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A Public Health Approach to Global Child Sex Trafficking

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Abstract

Human trafficking and child sex trafficking and sexual exploitation in particular are global public health issues with widespread, lasting impacts on children, families, and communities. Traditionally, human trafficking has been treated as a law enforcement problem with an emphasis on the arrest and prosecution of traffickers. However, use of a public health approach focuses efforts on those impacted by exploitation: trafficked persons, their families, and the population at large. It promotes strategies to build a solid scientific evidence base that allows development, implementation, and evaluation of prevention and intervention efforts, informs policy and program development, and guides international efforts at eradication. This article uses the public health approach to address human trafficking, with a focus on child sex trafficking and exploitation. Recommendations are made for public health professionals to contribute to antitrafficking efforts globally.

DEFINITIONS AND EPIDEMIOLOGY

Trafficking in persons violates fundamental human rights and jeopardizes the health of adults and children throughout the world (107, 109, 110). Its widespread distribution and global impact have led to a call for its eradication in the 2030 Agenda for Sustainable Development (SDG 8.7) (106). As defined in the United Nations Palermo protocol, severe forms of human trafficking involve three components: an action, a means, and a purpose. The action includes "the recruitment, transportation, transfer, harboring or receipt of persons," whereas the means refers to "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." Finally, the purpose of the action(s) and mean(s) is "exploitation," a term that includes "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 or the removal of organs" (108). Important caveats apply: (*a*) Means are irrelevant when the victim is a child (under age 18), and (*b*) prior consent of a person to the exploitation becomes irrelevant when/if any of the means described in the definition are present.

When creating antitrafficking legislation, signatory parties of the Palermo protocol generally have based their definitions of human trafficking on the wording used in the protocol. However, differences apply, and these variations in interpretation of the United Nations (UN) definition contribute to the difficulty in estimating the global prevalence of human trafficking. For example, the United States federal definition of human trafficking does not include organ trafficking, and its definition of child sex trafficking (CST) includes involvement of a child (under age 18) in any commercial sex act, whether or not a third party is involved in the transaction [Pub. L. 114–22; Pub. L. 106–386, Div. A 103(8)]. This broad definition of CST thus includes homeless/runaway/street children engaging in transactional sex to survive, an activity not considered trafficking in all countries. Transporting a person from one place to another is not a requirement for human trafficking in the United States, but in some countries this action is considered important.

Because of variations in the definition of CST, this article focuses on both CST and a closely related entity, child sexual exploitation (CSE). The latter term refers to any act in which a person under age 18 "takes part in a sexual activity in exchange for something (e.g., gain or benefit, or even the promise of such) from a third party, the perpetrator or by the child her/himself" (44). This may involve the exchange of money, drugs, food, shelter, luxury, or other items. Engaging a child living on the street in a sexual act in exchange for a meal is an example of CSE.

National and global estimates of human trafficking prevalence are fraught with challenges and issues of reliability related to the previously noted variation in definitions, the clandestine nature of the activity, the lack of a centralized database to track cases, underrecognition of trafficked persons by professionals and the lay public, underreporting of exploitation by trafficked persons, and specific priorities in investigative activities (62, 96, 110). Other factors that impact identification and tracking relate to corruption among authorities in some regions and a low priority placed on human trafficking by governments. Acknowledging the difficulties in estimating prevalence, the International Labor Organization estimated that 24.9 million people were victims of forced labor in 2016 (including forced labor in the private economy, state-imposed forced labor, forced sexual exploitation of adults and child commercial sexual exploitation). Of this group, 18% were children (4.5 million). Of the 15.4 million living in a forced marriage, an estimated 37% (5.7 million) were children. Finally, ~1 million children were victims of commercial sexual exploitation in 2016 (excluding forced marriage) (54).

While common notions of human trafficking assume that victims are transported across national borders, evidence suggests that domestic trafficking within the person's country of citizenship is more common (110). In addition, a greater proportion of identified victims are being trafficked within their home country's subregion than to distant regions across the globe. When the latter occurs, it tends to involve travel from relatively poor countries to relatively wealthy ones (110).

While the general focus of this review is on CST and CSE, it is critical to acknowledge that forced labor of adults and children constitutes a large proportion of all trafficking cases (54), and the majority of those cases have been identified in Africa and the Middle East (109). Forced labor may involve many occupational sectors, which depend in part on the geographic location. For example, trafficking of boys and men in the fishing industry is common in the region of Lake Volta (46), while trafficking and debt bondage of whole families in brick kilns is common in India (80). Common sectors for forced labor include farming, textiles, manufacturing, service industries, mining, domestic servitude and construction, nail salons, and forced begging (104). Many of the push factors that contribute to labor trafficking are also key factors in sex trafficking, such as extreme poverty, lack of economic opportunities, limited education, and migration (104).

Sex trafficking of minors (under age 18) has received a great deal of attention in the United States and throughout the world. Of identified human trafficking cases in a recent UN Office on Drugs and Crime study, 30% involved children (23% girls; 7% boys); of these, 72% of trafficked girls and 27% of boys experienced sexual exploitation (110). CST and CSE may take many forms, including prostitution, transactional sex involving sexual acts provided in exchange for something of perceived value, involvement of a child in the production of child sexual abuse materials (44) (formerly called child pornography), performance of sexual acts in a sex venue such as a strip club, involvement of a child in work within other venues supporting commercial sex [e.g., karaoke bars (105), massage parlors (10, 72), and cantinas (78)], child marriage, and mail-order brides (55). While studies tend to show a predominance of female victims of CST/CSE (85, 110, 111), the relative scarcity of identified boys is likely to be partially related to several social and cultural factors (113). Gender roles that require males to be seen as strong and invulnerable to sexual victimization may cause exploited males to hide their victimization due to shame or due to fear of social ostracism, of being perceived as weak, or of having their sexual orientation questioned (24, 81). Boys may be perceived as having more agency than girls, leading some to view them as offenders ("prostitutes") rather than as victims of exploitation (28). The general public's discomfort with the idea of men having sex with boys may preclude consideration of boys as victims of commercial sexual exploitation (28), leading to a lack of screening of high-risk boys and underrecognition of victimization. However, US studies of homeless and runaway youth engaging in transactional sex show high numbers of boys (21), and commercial sexual exploitation of males is well known in many parts of the world (23, 24, 43, 51, 69, 71), indicating that the problem is by no means exclusive to girls. Similarly, lesbian/gay/bisexual/transgender/queer (or questioning) and other (LGBTQ+) children and youth are often ignored in academic discussions of CST/CSE, yet they are very much at risk for sexual exploitation (17, 22, 25, 70). They are overrepresented in studies of homeless youth: In one such study, nearly 30% reported being homosexual or bisexual, and nearly 5% identified themselves as transgender (32). In addition, transgender youth were nearly 7 times more likely to engage in transactional sex than were nontransgender youth, while homosexual and bisexual youth were 6.6 times more likely than their heterosexual counterparts to do so (32).

In keeping with the socioecological model, risk factors for CST/CSE are found at the individual, relationship, community, and societal levels. Some of these factors are listed in **Table 1** (1, 15, 18, 22, 31, 34, 36, 47, 58, 61, 64, 68, 69, 75, 82, 84, 86, 90, 91, 93, 94, 116, 119). Owing

Table 1 Risk factors for child sex trafficking and sexual exploitation

Individual-level factors	Relationship-level factors	Community-level factors	Societal-level factors
"Street" children, homeless, runaway	Family dysfunction (violence, substance abuse, etc.)	Natural disasters/social upheaval	Gender-based violence and bias
Prior abuse/neglect	Poverty and unemployment	High levels of violence	Strict gender roles for males
LGBTQ+ status	Migration	Corruption of officials	Cultural beliefs/stigma
Substance abuse	Bullying and ostracism	Drug use and sales	Racial, ethnic, religious, sexual, and cultural bias/discrimination
Marginalized status due to discrimination	Gang affiliation	Increased travelers, tourists	Lack of effective antitrafficking laws/policies
Limited education	Limited education	Mass migration	Low recognition of child rights
	Abandonment by husband or loss of caregiver	Commercial sex in area	

Abbreviation: LGBTQ+, lesbian, gay, bisexual, transgender, queer or questioning.

to space limitations, the list is incomplete; the reader should refer to the citations above for further discussion. There is notable consistency around the world: Poverty, social inequality, gender-based violence, and other social determinants of health act as major drivers of trafficking and exploitation (47). Thus, committed and prolonged public health efforts to address these determinants are needed to reduce the prevalence of human trafficking.

RECRUITMENT AND CONTROL TACTICS

Children may be recruited into CST/CSE by strangers or intimate partners, by caregivers or other relatives, by employers, or by respected members of the community (2, 18, 21, 22, 49, 83, 90, 92, 93). Parents desperate to feed their families may be approached by a well-known person in the village who promises to find work for the oldest daughter in the nearest major city. Parents may or may not be aware that the recruiter will take the child to a brothel or a massage parlor. A runaway boy may find himself without food or money and decide to accept the advice of friends on the street to engage in transactional sex. An adolescent boy may convince his girlfriend to sell sex as a way to prove her love or to help him out of financial difficulties. Common recruitment tactics used by traffickers around the world entail seduction and false romance (47, 78), false promises for employment or a "better life" (2, 92), the bait-and-switch method (offer help or material goods without expectation of remuneration only to suddenly demand compensation at a later point) (83), creation of feelings of indebtedness toward the trafficker (30), mail-order bride schemes (2), kidnapping, and violence (with or without the use of drugs) (92, 93).

Trafficked and sexually exploited children and youth may remain in their situations for any number of reasons, ranging from a sense of helplessness and lack of resources, shame and stigma (feeling that they cannot go back to family or friends, that society will not allow them any other type of work), fear (of trafficker, of law enforcement, or immigration officials), debt bondage (the party giving a loan adds exorbitant and unreasonable costs that prevent the person accepting the loan from paying off the debt), or trauma bonding with the trafficker (through episodic demonstrations of affection, alternating with aggression and violence, the trafficker builds a strong bond with the victim such that the latter may not recognize their exploitative situation and may even defend the trafficker) (21, 30, 69, 104). Feelings of dependency may keep a trafficked person in their situation, as well (83). In cases of foreign-born trafficked persons, a lack of knowledge of the culture, of laws and legal rights, and of possible resources may prevent attempts to escape (104).

Finally, trafficked persons may perceive their situation as preferable to the one they left because they may have access to material goods, money to send home to family, other valued items, a feeling of acceptance, or a sense of family that is otherwise not available (21, 22, 69).

Trafficked persons may remain in their situation for days to years (69) and may eventually exit on their own or with assistance from others (e.g., family, law enforcement, victim-service organizations). Unfortunately, many trafficked children and youth return to their home only to find that conditions remain critical or perhaps have worsened (e.g., there is additional debt incurred from the trafficking process) (99). Family and community ostracism may be substantial; work and education options may be very limited (89, 99). Family dysfunction and strained relationships may persist, leading a person to leave home once again (89). All these factors increase the risk of retrafficking (89).

Persons trafficked across national borders may choose to stay in the country in which they were exploited. In this case, they may also encounter substantial challenges to recovery, including concerns about immigration status, housing, employment, adapting to new cultural practices and a new language, and potential social marginalization (for being foreign and/or for having been trafficked) (29). In the United States, federal assistance programs are available, including special visas (T- and U-visas) that allow the child and, in some cases, family members to stay in the country. However, stressors may be extremely strong, rendering the trafficked person vulnerable to renewed exploitation by the same or a different trafficker.

HEALTH IMPACT OF CST/CSE

CST and CSE are associated with a plethora of adverse physical and mental health conditions. Rates of sexually transmitted infections (STIs) are high: In one US study, 47% of sex-trafficked youth tested positive for an STI at the time of their evaluation, and 33% reported a prior history of STIs (40). In areas of the world where HIV rates are elevated, HIV infection among trafficked youth may be extremely high. A study of sex-trafficked Nepalese women and girls demonstrated especially high rates among the youngest group: Those under age 15 had a rate of 60.6%, which was 3.70 times the rate of those 18 years or older (92). HIV infection was also associated with being trafficked in Mumbai (versus other Indian cities) [adjusted odds ratio (AOR) = 4.85] and longer duration in brothel work (increased risk per month, AOR = 1.02) (92). Pregnancy rates are also high among sex-trafficked adolescents: In one study, 32% reported a history of a pregnancy (40). Substance use, including drugs and alcohol, is common, with rates as high as 92% of trafficked youth reporting this behavior (74). In one study of trafficked adolescents, 57% met screening criteria for substance use disorder (30). Drugs and alcohol may be used by trafficked persons to self-medicate against the stress of their situation and used to promote work (e.g., stay awake for long hours), to treat pain, or to suppress signs/symptoms of addiction. In some cases, traffickers encourage or even force drug or alcohol use, or customers pressure the person to consume substances. Violence is common among trafficked youth: In a study of sex- and/or labor-trafficked children and adolescents receiving services in Cambodia, Thailand, or Vietnam, 33% reported physical and/or sexual violence during their period of exploitation. Boys were more likely than girls to experience physical violence (41% and 19%, respectively ($p < 0.001$), although the reverse was true for sexual violence (1% boys, 23% girls). Of the girls trafficked into sex work, 71% reported experiencing sexual violence by a buyer (59). In another study of women and adolescent sex-trafficking survivors, nearly 95% reported either physical or sexual violence occurring during their period of exploitation, and 57% indicated that they had received physical injuries. Threats were similarly common: Nearly 90% reported threats to themselves, and nearly 35% reported threats to their families (121).

Mental health conditions associated with child trafficking and exploitation most commonly include post-traumatic stress disorder (PTSD), depression with self-harm, suicidal ideation and suicide attempts, hostility and aggression, and anxiety (19, 50, 59, 77). In a study of sexually exploited adolescent girls and women receiving posttrafficking services in one of several European organizations, high levels of depressive symptoms were identified in 55%, anxiety in 48%, and PTSD in 77%. Study participants reporting sexual violence were 5.6 times more likely to have high levels of PTSD symptoms [95% confidence interval (CI) 1.3–25.4]. A longer duration of trafficking was associated with higher levels of depression and anxiety (AOR = 2.2; 95% CI 1.1–4.5), and longer time since exiting exploitation (>3 months) was associated with lower levels of depression and anxiety (AOR = 0.40; 95% CI 0.2–0.8; AOR = 0.39, 95% CI 0.2–0.8, respectively) (50). Another study of commercially sexually exploited youth in the United States demonstrated rates of 71% and 50% for a history of cutting behaviors and of a suicide attempt within the past year (30).

Identifying CST/CSE in a health setting remains challenging owing to the lack of spontaneous disclosure by trafficked children/youth (38), lack of health care professional knowledge of human trafficking (9, 57), time constraints in busy health care settings, and the paucity of clinically validated screening tools (5). Trafficked persons may not disclose their exploitation to health professionals out of fear of retaliation by traffickers, fear of arrest and/or deportation, fear of bias and discrimination by health staff, shame, guilt, a sense of hopelessness, and a lack of recognition of their exploitative state (7, 38, 52, 53). However, evidence indicates that in some cases trafficked youth are willing to disclose their situation and willing to discuss it when approached by health professionals (35, 56), which suggests that a screening tool may be helpful in identifying trafficked children and youth and those at risk. Some tools have been developed for settings outside health care, but these tools tend to be lengthy and difficult to administer in a busy clinical situation (8, 112, 114). Two validated screening tools for sex trafficking have been developed for the health care setting: the Asian Health Services and Banteay Srei's CSEC (commercial sexual exploitation of children) Screening Protocol (13) and the CSEC/CST 6-item screening tool (40, 41, 56). The former is a 10-item high-risk indicator checklist (positive screen requires at least 2 positive indicators), and the latter is a 6-item screen of risk factors (positive screen entails 2 or more positive answers). Both tools target adolescents primarily and were deemed appropriate for the emergency department setting on the basis of the low number of screening items, ease of administration, use of multiple information sources, and lack of reliance on patient disclosure (5). However, more work needs to be done to design and validate tools for boys, LGBTQ+ youth, foreign-born adolescents, and young children. Also, it will be important to validate the tools in multiple types of clinical settings, in different cultural contexts, and using different methods of tool administration (e.g., verbal, printed format, iPad).

While a substantial number of trafficked persons obtain medical care during or after their exploitation, access to health care services is not necessarily easy in many areas of the world, and even in the United States and the United Kingdom, many barriers to health care exist. Factors precluding access to health services include refusal by the trafficker to allow the person to go to the hospital or clinic (12, 95, 115), the need to work and earn money rather than wait for many hours to be seen at a medical facility (66), lack of transportation to clinics and hospitals, and fear that health professionals will report trafficked persons to police and/or immigration officials (48, 52). Parents may not consent for their trafficked child to receive mental health services (33). Trafficked persons may initially have access to care but then be moved to other foster care settings or groups homes outside the catchment area of the initial provider (29). Lack of insurance and funding for care (12, 29), lack of knowledge of medical resources available (12, 115), and fear of judgment and stigmatization (115) may prevent trafficked persons from seeking care. Some youth

have concerns about confidentiality of sensitive information such as pregnancy or HIV status (52). Distrust of health care providers may be strong (67). Finally, local governments may have only poorly coordinated systems of health care for trafficked persons (66).

THE PUBLIC HEALTH APPROACH TO HUMAN TRAFFICKING

Human trafficking has traditionally been perceived as a law enforcement issue, and much effort is expended in US and global efforts to track the status of legislation criminalizing trafficking, as well as the number of arrests, prosecutions, and convictions for human trafficking (104, 110). While international conventions (20, 88, 108) and national legislation acknowledge the need for survivor services and prevention efforts [102, 117; Pub. L. 115–393; Pub. L. 106–386, Div. A 103(8)], only relatively recently has a concerted effort been initiated to view human trafficking as a public health issue (14, 66, 87, 100, 101). This approach is in line with the World Health Organization (WHO)'s stance on violence prevention (63). Human trafficking adversely impacts the health of individuals, groups, and society; combatting it requires an approach that addresses the health needs of entire populations. The public health approach prioritizes the following:

- Primary prevention. Identifying and prosecuting offenders may bring justice to victims, but it does not solve the problem of human trafficking; there will always be more traffickers to take the place of those sent to prison. To eradicate human trafficking, societies must prevent it from occurring. Primary prevention should be implemented at multiple levels, by a variety of professionals (63). Health, mental health, and public health professionals may educate patients/clients and their families about human trafficking and its risks and about common recruitment strategies used by traffickers (42). They may offer resources and education to address risk factors and vulnerabilities and discuss harmful cultural and social norms that help drive sexual exploitation. They may educate other professionals and the public about human trafficking (98) and support prevention efforts in schools and community-based organizations (42). They may advocate for policies and legislation that increase funding for primary prevention research, program implementation, and program evaluation and that address the social determinants of health that contribute to trafficking vulnerability (37, 42).
- Generation of an evidence base that drives policy, program development, and program implementation. The public health approach emphasizes continuous monitoring and evaluation to track the effects of policies, laws, and programs, with modifications based on results of outcomes studies. Research on human trafficking has grown remarkably over the past 15 years, but the evidence base remains relatively small. There are many prevention and intervention programs and initiatives in existence, yet there is a paucity of peer-reviewed publications describing formal outcomes studies (26, 27). Policies, legislation, and programs aimed at preventing human trafficking and effectively intervening to assist exploited persons must be based on sound empirical evidence regarding individual and community vulnerabilities, resilience factors, and structural conditions that impact human trafficking (60). While important information may be gleaned from lessons learned in the fields of child maltreatment and intimate partner violence, research is needed to identify ways in which human trafficking differs from these other forms of violence and learn how the risk factors, needs, and responses to intervention of subpopulations of trafficked adults and children differ. Multiple national health organizations, including the American Public Health Association (APHA; 4), have issued statements calling on health professionals to engage in research to inform policy, prevention, and treatment efforts (37). A public health research agenda for human trafficking prioritizes the following areas: (*a*) prevalence and incidence, (*b*) cost burden, (*c*) risk and protective factors, (*d*) screening and response, and (*e*) prevention strategies (87).

Evidence suggests that at least in some countries, many trafficked persons are able to access medical and/or mental health care (65, 77). This access presents an important opportunity to study risk and protective factors related to human trafficking, to characterize health issues associated with exploitation, and to evaluate treatment strategies and long-term health outcomes. Such research and evaluation would be facilitated if patients experiencing trafficking and exploitation could be identified in medical records. This approach would be accomplished most efficiently if specific codes for human trafficking were included in the International Classification of Diseases (ICD) system generated by the WHO (**http://www.who.int/classifications/icd/en/**). The ICD system provides a global framework for health professionals around the world to share critical information about diseases, injuries, genetic disorders, and other medical and surgical conditions. Each time a patient presents for medical care, documentation is made of their relevant diagnoses via the ICD coding system. Searching databases for specific ICD codes allows research to be done on large populations of deidentified patients, which in turn allows global monitoring of disease incidence and recurrence, characterization of short- and long-term adverse effects, assessments of treatment modalities, and estimations regarding cost of care.

Currently, the eleventh edition of the ICD codes released by the WHO has specific codes for several types of child maltreatment, sexual assault, and intimate partner violence but no codes for human trafficking and forced labor (**https://icd.who.int/en/**). Thus, critical data are lost because the latter conditions must be relegated to any of several generic code categories (e.g., sex trafficking coded as sexual assault). Fortunately, in 2018 the US Centers for Disease Control and Prevention (CDC) adopted new codes for labor and sexual exploitation of children and adults in the US revision of the ICD-10 coding system (ICD-10-US) (76). While this is an encouraging development, its impact is limited because the new codes are applicable only in the United States. Efforts must continue to advocate for the WHO to include human trafficking/exploitation codes in the global version of ICD-11 (39).

The public health approach to human trafficking incorporates the following activities:

- Surveillance of the problem, locally and globally. A major focus of public health is on local and global surveillance of diseases and other health conditions. For the reasons described above, local, national, and global estimates of incidence and prevalence of human trafficking are difficult to obtain and are generally not reliable (96). However, increasingly sophisticated efforts are being made to characterize the size and scope of the issue (54). Success will require extensive multidisciplinary collaboration and multiple sources of data, as well as clearly delineated definitions of key terms and complex methods of data analysis. An example of intense collaboration and consensus building around definitions may be found in the set of terminology guidelines regarding sexual exploitation and abuse of children created by an international working group (44). More of these efforts are needed, as are formal agreements to share data among agencies and organizations.
- Determination of vulnerability and resilience factors using a socioecological model (11, 63). The public health approach of targeting multiple levels of risk (63) is essential in the efforts to combat human trafficking. For example, a pediatrician may provide counseling and resources to a youth struggling with their transgender identity; this advice may prevent that youth from engaging in high-risk online activities in an effort to understand his situation and connect with others. The physician may educate the child's family about issues related to sexual identity and the need for support and understanding. These efforts may prevent the harmful social intolerance that would otherwise drive the child to run away from home, at which point they are at high risk of commercial sexual exploitation (17, 45). Health care professionals can actively model sexual tolerance by designing gender-neutral patient forms,

creating a gender-neutral clinical environment, and advocating for services for LGBTQ+ youth.

- Changing cultural norms that contribute to risk and inhibit effective intervention. The public health focus on changing cultural norms is vital to addressing widespread beliefs and practices that marginalize individuals and groups and condone situations that increase the risk of trafficking. Gender bias and discrimination, strict gender roles, homophobia, caste systems, racism, and religious/ethnic/social discrimination foster vulnerability to human trafficking; social tolerance of systematic marginalization and of individual and community violence allows it to thrive (25, 47, 71, 104). Some efforts are being made to address the widespread cultural view of girls and women as sex objects and the glorification of the pimp culture. The Chicago Alliance Against Sexual Exploitation (**http://caase.org/prevention**) brings an education program into schools that challenges adolescent boys to question their attitudes toward girls/women in the commercial sex trade, their definitions of masculinity, and beliefs about healthy relationships and violence against women. To the author's knowledge, this program has not had a formal evaluation published in peer-reviewed scientific literature.
- An interdisciplinary approach to problem solving, working with key stakeholders from a variety of fields. Multidisciplinary collaboration has shown success in the field of child abuse and neglect, based largely on the child advocacy center (CAC) model (73, 118) and the development of community protocols for child abuse investigation. Law enforcement, health, mental health, social service professionals, and victim advocates work together to share information, collaborate on investigations, and minimize retraumatization of the child and family. In many CACs, medical care and mental health care are integral components of the program, allowing the child to have their investigative interview, medical evaluation, and mental health treatment at a single location. Consistent with the public health approach, antitrafficking efforts must involve multidisciplinary collaboration of key stakeholders involved in prevention, identification, and treatment services (99, 103). CACs are increasingly being used to provide services to sex-trafficked children and youth, allowing integrated services to help fulfill the extensive needs of this population.

Given the extensive needs of trafficked persons, including housing, crisis intervention, medical and mental health care, education/skills training, immigration assistance, interpreter assistance, and legal aid, health professionals may feel overwhelmed and ill-equipped to connect trafficked patients/clients with appropriate services. They may lack awareness of local and national resources for trafficked persons or be unfamiliar with reporting and referral procedures. In fact, 44% of service providers in one study indicated that a common barrier to successful care involved ineffective coordination with federal agencies, and 39% reported a similar barrier with local agencies (16). While a national antitrafficking hotline exists (**https://humantraffickinghotline.org/**), only 14% of medical providers in one study contacted this hotline or made service referrals for suspected trafficked persons (9). These findings highlight the need for training of health professionals regarding human trafficking (79, 98), and medical societies have issued statements to this effect (3, 37). Specific protocols and guidelines for health professionals can help ensure that trafficked persons are recognized, appropriately treated, and offered needed resources (6, 38, 97, 120).

At a higher level, national and international multidisciplinary organizations such as HEAL Trafficking (**https://healtrafficking.org/**) have been formed to address human trafficking. HEAL brings together thousands of professionals dedicated to ending human trafficking and supporting trafficked persons using a public health approach. The organization works to bring multidisciplinary perspectives to advocacy, research, education, and direct service efforts. Many states have developed countywide and statewide antitrafficking task forces, such as the Georgia Criminal

Justice Coordinating Council's Statewide Human Trafficking Task Force (**https://cjcc.georgia.gov/human-trafficking-task-force**).

Other national and international initiatives involve a multitude of key stakeholders. In the United States, Truckers Against Trafficking (**https://truckersagainsttrafficking.org/**) unites truck and bus drivers in an effort to increase identification and reporting of situations suspicious for human trafficking. End Child Prostitution And Trafficking's (ECPAT) Tourism Child-Protection Code of Conduct (**https://www.ecpatusa.org/code**) enjoins travel and hospitality businesses to adopt antitrafficking principles and practices that prevent CST and CSE. Signatories of the Code promise to establish policies and procedures against sexual exploitation, to train employees, and to inform travelers about children's rights, the problem of human trafficking, and information about how to report suspected cases.

CONCLUSION: WHAT CAN PUBLIC HEALTH PROFESSIONALS DO TO ADDRESS CST/CSE?

To effectively combat human trafficking and forced labor, we need to take a public health approach, using public health's emphasis on rigorous scientific research to build an evidence base that will undergird prevention programs, legislation, and policy development; its dedication to constant monitoring, evaluation, and improvement of intervention strategies, and its focus on a socioecological model of risk reduction. Public health professionals can make critical contributions to the antitrafficking movement in the following ways.

Prevention

1. Learn from public health efforts to address child maltreatment and intimate partner violence. Identify similarities and differences between the populations and assess components of prevention and intervention programs that are likely to be relevant to trafficked children and youth.
2. Work to develop, implement, and evaluate primary prevention efforts targeting potential victims and traffickers, as well as potential buyers. These efforts should employ strategies at the individual, relationship, community, or societal levels. Schools are a promising venue for prevention efforts, as are public health facilities and clinics.

Education and Training

1. Advocate for training of health and public health professionals on all types of human trafficking. Curricula for public health graduate students and those training in medicine and nursing should include information on sexual and labor exploitation.
2. Advocate for available resources and technical assistance for health and public health professionals to supplement initial training (e.g., National Human Trafficking Training and Technical Assistance Center or HEAL Trafficking).

Research

1. Conduct rigorous research on human trafficking, focusing on (*a*) prevalence and incidence, (*b*) cost burden, (*c*) risk and protective factors, (*d*) screening and response, and (*e*) prevention strategies (87).
2. Engage in research on the sexual exploitation/trafficking of boys, LGBTQ+ youth, and runaway/homeless/street-based children.

3. Conduct research on the similarities and differences between trafficking of domestic versus foreign-national children/youth, including risk/resilience factors, prevention strategies, barriers to accessing health care, health care needs, and effective treatments.
4. Advocate for centralized surveillance and data collection on identified trafficked persons.

Public Policy and Legislation

1. Work with health professionals and others to facilitate a public health approach to human trafficking within the United States and abroad (14).
2. Be familiar with the components of the APHA and the American Academy of Pediatrics policies on human trafficking (4, 37), and advocate for strong action to be taken by these societies on national and international policies.
3. Support state, national, and international antitrafficking policies and laws to improve services for foreign national and domestic trafficked persons, including adequate insurance coverage to allow increased access to comprehensive, victim-centered, culturally sensitive, medical and mental health services; immigration assistance; and holistic, coordinated, and collaborative multidisciplinary provision of aftercare.
4. Support state, national, and international initiatives, policies, and laws addressing the social determinants of health that contribute to a person's vulnerability to human trafficking.
5. Advocate for WHO introduction of specific ICD-11 codes regarding forced sex and labor exploitation (39).

Direct Services

1. Continue to develop guidelines and protocols to assist health and public health professionals and health systems to respond appropriately to human trafficking. This initiative includes developing and validating screening tools and creating child-friendly, victim-centered, trauma-informed, and culturally sensitive environments where staff are knowledgeable about, and sensitive to, human trafficking and exploitation.
2. Encourage health and public health professionals to actively engage in a multidisciplinary community-based approach to identifying and serving trafficked persons. This initiative involves educating key stakeholders on the public health approach to human trafficking, increasing their awareness of the need for medical and mental health care for trafficked persons, and identifying key organizations that can provide victim services.
3. Develop, implement, and evaluate approaches to mental health assessment and treatment that are culturally appropriate and relevant to the needs and challenges of trafficked persons in diverse settings. These may involve Western talk therapies and/or alternative practices such as yoga, art therapy, music therapy, or dance therapy. Prioritize the need to incorporate culturally relevant beliefs and practices that will assist in the healing process.
4. Engage community public health workers in prevention and follow-up health care in rural communities to build resilience in vulnerable families and assist trafficked persons who are reintegrating into their villages and towns.

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