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Child Sex Trafficking and Commercial Sexual Exploitation: Health Care Needs of Victims

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abstract

Child sex trafficking and commercial sexual exploitation of children (CSEC) are major public health problems in the United States and throughout the world. Despite large numbers of American and foreign youth affected and a plethora of serious physical and mental health problems associated with CSEC, there is limited information available to pediatricians regarding the nature and scope of human trafficking and how pediatricians and other health care providers may help protect children. Knowledge of risk factors, recruitment practices, possible indicators of CSEC, and common medical and behavioral health problems experienced by victims will help pediatricians recognize potential victims and respond appropriately. As health care providers, educators, and leaders in child advocacy, pediatricians play an essential role in addressing the public health issues faced by child victims of CSEC. Their roles can include working to increase recognition of CSEC, providing direct care and anticipatory guidance related to CSEC, engaging in collaborative efforts with medical and nonmedical colleagues to provide for the complex needs of youth, and educating child-serving professionals and the public.

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INTRODUCTION

Human trafficking is a major global health and human rights problem, with reported victims in at least 152 countries.[1] The total number of victims is unknown, although estimates range into the millions.[2] Women and children predominate: in 1 global study, up to 49% of the victims were women and 33% were children.[3] Violence and psychological manipulation are common, and victims are at increased risk of injury, sexual assault, infectious diseases, substance misuse, untreated chronic medical conditions, malnutrition, post-traumatic stress disorder (PTSD), major depression and other mental health disorders, homicide, and suicide.[4–9] Given the large number of children and youth involved and the numerous adverse effects on the victim's physical and mental health, medical providers are in a unique position to help potential victims.[10]

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The United Nations' "Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Especially Women and Children," defines *severe trafficking in persons* as

> the recruitment, transportation, transfer, harboring, 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. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude, and the removal of organs.

When children/youth (<18 years) are involved, force, deception, or other means need not be present.[11] Commercial sexual exploitation of children (CSEC) is closely related to sex trafficking and involves "crimes of a sexual nature committed against juvenile victims for financial or other economic reasons.… These crimes include trafficking for sexual purposes, prostitution, sex tourism, mail-order-bride trade, early marriage, pornography, stripping, and performing in sexual venues such as peep shows or clubs."[12] Many also include "survival sex" in this definition (exchange of sexual activity for basic necessities such as shelter, food, or money), a practice commonly seen among homeless/runaway youth. When CSEC involves US citizens or legal residents victimized on US territory, this is termed *domestic minor sex trafficking*.[13] *Transnational trafficking* involves victims transported across national boundaries for the purposes of commercial exploitation; in 2012, the majority of transnational victims identified in the United States originated from Mexico, Thailand, the Philippines, Honduras, Indonesia, and Guatemala.[14]

Research on human trafficking is limited by the lack of a common database, challenges in victim identification, differences in definitions of terms, small sample sizes, and mixed populations (women and adolescents; victims of labor versus sex trafficking).[12,15,16] One of the main challenges to victim identification in many jurisdictions within the United States involves the misidentification of youth as criminals (eg, "prostitutes") rather than as victims of child abuse and exploitation. In their 2008 evaluation of English language research-based publications on human trafficking, Gozdziak and Bump reported that only 16% of 218 journal articles were based on peer-reviewed empirical research.[17] Only 8 of 218 articles were related to the medical field. Although research has continued and expanded in the ensuing years,[7] the many challenges described herein continue to limit empirically based, peer-reviewed, quantitative studies of commercially sexually exploited children and youth,[12] and research on male victims is especially sparse.[18]

RISK FACTORS FOR CSEC

Although results vary, studies generally indicate that age of entrance into sex trafficking and commercial exploitation is approximately 12 to 16 years.[13,19] By virtue of their young age, youth are vulnerable to manipulation and exploitation, because they have limited life experiences, an immature prefrontal cortex (with limited ability to control impulses, think critically about alternative actions, and analyze risks and benefits of situations), and limited options for action. They are learning about their own sexuality and adjusting to physical changes associated with puberty. However, some youth are at further risk because of individual, family, and community factors. Runaway and homeless youth, as well as thrownaway youth (those who are told to leave home or not allowed to return), are at especially high risk,[20,21] as are children with a history of sexual or physical abuse or neglect,[12] those from families with other dysfunction (eg, caregiver substance misuse, untreated psychiatric problems, intimate partner violence, criminality),[13] youth with a history of juvenile justice or child protective services (CPS) involvement,[22] and those who are lesbian/gay/bisexual/transgender or questioning.[12] Youth with substance use problems, behavioral and mental health problems, or learning disabilities may also be at increased risk,[13] as are girls associated with gangs[23] and children living in regions with high crime rates, adult prostitution, or poverty and areas with transient male populations (military bases, truck stops, convention centers).[13] Children and youth from countries with political or social upheaval or police/political corruption are at increased risk of trafficking.[3] Finally, societal attitudes of gender bias and discrimination, sexualization of girls, and glorification of the pimp culture add to youth vulnerability.[14]

The proportion of female to male victims is unknown, because reliable estimates of the prevalence of human trafficking are unavailable. Much more attention has been paid to female victims, and this may be related to a number of factors, including higher proportions of females being identified as victims in large-scale studies,[3,14] evidence to suggest that female victims are more likely than males to be controlled by pimps,[5] public discomfort with the idea of males having sex with men, public misperception that males cannot be objectified or coerced,[24] and a general lack of screening boys for possible CSEC activity.[18] It is likely that the number of male victims is grossly underestimated, because males may be less likely to be seen as victims by themselves[5] or others.

Male and female victims of trafficking and CSEC may be recruited by peers, relatives, or strangers who groom

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children and seduce them with promises of love, money, attention, acceptance, jobs, acting/modeling opportunities, drugs, or other desirables.[13,20] Recruitment may begin over the Internet using social media or may involve face-to-face encounters. The process may be abrupt or prolonged; it may be dominated by manipulation and deceit or by violence. Once recruited into trafficking and CSEC, many children experience repeated physical violence (eg, beating, choking, burning), sexual assault and gang rape, psychological abuse and manipulation, threats, and blackmail at the hands of the trafficker, facilitators in the trafficking trade, and buyers.[4,13,20] Traffickers use these strategies to establish and maintain total control over a victim. Alternating acts of violence and cruelty with acts of kindness and "love" helps to build strong bonds between trafficker and victim, making it very difficult for the victim to leave.[13] Indeed, the complex relationship between trafficking victim and exploiter has been compared with that between victim and perpetrator in some cases of intimate partner violence.[25]

As a result of the intense and prolonged psychological and physical trauma experienced by victims, many youth experience significant psychological adversity, including PTSD, major depression, suicidality, anxiety disorder, somatization, aggression, and oppositional behavior.[6,13,25–27]

VICTIM IDENTIFICATION AND EVALUATION

Medical providers may encounter CSEC victims in emergency departments, family planning clinics (including Title X clinics), public clinics or private offices, urgent care centers, or institutional settings.[6] Medical care may be sought for a variety of problems, including sexual assault, physical injury, infection, exacerbations of chronic conditions, complications of substance abuse/overdose issues, or pregnancy testing, contraceptive care, and other reproductive issues.[6] Pediatricians may provide care to a child whose parent is a CSEC/trafficking victim. Some victims have access to medical facilities for routine testing for sexually transmitted infections (STIs), contraceptive care, and general health care, but others have limited or no access, seeking care only when their conditions are severe.[4,5,28] However, identification of possible victims is difficult for pediatricians and other medical providers, because victims seldom self-identify,[13] and clinically validated screening tools for the health care setting are lacking.[12] Potential indicators of CSEC may be associated with the youth's presentation, historical factors, or physical findings. Some of the possible indicators are listed in Table 1.[10,12,13] When encountering such indicators or when there are other concerns of possible victimization, the pediatrician may ask more direct questions, such as

1. Has anyone ever asked you to have sex in exchange for something you wanted or needed (money, food, shelter, or other items)?
2. Has anyone ever asked you to have sex with another person?
3. Has anyone ever taken sexual pictures of you or posted such pictures on the Internet?

Obtaining a medical history from exploited youth may be challenging. The patient may be hostile and protective of the exploiter (who is regarded as a friend or paramour), fearful, ashamed, depressed, or intoxicated.[20,29–31] He or she may have been told to lie about his or her circumstances. It is helpful to build rapport with the patient before beginning the medical interview and to assure the youth that the questions asked are relevant to guiding the examination, determining health needs, and indicating appropriate referrals.[32] Limits of confidentiality should be reviewed, including a discussion of the pediatrician's role as a mandated reporter. The youth needs to be aware that he or she is not required to answer questions. This helps to give the patient a sense of control over the interview. The pediatrician needs to address safety issues during the evaluation, interviewing the youth outside the presence of those accompanying him or her and listening to patient concerns about dangers to self or family. Safety and security are emphasized in the World Health Organization's recommendations for interviewing trafficking victims.[33] Because discussion of the child's past may provoke stress and anxiety, it is important for the pediatrician to monitor signs of distress during the interview and minimize the risk of retraumatizing the child. Providing such trauma-informed care incorporates a pediatrician's understanding of how traumatic events can affect a child's development and an awareness of how to avoid causing additional trauma in the context of delivering care.

In addition to the typical elements of a medical history, information may be sought regarding whether the youth has a regular source of medical care or a medical home and his or her immunization status, reproductive history (STIs, pregnancy/abortions, anogenital trauma, number and gender of sexual partners, age at first intercourse, condom use, etc), history of inflicted injuries related to CSEC, physical abuse or dating violence, substance use, and history of mental health signs/symptoms.[10] Such information helps determine testing and referrals and opens the door for anticipatory guidance. Information regarding current housing and the youth's feelings of safety in that housing is also helpful. A mental health assessment may be especially important, because many victims of

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TABLE 1 Potential Indicators of Commercial Sexual Exploitation of Children[10,13,20,31,47]

Initial Presentation	Historical Factors	Physical Findings
Child accompanied by domineering adult who does not allow child to answer questions	Multiple sexually transmitted infections (STIs)	Evidence suggestive of inflicted injury
Child accompanied by unrelated adult	Previous pregnancy/abortion	Tattoos (sexually explicit, of man's name, gang affiliation)
Child accompanied by other children and only one adult	Frequent visits for emergency contraception	Child withdrawn, fearful
Child provides changing information regarding demographics	Chronic runaway behavior	Signs of substance misuse
Chief complaint is acute sexual assault or acute physical assault	Chronic truancy or problems in school	Expensive items, clothing, hotel keys
Chief complaint is suicide attempt	History of sexual abuse/physical abuse/neglect	Large amounts of cash
Child is poor historian or disoriented from sleep deprivation or drug intoxication	Involvement of child protective services (especially foster care/group home)	Poor dentition or obvious chronic lack of care
	Involvement with department of juvenile justice	
	Significantly older boyfriend	
	Frequent substance use/misuse	
	Lack of medical home and/or frequent emergency department visits	

CSEC experience PTSD, major depression, anxiety, and signs/symptoms of other emotional disorders. The provider may ask about past thoughts/actions related to self-harm, current suicidal ideation, and current symptoms, such as intrusive thoughts, nightmares, dissociation, and panic attacks. An emergency psychiatric evaluation may be indicated in some cases.

The medical examination and diagnostic evaluation focus on

1. Assessing and treating acute and chronic medical conditions;
2. Assessing dental health and care;
3. Referral to appropriate sexual assault response team, with forensic evidence collection, as indicated (pediatricians should work collaboratively with law enforcement investigators to refer the patient to the medical provider in the community that provides such services);
4. Documenting acute/remote injuries, genital and extragenital (cutaneous, oral, closed head, neck, thoracoabdominal injuries, and skeletal fractures);
5. Assessing overall health, nutritional status (including iron and other mineral or vitamin deficiencies), and hydration;
6. Assessing for mental health issues;
7. Testing for pregnancy, STIs, and HIV;
8. Urine and/or serum screening for alcohol and drug use, as clinically indicated;
9. Offering contraceptive options, with particular focus on long-acting reversible contraception; and
10. Offering prophylaxis for STIs and pregnancy

Pediatricians who do not routinely provide gynecologic services for adolescents are encouraged to familiarize themselves with the resources available in their communities, such as adolescent medicine specialists or gynecologists. It is important to obtain the patient's assent to the various processes associated with the examination and testing when at all possible and to respect his or her wish to decline the procedures if there would be no immediate danger to the patient's health or other compelling reason to proceed. The pediatrician should be aware of state laws regarding conducting medical evaluations (including sexual assault evidence kits) without guardian consent.[34,35] In many cases, the guardian does not accompany the victim, and laws regarding consent to examination, photography, testing, treatment, and obtaining forensic evidence are complex. Clarification and recommendations are available.[36–38] A staff chaperone should be present during the examination, and the patient may want the person accompanying them to be present as well. If that person is a suspected exploiter, his or her presence should be avoided if at all possible.[33] During the examination, it is helpful to carefully explain each step and monitor the patient for signs of distress.[32] Routine aspects of the examination may trigger traumatic memories; this often involves the anogenital examination or photography of injuries.

Documentation of acute and healed anogenital, oral, and cutaneous injuries is best accomplished with photography and detailed written description of the size, shape, color, location, and other notable characteristics of each mark.[39] Inflicted trauma may be suspected when injuries are noted in protected areas of the body (torso, genitals, neck, medial thighs),[40] when they have a patterned appearance, or when the explanation provided by the patient is incongruous with the

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injury.[39] Laboratory testing and diagnostic imaging for possible internal injury may be indicated.

The anogenital examination is best performed with the aid of a colposcope, digital camera, or camcorder. Complete visualization of the external genitalia and perianal area is necessary. For females, speculum examination may be indicated when pelvic inflammatory disease or internal injury is suspected and may also be helpful for evidence collection.[10] Although visible injury may be present, it is not unusual to have a normal or nonspecific anogenital examination.[41] Injuries that do occur typically heal quickly, within days to a few weeks, and scarring is very unusual.[42]

With the patient's assent, a sexual assault evidence kit may be obtained if the assault has occurred within the past 72 hours (up to 96 hours in some jurisdictions).[43] Pregnancy testing and baseline testing for STIs may be performed, including tests for *Neisseria gonorrheae*, *Chlamydia trachomatis*, *Trichomonas vaginalis*, syphilis, HIV, hepatitis B virus, and hepatitis C virus. Other testing may be considered (eg, hepatitis D, herpes simplex virus). The Centers for Disease Control and Prevention (CDC) has issued guidelines for testing/ treatment of STIs in cases of acute sexual assault.[44] Because follow-up of patients is not guaranteed, the pediatrician should consider offering the patient prophylaxis for *N gonorrhea*, *C trachomatis*, and *T vaginalis* infections (assuming a negative pregnancy test), as well as hepatitis B vaccination or hepatitis B immune globulin if the child has not been vaccinated previously. For females, emergency contraception may be offered as appropriate. In addition, human papillomavirus vaccination may be offered to the patient. Postexposure prophylaxis for HIV is also a consideration, and the pediatrician may want to consult with an infectious disease specialist or refer to the CDC guidelines.[44] Tetanus boosters may be considered if patients have open wounds without confirmation of up-to-date tetanus immunizations.

REFERRALS, RESOURCES, AND MULTIDISCIPLINARY INTERVENTION

- Pediatricians must comply with existing child abuse mandatory reporting laws. However, in some states, CSEC is not considered a form of child maltreatment when the alleged perpetrator is not a family member or caregiver, and these laws do not apply. The American Academy of Pediatrics supports chapter advocacy efforts to classify CSEC as a form of child maltreatment.
- In responding to cases of suspected CSEC/sex trafficking, a pediatrician should take all appropriate and/or mandated actions in such a way as to ensure no further harm to the child.
- Pediatricians need to consult relevant law and health administrators to determine whether to contact law enforcement, CPS, or other agencies in any given case.
- For assistance in determining how to proceed with a suspected CSEC/ sex trafficking case and to obtain information on relevant laws and reporting recommendations, pediatricians can contact
  - National trafficking organizations, such as the National Human Trafficking Resource Center Hotline (1-888-3737-888); Polaris Project (www.polarisproject.org) (sponsors the hotline above); Shared Hope International (sharedhope.org); or National Center for Missing and Exploited Children (www.missingkids.com);
  - Staff from state law enforcement task forces on CSEC and child trafficking;
  - State or local law enforcement and CPS agencies (the pediatrician may call and ask to discuss a "hypothetical case" with an investigator); or
  - Local child advocacy centers. These organizations may also offer medical, forensic interview, and behavioral health services.

Although laws and policies must be followed, providers should be aware of the potential issues related to reporting to authorities so that they can help minimize potential harm to the child. Depending on the services available to victims as well as the degree of understanding by CPS workers regarding the unique issues facing victims (which generally extend beyond those related to the home environment and caregiver behavior), making a report may not lead to positive intervention for the child, and the response to the report may be "uncertain and potentially ineffective or even harmful."[12]
In addition, although federal antitrafficking laws clearly indicate that a child cannot "consent" to engage in commercial sex acts and must be considered a victim,[45] many states view CSEC in terms of prostitution laws and treat minors engaging in these acts as criminals rather than as victims. Involvement in the juvenile justice system as an offender vastly decreases the likelihood that the child victim will receive critical services and protection and may lead to further trauma, including reentry into trafficking and involvement in other high-risk behaviors. A cogent discussion of the ethical issues related to CSEC reporting may be found in a report from the Institute of Medicine,[12] and information regarding individual state laws regarding child trafficking and commercial sexual exploitation may prove helpful to pediatricians.[46]

To help minimize potential harm associated with reporting CSEC/sex trafficking, it is important for pediatricians to emphasize to authorities that the child is a victim of

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exploitation who is in need of services rather than a juvenile offender in need of punishment. Describing a child's limited ability to understand sophisticated psychological manipulation practiced by traffickers and the lack of brain maturation, which limits their ability to weigh risks and benefits of various behaviors, may help investigators understand the child's victim status. Similarly, the pediatrician may stress the particular vulnerabilities identified in the youth which have made him or her susceptible to exploitation.

In addition to reports to law enforcement and/or CPS, pediatricians need to consider patient referrals for medical care, including gynecologic care, family planning, obstetrical care (for pregnant patients), human papillomavirus vaccination, drug rehabilitation, and HIV prophylaxis monitoring. Referrals to professionals competent in CSEC issues for mental health assessment and therapy are extremely beneficial to most CSEC youth. As noted earlier, local child advocacy centers may provide many helpful services, including forensic interviews, behavioral health treatment, and in some cases, second-opinion anogenital examinations.

To provide for the many needs of the CSEC victim requires pediatricians to work with law enforcement, social services, behavioral health professionals, and service organizations. Victims have immediate nonmedical needs (shelter, food, clothing, and emotional support) and long-term needs (housing, education, life skills and job training, victim advocacy, family services). Transnational victims often need interpreter services and legal assistance with immigration issues. To identify local, state, and federal resources, pediatricians can request assistance from the National Human Trafficking Resource Center Hotline (1-888-3737-888), which offers information in 170 languages and operates 24 hours per day. Additional interpreter, legal, and victim service assistance for transnational victims may be obtained from US Immigration and Customs Enforcement (1-866-872-4973). It is helpful for pediatricians to be aware of homeless and runaway shelters in their communities and of policies that may or may not allow organizations to provide shelter and support for a period of time before disclosing the youth's whereabouts to family or authorities. Information and resources for homeless and runaway youth are available at the National Network for Youth (http://www.nn4youth.org; 1-202-783-7949).

Pediatricians may also provide links to valuable resources for families of victims. Information regarding CSEC and human trafficking is available for laypeople on the national antitrafficking organization Web sites mentioned earlier, and local child advocacy centers may also provide resources to parents and caregivers.

A victim of CSEC faces numerous challenges to exiting a life of exploitation, including emotional bonds with the exploiter, fear of retribution, reluctance to return to a dysfunctional home, ostracism by family or community, and other difficulties. It is not unusual for victims to return to the life of trafficking and exploitation, sometimes several times, before finally extricating themselves.[19]

CONCLUSIONS AND GUIDANCE FOR PEDIATRICIANS

1. Male and female victims of sex trafficking and CSEC may present for medical care for a variety of reasons related to trauma, infection, reproductive issues, and mental health problems. They require a comprehensive evaluation and, often, numerous referrals. The pediatrician has the opportunity to work collaboratively as part of a team of professionals from a number of disciplines to address these needs.
2. Victims of CSEC rarely self-identify. Although some victims have no risk factors or obvious indicators, youth at risk for CSEC may have a history of running away from home, truancy, child maltreatment, involvement with CPS or the juvenile justice system, multiple STIs, pregnancy, or substance use or abuse.
3. Evaluations of CSEC victims may be challenging. A comprehensive history related to injuries/abuse, reproductive issues, substance use, and mental health symptomatology obtained with a nonjudgmental, open attitude may provide important revelations. However, this cannot be performed without attention to the youth's safety and potential distress during the interview.
4. Medical evaluation of a CSEC victim involves addressing acute medical/surgical issues, evaluating possible chronic untreated conditions, documenting acute/remote injuries, testing and treating STIs, and often, obtaining a sexual assault evidence kit.
5. Providers may advocate for victims by educating child-serving professionals and families regarding CSEC and child trafficking and giving anticipatory guidance to parents and children regarding Internet safety as well as common recruitment scenarios. They may also advocate to change state laws so that minors involved in commercial sexual exploitation are treated as victims rather than as juvenile offenders.
6. Pediatricians are mandated reporters of suspected child abuse and neglect. In states where CSEC/sex trafficking is considered a form of abuse, the pediatrician must make a formal report of suspected exploitation to law enforcement and to CPS as well, if indicated.

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RESOURCES

- National Human Trafficking Resource Center Hotline (1-888-3737-888);
- US Immigration and Customs Enforcement (1-866-872-4973);
- American Professional Society on the Abuse of Children. The Commercial Sexual Exploitation of Children: The Medical Provider's Role in Identification, Assessment and Treatment. Elmhurst, IL: American Professional Society on the Abuse of Children; 2013;
- Polaris Project: A national resource for human trafficking: http://www.polarisproject.org/what-we-do/global-programs.

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REFERENCES

1. United Nations Office on Drugs and Crime. Global report on trafficking in persons. Vienna, Austria: UNODC; 2014. Available at: https://www.unodc.org/unodc/data-and-analysis/glotip.html. Accessed November 30, 2014
2. United States Department of State. Trafficking in persons report. Washington, DC: US Department of State; 2014. Available at: http://www.state.gov/j/tip/rls/tiprpt/2014/?utm_source=NEW+RESOURCE:+Trafficking+in+Persons+R. Accessed July 18, 2014
3. United Nations Office on Drugs and Crime. Global report on trafficking in persons 2012. Vienna, Austria: UNODC; 2012. Available at: www.unodc.org/documents/data-and-analysis/glotip/Trafficking_in_Persons_2012_web.pdf. Accessed July 7, 2013
4. Raymond J, Hughes D. Sex trafficking of women in the United States: International and domestic trends. New York, NY: Coalition Against Trafficking in Women; 2001. Available at: www.uri.edu/artsci/wms/hughes/sex_traff_us.pdf. Accessed August 4, 2012
5. Curtis R, Terry K, Dank M, Dombrowski K, Khan B. The commercial sexual exploitation of children in New York City: Volume 1: The CSEC population in New York City: Size, characteristics and needs. Washington, DC, National Institute of Justice, US Department of Justice; 2008. Available at: www.ncjrs.gov/pdffiles1/nij/grants/225083.pdf. Accessed July 7, 2013
6. Lederer L, Wetzel C. The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities. *Ann Health Law*. 2014;23(1):61–91
7. Oram S, Stöckl H, Busza J, Howard LM, Zimmerman C. Prevalence and risk of violence and the physical, mental, and sexual health problems associated with human trafficking: systematic review. *PLoS Med*. 2012;9(5):e1001224
8. Macias Konstantopoulos W, Ahn R, Alpert EJ, et al. An international comparative public health analysis of sex trafficking of women and girls in eight cities: achieving a more effective health sector response. *J Urban Health*. 2013;90(6):1194–1204
9. Abas M, Ostrovschi NV, Prince M, Gorceag VI, Trigub C, Oram S. Risk factors for mental disorders in women survivors of human trafficking: a historical cohort study. *BMC Psychiatry*. 2013;13:204–214
10. American Professional Society on the Abuse of Children. The commercial sexual exploitation of children: The medical provider's role in identification, assessment and treatment: APSAC practice guidelines. Chicago, IL: APSAC; 2013. Available at: www.kyaap.org/wp-content/uploads/APSAC_Guidelines.pdf. Accessed July 7, 2013
11. United Nations Human Rights. Protocol to prevent, suppress and punish trafficking in persons especially women and children, supplementing the United Nations convention against transnational organized crime. Geneva, Switzerland: Human Rights Council; 2000. Available at: www.ohchr.org/EN/ProfessionalInterest/Pages/ProtocolTraffickingInPersons.aspx. Accessed July 7, 2013
12. Institute of Medicine and National Research Council. *Confronting commercial sexual exploitation and sex trafficking of minors in the United States*. Washington, DC: The National Academies Press; 2013
13. Smith L, Vardaman S, Snow M. The national report on domestic minor sex trafficking: America's prostituted children. Vancouver, WA: Shared Hope International (SHI); 2009. Available at: http://sharedhope.org/wp-content/uploads/2012/09/SHI_National_Report_on_DMST_2009.pdf. Accessed July 7, 2013
14. United States Department of State. Trafficking in persons report 2013. Washington, DC: US Department of State; 2013. Available at: www.state.gov/j/tip/rls/tiprpt/2013/. Accessed July 1, 2013
15. Todres J. Moving upstream: The merits of a public health law approach to human trafficking. *North Carol Law Rev*. 2011;89(2):447–506
16. Stansky M, Finkelhor D. How many juveniles are involved in prostitution in the U.S.? Durham, NH: Crimes Against Children Research Center; 2008. Available at: www.unh.edu/ccrc/prostitution/Juvenile_Prostitution_factsheet.pdf. Accessed July 7, 2013
17. Gozdziak E, Bump M. Data and research on human trafficking: Bibliography of research-based literature. Washington, DC: Institute for the Study of International Migration; 2008. Available at: http://www.ncjrs.gov/pdffiles1/nij/grants/224392.pdf. Accessed July 7, 2013
18. ECPAT USA. And boys too: An ECPAT-USA discussion paper about the lack of recognition of the commercial sexual exploitation of boys in the United States. Brooklyn, NY: ECPAT-USA; 2013. Available at: https://d1qkyo3pi1c9bx.cloudfront.net/00028B1B-B0DB-4FCD-A991-219527535DAB/1b1293ef-1524-4f2c-b148-

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91db11379d11.pdf. Accessed November 10, 2013

19. Gragg F, Petta I, Bernstein H, et al. *New York prevalence study of commercially sexually exploited children: Final report*. Rensselaer, NY: New York State Office of Children and Family Services; 2007. Available at: www.ocfs.state.ny.us/main/reports/csec-2007.pdf. Accessed July 7, 2013

20. Estes RJ, Weiner NA. The commercial sexual exploitation of children in the U.S., Canada and Mexico. Philadelphia, PA; Center for the Study of Youth Policy, University of Pennsylvania; 2001

21. Bigelsen J. Homelessness, survival sex and human trafficking: As experienced by the youth of Covenant House New York. New York, NY: Covenant House New York; 2013. Available at: www.covenanthouse.org/sites/default/files/attachments/Covenant-House-trafficking-study.pdf. Accessed November 30, 2014

22. Finklea K, Fernandes-Alcantara A, Siskin A. Sex trafficking of children in the United States: Overview and issues for Congress. Washington, DC: Congressional Research Service; 2011. Available at: www.fas.org/sgp/crs/misc/R41878.pdf. Accessed July 7, 2013

23. Shared Hope International. *Intervene: Identifying and responding to America's prostituted youth. Resource package*. Vancouver, WA: Shared Hope International; 2013

24. Dennis J. Women are victims, men make choices: The invisibility of men and boys in the global sex trade. *Gend Issues*. 2008;25(1):11–25

25. Williamson E, Dutch N, Clawson H. *Medical treatment of victims of sexual assault and domestic violence and its applicability to victims of human trafficking. Prepared for Office of the Assistant Secretary for Planning and Evaluation*. Washington, DC: US Department of Health and Human Services, ASPE; 2010. Available at: http://aspe.hhs.gov/hsp/07/HumanTrafficking/SA-DV/index.shtml. Accessed July 7, 2013

26. Zimmerman C. *Stolen smiles: A summary report on the physical and psychological consequences of women and adolescents trafficked in Europe*. London, UK: London School of Hygiene and Tropical Medicine; 2006. Available at: www.humantrafficking.org/uploads/publications/Stolen_Smiles_July_2006.pdf. Accessed July 7, 2013

27. Choi H, Klein C, Shin MS, Lee HJ. Posttraumatic stress disorder (PTSD) and disorders of extreme stress (DESNOS) symptoms following prostitution and childhood abuse. *Violence Against Women*. 2009;15(8):933–951

28. Muftic LR, Finn MA. Health outcomes among women trafficked for sex in the United States: a closer look. *J Interpers Violence*. 2013;28(9):1859–1885

29. Baldwin S, Eisenman D, Sayles J, Ryan G, Chuang K. Identification of human trafficking victims in health care settings. 2011. Available at: www.hhrjournal.org/2013/08/20/identification-of-human-trafficking-victims-in-health-care-setting/. Accessed September 21, 2013

30. Zimmerman C, Yun K, Shvab I, Watts C, Trappolin L. Treppete Mea. The health risks and consequences of trafficking in women and adolescents: Findings from a European study. London, UK: London School of Hygiene and Tropical Medicine; 2003. Available at: www.lshtm.ac.uk/php/ghd/docs/traffickingfinal.pdf. Accessed July 7, 2013

31. Clawson HJ, Dutch N, Solomon A, Grace LG. Human trafficking into and within the Unites States: A review of the literature. Washington, DC: US Department of Health and Human Services; 2009. Available at: http://aspe.hhs.gov/hsp/07/HumanTrafficking/LitRev/index.shtml. Accessed June 12, 2012

32. Kellogg ND. Medical care of the children of the night. In: Cooper SW, Estes R, Giardino AP, Kellogg ND, Vieth VI, eds. Medical, Legal and Social Science Aspects of Child Sexual Exploitation: A Comprehensive Review of Child Pornography, Child Prostitution and Internet Crimes Against Children. St. Louis, MO: GW Medical; 2005:349–368

33. Zimmerman C, Watts C. *World Health Organization ethical and safety recommendations for interviewing trafficked women*. Geneva, Switzerland: World Health Organization; 2003. Available at: http://whqlibdoc.who.int/publications/2003/9241546255.pdf?ua=1. Accessed July 7, 2013

34. Guttmacher Institute State Policies In Brief. An overview of minors' consent law. New York, NY: Guttmacher Institute; 2012. Available at: http://www.guttmacher.org/statecenter/spibs/spib_OMCL.pdf. Accessed July 7, 2013

35. Lukefahr J, Narang S, Kellogg N. *Medical Liability and Child Abuse. Medicolegal Issues in Pediatrics*, 7th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2012:255

36. Committee on Bioethics. Informed consent, parental permission, and assent in pediatric practice. Committee on Bioethics, American Academy of Pediatrics. *Pediatrics*. 1995;95(2):314–317

37. Committee on Pediatric Emergency Medicine and Committee on Bioethics. Consent for emergency medical services for children and adolescents. *Pediatrics*. 2011;128(2):427–433

38. McAbee GN; Committee on Medical Liability and Risk Management American Academy of Pediatrics. Consent by proxy for nonurgent pediatric care. *Pediatrics*. 2010;126(5):1022–1031

39. Kellogg ND; Committee on Child Abuse and Neglect American Academy of Pediatrics. Evaluation of suspected child physical abuse [Clinical Report]. *Pediatrics*. 2007;119(6):1232–1241

40. Labbé J, Caouette G. Recent skin injuries in normal children. *Pediatrics*. 2001;108(2):271–276

41. Drocton P, Sachs C, Chu L, Wheeler M. Validation set correlates of anogenital injury after sexual assault. *Acad Emerg Med*. 2008;15(3):231–238

42. McCann J, Miyamoto S. boyle C, Rogers K. Healing of hymenal injuries in prepubertal and adolescent girls: A descriptive study. *Pediatrics*. 2007;119(5). Available at: www.pediatrics.org/cgi/content/full/119/5/e1094

43. Jenny C, Crawford-Jakubiak JE; Committee on Child Abuse and Neglect; American Academy of Pediatrics. The evaluation of children in the primary care setting when sexual abuse is suspected. *Pediatrics*. 2013;132(2). Available at: www.pediatrics.org/cgi/content/full/132/2/e558

44. Workowski KA, Berman S; Centers for Disease Control and Prevention (CDC). Sexually transmitted diseases treatment

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guidelines, 2010. *MMWR Recomm Rep*. 2010;59(RR-12):1–110

45. United States Government. Trafficking Victims Protection Act of 2000. P-L. 106-386 Division A 103(8)2000. Available at: http://www.state.gov/j/tip/laws/61124.htm. Accessed July 7, 2013

46. Shared Hope International. Protected innocence challenge: State report cards on the legal framework of protection for the nation's children. Vancouver, WA: Shared Hope International (SHI); 2013. Available at: http://sharedhope.org/wp-content/uploads/2014/02/2013-Protected-Innocence-Challenge-Report.pdf. Accessed November 10, 2013

47. Greene JM, Ennett ST, Ringwalt CL. Prevalence and correlates of survival sex among runaway and homeless youth. *Am J Public Health*. 1999;89(9):1406–1409

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