POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics
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Global Human Trafficking and Child Victimization

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abstract

Trafficking of children for labor and sexual exploitation violates basic human rights and constitutes a major global public health problem. Pediatricians and other health care professionals may encounter victims who present with infections, injuries, posttraumatic stress disorder, suicidality, or a variety of other physical or behavioral health conditions. Preventing child trafficking, recognizing victimization, and intervening appropriately require a public health approach that incorporates rigorous research on the risk factors, health impact, and effective treatment options for child exploitation as well as implementation and evaluation of primary prevention programs. Health care professionals need training to recognize possible signs of exploitation and to intervene appropriately. They need to adopt a multidisciplinary, outward-focused approach to service provision, working with nonmedical professionals in the community to assist victims. Pediatricians also need to advocate for legislation and policies that promote child rights and victim services as well as those that address the social determinants of health, which influence the vulnerability to human trafficking. This policy statement outlines major issues regarding public policy, medical education, research, and collaboration in the area of child labor and sex trafficking and provides recommendations for future work.

A critical role of the pediatric health care professional is to advocate for the health and well-being of children and adolescents. Central to this role is the conviction that health and well-being depend on a guarantee of fundamental human rights. Victims* of trafficking routinely are deprived of

*"Victim" is used here in its objective, legal sense as indicating a person who has been harmed as a result of some event or action or who has suffered because of someone else's actions. It does not refer to how the person may feel or perceive himself or herself as a result of the event(s) and is not intended to be used to label that person.[91]

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TABLE 1 Child Rights Violated by Human Trafficking (From the United Nations Convention on the Rights of the Child)

Right to…
Privacy, liberty, and protection from violence, abuse, and exploitation
Appropriate medical care and adequate nutrition
Education
Living conditions adequate for physical, mental, spiritual, and moral development
Protection from economic exploitation and hazardous or inappropriate work
Protection from torture and cruel or inhuman treatment

Source: United Nations; Human Rights, Office of the High Commissioner for Human Rights. Convention on the rights of the child. 1990. Available at: www.ohchr.org/en/professionalinterest/pages/crc.aspx. Accessed October 27, 2017.

such rights, including several outlined in the United Nations Convention on the Rights of the Child[1] (see Table 1).

According to US federal law, child sex trafficking involves engaging a person younger than 18 years in a commercial sex act (sexual activity for which there is an exchange of something of value).[2,3] This may include exploitation of a child for prostitution (as a seller or a buyer), sexual exploitation in the context of travel and tourism, the mail-order bride trade and early forced marriage, production of child sexual exploitation material (pornography), live online sexual abuse, and performing in sexual venues.[4] US law also recognizes labor trafficking, defined as "the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery."[2] Other types of child trafficking include forced begging or engaging in criminal acts, forced participation in armed conflict, illegal adoption, or forced organ removal for donation. Globally, human trafficking is defined in the Palermo Protocol,[5] although interpretation of the definition varies among countries. Although cultural norms regarding child labor vary, 3 international conventions outline the legal conditions of child labor (United Nations Convention on the Rights of the Child, International Labour Organization Convention No. 182 on the Worst Forms of Child Labor,[6] and International Labor Organization Convention 138 on the Minimum Age for Admission to Employment[7]). Additional discussion of child labor, hazardous work by children, and the worst forms of child labor is available elsewhere.[8]

Child labor trafficking in the United States may occur in a wide variety of industries, especially in informal sectors. Some of the more common labor sectors in which youth are exploited include domestic servitude, construction, janitorial or cleaning services, door-to-door magazine sales,[9] agriculture, health and beauty services, begging or peddling, and hotel and restaurant businesses.[10–12] Outside the United States, forced labor involves children working in various hazardous settings, including brick kilns,[12] construction,[13] mines and quarries,[14] fisheries,[15] and farms.[16] Children and adolescents may serve as soldiers in armed conflict[12,17] or as forced participants in drug trafficking.[12]

Reliable estimates of the incidence and prevalence of child trafficking are not available. Efforts to estimate these statistics are thwarted by the criminal nature of the activity, lack of uniform definitions among those collecting data, the lack of a centralized database, and underrecognition of victims (especially for victims of labor trafficking)[4,18] However, in a study by the United Nations Office of Drugs and Crime,[19] it was determined that 33% of the 40 000 identified trafficking victims were children, and minors were subjected to exploitation in all areas of the world. The International Labour Organization estimates that children constitute 26% (5.5 million) of the 21 million victims of forced labor globally.[20] Accurate statistics on prevalence of child trafficking are similarly lacking in the United States, but researchers conducting studies of runaway and homeless youth have suggested that 9% to 28% of such youth report survival sex (sexual activity exchanged for items needed to survive).[21–25] In a study in San Diego County, it was estimated that 31% of unauthorized migrant Spanish-speaking laborers older than 16 years in that region were victims of labor trafficking.[11] Given that the National Human Trafficking Resource Center received information on only 1621 cases of child trafficking in 2015, it is highly likely that the known cases represent only a small fraction of the total.[26]

Although the United States is a "destination" country for trafficked persons from anywhere in the world, it was indicated in statistics from 2014 that the leading "origin" countries for federally identified victims (all ages, all types of trafficking) were the United States itself as well as Mexico and the Philippines.[27] In data on trafficked persons identified between January 2008 and June 2010 in cities with federally funded human trafficking taskforces, it was indicated that 94% of sex trafficking victims were female, and 55% were younger than 18 years. Nearly 85% were US citizens or permanent legal residents. Persons trafficked for labor tended to be female (68%), adults (90%), and foreign nationals (98%).[28] Of note, researchers in other studies have shown a predominance of boys in labor trafficking, suggesting that there may be regional differences among trafficking victims or a failure to recognize male victims in the United States.[29,30]

Factors at the individual, family, community, and societal levels

TABLE 2 Factors Contributing to Vulnerability to Child Trafficking

Individual	Family	Community	Societal
LGBTQ[37]	Poverty	Tolerance of sexual or labor exploitation	Gender-based violence and discrimination
Abuse or neglect	Unemployment	Natural disaster or community upheaval	Cultural beliefs or stigma
Sexual exploitation	Intrafamilial violence	Demand for cheap labor	Weak recognition of child rights
Substance misuse	Forced migration	Community violence	Political or social upheaval
Homeless, runaway, or thrown out of home	—	Lack of community resources/ support	—
Untreated mental health problems	—	Lack of awareness of trafficking practices	—
Behavioral problems	—	—	—
Involvement with legal system	—	—	—
Involvement with child protective services system	—	—	—
Lack of documentation (immigration, birth certificate, etc)	—	—	—
Unaccompanied status, including immigrant and refugee children	—	—	—

The following references were used as sources of information for this table: 4,12,13,17,23,27,31–34,38–40. —, not applicable.

contribute to human trafficking vulnerability in the United States and around the globe (Table 2). Children and youth who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ); those who are American Indian girls; and boys and girls with a history of abuse or neglect, substance misuse, or homelessness may constitute a significant proportion of trafficked youth.[23,31–34] Statistics reveal high rates of child protective service involvement among sex-trafficked young people: 78% of 1 group in California reported a history with child protective services, and 53% of another group reported residing in 1 or more foster care group homes.[35] Families experiencing financial crises, unemployment, or intrafamilial violence are particularly vulnerable to human trafficking.[12,13,17,36]

Community or governmental tolerance of labor or sexual exploitation, demand for cheap labor, or the occurrence of a natural disaster or major social upheaval may render children at risk.[12,36] Massive population migrations often involve large numbers of unaccompanied minors.[17,41] Unaccompanied children are at significant risk for labor and sex trafficking,[42] given their young age, lack of adult supervision, lack of knowledge of the host language and culture, and precarious legal status.[11] These children are particularly vulnerable if they lack the necessary authorization or documents required under immigration regulations and have been smuggled across an international border; traffickers may subsequently lure them into situations of severe exploitation or circumstances of debt, bondage, or other abuses and maintain control over them through violence, threats, or economic or psychological manipulation. Unaccompanied children are likely to be reluctant to report abuses to authorities because of concerns of corruption among officials (law enforcement, immigration, consular), highly stressful conditions in Customs and Border Protection processing centers,[43] and the child's fear of arrest and/or deportation. Finally, gender-based violence and discrimination, a cultural assumption that boys cannot be victims, cultural beliefs that children must support the family in crisis, the sexualization and objectification of girls, and weak recognition of children's rights are societal factors that contribute to vulnerability.[4,36,38–40]

Although researchers suggest that victims of sex trafficking in the United States are likely to seek medical attention at some point during their period of exploitation,[44,45] trafficked immigrant children detained at the United States border may receive insufficient care,[43] and those trafficked abroad may receive little or no care at all.[46,47] However, it is important for health care professionals all over the world to be alert to possible indicators of sex trafficking, and these are described in detail elsewhere.[31] With respect to labor trafficking, potential indicators may include a recent history of immigration, unfamiliarity with the city or town where the clinic or hospital is located, or apparent control and intimidation by an accompanying adult. Additional potential indicators are listed in Table 3. It is important to remember that the parents of the child may be victims of labor or sex trafficking, with or without victimization of the child.

The adverse health effects associated with child sex and labor trafficking are numerous and include traumatic injury from sexual and physical assault or work-related injury, sexually transmitted infections, nonsexually transmitted infections, chronic untreated medical conditions, pregnancy and related complications,

TABLE 3 Possible Indicators of Labor Trafficking

Recent immigration history (especially if patient or family lack access to immigration documentation)
Unfamiliarity with city or town
Apparent intimidation by person accompanying the child or family
Inconsistencies in information provided
Report of excessive, hazardous, or other inappropriate work conditions
Work-related (typically preventable) injuries (eg, chemical burns, irritation from toxic gases)
Delay in care (far-advanced medical conditions or untreated injuries)
Malnutrition or dehydration
Poor hygiene
Report of crowded, unhygienic, or otherwise inappropriate living conditions

Sources: Zimmerman C, Borland R, eds.; International Organization for Migration. Caring for trafficked persons: guidance for health providers. 2009. Available at: http://publications.iom.int/system/files/pdf/ct_handbook.pdf. Accessed May 24, 2014; and Polaris Project. Recognize the signs. Available at: http://polarisproject.org/recognize-signs. Accessed June 5, 2016.

chronic pain, complications of substance abuse, and malnutrition and exhaustion. Mental health consequences may include depression with suicide attempts, self-harm, flashbacks, nightmares, insomnia and other sleep problems, anxiety disorders, hypervigilance, self-blame, helplessness, anger and rage control problems, dissociative disorders, posttraumatic stress disorder, and other comorbid conditions.[30,45,47–53] It is important to note that major mental health issues may precede human trafficking (contributing to the child's vulnerability) and/or develop as a result of the complex trauma experienced during the period of exploitation. Such problems may be used as a ploy by the trafficker to discredit the victim, who may or may not actually have a disorder (eg, schizophrenia).[54]

The global prevalence of human trafficking, combined with its wide-ranging adverse health consequences, requires that these forms of severe exploitation be treated as an important public health problem. Applying public health strategies requires a multidisciplinary approach to identifying and analyzing the vulnerabilities leading to victimization and involves creating a strong evidence base for programs, strategies, and policies of prevention and intervention followed by rigorous scientific research on the impact and efficacy of those programs and policies. When resources are limited, the priority should be to target those most vulnerable to human trafficking. Much can be learned from other related public health problems that have been studied extensively, including child maltreatment, intimate partner violence, runaway or homeless youth, substance misuse, and poverty.

PUBLIC POLICY

The "Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children," was adopted by the United Nations General Assembly and enacted in December 2003.[5] It is the first global, legally binding instrument with an agreed definition on trafficking in persons. In response to the passage of the protocol, the number of countries instituting antitrafficking legislation more than doubled from 2003 to 2009. The United Nations Convention on the Rights of the Child is a human rights treaty that recognizes the rights of persons up to the age of 18 years and includes specific articles protecting children from violence, economic and sexual exploitation, sexual abuse, and all other forms of exploitation prejudicial to any aspect of the child's welfare.[1] Of 196 countries and dependencies, the United States is the only nation that has not ratified the agreement, although it signed it in 1995. Thus, the United States has indicated endorsement of the principles of the Convention on the Rights of the Child but has not committed to being legally bound by the Convention.

The cornerstone of US federal legislation is the Trafficking Victims Protection Act of 2000,[2] which recognizes human trafficking as a federal crime and offers protection in the form of T-visas. T-visas are nonimmigrant visas for victims of human trafficking. These documents protect victims, enable them to qualify for services, and allow them to stay in the United States for a given period. Since the Trafficking Victims Protection Act was passed, all 50 states have enacted legislation criminalizing human trafficking, to varying degrees. Multiple reauthorizations of the act have reaffirmed the US government's strategy to oppose human trafficking and expanded on the scope of the initial act.[55–57] The Trafficking Victims Protection Reauthorization Act of 2013,[58] which was passed as an amendment to the Violence Against Women Act, establishes and strengthens programs to ensure that US citizens do not purchase products made by victims of human trafficking and to prevent child marriage. It also puts into place emergency response provisions within the US Department of State to respond quickly to areas that have experienced disasters or crises, where people are particularly susceptible to being trafficked. The reauthorization also strengthens collaboration with state and local law enforcement to ease charging and prosecuting traffickers.

Although every state has laws on human trafficking, the scope of these laws varies significantly, with some laws restricting the protection to children younger than 14 to 15 years rather than the higher 18-year age threshold.[59] Information on related laws is available from the American

Academy of Pediatrics (AAP) Division of State Government Affairs (stgov@aap.org). In 2014, Congress enacted the Preventing Sex Trafficking and Strengthening Families Act (Pub L No. 113–183). This law requires that state child welfare agencies develop policies and procedures to identify, document, and determine appropriate services for children under their care or supervision who are victims of sex trafficking or who are at risk for becoming victims of sex trafficking.[60]

In 2013, the Uniform Law Commission adopted a Uniform Act on the Prevention of and Remedies for Human Trafficking,[61] which is built on the framework of penalizing traffickers, protecting human victims, and building public awareness and can serve as a public policy foundation for state lawmakers addressing this issue.

MEDICAL EDUCATION

Health care professionals and medical societies are recognizing the need to include information about human trafficking in medical education curricula. At the 2014 AAP Annual Leadership Forum, human trafficking education was ranked among the top 10 priority resolutions. The AAP resolved to "advocate that the subject of human trafficking should be a component of medical education and pediatric training for medical students, residents, fellows and all who provide healthcare for children and adolescents, to include information about recognition, management and linkages to community resources."[62] Stoklosa et al[63] advocated for a human rights-based framework when training health care professionals on human trafficking. They proposed that the medical education of health care professionals should be grounded in a victim-centered, culturally relevant, evidence-based, gender-sensitive, trauma-informed perspective and include the essential components of prevention and identification of trafficking and treatment of trafficking-related health conditions.[63]

Recent research has demonstrated the need for training regarding the identification and care of victims of human trafficking. In 1 study of health care professionals, 63% responded that they had never received training on how to identify sex trafficking victims. Those with training were more likely to report sex trafficking as a major problem locally ($P \leq .001$), to have encountered a victim in their practice ($P \leq .001$), and to have greater confidence in their ability to identify victims ($P < .001$). The greatest barriers to identification of victims were a lack of training (34%) and awareness (22%) of sex trafficking.[64]

In 2009, the International Organization of Migration published a manual for health professionals to provide practical, nonclinical guidance on recognizing and providing care to trafficked persons,[65] the focus of which is primarily adults. In 2015, the AAP published a clinical report on child sex trafficking, with a focus on domestic victims.[31] This report has been promoted at national and regional conferences. Additionally, there are emerging international efforts to educate health care and other professionals on human trafficking and professional organizations dedicated to training, advocacy, and policy. Some of these organizations include the American Medical Women's Association's Physicians Against the Trafficking of Humans and HEAL Trafficking (Health, Education, Advocacy, and Linkage).

RESEARCH

Although research on human trafficking has increased in recent years, there remains a narrow evidence base, and many studies have significant limitations. Some are published outside of peer-reviewed academic journals and may be difficult to access, leading to inadequate dissemination.[66,67] Empirical research is relatively limited. In 1 systematic review in which researchers examined the health problems and violence associated with human trafficking, only 19 studies were identified through August 2011. In the vast majority of these studies, researchers focused on women and girls experiencing sex trafficking,[50] revealing a paucity of research on male victims and victims of labor trafficking. In an updated review of violence and health consequences, in which researchers covered the period from 2011 to 2015, only 31 additional studies were identified.[51] Of these, only 12 included forms of trafficking beyond sexual exploitation, and none of the latter targeted the child population. In many studies on human trafficking, researchers have included aggregate results for adults and children,[68–70] boys and girls,[30] or individuals from multiple countries of origin.[71,72] Some researchers also combine victims of differing forms of trafficking.[44] Lacking disaggregated data, it is difficult to identify findings that may be specific to children or to subpopulations of child victims. Nonetheless, much can be learned from related areas of study, such as work with homeless or runaway youth, some of whom engage in survival sex and are, thus, victims of human trafficking.[21,23,32,73] Studies of adult populations are also helpful inasmuch as adult women involved in sex work were often recruited as juveniles and continue to experience some of the same hardships as sex-trafficked youth.[69,74] In 1 study of prostitution in 9 countries, 32% to 68% of women engaged in prostitution began sex work as minors.[75]

The lack of research on male victims of trafficking may indirectly support

the cultural belief that boys cannot be victimized and may exacerbate the problem of underrecognition. The paucity of research translates into limited empirical knowledge of factors that increase the vulnerability of boys to trafficking, of the unique experiences occurring during the period of exploitation, of the gender-specific adversities faced by male children, and of their unique needs for recovery and reintegration. A lack of knowledge and awareness likely contributes to the deficiency of services for male trafficking survivors[76] and a tendency to treat them as offenders rather than as children in need of help and protection.[77]

Another area with a relative scarcity of empirical research is labor trafficking in the United States, especially forced labor involving children. Existing studies tend to suffer from the limitations mentioned previously, especially with regard to researchers combining children with adults in the sample population[11,78] and inadequately distinguishing victims of labor trafficking versus sex trafficking.[44,70] Research is also difficult to conduct because of the complexity involved in identifying and distinguishing between child employment, child labor, hazardous child labor, forced child labor, and trafficking.[79] Because labor trafficking has not received the public attention accorded to sex trafficking, there is little awareness of the possibility that patients or their parents may be victims of labor trafficking, little impetus to conduct research, and scarce financial support available for such research.

Another limitation in the research is related to potential generalizability. Researchers suggest that identified victims represent only a small fraction of the total number of persons subjected to human trafficking.[36] It is possible that identified victims are fundamentally different in important respects from the main population of trafficked persons, which would significantly limit the generalizability of study results. This possibility may be more relevant for studies conducted on trafficking survivors who are actively seeking services than for studies involving street outreach and interviews of homeless or runaway youth engaged in survival sex. Research on trafficking victims, especially child victims, is particularly difficult because it involves a vulnerable study population.[4] Appropriately, service providers offering care to survivors are often cautious about the possibility of exposing survivors to stressful situations and may be reluctant to approach their clients regarding study participation, which may limit access to survivors and discourage attempts to conduct research. Finally, adults and youth who do participate may experience recall bias, especially if recounting events that occurred years earlier. Alternatively, they may provide inaccurate information in efforts to protect others or themselves from stigma, shame, reprisals, or other consequences.

COLLABORATION

Although multidisciplinary collaboration in the investigation and treatment of child abuse has become a widely accepted and successful strategy in the United States,[80–82] similar collaboration is much less well developed in the area of human trafficking in the United States and elsewhere.[83,84] Within a community, there may be little communication between investigators and service providers, jeopardizing prosecution success and thwarting the provision of services to victims. Collaboration may be rendered even more difficult when there is a need to manage victim service referrals across borders and communicate with authorities from another country or when trafficking investigations require communication and cooperation between tribal communities and the US federal government. In 1 national study of service providers for human trafficking victims, 44% reported that ineffective coordination with federal agencies was a common barrier to success, and 39% reported a lack of coordination with local agencies as being a significant barrier.[85] Health care professionals seeking to report cases to law enforcement and obtain services for victims often lack knowledge of reporting procedures and available community partners. Providers may not ask youth about experiences of trafficking because they do not have time to research possible resources or may assume no resources are available. National hotlines exist for assisting victims.[26,86] Efforts are being made to educate health care professionals and others about these resources,[31,84,87] although much work remains to be done. In 1 study of health care professionals, only 14% of the medical providers contacted the national hotline or made service referrals for suspected trafficking victims; they were significantly more likely to do so if they had received training.[64]

The percentage of US hospitals and clinics with functioning protocols for recognizing, responding, referring, and reporting cases of suspected trafficking is unknown, but experts believe it is small.[88] Little is known about the prevalence of protocols in health facilities elsewhere around the globe. A lack of guidance for health care professionals may decrease the likelihood that victims will be identified and receive critical assistance; health care professionals may, justifiably, be hesitant to ask patients about trafficking if they are unsure of how to respond and how to obtain assistance for the suspected victim. In addition, the lack of an established process means that each

time a victim is identified, the health care professional must rethink his or her response. What could be a routine set of activities may instead become a crisis, which can waste time and health resources and increase anxiety and stress for the health care professional and victim alike.

Finally, the lack of connection and collaboration among health care professionals and community service providers and investigators decreases the likelihood that victims being served in the community will receive adequate medical care for their many health needs. Professionals of all kinds tend to view situations through their own professional lens, and immigration attorneys, law enforcement officers, and workers at shelters, job training centers, and mentoring programs may not think about medical issues unless they routinely work with health care professionals who can emphasize the victim's physical and mental health needs.

RECOMMENDATIONS

The following recommendations apply to AAP chapters and to all individual health care professionals serving children, including physicians, nurses, advanced practice providers, dentists, behavioral health professionals, social workers, and trainees in these fields. All health care professionals and systems serving children (especially physicians, nurses, advanced practice providers, dentists, behavioral health professionals, social workers, and trainees in these fields) can prevent child trafficking, recognize victims, and intervene appropriately. The AAP recommends:

Public Policy

1. Support relevant state, federal, and international antitrafficking legislation and policies, including increased access to direct services for all victims, increased interagency collaboration, improved screening for human trafficking among immigrants detained at national borders, and assistance on immigration issues for foreign nationals. Increased access includes, but is not limited to, establishing insurance coverage for medical and mental health expenses and increasing the availability of trained pediatric examiners and child-friendly locations for victims to receive health care, especially in rural areas;

2. Support state, federal, and international legislation and policies that facilitate primary prevention of child trafficking through education of children and parents about risks, recruitment strategies, and adverse effects. These preventive efforts may include education of students in schools and also should include efforts to reach those who are not attending school;

3. Support US and global efforts to address the social determinants of health, which are intimately connected to push and pull factors for human trafficking;

4. Advocate for policies that protect children younger than 18 years who are victims of any type of trafficking from prosecution for related offenses, emphasizing treatment and services instead;

5. Work with other medical organizations in the United States and abroad to facilitate a public health approach to human trafficking and empower health care professionals to use a culturally sensitive, rights-based, victim-centered approach to human trafficking; and

6. Advocate for US ratification of the Convention on the Rights of the Child.[1,89] The Convention specifically recognizes the right of children to be protected from all forms of exploitation and encourages participating countries to take appropriate measures to prevent the abduction, sale, or trafficking of children for any purpose or in any form.

Medical Education

1. Advocate for training of health care professionals on human trafficking issues, including recognition, assessment, treatment, and referrals for services by using a trauma-informed, culturally sensitive, rights-based approach. Training should emphasize both sex and labor trafficking, the possibility of encountering parents who are victims of trafficking, and specific issues related to immigration for foreign victims and their families. Health care professionals need training on how to gather and document critical psychosocial and medical information to assist trafficked children in obtaining special visas that will allow them federally funded benefits and temporary residence in the United States (T- and U-visas)[43];

2. Advocate for timely medical education on human trafficking at the trainee level by encouraging the American Board of Pediatrics to include child trafficking, child rights, and trauma-informed care in its content specifications, as these guide residency curricula;

3. Encourage medical education curricula to include strategies for addressing social determinants of health, in particular including questions about adverse childhood events in the patient assessment, connecting to community resources, and building community resilience; and

4. Advocate for financial support and resources for development and global dissemination of

culturally appropriate, trauma-informed curricula for health care professionals addressing human trafficking. Encourage provision of continuing education credit for attendance (or other incentives relevant to professionals in a given country).

Research

1. Rigorous, empirically based research on child trafficking is necessary to (1) identify culture- and gender-specific risk factors; (2) determine approaches to asking about child trafficking in the health care setting; (3) estimate prevalence in different sectors and locations; (4) understand experiences during exploitation that place children at risk for serious harm; (5) evaluate the type and extent of adverse physical and emotional health consequences; (6) identify resiliency factors among child victims; (7) understand the connections between child trafficking, toxic stress, and long-term health outcomes; and (8) assess the effectiveness of psychosocial and mental health interventions. Researchers should focus not only on heterosexual female victims but also male and LGBTQ victims and give priority to the study of labor as well as sex trafficking;

2. Advocate for development of intervention strategies and rigorous empirical evaluation of their impact on child health and well-being. Conduct longitudinal and comparative studies on integration and reintegration to assess which factors within programs providing services to victims are most effective and whether significant differences exist between needs and outcomes of groups of survivors (eg, boys versus girls, LGBTQ versus heterosexual youth, domestic versus transnational survivors, those who have experienced prostitution versus production of child sexual abuse materials [formerly called "child pornography"] versus forced labor);

3. Advocate for research on trauma-informed care and on effective ways to implement this approach into a busy health care setting in which time restraints may impinge on the health care professional's ability to build patient rapport and establish the trust needed to identify and address patient needs[90];

4. Advocate for centralized surveillance and data collection on identified trafficked persons, allowing better determinations of prevalence, high-risk geographic areas, trends in trafficking, and other information to guide research and inform public policy[37]; and

5. Advocate for the adoption of specific *International Classification of Diseases* codes to report the types of human trafficking and distinguish them from other types of violence and exploitation. Tracking cases of human trafficking is critical to monitoring its incidence and recurrence, determining short- and long-term adverse effects on children and adults, assessing treatment modalities, and estimating cost of care. Such data are central to public health efforts to prevent and eradicate this severe form of exploitation.

Collaboration

1. Advocate for health care professionals in larger health care facilities to identify victim service providers and organizations in their communities (including homeless or runaway shelters, community centers, and residential treatment programs specifically for trafficking victims, resources for LGBTQ youth, drug rehabilitation programs, food pantries, refugee centers, legal professionals able to provide immigration assistance, etc). Encourage health care professionals to develop and test referral mechanisms to facilitate connection of victims with appropriate service providers. Having such mechanisms in place may not be practical for health care professionals working in solo or small practices, in which case collaborating with local, state, or national partners may be beneficial. Recommended collaborators include local public health departments, law enforcement agencies, local school districts, and community health centers. Health care professionals may also contact national human trafficking hotlines (including the National Human Trafficking Resource Center in the United States [1-888-373-7888]) or nongovernmental organizations (eg, International Organization for Migration or End Child Prostitution, Child Pornography and Trafficking of Children for Sexual Purposes);

2. Advocate for the inclusion of health care professionals as vital members of community multidisciplinary teams combatting human trafficking. To best serve victims, they need to become active members of a community response to human trafficking, building relationships with local providers and investigators. Health care professionals can educate team members on the health needs of survivors and facilitate services that will improve the physical and mental health of trafficked persons. Health care professionals can also learn from other team members and use this information

to improve their interactions with and support of survivors;

3. Advocate for development of clinic and hospital protocols outlining processes to help recognize and respond to child trafficking of all types as well as trafficking involving caregivers. These processes should include specific information on reporting requirements and processes for making reports to authorities as well as supported referral mechanisms to facilitate communication with health care professionals of varying subspecialties and with community partners;
4. Advocate for easily accessible, victim-centered, culturally appropriate medical homes for trafficked persons in the United States and other countries; and
5. Promote outreach and awareness at the community, state, national, and international levels.

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ABBREVIATIONS

AAP: American Academy of Pediatrics
LGBTQ: lesbian, gay, bisexual, transgender, or queer

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REFERENCES

1. United Nations; Human Rights, Office of the High Commissioner for Human Rights. Convention on the rights of the child. 1990. Available at: www.ohchr.org/en/professionalinterest/pages/crc.aspx. Accessed October 27, 2017
2. United States Government. Trafficking Victims Protection Act of 2000. Pub. L. No. 106-386 Division A 103(8)
3. United States Government. Justice for Victims of Trafficking Act of 2015. Public Law No. 114-22
4. 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
5. 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. 2000. Available at: www.ohchr.org/EN/ProfessionalInterest/Pages/ProtocolTraffickingInPersons.aspx. Accessed July 7, 2013
6. International Labour Organization. C182 - Worst Forms of Child Labour Convention, 1999 (No. 182). Available at: http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C182. Accessed October 27, 2017
7. International Labour Organization. C138 - Minimum Age Convention, 1973 (No. 138). 1973. Available at: http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C138. Accessed February 26, 2017
8. International Labour Office; International Programme on the Elimination of Child Labour. *Marking Progress Against Child Labour: Global Estimates and Trends 2000–2012*. Geneva, Switzerland: International Labour Organization; 2013
9. Polaris Project. Knocking at your door: labor trafficking on traveling sales crews. 2015. Available at: https://polarisproject.org/sites/default/files/Knocking-on-Your-Door-Sales-Crews.pdf. Accessed February 10, 2016
10. National Human Trafficking Resource Center. Child labor trafficking in the United States. Available at: https://traffickingresourcecenter.org/sites/default/files/Child Labor Trafficking.pdf. Accessed October 27, 2017
11. Zhang SX. *Looking for a Hidden Population: Trafficking of Migrant Laborers in San Diego County*. Washington, DC: United States Department of Justice, National Institute of Justice; 2012
12. Hepburn S, Simon RJ. *Human Trafficking Around the World: Hidden*

in Plain Sight. New York, NY: Columbia University Press; 2013

13. van de Glind H, Coenjaerts C; ILO-IPEC South-east Asia. Combating trafficking in children for labour exploitation in the Mekong sub-region: a proposed framework for ILO-IPEC action and proceedings of a Mekong sub-regional consultation. 1998. Available at: http://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/documents/publication/wcms_bk_pb_3_en.pdf. Accessed June 3, 2016
14. International Labour Organization. Child labour in Africa. Available at: http://www.ilo.org/ipec/Regionsandcountries/Africa/lang--en/index.htm. Accessed June 3, 2016
15. Thomas M. Child trafficking in Ghana: an examination of the cultural impact. Prospect: Journal of International Affairs at UCSD. 2011.Available at: https://prospectjournal.org/2011/09/13/child-trafficking-in-ghana/. Accessed June 3, 2016
16. Papantoniou-Frangouli M, Dourida V, Diamantopoulou A, Barla E, Kapsalis A. *Trafficking for Labour in Greece. Report Prepared in the Frame of the Project: Combating Trafficking in Human Beings–Going Beyond*. Athens, Greece: European Commission; 2011
17. International Centre for Migration Policy Development. *Targeting Vulnerabilities: the Impact of the Syrian War and Refugee Situation on Trafficking in Persons: A Study of Syria, Turkey, Lebanon, Jordan and Iraq*. Vienna, Austria: Migration for Development; 2015
18. Stransky M, Finkelhor D; Crimes Against Children Research Center. How Many Juveniles are Involved in Prostitution in the US?. Available at: www.unh.edu/ccrc/prostitution/Juvenile_Prostitution_factsheet.pdf. Accessed July 7, 2013
19. United Nations Office on Drugs and Crime. Global report on trafficking in persons. 2014. Available at: https://www.unodc.org/documents/data-and-analysis/glotip/2016_Global_Report_on_Trafficking_in_Persons.pdf. Accessed November 30, 2014
20. International Labor Organization. Global estimate of forced labour: executive summary. 2012. Available at: http://www.ilo.org/wcmsp5/groups/public/---ed_norm/---declaration/documents/publication/wcms_181953.pdf. Accessed December 23, 2014
21. Walls NE, Bell S. Correlates of engaging in survival sex among homeless youth and young adults. *J Sex Res*. 2011;48(5):423–436
22. Stoltz JA, Shannon K, Kerr T, Zhang R, Montaner JS, Wood E. Associations between childhood maltreatment and sex work in a cohort of drug-using youth. *Soc Sci Med*. 2007;65(6):1214–1221
23. 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
24. Haley N, Roy E, Leclerc P, Boudreau JF, Boivin JF. HIV risk profile of male street youth involved in survival sex. *Sex Transm Infect*. 2004;80(6):526–530
25. Whitbeck LB, Chen X, Hoyt DR, Tyler KA, Johnson KD. Mental disorder, subsistence strategies, and victimization among gay, lesbian, and bisexual homeless and runaway adolescents. *J Sex Res*. 2004;41(4):329–342
26. Polaris Project. National Human Trafficking Resource Center 2015 Hotline Statistics. Available at: https://polarisproject.org/resources/2015-hotline-statistics. Accessed February 2, 2016
27. United States Department of State. Trafficking in persons report. 2016. Available at: https://www.state.gov/documents/organization/258876.pdf. Accessed July 26, 2016
28. Banks D, Kyckelhahn T. *Characteristics of Suspected Human Trafficking Incidents, 2008-2010*. Washington, DC: United States Department of Justice; 2011
29. Owens C, Dank M, Breaux J, et al. *Understanding the Organization, Operation and Victimization Process of Labor Trafficking in the United States*. Washington, DC: Urban Institute; 2014
30. Turner-Moss E, Zimmerman C, Howard LM, Oram S. Labour exploitation and health: a case series of men and women seeking post-trafficking services. *J Immigr Minor Health*. 2014;16(3):473–480
31. Greenbaum J, Crawford-Jakubiak JE; Committee on Child Abuse and Neglect. Child sex trafficking and commercial sexual exploitation: health care needs of victims. *Pediatrics*. 2015;135(3):566–574
32. Dank M, Yahner J, Madden K, et al. *Surviving the Streets of New York: Experiences of LGBTQ Youth, YMSM, YWSW Engaged in Survival Sex*. Washington, DC: Urban Institute; 2015
33. Cochran BN, Stewart AJ, Ginzler JA, Cauce AM. Challenges faced by homeless sexual minorities: comparison of gay, lesbian, bisexual, and transgender homeless adolescents with their heterosexual counterparts. *Am J Public Health*. 2002;92(5):773–777
34. McIntyre S. Under the radar: the sexual exploitation of young men- Western Canadian edition. 2009. Accessed at: http://humanservices.alberta.ca/documents/child-sexual-exploitation-under-the-radar-western-canada.pdf. Accessed February 16, 2016
35. Walker K. Ending the commercial sexual exploitation of children: a call for multi-system collaboration in California. Available at: www.chhs.ca.gov/Child%20Welfare/Ending%20CSEC%20-%20A%20Call%20for%20Multi-System%20Collaboration%20in%20CA%20-%20February%202013.pdf. Accessed May 22, 2016
36. United States Department of State. Trafficking in persons report. 2015. Available at: www.state.gov/j/tip/rls/tiprpt/2015/. Accessed February 10, 2016
37. Polaris Project. Recognize the signs. Available at: http://polarisproject.org/recognize-signs. Accessed June 5, 2016
38. Raymond JG. Patterns, profiles and health consequences of sexual exploitation. In: Raymond J, D'Cunha J, Dzuhayatin SR, Hines HP, Rodriguez ZR, Santos A, eds. *A Comparative Study of Women Trafficked in the Migration Process: Patterns, Profiles and Health Consequences of Sexual Exploitation in Five Countries (Indonesia, the Philippines, Thailand, Venezuela and*

the United States). New York, NY: Coalition Against Trafficking in Women; 2002:54–74

39. Refugee Law Project. *Report on the 1st South-South Institute on Sexual Violence Against Men and Boys in Conflict and Displacement*. Kampala, Uganda: School of Law, Makerere University; 2013
40. Dennis J. Women are victims, men make choices: the invisiblity of men and boys in the global sex trade. *Gender Issues*. 2008;25(1):11–25
41. United Nations High Commissioner for Refugees. Children on the run: unaccompanied children leaving Central America and Mexico and the need for international protection. 2014. Available at: http://www.unhcr.org/en-us/about-us/background/56fc266f4/children-on-the-run-full-report.html. Accessed February 19, 2016
42. Chester H, Lummert N, Mullooly A. Child victims of human trafficking: outcomes and service adaptation within the US. Unaccompanied refugee minor programs. 2015. Available at: www.usccb.org/about/anti-trafficking-program/upload/URM-Child-Trafficking-Study-2015-Final.pdf. Accessed February 19, 2016
43. Linton JM, Griffin M, Shapiro AJ; AAP Council on Community Pediatrics. Detention of immigrant children. *Pediatrics*. 2017;139(5):e20170483
44. Baldwin SB, Eisenman DP, Sayles JN, Ryan G, Chuang KS. Identification of human trafficking victims in health care settings. *Health Hum Rights*. 2011;13(1):E36–E49
45. Lederer L, Wetzel C. The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities. *Ann Health Law*. 2014;23:61–91
46. Karandikar SA, Gezinski LB, Kaloga MEP. *Health Care Among Sex-Trafficked Women and Girls in India*. Hauppauge, NY: Nova Science Publishers, Inc.; 2015
47. 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
48. Willis BMLB, Levy BS. Child prostitution: global health burden, research needs, and interventions. *Lancet*. 2002;359(9315):1417–1422
49. Zimmerman C, Hossain M, Yun K, Roche B, Morison L, Watts C. *Stolen Smiles: A Summary Report on the Physical and Psychological Consequences of Women and Adolescents Trafficked in Europe*. London, United Kingdom: London School of Hygiene and Tropical Medicine; 2006
50. 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
51. Ottisova L, Hemmings S, Howard LM, Zimmerman C, Oram S. Prevalence and risk of violence and the mental, physical and sexual health problems associated with human trafficking: an updated systematic review. *Epidemiol Psychiatr Sci*. 2016;25(4):317–341
52. Kiss L, Pocock NS, Naisanguansri V, et al. Health of men, women, and children in post-trafficking services in Cambodia, Thailand, and Vietnam: an observational cross-sectional study. *Lancet Glob Health*. 2015;3(3):e154–e161
53. Kiss L, Yun K, Pocock N, Zimmerman C. Exploitation, violence, and suicide risk among child and adolescent survivors of human trafficking in the Greater Mekong subregion. *JAMA Pediatr*. 2015;169(9):e152278
54. Stoklosa H, MacGibbon M, Stoklosa J. Human trafficking, mental illness, and addiction: Avoiding diagnostic overshadowing. *AMA J Ethics*. 2017;19(1):23–34
55. United States Government. William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008. H.R. 73112008
56. United States Government. Trafficking Victims Protection Reauthorization Act of 2005. H.R. 972
57. United States Government. Trafficking Victims Protection Reauthorization Act of 2003. H.R. 2620
58. 113th United States Congress. Trafficking Victims Protection Reauthorization Act of 2013. H.R. 898
59. Polaris. Human trafficking issue brief: Safe Harbor Fall. 2015. Available at: https://polarisproject.org/sites/default/files/2015%20Safe%20Harbor%20Issue%20Brief.pdf. Accessed July 1, 2016
60. US Congress. Preventing Sex Trafficking and Strengthening Families Act (P.L. 113-183). 2014. Available at: https://www.congress.gov/bill/113th-congress/house-bill/4980. Accessed August 23, 2017
61. National Conference of Commissioners on Uniform State Laws. *Uniform Act on Prevention of and Remedies for Human Trafficking*. Boston, MA: National Conference of Commissioners on Uniform State Laws; 2013
62. American Academy of Pediatrics. Response from the AAP Board of Directors to the top ten 2014 resolutions. Available at: www.mdaap.org/chapters_districts_resolutions_2014_top_ten_resolutions_board_responses.pdf. Accessed June 16, 2016
63. Stoklosa H, Grace AM, Littenberg N. Medical education on human trafficking. *AMA J Ethics*. 2015;17(10):914–921
64. Beck ME, Lineer MM, Melzer-Lange M, Simpson P, Nugent M, Rabbitt A. Medical providers' understanding of sex trafficking and their experience with at-risk patients. *Pediatrics*. 2015;135(4). Available at: www.pediatrics.org/cgi/content/full/135/4/e895
65. Zimmerman C, Borland R, eds.; International Organization for Migration. Caring for trafficked persons: guidance for health providers. 2009. Available at: http://publications.iom.int/system/files/pdf/ct_handbook.pdf. Accessed May 24, 2014
66. ECPAT International. Situational analysis of the commercial sexual exploitation of children in Bolivia. 2015. Available at: www.ecpat.org/wp-content/uploads/2016/04/SITAN_BOLIVIA_ENG.pdf. Accessed June 4, 2016

67. Davis J, Miles G; Love146. "They didn't help me; they shamed me": A baseline study on the vulnerabilities of street-involved boys to sexual exploitation in Manila, Philippines. 2015. Available at: https://1at4ct3uffpw1uzzmu191368-wpengine.netdna-ssl.com/wp-content/uploads/2016/01/They-Shamed-Me-.pdf. Accessed June 4, 2016

68. Raymond J, Hughes D; Coalition Against Trafficking in Women. Sex trafficking of women in the United States: International and domestic trends. 2001. Available at: https://www.ncjrs.gov/pdffiles1/nij/grants/187774.pdf. Accessed August 4, 2012

69. Raphael J, Reichert J, Powers M. Pimp control and violence: domestic sex trafficking of Chicago women and girls. *Women Crim Justice*. 2010;20(1–2):89–104

70. Zimmerman C, Yun K, Shvab I, et al. *The Health Risks and Consequences of Trafficking in Women and Adolescents: Findings from a European Study*. London, United Kingdom: London School of Hygiene and Tropical Medicine; 2003

71. Sarkar K, Bal B, Mukherjee R, et al. Sex-trafficking, violence, negotiating skill, and HIV infection in brothel-based sex workers of eastern India, adjoining Nepal, Bhutan, and Bangladesh. *J Health Popul Nutr*. 2008;26(2):223–231

72. Decker MR, McCauley HL, Phuengsamran D, Janyam S, Silverman JG. Sex trafficking, sexual risk, sexually transmitted infection and reproductive health among female sex workers in Thailand. *J Epidemiol Community Health*. 2011;65(4):334–339

73. Grossman AH, D'Augelli AR. Transgender youth: invisible and vulnerable. *J Homosex*. 2006;51(1):111–128

74. Cimino AN, Madden EE, Hohn K, et al. Childhood maltreatment and child protective services involvement among the commercially exploited: A comparison of women who enter as juveniles or as adults. *J Child Sex Abuse*. 2017;26(3):352–371

75. Farley M, Cotton A, Lynne J, et al. Prostitution and trafficking in nine countries: an update on violence and posttraumatic stress disorder. *J Trauma Pract*. 2004;2(3–4):33–74

76. 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. 2013. Available at: https://d1qkyo3pi1c9bx.cloudfront.net/00028B1B-B0DB-4FCD-A991-219527535DAB/1b1293ef-1524-4f2c-b148-91db11379d11.pdf. Accessed August 16, 2017

77. Finkelhor D, Ormrod R. *Prostitution of Juveniles: Patterns from NIBRS*. Washington, DC: US Department of Justice; 2004

78. Loyola University New Orleans's Modern Slavery Research Project. Labor and sex trafficking among homeless youth: a ten-city study executive summary. 2016. Available at: http://covenanthousestudy.org/. Accessed July 1, 2017

79. International Labour Office. *Marking Progress Against Child Labour: Global Estimates and Trends 2000-2012*. Geneva, Switzerland: International Labour Organization; 2013

80. Miller A, Rubin D. The contribution of children's advocacy centers to felony prosecutions of child sexual abuse. *Child Abuse Negl*. 2009;33(1):12–18

81. Wolfteich P, Loggins B. Evaluation of the children's advocacy center model: efficiency, legal and revictimization outcomes. *Child Adolesc Social Work J*. 2007;24(4):333–353

82. National Children's Alliance. Measuring CAC outcomes. Available at: www.nationalchildrensalliance.org/proven-results. Accessed June 4, 2016

83. Macias Konstantopoulos WL, Munroe D, Purcell G, Tester K, Burke TF. The commercial sexual exploitation and sex trafficking of minors in the Boston metropolitan area: experiences and challenges faced by front-line providers and other stakeholders. *J Appl Res Child*. 2015;6(1):4

84. Isaac R, Solak J, Giardino A. Health care providers' training needs related to human trafficking: Maximizing the opportunity to effectively screen and intervene. *J Appl Res Child*. 2011;2(1):1–32

85. Clawson HJ, Small KV, Go ES, Bradley WM; US Department of Justice. Needs assessment for service providers and trafficking victims. 2003. Available at: https://www.ncjrs.gov/pdffiles1/nij/grants/202469.pdf. Accessed May 30, 2016

86. US Immigration and Customs Enforcement. Human trafficking: a global problem. Available at: https://www.ice.gov/human-trafficking. Accessed June 4, 2016

87. Ahn R, Alpert EJ, Purcell G, et al. Human trafficking: review of educational resources for health professionals. *Am J Prev Med*. 2013;44(3):283–289

88. Stoklosa H, Dawson M, Williams-Oni F, Rothman EF. A review of U.S. healthcare institution protocols for the identification and treatment of victims of human trafficking. *J Human Trafficking*. 2016;3(2):116–124

89. Council on Community Pediatrics and Committee on Native American Child Health. Policy statement–Health equity and children's rights. *Pediatrics*. 2010;125(4):838–849

90. American Academy of Pediatrics. Trauma toolbox for primary care. 2014. Available at: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Trauma-Guide.aspx. Accessed August 31, 2016

91. Greijer S, Doek J; Interagency Working Group on Sexual Exploitation of Children. *Terminology guidelines for the protection of children from sexual exploitation and abuse*. Luxembourg City, Luxembourg: ECPAT International; 2016

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