Spring 5-2015

Commercial Sexual Exploitation: The Role of the Advanced Practice Nurse in Screening Patient At-Risk

Sheri Rickman Patrick
Northern California Consortium, Doctor of Nursing Practice Program, California State University, Fresno and San José State University

Recommended Citation

COMMERCIAL SEXUAL EXPLOITATION:
THE ROLE OF THE ADVANCED PRACTICE NURSE
IN SCREENING PATIENT AT-RISK

By
Sheri Rickman Patrick

A doctoral project in partial fulfillment of the requirements
for the degree of Doctorate of Nursing Practice in the California
State University, Northern Consortium, Doctor of Nursing
Practice Program, California State University, Fresno

May 2015

APPROVED

For the Department of Nursing:

We, the undersigned, certify that the doctoral project of the following student meets the required standards of scholarship, format, and style of the university and the student's graduate degree program for the awarding of the doctoral degree.

Sheri Rickman Patrick
_____
Doctoral Project Author

Constance Hill   Nursing
_____
Chairperson's name (Chair)   Department name

Deepika Goyal   Nursing
_____
Committee member's name   Department name

Miranda Worthen   Nursing
_____
Committee member's name   Department name

AUTHORIZATION FOR REPRODUCTION OF DOCTOR OF NURSING

PRACTICE PROJECT

I, *Sheri Rickman Patrick*, grant permission for the reproduction of this project (*Commercial Sexual Exploitation: The Role of the Advanced Practice Nurse in Screening Patients At-Risk*) in part or in its entirety without further authorization from me, on the condition that the person or agency requesting reproduction absorbs the cost and provides proper acknowledgement or authorship.

Signature of DNP Project Author____*Sheri Rickman Patrick*_____

Date____5/1/15_____

Dedication

This doctoral project is dedicated to my parents, Emily and Clifford Rickman, who always taught me the importance of education and gave me my love of reading and learning.

Acknowledgements

First I want to thank my family, Amos Dorsey, Lydia and Chelsea Patrick for all their support and encouragement throughout this doctoral program. Kennedy Townsend allowing Mimi to share my love of theater when time permitted.

I would like to thank my committee, especially Dr. Connie Hill, you are a true mentor and I would never had made it thus far without your sage advice and encouragement; Deepika Goyal and Miranda Worthen for consenting to be a part of my journey by sharing their knowledge and experience; and finally to my classmates, especially Polly Patel and Carma Tobiassen, who without their support I would not have gotten across the finish line.

Commercial Sexual Exploitation: The Role of the Advanced Practice Nurse

in Screening Patients at Risk

Sheri Rickman Patrick

Northern California Consortium

January 27, 2015

Abstract

Problem: Human trafficking or commercial sexual exploitation (CSE) is a global problem effecting every country including the United States. The impact of human trafficking while it is devastating to individuals, the impact goes well beyond individual victims and undermines the health, safety and security of all nations (U.S. Department of State Publication, 2007, p. 5).This research is an attempt to assess the knowledge of advance practice nurses or nurse practitioners (NP) in the subject of commercial sexual exploitation and their willingness to screen their patients who may be at-risk.

Methods: The design was web-based with advanced practice nurses who are current and past members of the Sacramento Chapter of California Association for Nurse Practitioners (CANP) completed a pre-test, viewed an web-based educational intervention then completed the post-test and evaluation.

Results: Demographics were 34 females and 3 males with an $N = 37$. The majority of APNs were older, worked in family practice and were even dispersed between hospital-based clinics, community clinics, school-based clinics and private practice. Three hypothesis emerged from the data: did the educational intervention make a difference? With a web-based design, did the younger APNs, 25-35 age group, do better than the older APNs, 56-65 age group? And finally, was there a statistical significance in the years of experience or did those with less than 10 years do as well as those with more than 10 years? There was no statistical significance with hypothesis 1 and 2 with $p = 0.245$ and $p = 0.799$. However, there is a statistical significance with years of experience. The data showed APNs with more than 10 years of experience did better than those with less than 10 years, $p = 0.040$. Based on evaluation results 85% of respondents

felt the process of web-based design was very easy and the information very helpful, along with

85% very and somewhat willing to screen their patients.

Conclusion: Advanced practice nurses are knowledgeable in regards to the subject of

commercial sexual exploitation and are willing to screen their patients at-risk, especially for

those APNs who have more than 10 years of work experience.

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION

Significance & Background

In 2000, The Victims of Trafficking and Violence Protection Act (VTVPA) was enacted (Division A of Public Law 106-386). The VTVPA defines sex trafficking as "the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act" and a commercial sex act as "any sex act on account of which anything of value is given to or received by any person" (p. 3). A person under the age of 18, born in or outside the US and used for the purpose of a commercial sex act, is a trafficking victim.

Human trafficking or commercial sexual exploitation (CSE) is a global problem affecting every country including the United States. It has become a multi-dimensional threat depriving persons, especially children and adolescents, of their human rights and freedoms, increasing global health risks and has become a multi-million dollar industry feeding the growth of organized crime. Research shows female victims of sex trafficking are more prevalent than males (Hodge, 2008; McClain & Garrity, 2011). Males are more commonly victims of labor trafficking, especially in agricultural industry (http://www.polarisproject.org/). The impact of human trafficking while it is devastating to individuals, the impact goes well beyond individual victims and undermines the health, safety and security of all nations (U.S. Department of State Publication, 2007, p. 5).

While the body of literature on CSE in the past decade has increased in number, the statistical depth of the problem still eludes us (Stransky & Finkelhor, 2008; McClain & Garrity, 2011). The factors or reasons behind this elusion is multifactorial. First, due to the criminal nature of sexual exploitation, the crime may be overlooked or underreported occurring in the

shadows and fringes of society. Second, those exploited belong to the most vulnerable of us….children and adolescents who have been abused, neglected, are in foster care and criminal justice system, homeless, runaways; those children considered throw-aways (Clayton, Krugman, & Simon, 2014).

In terms of statistical data, estimates range from 1,400 to 2.4 million victims who have interfaced with the criminal justice system with charges of juvenile prostitution (Clayton et al., 2014; Mitchell, Finkelhor, & Wolak, 2010; Stransky & Finkelhor, 2008). In the United States, research of commercial sexual exploited adolescents is conducted in the field of juvenile prostitution and most states continue to arrest CSE children and adolescents instead of treating them as victims. The United Nations' Children's Fund (UNICEF) estimates over 100 million children and adolescents are exploited worldwide. The organizations, End Child Prostitution, Child Pornography and the Trafficking of Children for Sexual Exploitation (ECPAT) reports numbers between 100,000 to 300, 000 (Estes & Weiner, 2001). Innocence Lost National Initiative, which was founded in 2003 reports 3100 children and/or adolescents have been recovered; 2100 cases have been initiated; and 1400 convictions of which 11 are federal life sentences (S. Dillard, personal communication, April 16, 2014).

Policies and protocols specifically addressing CSE along with specialized training to properly identify and assist victims and survivors is lacking for all levels of professionals that interface with this vulnerable population (Clayton et al., 2014). It is clear that no one agency can do it all in terms of polices and training, but will need to be a multidisciplinary effort involving law enforcement, the Department of Health and Human Services (DHHS) and Child Protective Services (CPS), Advocacy organizations, and the healthcare industry. With all these various agencies tackling the problem from their vantage point, patients could easily fall through the

cracks. The majority of the literature demonstrates the prevalence of the problem in terms of educating nurses in combating by identifying the signs of CSE when the patient stands before the healthcare professional (Grace, Starck, Potenza, Kenney, & Sheetz, 2012; McClain & Garrity, 2011; Dovydaitis, 2010; Cole, 2009; Sabella, 2011).

The top priority of APNs and nurses is to promote advocacy for our patients. It is vital for the advance practice nurse to possess the training or education to assist patients who are at-risk of being commercially sexually exploited. Advanced practice nurses are instrumental in navigating this vulnerable population through the health care system and connecting them with the appropriate resources. The purpose of this capstone project is to assess the APNs' knowledge of commercial sexual exploitation in the Sacramento area and their willingness to screen their patients utilizing the theoretical framework of the theory of reasoned action.

CHAPTER 2: THEORETICAL FRAMEWORK

Theoretical Framework

The theoretical framework for this project is the theory of reasoned action or TRA which has its roots in the social cognitive model. TRA demonstrates that we learn in stages from infancy to old age and focuses on our perceptions, thinking, reasoning, developmental changes and how we process information (Braungart & Braungart, 2011). Ajzen and Fishbein are both social scientists, however, their theory is applicable to a middle-range nursing theory. TRA fulfills the criteria that middle-range theories should have: significance, internal consistence, parsimony and testability (Fawcett & Garity, 2009). Does TRA have real or potential social impact on the population in regards to a health issue? And conversely, does TRA assist in the advancement of understanding of a health condition to benefit society and patients?

Using TRA as a theoretical framework, researchers were able to able to predict the social norms involved which lead African American middle school girls to engage in early sexual behavior (Doswell, Braxter, Cha, & Kim, 2011). This research would enable school program planners to develop a program targeting those perceived behaviors that lead young girls, especially African American girls to participate in early sexual behavior. TRA clearly and concisely explain the concepts or assumptions involved in the theory. Azjen and Fishbein's (1975, 1980) definitions are consistently used throughout their literature and are easily applicable as frameworks for studies in other disciplines including nursing. There are four concepts which make up TRA, attitudes of an action, subjective norms of the action, intention of engaging in the action and participating in the action (Doswell et al., 2011). The four concepts are clearly

defined and easily understood fulfilling the fourth requirement of middle-range theories of parsimony.

Theory Assumptions

In TRA, Azjen and Fishbein (1980) renamed the behavioral hypothesis to a normative belief. The definition is that "a person's subjective probability that a particular normative referent (the experimenter) wants the person to perform a given behavior" (Ajzen, 2012, p.16). Similar to Dulany, the normative belief is also weighted by the motivation a person holds to comply with the referent's perceived expectation. For TRA, the assumption is that a person's normative belief can be effected by more than one referent individual or group unlike Dulany's model. The referent can be family, friends, peers and health professionals (Ajzen, 2012). In other words, TRA theorizes that a person's attitude (positive or negative feelings) towards a specific behavior and the subjective norms (whether peers or family agree on the behavior) surrounding the behavior predict the intention of performing the behavior (Doswell et al., 2011, Doswell et al., 2003, Tremblay & Frigon, 2004).

Education and training in nursing is an important component that all nurses embrace to remain current and learn new techniques or procedures. Nurses who work in medical centers and other health organizations are often required to participate in mandatory staff education. By using TRA as the theoretical framework, the normative referent (trainer) strives to get the recipient (APN) to perform the desired behavior. The APN's desire to perform the behavior is motivated by referents' expectation. The APN's attitude is motivated or influenced by their peers, patients and educational training in performing the desired behavior. If the DNP project is to train APNs to increase their knowledge base and to screen their adolescent patients in order to

identify those at-risk of commercial sexual exploitation (CSE), then TRA will work well to achieve the desired outcome.

Theory Application

The research question is how much do APNs know in regards to commercial sexual exploitation? And if their knowledge base was increased, would that increase their willingness to screen their patient, especially adolescent patients to identify those at-risk? In applying the theory of reasoned action, their subjective norms for APNs is to screen their adolescent patients and for adolescents, their subjective norms is in engaging in CSE. Remembering subjective norms are based on significant others who agree with said behavior. On the APN side, colleagues, education or training and personal bias would affect their subjective norms. For adolescents, peers, parents and pimps would impact their subjective norms. Both the attitude and subjective norm for either group would lead to an intention of performing either screening of at-risk teens or participating in CSE which will lead to the respective behavior.

Theory Concepts

Attitudes are defined as an evaluative dimension of a concept and mediating evaluative responses. In turn, beliefs are defined as the probability dimension of a concept. Is the concept probable or improbable? Beliefs in an object is described as the probability of a relationship between the object of belief and any other object, concept or goal. Belief about an object is defined as the probability dimension of a concept where the concept is a relational statement (Fishbein, 1963, p. 233). Normative belief as defined earlier is a person's subjective probability that a particular normative referent wants the person to perform a given behavior. Behavioral theories that preceded TRA thought the normative referent had to be an individual, however,

Fishbein and Azjen (1980) theorized that a person have multiple normative referents such as family, friends, peers and colleagues. They further define subjective norms as those beliefs held by referents that place social pressure on the person to perform the action. In other words, subjective norm (SN) is determined by a set of accessible normative beliefs held by important referents. The strength of the normative belief (n_i) is determined by the motivation (m_i) one has to comply with the referent (i) (Ajzen, 2012, p. 16). Algebraically, it comes together as such:

$$\text{SN} \infty \sum n_i m_i$$

Theory Propositions

Peers and persons of authority or the referent can be a major influence in what a person believes and how they behave. We not only behave on what those we deem as important want us to do or injunctive norms, but also based on observed behavior or inferred actions of the important people in our lives or descriptive norms (Ajzen, 2012). TRA predicts the intention of a person performing the desired behavior by looking at the attitude a person holds toward the desired behavior along with subjective norms. Performance of the behavior is dependent on the strength of one's intention and motivation (Doswell et al., 2011, Ajzen, 2012). TRA explains the APN's intention of training and screening of adolescents for CSE which is predicted by the APN's attitudes and the subjective norms of the referent groups. For APN, co-workers and nurse leaders are important referents, working collaboratively with other medical personnel to the benefit of their patients. TRA theorizes the intention to engage in training and screening is a based on the APN's attitude toward the behavior and the subjective norms of training and screening held by co-workers and nurse leaders (Ajzen & Fishbein, 1980, Doswell et al., 2011, Tremblay & Frigon, 2004).

Theory Relevance

Understanding the reasoning behind a person's decision to participate in a certain behavior can be the first step in either reinforcing positive behavior or changing negative or risky behavior. A literature search reveals extensive research in the adolescent population of TRA as the theoretical framework to explain or predict their sexual behavior. Guilamo-Ramos et al. (2008) studied middle school youth in inner-city New York and found injunctive norms to be robust predictors in behavioral intentions. Doswell and her team (2003, 2011) studied early sexual behavior in young African American adolescent girls and in both studies, TRA was a strong predictor of behavior, more so in terms of intention than attitude.

A literature search with TRA as theoretical framework predicting APNs' or NPs' intention to perform a behavior has not been as researched. Reeve, Byrd, & Quill (2004) studied health promotion attitudes and practices in Texas Nurse Practitioners. They found that Texas NPs have positive attitudes toward health promotion and support its practice. However, their intentions to performing the behavior shows room for improvement. With limited research focusing on advanced practice nurses' attitudes and behavioral intention, a real contribution can be made to increase the knowledge of understanding APNs' attitudes and beliefs, especially in the area of CSE while helping them to realize the nature of the problem and improving positive patient outcomes.

CHAPTER 3: LITERATURE REVIEW

Literature Review

Researchers conducting a meta-analysis will synthesize multiple studies to give the reader an overview of the research problem and what the data shows in the way of patient outcomes (Akobeng, 2005). In the area of commercial sexual exploitation there are very few randomized controlled trials. Most studies are conducted utilizing surveys or questionnaires. As Lalor and McElvaney (2010) discovered prevalence rates are only accurate to the extent to which respondents are willing to participate in the research.

Chase and Statham (2005) did a systematic review of commercial sexual exploitation of children and young people in the UK. Within their definition of CSE, they included child prostitution, child pornography and child trafficking. The purpose of the review was well thought out and stated clearly. The team wanted to explore the different mechanisms which exploit children and young people, the personal impact the exploitation has on their lives. The methodology utilized a literature review in various databases including Child Data Abstracts and the Electronic Library for Social Care (eLSC). Key words used in the searches included, but not limited to 'sexual exploitation', 'sexual abuse', 'prostitution', 'pornography', and 'trafficking'; combined with the words 'child' or 'children'. The team also contacted experts in the area to find out about ongoing research. The team systematically went through each category of sexual exploitation, defining it and explaining any risk factors found in the literature review. Current policies and legislation in place to protect children and young people are discussed. Each area,

prostitution, pornography and trafficking, bring their own unique problems in the area of protection. For prostitution, depending on the age of the victim and their behavior, some young people may wind up in the criminal justice system. Child pornography, especially in our digital age, is viewed as not having a clear distinction of harming the child or young person, so persons found guilty of possession or distribution of child pornography may receive minimal sentences (Chase and Statham, 2005). Lalor and McElvaney (2010) researched how child sexual abuse (CSA) can lead some children and adolescents down the path to becoming victims of sexual exploitation and assault. Worldwide the prevalence of CSA is greater for girls than boys, however, depending on definitions of CSA, unwanted sexual contact; contact abuse VS noncontact abuse; penetrative abuse VS non-penetrative abuse, can alter rates seen in CSA. Even with that, the studies do show a link between CSA and victimization in terms of either sexual exploitation or assault compared to those who were not abused.

Literature that addressed trafficking and adolescents primarily discuss the reasons or risk factors behind why adolescents are trafficked. Globally, adolescents or young women are seeking a better way of life or employment and may be enticed to cross the border of their homeland only to find themselves in the hands of traffickers (Rafferty, 2007). Worthen (2011) researched sex trafficking in Nepal and found approaching the problem from a labour exploitation framework instead of prostitution framework, one could obtain a better understanding of the problem. Again it comes down to defining terms. In the labour exploitation camp, "force" is defined as "violence or the threat of violence" compared to the prostitution camp which views poverty as an act of "force" which drastically limits women's choices (Worthen, 2011, p. 5). Recruitment of trafficked adolescents can come from any socioeconomic group, race or ethnicity. However, most pimps or traffickers look for vulnerable

teens, those who come from poverty, dysfunctional families, drug addiction, isolation, violence in family, poor school performance, and history of CSA (McClain & Garrity, 2011; Edinburgh & Saewyc, 2009).

In the area of commercial sexual exploitation, the number of randomized control trials are very few. Bramsen, Lasgaard, Koss, Elklit, & Banner (2012) conducted a prospective study over a 6 month period examining potential risk factors for first time adolescent peer-on-peer sexual victimization (APSV). Due to the disproportional gender distribution in sexual victimization, only female subjects were investigated, which included a school-based educational program for the intervention. Thirty middle schools in a region of Denmark were randomized with 10 schools serving as controls. 238 female students in the ninth grade were recruited with an average age of 14.9 years for first treatment group (TI), however, by treatment group 2 (T2) only 199 subjects remained, which translated into a 16% attrition rate. Subjects were given a unique identifier for follow-up if needed. There were four tools given to all subjects. It was discovered that the prevalence rates of initial APSV between the intervention and control groups at the 6 month follow-up were not statistically significant, so the two experimental groups were combined. The number of sexual partners and sexual risk behavior were the only variables that demonstrated statistical significance of $p<0.05$ for predicting APSV. CSA, early sexual onset and signaling sexual boundaries had no statistical significance in predicting APSV. Limitations to the study include there is no discussion on how schools were randomized or how many subjects were in the intervention or control groups before they were merged. The tools utilized were only a two-point questionnaire addressing CSA and did not ask about severity or duration, which could affect the results.

Qualitative research in this field of study seems more prevalent. One such study described the experiences of trauma and its aftermath for women who have experienced commercial sexual exploitation as told by front-line service providers (Hom & Woods, 2013). The researchers wanted to capture the experiences of trauma, mental health consequences and how to assist with healing and recovery for CSE victims in order to increase the knowledge base of service providers who work in the field. Agencies were recruited which include women empowerment centers, rape-crisis centers, free-clinics and non-profit organizations directly involved in research and program development for victims of CSE. The participants' professions included nursing, clinical directors, social workers, anti-trafficking task force members and developers. Semi-structured interviews consisting of eleven open-ended questions were conducted. There were six participants (front-line service providers) who were asked what did they considered as the greatest health needs and how best to assist in recovery of the women. Interviews were audio recorded and transcribed verbatim and both authors reviewed them for accuracy.

Content analysis was used to analyze the data collected. Analysis was performed in sequence and the initial data was coded. Key words and concepts were identified to facilitate the emergence of themes. The related words and phrases were organized into clusters and three primary themes emerged: Pimp Enculturation, Aftermath and Healing the Wound. Each main theme has one or more subthemes. The researchers did not specify if any observations were made during the interviews and how that could of affected the data. Investigator triangulation was utilized to ensure rigor of transcripts. They also developed an audit trail consisting of record of coded methods, coded transcripts and coded subthemes.   The findings are very credible. The themes and subthemes that came out of the interviews were supported in literature which adds

validity and reliability to the research. The direct quotes included from the informants not only supported the themes, but added extra layer of richness to the data. While the voices are not those of the actual victims of CSE, but those of front-line service providers who work closely with the women, which can be seen as a weakness to the study. However, the research does give one a glimpse into the world of human trafficking and what a victim experiences and long and hard journey it takes for them to get their health back (Hom & Woods, 2013). Two major limitations were discussed who the subjects were and sample size. Subjects were front-line service providers and not the victims of CSE which would have provided the researchers with further depth and accuracy. However, they did explain the reasoning behind recruiting providers instead of victims. The primary reason is safety of not only the victims, but the researchers as well. There also was no consistency of the subjects' profession, first-line providers came from differing fields, which could have an effect on the data. While this was a pilot study and the need for further research with a better sample was discussed; having only six subjects severely limits generalization to a large population.

Finally, one study actually looked at identifying victims of human trafficking in health care settings in the United States (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011). The research was conducted in two phases. The first phase consisted of face-to-face, in-depth, semi-structured interviews were done with six front-line workers who worked closed with trafficked victims. Phase two were interviews of twelve trafficked victims: eight victims of labor trafficking, three of sex trafficking and one victim of both. Results showed that 50% of the victims had been patients in a health care setting while still under the trafficker's control and not identified by the care provider as a trafficked victim. Labor victims presented to health care with complaints of upper respiratory infections, systemic infections or bodily injuries. Sex trafficked

victims were seen for STD treatment or testing along with unwanted pregnancies and abortions. The themes under covered where the many barriers to disclosure or discovery of a trafficking victims. Victims interfaced with major health care institutions to private clinics. Traffickers would accompany the victims communicating with staff and completing paperwork. The victim's shame and fear would prevent the patient from making a full disclosure about to the health care providers.

There is minimal literature regarding APNs' awareness and attitudes toward screening adolescents for CSEC. One study did examine Texas NPs attitude and practice toward health promotion, revealed that NPs held positive attitudes toward health promotion and practice, only 60% screened and encouraged their patients due to a lack of time (Reeve, Byrd & Quill, 2004). Edinburgh and Saewyc (2009) presented data on the Runaway Intervention Program (RIP) from 2003-2004 with the first 20 patients enrolled. RIP was an intensive home visitation and case management program assisting those adolescents who had been runaway and been sexually exploited. At baseline, majority of the adolescents had been involved in prostitution or "survival sex" and 75% had been ganged raped. Many reported their number of sexual partners were "too many to count"; 90% had run away from home at least once staying away anywhere from days to months and been truant from school for at least 10 or more days. More than half of the sample were diagnosed with chlamydia and 90% reported substance use and/or abuse of primarily alcohol, but marijuana, crack cocaine and crystal methamphetamines were also drugs of choice and no adolescent was using any form of birth control including condoms. The adolescents were all females ages 10-14 with the ethnic makeup consisting of 90% Hmong, 5% Native American and 5% Latina.

Those adolescents who had experienced recent intra-familial sexual abuse were excluded as they qualified for services from child protective services. Each adolescent was assigned an APN who provided four individual visits in the first month, two visits per month for the next 2 months and then monthly for up to a year. The APN could increase the frequency of visits if warranted due a subsequent health or social crisis. Visits were patient-centered with the adolescent taking the lead on what was discussed during the visit including, but not limited to goal setting, school connectedness, homework assistance, mental health screenings and referrals, community programs, health education in the areas of STI's, contraception, substance use and abuse, family conflict, nutrition and exercise, injury prevention, and daily living skills: taking the bus, making appointments and accessing healthcare (Edinburgh & Saewyc, 2009). Parental consent was required for the adolescent to participate in the problem and for the APN to obtain any pertinent medical records.

Outcomes at six months showed a decrease in chlamydial rates from 55% to 15%; re-enrollment in school, no pregnancies and decrease in risk behavior while away from home. Due to the fact parents and adolescent had differing definitions for runaways and most parents did not file missing person's reports due to language barriers, the study could not use running away episodes as a maker. By the twelve month mark, chlamydial rates decreased further to 5%, still no pregnancies were reported, the adolescents' knowledge of their healthcare and how to access care improved, all adolescents in the program were on birth control and could explain proper condom use, and only 20% reported on-going substance use and abuse. Utilizing ANPs instead of say RNs was essential to the program. With the adolescents' history of running away, risky sexual behavior and exploitation, the APN with prescriptive authority can only educate the adolescent test and treat STI, but educate and start contraception management at the initial visit.

Also based on the APNs' education and training, they are able to assess, treat and work as a multidisciplinary team with the adolescent's primary or specialty care. In this way, the adolescent over the year builds a trusting relationship with the APN which can assist them in their familial relationship, especially those with parents (Edinburgh & Saewyc, 2009).

Critique of Literature

The body of literature regarding commercial sexual exploitation discusses the problem, victims and how healthcare workers could identify victims. However, there is minimal research on the knowledge base of APNs and screening practices. This capstone project is the first step in filling that gap.

CHAPTER 4: METHODOLOGY

Design

The capstone project design is quasi-experimental and consist of web-based model that included pre-test, educational intervention, and post-test. IRB approval was obtained by the nursing department at California State University, Fresno. Permission was then obtained from the Sacramento Chapter' of the California Association for Nurse Practitioners (CANP) board of directors to utilize past and present members' email addresses. A fifteen question survey was developed in Google forms which became the pretest and posttest (Appendix 1 and 2). A pilot sample of 10 nurse practitioners was employed to test the ease of using Google forms and viewing the educational module, "Modern-Day Slavery in America: Recognizing and Responding to Human Trafficking in a Healthcare Context", found at https://polarisproject.adobeconnect.com/_a983384736/healthcare/ (Appendix 3-11).   A blind email was sent out to 678 nurse practitioners, current and past members of Sacramento chapter, which contained the pretest. Participants were given a two week response time frame to submit their pretest. The first email yielded twenty respondents, so a follow-up email was sent to remind participants and the deadline was extended for another ten days which yielded another seventeen respondents. Upon the closure of the pretest submissions, the next blind email was sent which included the Webinar address and posttest. Participants were again given a two week

time frame for submission. The first wave yielded only ten responses, so again a second email

was sent out as a reminder with an extension of the submission date and twenty-seven responses

were returned. Lastly, the evaluation was emailed to participants (Appendix 12). Collection of

all the data was completed within a six week period.

Results

Table 1 (p. 38) gives the breakdown of demographic information for the sample size of

37 subjects which include gender, age, specialty, practice site and years of experience. The

descriptive statistics reveal the mean, standard deviation, Skewness and Kutosis (Table 2). The

pre-test score's ratio test is -5.30 which does not meet normality as it is >2 or -2.   The ratio test

of the post-test score of -1.98 does meet normality. An outlier of pre-test score of 14 is pulling

the Skewness of the pre-test scores to the left (Appendix 13), whereas the post-test scores

Skewness and Kurtosis is expected (Appendix 14).

Statistics

		Pre-test Score	Post-test Score
N	Valid	37	37
	Missing	0	0
Mean		23.9459	24.5946
Median		24.0000	24.0000
Std. Deviation		2.33269	2.20428
Skewness		-2.055	-.767
Std. Error of Skewness		.388	.388
Kurtosis		8.239	1.117
Std. Error of Kurtosis		.759	.759
Minimum		14.00	18.00
Maximum		28.00	28.00

Table 2 Descriptive Frequencies

Using a dependent and independent paired T-test, there were three hypothesis the data of this

capstone attempted to answer. First, did the educational intervention have a statistical difference

in improving the knowledge base of advanced practice of advanced practice nurses (APNs)?

Second, since this capstone was web-based, did age of the subject make a difference or in other

words did the younger APNs, those 25-35, do statistical better than the older APNs, those 56-65?

And third, were years of experience either less than 10 years or greater than 10 years a statistical

difference in the knowledge base of the APNs?

Hypothesis 1

In comparing the pre-tests and post-tests, normality was met by the Shapiro-Wilk, for the

pre-test, t(37) = .722, p = .000 and the post-test, t(37) = .897, p = .002 (Table 3).

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Pre-test Score	.239	37	.000	.772	37	.000
Post-test Score	.204	37	.000	.897	37	.002

a. Lilliefors Significance Correction

Table 3

The dependent sample T-Test demonstrated that the 37 advanced practice nurses had an average

difference from pre-test and post-test of their knowledge of commercial sexual exploitation

(CSE) of -.65 (*SD = 3.33*), indicating the treatment for CSE resulted in a non-significant increase

in the knowledge of CSE, t(36) = -1.183, p = .245 (Table 4).

Paired Samples Test

	Pair 1
	Pre-test Score - Post-test Score

	Mean		-.64865
	Std. Deviation		3.33513
Paired Differences	Std. Error Mean		.54829
	95% Confidence Interval of	Lower	-1.76064
	the Difference	Upper	.46334
t			-1.183
df			36
Sig. (2-tailed)			.245

Table 4

The Pearson Correlation of 1 also confirms that there is no relationship between the pre-test and

post-test scores again demonstrating no statistical significance and the acceptance of the null

hypothesis (Table 5).

Correlations			
		Pre-test Score	Post-test Score
	Pearson Correlation	1	-.235
Pre-test Score	Sig. (2-tailed)		.332
	N	19	19
	Pearson Correlation	-.235	1
Post-test Score	Sig. (2-tailed)	.332	
	N	19	19

Table 5

The power test further shows that the effect size = 0.19 and based on Cohen's d is a small

effect size. The power (1-β err prob) in .020 or 20% detection rate or 80% we are getting a false

null hypothesis that there is no improvement in the knowledge base of APNs after completing

the educational intervention.

Hypothesis 2

      With the research web-based design, could the younger APNs, 25-35, do better than the

older APNs, 56-65? The analysis of the data for hypothesis 2 in regards to comparing the

younger and older APNs used the independent samples T-test. The 25-35 age group had N = 7

compared to the 56-65 age group of N = 12 (Table 6).

Case Processing Summary

	Age	Cases					
		Valid		Missing		Total	
		N	Percent	N	Percent	N	Percent
Pre-test Score	25-35	7	100.0%	0	0.0%	7	100.0%
	56-65	12	100.0%	0	0.0%	12	100.0%
Post-test Score	25-35	7	100.0%	0	0.0%	7	100.0%
	56-65	12	100.0%	0	0.0%	12	100.0%

Table 6

The normality is met with Ratio Test for Skewness of the pre-test each 25-35 age group is -0.47

and 56-65 age group is -2.84, and the post-test for 25-35 is 0.00 and 56-65 is -2.34. Normality is

confirmed by means of the Shapiro-Wilk (Table 7).

Tests of Normality

	Age	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
		Statistic	df	Sig.	Statistic	df	Sig.
Pre-test Score	25-35	.360	7	.007	.664	7	.001
	56-65	.252	12	.034	.815	12	.014
Post-test Score	25-35	.357	7	.007	.777	7	.024
	56-65	.250	12	.037	.799	12	.009

a. Lilliefors Significance Correction

Table 7

An independent sample t test showed that the difference in pre-test scores between the younger

APNs (*N* = 7, *M* = 23.14, *SD* = 1.07) and the older APNs (*N* = 12, *M* = 23.50, *SD* = 3.53) were

not statistically significant, *t* (17) = -0.36, p = 0.799, 95% CI [-3.276, 2.561], d = 0.32. The post-

scores are rejected as the mean is the same at (*M* = 24) for both groups. The power (1-β err

prob) is 0.01 or 10% detection rate or 90% of the time we are accepting the null hypothesis when

in fact it should be rejected.

Hypothesis 3

Finally, did the years of experience, less than 10 years or greater than 10 years, show a

statistical difference in test scores? An independent samples T-test was again utilized in the

statistical analysis of the data. The less than 10 years' experience was N = 16 and more than 10

years' experience was N = 21 (Table 8).

Table 8

Case Processing Summary

	RecodedYrsExp	Cases					
		Valid		Missing		Total	
		N	Percent	N	Percent	N	Percent
Pre-test Score	Less than 10 yrs exp	16	100.0%	0	0.0%	16	100.0%
	Greater than 10 yrs exp	21	100.0%	0	0.0%	21	100.0%
Post-test Score	Less than 10 yrs exp	16	100.0%	0	0.0%	16	100.0%
	Greater than 10 yrs exp	21	100.0%	0	0.0%	21	100.0%

The ratio test for Skewness for the post-test for both groups, less than 10 years' experience and

more than 10 years' experience, is -0.137 and -0.960 respectively. The pre-test ratio test for the

less than 10 years' experience is 1.807, however, for more than 10 years' experience is -5.904

due an outlier score of 14 in that group. But normality is met based on Shapiro-Wilk (Table 9).

Tests of Normality

	RecodedYrsExp	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
		Statistic	df	Sig.	Statistic	df	Sig.
Pre-test Score	Less than 10 yrs exp	.251	16	.008	.812	16	.004
	Greater than 10 yrs exp	.329	21	.000	.620	21	.000
Post-test Score	Less than 10 yrs exp	.215	16	.047	.921	16	.173
	Greater than 10 yrs exp	.335	21	.000	.805	21	.001

a. Lilliefors Significance Correction

b.

Table 9

The independent samples T-test demonstrates that the difference in pre-test and post-test scores between the less than 10 years' experience ($N = 16$, $M = 23.750$, $SD = 0.526$) and the more than 10 years' experience ($N = 21$, $M = 25.238$, $SD = 0.459$) were statistically significant, $t (35) = -1.488$, $p = 0.040$, 95% CI [-2.905, -0.071], d = 0.67. The Power (1-β err prob) is 0.50 or 50% detection rate or 50% of time we are accepting the null hypothesis when in fact it should be rejected.

Figure 1a shows the results of the evaluation which majority of respondents considered the process of a web-based design very to somewhat easy to complete. Viewing the educational intervention was no problem and the information it provided very helpful. When asked about screening their patients, most APNs were very and somewhat likely to screen, but were mixed about using a screening tool. And finally, the majority of respondents preferred the web-based design over an in-person educational module or lecture (Figure 1b).

Findings

When screening patients for any health problem such as diabetes, hepatitis, asthma or heart disease, the advanced practice nurse needs to understand the pathophysiology of the disorder or disease, signs and symptoms along with the best laboratory or radiologic tests

available. In screening patient for commercial sexual exploitation (CSE) or human trafficking, it

is no different. The capstone went about to discover the knowledge base of advanced practice

nurses in not only in Sacramento area, but those APNs who are also members of the Sacramento

Chapter of CANP.

What was revealed with this data set is APNs are knowledgeable about CSE being no

statistical differences between the pretests and posttests with regard to hypothesis 1, whether or

not the educational intervention improved the APN's knowledge base. For hypothesis 2, did the

age of the APN make a difference or did the younger, 25-35, APNs do better than the older, 56-

65, APNs. Again there was no statistical difference between the two groups. And the posttest

data was rejected as the mean for both groups was the same, $M = 24$. Finally, hypothesis 3

which looked at years of experience of the APN did have a statistical difference with those APNs

with greater than 10 years doing better from pretest to posttest as compared to APNs with less

than 10 years of experience.

Limitations

The limitations included, but not limited to the small sample size with $N = 37$. The

expectation based on the literature was a response rate of 30% if not higher (Asch, Jedrziewski,

& Christakis, 1997). This capstone yielded only a 6% response rate. Some of the issues behind

the small data set were respondents' inability to submit the Google form pretest. Even with a

trial run of small subset of subjects, respondents still had issues with submission of forms.

Another major limitation was the viewing of the educational intervention. Developed by the

Polaris Project, the power point, which discussed both sex and labor trafficking and how victims

may interface with the healthcare community, required the viewer to have Adobe Presenter to

access the power point. So those respondents with older software may not have had access and there is a cost to download the software.

Conclusion

All fifty states including the District of Columbia, America Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the US Virgin Islands have laws and policies that make medical personnel mandated reports of child maltreatment and neglect (http://www.ncsl.org/research/human-services/child-abuse-and-neglect-reporting-statutes.aspx). In California as most states, the Department of Health and Human Services put the laws and policies into practice and provide guidelines for health care providers. Children under the age of 14 who are having consensual sexual intercourse with a partner of the same age is not considered unlawful and not reportable, however if the other person is a year older, it's a crime and has to be reported. For those teens ages 14-15 years, if the partner is 21 or older, it's a crime and reportable. By the time a teen is 16 years old, the health care provider does not have to ask nor the patient need to answer about the age of the partner. For access barriers, patients' ages 12 to 17 years old living in California have the right to consent to contraceptive services, obstetrical and abortion services, drug rehabilitative services, and mental health services without their parents' permission or consent.   For adult women, 18 years and older, the woman has the right to decline police involvement unless there is a bodily or anogenital injury noted.

However, one must remember that the VTVPA defines sex trafficking as "the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act" and a commercial sex act as "any sex act on account of which anything of value is given to or received by any person" (p. 3). For children and adolescents, no matter their wishes or desires, APNs must report under 18 years older, but for those women 18 and older who

claim prostitution their profession and possess no physical injury do you report violating their

trust and confidentiality? Some of the barriers to reporting or intervention is failure to recognize

the signs and symptoms of the problem (Alvarez, Kenny, Donohue, & Carpin, 2004). With lack

of experience, training or recognition of the problem, an impetus to report may be lacking for

many nurse practitioners. With regard to commercial sexual exploitation for APNs the stakes are

different. Unlike child sexual abuse, others may not have reported the abuse or the patient has

not been referred to specialty care for the problem. The prospect of dealing with a trafficker who

may or may not be a family member is beyond the scope of the APNs training and the scope of

this project (Alvarez et al., 2004; Herendeen et al., 2014).

   Based on this project, web-based training is a potential solution to the problem of

time constraints with education. Nurses and APNs are continually challenged on how to

maintain and acquire new knowledge in an every changing field (Chen, Yang, Tang, Huang, &

Yu, 2008; Atack & Rankin, 2002). Web-based training or e-learning allows for self-pacing, 24-

hour access, no need to travel and can be accomplished around work schedules (Atreja et al.,

2008). The web-based design was preferred by the majority of APNs, 70%, for a means of

receiving information and/or training on this subject. With CSE being a worldwide problem

effectively literally every country, web-based training may be the best means to reach the most

people who can effect change, nurses and advanced practice nurses.

Discussion

 It is clear that the literature is sparse in the area of commercial sexual exploitation and the

role the advanced practice nurse plays in screening patients. Research assessing the screening

practices of APNs, any barriers to screening and determining the best method of providing

training is the next steps. It may be the future of combating this insidious health problem lays

with education. Societal demands can force a context-relevant curriculum change (Sheikh, 2014). The Healthy People Curriculum Task Force was instituted to ensure that a number of the schools of medicine and schools of nursing taught future physicians, nurses and nurse practitioners the core competencies in health promotion and disease prevention (Maeshiro et al., 2011). As the knowledge of CSE increases and through a curriculum change and education of APNs can we ensure that screening of patients at-risk will occur and continue. In turn APNs can play a vital role in the multidisciplinary partnership that is required between law enforcement, governmental agencies and policy stakeholders in improving patient outcomes for those who fall victim of commercial sexual exploitation.

.

References

Ajzen, I. (2012). Martin Fishbein's legacy: The reasoned action approach. []. *The annuals of the American Academy of Political and Social Science*, *640*(1), 11-27. http://dx.doi.org/DOI: 10.1177/0002716211423363

Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behavior*. Englewood Cliffs, NJ: Prentice Hall.

Akobeng, A. K. (2005). Understanding systematic reviews and meta-analysis. *Archives in disease in childhood*, *90*(8), 845-848.

Asch, D. A., Jedrziewski, M. K., & Christakis, N. A. (1997). Response rates to mail surveys published in medical journals. *Journal of Clinical Epidemiology*, *50*(10), 1129-1136.

Atack, L., & Rankin, J. (2002). A descriptive study of registered nurses' experiences with web-based learning. *Journal of Advanced Nursing*, *40*(4), 457-465.

Atreja, A., Mehta, N. B., Jain, A. K., Harris, C., Ishwaran, H., Avital, M., & J Fishleder, A. J. (2008). Satisfaction with web-based training in an integrated healthcare delivery network: do age, education, computer skills and attitudes matter? *BMC medical education*, *8*(1), 48. http://dx.doi.org/doi:10.1186/1472-6920-8-48

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: An International Journal*, *13*(1), 36-49. Retrieved from http://www.hhrjournal.org/archives/volume-13-issue-1/

Bramsen, R. H., Lasgaard, M., Koss, M. P., Elklit, A., & Banner, J. (2012). Adolescent sexual victimization: A prospective study on risk factors for first time sexual assault. *European*

child & adolescent psychiatry, *21*(9), 521-526. http://dx.doi.org/DOI 10.1007/s00787-012-0290-9

Braungart, M. M., & Braungart, R. G. (2011). Educational and learning theories. In J. B. Butts, & K. L. Rich (Eds.), *Philosophies and theories for advanced nursing practice* (pp. 203-245). Sudbury, MA: Jones & Bartlett Learning.

Chase, E., & Statham, J. (2005). Commercial and sexual exploitation of children and young people in the UK—A review. *Child Abuse Review*, *14*(1), 4-25.

Clayton, E. W., Krugman, R. D., & Simon, P. (Eds.). (2014). *Confronting commercial sexual exploitation and sex trafficking of minors in United States*. Washington, DC: The National Academies Press.

Cole, H. (2009). Human trafficking: Implications for the role of the advanced practice forensic nurse. *Journal of the American Psychiatric Nurses Association*, *14*(6), 462-470. http://dx.doi.org/DOI: 10.1177/1078390308325763

Doswell, W. M., Braxter, B. J., Cha, E., & Kim, K. H. (2011). Testing the theory of reasoned action in explaining sexual behavior among African American young teen girls. *Journal of Pediatric Nursing*, e45-e54. Retrieved from

Doswell, W., Yookyung, K., Braxter, B., Taylor, J., Kitutu, J., & Hsu, Y. A. (2003). A theoretical model of early teen sexual behavior: What research tells us about mother's influence on the sexual behavior of early adolescent girls. *Journal of Theory Construction & Testing*, *7*(2), 56-60.

Dovydaitis, T. (2010). Human trafficking: The role of the health care provider. *Journal of Midwifery & Women's Health*, *55*(5), 462-467. http://dx.doi.org/doi:10.1016/j.jmwh.2009.12.017

Edinburgh, L. D., & Saewyc, E. M. (2009). A novel, intensive home-visiting interventionfor

runaway, sexually exploited girls. *Journal for specialists in pediatric nursing*, *14*(1), 41-

48.

Estes, R. J., & Weiner, N. A. (2001). *The commercial sexual exploitation of children in the U.S.,*

Mexico and Canada. Retrieved from www.hawaii.edu:

http://www.hawaii.edu/hivandaids/Commercial%20Sexual%20Exploitation%20of%20Ch

ildren%20in%20the%20US,%20Canada%20and%20Mexico.pdf

Fawcett, J., & Garity, J. (2009). Evaluation of middle-range theories. In *Evaluating research for*

evidence-based nursing (pp. 73-88). Philadelphia, PA: F.A. Davis Company.

Fishbein, M. (1963). An investigation of the relationship between beliefs about an object and the

attitude toward that object. *Human Relations*, *16*(3), 233-239. http://dx.doi.org/doi:

10.1177/001872676301600302

Grace, L. G., Starck, M., Potenza, J., Kenney, P. A., & Sheetz, A. H. (2012). Commercial sexual

exploitation of children and the school nurse. *The Journal of School Nursing*, *28*(6), 410-

417. http://dx.doi.org/DOI: 10.1177/1059840512448402

Guilamo-Ramos, V., Jaccard, J., Dittus, P., Gonzalez, B., & Bouris, A. (2008). A conceptual

framework for the analysis of risk and problem behaviors: The case of adolescent sexual

behavior. *Social Work Research*, *32*(1), 29-45.

Hodge, D. R. (2008). Sexual trafficking in the United States: A domestic problem with

transnational dimensions. *Social Work*, *53*(2), 143-152.

Hom, K. A., & Woods, S. J. (2013). Trauma and its aftermath for commercially sexually

exploited women as old by front-line service providers. *Issues in mental health nursing*,

34(2), 75-81. http://dx.doi.org/doi:10.3109/01612840.2012.723300

Lalor, K., & McElvaney, R. (2010). Child sexual abuse, links to later sexual exploitation/high-risk sexual behavior, and prevention/treatment programs. *Trauma, Violence & Abuse*, *11*(4), 159-177.

McClain, N. M., & Garrity, S. E. (2011). Sex trafficking and the exploitation of adolescents. *Journal of Obsteric, Gynecologic, & Neonatal Nursing*, *40*(2), 243-252.

Mitchell, K. J., Finkelhor, D., & Wolak, J. (2010). Conceptualizing juvenile prostitution as child maltreatment: Findings from the national juvenile prostitution study. *Child Maltreatment*, *15*(1), 18-36. http://dx.doi.org/10.1177/1077559509349443

Rafferty, Y. (2007). Children for sale: Child trafficking in Southeast Asia. *Child Abuse Review*, *16*(6), 401-422.

Reeve, K., Byrd, T., & Quill, B. E. (2004). Health promotion attitudes and practices of Texas nurse practitioners. *Journal of the American Academy of Nurse Practitioners*, *16*(3), 125-133. http://dx.doi.org/doi:10.1111/j.1745-7599.2004.tb00383.x

Sabella, D. (2011). The role of the nurse in combating human trafficking. *AJN The American Journal of Nursing*, *111*(2), 28-37.

Stransky, M., & Finkelhor, D. (2008). *How many juveniles are involved in prostitution in the US*. Durham, NH: Crimes Against Children Research Center, University of New Hampshire.

Tremblay, L., & Frigon, J. (2004). Biobehavioural and cognitive determinants of adolescent girls' involvement in sexual risk behaviours: A test of three theoretical models. *The Canadian Journal of Human Sexuality*, *13*(1), 29-43.

U.S. Department of State Publication. (2007). *Trafficking In Persons Report* (11407). Washington, DC: Government Printing Office.

Worthen, M. (2011). Sex trafficking or sex work? Conceptions of trafficking among anti-

trafficking organizations in Nepal. *Refugee Quarterly Survey*, *30*(3), 1-20.

http://dx.doi.org/DOI:10.1093/rsq/hdr007

Yu, S., & Yang, K. (2006). Attitudes toward web-based distance learning among public health

nurses in Taiwan: A questionnaire survey. *International Journal of Nursing Studies*,

43(6), 767-774.

		Frequency	Valid Percent	Cumulative Percent
GENDER	MALE	3	8.1	8.1
	FEMALE	34	91.9	100.0
	Total	37	100.0	
AGE	25-35	7	18.9	18.9
	36-45	5	13.5	32.4
	46-55	13	35.1	67.6
	56-65	12	32.4	100.0
	Total	37	100.0	
SPECIALTY	FAMILY	25	67.6	67.6
	PEDIATRICS	4	10.8	78.4
	WOMEN'S HEALTH	2	5.4	83.8
	ADULT	4	10.8	94.6
	OTHER	2	5.4	100.0
	Total	37	100.0	
PRACTICE SITE	COMMUNITY CLINIC	7	18.9	18.9
	HOSPITAL-BASED CLINIC	9	24.3	43.2
	SCHOOL-BASED CLINIC	6	16.2	59.5
	PRIVATE PRACTICE	10	27.0	86.5
	EMERGENCY DEPARTMENT	1	2.7	89.2
	OTHER	4	10.8	100.0
	Total	169	100.0	
YEARS OF EXPERIENCE	0-5 YEARS	8	21.6	21.6
	5-10 YEARS	8	21.6	43.2
	10-20 YEARS	12	32.4	75.7
	20-30 YEARS	5	13.5	89.2
	>30 YEARS	4	10.8	100.0
	Total	37	100.0	

Table 1 Demographics

Appendix 1

Demographics

1. Female

   Male

2. Age

   25-35

   36-45

   46-55

   56-65

3. Specialty

   Family

   Pediatrics

   Women's Health

   Adult

   Acute Care

   Other, please specify:

4. Practice Site

   Community Clinic

   Hospital-based clinic

   School based clinic

   Private practice

   Emergency Department

   Other, please specify:

5. Years of practice

   0-5 years

   5-10 years

   10-20 years

   20-30 years

   >30 years

Pre-Test

1. The federal law which made human trafficking a federal crime was enacted in 1997.

    a. True

    b. False

2. Victims are allowed one day off a week.

    a. True

    b. False

3. Traffickers or pimps are always strangers to the victims.

    a. True

    b. False

4. Indicators of trafficking are: scars, inability to keep appointments, lack of ID, missing teeth, and inconsistent health histories. a. True

    b. False

5. Red flags that can indicate victims of sexual trafficking can be: problems with jaw or neck and presence of cotton or debris in vagina. a. True

    b. False

6. Victims are required to reach a quota (number of sexual partners) each day. a. True

    b. False

7. The definition of a commercial sexual exploitation is to induce a person to perform a sexual act by force, fraud or coercion no matter the person's age. a. True

    b. False

8. It is common for trafficking victims to cooperate with law enforcement. a. True

    b. False

9. Trafficking venues include massage parlors, residential brothels, truck stops and escort services a. True

    b. False

10. Victim of trafficking will disclose the problem on the first visit.

    a. True

    b. False

11. Victims may seek care for bronchitis, pneumonia, chronic pain, dental infection and sleep deprivation. a. True

    b. False

12. In the A-M-P (Action-Means-Purpose) Model fraud, force or coercion is not necessary for minors under 18 who are engaging in commercial sexual acts. a. True

    b. False

13. Trafficking victims commonly seek health care on a routine bases. a. True

    b. False

14. Providers should always discuss the patient's health concerns alone no matter the patient's age. a. True

    b. False

15. Victims are allowed to set their own quotas.

    a. True

    b. False

Appendix 2

Post-Test

1. The federal law which made human trafficking a federal crime was enacted in 1997.

    a. True

    b. False

2. Victims are allowed one day off a week.

    a. True

    b. False

3. Traffickers or pimps are always strangers to the victims.

    a. True

    b. False

4. Indicators of trafficking are: scars, inability to keep appointments, lack of ID, missing teeth, and inconsistent health histories.

    a. True

    b. False

5. Red flags that can indicate victims of sexual trafficking can be: problems with jaw or neck and presence of cotton or debris in vagina.

    a. True

    b. False

6. Victims are required to reach a quota (number of sexual partners) each day.

    a. True

    b. False

7. The definition of a commercial sexual exploitation is to induce a person to perform a sexual act by force, fraud or coercion no matter the person's age.

    a. True

    b. False

8. It is common for trafficking victims to cooperate with law enforcement.

    a. True

    b. False

9. Trafficking venues include massage parlors, residential brothels, truck stops and escort services

    a. True

    b. False

10. Victim of trafficking will disclose the problem on the first visit.

    a. True

    b. False

11. Victims may seek care for bronchitis, pneumonia, chronic pain, dental infection and sleep deprivation.

    a. True

    b. False

12. In the A-M-P (Action-Means-Purpose) Model fraud, force or coercion is not necessary for minors under 18 who are engaging in commercial sexual acts.

    a. True

    b. False

13. Trafficking victims commonly seek health care on a routine bases.

    a. True

    b. False

14. Providers should always discuss the patient's health concerns alone no matter the patient's age.

    a. True

    b. False

15. Victims are allowed to set their own quotas.

    a. True

    b. False

Appendix 3

Appendix 4

Appendix 5

Appendix 6

Appendix 7

Appendix 8

Appendix 9
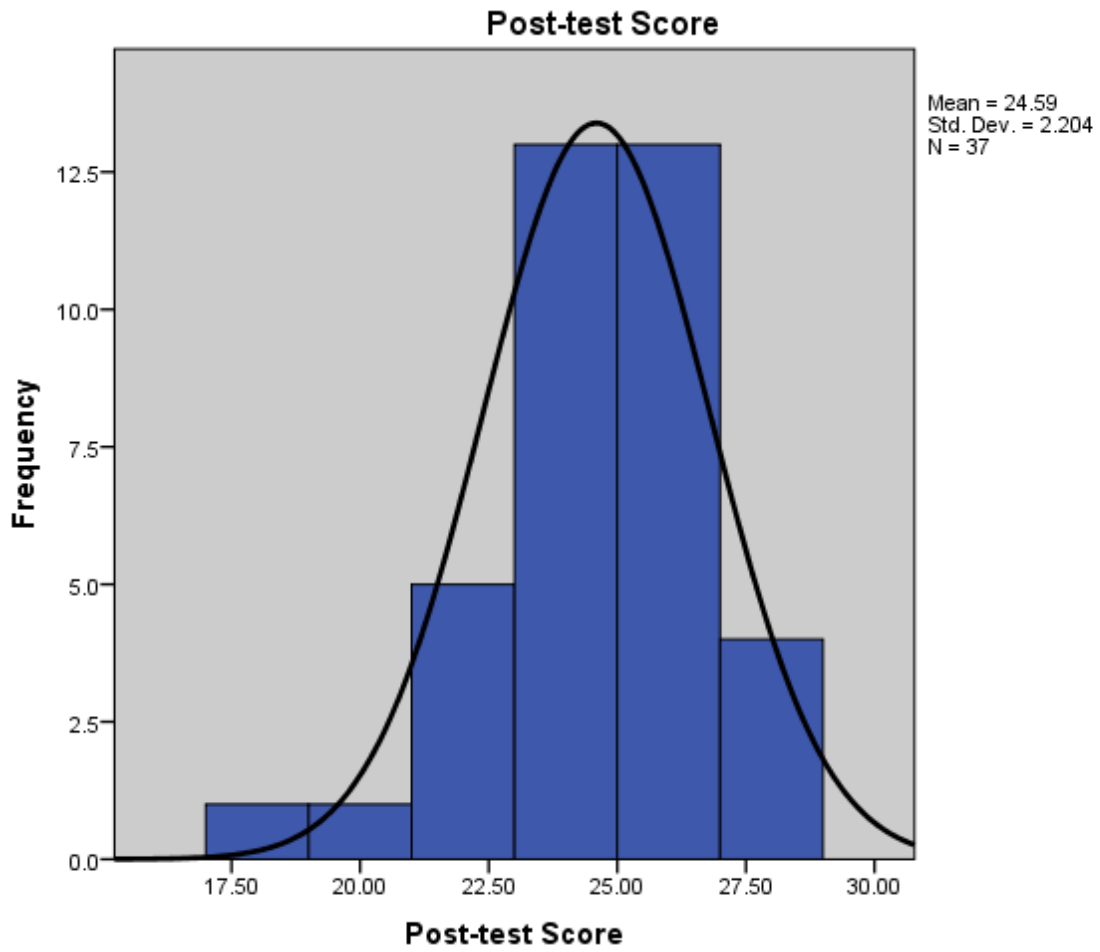

Appendix 10

Appendix 11

Appendix 12

Evaluation

1. How easy was it to complete both the pre and post-tests and submit them? (Responses: Very Easy, Somewhat Easy, Neutral, Somewhat Difficult, Very Difficult)

2. Were you able to view the video "Recognizing and Responding to Human Trafficking in a Healthcare Context"? (Responses: Yes, No)

3. Did you find the video helpful? (Responses: Very Helpful, Somewhat Helpful, Neutral, Not Helpful, Not Helpful At All)

4. How likely are you after completion of the webinar to screen your patients for human trafficking? (Responses: Very Likely, Somewhat Likely, Neutral, Not Likely, Not At All)

5. How likely are you to use the health assessment card in your practice? (Responses: Very Likely, Somewhat Likely, Neutral, Not Likely, Not At All)

6. Would you have preferred the information as WebEx or in-person program? (Responses: WebEx, In-Person)

7. Other comments:

Appendix 13

Pre-test Score

Mean = 23.95
Std. Dev. = 2.333
N = 37

Appendix 14

Post-test Score

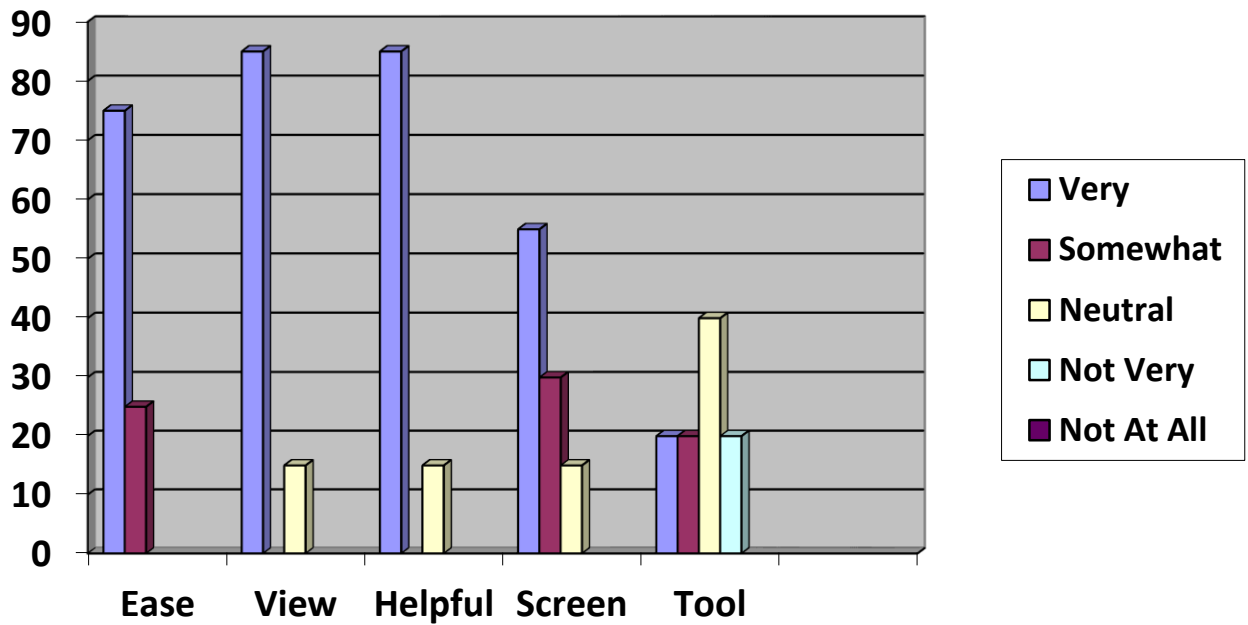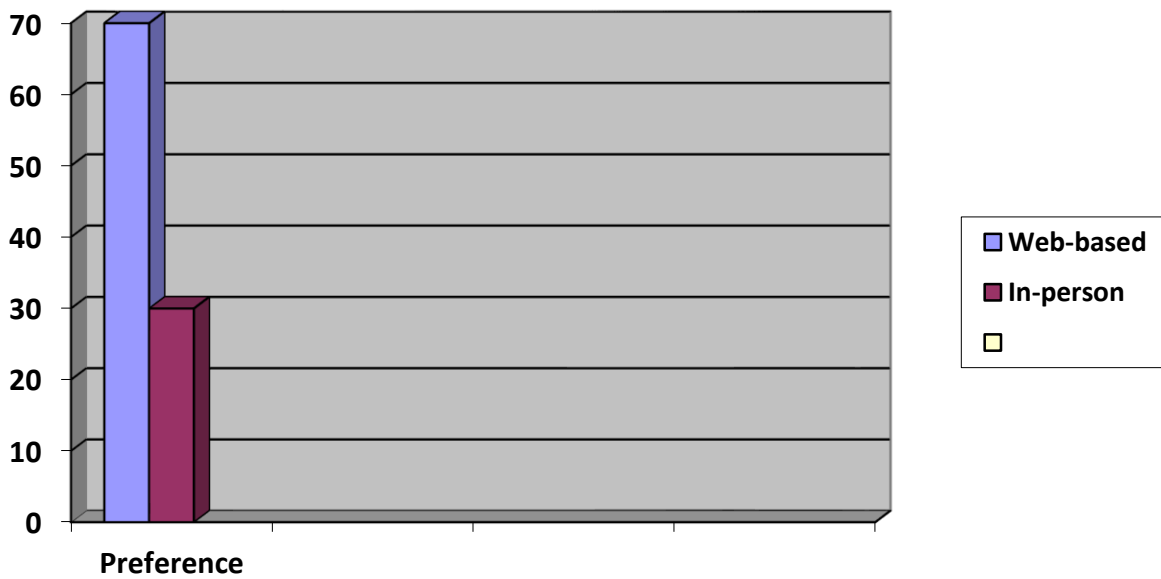Mean = 24.59
Std. Dev. = 2.204
N = 37
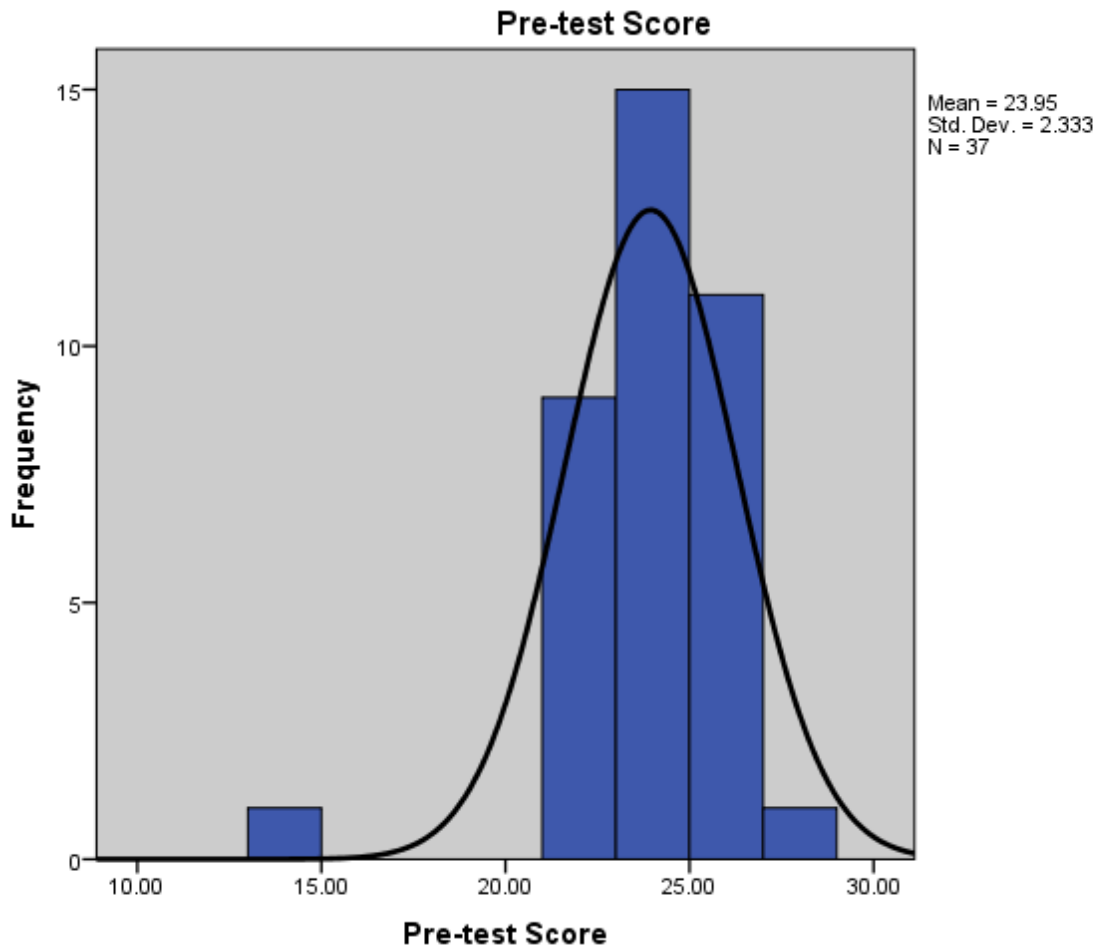
Figure 1A Percentage of Evaluation Results

Figure 1B Percentage of Evaluation Results