth interviews and focus groups (FG) (Supplementary Table S1). First, 2 FGs were carried out, each consisting of 4 midwives who worked in delivery rooms. Next, 6 in-depth interviews were performed, of which, 3 were with primary care midwives, 2 with emergency room midwives, and one with a labor and delivery midwife. Both the FGs and the in-depth interviews were carried out in person, complying with established safety measures. Each focus group was led by two researchers, one of whom was an expert in lead group dynamics, and an observer who assisted and took field notes. They were audio recorded and the mean duration of the FGs was 60-75 minutes, and the in-depth interviews, 30-40 minutes. Data collection came to an end when data saturation was reached and no new themes emerged. Before the analysis, the participants were given the opportunity to review the transcripts.

Ethical considerations

Approval was obtained from the Ethics Committee of the Department of Nursing, Physical Therapy and Medicine at the University of Almeria (EFM 137/2021) and all the ethical aspects of the Helsinki Declaration were taken into account. Prior to obtaining consent, participants were provided with information on the nature of the study, participation in the study, and the possibility of withdrawing at any time without the need to provide explanation. This ensured the protection of the subjects' right to free decision-making. The rights to privacy, confidentiality and anonymity were also guaranteed through alphanumeric IDs assigned to each participant (IT-X; for interviews or FGX-PX; for focus groups).

Data Analysis

Firstly, the recordings of the interviews and FGs were transcribed. Then, the ATLAS.ti 9 software was used as an analysis tool, performing a content analysis and following the phases proposed by Fleming and collaborators (2003): (i) deciding upon a question; (ii) identifying pre-understandings; (iii) gaining understanding through dialogue with the participants; (iv) gaining understanding through the dialogue with the text and (v) establishing trustworthiness.

Rigor

The consolidated criteria for reporting qualitative research (COREQ) recommendations were followed (Tong et al., 2007). Trustworthiness was determined using Lincoln and Guba (2006) criteria of credibility, transferability, dependability, and confirmability. In the event of a discrepancy, a third reviewer (C.R.-P.) was consulted. To ensure the validity of the study, data (interviews and FG) and researcher triangulation were used, and an independent content analysis was performed (C.R.-G. and P.R.). Set selection criteria and detailed demographic data were used to ensure transferability. Memo writings provided as documentation of analysis over time for dependability, and sharing these memos with co-researchers at each stage of analysis served to preserve confirmability.

FINDINGS

The study sample consisted of 14 midwives, with an average age of 43.7 years old (SD=4.68) and an average of 13 years experience (SD=3.56) caring for patients in gynecology and obstetrics. Conversely, data analysis highlighted two main issues that characterize midwives' perception and experience of caring for patients who are victims of sex trafficking (see Table 2 and Figure 1).

[INSERT TABLE 2 AROUND HERE]

[INSERT FIGURE 1 AROUND HERE]

Theme 1. Sex trafficking: a camouflaged reality on the invisible spectrum

Day after day, victims of sex trafficking live a life of exploitation and humiliation under a shroud of deception, silence and obligation to hide their suffering. Fear of dismantling their situation and their perceived defenselessness only strengthen the chains of the slavery, gradually leading to the vicious cycle of invisibility and ignorance. Certain situations, such as health-related issues, offer victims the opportunity to momentarily leave the "bubble" in which they live. However, the presence of both internal and external obstacles makes it difficult to recognize signs of trafficking, and thus, the likelihood of unmasking such dehumanizing treatment is reduced. Within this theme, three subthemes emerged (Figure 1).

Subtheme 1. Invisible signs, screaming for help

The internal terror experienced by sex trafficking victims is not outwardly evident, just as they often make no references to the situation they are immersed in. This subtheme includes all the signs or clues that professionals detect at the time victims come into contact with the healthcare system, which may cause them to suspect that the situation could be concealing a case of trafficking.

The first contact between the patient and the midwife who is assessing their needs will likely generate an initial shock for the midwife, as there is a discrepancy between what they witness and what they routinely see in their daily clinical practice.

> *"Despite knowing that patients were required to enter the examination room alone due to the pandemic, I did not expect the reaction I got from the person that was accompanying her when I told him that she had to come in alone. His aggressiveness left me puzzled"* (IT-1)

> *"She didn't greet me; she wouldn't even look me in the eye when I spoke to her. She looked like she had seen a ghost, and wouldn't stop shaking"* (IT-2)

Throughout the examination process, isolated, seemingly insignificant signs begin to appear, which the medical professional tries to piece together, while they also provide treatment for the problem which prompted the visit. Most of the midwives stated that, apart from seeking treatment for their health problem or situation, one of the patients' main objectives was to reveal as little as possible about themselves and hide as much information about their external life as possible, and to leave the establishment as quickly as possible, without leaving a trace.

> *"I always tried to speak to the patient, and the person with her always answered for her. I didn't even hear her voice; she just made a quiet sound to say yes to everything just to get it over with faster"* (IT-3)

> *"I got the feeling that everything she was saying had been memorized, like a script that they had studied before they came in"* (IT-1)

> *"She was in an advanced stage of pregnancy and I offered her information about maternity leave. She was unable to describe where she worked or where she lived, and I mentioned the possibility of calling in the translator from the health center. I was speechless when she refused"* (IT-4)

There is often a lack of coherence between patients' oral speech, body language and the examination performed by the professional, which reveals a high level of doubt and distrust. All of these are warning signs that provoke an in-depth investigation of the case in question. The physical examination is a fundamental tool used to clarify any uncertainty about the facts and reveals crucial information that is unlikely to be distorted by external agents. Gynecological examinations performed by midwives in primary care

as well as specialized care have been helpful in providing clues and aiding in the care of otherwise silent victims.

> *"Her wrists were covered in bruises and I asked her if she had had a problem. What she told me didn't add up with I was observing and their versions of the story also didn't match"* (IT-5)

> *"When I performed her vaginal exam, I couldn't believe what I found. I extracted tissues with dried blood on them from inside the vagina which were probably used to hide major bleeding"* (FG1-P1)

Subtheme 2. Concealing slavery through endless obstacles

There are many factors linked to the internal environment of sex trafficking victims that add even greater difficulty to the identification and control efforts made by healthcare professionals. The most frequently referenced obstacle by midwives who participated in this study was the language barrier. The impossibility of having a direct conversation with the patient and asking them necessary questions in order to complete their evaluation often invalidates the clinical experience, to the point of rendering it meaningless, and confusion, indignation and a feeling of inner emptiness prevail.

> *"When you try to inform them and dig a bit deeper, you find the patient looking at you with a weird face because they don't understand anything, and all your efforts go to waste"* (IT-6)

> *"If I notice something that catches my attention and the patient cannot speak my language, it is difficult to figure out whether it is actually true or if it is just a misunderstanding"* (FG2-P3)

The situation that the victims are living in directly impacts their mental health and their decision-making capabilities, as well as their ability to seek and accept help. The psychological trauma they carry distorts their world view and optimizes conditions for them to remain puppets under threat and coercion. This perception is demonstrated, not only when a patient is suspected to be involved in this type of violence, but also by the

testimonies that many women who have escaped sex trafficking have given to some of the midwives involved in the study.

> *"You meet a reserved, withdrawn woman, as if she were living in another dimension. You stop to think and you don't even want to imagine what might be going through her mind"* (IT-3)

> *"When I spoke with women whose pregnancies I had monitored, they assured me that they were under so much mental distress that they didn't even have the strength to ask for help"* (IT-6)

Another frequently repeated aspect in the sex trafficking world is the lack of identification documents patients have available to them to provide minimal information to healthcare facilities. This barrier often makes victims afraid to go to hospitals or health centers. In cases where such documentation is available, it is the trafficker or one of their collaborators who have the self-assigned authority and the power to control everything that has to do with the identity of the affected person. Similarly, a lack of knowledge about the healthcare system usually generates insecurity and reluctance to utilize it, further prolonging the situation.

> *"Some pregnant women who came to follow up when their pregnancy was very far along, the justification they gave me for postponing it when I asked them was their lack of documentation, the fear of being denied access and not knowing how the hospital worked"* (FG2-P4)

> *"It seemed very strange that the person accompanying the patient, who said she was her aunt, had a folder in her bag that included all the patient's documentation"* (IT-2)

Subtheme 3. A missed opportunity for liberation: the influence of the healthcare environment

When victims of sex trafficking decide to or find themselves obligated to use the healthcare system, it is a unique opportunity for healthcare professionals to recognize or bring attention to any suspicious signs or indicators. However, there are some instances

that the obstacles that interfere with or delay the possibility of patients disclosing their situation are not just related to those involved in trafficking, but rather, with the professionals and healthcare institutions themselves. A lack of knowledge on the topic, confusion among concepts and hesitancy in labeling the situation as trafficking are some reasons healthcare professionals cite as obstacles in treating victims.

> *"If I'm being honest, I wouldn't really be able to label something as trafficking because it's not something you see every day, and I don't know what medical signs or behaviors to look for"* (IT-5)

> *"Personally, I wouldn't be able to differentiate a sex trafficking victim from an abuse victim... You realize something is going on, but in one single examination it is hard to know exactly what"* (FG1-P3)

Some midwives in our study reported feeling a sense of shame when they have to ask probing questions to the patient and delve into a path that can be uncomfortable and intimidating for the person who has to answer.

> *"Sometimes, I feel like a judge asking questions that the patient might misinterpret and get angry"* (IT-3)

> *"When the woman says no, I don't ask her anymore. I feel bad forcing someone to answer who has already tried to stop me"* (IT-4)

The lack of a clear plan of action to follow may suppress any initiative to further investigate the case. If a case of sex trafficking is clearly identifiable, it is also met with doubt, of not knowing how to proceed and whether or not to act. Similarly, the confusion of roles among different healthcare professionals involved further complicates the process of recognition and intervention.

> *"What happens to me sometimes is, you see certain warning signs, but you don't dare take that next step. You know that you're not backed up by a clear action plan and you might put the person at risk"* (FG1-P2)

"We passed the buck back and forth between us, there was nothing defined" (IT-5)

The majority of the professionals we interviewed did not feel sufficiently prepared to intervene in the context of sex trafficking. A lack of training, individualized tools, and specific guidelines or intervention protocols were noted by the midwives as detrimental care to their clinical practice.

"I feel that we are not prepared to meet the needs of victims of sex trafficking, but we have not been trained enough" (FG2-P2)

"I don't understand how, in an area like this one, with so much immigration, we don't have any practical guidelines to give us some security" (FG1-P4)

Theme 2: A thirst for attention in the aftermath of violence

Any manifestation of violence leads to a variety of repercussions in all areas of the affected individual, like permanent scars that do not disappear even when the situation of sexual slavery ends. This magnifies the victims' vulnerability and increases their chances of developing health problems. Healthcare professionals act as a person of reference to listen and attend to the arsenal of concerns and feelings that patients entrust to them. Therefore, it is of vital importance to fully comprehend the needs that victims describe and make it a point to meet as many of them as possible, in order of priority. The identification of current shortcomings and the proposal of facilitating measures by healthcare workers contribute to progress and general well-being. Within this topic, three subthemes emerged (Figure 1).

Subtheme 1: Consequences of trafficking on the sexual and reproductive health of victims

A person that has been subject to a trafficking situation, regardless of their sex or age, is at risk of developing complications related their sexual and reproductive health. The midwives who treat issues related to obstetrics and gynecology, have identified two key factors that trigger most such problems: Forced sexual intercourse and abuse during pregnancy. The main reasons for seeking medical help related to forced sex are sexually transmitted diseases, bleeding, urinary tract infections and unwanted pregnancies.

303 *"There have been cases where women have come in who have various*
304 *sexually transmitted diseases at the same time and they come in very*
305 *advanced stages of infection"* (IT-1)

306 *"The person who accompanied her said that she bled when she had sex, and*
307 *it was very unpleasant and wanted us to do something about it fast, because*
308 *if not, the sexual encounters weren't satisfactory"* (IT-6)

309 *"It was the fourth time she had come to the emergency room for the same*
310 *reason. She needed something to terminate her pregnancy as soon as*
311 *possible"* (IT-5)

312 In general, the entire situation has severely negative effects on the correct progression of
313 the pregnancy. Sex trafficking victims require even closer monitoring of their pregnancy,
314 given their vulnerability and their likelihood to refuse care and monitoring. However,
315 difficulty in both identifying the victims and effectively communicating with them
316 impedes or delays early detection and implementation of preventive and evaluative
317 measures. In addition, to a large extent, episodes of abuse throughout a pregnancy alone
318 are a decisive factor which determines the evolution and outcome of the pregnancy.
319 Among the main adverse events that may occur, midwives point out the dangers of
320 miscarriage and miscarriage itself, premature birth, low birth weight, fetal death, and
321 increased perinatal mortality.

322 *"The whole situation that the mother is going through is going to end up*
323 *affecting the fetus, sooner or later"* (FG1-P4)

324 *"I was shocked by the case of one 40-year-old pregnant woman who came*
325 *into the hospital because of an absence of fetal movement, and it ended up*
326 *being a stillbirth. With time, I discovered that she was a possible sex*
327 *trafficking victim and some of the aspects of her care that had previously*
328 *disconcerted me started to make sense"* (IT-4)

329 *"The stress and fear they are constantly subject to, complicated further by*
330 *the violence of the whole situation, leads to a huge increase in miscarriages"*
331 (FG2-P2)

Subtheme 2. Medical professionals: seeking to meet vital needs

The needs of people who are suffering from the effects of sex trafficking may vary and need to be adapted to the circumstances of their particular situation. Therefore, healthcare professionals involved in their care process should identify at what stage the victim is in, encourage them to express their feelings or concerns, and take available appropriate measures to try to solve the problem. The midwives we interviewed cite two different points of view in the detection of needs: Those recognized by healthcare professionals and those referred to by victims.

> *"The first thing that comes to mind is to think that victims need to regain their physical, psychological and emotional health, and to get out of that traumatic environment at once. But then you realize that what they simply need is to live, get through today and focus on their day-to-day"* (IT-4)

> *"Although it is crucial, they don't really care about following any programs or therapy for recuperation or reinsertion into society...they care more about providing food and shelter for their loved ones and protecting them"* (IT-2)

Initially, when the truth of the situation comes to light, the main priorities for midwives are maintaining the patients' privacy, keeping the confession secret and ensuring that the confession does not have consequences on their family situation. Once these needs are met, the process of internal focus and self-concern begins, with midwives attempting to be in the best possible position to serve as a mentor and a protective figure in the victims' immediate environment. In order to offer an answer to the concerns raised, first, any imminent priority issues must be resolved. Only then can they move forward with the strategy that has been determined by the patient and the healthcare professional.

> *"They don't want anything to go wrong, that anyone finds out what they've told us. They feel threatened and even the tiniest mistake might affect their family. For this reason, the first thing they ask for is that we keep silent about it"* (IT-4)

"They feel confused. They want to get out of the exploitation they are living in, but they are more concerned about their role as a mother and protector, who provides for her family" (IT-1)

"The first thing you have to do is try to cover her basic needs. If you skip that step, any other efforts you make will be in vain because they would just be trying to solve the needs that were skipped" (IT-3)

Subtheme 3: Building a way out of slavery

Medical professionals play a crucial role in the process of preventing, identifying and taking action against sex trafficking, and are one of the few figures that most frequently have contact with victims at any time during their exploitation. Despite this fact, the majority of healthcare providers receive little to no training on the subject of human trafficking and feel unprepared to identify or assist victims. Thus, an effort must be made to develop collective measures and encourage the participation of healthcare workers in strategies related to this topic to bring about a change in action and put an end to this situation. The midwives who participated in this study pointed out that training strategies are fundamental, crucial and urgent.

"We should at least be given a course or some training classes that would give us the tools we need, to know what we are facing and how to act" (FG1-P3)

"It would be great to participate in practical workshops where we do role-play or take on a simulated case, so we can learn about the context and have an expert on the topic give us some guidelines" (FG1-P2)

"A good idea would be to prepare a round table discussion that includes professionals and people that have been through this situation. That way, you learn from their experiences" (IT-5)

Once medical professionals have undergone training, action protocols which clearly define practical clinical steps to follow must be created. This would make it less complicated for professionals and save more time for victims. Midwives point out that

this strategy would also facilitate and improve coordination among professionals, interdisciplinary approaches and patient follow-up.

> *"Apart from training, we need some sort of clinical practice guide that addresses this topic that we can keep as a reference when we encounter a case like this"* (FG2-P1)

> *"It would be a good idea to have a document to familiarize ourselves with the local support services available to us that work with the topic of trafficking and their phone numbers to consult with them when needed"* (IT-2)

> *"Being clear about the role of each professional in each case, the objectives, what should be done...and this would also be useful for patient follow-up"* (FG1-P3)

DISCUSSION

The objective of this study was to explore midwives' perceptions and experiences in the care of sex trafficking victims. The phenomenological approach used for this study has allowed us to reach an understanding of the phenomenon in question from a personal, social and professional point of view. The information we collected focused on the view of sex trafficking as a health problem which is difficult to identify, the overall impact on victims' health and a view towards improving the care process proposed by the midwives. Compared to existing studies about this topic, our study provides a more specific and practical look into the issue, with emphasis on healthcare workers and addressing the measures in place to prevent and reduce sex trafficking.

Midwives perceive a number of challenges and obstacles that make identifying and caring for sex trafficking victims increasingly difficult. For instance, Williamson and collaborators (2020) point out that some characteristics such as the language barrier or lack of documentation hinder the process of referral to other services and the monitoring of the victims' health situation. As some studies show, factors linked to the victim and their environment, such as fear of retaliation by traffickers or the continued control imposed upon them, delay access to health services or distort the real reasons why care is being sought (Rajaram & Tidball, 2018; Ravi et al., 2017; Westwood et al., 2016). In

addition, the healthcare system and healthcare providers play a major role in the incorrect identification of victims as well as delays in adopting control measures (Gerassi & Pederson, 2021; Tracy & MacIas-Konstantopoulos, 2017). Participants in several studies have recognized and linked this problem to the limited training they receive about the subject of sex trafficking and the lack of knowledge about systems of intervention available in their field (Murwill, 2018; Ross et al., 2015).

Sex trafficking causes problems in different areas of victims' lives, with health being one of the most seriously affected (Ottisova et al., 2016). In this sense, gynecology and obstetrics services represent a meeting point, where people suffering from sexual exploitation are likely to go for help (Zimmerman et al., 2014). In accordance with the results of our study, the research performed by Bick and collaborators (2017) highlights unwanted pregnancies and miscarriages as the main causes for seeking healthcare among victims. However, the needs identified by healthcare professionals do not always coincide with those of sex trafficking victims (Schwarz et al., 2016). Regarding this fact, Hemmings and collaborators (2016) argue that healthcare workers who provide care for victims must be attuned to victims' needs as much as possible, and a multidisciplinary approach must be taken to respond to them.

Regarding the structure of the healthcare system and the resources available to manage this situation, we have found significant shortcomings. The lack of professional training and the limited availability of accessible tools directly impact patient care (George et al., 2017). With few properly-equipped and trained workers, misidentification and under-preparedness continue to be a significant obstacle to adequate care (Hemmings et al., 2016). This leads to missing a unique opportunity to intervene in the cycle of exploitation and improve the health of victims (Gibbons & Stoklosa, 2016). All of these characteristics, together with the sensitivity expected by the situation, heighten the vulnerability of professionals who have direct contact with victims of sex trafficking, increasing the risk of psychological and emotional disorders. Burnout and secondary traumatic stress disorder are two of the most commonly associated problems with professionals caring for such patients, who exhibit fatigue, helplessness, a lack of understanding, hopelessness, and a constant concern for the well-being of the victim (Horvath et al., 2020; Kliner & Stroud, 2012).

In additional to continued professional development strategies (Davy, 2016), participants in this study emphasized the need for the creation of protocols and guidelines to action as key factors in improving their approach to and understanding of sex trafficking victims. Related to this fact, McDow and Dols (2021) developed a model composed of 5 simple questions healthcare professionals can use to rapidly identify possible victims. Therefore, it is recommended that sex trafficking be included within healthcare workers' compulsory professional development, as well as implementing the use of a homogenous practical tool to intervene in situations where sex trafficking is suspected. That way, sex trafficking it would go from being a hidden and forgotten topic to a potentially detectable and avoidable reality (Macias-Konstantopoulos, 2016).

Limitations

There are several limitations to this study that must be taken into account when interpreting the results. The study sample was composed solely of midwives who worked within the public healthcare system. Thus, a more heterogeneous sample of professionals who care for victims would have provided different perspectives. Nonetheless, with the goal of obtaining a representative sample of the target population, midwives from different areas were selected for our study. On the other hand, the perception of care for male victims of sex trafficking has not been taken into account, because they are generally not treated by midwives. Regarding sample selection, this study addresses a serious problem from the perspective of healthcare professionals who have experience with sex trafficking victims. However, the perceptions and experiences of the affected women themselves were not considered. Therefore, future studies should include sex trafficking victims among their participants, with the objective of better identifying their needs.

CONCLUSIONS

In this study we have explored the perceptions and experiences of midwives in the treatment of sex trafficking victims. Midwives consider trafficking a reality that is hidden in the day-to-day lives of their patients, and there are both factors related to the victims and to the health system itself that make recognizing cases and taking action difficult. While sex trafficking has negative repercussions on the heath of the affected patients, with serious consequences, especially on women's sexual and reproductive health, there

are also some important negative impacts on emotional and psychological health for professionals to consider, which may lead to mental disorders such as burnout or secondary stress disorder. The situation of sexual slavery that victims are involved in presents many needs and priorities, which professionals must recognize and respond to before the situation worsens. Therefore, healthcare managers and providers who encounter sex trafficking situations in their clinical practice consider it vitally important to acquire specific knowledge in order to minimize negative consequences for both sex trafficking victims and professionals, as well as better resource-allocation strategies to eliminate or mitigate this type of violence as a public health problem.

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CONFLICT OF INTEREST

The authors have no conflict of interest to report.

REFERENCES

Baird, K., McDonald, K.P., & Connolly, J. (2020). Sex trafficking of women and girls in a southern Ontario region: Police file review exploring victim characteristics, trafficking experiences, and the intersection with child welfare. *Canadian Journal of Behavioural Science*, *52*(1), 8–17. https://doi.org/10.1037/cbs0000151

Baldwin, S.B., Eisenman, D.P., Sayles, J.N., Ryan, G., & Chuang, K.S. (2011). Identification of human trafficking victims in health care settings. *Health and Human Rights, 13*(1), E36-49.

Beck, M.E., Lineer, M.M., Melzer-Lange, M., Simpson, P., Nugent, M., & Rabbitt, A. (2015). Medical providers' understanding of sex trafficking and their experience with at-risk patients. *Pediatrics*, *135*(4), 895–902. https://doi.org/10.1542/peds.2014-2814

503 Bick, D., Howard, L.M., Oram, S., & Zimmerman, C. (2017). Maternity care for
504 trafficked women: Survivor experiences and clinicians' perspectives in the United
505 Kingdom's National Health Service. *PLoS ONE*, *12*(11), 1–13.
506 https://doi.org/10.1371/journal.pone.0187856

507 Chisolm-Straker, M., Baldwin, S., Gaïgbé-Togbé, B., Ndukwe, N., Johnson, P.N., &
508 Richardson, L.D. (2016). Health care and human trafficking: We are seeing the
509 unseen. *Journal of Health Care for the Poor and Underserved*, *27*(3), 1220–1233.
510 https://doi.org/10.1353/hpu.2016.0131

511 Davy, D. (2016). Human Trafficking and Slavery in Australia: Pathways, Tactics, and
512 Subtle Elements of Enslavement. *Women and Criminal Justice*, *26*(3), 180–198.
513 https://doi.org/10.1080/08974454.2015.1087363

514 Fazio, N., Lynch, J., Devlin, M., & Kameg, B. (2021). Mental health problems among
515 youth experiencing sex trafficking. *Nursing*, *51*(3), 24–29.
516 https://doi.org/10.1097/01.NURSE.0000733940.33418.9d

517 Fleming, V., Gaidys, U., & Robb, Y. (2003). Hermeneutic research in nursing:
518 Developing a Gadamerian-based research method. *Nursing Inquiry*, *10*(2), 113–
519 120. https://doi.org/10.1046/j.1440-1800.2003.00163.x

520 Gadamer, H.G. (2007). Fundamentos para una teoría de la experiencia hermenéutica.
521 *Verdad y Método I*, 331–458.

522 George, E., McNaughton, D., & Tsourtos, G. (2017). An Interpretive Analysis of
523 Australia's Approach to Human Trafficking and Its Focus on Criminal Justice
524 Over Public Health. *Journal of Human Trafficking*, *3*(2), 81–92.
525 https://doi.org/10.1080/23322705.2016.1153367

526 Gerassi, L., & Pederson, A. (2021). "Have you ever traded sex for money or drugs?"
527 Health care providers' perspectives on sex trafficking risk assessments in clinics.
528 *Journal of Health Services Research & Policy*, 1355819621997478.
529 https://doi.org/10.1177/1355819621997478

Gibbons, P., & Stoklosa, H. (2016). Identification and Treatment of Human Trafficking Victims in the Emergency Department: A Case Report. *Journal of Emergency Medicine*, *50*(5), 715–719. https://doi.org/10.1016/j.jemermed.2016.01.004

Hemmings, S., Jakobowitz, S., Abas, M., Bick, D., Howard, L.M., Stanley, N., Zimmerman, C., & Oram, S. (2016). Responding to the health needs of survivors of human trafficking: A systematic review. *BMC Health Services Research*, *16*(1), 1–9. https://doi.org/10.1186/s12913-016-1538-8

Hermanus-Demon, J.G. (2013). La hermenéutica según Hans-Georg Gadamer y su aporte a la educación. *Sophia, Colección de Filosofía de la Educación*(15), 33–84.

Horvath, M.A.H., Massey, K., Essafi, S., & Majeed-Ariss, R. (2020). Minimising trauma in staff at a sexual assault referral centre: What and who is needed? *Journal of Forensic and Legal Medicine*, *74*, 102029. https://doi.org/10.1016/j.jflm.2020.102029

International Labour Office (2017). *Global estimates of modern slavery: Forced labour and forced marriage* (p. 68). International Organization for Migration. https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/publication/wcms_575479.pdf

Kliner, M., & Stroud, L. (2012). Psychological and Health Impact of Working with Victims of Sex Trafficking. *Journal of Occupational Health*, *54*(1), 9–15. https://doi.org/10.1539/joh.11-0125-OA

Le, P.D., Ryan, N., Rosenstock, Y., & Goldmann, E. (2018). Health Issues Associated with Commercial Sexual Exploitation and Sex Trafficking of Children in the United States: A Systematic Review. *Behavioral Medicine*, *44*(3), 219–233. https://doi.org/10.1080/08964289.2018.1432554

Lederer, L., & Wetzel, C. (2014). The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities. *Annals of Health Law*, *23*(1), 61.

Lepianka, C., & Colbert, A.M. (2020). Characteristics and Healthcare Needs of Women Who Are Trafficked for Sex in the United States: An Integrative Literature Review. *Journal of Forensic Nursing*, *16*(1), 6–15. https://doi.org/10.1097/JFN.0000000000000273

Lincoln, Y.S., & Guba, E.G. (2006). *Naturalistic inquiry*. SAGE Publications.

Macias-Konstantopoulos, W. (2016). Human trafficking: The role of medicine in interrupting the cycle of abuse and violence. *Annals of Internal Medicine, 165*(8), 582–588. https://doi.org/10.7326/M16-0094

McDow, J., & Dols, J.D. (2021). Implementation of a Human Trafficking Screening Protocol. *Journal for Nurse Practitioners*, *17*(3), 339–343. https://doi.org/10.1016/j.nurpra.2020.10.031

Murwill, P. (2018). A world without barriers to healthcare. *Practice Management*, *28*(1), 12–15. https://doi.org/10.12968/prma.2018.28.1.12

Ottisova, L., Hemmings, S., Howard, L., Zimmerman, C., & Oram, S. (2016). Prevalence and risk of violence and the mental, physical and sexual health problems associated with human trafficking: An updated systematic review. *Epidemiology and Psychiatric Sciences*, *25*(4), 317–341. https://doi.org/10.1017/S2045796016000135

Rajaram, S., & Tidball, S. (2018). Survivor'svoice:Complexneedsof sex trafficking survivors in the Midwest. *Behavioral Medicine*, *44*(3), 189–198. https://doi.org/10.1080/08964.2017.1399101

Ravi, A., Pfeiffer, M.R., Rosner, Z., & Shea, J.A. (2017). Identifying Health Experiences of Domestically Sex-Trafficked Women in the USA: A Qualitative Study in Rikers Island Jail. *Journal of Urban Health*, *94*(3), 408–416. https://doi.org/10.1007/s11524-016-0128-8

Ross, C., Dimitrova, S., Howard, L.M., Dewey, M., Zimmerman, C., & Oram, S. (2015). Human trafficking and health: A cross-sectional survey of NHS professionals'

584 contact with victims of human trafficking. *BMJ Open*, *5*(8), e008682.
585 https://doi.org/10.1136/bmjopen-2015-008682

586 Rothman, E.F., Stoklosa, H., Baldwin, S.B., Chisolm-Straker, M., Price, R.K., &
587 Atkinson, H.G. (2017). Public health research priorities to address US human
588 trafficking. *American Journal of Public Health*, *107*(7), 1045–1047.
589 https://doi.org/10.2105/AJPH.2017.303858

590 Schwarz, C., Unruh, E., Cronin, K., Evans-Simpson, S., Britton, H., & Ramaswamy, M.
591 (2016). Human trafficking identification and service provision in the medical and
592 social services sectors. *Health and Human Rights Journal*, *18*(1), 11.

593 Talbott, J.M.V., Dutcher, J.S., Pougnier, C.A., Calvin, S.L., Roe-Sepowitz, D., & Kling,
594 J.M. (2020). Review of Published Curriculum on Sex Trafficking for
595 Undergraduate Medical Trainees. *American Journal of Preventive Medicine*,
596 *58*(4), 604–611. https://doi.org/10.1016/j.amepre.2019.11.013

597 Testa, D. (2020). Hospital Health Provider Experiences of Identifying and Treating
598 Trafficked Persons. *Australian Social Work*, *73*(1), 92–104.
599 https://doi.org/10.1080/0312407X.2018.1529812

600 Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative
601 research (COREQ): A 32-item checklist for interviews and focus groups.
602 *International Journal for Quality in Health Care*, *19*(6), 349–357.
603 https://doi.org/10.1093/intqhc/mzm042

604 Tracy, E.E., & MacIas-Konstantopoulos, W. (2017). Identifying and Assisting Sexually
605 Exploited and Trafficked Patients Seeking Women's Health Care Services.
606 *Obstetrics and Gynecology*, *130*(2), 443–453.
607 https://doi.org/10.1097/AOG.0000000000002144

608 United Nations Office on Drugs and Crime (2014). *Global report on trafficking in*
609 *persons* (p. 90). United Nations. https://www.unodc.org/documents/data-and-
610 analysis/glotip/GLOTIP_2014_full_report.pdf

United Nations Office on Drugs and Crime (2020). *Global report on trafficking in persons* (p. 176). United Nations. https://www.unodc.org/documents/data-and-analysis/tip/2021/GLOTiP_2020_15jan_web.pdf

Westwood, J., Howard, L.M., Stanley, N., Zimmerman, C., Gerada, C., & Oram, S. (2016). Access to, and experiences of, healthcare services by trafficked people: Findings from a mixed-methods study in England. *British Journal of General Practice*, *66*(652), 794–801. https://doi.org/10.3399/bjgp16X687073

Williamson, V., Borschmann, R., Zimmerman, C., Howard, L.M., Stanley, N., & Oram, S. (2020). Responding to the health needs of trafficked people: A qualitative study of professionals in England and Scotland. *Health and Social Care in the Community*, *28*(1), 173–181. https://doi.org/10.1111/hsc.12851

Zimmerman, C., Kiss, L., Pocock, N., Naisanguansri, V., Soksreymo, S., Pongrungsee, N., Sirisup, K., Koehler, J., Dung, D.T., Nguyen, V.A., Dickson, B., Dhavan, P., Rathod, S., & Borland., R. (2014). *Health and human trafficking in the Greater Mekong Subregion Findings from a survey of men, women and children in Thailand, Cambodia and Viet Nam* (p. 102). International Organization for Migration and London School of Hygiene and Tropical Medicine. https://publications.iom.int/system/files/pdf/steam_report_mekong.pdf