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# Experiences of pregnancy and maternity care in women exposed to human trafficking a qualitative evidence synthesis

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# Experiences of pregnancy and maternity care in women exposed to human trafficking: A qualitative evidence synthesis

**by**

**Samantha Nightingale**

**Masters by Research (MScR)**

**May 2019**


***A thesis submitted in partial fulfilment of the University's requirements for the Degree of Master of Research***

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# Certificate of Ethical Approval

Applicant:

Samantha Nightingale

Project Title:

A review of maternal and neonatal outcomes for women who have experienced human trafficking and sexual violence

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Low Risk

Date of approval:

13 December 2017

Project Reference Number:

P65495

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## ABSTRACT

### Background

Emerging research has linked human trafficking and sexual exploitation to poor health outcomes. Of women who die in pregnancy, or up to a year postnatally (in the UK), two-thirds had pre-existing physical or mental health problems. Experiences of intimate partner violence and sexual violence are associated with poor maternal outcomes, and these risk factors share characteristics with human trafficking and sexual exploitation. However, studies on human trafficking/sexual exploitation are relatively sparse, and to date, there is no synthesis that draws together the existing evidence.

### Methods

A systematic review was undertaken to critically evaluate studies that had examined women's experiences of pregnancy, and maternity services. Eight electronic databases were searched using predefined search terms. Studies were included where participants were female and had experienced trafficking or sexual exploitation and pregnancy, if they reported primary qualitative data, and were reported in English in peer-reviewed journals. The analysis used 'Thematic Synthesis' which promotes synthesis of findings from multiple qualitative studies.

### Findings

Thirteen studies were included in the final analysis. Eight descriptive themes emerged; barriers to healthcare (generally); late access to maternity care; thwarted continuity of care; communication difficulties; stigma; co-morbidities: women's experiences of multiple, complex health issues; polyvictimisation; issues regarding health and care of babies. These themes developed into three analytical themes; Access, Person-centred, Poor health, with an underpinning theme of Safeguarding.

### Discussion

Human trafficking victims face many barriers and abuses which cause them extreme and often multiple physical, mental, sexual health and social problems. Further research into pregnancy and neonatal outcomes of women victims and survivors of human trafficking is needed, specifically examining the quantitative data

linking causal factors with maternity/neonatal outcomes, and interventions to support staff to recognise and respond human trafficking/sexual exploitation. However, the findings provide essential knowledge for healthcare providers, with the new “POPPY” approach offering guidance around provision of care based on the analytic themes - POor health, Person centred, People who need us to say Yes to access, with an underpinning theme of safeguarding the family, mother and baby together as a family unit.

**Acknowledgements**

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I am incredibly grateful for the support and encouragement from Professor Jane Coad and Dr Liz Bailey, who have guided me through the start of this clinical academic journey, my Director of Studies Dr Lorna O'Doherty, who has challenged me to think beyond the clinical, Dr Geraldine Brady, for her kindness and encouragement and Dr Diane Phimister, for helping me to join up the clinical and academic thinking and writing.

And finally, to my four-legged companions keeping me company during many hours of reading and writing; Hershey, Mango and Coconut.

**Table of Contents**

# 1.0 Background

## 1.1 Overview of international and domestic context of trafficking and sexual exploitation of women

Human trafficking is a form of modern-day slavery (International Labour Organisation ILO 2017) and described by the United Nations office on Drugs and Crime (UNODC 2017) as a serious crime and a grave violation of human rights. Kevin Hyland the UK's first Independent Anti-Slavery Commissioner (Bales, Hedwards & Silverman 2018:5) stated, "Modern slavery is a brutal abuse, denying people their dignity, safety and freedom." The UNODC (2017:para 2) defines trafficking of people as, "the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation". Human trafficking is a growing problem, but due to its illegal nature it is difficult to know the exact figures (Zimmerman and Stöckl, 2012). The ILO (2017) points out that trafficking affects every country of the world, and estimates that, in 2016, 40.3 million people were victims of trafficking; women and girls were disproportionately affected by forced labour and made up 99% of victims in the commercial sex industry, and 58% of victims in other sectors. Sexual exploitation which has many overlaps within human trafficking is defined by the World Health Organisation (WHO 2017:4) as, "any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, threatening or profiting monetarily, socially or politically from the sexual exploitation of another."

Modern slavery, an overarching term which includes human trafficking, is one of the ten categories of adult abuse categorised in the UK (Social Care Institute for Excellence 2018). Legislation around the issue of human trafficking with the Modern Slavery Act 2015 has ensured that processes have been put in place to both prosecute perpetrators and offer a referral and support mechanism for victims. In 2016, the UK Government declared its commitment to bringing the perpetrators of sexual exploitation and trafficking to justice, and to increase the support available

to victims (HM Government 2016). Some indication of the scale of human trafficking within the UK can be obtained from the National Referral Mechanism (NRM) (National Crime Agency NCA 2019). NCA data for 2018 identified 6504 victims, a 26% increase on the 2017 data (NCA 2018). Whether this is an increase in the number of victims, or an indication that more victims are being identified is difficult to clarify, as these figures only represent those who have escaped trafficking and are in contact with either statutory or voluntary agencies (Stanley et.al 2016). The increase in referrals to the NRM may represent some success in the UK government's strategy, however, it may also represent an increase in detection of human trafficking while there remains a largely undetected majority. Breaking the cycle (2019) are one of the organisations who describe the statistics around known human trafficking victims as the "tip of the iceberg".

## 1.2 Trafficking and health

Zimmerman and Stöckl (2012) discuss in the WHO report 'Understanding and addressing violence against women: Human Trafficking' a WHO report, ways in which victims of trafficking are subject to many health issues. They cite exploitation and conditions in which trafficked people are forced to live, physical and mental health issues, forced use of drugs and alcohol or substance misuse as a coping method by the victims themselves. The International Organisation for Migration (IOM 2009) highlights that health care providers may encounter trafficking victims at different stages of the trafficking process and recovery, and that contact with someone in healthcare may be their only opportunity to explain what has happened and ask for help. However, Ottisova et al. (2016) found that the evidence to inform the identification, referral and care of trafficked people is extremely limited. This is of serious concern as the emerging research links human trafficking to poor health outcomes, both mentally and physically (Hossain et al. 2010; Kiss et al. 2015; Oram et al. 2012; Oram et al. 2016; Stanley et al. 2016)

These studies show that mental health is especially poor, with suicidality and post-traumatic stress disorder (PTSD) the most common mental health issues. Stanley et al. (2016) discuss that chronic illnesses and symptoms from physical injuries are also a major issue. They also highlighted barriers faced accessing health care which include restrictions to liberty, language difficulties, fear for own safety, and the

complex “gatekeeping” barriers to accessing a GP without identification and address, alongside difficulty navigating the UK health system. These problems were raised by Bick et al. (2017) when looking at trafficked women’s access to maternity care. Zimmerman et al. (2003) argue that the health risks, and barriers to services for trafficked women are similar to those experienced by other vulnerable groups such as migrant women, women experiencing sexual abuse, domestic violence, or torture, women sex workers, and exploited women labourers. The claims of Zimmerman et al. (2003) however have not been specifically substantiated in relation to pregnancy and pregnancy outcomes.

## 1.3 Maternal health

Human Rights First (2017) states that 71% of trafficking victims around the world are women and girls. 15.4 million victims (75%) are aged 18 or older with under 18s estimated at 5.5 million (25%). A significant proportion of those who experience trafficking are of child-bearing age. The barriers highlighted above mean women often present late in pregnancy for maternity care, a known risk which can lead to poor maternal and neonatal outcomes (National Institute for Health and Care Excellence (NICE) 2010; Pacagnella et al. 2014).

The Time to Deliver report (Brotherton 2016) discusses pregnancy and parenthood in the UK’s response to human trafficking. However, in discussing pregnancy, it considers the psychological impact on pregnancy and motherhood following the sexual abuse that women are likely to have experienced during sexual exploitation, but it does not consider the outcomes for mother and baby from a midwifery or obstetric point of view. While the psychological impact is of great concern, this cannot be considered in isolation from the potential midwifery and obstetric outcomes which are likely to increase maternal and neonatal morbidity and mortality. The MBRRACE-UK 2018 report, “Saving Lives, Improving Mothers’ Care” (Knight et al. 2018) highlighted that of the women who died in pregnancy, or up to a year postnatally between 2014-2016, two thirds had pre-existing physical or mental health problems. Mental health remains a major concern highlighted in the report, with suicide being the third leading cause of direct maternal death up to 42 days postnatally, and the leading cause of direct death up to a year postnatally. The report highlighted that 114 women died from mental health-related causes during or

up to one year after pregnancy in the UK and Ireland, a mortality rate of 4.57 per 100,000 maternities. Women with vulnerabilities are also highlighted in the MBRRACE-UK 2018 report (Knight et al. 2018). Fourteen women were murdered by a partner or a former partner, and 43 women died in relation to drug and alcohol misuse. The MBRRACE-UK 2015 report (Knight et al. 2015) recommended the introduction of practical national guidance for the management of women with multiple morbidities and social vulnerabilities during and after pregnancy. These recommendations have still not been undertaken (Knight et al. 2018). This is of relevance to victims of trafficking who are likely to have pre-existing physical and mental health conditions and not access maternity services early or consistently in their pregnancies and therefore are at higher morbidity and mortality risk.

On a related point, Gisladottir et al. (2016) found that women who have experienced sexual abuse and violence are at an increased risk of maternal distress during labour, prolonged first stage of labour, antepartum bleeding and emergency instrumental delivery, with higher risk for women assaulted as teenagers compared to older women. Alhusen et al. (2015) identified that low birth weight and increased rates of preterm birth are significant factors in neonates whose mothers are victims of intimate partner violence. Deisher et al. (1991) found that adolescents affected by prostitution had increased frequency of preterm birth, low birth weight, and small-for-gestational-age babies. Deisher et al. (1991) also highlighted the chaotic lifestyles and constant stress, poor nutrition, substance misuse, violence, and chronic illness that were factors in these young women's lives, and that 69% of their babies had positive toxicology results. Fanslow (2017) in her paper looking at the issues of intimate partner violence and women's reproductive health highlighted the adverse pregnancy outcomes associated with violence in pregnancy; miscarriages, stillbirth, preterm labour, low birth weight, and placental abruption. This combination of factors may also present in many victims of human trafficking, which highlight the increased potential risks of maternal and neonatal morbidity and mortality for women who have experienced sexual and physical violence and are potentially transferrable to women who have experienced sexual and physical violence within a human trafficking context.

No systematic review has been identified to date which synthesises the international evidence on experiences and impacts associated with trafficking of women and

maternal health and pregnancy outcomes. The problems trafficked women experience are not sufficiently stated in terms of women's choices around reproductive control, access to maternity specific healthcare and experience of pregnancy and childbirth, including the outcomes that result from these issues for the women and their babies.

### 1.4 Objectives

This review draws together and critically evaluates studies that have examined women's experiences of pregnancy in the context of trafficking and sexual exploitation. It aims to identify and synthesise available evidence on trafficked women's access to and experiences of maternity services, reproductive control, pregnancy, birth experiences and outcomes.

# 2.0 Methods

### 2.1 Approach

The methodology used stemmed from an interpretivist paradigm. In interpretivism the social world is studied in a way that reflects the distinctiveness of humans (Bryman 2012:28). Interpretivists share a belief that the studying of social sciences is fundamentally different from the study of the natural sciences (Bryman 2012:28). Bryman (2012:28) goes on to discuss how in the positivist paradigm, human behaviour is explained, whereas in interpretivism, human behaviour is understood with empathy. Flick (1999:5) discussed that qualitative research does not just study single variables, rather the complexity and entirety of situations is considered.

My aim was not purely to measure outcomes with descriptive statistical data, but to look more deeply at the outcomes for this group of women, to identify recurrent themes with qualitative data. Preliminary scoping of the literature has shown that many of the studies researching human trafficking have used positivist approaches to measure the frequency and types of physical and mental health symptoms using mainly quantitative approaches. However, more recently, studies have used mixed methods approaches capturing statistical data, alongside the rich data that comes with qualitative methods. Qualitative methods include interviews, which can be structured with tightly constructed questions, or semi-structured, using broad or open-ended questions. Interviews are usually informal, and a skilled researcher can

make the participant feel they are in a conversation, which encourages honest and open responses (Denscombe 2007:192). Interviews can be one to one, or run as focus groups, which are good in situations of limited resources, and where group dynamics can broaden conversation, however, are not suitable when discussing sensitive information (Denscombe 2007:183) and would not be appropriate for discussing subjects such as human trafficking.

This research study utilises a systematic review. The Centre for Research and Dissemination (CRD) (2008: pv) states that, “Systematic reviews aim to identify, evaluate and summarise the findings of all relevant individual studies, thereby making the available evidence more accessible to decision makers”. Glasziou et al. (2001) describe the major benefit of a systematic review as the improved reliability of combining data. Given that not all evidence is equal in terms of bias and risk of error (Evans 2003), the systematic review is increasingly being used in healthcare to ensure care is based on robust and reliable findings, and to make decisions on how to take new research forward.

Part of any systematic review is the analysis of the data. Aronson (1994) discussed the process of thematic analysis and described several steps to be taken. Collection of the data, then identification of all data that relate to already classified patterns, and then the combination of data into themes. Aronson describes how the themes should collect together to create a complete understanding of the separate factors. The final step is to build a valid argument for choosing the themes, through referring to the literature and the development of a story line. Aronson (1994) uses the term thematic analysis for the analysis of ethnographic interviews. Thematic analysis is often used to analyse data in primary qualitative research.

In discussions regarding the potential of qualitative research findings being used to inform decision-making processes in policy and practice there has been an increased interest in qualitative evidence synthesis (Hannes, Lockwood and Pearson 2010). There is a paucity of high-quality reviews of qualitative findings to inform health care decision making. However, as qualitative data is required to answer questions which quantitative data alone cannot answer, Thomas and Harden (2008) argue that there is a need for qualitative reviews to synthesise the many papers that are available to inform healthcare and practice. Thomas and

Harden (2008) developed thematic analysis in qualitative research further through the use of “Thematic Synthesis”. They describe Thematic Synthesis as an approach to integrating findings from multiple qualitative studies through the synthesis of findings from research particularly in the use of the systematic review method. Thomas and Harden (2008) concur with Boyatzis (1998:4) that thematic synthesis is not "another qualitative method but a process that can be used with most, if not all, qualitative methods”, to formalise the identification and development of themes. Thomas and Harden (2008) argue that Thematic Synthesis can be used to facilitate effective and appropriate health care when applied to systematic reviews that address questions about people's perspectives and experiences.

Noyes (2018) in her instruction for use of qualitative synthesis methods appropriate for use in Cochrane reviews, highlighted the use of Thematic Synthesis through the work of Thomas and Harden (2008) as one of the three most appropriate methods of qualitative synthesis. Noyes (2018) highlighted that Thematic Synthesis was a useful tool for qualitative synthesis where Framework synthesis was too constraining. Noyes (2018) described the three processes of Thematic Synthesis, line by line inductive coding, development of descriptive themes and development of analytical themes, which will be followed here.

The review protocol for this systematic review is registered on Prospero (Centre for Reviews and Dissemination 2018) (CRD42018117601).

## 2.2 Selection Criteria

Studies selected for this research were worldwide. Settings included maternity care (antenatal, intrapartum, postnatal), community settings, post-trafficking support organisations and refugee camps.

Studies were included if they:

- Included women who had experienced trafficking, sexual violence and pregnancy.
- Reported primary qualitative data;
- Were reported in peer reviewed journals or in UK government or charity reports;

Studies reported in a language other than English were excluded and there was no limit placed on historical dates for papers.

This review aimed to draw together and critically evaluate studies that had examined women's experiences of pregnancy, and maternity services. The review also aimed to review maternal and neonatal outcomes in the context of trafficking and sexual exploitation. It aimed to identify and synthesise available evidence on trafficked women's access to and experiences of maternity services, reproductive control, pregnancy, birth experiences and outcomes.

Though these outcomes were not specified inclusion criterion, outcomes of interest were:

- Maternal health;
- Morbidity and mortality due to pre-existing conditions;
- Haemorrhagic, hypertensive, and other complications of pregnancy;
- Pregnancy outcomes included miscarriage, termination of pregnancy (TOP), low-birth weight, premature birth, neonatal morbidity and mortality;
- Mental health issues which included depression, anxiety, post-traumatic stress disorder (PTSD), suicidality and puerperal psychosis.

The initial inclusion criteria were extended beyond peer-reviewed journals to include government and charity reports published in the UK. This decision was made following the discovery of the Zimmerman et al. (2003) report found through reference searches of retrieved studies. Identifying this study signalled the potential to retrieve additional important data in the grey literature. Conducting searches of international grey literature was beyond the scope of the study.

## 2.3 Search Methods

Electronic databases were searched to ensure that all available evidence was reviewed. The following electronic databases were searched up to 31st January 2019:

Cinahl plus

Cochrane Database of Systematic reviews (CDSR)

ClinicalTrials.gov

Embase

Medline

PsycInfo

Pubmed

Scopus

These electronic databases were used to identify papers meeting the search criteria. Reference lists from identified papers were also checked for papers meeting the search criteria.

Google was also used to search for official reports from UK Government organisations and charities, as well as to locate reports cited within hits found on Google. These reports were searched up until 06/03/19.

Search “hits” were recorded and stored in the Refworks Proquest referencing management system, to ensure all references could be effectively stored, retrieved and followed through the systematic review process.

## 2.4 Search terms

The following search terms were used to search the electronic databases to start the process of searching for relevant papers:

Human trafficking OR Sexual exploitation

AND

Pregnan* OR antenatal OR postnatal OR perinatal OR maternal OR neonatal

All titles and abstracts of papers highlighted through the electronic database search, and internet searches for relevant reports were screened using the inclusion and exclusion criteria. Papers and reports that met criteria based on title and abstract were retrieved for further examination by the primary researcher (SN) and the supervisory team (LOD, GB and DP). SN reviewed all 29 papers and reports, all 29 papers and reports were also examined by a second person (LOD, GB, and DP) to ensure consistency in application of the inclusion and exclusion criteria. Any disagreements were discussed amongst members of the team to achieve

consensus. Data from the final included studies were extracted using an electronic form and included variables such as characteristics of the trafficking experience – survivor's country of origin and country trafficked to, length of time in trafficking – design of the study, and primary findings related to health service encounters, medical and mental health problems, and pregnancy related information.

Searches generated 1622 papers through electronic databases and a further 114 through searching reference lists and research reports. 30 papers were duplicates and excluded. One thousand seven hundred and thirty-six abstracts were screened by title and abstract. Twenty-nine papers and reports met the initial eligibility criteria based on title and abstract and full text studies were retrieved. Following full text review by SN and LOD, GB and DP, 15 studies were excluded. Reasons for exclusion are set out within the PRISMA flow diagram (Table 1). Therefore 13 studies were included in the final analysis, described in 14 reports. The selection process is demonstrated by PRISMA flow diagram Table 1.

The search for charity and government reports was undertaken by searching Google for:

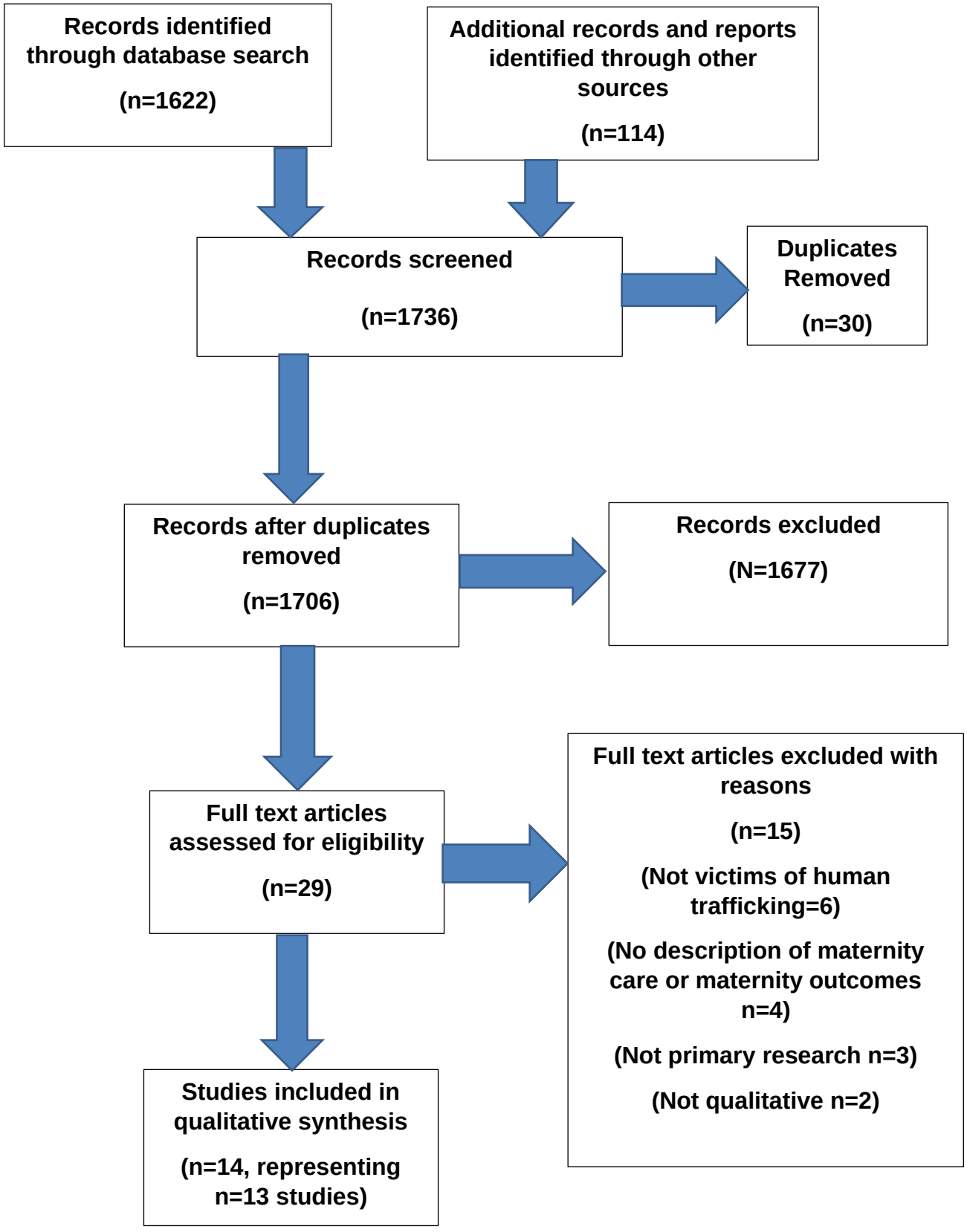
Charities AND Human trafficking

Government AND Human trafficking.

The inclusion criteria used for the peer-reviewed journals were applied to the reports identified.

Six reports were identified through Google search (Beddoe 2007; Brotherton 2016; Edwards 20012; Skrivánková 2006; Somerset 2004; The Anti Trafficking Monitoring Group 2018); two met the initial inclusion criteria, but were excluded because of lack of qualitative data (Beddoe 2007), and healthcare professionals data rather than human trafficking victims data reported (Brotherton 2007). Therefore, no further reports other than Zimmerman et al (2003) were included in the final analysis of the systematic review.

Table 1: PRISMA Flow Diagram



## 2.5 Quality Appraisal

Many reviewers use the critical appraisal skills program (CASP) tool to complete their critical appraisal exercise, however Hannes, Lockwood and Pearson (2010) argue that CASP appears less sensitive to aspects of validity than some other evaluation tools. Voss and Rehfuess (2013) reviewed different quality appraisal tools. They argue that the Critical Appraisal Skills Programme (CASP 2018) is the most inclusive in relation to study quality, and that while none of the tools are perfect it is better to use any of the quality assessment tools rather than ignore quality appraisal altogether. Therefore, the CASP checklist for qualitative research was used given the qualitative nature of the included research. Although some papers were mixed methods, only the qualitative data were analysed. Ten items aid evaluation of the research in areas of reliability, relevance and bias systematically (CASP 2018). The checklist was applied to each of the papers taken forward for synthesis. The CASP assessments are presented in Table 4. Quality assessment is used to understand the strengths and weaknesses of evidence and is then considered during the process of synthesis (CRD 2008:227).

Only one study (Bick et al. 2017) was rated as high quality using the CASP appraisal tool or, alternatively put, at low risk of bias. Bick et al. (2017) provided a strong description of the systems in place to ensure the interviewing was appropriate for victims of human trafficking (WHO guidance for interviewing trafficked women) adding to the validity of the findings; similarly, interviews were undertaken by trained independent researchers and supported by independent interpreters as required. Twenty-eight women were interviewed for the study, an appropriate sample size for a qualitative study. All of these factors added together were the reason this study was rated as high value compared to the other studies, which had some or none of these factors. Additionally, though not relevant necessarily to study quality, Bick et al. (2017) was the only study to specifically interview human trafficking victims who had experienced at least one pregnancy, and thus was also the most relevant study as a whole study to the review.

## 2.6 Analysis

Analysis was undertaken using the framework of Thematic Synthesis described by Thomas and Harden (2008). Primary data in the form of quotes were taken from the

papers. The data were coded according to meaning and context and entered into a MS Word table used for extraction of data. The use of line by line coding allowed the key task of synthesis of qualitative research (Thomas and Harden 2008). Thomas and Harden (2008) describe how as you add to the bank of codes; new codes are developed as needed. Every relevant quote had at least one code applied, and some had several codes. This initial stage of coding was checked by a second review author (LOD) to ensure agreement. Similarities and differences between the codes and descriptive themes were then identified to group them into a hierarchical tree structure. New codes in the form of analytical themes were then born which captured the meaning from the initial group of codes. These analytical themes layer on top of the descriptive themes in a tree like structure. The structure of these codes and themes was reviewed with the team to ensure agreement.

# 3.0 Findings

## 3.1 Characteristics of the Included Studies

Thirteen studies were selected for inclusion in this review (Table 2) (Bick et al. 2017; Caretta 2015; Karandikar, Gezinski and Kaloga 2016; Karandikar and Prospero 2010; Lederer and Wetzel 2014; Peled and Parker 2013; Ravi et al. 2017; Stanley et al. 2016; Stöckl et al. 2017; Surtees 2017; Willis et al. 2016; Westwood et al. 2016; Zimmerman et al. 2003). Oram et al. (2015) discussed the same study as Westwood et al. (2016). Westwood et al. (2016) was reported here as the primary report on the study. Excluded studies at the point of full-text retrieval and reasons for exclusion are set out in Table 3.

Bick et al. (2017), Lederer and Wetzel (2014), Ravi et al. (2017), Stanley et al. (2016), Westwood et al (2016), Willis et al. (2016) and Zimmerman et al. (2003) undertook mixed methods studies. All undertook interviews to collect qualitative data, except Lederer and Wetzel (2014) who undertook focus groups to collect their qualitative data.

Caretta (2015), Karandikar, Gezinski and Kaloga (2016), Karandikar and Próspero (2010), Peled and Parker (2013), Stöckl et al. (2017) and Surtees (2017) undertook purely qualitative methods for their studies. Caretta (2015) undertook the gathering of qualitative data as a non-participant observer, moving to a participant observer

duiring a two month internship at a shelter for victims of human trafficking in Italy, of fifteen Nigerian women. The other purely qualitative studies undertook interviews to gain their data.

Ethical approvals were not reported for Karandikar, Gezinski and Kaloga (2016), Lederer and Wetzel (2014), Surtees (2017) and Zimmerman et al. (2003).

The researchers used a variety of methods to recruit their participants, Bick et al. (2017) obtained recruitment through voluntary sector organisations offering government funded post trafficking support, healthcare providers and social service departments; Caretta (2015) undertook an internship and collected data as a participant and non-participant observer; Karandikar, Gezinski and Kaloga (2016) conducted field visits to interact with sex workers; Karandikar and Próspero (2010) worked in partnership with a local social work organisation; Lederer and Wetzel (2014) partnered with local leaders in the anti-trafficking movement to locate survivors who wished to participate; Peled and Parker (2013) recruitment was undertaken through the second author a former social worker at a shelter for victims of sex trafficking where the women were living; Ravi et al. (2017) recruited through health education programmes or therapeutic programming co-ordinators within the Rikers jail; Stanley et al. (2016) recruited via support workers at voluntary sector organisations providing post trafficking support in England; Stöckl et al. (2017) recruited via post-trafficking support organisations; Westwood et al. (2016) recruited via voluntary sector organisations providing post-trafficking support, healthcare organisations and social services; Willis et al. (2016) recruited via organisations offering services to survivors of sex trafficking, and Zimmerman et al. (2003) recruited via support organisations.

Surtees (2017) do not identify how their respondants were recruited, but state it was in the context of three research studies.

Understanding of the difficulties of interviewing women who have experienced human trafficking and documentation regarding the strategies put in place to prevent further trauma were only documented by Bick et al. (2017) and Stöckl et al. (2017).

Translation and interpreting strategies were documented by Karandikar, Gezinski and Kaloga (2016), Karandikar and Próspero (2010), Stöckl et al. (2017) and Westwood et al (2016).

The thirteen studies represented the experiences of 883 trafficked women and girls. Their ages ranged from ten to sixty years old, where ages were indicated (Bick et al. 2017; Karandikar and Prospero 2010; Karandikar, Gezinski and Kaloga 2016; Peled and Parker 2013; Ravi et al. 2017; Stanley et al. 2016; Stöckl et al. 2017; Surtees 2017; Westwood et al. 2016).

The women in these studies were trafficked from many countries: Albania, Bangladesh, Bosnia-Herzegovina, Former Soviet Union, Ghana, India, Lithuania, Latvia, Moldova, Nepal, Pakistan, Poland, Nigeria, Romania, Serbia, Slovenia, Slovakia, USA, Vietnam, and trafficked to Albania, Bosnia-Herzegovina, China, France, Germany, India, Israel, Italy, Kosovo, Nigeria, Poland, Portugal, Romania, Russia, Serbia, UAE, UK, USA.

Eight studies identified the number of women who experienced pregnancies, of which there were 229 (Bick et al. 2017; Caretta 2015; Lederer and Wetzel 2014; Peled and Parker 2013; Stanley et al. 2016; Stöckl et al. 2017; Surtees 2017; Zimmerman et al. 2003). Four of the studies discussed the number of terminations of pregnancy (TOP) (Bick et al. 2017; Lederer and Wetzel 2014; Stanley et al. 2016; Zimmerman et al. 2003); 72 women had at least one TOP and 41 women had more than one TOP. Eighteen women experienced forced TOPs.

The types of exploitation experienced was discussed in eleven of the studies (Bick et al. 2017; Caretta 2015; Karandikar and Prospero 2010; Karandikar, Gezinski and Kaloga 2016; Lederer and Wetzel 2014; Peled and Parker 2013; Ravi et al. 2017; Stanley et al. 2016; Stöckl et al. 2017; Westwood et al. 2016). Sexual exploitation was experienced by 573 victims; domestic servitude by 53 victims; forced labour by 58 victims; and forced marriage by 54 victims. Some victims experienced more than one type of exploitation, for example, those exploited to forced marriage were also sexually exploited or used for forced labour.

Six studies gave numbers for mental health or psychological disorders (Bick et al. 2017; Lederer and Wetzel 2014; Stanley et al. 2016; Stöckl et al. 2017; Westwood et al. 2016; Zimmerman 2003). Symptoms of depression affected 47% and 88.7%

of women in two studies respectively. Suicidal thoughts were reported by 37.9% and 66.7% of women in two studies respectively . Two papers discussed victims who had suicide attempts, 4% and 41.5% of participants, respectively. Post-traumatic stress disorder data were given by three papers, with 54.7%, 52% and 14% of participants affected in those studies. Rates for anxiety were given in two papers, at 76.4% and 29% of participants. These figures demonstrate the substantial negative impact on women's health experienced as a result of trafficking.

Physical health statistics were given by three papers, Lederer and Wetzel (2014) described 99.1% of women complaining of physical symptoms. Stanley et al. (2016) described different symptoms with results ranging from 21% for dental pain, to 52% for headaches in victims. Lederer and Wetzel (2014) and Stanley et al. (2016) also gave statistics for those having experienced physical injuries, 70% and 55% of victims. Four papers discussed experiences of physical violence (Lederer and Wetzel 2014; Stanley et al. 2016; Stöckl et al. 2017; Zimmerman et al 2003), at 61%, 72%, 89% and 92.2% of victims. Sexual violence was described in three of the studies (Stanley et al. 2016; Stöckl et al. 2017; Zimmerman 2003), and was experienced by 55%, 86% and 100% of victims in those studies.

Two studies highlighted the use of alcohol and or drugs (Lederer and Wetzel 2014; Zimmerman 2003) which were used by 84.3% and 42% of victims. Two studies highlighted the forced use of drugs and or alcohol (Lederer and Wetzel 2014; Stanley et al. 2016), which was an issue for 27.9% and 41% of victims.

Sexually transmitted infections (STIs) were highlighted in four of the studies (Bick et al. 2017; Lederer and Wetzel 2014; Stanley et al. 2016; Zimmerman et al. 2003). STIs affected 9%, 13.8%, 50% and 67.3% of victims. The figures for levels of STIs faced vary in this study and may reflect the different countries in which these studies are undertaken in women's access to healthcare and contraception.

Two studies (US and UK) made reference to those experiencing healthcare whilst being trafficked - 87.8% in Lederer and Wetzel (2014) and 19% in Westwood et al. (2016). Given the contextual differences around access to healthcare in the US and UK, these rates are surprising.

Two studies highlighted the numbers of men that trafficked women were sexually abused by over a day. Lederer and Wetzel (2014) stated women were abused by

an average of thirteen men a day, with some numbers of abuse by 30-50 men a day. Zimmerman (2003) stated abuse by an average of 10-25 men a day, with some stating abuse by between 40-50 men a day.

| **TABLE 2**<br>**Author/**City & Country | Aims | Country of origin/ Trafficked to | Population | Design | Key Findings |
|---|---|---|---|---|---|
| **Bick et al. (2017)/** London, UK. | To explore the experiences of women trafficked in the UK who became pregnant and had accessed care provided by the NHS | ¾ from Albania and Nigeria, the rest of victims were from from Latvia, Romania, Slovakia, Pakistan, Modovia, Ghana and Lithuania/ UK | 98 trafficking survivors, 28 (29%) of these women reported one or more pregnancy while trafficked,<br>12 (42.8%) women reported at least one termination of pregnancy, 64.3% of the women had children | Cross-sectional survey,<br>Interviews,<br>Thematic framework analysis | One in four women become pregnant while trafficked,<br>12 (42.8%) at least one termination of pregnancy (TOP) while in trafficking,<br>25 (89.3%) experienced mental health disorder,<br>Quarter trafficked for sexual exploitation, 6 for domestic servitude, 2 for forced labour<br>Restrictions on women's movements/ freedom,<br>Poor knowledge of how to access maternity care,<br>Poor understanding of entitlement to healthcare,<br>Concern about confidentiality. |
| **Caretta (2015)/** Stockholm, Sweden | To close the gap in research reporting practitioners experiences in assisting victims of human trafficking | Nigeria/ Italy | 15 women at shelter for victims of sexual trafficking | Ethnographic qualitative approach,<br>data collected informally during daily interaction with the women | Review of Casa Rut social co-operative NGO, includes tutoring in Italian & vocational training,<br>Highlights forced sexual exploitation, restriction of freedoms/ movement, debt bondage, poor living conditions, forced TOPs. |

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| **Karandikar, Gezinski & Kaloga (2016)/** Ohio, USA | To explore sex workers process of entry into sex work, to explore sex workers health problems, to explore the disparity in access to healthcare as a result of trafficked status | India, Nepal, Bangladesh/ India | 15 women | Interviews, open & closed ended questions Thematic analysis | Trafficked by family members, Restriction of freedoms/ movement, physical & mental ill-health, suicidality, physical violence, TB, HIV, STIs, drug & alcohol dependence as coping method or medicated by trafficker, saw doctor only if extremely sick, or pregnant, Multiple miscarriages & TOPs, Stigma & difficulties accessing healthcare. |
| **Karandikar & Prospero (2010)/** Utah, USA | To investigate the experiences of intimate partner violence among sex workers | Not stated/ India | 10 women age 10-17 at time of trafficking, interviewed at age 20-35 | Interviews, Thematic analysis | Not identified as victims of trafficking in the study (Criteria met as minors at entry, coerced, debt bondage) restriction of freedoms/movement, coercion, physical, sexual & emotional violence, physical injuries, mental health problems, suicidality, HIV, premature & stillbirth, forced prevention of barrier contraception methods, alcohol & drug use as coping method. |

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| **Lederer & Wetzel (2014)/** Georgetown, USA | Explore the health consequences and healthcare experiences of women and girls trafficked in the USA for commercial sex | Not stated/ USA | 107 women who were victims of sex trafficking age 14-60 | Structures interview, Focus groups. | Multiple physical & mental health problems, PTSD & suicidality,<br>physical, sexual & emotional abuse (92% experienced physical violence),<br>Deprived of basic physical needs, such as food & sleep,<br>67% contracted an STI,<br>47 (71% of answers) victims reported at least one pregnancy while trafficked, 14 (21% of answers) reported 5 or more pregnancies, 35 (55% of answers) reported at least one miscarriage, 19 (30% of answers) more than one, 55% of respondents had at least one TOP, 18 (53% of answers) reported forced TOPs,<br>98 (88%) had contact with healthcare while trafficked, most common was emergency room, or planned parenthood clinics, where they attended for TOPs & contraception. |
| **Peled & Parker (2013)/** Tel Aviv, Israel | Explore the mothering experiences of sex trafficked women | Former Soviet Union/ Israel | 8 women in a shelter for victims of sex trafficking<br>Age 25-32 | Naturalist methodology, Interviews Thematic Analysis | Mothering experiences,<br>Felt judged as negligent or abandoning mothers if left children in country of origin,<br>If free of traffickers felt judged as having children to gain access to child-care rights & benefits,<br>Participants sought to settle in Israel & be “normal”,<br>Fear of children being “removed”. |

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| **Ravi et al. (2017)/** Pennsylvania, USA | Identify the experiences of domestically sex trafficked women regarding healthcare access, reproductive health, and infectious diseases while trafficked in the USA | USA/ USA | USA female prison facility<br>21 women, Age 19-60 | Interviews | Common reasons for seeking healthcare- STI & HIV testing, unintended pregnancy, violence related injury, chronic disease management,<br>Locations- emergency departments(ED), jails, planned parenthood, free health clinic,<br>Lack of ID/Insurance reason for choosing ED as opposed to other facilities,<br>Barriers to healthcare- limited by traffickers, traffickers treated/medicated women, women prioritised substance misuse over healthcare, criminal justice fears, logistics of follow-up care & medication instructions,<br>Pregnancy, fear of increased violence from trafficker,<br>Condom most common form of contraception, Often pressured to not use condoms,<br>Poor access to TOP facilities,<br>Transport & financial implications, lead to late proceedures,<br>Antenatal care, some connected with care, others did not,<br>HIV biggest health related fear. |
| **Stanley et al. (2016)/** Lancashire, UK | To better understand the health and healthcare needs of | 12 countries including Nigeria, Albania & Slovakia/ UK | 29 young people, age 16-21 (24 female)<br>5 had been pregnant as a result of trafficking. | Interviews<br>Framework Analysis | Physical, sexual & emotional abuse while trafficked, threats to family,<br>Denied freedom, ID removed, poor living & hygiene conditions, lacked food & water, |

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| | young people trafficked in the UK | | 3 currently pregnant | | Of 5 women pregnant while trafficked, none had seen a midwife,<br>STI, HIV, physical & mental health problems including PTSD & suicidality,<br>Barriers to accessing healthcare- restricted by traffickers, complex gatekeeping systems, language barriers,<br>Positive Experiences of healthcare- making choices in healthcare, having a female healthcare provider, maternity services particularly helpful, where appreciated staff continuity, opportunity to build trusting relationships,<br>Can remain fearful of traffickers even after escape, want reassurance re confidentiality,<br>Some find it distressing discussing past experiences. |
| **Stöckl et al. (2017)/** London, UK | Describe the experiences of women before, during and after being trafficked into forced marriage | Vietnam/ China | 51 women sold into Marriage in China<br>19 (37%) of the women had children | Interviews | Extreme restrictions of freedom, physical & sexual violence,<br>mental health problems (depression, PTSD, suicidality), physical ill-helath,<br>7 (16%) pregnant at interview,<br>10 (22%) reported pregnancy during trafficking,<br>7 (16%) had intended TOP while trafficked. |

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| **Surtees (2017)/** Washington, USA | To explore the tensions, complications and challenges of children born of trafficking and their mothers face on integration | Moldova, Albania, Bosnia-Herzegovina, Serbia, Slovenia/ Albania, Bosnia-Herzegovina, France, Germany, Italy, Kosovo, Poland, Portugal, Romania, Russia, Serbia, UAE | 15 women who had a baby while trafficked or on return home.<br>Age 16-36 (age 15-33 when trafficked) | Interviews, thematic Analysis | Children born into trafficking- exposed to mothers exploitation, as well as themselves, poor physical condition, behavioural problems, difficulties in relationships with other children,<br>Children born after trafficking- in-utero exposure to maternal exploitation, such as developmental delay, health issues.<br>Alcohol abuse of mother leading to potential child physical & development delays,<br>Premature birth & low birth weight led to severe health problems,<br>Maternal relationships with children, often complicated & contradictory. Attachment issues. |
| **Westwood et al. (2016)/** Stirling, UK | To explore trafficked people's access to and use of health care during and after trafficking | Albania, Nigeria, Poland (& other)/ UK | 136 Trafficking survivors,<br>91 (67%) were women,<br>33 women (36%) age 16-25,<br>49 (54%) 26 or over | Cross-sectional survey, structured interview & open-ended questions, Thematic Analysis | 26 (19%) reported access to healthcare while trafficked (most often GP or walk in centres),<br>Traffickers restricted access to healthcare,<br>Self medication provided by traffickers,<br>If allowed access to healthcare, close monitoring by traffickers,<br>barriers to access, ID, language, no knowledge of system, concern about repercussions from traffickers, police or immigration. |

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| | | | | | Positive experience of care- time to talk to GP, felt listened to, medical proceedures clarified, continuity of professional.<br>Negative experiences of healthcare- didn't receive sufficient information about proceedures or results, delays in finding out results, did not understand information |
| **Willis et al. (2016)/** Portland, USA | Identify health problems experienced by children whose mothers are trafficked or in sex work in the USA | Not stated/ USA | 76 adolescent women asked about the health and wellbeing of children known to them whose mothers were trafficked or in sex work | Interviews | 10-100% women they knew became pregnant while trafficked,<br>20% adolescents & 45% adults received antenatal care,<br>83% adolescents 78% adults birthed babies in hospital,<br>Adolescents median 2 children each, adults median 3 children each,<br>80% thought children have mental health problems,<br>92% reported children given alcohol or over-the-counter medication to make them sleep,<br>72% reported children physically abused,<br>72% reported children sexually abused,<br>29% new of a child death,<br>11% reported knew of a child had died from physical abuse,<br>Deaths included neglect, SIDS, HIV, poisoning, low birth weight, prematurity, shaken baby syndrome, murder,<br>90% reported children witnessed physical abuse of mothers, |

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| | | | | | 81% have seen mothers sexually abused, 85% reported some daughters are trafficked into prostitution. |
| **Zimmerman et al. (2003)/** London, UK | Explore women's health and trafficking to the European Union | Not stated/ Europe | 23 women | Literature review<br>Conceptual framework<br>Legal & human rights analysis<br>Questionnaire<br>Interviews | Sexually, physical and emotional abuse, physical injuries, physical mental ill-health, STIs, HIV, deprived of food, and deprived of freedom, forced use of drugs or alcohol, or choose use as coping strategy.<br>Unable to access healthcare, limited use of contraception,<br>Coercion, & fear tactics,<br>Restricted movement, absence of social support, language barriers, debt bondage, no ID, fear re immigration status,<br>TOPs |

**Table 3 Exclusions following full-text review**

| Reason studies not included in synthesis | Number | Studies excluded final synthesis |
|---|---|---|
| Did not include victims of human trafficking | 6 | Anderson and Van Eea 2018; Alzate (2008), Atwood et al. (2011), Brotherton (2016), Hegde et al. (2012), Hutchinson et al. (2016) |
| No description of maternity care or maternity outcomes | 4 | Barnert et al. (2017), Beck et al. (2017), Beddoe (2007), Geynisman-Tan et al. (2017) |
| Not primary research | 3 | Dovydaitis (2010), Makinde (2016), Miller et al. (2007) |
| Not qualitative research | 2 | Reid (2018), Deisher et al. (1991) |
| Total not included | 15 | |

## 3.2 Appraisal of the Evidence

The CASP table represents the responses to the CASP questions for assessing the quality of the included qualitative studies. The strength of evidence was considered when analysing the data (Table 4 CASP Appraisal).

Bick et al. (2017) was the only paper which was evaluated as “High” quality in the CASP analysis. This was also the only paper which specifically reviewed maternity care. Caretta (2015), Lederer and Wetzel (2014), Ravi et al. (2017), Stanley et al. (2016), Surtees (2017), Westwood et al. (2016) and Zimmerman (2003) were all evaluated as “moderate” quality. These studies discussed pregnancy and maternity situations, but they were not specifically related to maternity care. Karandika and Prospero (2010), Peled and Parker (2013) and Stöckl et al. (2017) were also rated as moderately useful, but overall were less useful to the aims of this research. All of the papers which were evaluated as very or moderately useful, met the CASP criteria well with clear statement of the aims of the research, appropriate methodology, appropriate research design, appropriate recruitment strategy, data collected in a way that addressed the research issue, relationship between the researcher and participants considered, rigorous data analysis, and a clear

statement of findings. Willis et al. (2016) was the only paper evaluated as of “minimal” quality. This paper was also the main paper that discussed child outcomes. The evidence was anecdotal and historical, and therefore less robust. Willis et al (2016) was included in the systematic review but the evidence from the study was weighed up in accordance with its CASP rating when the analysis stage was undertaken.

| **Table 4**<br>**CASP Appraisal** | Bick et al. (2017) | Caretta (2015) | Karandika, Gezinski & Kaloga (2016) | Karandika & Prospero (2010) | Lederer & Wetzel (2014) | Peled & Parker (2013) | Ravi et al. (2017) | Stanley et al. (2016) | Stöckl et al. (2017) | Surtees (2017) | Westwood et al. (2016) | Willis et al. (2016) | Zimmer man et al. (2003) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Was there a clear statement of the aims of the research? | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Is a qualitative methodology appropriate? | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Was the research design appropriate to address the aims of the research? | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Limited qual evidence | Yes |
| Was the recruitment strategy appropriate to the aims of the research? | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Was the data collected in a way that addressed the research issue? | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Limited qual evidence | Yes |
| Has the relationship between the researcher & participants been adequately considered? | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Have ethical issues been taken into consideration? | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Was the data analysis sufficiently rigorous? | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Limited qual evidence | Yes |
| Is there a clear statement of findings? | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Limited qual evidence | Yes |
| **How valuable is the research?** | **High** | **Mod** | **Mod** | **Mod** | **Mod** | **Mod** | **Mod** | **Mod** | **Mod** | **Mod** | **Mod** | **Minimal** | **Mod** |

## 3.3 Initial stages of Thematic Synthesis

Stage one of Thomas and Harden's (2008) Thematic Synthesis is the line by line coding of the quotes from the text in the studies. Following this analytical method, the texts from each paper were read and coded line by line and recorded/organised in an MS Word table. The similarities and differences in the codes were used to identify and develop the descriptive themes which were added to the MS Word table (Appendix Table 5). Eight descriptive themes emerged. The descriptive themes were; barriers to healthcare; late access to maternity care; continuity; communication; stigma; physical sexual and mental health problems; physical, sexual and emotional abuse; care of baby. Below is a summary of how the descriptive themes were developed, with quotes and a summary of the studies describing the issues.

### 3.4.1 Sexual, Physical and Mental Health

Health problems is one of the most discussed themes across the studies and a major concern for participants in those studies.

Four studies discussed the issues of multiple miscarriages, termination of pregnancy (TOP), and forced TOP amongst trafficked women (Karandikar, Gezinski and Kaloga 2016; Lederer and Wetzel 2014; Ravi et al. 2017; Zimmerman 2003);

"I miscarried two times in 5 years and had to be hospitalized both times due to heavy bleeding. All this was very expensive treatment and the gharwalli (brothel-keeper) charged money for all this" (Karandikar, Gezinski and Kaloga 2016).

Victims often had multiple terminations of pregnancy (TOP);

"I got pregnant six times and had six abortions during this time. Several of them were from a doctor who was a client, he did them 'back door', I came in the back door after hours and paid him off the books" (Lederer and Wetzel 2014).

Victims often accessed TOP late in pregnancy, sometimes under pressure or force from traffickers, and at times the procedures were not done in professional healthcare facilities, which caused pain, infections and haemorrhage and threatened women's lives;

"Abortion was forbidden because of the faith. I was past my fifth month, when the abortion was done. I didn't know I was pregnant. The abortion was done illegally in

terrible unsanitary conditions. The operation was very difficult, so I was nearly dead. There was no anaesthetic. The doctor said he would inject soap water into the uterus and the foetus would go out. Then I was sent to the toilet and was told to wait. I paid 2500 drachmas for the abortion. After the abortion I felt very bad, like I would die, and I was taken to the American hospital" (Zimmerman et al. 2003).

Ravi et al. (2017) and Karandikar and Prospero (2010) discussed the issue of contraception. Women have difficulty in accessing contraception;

"…if I didn't make money, then, sometimes I would have to wait for my prescriptions for days before I could, yeah…. you can take it [emergency contraception] up to 72 hours. So…I would try and go right away. Sometimes, I would take it at the last minute. I've had so many abortions because it was too late to take it" (Ravi et al. 2017).

Women are often under pressure not to use barrier methods of contraception and risk physical assault and abuse if they refuse sexual activity without barrier methods of contraception;

"Well, I've always carried condoms with me. But there were men that didn't wanna use condoms. And if I refused, it was – my pimps were gonna find out. Because I would come back, lose a trick, lose a date, and lose money. And then my type of people would beat us" (Ravi et al. 2017).

Sexually transmitted infections (STIs) are a frequent problem for victims of human trafficking who have experienced sexual exploitation. These issues were discussed by Karandikar, Gezinski and Kaloga (2016), Lederer and Wetzel (2014) and Ravi et al. (2017);

"If I hadn't had my children when I was young, I wouldn't be able to have them because I have had so many STDs and gynaecological problems— including pelvic inflammatory disease, cervical infections, gonorrhoea, herpes, chlamydia—I can't have children now" (Lederer and Wetzel 2014),

"I started getting STDs frequently and had to take medical help" (Karandikar, Gezinski and Kaloga 2016).

Serious infections such as HIV and TB are frequent among victims and survivors, and with limited access to healthcare and poor living conditions, this often means a very

short life expectancy. These issues were discussed by Karandikar, Gezinski and Kaloga (2016), Karandikar and Prospero (2010) and Ravi et al. (2017);

“Five years back I was detected HIV positive, when I was very sick with TB. I know my life is short now” (Karandikar, Gezinski and Kaloga 2016),

“When they did the blood test, I was detected HIV positive. Now I live in fear that I will die soon. If I have any disease I will die” (Karandikar, Gezinski and Kaloga 2016).

Karandikar, Gezinski and Kaloga (2016), Lederer and Wetzel (2014), Stanley et al. (2016) and Zimmerman et al. (2003) highlight the issues victims suffer with a mixture of physical and mental health problems, and physical injuries;

“I have so many scars all over my body and so many injuries and so many illnesses. I have hepatitis C and stomach and back pain and a lot of psychological issues. I tried to commit suicide several times” (Lederer and Wetzel 2014),

“I was always sick, from the moment I went out to work, and I always felt tired. I felt really bad inside. I could not feel good. I was stressed, tired” (Zimmerman 2003).

Many of the women had attempted suicide and were suffering from extreme mental health problems. Karandikar, Gezinski and Kaloga (2016), Lederer and Wetzel (2014), Stanley et al. (2016) and Zimmerman (2003) discussed the often-severe mental health issues faced by victims;

“The mental health problems are the worst and most long lasting. I was diagnosed with chronic depression, have anxiety, post-traumatic stress syndrome, nightmares, flashbacks, disorientation. I’ve been suicidal at times. I don’t think anyone is out on the street without having these long-lasting effects” (Lederer and Wetzel (2014).

These mental health issues last for a long time after women escape the trafficking situations;

“If there was anything, I could do to just clear the memory, I would do it, just erase everything…all of it” (Stanley et al. 2016).

### 3.4.2 Physical, sexual and mental abuse

Physical, sexual and mental abuse is a much-discussed theme, highlighted in five of the studies (Caretta 2015; Karandikar and Prospero 2010; Lederer and Wetzel 2014; Ravi et al. 2017; Zimmerman et al. 2003). Much of the abuse faced was not only physical and sexual but included coercive emotional abuse and threats, and women suffered many mental health problems;

“I had a breakdown. I just wanted to hurt myself. I would cry a lot. I was scared and worried. I was bruised. The back of my neck was bleeding from being hit with the thick gold chain. They beat me and kicked me. They told me ‘Don’t scream or we will kill you.’ They would” (Zimmerman 2003).

Victims are at serious risk of physical and sexual abuse;

“I was frequently afraid of my pimp beating me up, as they all used to do, and sexually abusing me. I was in a continual state of anxiety and worry so that sometimes I couldn’t sleep, also causing me headaches” (Zimmerman 2003),

“Another girl…he beat her up really bad. She was pregnant and he beat her up really, really, really, really, really, really bad and he put her in to a full body cast. And she went into the hospital. But she didn’t tell on him. She just told that a guy beat her up or whatever” (Ravi et al. 2017).

Use of drugs and or alcohol as a coping mechanism for the abuses and hardships faced by victims was highlighted by Karandikar, Gezinski and Kaloga (2016) and Lederer and Wetzel (2014);

“Life is hard and there is no money. What can I do? When there is nothing else, I drink to forget the pain” (Karandikar, Gezinski and Kaloga 2016),

“I also started drinking and started taking drugs [hashish]. That made me feel better, and I think I can handle the pain and the hurt only because I have gotten addicted” (Karandikar and Prospero 2010).

Zimmerman (2003) also highlighted the use of drugs being used by traffickers as a means of control over their victims;

“Every morning at 8 o'clock the employer gave us a spoonful of very bitter powder which we had to eat. During the first week, I could not eat any food because the bitter

taste stayed with me. I asked them one day what it was. They shouted at me and said, "if you are lazy you have to take it!" I was forced to take it from the day I arrived. I often got very bad headaches, especially when I thought about my family. Sometimes I couldn't bear the pain. When I told them, they gave me a pack of "tunjai"" (Zimmerman 2003).

### 3.4.3 Barriers to Healthcare

Barriers to healthcare was another widespread theme through the studies in the systematic review.

Bick et al. (2017), Stanley et al. (2016) and Westwood et al. (2016) highlighted the issue of women not able to register for healthcare or maternity services through gatekeeper services such as general practitioners due to their lack of documentation. This was an issue for many women without identification documentation;

"When I was 4-5 months pregnant... I snuck out of the house and went to the local GP [family doctor] practice. When I arrived, they told me I needed a passport and proof of address. I explained that I didn't have this documentation and they turned me away" (Bick et al. 2017).

Karandikar, Gezinski and Kaloga (2016), Ravi et al. 2017 and Westwood et al. (2016) described how the traffickers controlled women's access to healthcare;

"I thought I needed to see a doctor … they wouldn't take me" (Westwood et al. 2016).

Another woman described how she was only allowed access to a doctor when she got pregnant, previously to that the traffickers would supply medicines;

"The first time I saw a doctor was when I got pregnant. Before that when I used to be sick, I was just given medicine by someone around me" (Westwood et al. 2016).

However, some women chose to self-medicate rather than accessing healthcare;

"….I'd buy off-the-counter antibiotics, which in my neighbourhood, there's a lot of those. And I used to buy off-the-counter antibiotics and just drink them for a few days" (Ravi et al. 2017).

Stanley et al. (2016) and Westwood et al. (2016) discussed that when women were allowed access to healthcare, they often had no access to interpreters to be able to

explain their situations, symptoms or understand the advice or treatment they were being given;

“I had no interpreter and so I couldn’t understand what happen to me, what happen to my health” (Westwood et al. 2016).

However even when women were able to communicate directly with professionals the traffickers often spoke for them;

“He told staff that I can’t speak any English … he will interpret for me and he told them some story … the doctor asked me directly as well … I didn’t want to say it was this person because he was there with me” (Westwood et al. 2016).

Women were often prevented from talking to healthcare professionals by the fear and presence of their traffickers (Bick et al. 2017; Ravi et al. 2017; Stanley et al. 2016; Westwood et al. 2016; Zimmerman 2003);

“I became pregnant [while in the house]. I had an abortion, but they guarded me while I was [at the clinic] and I couldn’t talk to anyone” (Zimmerman 2003).

The presence of traffickers in healthcare encounters, prevented victims from answering truthfully about their situations;

“I was taken to the GP to register … by my trafficker … he was there with me … I wasn’t really comfortable to tell him [GP] stuff” (Westwood et al. 2016).

Even in situations where women were able to access healthcare alone, there is still the fear of recrimination from traffickers;

“I went to the emergency room once for an asthma attack…It was one of the days where I wasn’t with him so I just went and I was released…like six hours later, so he didn’t really know. And it was better that way in my opinion because I don’t know how he would have reacted to me saying I went to the emergency room, even if it was for something like my asthma. And I don’t know how he would have reacted to that maybe thinking that I was lying or that I’m snitching on him or something like that. So, yeah, no. He didn’t know about it” (Stanley et al. 2016).

Victims also fear accessing services due to the fear of authorities such as the police or immigration;

“We don’t wanna go to the hospitals because we feel like they’re gonna check there. Or we go to the hospital, our names are ran, and the cops come and they take us. And that has happened a lot” (Ravi et al. 2017).

### 3.4.4 Late Access

The issue of late access to maternity care was highlighted by Bick et al. (2017), Caretta (2015), Ravi et al. (2017) and Westwood et al. (2016). Women described how access to maternity services would often happen late in pregnancy;

“When I had my first visit at the hospital, the doctor she told me when she saw the baby, she told me that the baby seemed bigger than it should be. ‘You should have come earlier, actually, to see me’” (Bick et al. 2017).

For some in pregnancy access to maternity care only occurred in an emergency situation;

“I was found unconscious in the street when I was heavily pregnant … I was taken to the hospital by ambulance” (Westwood et al. 2016).

The women would try and hide their pregnancies for fear of recrimination from traffickers;

“It was always something I was worried about. And even if my period was like three days late, I would start freaking out and crying…because the last thing I wanted was to get pregnant, because that would affect my boss, how he would treat me. Like he would probably beat the shit out of me more because I wasn’t able to work because I was like a big belly or something like that, and I also wouldn’t have the money to get an abortion, or like the little things like that really scared me” (Ravi et al. 20017).

### 3.4.5 Stigma

The issue of shame and judgemental issues was highlighted by Bick et al. (2017), Karandikar, Gezinski and Kaloga (2016), Peled and Parker (2013), Surtees (2017) and Westwood et al. (2016). When healthcare professionals ask questions, they may not have done so in an effective and supportive way. This quote was from a woman being sexually exploited, who had been questioned by a sexual health worker;

“They ask me why are you doing this, do you like doing this? I say yes, because I was scared” (Ravi et al. 2017).

Many victims talked about the judgemental attitudes they faced from healthcare professionals when they accessed healthcare;

““Why are you here?” And they then wrote in the paper that you were trafficked, you was a prostitute. They not nice to you....and they was treating me exactly like, er, a prostitute” (Bick et al 2017).

Survivors discussed the shame they felt. This shame was also an issue placed on the victims from their home communities;

“We have very serious prejudice about prostitution and people don’t try to see if [women] were forced or not forced to do sex work … We even have a tradition, when a person working in prostitution has a gate to the house and it is painted black. It’s a tradition of our society to ostracize [prostitutes]” (Surtees 2017).

However, other survivors discussed the support they had received from healthcare professionals;

“I had lots of doctors coming in and just to check; they were trying to discuss what to do and they were very good to me and I’m very very grateful to everybody that helped” (Bick et al. 2017).

Experiences when staff acted above and beyond what was expected of them as healthcare professionals was especially appreciated;

“They found all the nurses that worked in the hospital (who spoke the same language) and got one to come and talk to me to see how I was and to translate for me. They were really nice and friendly, and they got me clothes, food and toiletries; one of the nurses even did my hair for me” (Bick et al. 2017).

### 3.4.6 Communication

The importance of communication was described by Stanley et al.(2016) and Bick et al. (2017). Victims wanted to be listened to and heard;

“The most important thing is to ask, and to give you time to explain how you are feeling instead of just assuming what is wrong, giving you the chance to explain, and listening to your opinion about why you feel like that” (Stanley et al. 2016).

Victims also discussed the importance of information being given in a way that could be understood, as even if an interpreter was present, if complicated language was used the victims may not understand;

“Put it in pieces for me so I understand” (Stanley et al. 2016).

Victims expressed that also sometimes interpreters were used, however they weren’t face to face interpreters, many healthcare facilities use telephone interpreting services. This lack of face to face interpreting service can be another barrier for trafficked women who have often been betrayed by people they know. If victims cannot see who is interpreting it does not support effective communication and understanding, and the possibility of discussing their circumstances;

“Maybe it would be better if the interpreter came in person” (Stanley et al. 2016).

However, for some survivors, they did not want to have to keep repeating their story, they just wanted to be able to move on, and found repeating their story distressing;

“I want to forget what happened. I just want to move on. I just want to get my own flat and live and maybe get a job” (Stanley et al. 2016).

There is evidence that even when victims access healthcare they are either not recognised, or the healthcare professionals do not ask questions that could lead to the identification of the situation (Lederer and Wetzel 2014);

“During the time I was on the street, I went to hospitals, urgent care clinics, women’s health clinics, and private doctors. No one ever asked me anything anytime I ever went to a clinic, I was on birth control during the 10 years I was on the streets, mostly Depo-Provera shots which I got at the Planned Parenthood and other neighbourhood clinics. I also got the morning-after pill from them. I was young and so I had to have a waiver signed in order to get these—one of the doctors (a private doctor I think) signed this waiver when my uncle took me to see him” (Lederer and Wetzel 2014).

The issue of confidentiality was raised with regards to good and poor communication (Bick et al. 2017; Stanley et al. 2016). Survivors appreciated the confidentiality that they experienced, and it helped them to trust the healthcare professionals;

“It made me feel comfortable that everything is confidential, I wasn’t worried about everything being said, I was happy that if I’m gonna move from this area to another, it is OK for information to go to another doctor” (Bick et al. 2017).

### 3.4.7 Continuity of care

Continuity of care was a descriptive theme which was highlighted by Bick et al (2017) and Westwood et al. (2016). Continuity of care helped with the feeling of trust and being cared for in the survivors;

“‘Once a month she [health practitioner] sees me. She will sit for at least half an hour talking to me. She encourages me” (Westwood et al. 2016).

Poor continuity of care caused extra stress, and difficulties for survivors;

“The one I know before (family doctor) that I was used to, maybe then next time I go again I sit there, and I see another face and I have to get use to another face again. As soon as you meet a new doctor, they give you a new prescription” (Bick et al. 2017).

The governmental policy of dispersal, where asylum seekers, and trafficking survivors are moved to different parts of the country for housing, is a policy which aggravates the problem of continuity for survivors;

“Because I just moved one month ago, and actually I need to go to my appointments for my liver and hepatitis to check everything. And to transfer me here (to another part of the country), it takes three to four months [to sort paperwork needed to register with a new family doctor] they say to me” (Bick et al. 2017).

### 3.4.8 Child Health

The difficulty for victims of caring for their babies following the personal abuse experienced by these women, was the final descriptive-level theme discussed in Peled and Parker (2013) and Surtees (2017). The difficulty of caring for a baby with no help and support was raised;

“I remained alone, like this, with a 2-day-old child on my hands —and I was in shock. I didn’t know anything, there was no mother by my side who would help, explain to me how to change diapers, how to give him a bath, I’m only 22-year-old, what could I

know? I didn't know anything why he was crying, I didn't know what to do, didn't understand anything" (Peled and Parker 2013).

One mother discussed the difficulties she faced caring for her baby born with low birth weight and premature, both risk factors of trafficking situations;

"[After I gave birth], the child was kept in an incubator because he was very weak. When I came home it was very difficult. My son was only 1200 grams [2.6 pounds]. He was supposed to be 2 kg [4.4 pounds] before coming home, but he was only 1.2 kg [2.6 pounds]. If he gets ill now, it is more complicated, because he is very weak. I must always have medicine for coughing and colds because, if he gets sick, he gets weaker. When I wash his clothes, I have to use fabric softener, because he gets a rash. I can't use soap if I wash him, he gets allergies" (Surtees 2017).

Willis et al (2016) discussed the knowledge of children who had been harmed as a result of their mothers being trafficked; children had mental health problems, were given alcohol or over-the-counter medication to make them sleep, experienced physical and sexual abuse. Deaths of children were also reported from physical abuse, neglect, sudden infant death syndrome (SIDS), HIV, poisoning, low birth weight, prematurity, shaken baby syndrome and murder. Children also commonly witnessed the physical and sexual abuse of their mothers. This study was the only research to highlight such specific poor outcomes and dangers for children around trafficking, and the concerns raised add to the overall safeguarding issues raised throughout the systematic review. The women in the study were reporting on children they knew of. These could be stories, which can change and be exaggerated over time, but also the women may have been discussing the same children, skewing the overall findings.

## 3.5 Development of Analytical Themes

The development of analytical themes is the final process in the Thematic Synthesis model of Thomas and Harden (2008). Thomas and Harden (2008) discuss that while the descriptive themes remain close to the primary studies, the analytical themes go beyond the original research and are developed into new interpretive constructs, explanations or hypotheses. The descriptive and analytical themes are displayed in Figure 1 (Thematic Synthesis Diagram).

### 3.5.1 Access

The descriptive themes of “Barriers to accessing healthcare”, “Late access to maternity care”, and “Continuity of care” were encompassed within the analytical theme of “Access”. All of these descriptive themes represent scenarios which reduce the women’s access to healthcare. The trafficked women are prevented in accessing appropriate healthcare in a timely manner, this may be for physical, sexual and mental health needs which are as a result of illness or abuse (Ravi et al. 2017; Stanley et al. 2016; Westwood et al. 2016; Zimmerman et al. 2003). The traffickers control women (Bick et al. 2017), often locking them in rooms or houses, physically preventing them access to healthcare (Karandikar, Gezinski and Kaloga 2016; Ravi et al. 2017; Zimmerman et al. 2003). Even if women do access healthcare they are unlikely to be able to attend any follow-up appointments (Ravi et al. 2017). The women also fear reprisals for themselves or their families if they reveal the situations in which they are living, and are being exposed to (Bick et al. 2017; Zimmerman et al. 2003). Often women who do access healthcare are accompanied by their traffickers who speak and complete paperwork on their behalf (Westwood et al. 2016), sometimes when the women are unable to speak and write the native language (Stanley et al. 2016; Zimmerman et al. 2003 ), and others where women are able to communicate in the language of the healthcare professionals but are prevented from doing so as a method of coercive control exerted by the traffickers (Zimmerman et al. 2003). Interpreters are often not available, or independent professional interpreters who can be trusted by victims are not used (Bick et al. 2017, Westwood et al. 2016). Sometimes telephone interpreters are used, which does not aid effective communication in these difficult situations (Bick et al. 2017; Stanley et al. 2016) . Often the presence of the traffickers themselves is a barrier to women speaking freely due to the coercive control over them, and the fear of repercussions (Stanley et al. 2016). Traffickers often pretend to be a family member, and speak on behalf of the women, even when women understand the language and would therefore have the ability to speak for themselves (Bick et al. 2017).

Women also fear authoritative figures such as the police and immigration. They fear if they access healthcare they will be reported to the authorities and either arrested or deported (Ravi et al. 2017). Women often have no understanding of their situations, for example that they are victims of human trafficking (Ravi et al. 2017), and therefore

have legal rights of access to healthcare, and protection. Many countries around the world have legislation recognising the needs of victims of human trafficking and criminalising the traffickers. In the UK this is underpinned by the Modern Slavery Act 2015.

For women who may be from different countries or speak a different language, they may not understand the healthcare system of the country they are in, and how to access that healthcare (Zimmerman et al. 2003 ). They may also have concerns about how to pay for the healthcare, and if in the UK, not understand that they are entitled to free healthcare as victims of trafficking (Stanley et al. 2015). The women may also find the healthcare staff they come across are not aware of the entitlements to healthcare that women have as well (Bick et al. 2017; Stanley et al. 2016), and be inappropriately refused access to healthcare due to lack of identification (Bick et al. 2017; Westwood et al. 2016).

Women are known to self-medicate where they can to either avoid healthcare or because of the poor access to it (Ravi et al. 2017). Medication is sometimes provided for the women by their traffickers without having seen a healthcare professional themselves (Karandikar, Gezinski and Kaloga 2016) .

Women often fear pregnancy and the repercussions it may have on them. It may lead to an increased level of violence as women risk losing income for the traffickers (Ravi et al. 2017). They may be forced to have a termination of pregnancy (TOP), or may want to access a TOP, but due to poor access to TOP provider services, access these services late in pregnancy and need more invasive procedures, or be unable to proceed with the TOP (Ravi et al. 2017, Surtees 2017; Zimmerman et al. 2003 ). Women may also be subject to illegal procedures with the risks of haemorrhage and infection, and the mortality that this may lead to (Zimmerman et al. 2003).

Late access to maternity care itself is a risk factor for morbidity and mortality for mother and baby (Knight et al. 2018). Women may only present in labour for maternity care, or in emergency situations (Bick et al. 2017; Westwood et al. 2016), or may have irregular attendance to appointments. Attending scheduled appointments can be extremely problematic for women who have no control of their own lives (Bick et al. 2017; Ravi et al. 2017 ). Women may also be subject to dispersal to different areas. This may be due to the traffickers themselves, or due to government authority

procedures, where people are moved to different parts of the country when claiming asylum, or when awaiting the outcome of a human trafficking application (Bick et al. 2017; Ravi et al. 2017).

### 3.5.2 Person-Centred

The descriptive themes of Communication, Confidentiality and Stigma were encompassed within the analytical theme ‘Person-centred’. Communication is a vital descriptive theme. Healthcare professionals often speak in language and terminology that is difficult for others to understand, let alone for those whose first language is not the one being spoken by that healthcare professional (Stanley et al. 2016; Westwood et al. 2016 ). Therefore it is essential that healthcare professionals use language that is sensitive and appropriate for the individual. Victims who are not able to speak for themselves or who are scared of people in authority are extremely unlikely to ask questions or ask for clarification about what has been said to them (Stanley et al. 2016; Westwood et al. 2016). This emphasises the importance of checking understanding about information that has been given, as well as using language that is appropriate to the individual. It is essential that healthcare professionals listen carefully to vulnerable women, especially those who may be victims of human trafficking and/or sexual exploitation. The situation of presentation to healthcare may be the one opportunity that victim gets to explain some of their situation, or even give small clues to what their situation is (Lederer and Wetzel 2014). This may be the one opportunity a victim uses to give clues about their situation, or indeed may arouse suspicion even unwittingly by information they give about their circumstances, to a professional who listens well. Healthcare professionals are known to have treated victims unknowingly, or sometimes even knowingly (Lederer and Wetzel 2014), but not known where to direct them to the most appropriate help (Stanley et al. 2016). This raises the importance of training for healthcare professionals in how to spot the signs of trafficking, but also how to refer to the correct help and support, and how to respond safely and appropriately in these situations.

Access to appropriate face to face interpreting services is vital for trafficked women who do not speak the same language as the healthcare providers (Westwood et al. 2016). Trafficked women have often been tricked, coerced or sold into trafficking by family or friends (Caretta 2015; Karandikar and Prospero 2010; Karandikar, Gezinski

and Kaloga 2016; Lederer and Wetzel 2014; Stöckl et al. 2017; Zimmerman 2003) and therefore have difficulty trusting people. If the women are unable to see the interpreter face to face this is likely to impact their ability to communicate their vulnerable situation. Women who have been tricked and abused by people they know, are likely to be very suspicius of being honest with people on the phone when they have no idea who they are.

Victims often don't want to talk about their past experiences, they find reliving the past distressing, they may not want to relive what has happened to them, they may want to keep the abuse in the past and move on (Stanley et al. 2016; Zimmerman et al. 2003). This can be an issue for those who have escaped trafficking; however, it can lead to missed opportunities to treat or prepare women for care or treatment that will or should happen. This is expecially relevant in maternity care, where women may experience flashbacks or psychotic incidents due to the mental ill-health they exerience as a result of the trauma and abuse they have faced (Seng and Hassinger 1998; Gottfried et al. 2015). Labour itself, vaginal examinations or the presence of men in delivery rooms can all add to the suffering of victims, and increase the likelihood of worsening mental health problems (Gottfried et al. 2015). If healthcare professionals are not aware of the past or ongoing trauma, they may not practice with the extra sensitivity and gentleness of approach which is required. Mental ill-health has a strong link to maternal morbidity in pregnancy and the year following the birth of baby (Knight et al. 2018).

Confidentiality is an important issue for victims. Confidentiality experienced well for victims increases trust, and builds relationships with healthcare professionals (Bick et al. 2017; Stanley et al. 2016). Women are very aware that they may appear different to many other women having babies in hospitals, in loving relationships, and do not want their situations to be discussed in areas which can be overheard by other families (Bick et al. 2017). Experience of poor confidentiality can destroy relationships with professionals and put women at greater risk of harm (Bick et al. 2017). Victims really appreciated kindness and support that was shown to them in ways that were small, but went above and beyond the professional role of the healthcare providers, for example providing clothes and equipment for the baby, and ensuring that the healthcare professional caring for them spoke their language where that was possible (Bick et al. 2017), and continuity of care provided by healthcare professionals was

highly valued (Westwood et al. 2016). This was often represented with regular appointments with the same healthcare professionals, so women did not have to retell their “story”, and test results and treatment options could be followed through appropriately and in good time.

Victims are very aware of judgemental attitudes towards them, being judged as a sex worker, rather than a victim of trafficking, by professionals (Bick et al. 2017; Karandikar, Gezinski and Kaloga 2016; Zimmerman et al. 2003), as well as family back home (Surtees 2017). Healthcare professionals may assume that women are choosing their situation as sex workers, rather than being forced, abused and coerced into the situation (Lederer and Wetzel 2014). Healthcare professionals can also be complicit in the trafficking, providing “back door” access to the healthcare these women need, working in partnership with the traffickers (Lederer and Wetzel 2014). In the circumstances outlined by Lederer and Wetzel (2014), healthcare professionals abused their professional position and skills by working with the traffickers to either treat or aid in health care treatment for the women, but in a way that the women would not be seen and in circumstances that would not allow other staff to come across the women, or records to be kept about them, so that their trafficking and situations of abuse were being perpetuated. Healthcare professionals were complicit in the hiding of abuses, rather than undertaking their professional safeguarding responsibilities for the women.

Women carry the stigma and shame of the sex work they have been forced, abused and coerced into doing, as if it was their fault (Peled and Parker 2013; Stöckl et al. 2017; Surtees 2017; Zimmerman et al. 2003). Pregnancy and the children they bear may be perceived as a sign of liberty taken from them or lost childood and other symbols of loss and injustice. In some nationalities the women have a name associated with the stigma and shame they carry, and symbols of their abuse are even painted on the gates and doors of their homes, so all around label them as prostitutes (Surtees 2017). This is despite many victims being sold or tricked into the trafficking situations by their own families (Karandikar, Gezinski and Kaloga 2016).

The voices of the women point to a need for a person-centred approach for supporting these women and promoting recovery. If healthcare professionals are aware and practice in a sensitive manner, then more victims could be identified and helped.

The World Health Organisation (WHO) (2013) guidelines for responding to women who have experienced sexual violence recommends that first line responders should provide practical care and support in a way which offers women the choice to make their own decisions, and not be coerced, listen without pressurising for further information for the woman to disclose, offer comfort to help reduce anxiety and offer information and assistence to connect to appropriate services and agencies. These guidelines are an appropriate starting place for healthcare professionals who come across women who have experienced trafficking and likely sexual exploitation, as appropriate ways to approach and offer support to women.

### 3.5.3 Poor Health

The third analytical theme is poor health. Trafficked women are plagued by numerous health issues, when many women are at a time in their lives that if it were not for the trafficking and exploitation, they would be fit healthy women. Trafficking leads to massive inequalities in their health status.

Sexually transmitted infections (STIs) are common among women who are forced to have multiple sexual encounters (Karandikar, Gezinski and Kaloga 2016; Lederer and Wetzel 2014; Ravi et al. 2017; Stanley et al. 2016; Zimmerman et al. 2003), and often without access to barrier methods of contraception (Karandikar & Prospero 2010). Women may be unable to access the treatment they need, or follow instructions for the treatment given, for example to refrain from sexual activity for so many days while having treatment. Women fear the long-term implications of the multiple STIs that they experience (Lederer and Wetzel 2014).

Human immunodeficiency virus (HIV) and tuberculosis (TB) are two infections that victims both fear and experience in equal measure (Karandikar and Prospero 2010; Karandikar, Gezinski and Kaloga 2016; Ravi et al. 2017; Stanley et al. 2016; Zimmerman et al. 2003). The poor living conditions women experience, and the multiple sexual encounters without protection against STIs, mean these diseases are highly likely, and without adequate healthcare likely to be severely life-limiting. Women are likely to fear being abused and assaulted more by their traffickers if their diagnosis is known, as this will affect their ability to earn money for their traffickers (Ravi et al. 2017). This fear will reduce the likelihood of women seeking medical help until their disease is at an advanced state and less likely to be curable.

Physical health problems of all types are quite high, with untreated chronic conditions frequent. Physical problems from skin, neurological, heart and respiratory are not unusual (Lederer and Wetzel 2014; Stanley et al. 2016; Stöckl et al. 2017; Zimmerman et al. 2003). Women in the UK are likely to present in emergency departments with these complaints, rather than access regular care through a GP (Stanley et al. 2016).

Mental health problems, are very common in victims and survivors of human trafficking. These mental health issues are likely to be serious with suicidality very common, as well as complex post traumatic stress disorder (PTSD). Women are extremely unlikely to access mental health care while still in trafficking situations (Karandikar, Gezinski and Kaloga 2016; Lederer and Wetzel 2014; Stanley et al. 2016; Stöckl et al. 2017; Zimmerman et al. 2003).

Women also face physical, mental and sexual abuse regularly (Karandikar and Prospero 2010; Karandikar, Gezinski and Kaloga 2016; Lederer and Wetzel 2014; Ravi et al. 2017; Zimmerman et al. 2003 ). They experience fear with coeorcive control threats against themslves and their families (Geynisman-Tan et al. 2017). Women experience physical and sexual abuse from their traffickers as well as the men they encounter within the context of their exploitation (Caretta 2015; Karandikar, Gezinski and Kaloga 2016; Karandikar and Prospero 2010; Lederer and Wetzel 2014; Ravi et al. 2017; Zimmerman et al. 2003). Women will often be exposed to multiple physical injuries, which are often not properly treated or treated at all (Karandikar, Gezinski and Kaloga 2016; Zimmerman et al. 2003).

Women will often use drugs and alcohol as a way of coping with the daily abuse and neglect they face (Karandikar, Gezinski and Kaloga 2016; Lederer and Wetzel 2014; Ravi et al. 2017; Zimmerman et al. 2003 ). There are also situations where women are forced to take drugs or alcohol by their traffickers to ensure compliance in their exploitation (Lederer and Wetzel 2014; Zimmerman et al. 2003 ).

Women in sexually exploitative situations may not have access to adequate contraception, especially barrier methods as previously discussed, and even where available the men exploiting women often refuse to use barrier methods of contraception (Karandikar and Prospero 2010; Ravi et al. 2017). In the UK contraception is freely available from sexual health clinics, but women may not be aware of these services, or the availability of free contraception.

Women who face sexual exploitation often experience repeated miscarriages and TOPs (Karandikar, Gezinski and Kaloga 2016; Lederer and Wetzel 2014; Stanley et al. 2016; Stöckl et al. 2017; Zimmerman et al. 2003 ). The TOPs may be forced (Caretta 2015; Lederer and Wetzel 2014) or sought by the woman herself to avoid the birth of a baby through sexual abuse. Many women in these situations are denied the appopriate healthcare needed, and face life threatening complications from haemorrhage and infection (Karandikar, Gezinski and Kaloga 2016; Zimmerman et al. 2003).

There are strong links with bonding issues for mothers and babies who have been in abusive situation, even when they have then escaped the abuse (Surtees 2017). Bonding starts in utero, and the abuse and stress that women face in situations of abuse has the potential for a physiological impact on the neurodevelopment of the fetus leading to delayed mental and motor development and impaired cognitive performance (Buss et al. 2012). Chronic maternal stress has also been shown to increase cortisol levels (Sandman et al. 2007) which negatively impacts uterine perfusion in pregnancy and therfore the transfer of essential nutrients essential for fetal growth which is a known factor associated with intrauterine growth restriction. Cortisol is also associated with an increase in uterine irritability which can lead to preterm births (Hoffman & Hatch 2000; Pico-Aifonso et al. 2004). The impacts of inutero abuse can therefore have a lifetime of impact both from neurological development, premature birth, or restricted in utero growth.

Babies born from trafficking situations have had issues such as low-birth weight and prematurity (Stanley et al. 2016; Surtees 2017; Willis et al. 2016), and are known to be exposed to physical, sexual and emotional abuse themselves as well as witnessing the abuse of their mothers (Surtees 2017; Willis et al. 2016), suffering from physical and or developmental delays (Surtees 2017). Children are also known to have behavioural and mental health issues (Willis et al. 2016). Child deaths were also reported due to neglect, abuse, sudden infant death syndrome, suicides, HIV and murder (Willis et al. 2016).

### 3.5.4 Underpinning Theme: Safeguarding

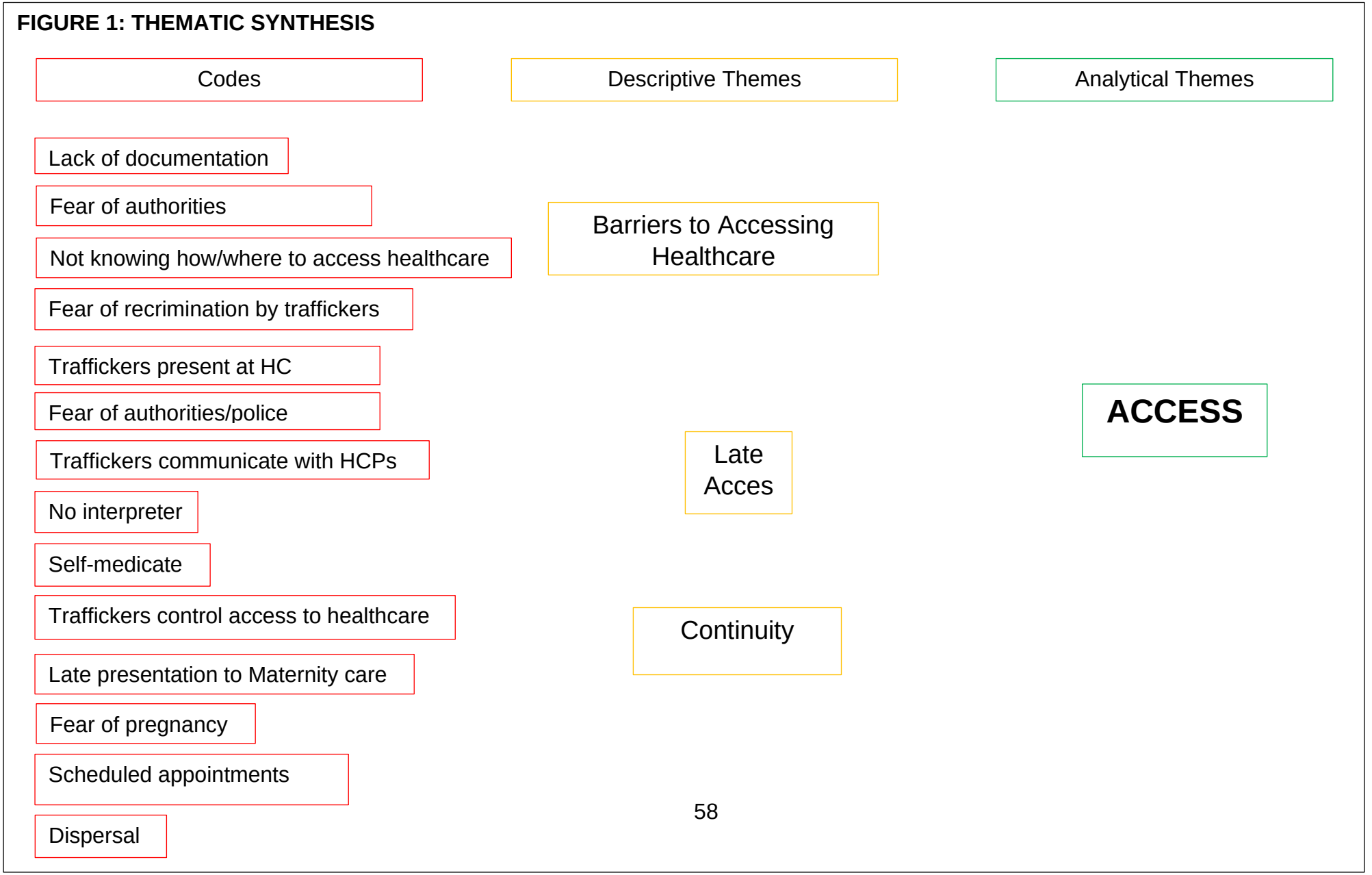
It has clearly been demonstrated that mothers and their babies are exposed to multiple abuses, with the risks of morbidities and mortality being extremely high for those experiencing exploitation.

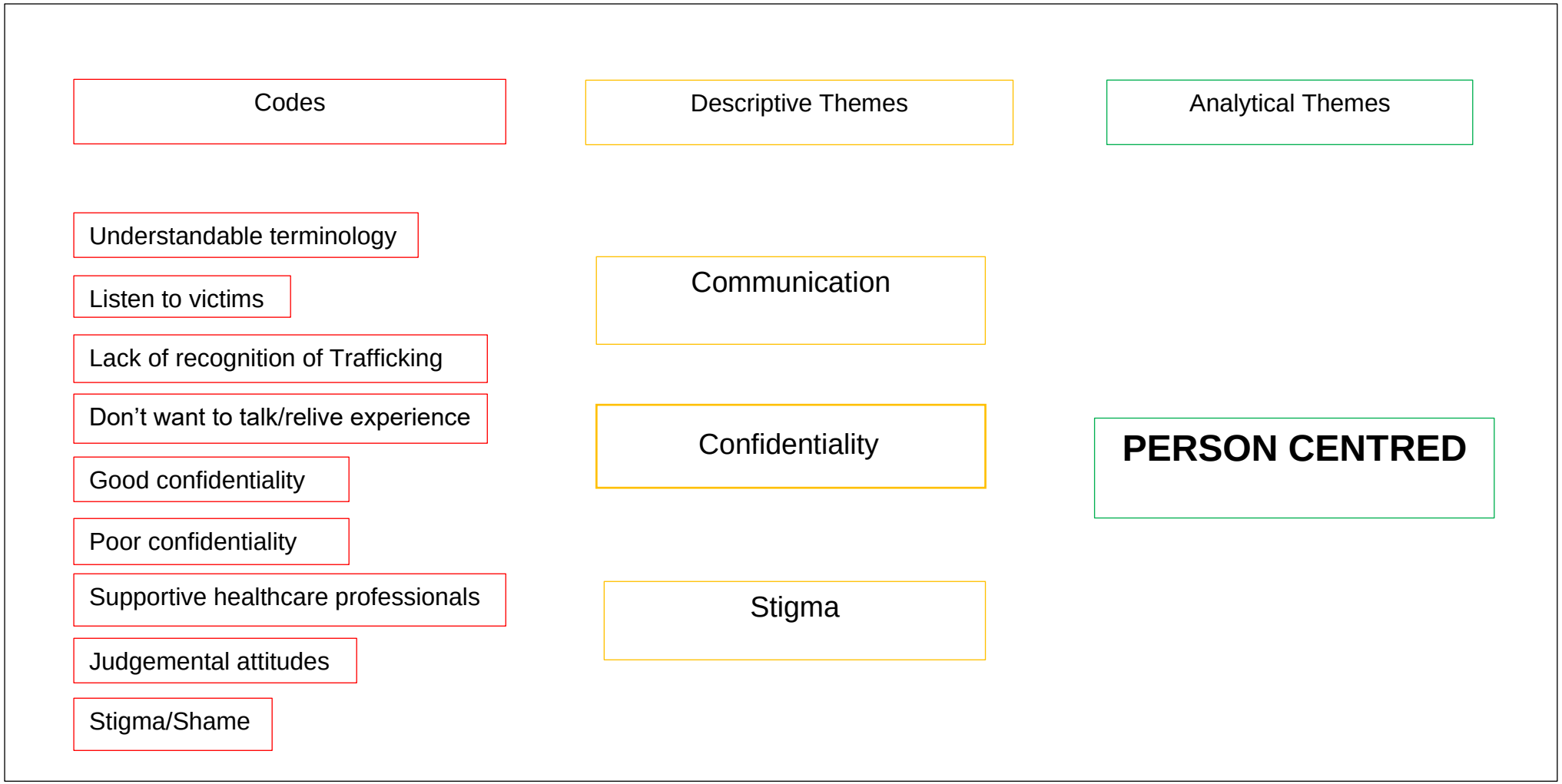
The risks to babies in trafficking situations, highlight the safeguarding concerns there are for these babies. Clearly any child that returns to a situation of trafficking with its mother is at serious risk of harm (Surtees 2017; Willis et al. 2016). The mother is also in need of safeguarding support to prevent further abuse and harm, and needs access to support to escape abuse, start their road to recovery, and to prevent the risk of re-trafficking (Zimmerman et al. 2003). Mothers and babies as a family are also in need of support (Peled and Parker 2013).

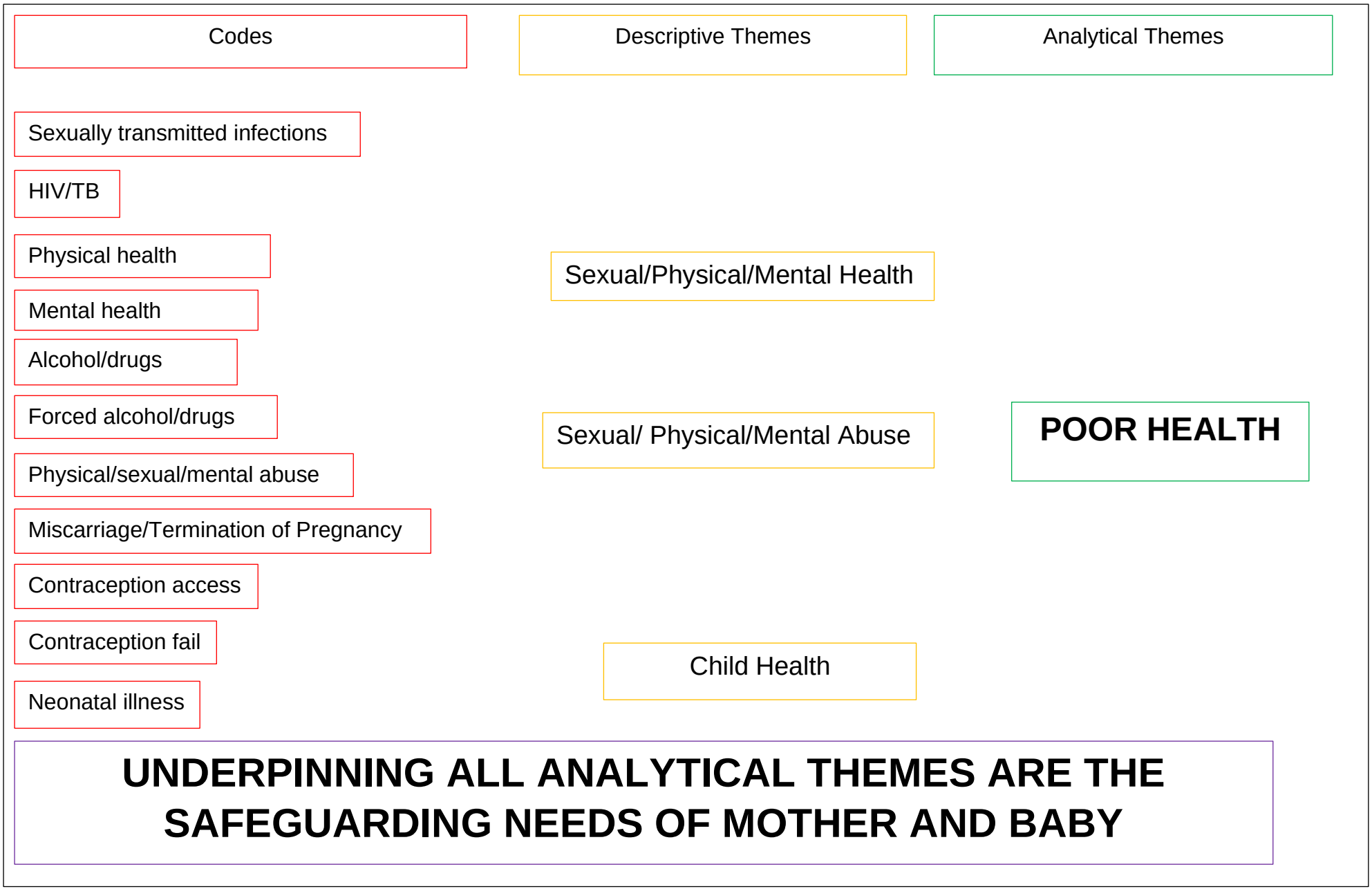
Under the Care Act (2014), in the UK people have the right to live in safety, free from abuse and neglect. Modern Slavery is one of the ten categories of abuse highlighted (Social Care Institute for Excellence 2018). The Children and Social Work Act (2017) lays out the requirements to prevent harm and neglect for all children in the UK. In view of UK legislation, healthcare professionals have a duty of care to safeguard mothers and babies in situations of human trafficking. In maternity care especially, healthcare professionals are very aware of their responsibilities to safeguarding babies (Lazenbatt and Greer 2009), so it is essential to emphasise the importance in situations of human trafficking that all victims, which includes the mothers, are entitled to safeguarding help and support.

The healthcare needs highlight specific areas where well trained healthcare professionals could spot the signs of trafficked women, and know where to signpost victims for help and support (Bick et al. 2017). Sexual health services and TOP providers are key areas where sexually exploited women may access services. Healthcare professionals in emergency departments and maternity services also need to be acutely aware of the signs of vulnerability, and trained in how to respond and where to go to access support services for these vulnerable women to ensure mum and baby can be adequately safeguarded.

**FIGURE 1: THEMATIC SYNTHESIS**




Codes
Descriptive Themes
Analytical Themes
Understandable terminology
Listen to victims
Lack of recognition of Trafficking
Don’t want to talk/relive experience
Good confidentiality
Poor confidentiality
Supportive healthcare professionals
Judgemental attitudes
Stigma/Shame
Communication
Confidentiality
Stigma
PERSON CENTRED


Codes
Descriptive Themes
Analytical Themes
Sexually transmitted infections
HIV/TB
Physical health
Mental health
Alcohol/drugs
Forced alcohol/drugs
Physical/sexual/mental abuse
Miscarriage/Termination of Pregnancy
Contraception access
Contraception fail
Neonatal illness
Sexual/Physical/Mental Health
Sexual/ Physical/Mental Abuse
Child Health
POOR HEALTH
UNDERPINNING ALL ANALYTICAL THEMES ARE THE SAFEGUARDING NEEDS OF MOTHER AND BABY

# 4.0 Discussion

The aim of this study was to draw together and critically evaluate all of the available international studies and UK based reports that examined women's experiences of pregnancy in the context of human trafficking and sexual exploitation, to identify and synthesise evidence on trafficked women's experience of maternity services, reproductive control, pregnancy, birth experiences and outcomes. A systematic review of qualitative studies was undertaken, and thirteen studies were taken forward for the analysis by thematic synthesis (Thomas and Harden 2008).

## 4.1 Key findings and take-home messages

The key findings are the three analytical themes which developed from the synthesis. Access was the first of these themes. Human trafficking victims experience many circumstances which result in a barrier to them accessing care. These barriers are due to the control and intimidation exerted by their traffickers, the lack of freedom women experienced, their lack of understanding of where and how to access healthcare, and fear of authorities if they did so, women's lack of documentation to allow them to register for healthcare, and the lack of recognition by those in healthcare that allows women access to health services as well as language barriers (Bick et al. 2017; Ravi et al. 2017; Stanley et al. 2016; Westwood et al. 2016; Zimmerman et al 2003). Lack of continuity of care was a barrier for women, because of their inability to attend repeat appointments due to some of the barriers discussed, or to access or follow prescribed treatment, due to cost or the logistics of following medical instructions. However, women were also moved locations by traffickers, but also by governments when being offered support. Both situations affected women's ability to maintain continuity in their healthcare. Where continuity was given, it allowed ongoing care without the burden of having to share their story over and again causing additional stress and was really appreciated by the women (Bick et al. 2017; Ravi et al. 2017).

Late access to maternity services, a known risk factor in itself for poor maternal morbidity and mortality (Knight et al. 2018) is a common feature of maternity care for women who are experiencing human trafficking. The lack of assessments and planning for ongoing health problems which can impact pregnancy is likely to negatively impact outcomes for mother and baby.

Person centred was the second analytical theme. This theme highlighted the benefits of person-centred care as well as situations where lack of person-centred care was detrimental for the women. Effective communication is an essential skill for healthcare professionals. Some of the barriers highlighted above overlap with the needs to be person-centred. Appropriate use of independent professional face to face interpreters can aid effective communication between healthcare professionals and women (Westwood et al. 2016). Healthcare professionals need to use understandable language and check women's understanding of information discussed and advice given.

Women who have experienced multiple abuses and have complex mental health issues will need sensitive care in labour especially, and an understanding of these issues by healthcare professionals is vital to prevent further trauma (Gottfried et al. 2015). The role of the midwife as an advocate of women's wishes and rights in pregnancy and labour is especially vital for women who have experienced multiple and complex abuse and exploitation.

Women who have experienced sexual exploitation are very aware of the stigma and shame that they can face. This stigma can be exacerbated by healthcare professionals, especially if treating women as "prostituted" rather than trafficked. (Bick et al. 2017; Karandikar, Gezinski and Kaloga 2016; Zimmerman et al. 2003) Women are aware of the stigma they will face if and when they return home and they also carry that shame themselves (Surtees 2017). Women who experienced kindness shown by healthcare professionals really appreciated this, especially where kindness and care given was seen to be above and beyond their expectations (Bick et al. 2017; Westwood et al. 2016).

Much of the available evidence focussed on the general health experiences and needs of victims. Poor health was the third analytical theme. Four of the papers (Lederer and Wetzel 2014; Ravi et al. 2017; Stanley et al. 2016; Westwood et al. 2016) focussed on the health experiences of trafficked victims. The physical symptoms described within the studies cover all aspects of physical health, from dermatological to neurological and respiratory. Lederer and Wetzel (2014) indicated that almost their entire sample was affected by physical symptoms; two thirds experienced physical injuries, and almost four-fifths experienced physical violence.

The figure of almost 80% of women experiencing sexual violence, while horrific in itself, must also have an impact on overall mental and physical health. Trafficked women experience high levels of violence, abuse and ill-health. It is entirely justifiable to summarise that trafficked women are plagued by physical,mental and sexual health problems which are way beyond what is expected as usual for women of their age, and beyond the usual for women overall of any age.

Women experienced multiple miscarriages and TOPs, and often forced TOPs in unsanitary conditions, and experienced multiple STIs (Karandikar, Gezinski and Kaloga 2016; Lederer and Wetzel 2014; Ravi et al. 2017; Stanley et al. 2016 Zimmerman et al. 2003). The lack of appropriate healthcare experienced by women put their lives at risk due to haemorrhage or septic complications (Karandikar, Gezinski and Kaloga 2016; Zimmerman et al. 2003). Other women discussed how they were seen by healthcare providers in these situations, and often not recognised as victims of trafficking, or if recognised not offered appropriate help and support (Lederer and Wetzel 2014; Stanley et al. 2016).

Sexual violence was also discussed in relation to the number of men, the women were exploited by on a daily basis. This underlined the lack of freedom experienced by women, and the lack of any control women have over their lives. It also speaks to the high levels of violence and abuse faced by victims to ensure their co-operation when faced with such constant and ongoing abuse (Lederer and Wetzel 2014; Zimmerman et al. 2003).

Crenshaw (1991) in her work on intersectionality, highlighted the many factors that combine which make women more vulnerable to abuse and control. In her work Crenshaw discussed the poverty and lack of employability skills and jobs that for women of colour was normal, reducing their opportunities, and making them extremely vulnerable to domestic violence and rape. Crenshaw highlighted that these vulnerabilities were the result of gender and class oppression, and made worse by racial discrimination. Herrera Vivar (2011) goes further to describe how this leads to an invisibility which increases vulnerability, abuse and discrimination. There are parallels of intersectional invisibility highlighted by these authors which are real for women who are victims of human trafficking, often coming from situations of poverty, lack of education and opportunities for women. This

intersectional invisibility also increases the multiple abuses or polyvictmization faced by women experiencing human trafficking. Polyvictimization increases the complex mental health issues and psychological trauma experienced by women (Macdonald et al. 2010). This apparent invisibility highlights the importance of raising awareness of the signs of human trafficking and educating healthcare professionals to spot the signs, and the knowledge and skill to respond appropriately.

The underpinning theme of safeguarding relates to the safeguarding of mother and baby together, recognising that both are victims and need to be offered appropriate help and support. This theme relates to the training that healthcare professionals especially need.

There are however, several concerns being voiced about the safeguarding support which victims receive both during and following the National Referral Mechanism (NRM) process. A Commons Select Committee highlighted in 2017, some of the shortfallings of the current system (Parliament UK 2017). Victims are given support including finance and housing for the 45 days of the NRM process. However, following this, if there is a negative finding, there is no right to appeal, and even with a positive result, there is a limited period of time available for victims to remain in the supported housing and given benefits support. There is no automatic “leave to remain” given even when human trafficking is confirmed. Baroness Butler-Sloss, a member of the Select Committee (Parliament UK 2017) called for a twelve month period of “leave to remain” to be given following a positive NRM finding with a pathway of support to allow victims time to get their lives “on track”, with a benefit entitlement, access to housing and healthcare. The Select Committee also highlighted that the government recognises that victims of domestic violence need additional support when accessing the benefits system, and argued that these reasons for extra support also apply to victims of modern slavery, and therefore victims should also receive extra support to navigate the benefits system.

Without the extra support discussed by the Commons Select Committee above, victims of human traffciking are at risk of being re-trafficked, when they leave the NRM process. It could therefore be argued we are potentially putting trafficked women at more risk, at the hands of traffickers who they may have given information

about to the police, but have not been prosecuted due to victims dissappearing from the system as they are not supported beyond the NRM process.

Adams (2017) on behalf of CARE, presented recommendations to the Select Committee. CARE submitted that many victims are unable to pass eligibility tests and these tests can be extremely distressing and force victims to re-live their exploitation in interviews with Job Centre staff, and without clear entitlements to housing benefit and job seeker's allowance in order to buy essentials such as food, victims were all too often falling through the net – and at severe risk of being exploited again once their 45 days of government support ran-out, meaning that many ended up homeless, and at risk of being re-exploited.

ECPAT UK (Every Child Protected Against Trafficking) an organisation committed to ending the exploitation of children, highlighted the case of a British teenager who was sexually exploited for five years in the UK,

"I should never have been trafficked for that many years undetected," Maya said. "I was not only a child, but I was a child in a school, a child with a GP, a child with foster parents and social workers, all of which failed throughout seven years to identify that I was being tricked, controlled, tortured and sold every day. Through this crime, everything was taken from me: my control, my dignity, my future, my voice. It was impossible for me to speak out and nobody around me took any notice of the signs right in front of them".

However, she discusses that in the two years following her identification as a victim of modern slavery, authorities failed to provide adequate support in her recovery, which led to her mental and physical health suffering enormously. She was eventually offered the help and support she needed through a charity organisation set up to support victims of trafficking (ECPAT UK, 2019).

The work of organisations such as as CARE and ECPAT UK, alongside the submissions of the Select Committee, highlight that although safeguarding is of major importance for victims of trafficking, there are currently many shortfalls in the process, which can lead to more significant harm. This is of grave concern, given safeguarding being the central theme in this research study, and clearly more work needs to be done to ensure that victims are given the appropriate and much needed support to start to rebuild their lives.

## 4.2 Strengths and challenges

The strength of this research is the systematic review approach to ensure that all of the available evidence has been reviewed. Much of the work around human trafficking has focussed on statistical analysis of the descriptive statistics of where women are from, their age, type of exploitation, effects on victims, and health problems encountered. However this study used a synthesis of qualitative studies interviewing women who had experienced human trafficking to hear their voice, and the information that was important for them to tell.

Significant analytical themes evolved highlighting important areas for healthcare professional's awareness and learning. The dissemination of these findings will be central to the impact of theses findings.

However there were also challenges. The studies all mention pregnancy experiences, but the Bick et al.(2017) study is the only study to have looked at the issues independently from general health issues. The remaining studies in the systematic review all mention pregnancy or the outcomes of pregnancy in their papers, but this was not the main forcus of the paper. The evidence for pregnancy and neonatal outcomes for trafficked women is especially lacking. Much of the available evidence for poor maternity outcomes is from evidence to outcomes in relation to domestic violence, or prostituted women (Buss et al, 2012; Deisher, Litchfield and Hope 1991; Fanslow 2017; Gisladottier et al. 2016; Sandman et al. 2007), rather than specifically to women who are victims of human trafficking, and have experienced a mutiple and complexity of abuse, violence and neglect. The specific areas of interest identified in the study aims, complications of pregnancy such as haemorrhage, hypertensive disorders, low-birth weight, premature birth, neonatal morbidity and mortality were not answered by this research study.

In all but the Bick et al. (2017) study it was impossible to differentiate whether each of the quotes were regarding women who had experienced pregnancy, apart from where the quote was specifically about pregnancy. It was also not possible to always differentiate between those who had experienced a pregnancy as a result of trafficking or after trafficking, whether the pregnancy was a result of sexual violence and abuse. Indeed for Stanley et al. (2016) and Westwood et al. (2016) it was not always possible to differentiate between quotes that were from men and women.

Sexual violence was not always discussed in relation to the quotes, however the papers all discuss the impact of the polyvictimisation, including sexual violence these women experienced while being trafficked. All the evidence presented is central around the themes of the research, with assumptions that the developed themes would have been appropriate to women experiencing pregnancy and maternity care as much as the general trafficked population.

## 4.3 Implications/recommendations

The findings of this systematic review provide important knowledge that is essential for healthcare professionals in clinical maternity and wider clinical situations to be aware of. Dissemination of research findings is an essential part of the research process, which enables clinicians to make evidence-based decisions about practices which are most effective (National Institute for Health Research (NIHR) 2019). Walshe and Rundall (2001) discussed the importance of using research in clinical practise, highlighting the gap between research and clinical practise.

An effective way of narrowing the research clinical gap is to take the research to clinicians in a memorable format. This principle has been used to develop an aide memoire and mnemonic representation of the findings. An aide memoire refers to documention that summarises the key findings and important recommendations of the message needed to disseminate (Better Evaluation 2019). Scruggs et al. (2010) discuss how mnemonic strategies can be used to enhance learning and improve the memory of the learning.

The mnemonic “POPPY” was developed. “POPPY” represented the three analytical themes, POor health, Person centred, People who need us to say Yes to access, with the underpinning theme of safeguarding the family, mother and baby together (Appendix Figure 2). The underpinning theme; safeguarding the family, is represented by the stem of the poppy, representing the underpinning central theme. While this mnemonic and aide memoire is quite simplistic, the idea is for it to be displayed in clinical areas, where staff can be drawn to the message, read and understand the issues, and remember the key details. In a busy clinical environment, it is essential to be able to effect healthcare professional learning in an effective and memorable way. Not all healthcare professionals have frequent access to conferences where research may be presented, and so it is hoped that

through the development of this mnemonic aide memoire displayed in a poster format in clinical areas and shared on social media, that learning, knowledge and change can be impacted.

The issues raised in this research, which feed into the themes highlighted in the mnemonic, can assist healthcare professionals to build awareness of the vulnerabilities of victim/survivors of trafficking and the dangers that these women face; it may also increase their capability around identifying victims in their day-to-day clinical practice. Women with multiple unmet healthcare needs, repeated pregnancies, STIs, mental health issues; women accompanied by controlling people; without ID, unable to speak for themselves, not approprately clothed, malnourished, and with poor personal hygiene, have all been identified as some of the potentail “red flags” for concern. It is essential that healthcare staff are able to respond appropriately and sensitively, not taking situations at “face value”, are prepared to gently probe further to uncover the abuse when suspicions are raised. The research has highlighted how victims appreciate being treated kindly, with empathy, using appropriate communication skills, verbal and non-verbal, and to be dealt with in a confidential manner. Shame is an emotion carried by many victims of trafficking, and to build up a trust with victims, will require gentleness and kindness in words and actions, alongside a knowledge of referral pathways and where to access appropriate support and help. Staff also need to be supported to support women presenting under such circumstances.

The objective of this research was to identify and synthesise available evidence on trafficked women’s access to and experiences of maternity services, reproductive control, pregnancy, birth experiences and outcomes. The hope was always that this study would result in the reduction of morbidity and mortality for mothers who have experienced human trafficking and sexual exploitation and their babies. This reduction in morbidity and mortality could be influenced by the increased awareness of the factors demonstrated in this study, and better informed and educated healthcare professionals around the area of human trafficking. However, there are many questions not answered by this study, and further work is required.

This systematic review does highlight the gross health inequalities and multiple abuses faced by women who are victims of human trafficking, however, it does not

provide answers around pregnancy and neonatal outcomes for women victims. Therefore it is the recommendation from this study that further primary research needs to be undertaken to better understand the specific maternity experiences, and maternity and neonatal outcomes that effect victims of human trafficking.

Further research needs to be undertaken which investigates the evidence around the number of women who are victims of human trafficking that experience pregnancy, and the outcomes for them, in terms of sexual health, miscarriage, TOP, and more specifically adverse maternity and neonatal outcomes around birth and the causal links for these issues. Also specific perinatal mental health issues such as puerperal psychosis have not been addressed in any of the studies reviewed. Given that the women represented in these studies experienced severe, multiple and complicated mental health issues, more work needs to be undertaken to review the perinatal mental health outcomes for this group of women.

Further research needs to be undertaken with healthcare professionals such as TOP and sexual health service providers, emergency department and paramedic staff as well as midwives specifically working in front line triage who are likely to come into contact with victims of human trafficking in their roles, as well as other maternity staff to evaluate interventions which inform and improve effective understanding and response to the issues of trafficking and sexual exploitation.

Further research could help inform national policy within professional bodies such as the Royal College of Midwives. However, it could also inform more widely in situations such as Commons Select Committees and the NRM to improve legislation and support for victims of trafficking. Further evidence would have the potential to enable healthcare professionals to be better informed, and government organisations improve legislation, support and provision for women who have experienced human trafficking, thereby improving outcomes for mother and their babies.

This research will assist healthcare professionals in their identification of women who are experiencing human trafficking, and increase their understanding of the dangers and the vulnerabilities that women may be experiencing. However, further work needs to be done to ensure that healthcare professionals, and other front line service professionals know how to respond appropriately and that organisations

have policies and training to ensure the readiness of staff to manage these complex situations. Healthcare and other front line professionals need to respond sensitively, and to ensure that women's safety needs are paramount. Healthcare professionals need to have established referral pathways to safeguarding internally and external support organistions (Oram et al. (2015). They need to have understanding of the role of power dynamics and manage such factors as part of ensuring effective response. Ramsay et al. (2012) highlighted that only about one quarter (29%) of responders reported feeling prepared to ask appropriate questions about domestic violence, and only 24% to make appropriate referrals for the women. This lack of confidence to pursue suspicions of or undertake routine screening for domestic violence and respond with appropriate referrals, highlights the extent of the gap in training needs around humna trafficking and sexual exploitation.

There is therefore a clear need for relevant up to date pathways to be in place within NHS trusts and other client facing organisations, that identify how to respond, and where to signpost to or assist women in situations where women are identified as potential victims of trafficking. The pathways need to be specific to human trafficking, and not an add on to generic safeguarding policies, so that the specific potential vulnerabilities and dangers faced by mother and baby together can be acknowledged and addressed.

As national and international awareness of human trafficking increases, it highlights the needs for protocols and policies to be put in place to ensure that legislation is not only adhered to, but also front line professional as well as the wider public are aware of the issues and the legislation that is in place to protect victims and enable perpertrators to be prosecuted.

## 4.4 Dissemination Plan

It is an important part of any research undertaken to have a dissemination plan for findings to ensure the work has the greatest possible impact. My study aimed to identify factors associated with pregnancy for women who have been exposed to human trafficking and sexual exploitation. The aim of this work was to better understand the experiences of women in maternity services who have experienced human trafficking which can lead to an improved awareness of the risk factors as well as "red flags" for maternity healthcare professionals. This may help maternity

healthcare professionals to identify these women who are extremely vulnerable and may not even be aware of their own exploitation, or be too fearful to disclose their situations, and therefore be in a position to improve maternal and neonatal outcomes.

The dissemination plan is therefore:

- To publish the findings in a national journal with high impact for maternity healthcare professionals;
- To present the findings at national maternity conferences, both in poster and oral presentation format;
- Dissemination of findings on social media
- To work with local maternity managers and safeguarding lead to disseminate findings locally
- Develop pathways with local safeguarding team that ensure maternity staff know how to respond to any women that may be identified as victims
- Pursue options to continue this work to doctorate level, where further work can be undertaken to increase the impact.

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# Appendix

| Table 5 Codes, Descriptive Themes and Quotes Descriptive Themes | Codes | Quotes | |
|---|---|---|---|
| **Barriers to healthcare** | Lack of documentation | When I was 4–5 months pregnant... I snuck out of the house and went to the local GP [family doctor] practice. When I arrived they told me I needed a passport and proof of address. I explained that I didn't have this documentation and they turned me away | Bick et al. (2017) |
| | Lack of documentation/late access to mat care | It wasn't easy, because my friend tried many times before to register with a GP because it was kind of an emergency. I needed to see a doctor because I was pregnant, but the GP wouldn't register me without any papers from the home office, so we had to wait until that paper arrived and then I was registered | Stanley et al. (2016) |
| | Lack of documentation | The GP wouldn't register me without any papers from the Home Office | Westwood et al. (2016) |
| | Lack of documentation/fear of authorities | I was just worried because I have no legal paper work or anything | Westwood et al. (2016) |
| | Not knowing how/where to access | 'I explain to him [friend/acquaintance] that I'm pregnant and he took me to a nearby doctor.' | Westwood et al. (2016) |
| | Fear of recrimination by traffickers | If he [family doctor] asked me in the first place, I wouldn't [reveal the true identity] because I would be scared. Even the guy that took me to the doctor–I just tell him they are like family friend | Bick et al. (2017) |
| | Fear of traffickers/present at healthcare encounters | I was taken to the GP to register … by my trafficker … he was there with me … I wasn't really comfortable to tell him [GP] stuff.' | Westwood et al. (2016) |
| | Fear of traffickers | They ask me why are you doing this, do you like doing this? I say yes, because I was scared. (woman with sexual health worker) | Ravi et al. (2017) |

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| | Fear of traffickers | I went to the emergency room once for an asthma attack…It was one of the days where I wasn't with him so I just went and I was released…like six hours later, so he didn't really know. And it was better that way in my opinion because I don't know how he would have reacted to me saying I went to the emergency room, even if it was for something like my asthma. And I don't know how he would have reacted to that maybe thinking that I was lying or that I'm snitching on him or something like that. So, yeah, no. He didn't know about it. | Stanley et al. (2016) |
| | Fear of authorities/police | we don't wanna go to the hospitals because we feel like they're gonna check there. Or we go to the hospital, our names are ran. And the cops come and they take us. And that has happened a lot | Ravi et al. (2017) |
| | Traffickers communicate with Health care professionals (HCPs)/no interpreter | She [trafficker] spoke for me, I was learning English at the time.' | Westwood et al. (2016) |
| | Traffickers communicate with HCPs/no interpreter/fear of trafficker | He told staff that I can't speak any English … he will interpret for me and he told them some story … the doctor asked me directly as well … I didn't want to say it was this person because he was there with me.' | Westwood et al. (2016) |
| | No interpreter | I had no interpreter and so I couldn't understand what happen to me, what happen to my health. | Westwood et al. (2016) |
| | No interpreter | really my problem is that I can't speak English | Westwood et al. (2016) |
| | No interpreter | 'She (the support worker) went with me twice and then on a third occasion I had a Polish interpreter | Westwood et al. (2016) |
| | Traffickers control access to healthcare | When I would fall sick they would just get medicine from outside. I did not see the doctor but after one year I was released and I was on my own. | Karandikar, Gezinski & Kaloga (2016) |

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| | Traffickers control access to healthcare | For STDs the doctor came to the brothel and gave me medicine. | Karandikar, Gezinski & Kaloga (2016) |
| | Traffickers control access to healthcare | When I was in the brothel, I used to get cold, cough but they got medicines and that was it. When I would get my periods I got cramps really bad but the other women gave me something from the chemist. I was not allowed to go out. | Karandikar, Gezinski & Kaloga (2016) |
| | Traffickers control access to healthcare | For any other problems they will call doctors and I never went out. | Karandikar, Gezinski & Kaloga (2016) |
| | Traffickers control access to healthcare | The first time I saw a doctor was when I got pregnant. Before that when I used to be sick, I was just given medicine by someone around me. | Karandikar, Gezinski & Kaloga (2016) |
| | Traffickers control access to healthcare | Health problems like cold-cough-fever are so common that I can't even complain. Women are dying on the street – at least I'm not like that. If I had a madam, I would be dying. Those girls are in a terrible situation. Even when they are vomiting and throwing [up] blood, they are locked up in rooms. If they live they get money from prostitution. I think it's better if they die. At least they are set free. | Karandikar, Gezinski & Kaloga (2016) |
| | Traffickers control access to healthcare | You can't just ask your pimp; can I go to the doctor? And they're like, no, you haven't made enough money yet today, we don't have time to take you out to go to the hospital or go to the doctor | Ravi et al. (2017) |
| | Traffickers control access to healthcare | I thought I needed to see a doctor … they wouldn't take me | Westwood et al. (2016) |
| | Traffickers control access to healthcare | My admi beat me black and blue but I never reached the doctor | Karandikar, Gezinski & Kaloga (2016) |
| | Lack of recognition of human trafficking | During the time I was on the street, I went to hospitals, urgent care clinics, women's health clinics, and private doctors. No one ever asked me anything anytime I ever went to a clinic. . . . I was on birth control during the 10 years I was on the streets—mostly Depo-Provera shots which I got at the Planned | Lederer & Wetzel (2014) |

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| | | Parenthood and other neighbourhood clinics. I also got the morning-after pill from them. I was young and so I had to have a waiver signed in order to get these—one of the doctors (a private doctor I think) signed this waiver when my uncle took me to see him | |
| | Self-medicate | I would drink a lot of alcoholic stuff, and I'd buy off-the-counter antibiotics, which in my neighbourhood, there's a lot of those. And I used to buy off-the-counter antibiotics and just drink them for a few days. | Ravi et al. (2017) |
| **Late access to maternity care** | Late access | When I had my first visit at the hospital, the doctor she told me when she saw the baby, she told me that the baby seemed bigger than it should be. 'You should have come earlier, actually, to see me' | Bick et al. (2017) |
| | Late access | …the madam took me to a doctor who said I was pregnant. When the madam found out I was pregnant she tried to force me to have an abortion. I didn't consent even though she said she would sell my child to white people. She kept on sending me to the street. There I tried hitchhiking in order to flee. Finally, I managed to get in contact with the doctor who had seen me for a check-up. He first took me to a kind Neapolitan lady who then brought me here to Casa Rut. The following Wednesday, my son was born. I lived through a nightmare. | Caretta (2015) |
| | Late access/drug abuse/trafficker control | When I did get pregnant…and still smoking, he was locking me in closets in the room…with guns and stuff like that…Because he didn't want me to go out…I was pregnant with his baby…I did break out a couple of times and went to hotels and got high | Ravi et al. (2017) |
| | Late access | I was found unconscious in the street when I was heavily pregnant … I was taken to the hospital by ambulance | Westwood et al. (2016) |
| | Fear of pregnancy | it was always something I was worried about. And even if my period was like three days late, I would start freaking out and crying…because the last thing I wanted was to get pregnant, because that would affect my boss, how he would treat me. Like he would probably beat the shit out of me more because I wasn't able to work because I was like a big belly or something like that, and I also wouldn't have the money to get an abortion, or like the little things like that really scared me | Ravi et al. (2017) |

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| | Miscarriage/Termination of pregnancy (TOP) | I miscarried two times in 5 years and had to be hospitalized both times due to heavy bleeding. All this was very expensive treatment and the gharwalli (brothel-keeper) charged money for all this. | Karandikar, Gezinski & Kaloga (2016) |
| | Miscarriage/TOP | I have been hospitalized several times…for aborting two times and miscarrying three times. | Karandikar, Gezinski & Kaloga (2016) |
| | Forced TOP | I wasn't feeling well, so the madam took me to a doctor who said I was pregnant. When the madam found out I was pregnant she tried to force me to have an abortion. | Caretta (2015) |
| | Miscarriage/TOP | I was given medicines and even went to hospitals for miscarriages, but no one knew. | Karandikar, Gezinski & Kaloga (2016) |
| | Miscarriage/TOP | I had three abortions in the first five years, and all were in the night. They took me to a clinic and did the procedure. | Karandikar, Gezinski & Kaloga (2016) |
| | Miscarriage/TOP | I had forced unprotected sex and got pregnant three times and had two abortions at [a clinic]. Afterward, I was back out on the street again. | Lederer & Wetzel (2014) |
| | Miscarriage/TOP | I got pregnant six times and had six abortions during this time. Several of them were from a doctor who was a client—he did them 'back door'—I came in the back door after hours and paid him off the books. | Lederer & Wetzel (2014) |
| | TOP/late access to care | I went there {Planned Parenthood} to have an abortion…he told me to go get it…I took a pregnancy test. I missed my period for a few months. And I went and bought a test from the store and took it…He told me I should probably get an abortion. And we waited a few months…It was more or less getting together the money and just getting up the strength to go to it. Because I wouldn't do it before…No {he did not help pay} …I had sex with people | Ravi et al. (2017) |
| | TOP | I became pregnant [while in the house]. I had an abortion, but they guarded me while I was [at the clinic] and I couldn't talk to anyone | Zimmerman et al. (2003) |
| | TOP | Abortion was forbidden because of the faith. I was past my fifth month, when the abortion was done. I didn't know I was pregnant. The abortion was done illegally in terrible unsanitary conditions. The operation was very difficult, so I | Zimmerman et al. (2003) |

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| | | was nearly dead. There was no anaesthetic. The doctor said he would inject soap water into the uterus and the foetus would go out. Then I was sent to the toilet and was told to wait. I paid 2500 drachmas for the abortion. After the abortion I felt very bad, like I would die, and I was taken to the American hospital. | |
| | TOP/ contraception | …if I didn't make money, then, sometimes I would have to wait for my prescriptions for days before I could, yeah…. You can take it {emergency contraception} upto72hours. So…I would try and go right away. Sometimes, I would take it at the last minute. I've had so many abortions because it was too late to take it | Ravi et al. (2017) |
| | Contraception access | … {the trafficker} always supplied the condoms. He would get them from the clinics. He would get them from the clinics, packets of them. Women's lubricant, all types of stuff, he would give us the packets. But he would get them. We wouldn't be able to | Ravi et al. (2017) |
| | Contraception access | …The hotels have them sometimes. Sometimes they sell them. But yeah, they gave them to me for free because I made enough money. I paid them…I paid them when I make good money, so when I don't have money, I can get in and make money…So it's investing in yourself…It's business. | Ravi et al. (2017) |
| | Contraception | Well, I've always carried condoms with me. But there were men that didn't wanna use condoms. And if I refused, it was – my pimps were gonna find out. Because I would come back, lose a trick, lose a date, and lose money. And then my type of people would beat us. | Ravi et al. (2017) |
| | Contraception | 5 years back I found out that I am HIV positive. It is because of my work that I am positive. In the brothel there were no condoms. | Karandikar, Gezinski & Kaloga (2016) |
| | Contraception/physical abuse | I mean, it's–basically there is no negotiation. It's either happening, or I'm going to leave. Actually, one of the times that I got beat up was because I didn't want to use a condom…I refused to not use a condom. Yeah, and he wanted to not use one, so | Ravi et al. (2017) |

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| | Contraception/physical abuse | He beats me if I refuse to have sex with him. He hurts me during intercourse and insists on not using condoms. | Karandikar & Prospero (2010) |
| | Contraception (fail) | I was really nervous. Wow, my heart's racing. When condoms used to break…I would carry baby wipes and I would scoop as much as I can out. Even though didn't make a difference but I did. I would try to urinate it out. And wash up is pretty much it | Ravi et al. (2017) |
| | Contraception fail/ fear of human immunodeficiency virus (HIV) | Because my doctor wanted to know why I keep wanting an HIV test. I just took one. It'd be a month and I just went…I told her because my condom broke…I says I have more than one partner, and my condoms – it broke, so I got terrified, so I came back in. And she's like it's not even three months and you're coming back for another test; we can't keep giving you tests. So, I told her the truth, I'm at risk, I'm having sex every day with at least 20 different men, and sometimes the condom breaks. So, I get scared. She said… we can't find out if you have AIDS just from right now… you have to let some time go by…I didn't like that she said I had to wait…Why can't we know right now from her taking my blood right now. I told her to take blood from my arm… I thought that if you take blood from your arm, you can find out right away. | Ravi et al. (2017) |
| **Communication** | Understandable terminology | Put it in pieces for me so I understand (support worker broke down HCPs communication into understandable messages | Stanley et al. (2016) |
| | Interpreters | Maybe it would be better if the interpreter came in person (use of telephone interpreters) | Stanley et al. (2016) |
| | Listen to victims | The most important thing is to ask, and to give you time to explain how you are feeling instead of just assuming what is wrong, giving you the chance to explain, and listening to your opinion about why you feel like that | Stanley et al. (2016) |
| | Listen to victims | It's good to listen to children…check then what they say…. when I had the pain in my throat he (GP) didn't give me any medicine (reported not listened to or taken seriously by HCPs) | Stanley et al. (2016) |
| | Don't want to talk/relive experience | I want to forget what happened. I just want to move on. I just want to get my own flat and live and maybe get a job. | Stanley et al. (2016) |

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| | Don’t want to talk/relive experience | I’ve said me, everything I know, to police, to social worker, to social services, so…. I’ve gone through a lot of things, so I don’t think I can say anything more, much like that anymore. I need to forget…. I don’t want to remember them anymore | Stanley et al. (2016) |
| **Confidentiality/good support by HCPs** | Good confidentiality | It made me feel comfortable that everything is confidential–I wasn’t worried about everything being said, I was happy that if I’m gonna move from this area to another, it is OK for information to go to another doctor | Bick et al. (2017) |
| | Poor confidentiality | The doctors ... were discussing my case but did it in a room with other people and by the door that led onto the corridor, so if I could hear other people could hear. In the (first) hospital, when they came to talk to me they would close the door so nobody else could come in. Even the police when they came to see me were in plain clothes..... nobody could find out about my situation | Bick et al. (2017) |
| | Supportive HCPs | Because they were there with me when I needed them (emergency admission late in pregnancy found midwives very reassuring) | Stanley et al. (2016) |
| | Supportive HCPs | I had lots of doctors coming in and just to check; they were trying to discuss what to do and they were very good to me and I’m very grateful to everybody that helped | Bick et al. (2017) |
| | Supportive HCPs | They found all the nurses that worked in the hospital (who spoke the same language) and got one to come and talk to me to see how I was and to translate for me. They were really nice and friendly and they got me clothes, food and toiletries; one of the nurses even did my hair for me | Bick et al. (2017) |
| **Stigma** | Judgemental attitudes | “Why are you here?” And they then wrote in the paper that you were trafficked, you was a prostitute. They not nice to you....and they was treating me exactly like, er, a prostitute.’ | Bick et al. (2017) |
| | Judgemental attitudes | When I was sick the doctor came and gave medicine. He also did not look at me with respect. I hate this place. | Karandikar, Gezinski & Kaloga (2016) |
| | Judgemental attitudes | The hospitals are huge; I don’t know how to get there on my own. The doctors and nurses talk down on me because I am a sex worker. They know I am dirty and I have HIV. | Karandikar, Gezinski & Kaloga (2016) |

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| | Judgemental attitudes | I will never go alone to the clinic, I don't know how to read and write and they will not talk to me properly. | Karandikar, Gezinski & Kaloga (2016) |
| | Judgemental attitudes | I am afraid that the doctor will scold me for being sick and getting STDs. | Karandikar, Gezinski & Kaloga (2016) |
| | Judgemental attitudes (not HCP) | He married me and took me to his house. After a year of staying with his family, I started falling sick. I was detected HIV positive. His family refused to care for me. | Karandikar & Prospero (2010) |
| | Judgemental attitudes (not HCP) | All the time I'm thinking, and they say to you, "You worked in prostitution," and everywhere I go with Jenny, I'm all the time looking behind 'cause maybe somebody will say that "you're not allowed to do this because we can say that you worked in prostitution."… When I'm next to people who don't know it, then I can forget, but when you're with people you all the time hear, like someone hit you on the head: "You're a slut!"—It's not nice. I just want to say to them that I'm Natasha, an OK girl, mother of Leonid and Jenny. | Peled & Parker (2013) |
| | Judgemental attitudes (not HCP) | My husband doesn't let me out much. All year that I have been married, I have been at home because he doesn't trust me. My husband knows about the trafficking experience and that is partly why he is jealous. But even he, the most important things about trafficking, he doesn't know. He doesn't let me out because he thinks that I might be meeting another man. | Surtees 2017 |
| | Stigma | was really worried about how affected I am from abortion and how fertile I am … and then support worker told her that I was human trafficking victim and she somehow changed attitude. | Westwood et al. (2016) |
| | Well supported by HCPs | I had lots of doctors coming in and just to check; they were trying to discuss what to do and they were very good to me and I'm very grateful to everybody that helped | Bick et al. (2017) |
| | Well supported by HCPs | They found all the nurses that worked in the hospital (who spoke the same language) and got one to come and talk to me to see how I was and to translate for me. They were really nice and friendly and they got me clothes, food and toiletries; one of the nurses even did my hair for me | Bick et al. (2017) |

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| | Shame | … stepping outside the door with my pregnant belly was an exercise in shame, because I knew what my family thinks about it. I felt very dirty. It shouldn't have been like that, because being a survivor of human trafficking and pregnant as a result is nothing to be ashamed of. I was not dirty. Shame did not belong to me. But they did not understand me at all … One of the worst things was the loneliness. | Surtees (2017) |
| | Shame | … The attitude of the community may lead to some negative consequences, because everyone is whispering and saying: "What has she been doing? Why are you going to continue living with her?" and so on and it might lead to divorce. I don't know any case where the victim returned with a child and the child was accepted by the husband. | Surtees (2017) |
| | Shame | The [family] reaction is worst when they hear that she's pregnant or she's back with a child … We try by phone calls at the beginning to connect them with parents and other family members and I see that this issue they hesitate [to raise] at the beginning, they hesitate a lot. "What can I say if they hear that I am pregnant" or "If they hear I have a child they will reject me definitely." This is an issue that makes it more difficult to repair the relationship between parents and the woman. | Surtees (2017) |
| | Shame | These parents and their behaviours, they are influenced and affected by the whole community. This is connected with mentality. I have felt that this stigma, besides affecting the lives of the victims, very often affects the lives of the children of the victims of trafficking. | Surtees (2017) |
| | Shame/stigma | We have very serious prejudice about prostitution and people don't try to see if [women] were forced or not forced to do sex work … We even have a tradition, when a person working in prostitution has a gate to the house and it is painted black. It's a tradition of our society to ostracize [prostitutes]." | Surtees (2017) |
| | Shame | Generally, women did not want to have a child from trafficking since it is bad sign in a village when a woman has a child being unmarried. It's a shame and it means that she will never marry again and her child will stay without a father. It is a stigma. [We have] a saying: "A child born in flowers," which means born out of marriage. | Surtees (2017) |

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| | Shame | Now that she has a husband she can go to the community with her husband. The problem was going to the community with children without a husband … This is the mentality, that if you have children you should have a husband, at least in her village. | Surtees (2017) |
| | Shame/stigma | The most problematic are reactions of other village children, who may stigmatize the child born in flowers. Upon return, usually women with the child prefer to stay in the house, not going outside the house, exposing the child to the public, avoiding stigmatization and feelings of shame. | Surtees (2017) |
| | Shame/stigma | I'm really upset sometimes because I don't want to think at all … 'cause these are unpleasant and black thoughts. All the time I'm thinking, and they say to you, "You worked in prostitution," and everywhere I go with Jenny, I'm all the time looking behind 'cause maybe somebody will say that "you're not allowed to do this because we can say that you worked in prostitution." | Peled & Parker (2013) |
| **Continuity** | Scheduled appointments | They advised me to go to a children's and new mother's group, to get with other mothers, there are a lot of things I can do. They weighed him and checked his eyes and advised me about breastfeeding | Bick et al. (2017) |
| | Scheduled appointments | I've been worried about hepatitis, I say, like if my baby can [get] hepatitis from me. And they try to explain me many times, like after the delivery, they came and checked the baby. And after three or four injections she is 100% protected from hepatitis | Bick et al. (2017) |
| | Poor continuity of care | The one I know before (family doctor) that I was used to, maybe then next time I go again I sit there and I see another face and I have to get use to another face again. As soon as you meet a new doctor, they give you a new prescription. | Bick et al. (2017) |
| | Poor continuity due to dispersal | Because I just moved one month ago, and actually I need to go to my appointments for my liver and hepatitis to check everything. And to transfer me here (to another part of the country), it takes three to four months [to sort paperwork needed to register with a new family doctor] they say to me | Bick et al. (2017) |
| | Poor continuity | When the doctor there finished she told me everything is fine … "I will send the result to your GP." And it's more than 2 months. Nothing came from them | Westwood et al. (2016) |

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| | Poor continuity | It still hasn't been explained by the doctor what happened to me | Westwood et al. (2016) |
| | Continuity of HCP | 'Once a month she [health practitioner] sees me. She will sit for at least half an hour talking to me. She encourages me. | Westwood et al. (2016) |
| **Physical & Mental Health Problems** | Sexually transmitted infections (STIs) | I started getting STDs frequently and had to take medical help | Karandikar, Gezinski & Kaloga (2016) |
| | STIs | I got STD's and had to be treated. | Karandikar, Gezinski & Kaloga (2016) |
| | STIs | If I hadn't had my children when I was young, I wouldn't be able to have them because I have had so many STDs and gynaecological problems— including pelvic inflammatory disease, cervical infections, gonorrhoea, herpes, chlamydia—I can't have children now. | Lederer & Wetzel (2014) |
| | STI | One time I came in here…I had chlamydia again and…I didn't know I had it. And it was really bad…But I didn't know I had it out there. And thank God that I came here (jail). Because I would not have known I had it. | Ravi et al. (2017) |
| | STI | that's my first STD –I caught an STD from a pimp…that was his choice not to use a condom. He told me that I couldn't use a condom with him, but I had to use it with the johns. | Ravi et al. (2017) |
| | HIV/Tuberculosis (TB) | Five years back I was detected HIV positive, when I was very sick with TB. I know my life is short now. | Karandikar, Gezinski & Kaloga (2016) |
| | HIV/TB | I don't know if I'm HIV positive. I am afraid of the blood test so I have not done it. | Karandikar, Gezinski & Kaloga (2016) |
| | HIV/TB | When they did the blood test I was detected HIV positive. Now I live in fear that I will die soon. If I have any disease I will die | Karandikar, Gezinski & Kaloga (2016) |

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| | HIV/TB | After two years I got TB and that was the time I went to the doctor | Karandikar, Gezinski & Kaloga (2016) |
| | HIV/TB | 5 years back I found out that I am HIV positive. It is because of my work that I am positive. In the brothel there were no condoms. | Karandikar, Gezinski & Kaloga (2016) |
| | HIV/TB | I was detected HIV positive. | Karandikar & Prospero (2010) |
| | HIV/TB | He tells me to take clients without condoms because it will give him more money. He knows that I am HIV positive and it's dangerous, but who will explain this to him. | Karandikar & Prospero (2010) |
| | HIV | Without any mistake of mine, I got burned, and after that, I got HIV infection. I just have to wait for death to come. | Karandikar & Prospero (2010) |
| | Fear of HIV | would tell them that I had sex with somebody…that I believed that was HIV-positive…I would say…I need to be tested…I used to make up stories…I feel like I have lesions on my skin.…I made up stories to be tested | Ravi et al. (2017) |
| | Physical & mental health | I have so many scars all over my body and so many injuries and so many illnesses. I have hepatitis C and stomach and back pain and a lot of psychological issues. I tried to commit suicide several times. | Lederer & Wetzel (2014) |
| | Physical & mental health | I was always sick, from the moment I went out to work, and I always felt tired. I felt really bad inside. I could not feel good. I was stressed, tired | Zimmerman et al. (2003) |
| | Physical & mental health | I was frequently afraid of my pimp beating me up — as they all used to do — and sexually abusing me. I was in a continual state of anxiety and worry so that sometimes I couldn't sleep, also causing me headaches. | Zimmerman et al. (2003) |
| | Mental health | The mental health problems are the worst and most long lasting. I was diagnosed with chronic depression, have anxiety, post-traumatic stress syndrome, nightmares, flashbacks, disorientation. I've been suicidal at times. I don't think anyone is out on the street without having these long lasting effects | Lederer & Wetzel (2014) |

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| | Alcohol addiction/ mental health | Life is hard and there is no money. What can I do? When there is nothing else I drink to forget the pain. | Karandikar, Gezinski & Kaloga (2016) |
| | Alcohol addiction/ mental health | I want cry and shout and when I drink it all goes away. | Karandikar, Gezinski & Kaloga (2016) |
| | Alcohol addiction & HIV | I drink a lot. Every day in the morning and evening. I don't care about anything. The very little money that I get all goes in drinking but that is my life. I live on the street and sleep in the road…The doctor scolds me for drinking so much. Anyway I am [HIV] positive… You think I will live a long life? | Karandikar, Gezinski & Kaloga (2016) |
| | Alcohol addiction/ mental health | I listen to the [social] workers and they teach me how to stay healthy. But it's too late. One day I will die and it will be too soon. I am worried about my children. Who will look after them? How can they live without a mother? I drink a lot thinking about this. This is my tension and drinking makes me feel better. | Karandikar, Gezinski & Kaloga (2016) |
| | Alcohol addiction/ mental health | I also started drinking and stared taking drugs [hashish]. That made me feel better, and I think I can handle the pain and the hurt only because I have gotten addicted. | Karandikar & Prospero (2010) |
| | Alcohol/drugs/physical health | I am telling you that you have to not be in your sober mind to run these tricks—you just can't do it straight so everyone on the street is hooked on some drug. I've done drugs so long I have really hurt my body. I have kidney disease, liver problems, hepatitis C, high blood pressure, polymyositis [an inflammatory muscular disease], and fibroid tumours. | Lederer & Wetzel (2014) |
| | Forced alcohol/drugs | Yes, one to two bottles of 0.5 whiskey each night. It was a condition of our work. | Zimmerman et al. (2003) |
| | Forced alcohol/drugs | Every morning at 8 o'clock the employer gave us a spoonful of very bitter powder which we had to eat. During the first week, I could not eat any food because the bitter taste stayed with me. I asked them one day what it was. They shouted at me and said, "if you are lazy you have to take it!" I was forced to take it from the day I arrived. I often got very bad headaches, | Zimmerman et al. (2003) |

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| | | especially when I thought about my family. Sometimes I couldn't bear the pain. When I told them, they gave me a pack of "tunjai" | |
| | Physical abuse | Another girl…he beat her up really bad. She was pregnant and he beat her up really, really, really, really, really, really bad and he put her in to a full body cast. And she went into the hospital. But she didn't tell on him. She just told that a guy beat her up or whatever | Ravi et al. (2017) |
| | Physical mental & sexual abuse/ control of traffickers | Sergey took me to his apartment in Milan, were I met another Albanian woman, Jacklin…She told me she was working in the streets of Milan as a prostitute and that this would be my work also for the future. I tried to leave from that place once I understood his intention, but he mentally, physically and sexually abused me in order to force me. As a result of such behaviour I was hospitalised for about 3 months, with Jacklin staying with me all the time to guard me | Zimmerman et al. (2003) |
| | Physical abuse | I had a breakdown. I just wanted to hurt myself. I would cry a lot. I was scared and worried. I was bruised. The back of my neck was bleeding from being hit with the thick gold chain. They beat me and kicked me. They told me "Don't scream or we will kill you." They would. | Zimmerman et al. (2003) |
| | Physical/mental abuse | When we went back home, the madam hit me and locked me up in a dark room without food for five days. | Caretta (2015) |
| | Physical mental & sexual abuse | They beat me and kicked me. They told me, 'Don't scream or we will kill you.' I kept quiet. I was a virgin before they raped me. | Zimmerman et al. (2003) |
| | Physical abuse | I was beaten in the abdomen and head, but never in the face because they didn't want to ruin the merchandise. Sometimes I was kicked in the stomach and in the legs. | Zimmerman et al. (2003) |
| | Physical abuse | He was so angry because I did not give him money that he pushed me to the ground and kicked me on my stomach and back. He got a cycle chain and beat me with it. I started bleeding profusely and had to be rushed to the hospital. | Karandika and Prospero (2010) |
| | Physical abuse | He beats me on the stomach and the chest and is very demanding if I don't give him what he wants he hurts me till I start bleeding. He forces me to have | Karandika and Prospero (2010) |

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| | | anal sex and I cannot bear the pain. After his beating I have had to go and take help from doctors almost thrice so far. | |
| | Physical abuse | My admi beat me black and blue but I never reached the doctor | Karandikar, Gezinski & Kaloga (2016) |
| | Physical/sexual abuse | I do the same for work and for a living [sex] and after coming home to forced sex is unbearable. I can't tolerate it and I tell him to go away, but he does not listen. We always fight on this issue. He takes drugs and asks for sex and I hate that. He beats me because of this. | Karandika and Prospero (2010) |
| | Physical/sexual abuse | I used to have frequent arguments with him regarding his obsessive sexual demands. He would force me to have sex with him. He threatened to leave me many times and would beat me and kick me if I refused to have sex with him | Karandika and Prospero (2010) |
| | Physical/sexual abuse | He is obsessive about sex. He beats me if I refuse to have sex with him. He hurts me during intercourse and insists on not using condoms. | Karandika and Prospero (2010) |
| | Physical/sexual abuse | He follows me to the brothel when I take clients. He keeps track of my time and gets angry at me and beats me if I take slightly longer time with a particular client. He tells me to take clients without condoms because it will give him more money. | Karandika and Prospero (2010) |
| | Physical/sexual/mental abuse | I was delivered to one of the houses near the forest. The employer told me that here I will have to sell my body. I was very scared and started crying. They confined me in a room for one week. Every day they beat me and forced me to accept the job. The second week I could not bear the pain any more and I agreed to accept the client. Anyway, after eight days of torture, I thought I will accept the job to save my life. I hoped that I might be able to seek help from the client. But every time when I told my story and asked for help the clients told the employer and I was beaten harder and harder. So I accepted my fate. | Zimmerman et al. (2003) |

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| | Physical/sexual/mental abuse | I was not fed, was beaten and was locked in the bathroom till night…It lasted more than two weeks and when the ambulance driver came, he told the mistress that I lost consciousness due to starvation. | Zimmerman et al. (2003) |
| | Physical/sexual/mental abuse | I said, “no” [to prostitution] …For me, I never did anything like this. Sascha said, tomorrow you must go to work… That night he raped me and hit me in the head and kicked me in the leg. He raped and beat me so that I would understand that I am just the same as all the rest. No better. | Zimmerman et al. (2003) |
| | Physical abuse | Over the years I had pimps and customers who hit me, punched me, kicked me, beat me, slashed me with a razor. | Lederer & Wetzel (2014) |
| | Physical/sexual/mental abuse | I’ve been hit, punched, kicked, beaten, whipped with a belt, forced to have sex, threatened with a weapon, shot at, and had my head split open | Lederer & Wetzel (2014) |
| | Physical/sexual/mental abuse | They held me against my will, put a belt around my neck, and forced me to do all kinds of horrible things. When I said I didn’t want to they said they would kill my family | Lederer & Wetzel (2014) |
| | Fear/retribution | Fearing the trafficker come back to retaliate against me | Stöckl et al. (2017) |
| | Mental abuse/control | I had to do what he said. He forced me to have sex in the day time and did not give me any money that I earned. He had become my pimp. | Karandika and Prospero (2010) |
| | Mental health | God took away everything from me but he kept me in this world to suffer. I am very sad because I am still living. | Karandikar, Gezinski & Kaloga (2016) |
| | Mental health | I have tried to kill myself three times by cutting my nerves but never died. Even God does not want me. | Karandikar, Gezinski & Kaloga (2016) |
| | Mental health | Once that organization lady (social worker) took me to a doctor. She gave me some medicines and said I had a problem with my head (mental illness). I was mad! I don’t believe her… Everyone calls me mad and I know that I am not mad. | Karandikar, Gezinski & Kaloga (2016) |

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| | Mental health | The social workers took me to a doctor to check my head (psychiatrist). That doctor gave me medicines that drove me crazy. I could not sleep all night. I stopped taking the medicines and it made me feel worse. I threw away all the tablets. Before the medicines I used to have bad thoughts in my mind. Now it's even worse, but I will never go to that doctor again. | Karandikar, Gezinski & Kaloga (2016) |
| | Mental health / HIV | I could have died. I wonder if it would have been better if I had died rather than living because I look so ugly now. I hardly get any clients. Without any mistake of mine, I got burned, and after that, I got HIV infection. I just have to wait for death to come. | Karandikar & Prospero (2010) |
| | Mental health | "The mental health problems are the worst and most long lasting. I was diagnosed with chronic depression, have anxiety, post-traumatic stress syndrome, nightmares, flashbacks, disorientation. I've been suicidal at times. I don't think anyone is out on the street without having these long lasting effects | Lederer & Wetzel (2014) |
| | Mental health | If there was anything, I could do to just clear the memory, I would do it, just erase everything…all of it | Stanley et al. (2016) |
| | Mental health | I tried suicide…. some people can't open up and talk, and then I saw a doctor who is professional….you can talk and open up | Stanley et al. (2016) |
| | Mental health | I'm afraid to guess what would have happened to me if I hadn't come here. Because of my depression, I'm afraid that I could have killed myself | Surtees (2017) |
| | Mental health | After all what was happening to me, I was more than unhappy, I was desperate all the time. | Zimmerman et al. (2003) |
| | Poor living conditions | I also had to pay for utilities and for the mattress I was sleeping on. I was living in a house in Pineta Mare together with several girls. We didn't even have a bed, only mattresses. I worked from 1 pm to 8 am; | Caretta (2015) |
| | Locked in a room | When my first client came near me I was very afraid. I cried a lot but it didn't help. After that I realized I was trapped. I could not escape… I was not allowed to get out of the house… She locked me in a room and did not give enough food to eat. She did not allow me to talk to anyone and I was allowed to leave the room only if I had to go to the toilet. | Karandikar, Gezinski & Kaloga (2016) |

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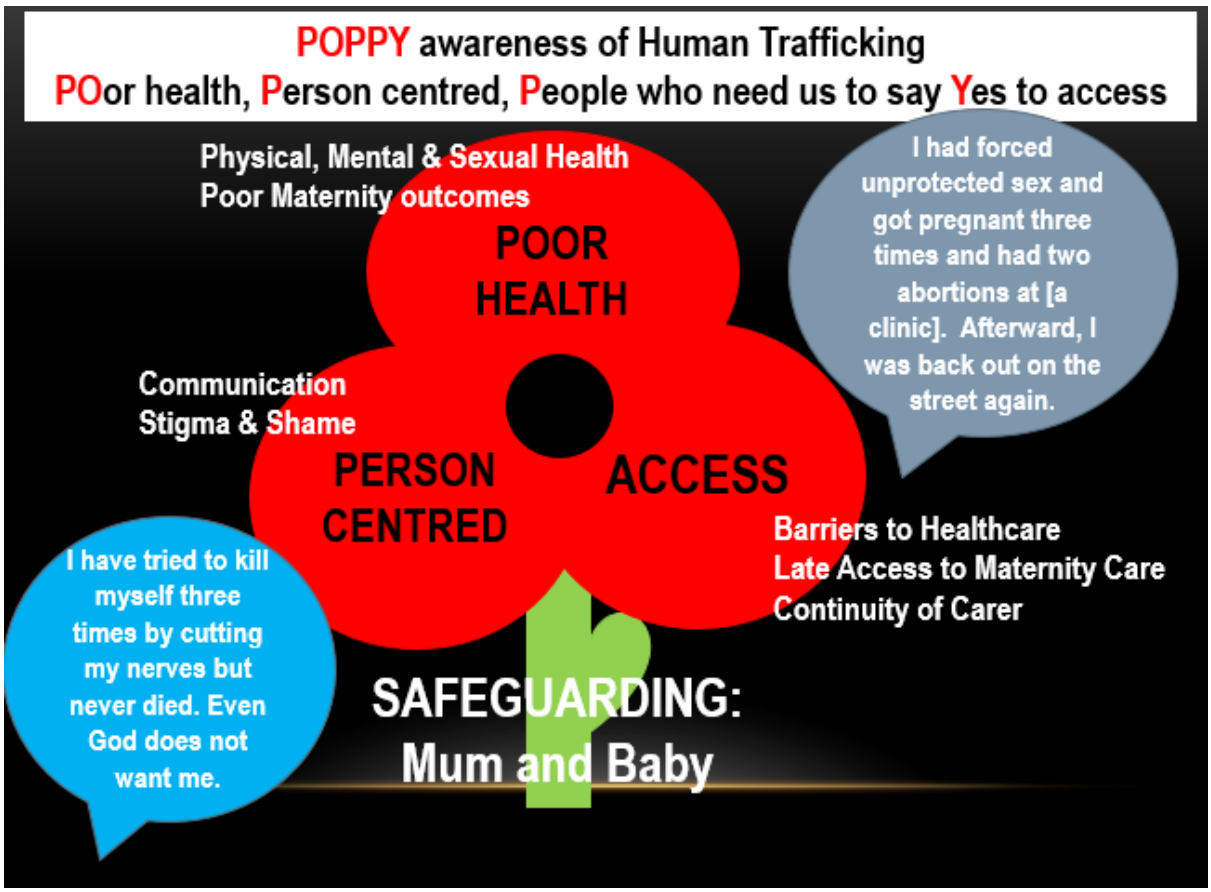
| | Locked in a room/physical abuse | I was locked up and could not come out. Some days I would not even see when it was night and when it was day. I was just given food in the day time and at night had to work. No money came in my hand and I had to talk to madam if I needed anything. They beat me up when I resisted. Did not give me food and water when I said no to taking clients. | Karandikar, Gezinski & Kaloga (2016) |
| **Care of baby** | Lack of support | I remained alone, like this, with a 2-day-old child on my hands —and I was in shock. I didn't know anything, there was no mother by my side who would help, explain to me how to change diapers, how to give him a bath, I'm only 22 year old, what could I know? I didn't know anything why he was crying, I didn't know what to do, didn't understand anything | Peled & Parker (2013) |
| | Lack of support/ Poor Health | [After I gave birth], the child was kept in an incubator because he was very weak. When I came home it was very difficult. My son was only 1200 grams [2.6 pounds]. He was supposed to be 2 kg [4.4 pounds] before coming home, but he was only 1.2 kg [2.6 pounds]. If he gets ill now, it is more complicated, because he is very weak. I must always have medicine for coughing and colds because, if he gets sick, he gets weaker. When I wash his clothes, I have to use fabric softener, because he gets a rash. I can't use soap if I wash him, he gets allergies | Surtees (2017) |

**Figure 2** POPPY Mnemonic



## Figure 3 Ethics Approval

Some materials have been removed from this thesis due to Third Party Copyright or confidentiality considerations. Pages where material has been removed are clearly marked in the electronic version. The unabridged version of the thesis can be viewed at the Lanchester Library, Coventry University