Healthcare Provider Toolkit & Resources

For working with victims and survivors of sex trafficking and the sex trade

REST

REAL ESCAPE FROM THE SEX TRADE

Introduction

It is estimated that 88% of survivors of sex trafficking come in contact with healthcare providers every year (Seattle Against Slavery, 2019). In a survey conducted in the United States, only 6% of healthcare providers thought they had ever cared for a victim of trafficking (Ross, Dimitrova, Howard, Dewey, Zimmerman, & Oram, 2015). The purpose of this toolkit is to equip healthcare providers with the information and knowledge to best care for survivors based on a trauma-informed care (TIC) approach.

In this toolkit "healthcare worker" (HCW), "healthcare professional" (HCP) or "healthcare provider" (HCP) are used to refer to any individual who works in healthcare; this includes but is not limited to doctors, nurse practitioners, registered nurses, certified nursing assistants, social workers, and administrators.

This document will explore the definition of sex trafficking and the sex trade, how to identify survivors, and population-specific health needs. It will also cover the barriers to accessing care from survivors' perspectives, trauma-informed care, and how to tangibly implement it. It will define the provider's role in providing care, essentials of reporting, the do's and don'ts of taking a health history/conducting a physical exam for survivors of sex trafficking, and how to prevent secondary trauma.

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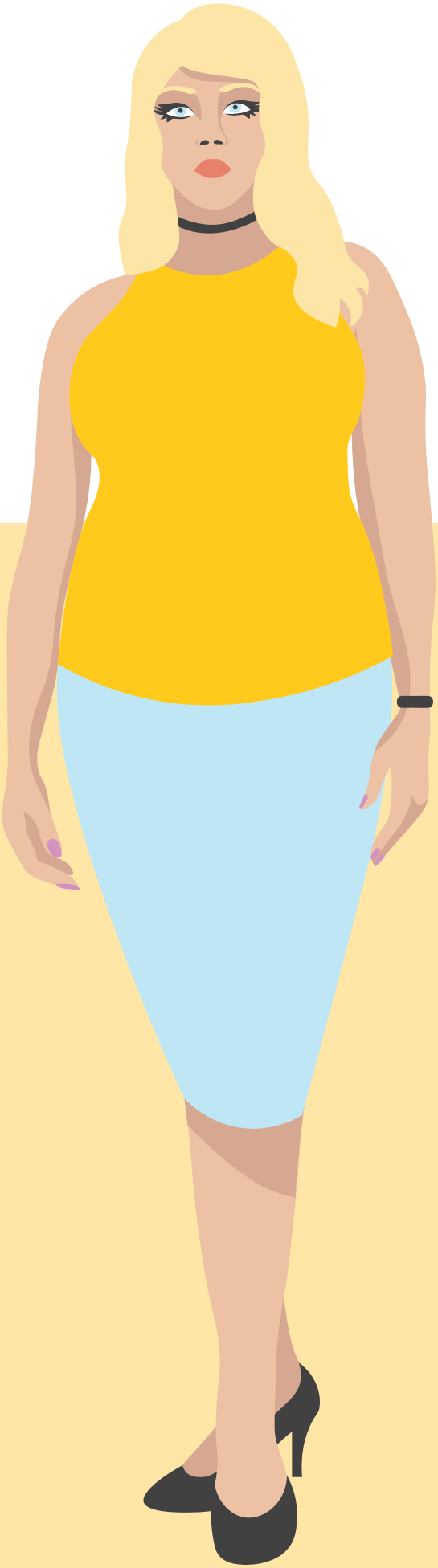


Dear healthcare providers

Hi, my name is Star and I hate going to the clinic. Healthcare workers cut me off, judge me, and don't listen. In my work, day in and day out, I go to a room that is not familiar and I exchange sexual services for money. Sometimes this goes well, sometimes it doesn't. I've been raped, robbed, and treated disrespectfully by my customers. I work hard to stay safe, but I have to take chances. I follow someone to a room, they walk in behind me and close the door. They ask me to take off my clothes, tell me to lay down in an uncomfortable position and begin to touch me. Healthcare providers do this too when I go to the clinic! If healthcare workers knew the similarities, maybe things could change for me when I go to the clinic.

What is sex trafficking and the sex trade?

Sex trafficking refers to the recruiting, enticing, obtaining, providing, moving, and/or harboring a person or to benefit from such activities knowing that the person will be caused to engage in commercial sex acts. In order for a person to qualify legally as a sex trafficking victim, they need to be under the age of 18 or for individuals older than 18, force, fraud, or coercion must be proven. The sex trade refers to the commercial sex industry, and includes sex trafficking victims, as well as adults that engage in sex work without a third party's influence. Survivors of the sex trade often do not identify as victims. Their experience in the sex trade can vary over time between working because of force, fraud or coercion to working independently.

A commercial sex act refers to any sex for which anything of value is given to or received by any person. This can include:

- Trading sex for food, housing, or other basic needs, street prostitution, escorting, exotic dancing/stripping, erotic/nude massage, pornography, phone sex lines, cyber sex

Sexual exploitation:

- Affects ALL genders, ages, economic classes, races, education levels
- Disproportionately affects people that are young, financially poor, people of color, immigrants, LGBTQ2IA+
- Includes both international and domestic recruitment for the sex trade

Types of traffickers:

- Boyfriend, guerrilla, peer, parent, gang, organized crime

Boyfriend pimp:

Shanice met T at a store one day. He noticed her, approached her, and told her how beautiful she is. She fell in love with him and he began to provide for her. She didn't have anywhere else to be, so she spent her every moment with him. One day, he told her that he needed money to pay his court fees and asked for her help—just this one time. He taught her how to have sex, negotiate money, make sure the date wasn't a cop, and then return the money to him. She did it. The first man she had sex with for money was much older than she was, unkempt, and reminded her of her dad. She felt so disgusting she wanted to shower, but she also felt proud to provide for her boyfriend in this way.

Guerilla pimp:

Sarah filled out an application at a kiosk in the mall. She didn't write any references on it because she didn't know anyone that would speak well of her. She didn't write an address on it, because she was currently moving around. She was surprised to get an interview, but quickly learned it wasn't what she expected. When she showed up ready to present herself, a large man put her in the back of a van, drugged her, and raped her. He beat her regularly, threatened her anytime she tried to leave, and began forcing her to sell sex. She felt she needed to appease him in order to stay safe.

Peer:

Michael was staying in a shelter and feeling depressed about his life. He met another guy who had nice clothes and confidence. They became friends and the man told him that he was once broke too, but now knows how to make fast cash. The man explained the rules and introduced Michael to some new men. With this new cash influx, Michael was able to move out of the shelter, into motels, and finally bought the clothes that made him feel better about himself.

Parent:

Maria was born into a family that had ties to a pedophilia ring. By the time she was five, she was regularly being sold to men who had "particular tastes." She tried to run a couple of times, but her mom found her each time and would bring her back home. She knew no life, except her own, and assumed that this was normal and no other options existed.

Gang:

Manny felt like he didn't belong anywhere. He met a friend on Facebook, who met him in person and introduced him to others—he finally felt like he had found "his people." They jumped him to officially make him part of the gang, then continued to set him up with dates. When he wasn't trading sex, he was with his friends—who he liked. He knew that he couldn't leave if he wanted and he felt trapped, but most of the time, he liked being a part of their group.

Organized crime (business):

Hua was recruited to work in the US with a work visa. The recruiting agency provided housing, food, and all basic needs. She was brought to an apartment building, where she met other women working for the same company. The business had a board of directors and managers. Her manager explained the type of work she would do—providing sexual services to clients. He kept her visa and the money, giving her a minimal amount of money to send home to her family. She was proud to provide for her family and knew that it would be impossible to find another job without documentation, language skills, or connections to other local people.

Types of recruitment techniques:

- Selling the dream, promises, threats and violence

Selling the dream:

Naomi grew up in a home where her basic needs were not met. She never knew her father, and her mother struggled to provide for her and her siblings while she unsuccessfully attempted to overcome substance addiction. One day, Naomi was invited to an after school group with a friend and a volunteer leader began to learn about her vulnerable story. He became close with her, learned about her interests, and her hope for a better life. One day he told her about a way she could make a lot of money fast, finally getting closer to the American dream. He painted a picture for her future that promised things she felt she could never attain on her own. Maybe she could even make enough money for college some day.

Promises:

Monica was a single woman, who worked three jobs to support herself and her emotionally abusive father. One night she went out and met Ryan, who worked as a police officer. Ryan was friendly, charming, and made Monica feel safe. They went on a few dates and Monica opened up to Ryan about her emotionally abusive father and how she feels so alone. Ryan told Monica that he would protect her and that she never had to worry about being alone again. He promised her that she would be able to make $1,000 a night and he would to take care of her. All she had to do was a few small "favors" for him, and he promised to shield her from any legal repercussions.

Threats and violence:

Alyiah was a senior in high school when she started receiving threats from Todd. Todd graduated two years before her. He would burn her with cigarette butts or hit her if she didn't fulfill his demands of having sex with him and his friends. He then escalated his threats to entail hurting her family if she didn't deliver on time and to the degree they expected from her. One day, when she refused to work for him, he had his friend kidnap and sexually assault her sister and told her he'd do it again anytime she said no to him. This terrified her as Alyiah loved her sister. He also convinced her that no one would believe her if she reported him as he had been a well-liked student at the high school.

Individuals engaging in sex work may:

- Not understand or identify with the terms "trafficking" or "exploitation"
- Show signs of dissociation from trauma via physical, mental, or emotional symptoms
- Experience trauma bonds with their traffickers (Stockholm Syndrome)
- Be defensive, protective, or distrusting of people trying to help
- Have limited agency and personal freedom
- Have difficulty remembering and/or explaining their situation
- Not want to share their experiences or may lie about their experiences
- Feel ashamed and stigmatized
- Feel empowered by sex work

After trafficking:

- It is common for a person that has experienced sex trafficking in the past to continue to engage in sex work without being forced, threatened with fraud, or coerced into commercial sex acts.
- Many believe that it is their fault and there is nothing else they can do to earn money.
- Many believe that they will always be recognized as a sex worker, which brings stigma and shame.

Common beliefs for individuals involved in the sex trade:

- Competitive nature, limited resources
- Power dynamics: you either pimp or get pimped, you either have control or none, you're either dominating or being dominated
- Most men are viewed as either pimps or buyers
- The world is viewed as those "in the life" or those out of it ("squares")
- You're either being punished or rewarded
- "Always a dollar short and a day late" (Nothing works out for me.)
- My appearance is above my basic needs, including dental and health care
- "Once a ho, always a ho" (People will always know who you are.)

Identifying individuals in the sex trade in healthcare settings

Common signs:

- Is not free to leave or come and go as he/she wishes
- Is fearful, anxious, depressed, submissive, tense, nervous/paranoid, hypervigilant
- Exhibits distrust towards the healthcare provider
- Exhibits unusually fearful or anxious behavior when discussing security or law enforcement
- Anxiety about sexual history or work responsibilities
- Avoids eye contact
- Appears malnourished
- Shows signs of repeated exposure to harmful chemicals
- Shows signs of physical and/or sexual abuse, physical restraint, confinement, or torture
- Lacking basic needs
- Signs of branding or “ownership” (tattoos, jewelry)
- Excess amounts of cash or new clothing, hair, nails, style

Lack of control:

- Few or no personal possessions
- Not in control of their own money, financial records, or bank account
- Not in control of their own identification documents (ID or passport)
- Not allowed or able to speak for themselves (a third party may insist on being present and/or translating)
- Signs of reporting to a controlling person
- Illogical relationships (20-year-old patient with a 50-year-old present at appointment)

Other:

- Claims of just visiting and inability to clarify where they are staying/address
- Lack of knowledge of whereabouts and/or of what city they are in
- Loss of sense of time
- Inconsistencies in story, signs of trauma
- Hotel room keys, provocative clothing, sex toys, condoms
- Use of vocabulary from “the life”

Vocabulary from “the life”	
Sex buyer	Date, trick, john
Trafficker	Daddy, boyfriend
Area/street where sex is bought	Track, blade, stroll
People not in the sex trade	Squares
Being forced into sex work	Turned out
Set amount of money individual must earn each day	Quota
Leaving your pimp	Blowin’ up

Population-specific health needs

Medical care needs	
Short-term/immediate	Long-term
Chronic pain, complications from unsafe abortions, oral health problems, headaches, vaginal and anal health problems, anxiety, depression, suicidal ideation, suicide, Post-Traumatic Stress Disorder (PTSD), somatic disorders, substance abuse related health issues: abscess, HIV+, Chronic Venous Disorders	Physical abuse, head/neck/spine injuries, fractures, burns, contusions, wound care, sleep deprivation, psychosis, dehydration/malnutrition, gastrointestinal problems, ingestion of poisons, vaginal/anal pain and lacerations, unintended pregnancy, Sexually Transmitted Infections (STI's), HIV exposure (PrEP), contraception

This information is adapted from (Macy, & Johns, 2011; Dovydaitis, 2010).

Other needs	
Immediate Needs	Emergency housing, food, medical care, safety and security, language interpretation, legal services
Mental health assistance	Counseling, medication management, support groups
Income support	Cash, living assistance, employment
Legal services	T-Visa (Trafficking visa), immigration, certification, witness protection, no-contact orders, divorce assistance, legal counsel/case management
Short/long-term	Stable housing, legal assistance, advocacy, translation, medical care, substance abuse treatment, life skills, education, child care, financial wellness/management

International Organization for Migration. (2009). Caring for trafficked persons: Guidance for health providers [PDF file]. International Organization for Migration: Switzerland.

Substance use disorder and trauma

It is imperative that healthcare professionals acknowledge the intersection of trauma, sex work, and substance use. Many HCPs tend to focus on how the substance abuse contributed to the trauma, instead of recognizing how the trauma could be impacting the substance use. HCPs can ask about alcohol and/or substance misuse and explore this in an open and non-judgmental manner. Substance misuse is commonly coupled with depression and physical ailments that are prevalent in this population. "In many settings, trafficked persons are provided with alcohol and drugs during their abuse to reduce their resistance and increase their dependence on traffickers. Their use may have become a way of coping with intense, painful emotions" (Caring for trafficked persons, 2009, p.139).

Healthcare professionals can:

- Show respect for how the individual has coped thus far, even if their coping mechanisms were maladaptive, e.g., substance abuse and self-harm.
- Give non-judgmental, supportive advice about alcohol and substance misuse. Help patients set goals for ceasing consumption when ready and encourage them to express their own motivations for reducing consumption.
- Accept the patient and provide needed care *if possible* even if patient presents to clinic under the influence of alcohol or other substances, acknowledging that consent for invasive exams or procedures cannot be obtained if patient is not sober
- Make it clear that sobriety is not a condition needing to be met before the HCP will provide help to the patient
- Attend to the intoxicated patient's personal safety throughout the healthcare encounter

What is trauma-informed care?

Trauma-informed care (TIC) shares many principles with patient-centered care. TIC is influenced by an understanding of the impact of interpersonal violence and victimization on an individual's life and development. "Providers of trauma-informed care incorporate into their routine clinical practice an appreciation of how traumatic experiences may affect their patients' behaviours and perceptions of their bodies and health" (Zimmerman & Borland, 2009, p. 34).

Preventing retraumatization

Preventing retraumatization is one of the most important goals that a provider can have in any healthcare interaction, and a vital component of providing TIC. "Making connections between a survivor's past experiences and their current situation is crucial. This does not mean pushing a survivor to uncover memories when they are already overwhelmed. It does mean understanding the impact of trauma, how current problems relate to past trauma, and the need to provide survivors with an integrated model of recovery." (Elliott, et al. 2005, p. 468) "Traumatic reactions, or fear of them, prevents many [survivors] from seeking healthcare and may interfere with their ability to hear or remember information given during healthcare visits. Thus, it is important to review this information at several stages, and to monitor whether aspects of an exam or procedure are triggering traumatic reactions. Following an office visit, a survivor may need some time to ground themselves to become ready to travel home safely" (Elliott, et al. 2005, p. 473).

How a clinic visit can mimic being sold for sex

- Private room with the door closed, without the HCP asking permission to close the door
- Power dynamic between the patient and HCP
- The HCP tells the patient what to do throughout the encounter with every expectation that the patient will comply
- Patient may be laying on their back in a vulnerable position
- Patient is being touched—this may be more retraumatizing if the HCP doesn't ask for consent
- Patient is undressed, often in a flimsy gown with no underwear

Goals of trauma-informed care:

The primary goal of trauma-informed care is to avoid retraumatizing the patient.

The goal is NOT to obtain disclosure, or to be a hero for the patient.

The goal IS to create:

- Trust within the healthcare system
- A safe environment where patients are able to share as little or as much as they want to
- A culture that fosters consent for all kinds of care provided
- An experience that the patient feels comfortable returning to when healthcare is needed in the future

Six foundations of trauma-informed care:

1. Safety

Throughout the organization, staff and the people they serve feel physically and psychologically safe.

- The healthcare provider uses trauma-informed care for EVERY patient, regardless of trauma disclosed
- The HCP is warm and inviting, patient care is individualized, supportive, non-judgmental, and integrated
- Patient rights and consent are respected at all times
- The HCP informs the patient of the right to translator services and provides these services when requested by the patient
- The HCP emphasizes the patient's control over the examination and care

2. Trustworthiness and transparency

Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of those receiving services.

- The HCP informs the patient of the right to privacy, confidentiality, and to stop any procedure at any time, for any reason; rights are communicated verbally and written, in patient's preferred language of communication
- The HCP is aware of mandatory reporting for any patient who discloses a history of sex trafficking and is under 18 years; HCP informs the patient that they are a mandatory reporter
- The HCP and staff believe the patient and their disclosed trauma

3. Peer support and mutual self-help

These are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.

- The HCP makes every attempt to connect the patient to identified needs, including holistic health services and support organizations to address needs such as food, housing, shelter, education, legal aid and job-skills development.

4. Collaboration and mutuality

There is true partnering and leveling of power differences between staff and clients and among organizational staff from direct care staff to administrators. The organization recognizes that everyone has a role to play in a trauma-informed approach.

- The HCP acknowledges that irritability, withdrawal, or avoidance may be manifestations of post-trauma stress, and do not hold this against the patient
- The HCP acknowledges that every interaction with a patient can create a positive or negative experience, and makes every attempt to create positive experiences
- The HCP strives to do no harm, prevent retraumatization, and support individuals

5. Empowerment, voice, and choice

Throughout the organization and among the clients served, individuals' strengths are recognized, validated, and built on, and new skills developed as necessary. The organization aims to strengthen the staff's, clients', and family members' experience of choice and recognize that every person's experience is unique and requires an individualized approach. This includes a belief in resilience and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. This builds on what clients, staff, and communities have to offer, rather than responding to perceived deficits.

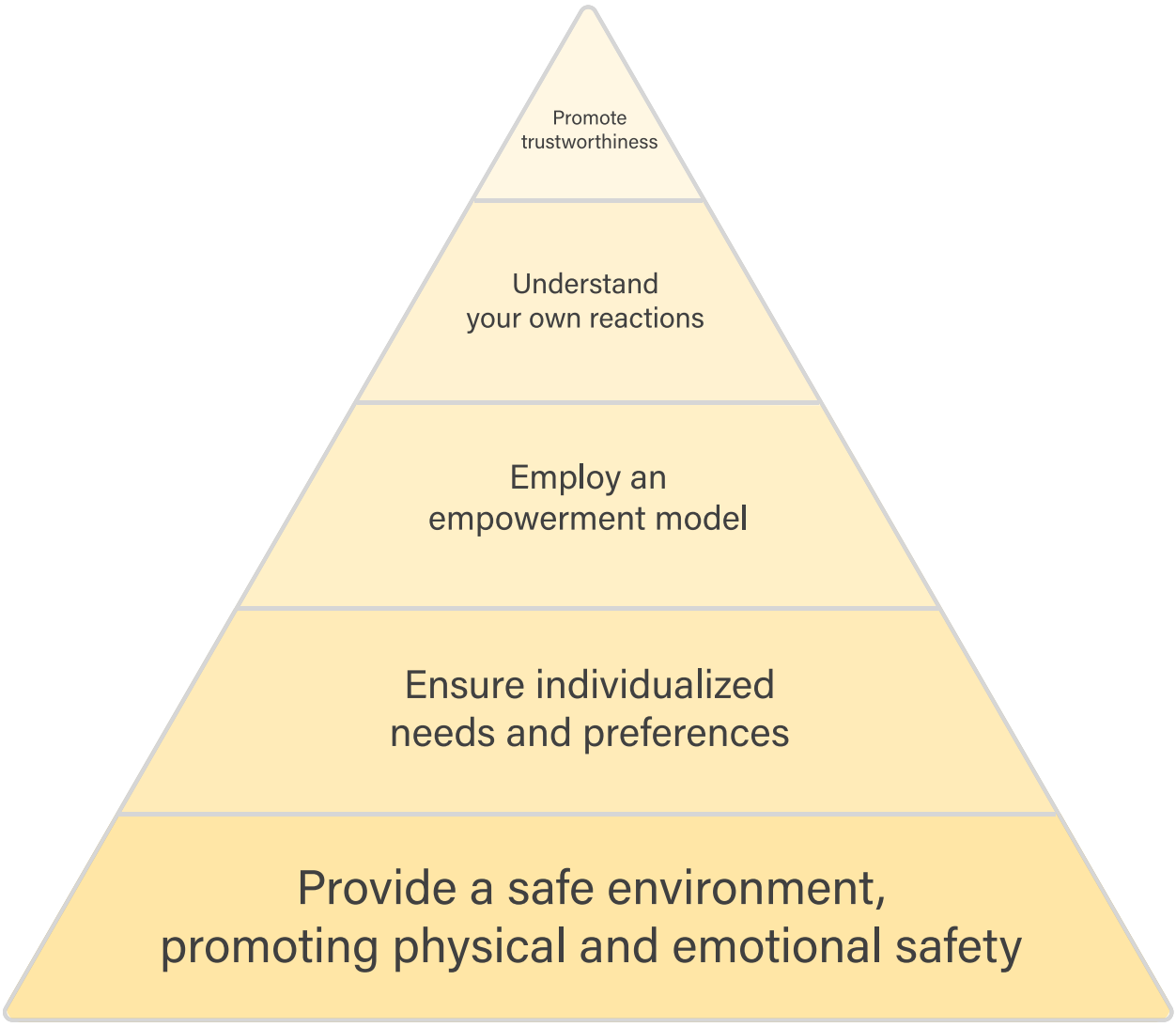
- Staff communicate all information slowly and clearly to the patient, with accurate and easy to understand language
- The HCP identifies patient strengths and informs and affirms these strengths to the patient; the HCP provides care and assessment from a strengths based approach
- The staff gives every option available for treatment to the individual without bias, and allows the individual to make their own health decisions, regardless of what the HCP believes to be best (informed refusal)

6. Cultural, historical, and gender issues

The organization actively moves past stereotypes and biases (e.g., based on race, ethnicity, sexual orientation, age, geography and worldview), offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.

- The HCP is culturally informed and provides culturally competent care to every individual, regardless of stereotypes and biases
- The patient’s wishes for a provider of the same gender is respected when possible, as well as the patient’s choices about whom they would permit to examine them
- The HCP recognize the importance of religious beliefs in a patient’s recovery, as well as their understanding of the trafficking experience in the context of their religion and cultural beliefs.

Hierarchy of trauma-informed care:



The primary goal of trauma-informed care is to prevent further traumatization of survivors of trauma. It is helpful for the patient to feel a sense of compassion and humanity from their healthcare providers. Providers must assess each patient as an individual person with unique needs and preferences. Empowering the individual occurs through a strengths based approach, and the provider should be aware of their own biases. The ultimate goal is to promote the development of trust.

Are your behaviors showing EMPATHY?	
E	Eye contact
M	Muscles of facial expression
P	Posture/Position
A	Affect
T	Tone of voice, touch with permission
H	Hearing the whole person
Y	Your response

Many healthcare providers believe they display empathy, but unfortunately, that is not what many patients experience. It is important for healthcare providers to practice these behaviors and get feedback to ensure that their patients receive empathetic care.

HCPs can practice their pleasant, open, non-judgmental face in the mirror or in front of a colleague to gather feedback and adapt as necessary.

Provider's role in providing care, reporting, and what to do when someone discloses

This section utilizes information and ideas from (Macy, & Johns, 2011; Dovydaitis, 2010)

What's the provider's role for identifying victims? What are they required to do by law? Under or over 18 years?

- Every person engaging in sex work and under 18 years old is considered a victim of sex trafficking.
- For victims under age 18, the provider is legally obligated to contact Child Protective Services.
- For those over 18 years old, force, fraud or coercion must be proven for a survivor to take legal action on their trafficker, and the HCP is not obligated to report even if fraud, force or coercion exist.
- Do not call authorities, such as police or immigration services, unless given the consent of the person over 18.
- Persons may have well founded reasons for avoiding authorities. Attempts should be made to discuss viable options and the HCP must gain consent for actions.

What's the provider's role if a survivor discloses?

- Acknowledge what the patient discloses, validate that you believe them and that they are brave and didn't deserve this, and then move on (don't get stuck in the disclosure, it's not why the patient came to the clinic).
- Offer the patient the option of interacting with male or female staff or interpreters.
- Maintain a non-judgmental and empathetic manner and show respect for and acceptance of each individual, their culture, and situation.
- Show patience. Do not press for information if individuals do not appear ready or willing to speak about their situation or experience.
- Tell the person that they do not have to answer if they do not want to. If they say they do not want to answer, it is the healthcare provider's responsibility to accept their decision.
- Ask only relevant questions that are necessary for the assistance being provided. Do not ask questions out of simple curiosity (i.e. about the person's virginity, money paid/earned, number of sexual partners).

Do's and don'ts for taking health history and conducting a physical exam for individuals in the sex trade

Do:

- Review the details of their history that is already in the medical record. Some individuals have disclosed their trauma history previously, so this avoids the need to re-question the patient about the trauma.
- Have patience with survivors. The tasks you need to get done are not as important as displaying empathy and care for your patient during this experience that might be extremely difficult for them.
- Allow the patient to follow you into the exam room upon arrival, and follow you out at the end. The patient should be "last in, last out" as you transition rooms.
- Explain principles of confidentiality and medical privacy laws as it is important for reassuring individuals in the sex trade.
- Emphasize that the patient has complete control over their medical care. If the patient seems too upset or apprehensive to tolerate an examination, offer the opportunity to complete the physical examination at a later visit.
- Ask the patient if there is anything that will make the experience more tolerable when performing a physical examination.
- Give the option of shifting an item of clothing out of the way rather than putting on a gown when an entire area does not need to be visualized. If a gown is necessary, invite the patient to keep on as much clothing as possible, e.g., underwear and/or shirts. An alternative approach during the physical exam might be to offer the option of a mirror so they can see procedures or examinations that are out of the patient's visual field.
- Clearly state that the findings are normal when applicable because a survivor may be worried that their trauma history had negative physical consequences to their body.
- Only touch the patients when needed for an exam with clear and ongoing consent.
- Respect the rights, choices, and dignity of the patient by maintaining a non-judgmental and sympathetic manner and showing respect for and acceptance of the patient.

- Treat all contact with patients as a potential step towards improving their health. Every interaction with a person can have positive or negative effects on their overall health and wellbeing.
- Give patients space to tell their story and let them take the lead.
- Ask the patient to summarize their understanding during the exam to assess whether your explanation is being received. This also highlights ongoing consent.
- Use grounding techniques. Grounding techniques help the person feel safe in the here and now. "Put your feet on the floor and feel your presence. You are safe here."
- Thank them for their courage in sharing their story, empower them and respond to any dissociation.

Don't:

- Walk behind the patient to the exam room.
- Stand or sit between the patient and the door of the exam room if it is possible. If not possible due to room configuration, provide support and let the person know that they can leave the appointment at any time.
- Touch the patient if you do not have to. Talk through your necessary touches. Limit the exposure of the patient's body as much as possible and explain what is being examined and why.
- Use unneeded touch such as a handshake, touching patient's shoulder, etc.
- Call authorities, such as police or immigration services, unless given the consent of the person. Persons may have well founded reasons for avoiding authorities. Attempts should be made to discuss viable options and you must gain consent for actions.
- Press for information. Ask only relevant questions that are necessary for the assistance being provided.
- Ask questions out of simple curiosity.
- Appear shocked, fearful or disgusted.
- Show discomfort with silence and hesitation (see table below) (Raja, Hasnain, Hoersch, Gove-Yin, Rajagopalan, 2015 & Ades et. al., 2019).

The Patient	The Healthcare Provider
Fearful body language: › Refuses exam or touch › Limited or no eye contact › Becomes quiet and distant during procedures Negative self-talk: › "I was the one who did something wrong" › "This is all my fault" › "No one will love me" › "I know I am crazy" Signs of trauma or distress: › Crying › Difficulty breathing › Irritable › Flat affect › Withdrawn › Anger › Aggression	Maintain open and accepting body language: › Maintain relaxed body posture, neutral positions with hands at side, and be mindful to keep legs together › Ask permission to make physical contact every time, and explain procedure before making contact Attitudes: › Don't stigmatize, victimize, or ask questions that are not pertinent. › Normalize the experience for the patient. › Believe and validate the patient, confront any biases and empathize. Provide empathetic and empowering statements such as: › "It is normal to feel this way" › "Thank you for sharing with me" › "You are very brave to tell me" › "I am so sorry that this happened to you. No one deserves that" › Use non-judgmental language such as "sex without a condom" vs "risky sex" Use the term "survivor" vs "victim" Encourage patient autonomy by saying "Is it okay if I?" instead of "I need to" Ask "What is the most important thing you need right now?

This table was adapted from An Integrated, Trauma-Informed Care Model for Female Survivors of Sexual Violence: The Engage, Motivate, Protect, Organize, Self-Worth, Educate, Respect (EMPOWER) Clinic. (Ades et. al., 2019).

Barriers to accessing care from survivors' perspectives

Conventional health settings and clinic structures often present barriers to people working within the sex trade who are seeking healthcare services. These barriers can result in untreated sexually transmitted infections (STIs), an increased risk of HIV infection, anxiety, bodily injury, high blood pressure, and chronic conditions (Jeal & Salisbury, 2004).

People involved in the sex trade have had buyers who are a part of the healthcare profession, law enforcement, or other non-profit work. It is retraumatizing for individuals to have healthcare professionals who are considered to be in a helping role, be the same people that are soliciting sex.

People working within the sex trade often do not seek public healthcare services due to their negative experiences in these settings. They fear that they will be refused service and may experience public humiliation by health workers (Jeal & Salisbury, 2004). The literature also shows that the location of the health facilities and their hours of operation are inconvenient for sex workers.

Patients know that prostitution is a crime, and that they are considered to be criminals. Sex work is also highly stigmatized and sex workers are often treated differently when they share about their experience. This may hinder them from disclosing their experiences or sharing any information related to their lives involved in the sex trade.

Street based sex workers that do have frequent contact with health services, often use services inconsistently and their use of preventative healthcare is poor. Most of the time they are accessing care in urgent care or Emergency Room settings when symptoms become severe (Stadler & Delany, 2006).

The most common barriers for individuals in the sex trade accessing healthcare services are: having to wait for available appointments, difficulty keeping the appointments that are made due to life circumstances beyond their control, and the perception of being judged by the staff. When individuals were asked to suggest a possible solution for attendance, a 'no-appointment' system was suggested. Another suggestion was to have a clinic close to their place of work with more unconventional hours (Jeal & Salisbury, 2004).

One way that providers can try to mitigate no-show appointments would be for providers and people scheduling the appointments to be upfront about their no-show policies when making the appointment. This way, if there is a cancellation policy, it can be explained to patients when the appointment is made so that they better understand their responsibilities and the penalties if they no-show. Another way is to have walk-in appointments for primary care providers.

Here are a few examples of how unconventional and innovative clinics can be successful in reaching this population in a way that is more adequately able to meet their needs:

The Healthy Brothel:

This paper reports an intervention used in Hillbrow, South Africa where a clinic that provided sex workers with quality healthcare to treat STIs and other reproductive health disorders and to provide HIV/AIDS education and counselling was created within the hotels in which the sex workers operated.

Some of the words from the sex workers interviewed stated that this clinic is convenient because when they want to go, they just "wake up and go." They do not have to make an appointment or try to find the time to go to a clinic that is not as easily accessible. They also stated that this clinic does really well at explaining the procedure before treating them, that everything is done after consent is obtained, and the healthcare providers are patient. The workers feel afraid of getting infected with HIV and they wanted to prioritize their health, so this clinic allows them to get their health needs met right where they are working.

This article found that it is possible to provide quality services to people who are involved in the sex trade outside of the conventional clinical setting. Sex workers responded positively to the clinic and changed aspects of their health seeking behavior, which fostered an environment where safer sexual practices were more possible than before (Stadler & Delany, 2006).

Medical Home For Survivors:

An interdisciplinary medical home was created in central Texas to serve as a model for delivery of care to survivors of sex trafficking in a way that is sensitive to their history of trauma. "Hope Through Health Clinic with CommUnityCare" opened in August 2013 and created a unique way to provide trauma-informed care to survivors of the sex trade.

The physician encounter begins by taking a standard medical history, while at the same time the patient is encouraged to ask questions and they are reminded that they have the right to decline any component of the evaluation. They are screened for mental health conditions and after the encounter they are offered a communal meal in order to foster a sense of community as a part of the reintegration process after trauma.

Some of the elements of the Hope Through Health Clinic with CommUnity Care include a human trafficking training that includes the local prevalence, how to identify, and the aspects of providing trauma-informed care. The clinic is founded on the unique health needs of survivors as well as the optimal manner for providing comprehensive care to these patients. This clinic is also available to patients in the evenings offering appointments outside the typical hours of operation for healthcare clinics. This clinic model strives to restore community and empower their patients while encouraging healthcare worker's capacity to address the human rights atrocity (McNiel, Held, & Busch-Armendariz, 2014).

EMPOWER Model:

The EMPOWER clinic is an example of an integrated, long-term, trauma-sensitive care model that provides integrated care for survivors of sexual and gender based violence. There are very few clinics in the US that are dedicated to managing the significant long-term medical consequences of sexual violence in a trauma-informed healthcare setting.

This clinic provides unique considerations for treating survivors which includes a discrete location for the clinic, particularities of obtaining health history, the adaptations to the physical and gynecologic evaluation, the importance of psychiatric support, being explicit about confidentiality and disclosure, facilitating follow-ups and trauma sensitive referrals, and incorporating legal needs. The EMPOWER clinic is a model for future innovation efforts to treat and meet the needs of this vulnerable population (Ades et. al., 2019).

Gender and sexual minorities

Sex workers and gender sexual minorities (GSM) often feel ostracized by healthcare workers (HCW), therefore gender-sexual minorities experiencing the sex trade are often twice marginalized by HCW. This section of the toolkit is intended to acknowledge gender and sexual minorities' specialized health needs.

Below are the powerful words of a trans individual who worked in the sex trade that explains the double stigmatization and extra challenges that individuals face who work in the sex trade and are part of a gender and sexual minority.

- "As a trans individual, I was hesitant to go to the clinics as you never know the criticisms you might get from staff or doctors. For one, you never know who you are going to get—one week you could get a real positive person and another you could be getting someone that is real sex negative or transphobic. Once I started sex work I put it off or avoided getting checked because I just don't want to deal with the judgement from the staff. If I got this much grief and negative attitude just for being trans and getting an STI check, I could only imagine what would be the judgements if I told them I am a sex worker. Today, I still have not told my family doctor for the same reason" (Roche and Keith, 2014).

Gender and sexual minority individuals who work in the sex trade are frequently overlooked and under-reported by law enforcement and HCW due to underlying stigma and beliefs (Martinez & Kelle, 2013). Those at highest risk for entering the sex trade are GSM individuals due to systems of bias and oppression in place within our culture and society (Martinez & Kelle, 2013). The literature shows that because of the high amount of rejection from families and communities gender and sexual minorities live on the edges of our society and make up a disproportionate number of homeless, unemployed, drug sellers, and sex workers (Winter et al., 2016; Stepleman et al., 2019; Rodriguez, Agardh, & Asamoah, 2018). Marginalization and discrimination take a significant toll on the health and wellbeing of the GSM population. In addition, as these populations are often hesitant to seek medical care, they frequently experience worse health conditions that leave them vulnerable to treatable STIs and infections (James et al., 2016; Smith, 2015; Winter et al., 2016; Stepleman et al., 2019).

- 31% of transgender sex workers (TSW) felt "disrespected" by HCW and 28% delayed treatment because of fear of discrimination (Roche & Keith, 2014).
- 60% of respondents to the National Transgender Discrimination Survey, reported that they had attempted suicide. This is nearly 37 times the rate of the general population (Fitzgerald, Patterson, Hickey, Biko, & Tobin, 2015).

Vocabulary from the community (Killermann, 2020)

It is helpful to understand the language that is commonly used in the GSM community. However, it is also regularly changing and evolving. Here are some common terms that are used at this time:

- Binder/binding: Wearing an undergarment that achieves the purpose of altering the appearance of an individual's breasts
- Bottom surgery: Surgery done on one's genitals as part of gender reassignment
- CIS-gendered: When someone's sex assigned at birth corresponds with their gender identity in an expected way
- FTM (female to male): Transgender man, assigned female at birth and is changing or has changed their body and/or gender role from female assigned at birth to a more masculine body or role
- Folx: Umbrella term for people with a gender-neutral sexual orientation or identity
- Gaff: Underwear designed specifically for tucking the penis to create a femme and or gender neutral crotch
- Gender affirming surgery: A surgery to affirm a person's gender identity that changes primary and/or secondary sex characteristics that helps to mitigate gender dysphoria
- Gender dysphoria: Current term in the DSM-5 used to describe distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). This term has a history of being weaponized to discriminate against GSM individuals and should only be used in medical paperwork when necessary for insurance coverage of gender affirming care
- Gender expression: The external display of one's gender via clothes, hair, etc.
- Gender identity: A person's intrinsic sense of being male (boy or man), female (girl or woman), or an alternative gender (ie boygirl, girlboy, transgender, genderqueer, eunuch)
- Gender-nonconforming: A term used to describe people who do not conform to the traditional gender binary of male and female. One may identify as male, female, or trans or as gender non-conforming
- GSM: Gender/Sexual Minority is used in place of LGBTQ, to be inclusive of all individuals

- Intersexed-person/intersex: One whose biological sex includes a combination of chromosomes, hormones, internal sex organs, and genitals that are different than that expected of a male or female
- MTF (male to female): Transgender woman, assigned male at birth and is changing or has changed their body and/or gender role from male assigned at birth to a more feminine body or role
- Natal sex: The sex that a person was assigned at birth based on observable genitalia. Also commonly known as "sex assigned at birth"
- Otherkin: People who identify as something other than human
- Organ inventory: A medical assessment tool that allows providers to document, for health purposes, the organs an individual is born with and acquires to ensure that appropriate preventative care is given
- Queer: An umbrella term to describe individuals who don't identify as straight and/or cisgender. This term was historically used as a derogatory term and is still considered a slur in many communities. It is not universally embraced by all GSM individuals, and thus it should not be used unless the individual gives permission
- Transition(ing): Referring to the process of a transgender person changing aspects of themselves
- Transgender: An umbrella term that refers to individuals whose sex at birth and sexual identity do not align
- Tucking: A method to hide the bulge from the penis and testicles so that they cannot be seen through clothing
- Sexual orientation: The type of sexual attraction one has the capacity to feel for others, generally labeled based on the gender relationship between the person and the people they are attracted to. Often confused with sexual preference (Comprehensive List, 2020)
- Sexual preference: The types of sexual intercourse, stimulation, and gratification one likes to receive and participate in. Generally, when this term is used, it is being mistakenly interchanged with "sexual orientation," creating an illusion that one has a choice (or "preference") in who they are attracted to (Comprehensive List, 2020)
- Ze/Xer: Pronounced "zee" and "zer" a non-gendered pronoun, for example: Ze loves zemself

Do's and don'ts:
Caring for GSM individuals in the sex trade

Do

- Ask and use the individual's pronouns when communicating
- Ask permission before touching any body part or performing any procedure to limit discomfort and fear
- Be welcoming and non-judgmental to promote a healthy trusting relationship between HCW and patient
- Keep communication professional
- Provide holistic trauma informed care
- Self-reflect on personal biases, strive to improve character, and reserve judgment
- Provide staff training on transgender competency, barriers of care, and bodily boundaries
- Treat whatever organs the patient comes with, using an organ inventory, a supportive tool of care, while respecting their gender identity
- Watch for signs of dissociation. If your patient appears to be inattentive, emotionally absent, or physically frozen, verbally check in and take a break which allows the patient extra time to become grounded
- If corrected while using incorrect pronouns, apologize, move on, and use the correct pronouns
- Ensure that the patient is aware of their rights and can refuse to answer questions and refuse treatment . This gives individuals autonomy and choice which isn't always given in sex work
- Explain to the patient the reasons for the questions you ask—open communication is key
- Lead the way to the clinic room—it feels safer to follow the HCW and not have someone behind them

Don't

- Ask questions that are not relevant to the health care visit
- Bring personal judgments or prior experience into the professional relationship between a HCW and patient
- Forget about screening for health issues based on the individual's organs or hormones (ex: breast, prostate or menses) in a transgender patient. Existing organs or hormones, even if not aligned with gender identity/presentation, could potentially cause health issues
- Use the term homosexual when describing a queer patient
- Make statements about patient's appearance or attire (e.g. "you're so pretty" or "I could never tell you were a male/female," as this reinforces belief that a person is only valued for their body/appearance)
- Express frustration with your patient on their change in pronouns, gender identity, gender expression

Go to Do's and don'ts for taking health history and conducting a physical exam for individuals in the sex trade

Create an inclusive clinic

Ensure that your physical clinical space is welcoming for GSM individuals by:

- Providing gender neutral bathrooms or bathrooms that are open to the identified gender with signage supporting ("Gender Neutral Bathroom" on single stall restrooms or "You're welcome to use the restroom that best fits your gender identity" on traditional, multi-stall Male/Female designated bathrooms)
- Displaying statements that this space is a safe space for all and discrimination is not tolerated and action is taken to protect the safety and dignity of all in the space.
- Providing chairs and exam tables that work for all bodies/sizes
- On all intake paperwork, providing a space to fill in their gender (to include non-binary and other gender identities) and pronouns
- Avoiding overly gendered environment for sexual health clinics

- Providing gender diverse images in patient education documents and in clinic spaces (avoid stereotypical pictures of "nuclear families" and/or "gay/lesbian" individuals looking pristine/perfect. Find pictures that represent the community you serve)
- Training everyone in the clinic, from front desk staff to providers, about how to care for GSM patients in respectful, non-judgmental, and culturally appropriate ways. Asking questions and inviting consent is noted as a safe place for GSM folx
- Ensuring that from the time of check-in and throughout the patient visit, the patient is referred to by their name and pronoun they have expressed to HCWs
- Putting HCW pronouns on employee name badges—this gesture goes a long way

What to do when you make a pronoun mistake

Learning to use pronouns properly when providing care to GSM patients takes some work. Mistakes will likely happen as a part of the learning process about this community. Acknowledging your mistake and apologizing are crucial. Here are some general guidelines that can help.

- Example 1: You use the wrong pronouns when speaking about someone.
    - "She said she's been on birth control for six months. I'm sorry, I meant to say that he has been on birth control for six months. He can't quite remember the prescription, but said he'd bring it next time."

Don't make a big deal out of a pronoun slip-up. Simply apologize and move on to use the correct pronoun throughout the rest of the discussion. The bigger deal you make it, the more uncomfortable it is for everyone. Also, this is something that occurs and should be noted but not doted on. We make mistakes and it's ok.

- Example 2: You publicly use the wrong pronoun. You're speaking about someone who uses "they/them" pronouns.
    - "He said he would...."

When publicly using the wrong pronoun, try not to draw everyone's attention to it. Simply start using the correct pronoun when you realize you've made a mistake. If you realize later you've made a mistake, apologize quickly in person and in private by saying "I'm sorry for using the wrong pronouns earlier. I know you prefer ____, and I'll work hard to get it right next time." Don't linger on the topic. Don't make it about yourself.

When in doubt:

- Use they/their pronouns or their name
- Be genuine and sincere as you apologize, and let the patient know you want to correct your language in the future. "I'm sorry for using the incorrect pronoun. I know you use _____" and end with "I'll work on getting it correct next time."

Common healthcare needs and concerns

Mental health

- Main factors linked to poor mental health outcomes such as depression and suicidality are marginalization, isolation, rejection, and phobic behavior (Wilson & Cariola, 2019)
- Global mental health problems are elevated among LGB youth (Russell & Fish, 2016)
- Risk factors for GSM youth:
  - Greater likelihood of experiencing universal factors such as family conflict or child maltreatment (Russell & Fish, 2016)
  - Stigma, discrimination, and compound everyday stressors exacerbate poor outcomes for mental health (Russell & Fish, 2016)
  - Lack of support at many institutions that guide their lives, such as school, which leads to increased vulnerability for GSM youth (Russell & Fish, 2016)
- Substance abuse:
  - 39.1% of sexual minority adults reported using drugs compared to 17.1% of sexual majority adults (Medley et al., 2016)
  - 93% of GSM adults and 94% of GSM adolescents indicated an increased risk of drug use/abuse (Plöderla & Tremblay, 2015)
  - LGBT individuals who reported lifetime substance use problems reported higher rates of suicidal ideation
- Depression and anxiety:
  - GSM youth are 3x more likely to communicate symptoms of depression and 2x more likely to self-harm than heterosexual youth (Wilson & Cariola, 2019)
  - Rates of depression and anxiety are increased across sexual minority subgroups in all dimensions of sexual orientation (behavior, attraction, identity) (Plöderla & Tremblay, 2015)

    - Transgender identity was associated with higher odds of discrimination and depression symptoms as compared to LGB participants (Su et al., 2016)
    - Discrimination and lack of LGBT identity acceptance were primary contributors to depression and anxiety (Su et al., 2016)
- Suicide
    - The National Transgender Discrimination survey found that 60% of respondents reported that they had attempted suicide, which is nearly 37x the rate of the general population (Fitzgerald, Patterson, Hickey, Biko, & Tobin, 2015)
    - Amongst a systematic review, 98% of included studies reported elevated attempted suicide rates for adult and youth sexual minorities across lifetime (Plöderla & Tremblay, 2015)
    - Sexual minority youth were almost 3x as likely to report suicidality (Russell, & Fish, 2016)
    - Risk factors for suicide include depression and substance abuse, which are prevalent in GSM individuals (Coker, Austin, & Schuster, 2010)
    - Risk factors for suicide specific to GSM individuals include:
        - Early openness about sexual orientation
        - Parental disapproval
        - Parental psychological abuse (Coker, Austin, & Schuster, 2010)

Providers should be able and willing to provide referrals to therapists and psychiatrists when needed in order to assist with mental health issues and to provide holistic, individual patient centered care.

Chest binding

Chest binding is a technique used to flatten and compress the chest tissue to present more masculine or neutral (Jarrett, Corbet, Gardner, Weinand, & Peitzmeier, 2018).

- Health risks can include rib fractures, local skin irritation, fungal infections, back pain, overheating, chest pain, shortness of breath, and potential scarring (Jarrett, Corbet, Gardner, Weinand, & Peitzmeier, 2018; Deutsch, 2016)
- Methods include wearing commercial binders, elastic bandages, duct tape, plastic wrap, or multiple sports bras (Jarrett, Corbet, Gardner, Weinand, & Peitzmeier, 2018)
- Patients who chest bind are not likely to bring their complications to the attention of a doctor because a doctor's advice is typically to stop wearing the binder, and this causes psychological distress (Tsjeng, 2016)

- 88.9% of individuals who bind their chest experience at least one negative physical symptom, but only 14.8% seek care. This is because many transgender individuals do not feel safe and comfortable with their physician (Jarrett, Corbet, Gardner, Weinand, & Peitzmeier, 2018)

A trusting relationship with the HCW is of the highest priority to increase patient engagement in care (Jarrett, Corbet, Gardner, Weinand, & Peitzmeier, 2018). Providers rarely mention, ask or educate their transgender patients about chest binding, even if they know their patient is binding. Consider providing education and offering non stigmatizing positive options to patients (Jarrett, Corbet, Gardner, Weinand, & Peitzmeier, 2018). Providers can help relieve physical symptoms such as acne, rib fractures, local skin irritations and fungal infections (Jarrett, Corbet, Gardner, Weinand, & Peitzmeier, 2018).

Tucking / taping (Dornheim, 2020; Moffa, 2019)

Tucking can be defined as a method to hide the bulge from the penis and testicles so that they cannot be seen through clothing. For many individuals, tucking is a way to more easily wear clothes that affirm the individual's identity. Talk to the patient about the options and risks regarding tucking and ways to minimize the risk. When discussing tucking with patients it's important to ask about their future desires and goals about transitioning via gender affirming surgery if applicable. Also, if they are not wanting to engage in "bottom" surgery, discussing alternative methods of gender-affirming presentation and embodiment is encouraged.

- Patients should have appropriate supplies such as:
  - Snug pair of underwear
  - A gaff (if desired)
  - Medical tape (tucking can be performed without tape)
- Patients should be encouraged to go slow and be gentle when tucking the testes into the inguinal canal
- If using tape, patients should always use medical tape and remove hair from the areas of the skin where the tape will be applied
- Encourage patients to practice tucking at home or in another safe space where they are more likely to go slow and not tuck too tightly due to stress/urgency

Safety

- Encourage patients to untuck before going to bed and not to tuck tightly all day long to prevent chafing as well as other complications
- It is unknown if tucking is related to infertility. It is speculated that tucking the testes into the inguinal canal raises the temperature and may therefore damage sperm
- Epididymo-orchitis, prostatitis, cystitis, urinary reflux, prostatism, or infection can occur as a result of prolonged tucking (Zevin, 2016)
- Prolonged tucking may result in pain and can cause testicular torsion
- Patients with a history of tucking and genital pain should be evaluated for serious complications of tucking such as orchitis and epididymitis
- Encourage patients that even when tucking to still stay hydrated and go to the bathroom regularly to reduce the risk of UTIs
    - Not using tape to tuck can make going to the bathroom easier

Go to Barriers to accessing care from survivors' perspectives

Contraception and Pregnancy

Contraception and pregnancy in transgender individuals are important topics that tend to be under-discussed. The current standard of care is to discuss fertility desires with transgender individuals prior to medically or surgically transitioning. Due to rapidly changing practices in both GSM and medical communities, contraception and pregnancy need to be ongoing discussions throughout patients' reproductive years (Light et al., 2018). Furthermore, Amato (2016) states, all transgender people who have gonads and are sexually active with partners that could result in pregnancy, should be counseled on contraception necessity, as infertility is not definite for all transgender individuals on hormone therapy.

There are many misconceptions among both medical and GSM communities regarding contraception and pregnancy in GSM individuals (Light et al., 2018 and Cipres et al., 2017).

Myth	Fact
› Transgender men do not want to become pregnant › Testosterone is an effective contraceptive › Amenorrhea due to hormone therapy equates infertility › Testosterone is a safe contraception for pregnancy › Hormonal contraceptives are safe while on testosterone therapy	› Transgender pregnancies can be planned or unplanned › Individuals on testosterone therapy are still at risk of pregnancy › Testosterone can cause amenorrhea, but individuals may still get pregnant › Testosterone is a teratogen and can cause harm to the baby › There is not conclusive evidence about interactions between hormonal contraceptives and testosterone

For those who do carry their pregnancy, there can be challenges for parents who identify as members of the GSM community. Aside from social perception and judgment, parents who are not heteronormative can struggle with a lack of clear role models of what a positive, well integrated, gender-variant parental role looks like (Obedin-Maliver & Makadon, 2015). Due to these misconceptions and additional barriers, it is important to focus on providing affirming and inclusive care beginning with preconception counseling and continuing through the postpartum period (Obedin-Maliver & Makadon, 2015).

Hormone therapy

Hormonal therapy is used by transgender individuals to develop secondary sex characteristics of the sex they identify with and suppress/minimize the secondary sex characteristics of their natal sex (Deutsch, 2016b).

The hormones that transgender individuals take to help transition can have many health risks.

- For transgender women taking estrogen hormones, some health risks are blood clots, high blood pressure, type 2 diabetes mellitus, cardiovascular disease, and migraines. Many of these risks also increase with tobacco usage, and HCWs should provide education surrounding smoking cessation (Deutsch, 2016b). Another side effect is low libido, or sexual dysfunction, which should be discussed with transgender women before starting hormone therapy.

- For transgender men taking testosterone, there is a risk for acne, weight gain, hair loss, migraines, polycystic ovarian syndrome, pelvic pain, persistent menses, severe cramping, and polycythemia. With the suppression of estrogen in transgender men, there is a major risk for bacterial vaginosis and vaginitis, as well as dry, burning vaginal discomfort (Deutsch, 2016c). These potential health issues should be discussed with transgender men before starting hormone therapy.

With hormonal therapy there is a risk for emotional and mental health issues, including PTSD and depression. Routine screening for these issues, providing appropriate referrals to competent mental health specialists should be considered as an initial step to providing care (Deutsch, 2016b).

Silicone fillers (Zevin & Deutsch, 2016)

Silicone injections are used for immediate body changes in order to help individuals align their outward appearance with their gender identity.

- A major risk with many silicone injections, fillers and implants is that many times the procedure is done by unlicensed individuals. These individuals may not use sterile technique and may use substances that are not medical grade, including aircraft lubricant, petroleum jelly, or tire sealant
- Some rapid side effects include pain, bleeding, infection, edema and allergic reactions. Long term side effects, however, are more severe and could include granulomas, fistulas, lymphedema and sepsis

Prevention is critical, and HCWs can advise transgender women against seeking cheaper, back-alley options for these procedures from unlicensed personnel and provide relevant education and plausible options for their needs, including hormone therapy and surgery, as well as providing referrals to licensed specialists and GSM-competent surgeons.

Gender affirming surgery

In the GSM community, gender affirming surgery can be an important step for some people. It allows individuals to feel more comfortable in their own body. Individuals who decide to get gender affirming surgery should be counseled before and after the procedure. Experts point out the needs of many GSM members post-operatively saying, “recovery from gender affirming surgeries can be complex and involved processes, and there is an additional need for assessment of overall psychosocial functioning and support, health literacy, capacity for self-care, and social support structure in place” (Dickey, Karasic, & Sharon, 2016). It is also

important to recognize that transgender individuals in the sex trade cannot always pursue gender affirming surgeries due to the reliance the individual has on their genitalia to provide for themselves in sex work. They may not also be able to afford to take the time off from sex work while recovering from top or bottom gender affirming surgery.

- In FTM transgender individuals, masculinizing chest surgery is a common gender affirming top surgery that involves removal of breast tissue in order to sculpt a masculine chest that appears natural with the patient's body (Wang & Kim, 2016a). This surgery has a 12% complication rate. Common complications seen after this procedure include scarring, infection, hematoma, seroma, graft complications, and contour irregularities (Wang & Kim, 2016a). The healing and remodeling of the tissue occurs over a year and can be a painful process (Wang & Kim, 2016a)
- In MTF transgender individuals, feminizing augmentation mammaplasty is a common gender affirming top surgery that involves implant-based augmentation mammaplasty (Wang & Kim, 2016b). While complications are rare with this procedure, there is risk of hematoma, seroma, infection, incisional complications, implant rupture, and implant malposition and capsular contracture. Recovery for this procedure occurs over the course of several weeks, though some patients may experience prolonged soreness, swelling, and bruising (Wang & Kim, 2016b)

Barriers to healthcare for GSM individuals

There are many significant barriers and challenges for GSM related to taking care of their own health or actively seeking the help of HCW. The National Transgender Survey of the U.S found that 28% of those surveyed reported delaying seeking treatment or medical care due to a fear of discrimination (Grant, Motter, & Tanis, 2011). In another national survey, one third of transgender individuals seeking healthcare reported harassment, were refused treatment, or had to educate providers on transgender health needs (Learmonth, Viloria, Lambert, Goldhammer, & Keuroghlian, 2018). This is a serious issue because delay or avoidance of healthcare visits, such as a physical checkup, can lead to delays in diagnosis and treating serious health issues.

Furthermore, after seeking medical treatment, GSM individuals are likely to be denied healthcare coverage (Learmonth et al., 2018). One survey found that over 50% of transgender individuals who requested coverage for gender affirming surgery were denied (Learmonth et al., 2018). Many GSM individuals find themselves working in the sex trade due to lack of job opportunities and struggling with homelessness (Roche & Keith, 2014). Furthering the cycles of homelessness and limited job opportunities is that many gender non-conforming people drop out of schooling early due to bullying and discrimination faced in the educational setting (Roche & Keith, 2014). This cycle has a significant toll on the mental health of GSM individuals.

One study that analyzed the data from a survey of 770 GSM individuals aptly illustrates the mental health problem saying, "Limited access to competent healthcare services is a critical barrier to suicide prevention among transgender persons, and the economic disadvantage disproportionately experienced by transgender individuals can further restrict timely access to needed care. Furthermore, there is a gap between the healthcare needs of transgender individuals and the supply of care providers who have the sensitivities and expertise to provide culturally relevant care" (Su et al., 2016).

GSM individuals also face many barriers when it comes to the health of their urinary tract system and bladder due what should be a seemingly simple process of going to the bathroom. Unfortunately, what is normally a perfunctory, simple experience for cis-gendered individuals can be an anxiety-inducing and even dangerous experience for gender and sexual minorities. Many GSM individuals perceive going to the bathroom as a dangerous activity; especially male bathrooms where GSM individuals or friends they know have been assaulted because, "they failed to pass as male" (Hardtacker et al., 2019). Physical health issues are common from trying to avoid using public bathrooms (Herman, 2013). Some of these issues include purposeful dehydration so as not to have to use the bathroom (Herman, 2013). This has led to a disproportionate number of urinary tract infections, kidney issues, and other bladder related issues in gender sexual minorities because they view using a public bathroom riskier than the health issues that could arise from not voiding when they need to (Herman, 2013).

Fortunately, there are ways to address these barriers and reduce the marginalization that GSM communities can face. HCWs should explore, acknowledge, and have sufficient outlets to process their own biases. In order to prepare themselves to be able to deliver non-judgmental and culturally competent care to this population, HCWs should work towards processing these biases outside of a patient care setting. Implicit bias training is vital when entering the workplace to ensure quality care. HCW education and training specifically with a GSM focus can lead to increased confidence, aid to establish a positive attitude and positive performance, and result in safe and comfortable provider visits for GSM patients (Paradiso & Lally, 2018).

Resources for learning more

- Measure implicit (unconscious) bias:
  - https://implicit.harvard.edu/implicit/takeatest.html
  - https://www.lgbthealtheducation.org/wp-content/uploads/2018/10/Implicit-Bias-Guide-2018_Final.pdf
  - https://www.thomasjbillard.com/attmw
- Meeting the healthcare needs of transgender people: https://www.lgbthealtheducation.org/wp-content/uploads/Sari-slides_final1.pdf
- Asking for and using pronouns: https://www.brynmawr.edu/sites/default/files/asking-for-name-and-pronouns.pdf
- Providing Inclusive Services and Care for LGBT People: https://www.lgbthealtheducation.org/wp-content/uploads/Providing-Inclusive-Services-and-Care-for-LGBT-People.pdf
- LGBT health learning models: https://www.lgbthealtheducation.org/resources/
- Trans toolkit: http://www.cedarriverclinics.org/transtoolkit/
- Transhealth: https://callen-lorde.org/transhealth/

Finding a trans/GSM friendly HCW and health services for your patient:

- Ingersoll Center (plug in the insurance type, location and specialty desired and a list will come up of available providers)
- Stonewall Youth (a list of providers in Seattle and Olympia)
- Seattle area clinics
  - Polyclinic (Dr. Kevin Hatfield)
  - Virginia Mason Transgender Health
  - Seattle Children's Hospital Gender Clinic
  - Cedar River Clinics

Preventing secondary trauma and maintaining hope

Adapted from Zimering and Gulliver (2003)

What is secondary trauma?

- Unlike primary trauma, which occurs when an individual has been directly affected by an event, secondary trauma can occur from indirect exposure to trauma through listening to a narrative or firsthand account.
- Providing care to individuals who have experienced trauma is important and ongoing work. It is very important for providers to continue to address their own needs during this time to prevent secondary and vicarious trauma.
- The vivid recounting of trauma or repeated exposure to individuals who have been affected by primary trauma can result in subsequent reactions and emotions that parallel PTSD.
- Secondary trauma can be seen in healthcare professions. It is important to prevent this by taking a few essential steps when providing care.

How to prevent secondary trauma

Risk factors for secondary trauma include insufficient training, having a personal identification with survivors, not having enough support in the workplace, and not having sufficient interpersonal support outside of the workplace.

Training

Seek training in how to deliver trauma-informed care, such as resources on this website.

Identification

Take time to recognize that you are caring for humans just like yourself. Think about how you are alike and different. Make personal distinctions between yourself and your patients. Recognize your role and professional boundaries, while maintaining compassion and care for these individuals.

Recognize

Take a moment to recognize that by seeking resources such as this, you are becoming a more informed provider of care. No one is going to provide perfect trauma-informed care, so be patient with yourself in the process of learning to be more sensitive and informed. Recognize that this area of care is emotionally heavy, and that it is acceptable to feel these emotions.

- One technique to recognize the weight of this topic is to have a special place that you can go to alone. Go to this place after work, or after particular interactions that require reflection, and think about how your work has affected you. After exploring these thoughts, envision a box, where you can safely store and cherish these interactions and individuals. This is not the same as burying emotions, but rather, it is recognizing them as meaningful, giving them due attention, and then allowing yourself to step away for periods of time.

Professional strategies

Focus on balancing caseloads and seeking accessible supervision.

Personal strategies

Respect your own limits, determine your best general coping strategies such as physical exercise, journaling, or expressive art. Find a person that you trust to explore your emotions with. Therapy is a wonderful resource for individuals seeking a safe place to explore thoughts and emotions.

The role of hope

Survivors of human trafficking have experienced trauma, which can be very troubling. As a healthcare provider, it is valuable to see the strengths of these individuals, and the incredible hope that manifests. You will be exposed to individuals with unbelievable resiliency, amazing stories, and redemption from hardship. By being informed and compassionate, you can play a part in making a positive impact in the health and well being of these individuals, which is something to be celebrated.

Recognizing the signs of secondary trauma

Across the resource literature, several signs and symptoms appear consistent throughout individuals who experience secondary trauma:

- Physical warning signs: exhaustion, headaches, grinding teeth at night, heart palpitations, increased illness
- Behavioral signs: substance use, anger and irritability, avoiding social events, feelings of helplessness when hearing a difficult story, lack of empathy for clients
- Emotional signs: increased anxiety, depersonalization, intrusive imagery, depression

If you are experiencing secondary trauma:

- Seek help and treatment through mental health services in your area and medical professionals—it is perfectly acceptable to start this conversation with your primary healthcare provider, who may refer you to other trained professionals
- Discuss your concerns with your supervisor to make adjustments in caseloads
- Think about taking a break from your specific work to equip yourself with the tools and resources for trauma and provide for a season to refresh
- Encourage regular staff meetings or case review times with the staff to discuss issues, hard feelings, personal concerns, errors, and/or areas of improvement

Ten principles of trauma-informed care

Many individuals who have been physically and/or sexually abused do not utilize healthcare services due to the likelihood that the experience will be retraumatizing. It is imperative that all healthcare workers treat and approach every patient as a potential survivor of trauma, using a trauma-informed approach to their care.

Below are ten guiding principles for healthcare workers and their facilities to utilize in the implementation of trauma-informed care. All of this information has been gathered and adapted from the article "Trauma-Informed or Trauma-Denied: Principles and Implementation of Trauma-Informed Services for Women" in the Journal of Community Psychology (Elliott, Bjelajac, Fallot, Markoff, Reed, 2005).

1. Trauma-informed services recognize the impact of violence and victimization on development and coping strategies.

- Trauma-informed staff recognize the continuing effects that trauma has on an individual's life, resulting in lack of engagement in healthcare, hyperarousal, avoidance and coping strategies. A trauma-informed organization recognizes and validates an individual's experiences and ensures their safety.

2. Trauma-informed services identify recovery from trauma as a primary goal.

- Trauma-informed programs offer care directly related to recovery from past trauma along with holistic healthcare services, recognizing that the two coexist and are not to be treated separately.

3. Trauma-informed services employ an empowerment model.

- An empowerment model puts the patient in charge of the care, allowing choice and control over the treatment provided. The goals for treatment are mutually established and the patient is validated. The healthcare provider approaches the patient with a strengths based approach, building off of the strengths present in that patient.

4. Trauma-informed services strive to maximize an individual's choices and control over their recovery.

   › Trauma-informed care ultimately strives to allow for a patient to utilize conscious choice, increased options and a sense of control over their life decisions, taking them away from previous experiences of powerlessness. If a healthcare provider does not understand and/or approve of a choice a patient is making, they will work to gather more information from the patient to aim to understand the patient's choices.

5. Trauma-informed services are based in a relational collaboration.

   › Trauma-informed services acknowledge that interpersonal trauma must be healed with relationships that are the opposite of traumatic, and are therapeutic. Therapeutic relationships are approached with respect, information, connection and hope (RICH) creating safety and trust. A safe relationship is consistent, predictable, nonviolent, non-shaming, and non-blaming. The helper and helped mentality must be eliminated, and the patient's right to refuse to answer a question, refuse treatment or ask for alternative treatment must be made clear.

6. Trauma-informed services create an atmosphere that is respectful of survivors' need for safety, respect, and acceptance.

   › Trauma-informed services strive to create a safe space, modifying programs, procedures and the physical setting to create a non-threatening and safe space for survivors. This includes visuals such as magazine covers in the waiting room and sufficient staff to monitor public areas.

7. Trauma-informed services emphasize individuals' strengths, highlighting adaptations over symptoms and resilience over pathology.

   › "The medical model highlights pathology and inadvertently gives the impression that there is something wrong with a person rather than that something wrong was done to that person. Trauma-informed practice recognizes symptoms as originating from adaptions to the traumatic event(s) or context. Validating resilience is important even when past adaptations and ways of coping are now causing problems. Understanding a symptom as an adaptation reduces the client's guilt and shame, increases [their] self-esteem, and provides a guideline for developing new skills and resources to allow new and better adaptations to the current situation" (Elliott, et al. 2005, p. 467).

8. The goal of trauma-informed services is to minimize the possibilities of retraumatization.

   › Trauma-informed providers acknowledge and understand the potential for retraumatization for patients in a healthcare setting. Invasive or insensitive procedures may trigger trauma-related symptoms and staff actions in stance and communication may induce trauma responses. "Making connections between a survivor's past experiences and their current situation is crucial. This does not mean pushing them to uncover memories when they are already overwhelmed. It does mean understanding the impact of trauma, how current problems relate to past trauma, and the need to provide survivors with an integrated model of recovery" (Elliott, et al. 2005, p. 468). "Traumatic reactions or fear of them prevents many survivors from seeking health-care and may interfere with their ability to hear or remember information given during healthcare visits. Thus, it is important to review this information at several stages, and to monitor whether aspects of an exam or procedure are triggering traumatic reactions. Following an office visit, a survivor may need some time to ground themselves to become ready to travel home safely" (Elliott, et al. 2005, p. 473).

9. Trauma-informed services strive to be culturally competent and to understand each individual in the context of their life experiences and cultural background.

   › Trauma-informed health providers take into consideration a survivor's cultural context. Understanding the influence of someone's culture is essential to making an effective therapeutic connection and being a part of a survivor's recovery. The meaning that one gives violence and trauma can vary by culture. Cultural competence does not require that every provider have detailed knowledge of every culture, but rather that he or she recognize the importance of cultural context. Ask questions, be open to being educated, and try to understand the survivor's experience and responses through the lens of the cultural context.

10. Trauma-informed agencies solicit consumer input and involve consumers in designing and evaluating services.

   › Trauma-informed services acknowledge the importance of involving survivors in the ongoing creation and evaluation of the services and changes being implemented. Survivors should be integrated and actively involved in the development, delivery and evaluation of services and protocols that are created.

Seattle and national resources for providers and survivors

National Human Trafficking Resource Center
- Call: 1-888-373-7888
- Text: 233733
- https://humantraffickinghotline.org/

King County Crisis Hotline
- Call: 1-800-621-4636
- https://www.crisisconnections.org/king-county-2-1-1/

REST | Real Escape from The Sex Trade
- 24/7 Hotline: (206) 451-REST
- https://iwantrest.com
- Community Advocacy, Drop-In Center, Integrated Health Clinic, Emergency Receiving Center Shelter, Residential program

SHE Clinic
- Wednesday drop-in clinic for individuals in the sex trade from 11:00 a.m. – 2:00 p.m.
- Held at Aurora Commons by trauma-informed clinicians
- https://www.auroracommons.org/she-clinic

Organization of Prostitution Survivors
- Hotline 10:00 a.m. – 6:00 p.m.: (206) 853-6243
- http://seattleops.org
- Drop-in, Community Advocacy, Healing through Art and Yoga, Mentorship Opportunities, Men's Accountabilty, Community Education

YouthCARE
- (855) 400-273 | (800) 495-7802
- https://youthcare.org/
- Services for homeless and at-risk youth

Washington Anti-trafficking Response Network
- (206) 245-0782
- http://www.warn-trafficking.org/

API Chaya

- 1-877-922-4292
- https://www.apichaya.org/
- Survivor support services, support groups, resources and referrals for housing, legal and immigration assistance, mental health, food and financial assistance programs

Refugee Women's Alliance

- (206) 721-0243
- https://www.rewa.org/

Victims of Trafficking and Violence Protection Act of 2000

- https://www.state.gov/documents/organization/10492.pdf

Safe Horizon

- 24/7 Hotline: 1-800-621-HOPE (4673)
- Anti-Trafficking Program: (718) 943-8631
- https://www.safehorizon.org/anti-trafficking-program/

Victim Connect Resource Center

- Confidential referrals for crime victims
- 855-4-VICTIM (855-484-2846) from 8:30 a.m. – 7:30 p.m. ET

Office for Victims of Crime: Directory of Crime Victim Services

- https://ovc.ncjrs.gov/findvictimservices/default.html

American Pregnancy Helpline

- (866) 942-6466

GLBT National Youth Talk Line

- (800) 246-7743

National Domestic Violence Hotline

- (800) 799-7233

National Runaway Safeline

- (800) 786-2929

National Sexual Assault Hotline
› (800) 655-4673

Planned Parenthood
› (800) 230-7743

Suicide Prevention Lifeline
› (800) 273-8255

The International Organization for Adolescents (IOFA)
› http://iofa.org/

World Hope International: Anti-Trafficking and Gender-Based Violence
› https://www.worldhope.org/our-work/anti-trafficking-and-gender-based-violence/

Free the Captives: Survivor Care
› http://www.freethecaptiveshouston.com/our-work/survivor-care

Polaris
› Services in Your Community
› Global Modern Slavery Directory
› https://polarisproject.org/get-assistance

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This article explains the importance of integrated gynecologic and psychiatric care of survivors of sexual and gender-based violence at the EMPOWER clinic.

Link to PDF

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) doi:10.1542/peds.2014-281

A review that surveyed Healthcare Providers' knowledge and ability to adequately identify individuals in the sex trade and how a lack of knowledge and confidence results in misidentification, broken relationships, and inadequate care. Pushes for universal hospital policies and procedures and step by step information on how to provide care for individuals who might be in the sex trade and what resources they need.

Link to PDF

Caring for trafficked persons: Guidance for health providers. (2009). Retrieved from http://publications.iom.int/system/files/pdf/ct_handbook.pdf

An online downloadable PDF that provides valuable information about human trafficking, and how to care for this population.

Link to PDF

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

Describes the scope of the problem, defines and outlines differences between sex trafficking and prostitution. Discusses the common health problems seen in victims along with resources to assist them such as the Campaign to Rescue and Restore Victims of Human Trafficking, the National Human Trafficking Resource Center. It also discusses the provider's role and how they will not be able to fix everything as it will require an interdisciplinary healthcare team to adequately treat them, however, the provider can use this opportunity to break the chain of making the victim feel powerless by including them in their healthcare decisions and promoting their autonomy.

Link to PDF

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology. 33*(4) 461-477. doi:10.1002/jcop.20063

Provides a systematic review from 10 healthcare facilities who strive to provide trauma-informed care that has created ten categories for health care providers to know and implement in their facilities as they implement trauma-informed care. A broad general guideline, useful for getting an idea, and can be coupled with more specific tips from other resources. Adaptation for 10 major points for health care providers to know.

Link to PDF

Hardy, V. L., Compton, K. D., & McPhatter, V. S. (2013). Domestic minor sex trafficking: Practicing implications for mental health professionals. *Affilia, 28*(1), 8-18 doi:10.1177/0886109912475172

Describes the importance of assessing the psychological needs of survivors of trafficking, including the increasing diagnosis of complex trauma PTSD. Along with this, it is very important to implement trauma-informed care, asking sensitive questions that get right to the point that focus on immediate safety and needs.

Link to PDF

Hemmings, S., Jakobowitz, S., Abas, M., Bick, D., Howard, L., Stanley, N., Zimmerman, C., & Oram, S. (2016). Responding to the health care needs of survivors of human trafficking: A systematic review. *BMC Health Services Research 16*(320). doi:10.1186/s12913-016-1538-8

Reviews health care needs for survivors of human or sex trafficking, systematic review. Specifically references the need and importance for trauma-informed care and cultural sensitivity.

Link to PDF

Issac, R., Solak, J., & Giardino, A.P. (2011). Health care providers' training needs related to human trafficking: Maximizing the opportunity to effectively screen and intervene. *Journal of Applied Research on Children: Informing Policies for Children at Risk, 1*(22). Retrieved from: https://digitalcommons.library.tmc.edu/cgi/viewcontent.cgi?Referer=https://scholar.google.com/&httpsredir=1&article=1029&context=childrenatrisk.

Reviews building rapport with individuals who are in the sex trade industry and how healthcare workers can identify needs and interventions for individuals, without retraumatizing them and destroying relationships. Provides case study examples on how HCP could build rapport and survivors would open up about their situation and disclose needs.

Link to PDF

Jeal, N., & Salisbury, C. (2004). Self-reported experiences of health services among female street-based prostitutes: A cross-sectional survey. *The British Journal of General Practice: The Journal Of The Royal College Of General Practitioners, 54*(504), 515–519. Retrieved from http://ezproxy.spu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&AuthType=ip&db=cmedm&AN=15239913&site=ehost-live

This study examined the current use of health care services and explored the perception of barriers to health care from the perspective of people who have experienced the sex trade. One of the most common barriers for these sex trade workers was having to wait for appointments, as well as the feeling of being judged by staff and other patients in the waiting room. These are just a few examples of these individual perspectives and this article will dive into more depth to explore the difficulties in accessing the health care system from the mouths of the survivors themselves.

Link to PDF

Konstantopoulos, W. M. (2016). Human trafficking: The role of medicine in interrupting the cycle of abuse and violence. *Annals of Internal Medicine. 165*(8). Retrieved from: https://annals.org/aim/article-abstract/2542525/human-trafficking-role-medicine-interrupting-cycle-abuse-violence

This article explores the role and importance of trauma-informed care in the clinical setting. It delineates several important attitudes for healthcare professionals to hold, such as taking cues from patients, creating a non judgmental atmosphere, and managing self biases. The article emphasizes using trauma-informed care.

Link to PDF

Levy-Carrick, N., Lewis-O'Connor, A., Rittenberg, E., Manosalvas, K., Stoklosa, H., & Silbersweig, D. (2019). Promoting health equity through trauma-informed care: Critical role for physicians in policy and program development. *Family & Community Health., 42*(2), 104.

Talks about universal trauma precautions and the important role they play for health workers and for policy development.

Link to PDF

Macy, R. J.,& Johns, N. (2011). Aftercare services for international sex trafficking survivors: Informing U.S. service and program development in an emerging practice area. *Trauma, Violence, and Abuse. 12*(2) 87-98. doi:10.1177/1524838010390709

A systematic review of 20 articles discussing the needs of survivors of sex trafficking and the continuum of services needed depending on the survivors' stage spanning from initial freedom to recovery and ultimately independence. Providing a framework and timeline for providers to adequately care for their patients who are survivors.

Link to PDF

McNiel, M., Held, T., & Busch-Armendariz, N. (2014). Creating an interdisciplinary medical home for survivors of human trafficking. *Obstetrics and Gynecology, 124*(3), 611–615. doi:10.1097/AOG.0000000000000419

This article explores an interdisciplinary health care team that created a clinic to provide trauma-informed care to trafficked individuals.

Link to PDF

Oral, R., Ramirez, M., Coohey, C., Nakada, S., Walz, A., Kuntz, A., Jenna, B., & Asa, C. (2015). Adverse childhood experiences and trauma-informed care: The future of healthcare. *Pediatric Research 79*, 227-233. doi:10.1038/pr.2015.197

This article explores the effect of trauma and toxic stress on neurobiological processes and emphasizes the importance of not re-traumatizing victims of adversity and delineated effective tools to do so through trauma-informed care. The article states that trauma can rewire certain parts of the brain, such as the amygdala and hippocampus, which decreases memory and stimulates fear and negative behavioral response in those who have experienced chronic toxic stress, such as prostitution.

Link to PDF

Powell, C., Dickins, K., & Stoklosa, H. (2017). Training US health care professionals on human trafficking: Where do we go from here? *Medical Education Online, 22*(1), 1267980. do:10.1080/10872981.2017.1267980

Describes the problem of human trafficking with the results of a mixed-methods study. One aspect of the study were interviews with experts in human trafficking and provider education and the other part analyzed data from providers calls to the National Human Trafficking Resource Center.

Link to PDF

Raja, S., Hasnain, M., Hoersch, M., Gove-Yin, S., & Rajagopalan, C. (2015). Trauma-informed care in medicine: Current knowledge and future research directions. *Family & Community Health 38*(3), 216-226. doi:10.1097/FCH0000000000000071

Discusses the importance of providers being educated on trauma-informed care, their own experiences with trauma and discomfort with addressing it and provides a pyramid of priorities for approaching each patient with a trauma-informed perspective. The article goes even further to provide specific tips for providers as they approach routine exams, and gives suggested questions that they can ask each patient. This article addresses maladaptive coping secondary to past/current trauma, the importance of avoiding retraumatization and the negative mental and physiological effects trauma has on the body.

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Ravi, A., Pfeiffer, M. R., Rosner, Z., & Shea, J. A. (2017). Trafficking and trauma insight and advice for the healthcare system from sex-trafficked women incarcerated on Rikers Island. *Medical Care, 55*(12), 1017-1022 doi:10.1097/MLR.0000000000000820

Gathered information from 21 interviews of women who had experienced human trafficking in their life. Survivors provided insight into the barriers that prevent them from accessing healthcare, and give suggestions for TIC in routine examinations, and recommendations for further holistic care.

Link to PDF

Stadler, J., & Delany, S. (2006). The healthy brothel: the context of clinical services for sex workers in Hillbrow, South Africa. *Culture, Health & Sexuality, 8*(5), 451–464. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&AuthType=ip&db=cmedm&AN=16923648&site=ehost-live

An innovative approach to providing clinical services to people within the sex trade by opening a clinic in a common hotel where sex work is conducted.

Link to PDF

Thulien, N. S. (2014). Innovative approaches to cervical cancer screening for sex trade workers: An international scoping review. *Journal of Obstetrics and Gynaecology Canada: JOGC Journal D'obstetrique Et Gynecologie Du Canada: JOGC, 36*(3), 231–239. doi:10.1016/S1701-2163

This article offers unconventional methods of offering cervical and STI screening to people working in the sex trade. One of the main elements of successful screening initiatives that this study highlighted was the importance of unconventional hours of operation, and for health care professionals to recognize that not all sex trade workers will work the same hours. Understandably there is difficulty finding staff willing to work these unconventional hours, but this article examines the importance of these strategies so that health care can be more accessible for this population.

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Zimering, R., & Gulliver, S. B. (2003). Secondary traumatization in mental health care providers. Psychiatric Times 20(4). Retrieved from: https://www.psychiatrictimes.com/ptsd/secondary-traumatization-mental-health-care-providers/page/0/1

This article discusses the prevalence of secondary trauma in health care providers who are caring for individuals suffering from primary trauma. It reviews the definition, risk factors, and preventative strategies.

Link to PDF

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