Child Trafficking and Commercial Sexual Exploitation of Children: Medical & Psychosocial Services for the Victims

October 13, 2016
India International Center Annex Lecture Hall 1, New Delhi

REPORT
### Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>3</td>
</tr>
<tr>
<td>Report of Proceedings</td>
<td>6</td>
</tr>
<tr>
<td>Conclusion &amp; Summary of Observations and Recommendations</td>
<td>19</td>
</tr>
<tr>
<td>Annexures</td>
<td>25</td>
</tr>
</tbody>
</table>
Executive Summary

Child Trafficking and Commercial Sexual Exploitation of Children (CSEC) are violations of the fundamental rights of children to be safe and are in contravention to the United Nations Convention on the Rights of the Child (UNCRC).\(^1\) The exact numbers of victims of child trafficking and commercial sexual exploitation are unknown, although estimates range into millions. The interaction of poverty and gender-based violence in developing countries heightens the risk of sex trafficking and CSEC.

Medical evaluation in CSEC and sex trafficking is an emerging area of research and practice and few healthcare settings have established screening practices, policies and protocols.\(^2\) There is limited information available to paediatricians and allied health professionals on how to protect trafficked and vulnerable children. Evaluations of CSEC victims may be challenging. Children are rarely forthcoming about their actual history and it requires patience and a secure environment to gain their trust. Knowledge of risk factors, recruitment practices, and common medical and mental health problems experienced by victims will help the paediatricians recognise potential victims and respond appropriately. In addition, all medical and multidisciplinary professionals must comply with child abuse mandatory reporting laws and existing legislation in their regions/country.\(^3\)

A one day consultation on the issue of Child Trafficking and Commercial Sexual Exploitation of Children (CSEC): Medical and Psychosocial Services for Victims” was held on 13 October, 2016 at the India International Centre, Lodi Estate, New Delhi. The consultation aimed to help professionals, coming in contact with survivors/victims of child sexual abuse, get a better understanding of the issue of CSA and equip them with information to prevent and respond to victims of sexual abuse. Participants included paediatricians, physicians, mental health professionals, academicians, psychologist, nurses, medical social workers, child rights activists, allied NGO’s, Government & International Agencies.

The specific objectives of the consultation were: i) to create awareness and sensitise the paediatricians and allied professionals to prevent and respond to victims of “Child Trafficking and Commercial Sexual Exploitation of Children”; ii) to educate paediatricians and allied professional to improve provision of direct medical care, anticipatory guidance and collaborative referrals to non-medical colleagues for complex health needs and psychosocial services to victims of CSEC; iii) to provide useful information to paediatricians and allied health professionals regarding existing child protection systems available in the country.

Presentations at the consultation provided global and national perspectives on the status of Child Trafficking and Commercial Sexual Exploitation of Children that included legislative and policy initiatives. The term trauma informed approach and trauma informed care, while responding to children who have been sexually exploited, were introduced as was the importance of including mental health and emotional evaluations and interventions along with the medical treatment. Representatives from international agencies, government, advocates and representatives from civil society discussed the pros and cons of the draft Anti Child Trafficking Bill, community based child protection systems, child helpline and the importance of documentation for providing medical evidence in court.

Participants agreed on the need for a multi-disciplinary approach to interventions and for focussed initiatives to prevent trafficking and child sexual abuse by strengthening child protection mechanisms in the community. Attitudinal change was identified as a key factor for bringing


about real changes in the lives of children at risk of sexual exploitation. Given the general lack of awareness while examining child victims of sexual abuse, it was agreed that medical curriculum must include modules to train doctors on key medico legal aspects that include comprehensive history taking, identifying psychosocial and mental health symptoms with a non-judgmental and open attitude. Knowledge of risk factors, recruitment practices, and common medical and mental health problems experienced by victims will help the paediatricians recognise potential victims and respond appropriately. In addition, all medical and multidisciplinary professionals must comply with child abuse mandatory reporting laws and existing legislation in their regions/country.

Summary of observations and recommendations:

**Attitudinal Change**: All stakeholders must reflect on our attitudes towards children. This reflection must include how we implement policies and invest resources for children. The child must be seen as the index for respect of the village and every village must respect its children. The nation needs to invest abundantly and optimally on children’s survival, protection, development and participation.

**Defining Child Protection**: There exists very little understanding of what protection entails for children. The concept of child protection needs to be understood and redefined within the Indian context. Community awareness on the issue must be increased through sustained advocacy and communication measures.

**Increase attention to Prevention**: Interventions on trafficking need to begin with prevention measures. These include providing safety nets in the form of community monitoring and support systems, keeping children in school, ensuring access to incentives and schemes by children in especially difficult situations.

**Trauma informed approach to assessments and interventions**: Children who are trafficked and have been sexually abused have lived for a considerable period in situations of extreme stress and fear. This must be recognised and inform all decisions while providing professional assistance. A multi-disciplinary approach is required to address the needs of children.

**No Health without Mental Health**: Medical assessments and interventions should go beyond physical treatment of injuries, to also include the mental health of victims of child sexual abuse. The psychosocial impact of prolonged bondage and subjugation, must be acknowledged and addressed. Measures need to be taken to address the lack of trained professionals in this field.

**Invest in capacity building of health professionals**: The current curriculum of medical training for doctors and other allied health services does not cover examination or treatment protocols involved in instances of child sexual abuse. Doctors also need to update their communication skills.

**Ensure the implementation of existing policies, programmes and legislation**: India has some strong legislation and good policies and programmes, however the challenge continues in the implementation of these. Concerted efforts must be made to involve various sectors to ensure that the benefits of these policies and programmes reach the most marginalised.
Report of Proceedings

The programme was anchored by Dr. Rajeev Seth. Dr. Seth welcomed participants to the consultation and expressed the hope that the day would bring about learning and clarity on the issue of Child Trafficking and Commercial Sexual Exploitation of Children and the role of the medical and health professionals in providing medical services to children traumatised by sustained abuse.

Session 1: Overview of the problem of Child Trafficking and Commercial Sexual Exploitation in India

Speaker: Ms/ Enakshi Ganguly, Co- Director, HAQ Centre for Child Rights
Moderator/s: Dr. A.K. Shiv Kumar, Global Co- Chair, Know Violence in Childhood

In 2001, HAQ Centre for Child Rights undertook a comprehensive study on Child Trafficking in India for Terre de homes (Germany). The discussions and deliberations around the findings of the study led to the launch of the Campaign against Child Trafficking (CACT) on December 12, 2001, in New Delhi. CACT currently has chapters in 12 states across the country. Fifteen years on, HAQ revisited the issue and released an updated version of the report in June 2016.

An audio visual presentation consolidating the findings of the study gave the participants an overview of the situation of child trafficking in India. Painting a grim picture of the status of child trafficking in the country, the report highlighted the absence of data, the lack of sustained follow up after an initial uproar, including in instances that had received massive media coverage (Nithari, various search and rescue by NGOs). Adding to the confusion are the multiplicity of interventions and a seeming absence of synergy in multiple interventions introduced by the Government. An illustration of this is the lack of convergence between the Track Child programme of the Ministry of Women and Child Development and the Anti-Human Trafficking Units (ATHU) of the Ministry of Home affairs. Prior to the HAQ study, trafficking was thought to be synonymous with women and girls. The study expanded the group to include boys and men. The dissemination of the report provided an opportunity for deliberation on the issue among multiple NGOs and child rights activists, many of whom came together to form the Campaign against Child Trafficking. It was the sustained campaign by CACT that ensured attention to and the inclusion of Child Trafficking in the National Plan of Action, 2005. Internationally the Government of India ratified the UN Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography.

Revisiting the issue 15 years later, the report found that despite increased awareness on the issue, positive changes in legislation and the introduction of child protection schemes, the situation for children at risk remained, more or less, the same. Studies indicate that over 36

4https://www.youtube.com/watch?v=Gc2lvvdjzHU
percent of children continue to be at risk of child trafficking. The United Nations Office on Drugs and Crime (UNODC) report in 2013\(^5\) came up with a report on trafficking rackets and gangs. Children were reported to being kidnapped for various purposes including begging, sex trafficking and for cheap child labour. Post disasters, children are at a higher risk of being trafficked as demonstrated after the Nepal earthquake in 2013. A large number of new-borns go missing from nursing homes. A perusal of the questions asked in Parliament indicated that while most of these related to the gravity of the situation, government responses were limited to government schemes, seldom addressing the human issue at hand.

With response to child trafficking becoming specialised (special Anti-Human Trafficking Units have been set up), the role of the local police has become minimised. There are serious discrepancies in data provided by various departments involved in responding to trafficking or collecting information. Rehabilitation efforts have failed to bring about desired change and the absence of cohesion and multiplicity of agencies make it difficult for victims to seek redressal.

Ms. Ganguly elaborated on the consequences of trafficking and the challenges in the rehabilitation of the survivors by citing the example of a girl, HAQ had come in contact with, following her rescue. The girl had been trafficked from NOIDA, taken to Dubai and was subsequently found and rescued in Jalpaiguri, West Bengal. To keep her quiet and submissive, she had been drugged and plied with alcohol. She had also been given hormonal injections to hasten the appearance of secondary sexual characteristics. Rescued 3 years back, she is a recovering alcoholic, a drug addict, is unable to concentrate, and frequently demonstrates aggressive behaviour. The girl continues to seek justice, against the nine accused, in court. Three years down the line, the staff at HAQ are still struggling to discover what they should do to make her feel whole again. Unlike other violent crimes, trafficked individuals face sustained trauma with repeated sexual assaults. Torture, manipulation, abusive living conditions are part and parcel of a survivor’s life.

Post-traumatic stress disorder, aggression, feelings of alienation and disruption of family life are common among the rescued. Violence need not necessarily end when the trafficking is over, it may continue in the family as parents may be unable to understand the changed behaviour pattern in their child.

Although Standard Operation Procedures (SOP), to respond to the medico-legal needs of trafficked women and children, have been developed in India, these remain largely underutilised and unimplemented. The situation is further compounded for children who fall in between many silos. Addressing their needs is divided between the Ministry of Women and Child Development, the Ministry of Labour and the Ministry of Home Affairs. The situation gets further complicated for children trafficked from or to another country.

Open session:
Key points that emerged from the open session following the presentation:
- The need to understand what constitutes ‘protection’ and bring about an attitudinal change among adults on the issue of child protection.
- The need for awareness of increased and emerging threats for children through online and digital platforms
- The absence or inadequacy of the interventions towards prevention of trafficking: Despite programmes like the Integrated Child Protection Scheme that provide for community protection systems at various levels, children continue to remain at risk owing to the limited reach of the scheme in the communities
- Limitations of rescue and rehabilitation: The follow up to prevent further trafficking is missing. Often rescuing children from brothels is like fishing in an aquarium – nothing changes for them.
- Need for policy changes to address the issue of rescue and rehabilitation

\(^5\) Status of victim service providers and criminal justice actors in India", UNODC, 2013.
- Need for psychosocial interventions that are individualised since coping mechanisms among individuals vary.
- Trauma intensified by the delay in court procedures – victim unable to get closure owing to prolonged trials. Special courts continue to be limited in numbers. How do we restore a sense of justice to the survivors?
- Challenges of medical examinations and the need to avoid value judgement while doing medical examinations – Need to include the procedures for such special examinations in the clinical curriculum
- Every practitioner must understand what protection means — every paediatrician must recognise abuse, every health worker must recognise symptoms of the possibilities of vulnerabilities.

Summing up the discussions, Dr, Shiv Kumar reemphasised the need to focus on prevention and the necessity to recognise and identify the social and societal factors that have to be addressed to prevent sexual exploitation that can be seen as an extreme form of modern slavery. Dr. Kumar recommended against categorising different forms of violence as these are interconnected and are drivers of social behaviour. The child who is bullied, faces violence and runs away. Trafficking, then, is a via media of perpetuating violence. Unless we create an environment that is protective, the issue of trafficking and CSEC will not be addressed. Dr. Kumar also drew attention to the emerging threats from the digital and online spaces and the proliferation of child pornography across virtual borders.

Session 2: Global Sex Trafficking and Commercial Sexual Exploitation of Children: Medical Services for Victims

Speaker: Ms. Jordan Greenbaum, MD, Paediatrician, Atlanta USA & Director of the Global Health and Wellbeing Initiative with the International Centre for Missing and Exploited Children.

Moderators: Dr Sunil Mehra, Founder and Director, MAMTA & Ms. Razia Ismail Convener IACR

Introducing the session, Ms. Razia Ismail, convener, India Alliance for Child Rights, recalled four points that had emerged in the previous session: the need to communicate; early detection; timely intervention; and no displacement. Within the continuum of “What we might look at – before, during and after”, she wondered when it is that a child is brought in front of a health professional in instances of CSEC - and what is the ‘before’ in CSEC. Reminding the participants that safety for children was not merely the presence of a safe room, she stressed on the need for professionals to be watchful, and be alert to the possibility of abuse while examining children.

The keynote address by Dr. Jordan Greenbaum, covered i) the scope of global human trafficking and risk factors involved; ii) familiarising the participants to a trauma informed approach to medical assessment and iii) recalling the steps of medical evaluation. Dr. Greenbaum, clarified, at the onset, that the use of the word “victim” in her presentation was solely from the medico-legal perspective and not applied to the social context.
Commercial Sexual Exploitation of Children (CSEC) occurs “when a person induces a minor to engage in a sex act in exchange for remuneration in the form of money, food, shelter or other valued entity.” These include survival sex, trafficking a child for commercial sex act (on account of which anything of value is given to or received by any person), pornography, sex tourism, and the use of a child in sexually oriented business. It does not require force, coercion or violence.

Differentiating between human trafficking and the trafficking of a minor, Dr. Greenbaum explained that while trying traffickers for CSEC, demonstrating means of inducement is not necessary since children, unlike adults, are below the legal age of consent.

A summary of key presentation points by Dr. Greenbaum is given below: The complete PowerPoint presentation is attached.

**Scope of global human trafficking and risk factors involved:** The exact incidence and prevalence of trafficking is unknown and difficult to estimate owing to the criminal nature of the activity and its happening under the radar. The ILO estimates the number to be about 20 million.

Disaggregated data on the identified victims of trafficking indicate that out of all people identified as trafficked, women made up 49 percent while children comprised 33 percent (12 percent boys and 21 percent girls). 36 percent of total persons trafficked in South East Asian countries were children.

**High risk groups vulnerable to being trafficked include** those affected by poverty, girls left out of the education system owing to gender bias, street children, children from marginalised communities, sexual minorities, children affected by upheavals arising from natural disasters or community violence.

It is hard for children and even adult victims of trafficking to get medical care as very often the person is not in a situation where they can freely move. The health professional is approached only when the child is in an advanced stage of ill health.

Dr. Greenbaum listed the adverse health effects of CSEC. One study had indicated that approximately 50 percent of rescued children have an STI. The children face physical violence at the hands of traffickers and buyers - they are treated as objects rather than as human beings. Victims of CSEC may experience a variety of injuries (burns, bruising, broken bones, head injury) chronic pain, and malnutrition. In addition there is significant impact on the mental health of these victims with one study estimating up to 75 percent of survivors suffered from symptoms of Post-Traumatic Stress Disorder (PTSD). Almost half of them had attempted suicide in the previous year. In India, a study pointed to the very high rates of HIV among young girls trafficked to Mumbai. Immature genital tracts make young girls more vulnerable to attacks by the human immunodeficiency virus and human papilloma virus, as does the fact that younger girls are more likely to be trafficked to multiple brothels as they are “valued” more by clients. They also have lesser access to health care.

Recognising a victim of child trafficking could be extremely challenging. Most of them would not self-identify and would be reluctant to disclose any details owing to fear, shame and other factors. First impressions could give the medical professional possible indicators of trafficking.

---

7 UNODC report, 2014
The youth may appear afraid of adults or be overly submissive, anxious. They may give false demographic information and provide an inconsistent history. They may show delayed presentation of illness since they would have been brought in only at a much later stage. The child may not speak the local language indicating that they may have come from outside the community.

Dr. Greenbaum spoke of the paradigm shift while conducting medical examination of victims of sexual abuse from 'what's wrong with you to what has happened to you". She emphasised that having the right attitude was crucial while conducting medical evaluation of the child. She said that trauma affects behaviour, belief and attitudes. Trauma informed care is an approach to dealing with an adult or child who has experienced significant trauma. Central to the approach is the recognition that trauma affects the way a victim thinks, feels and acts, how they see the world. The health professionals need to acknowledge that the young person's actions may be influenced by what they have experienced. Talking to the child about trauma may trigger anxiety and fear related to the experience.

There is a need to minimize re-trauma, establish emotional and physical safety and encourage resilience. A human rights approach would ensure that the victim is treated with respect and empowered to make decisions. They must be informed of the actions that are being recommended including possible examinations and tests, and must realize they have the right to say NO.

It is essential for doctors to be non-judgemental while examining a victim of SEC, and avoid blaming them. When interpreters are required, they must be educated about human trafficking and employ a trauma-informed approach. Doctors must focus on the information they need and not try to ask questions only to satisfy their curiosity.

Before they begin the medical examinations, there are 4 actions to be taken: Provide the patient with explanations of what the exam and evaluation entails, ensure confidentiality and privacy of patient interactions, ensure physical and psychological safety of the patient and staff, and obtain permission by the patient/caregiver to proceed.

Mental Health Assessment is critically important and the doctor must assess the need for emergency psychiatric evaluation and help initiate referrals for full assessment and counselling. Drug testing is recommended in certain situations such as when the patient reports periods of memory loss within the past 72 hours, presents for medical care intoxicated, or reports taking substances within the past 72 hours. Again, informed consent for drug testing is necessary.

Dr. Greenbaum presented two case studies to take the participants through possible interventions

**CASE 1:**
16 year old female brought to your clinic by NGO staff. Patient with history of pelvic pain and vaginal discharge x 2 weeks. History of trafficking from Nepal at age 14; drugged at village event, kidnapped, sold to brothel. Illiterate, no education. History of sexual abuse by uncle. In brothel, had 10-20 clients per night; No health care. Not allowed out of brothel. Housed in single room with 9 other women/girls.

**Case 2**
13 year old homosexual male is brought in by police after being found in apartment of local man. Child ran away from home and parents called police.
Child tells you he has no friends, is ostracised for his sexuality, and feels alienated from his parents. He ran away and met a man on the street who offered to let him stay at his apartment. He had sex with the man, stayed with him for 4 days and then the man began bringing other men home to have sex with patient. Police were called when neighbor became suspicious of all the activity.
Key points emerging from the discussions around the case studies were

Need to ensure that the medical examination includes documentation of any recent or remote injuries and if the child will allow it, documentation of these with photographs. If at all possible, victims need to be tested for HIV, Syphilis, hepatitis, N. gonorrhoea, C. trachomatis, T. vaginalis, other STIs that are common in the region and, potentially, diseases that are endemic in their home country. At all times, patient consent is essential. In many instances there are no signs of anogenital trauma and when injuries do occur, they heal quickly and completely, typically without any scarring. Therefore, a lack of trauma on exam does NOT rule out the possibility of sexual contact.

Having a chaperone during the exam, excluding the trafficker when speaking with the patient, monitoring for signs of distress during the history and physical exam, explaining all procedures to the child and asking the child if they have any questions about their body were some of the tips provided by Dr. Greenbaum. She was highly appreciative of the Standard Operating Procedures outlined by the Ministry of Health, Government of India.

Fig 1. Comprehensive Medical Response to Sexual Violence

In terms of common reports and referrals, Dr. Greenbaum mentioned the need to consider:

- Authorities, if not already involved
- Trauma-focused mental health assessment and therapy
- Referral to primary care resource if child lacks ongoing care
- Referral for medical specialty care if indicated (obstetrician for the pregnant patient, for example)
- Follow up of STI test results, and treatment if indicated (if child did not receive treatment during initial visit)
- Counsel on exploitation prevention, internet safety
- Crisis hotline (include Human trafficking hotline if available)
- Follow up with child if possible, to help facilitate services, provide support
- Resources for LGBTQ youth, as appropriate

Concluding her presentation, Dr. Greenbaum summed up key points made during the presentation:

- Trafficking victims experience many adverse health consequences
- Medical evaluation needs to be trauma-informed, sensitive
- Systematic evaluation with documentation is critical

Wrapping up the session, Dr Sunil Mehra, Director, MAMTA, highlighted the complexity of the issue and wondered how it would be possible to encapsulate what was needed within a fragile health system such as the one that exists in India. Dr. Mehra said that speaking from personal experience, the biggest problem for medical professionals was that they were trained to be prescriptive, not participatory. To have any strategy for adolescents in this age group in different scenarios is difficult. Besides, ensuring confidentiality is a big problem in providing adolescent friendly health services. The problem is not the concern of doctors alone, there are many below and above who need to be worked on.

Dr. Mehra emphasised that if attitudes are right, much could be resolved. He was of the view that the focus needs to be on prevention and how we go about it. Referring to multiple articles every day in the newspaper on status of malnutrition, child marriage in our country, Dr. Mehra felt it was time we reflected on how we dealt with our children, gearing policy which protect. More importantly, there is a need to define protection. Can we say that the child is the index of the respect of the village and that every village respect its children? There is a need to invest abundantly in this subset so that children do not just survive but thrive. He wondered whether the Indian Association for Paediatrics (IAP) was geared to generate support from the private sector that has a significant role to play. Stressing on the need for more interventions at the societal level, Dr. Mehra expressed the opinion that denominators of social interventions are still not fully understood. Management is not about getting early detection, instead it is about identifying vulnerable groups, providing clinical care to prevent long term trauma.

Key discussion points at the open session:

- Prevention most important – number of trafficked children coming in contact with doctors is negligible.
- There is a need for medical syllabus to include sensitivity and communication skills.
- The traffickers may have their own doctors and these people may be difficult to influence as they had voluntarily decided to profit from the trade.
- Medical examinations need to include checking for the presence of warts, check whether the child has advanced sexual maturity – she may have been given hormonal injections
- Documentation of medical assessment is essential - as one participant put it - “If you didn’t write it, you didn’t do it”
- It is mandatory for doctors to report any instance of sexual abuse
- The trauma informed approach presented by Dr. Greenbaum is relevant as a framework for most systems including the police and the judiciary. The approach can be taken to every discipline.
- The detection of medical age may be affected by hormonal injections – however, it was suggested that teeth, bone age, bone density tests would not be affected
- Dilemmas of doctors around mandatory reporting especially in instances where young persons below 18 years have “consensually” entered into sexual activity.
- The doctor must limit their role to medical issues and not play a judge
Dr. D.N. Virmani, Past President IAP, Delhi introduced the speaker for the session and mentioned that not many paediatricians have had training on physical examination of trauma victims. Thanking the organisers for the consultation, he highlighted the fact that child victims of sexual abuse were severely mentally traumatised. The scarcity of mental health professionals is a matter of concern given the need for intervention in many social cultural practices that lead to mental health disturbances.

Speaking on the issue of psychosocial context of child trafficking and child sexual abuse, Dr. Rajesh Sagar highlighted the proactive role of the medical professional in identifying the hidden, unidentified mental health problem. Stating that there is “No Health without Mental Health”, he expressed concern that despite its importance especially in instances of continuous abuse such as those experienced by victims of CSA, the physical component gets more attention compared to the mental.

From the mental health perspective, coercion has a bearing on the mind and on mental health since it has to do with the use of power. This includes child marriage.

Although the situation of trafficking is alarming, it is not discussed much in India or given the consideration it deserves. The dearth of professionals in the field also does not help the situation.

Dr Sagar spoke of the push and pull factors that lead to trafficking. While poverty, inequality and disempowerment are factors that push people and children towards trafficking, the demand for trafficked individuals and the money involved act as a pull factors.

Reiterating the points made during the earlier sessions, he regretted the absence of curricular inputs to develop communication skills. Children with psychiatric problems are more vulnerable to trafficking.

Dr. Sagar advised doctors, observing multiple medical problems in the Paediatric setting, to always ask questions which may identify a mental health problem – to always ask these when they see an injury. He highlighted the risks faced by children in institutions. Speaking of anger management, he mentioned that there were a wide range of symptoms and these were not difficult to diagnose. Dr. Sagar emphasised the need to talk, to work on aggression issues which may be directed internally or outward. Symptoms of mental health may not be at the extreme criteria of disorder but children may demonstrate symptoms. Assessment in the mainstream must be handled in a multi –
disciplinary manner with sensitivity. Each child has a different need and a needs assessment is required along with assuring the child of safety and confidentiality.

Dr. Sagar provided examples of Indian initiatives that he had personally been engaged in. Among these were ‘Developing Guidelines for Prevention of Child Abuse’ by the Delhi Commission for the Protection of Child Rights, the training of doctors and health professionals in accordance with the POCSO Act. The training included prevention and response to protection issues.

In the context of technology, Dr. Sagar spoke of the impact of cyberbullying, sexting, online abuse. He pointed out that the issue had far reaching implications needing intervention beyond that provided by health professionals.

A review of literature on child sexual abuse indicated some effective solutions. Therapies like Cognitive Behavioural Therapy have been found to be useful. Referring to the World Mental Health Day, Dr. Sagar reiterated that every child who has gone through a trauma needed, at the very least, a First Aid level of intervention. He listed the basic steps to reinstate psychological wellbeing - talk, instil hope, and communicate - can be beneficial for any person in distress. Training on this could be provided at the community level.

Dr. Sagar felt that it was important for professionals to develop skill sets to be able to help victims re-establish identify. The empowerment of the child is important and it is necessary to build a rapport before asking the child for information.

Concluding the session, Dr. Kiran Mody spoke of the risks and consequence, beginning from the time of recruitment, that children who were trafficked faced. Post rescue, their situation is devastating and it is essential to go beyond survival to getting them to thrive. There is a need to focus on attitudinal shift not only among doctors but among family, community. The mantra of protection must be on everyone’s mind. In the absence of adequate number of professional counsellors, she suggested training of people who could be para counsellors.

**Session 3: Government Initiatives & Draft Anti-Trafficking Bill**

**Special Guest:** Ms Rupa Kapoor, Member, National Commission for Protection of Child Rights (NCPCR)

**Speaker:** Dr Professor Pravin Patkar, Fulbright Nehru Academic & Professional Excellence Fellow- 2015-16, Co-founder & Director, PRERNA, Mumbai

**Moderators:** Ms Tannistha Datta, Child Protection Specialist UNICEF & Dr Rajeev Seth, Chair ICANCL.

Introducing the session, Ms. Tannistha Datta, UNICEF provided some general comments on the Bill and brought to the participants’ notice, the need to review the provisions of the current Bill in the context of existing legislations to identify overlapping elements. She spoke of the challenges in implementation of the draft legislation and of the heightened responsibility that this placed on the police.

While it was heartening to see Prevention highlighted, she felt that the issue needed to have been thought through in the context of the child protection systems established under the ICPS. Another area of concern was that
rehabilitation seemed to be synonymous with institution based approach and there was a lack of focus on non-institutionalised services.

Ms. Datta wondered where the specialised focus on children was and said she had struggled to place children in the Bill. Owing to the confusing wording, it was not clear whether the child needed to be presented to one agency or multiple agencies.

Ms. Datta maintained that law making should be based on experience of approaches and suggested that the current bill provided a good opportunity to deliberate more thoroughly on the issue.

Ms. Rupa Kapoor, member NCPCR, shared her initial experiences of working with sex workers and their children in Sonagachi in West Bengal. Describing the miserable condition that the young girls involved in sex work lived in, she also shared how many of them had told her that going back was not an option for them. Ms. Kapoor also spoke of the children of sex workers who seemed to be resigned and accepting of the fact of following in their mother’s footsteps. The biggest aspect was the stigma attached to the victims of sex work especially if one did not have a rehabilitation package.

Expressing dismay at the levels of insensitivity displayed by the media and doctors that she had witnessed in inquiries that the NCPCR had taken suo motu cognizance of, Ms. Kapoor said that there needed to be an individualised approach to addressing rehabilitation needs of survivors of sexual abuse.

Ms. Kapoor shared her experiences of the Positive Deviance approach where solutions come from the involvement of the community. She gave the example of a study conducted in East Java where earlier no one talked of the children who went missing. Researchers visited the leaders and worked with them to conduct a mapping exercise, and set up a community watch dog group. After 3 years, they realised that they had saved hundreds of girls.

Ms. Kapoor spoke of the NCPCR initiative of piloting Child friendly villages where the Panchayat tracks its children. Committees are operational and benefit from all schemes available for them. In 50 villages in Andhra Pradesh, the entire focus is on child protection. A Manual is in place for capacity building of all stakeholders. In the same context she spoke of the Integrated Child Protection Scheme (ICPS), children in institutions and residential institutions.

She shared information about the “e button” project initiated by the Ministry of Women and Child Development after the Protection of Children from Sexual Offences (POCSO) Act, 2015 came into being. A web based programme, it shows 6 instances of abuse that the child could indicate on. On the draft Anti Trafficking Bill, the NCPCR had spoken of stringent punishment for perpetrators and had expressed its willingness to be part of the anti-trafficking rehabilitation committee since rehabilitation is a key component. While concluding her presentation, Ms. Kapoor reemphasised the need for community based approaches.

Professor Pravin Patkar, Director, PRERNA, expressed his happiness at seeing people from different disciplines coming together. Dr. Patkar shared that his competence to speak on the piece of legislation under discussion came from his work and teaching for over 20 years and protecting children and women from violence in the red light area of Kamatipura in Mumbai. Dr. Patkar and his wife who live and work in this area started a school that catered to children who were born and lived in dangerous situations. Very often these children would be drugged to prevent them from making a noise or go to sleep while their mothers were with their clients. They
would be asked to close their eyes and be pushed under the bed. Older children would be sent out of the house. Professor Patkar and his wife established night care centres that ran educational programmes for these children and kept them safe. Professor Patkar participation in an Asian think tank group on Trafficking made him realise the need for advocacy to influence programmes for sex workers and their children.

Giving a background to the legislations already in place, Dr. Patkar pointed out that while the laws are good in India, what was lacking was action on these. He submitted that the earlier Immoral Trafficking Prevention Act, 1956 was a watershed in the development of legislation for preventing sex work. The Act spoke of organ trade, destination crimes and defined trafficking as an activity that procures people from exploitation and put them in an exploitative situations. In comparison, he expressed regret that the current draft 'Trafficking of Persons (Prevention, Protection and Rehabilitation) Bill, 2016', fell short on several measures.

Calling the earlier legislation, pro women and pro victim, he mentioned that in India, it was not a crime in India for an adult woman to voluntarily sell her body for money. He pointed out that the 1956 Act was one of the least used legislations and statistics showed that eleven times more booking was done under Bombay police act – behaving indecently in public

Dr. Patkar said that it was unclear to many activists as to why the new draft omnibus bill had been written in the first place. There was no court order, no demand for this new legislation. The lack of consultation had been an issue of concern for many in civil society. It was not clear how this would be implemented and how the government planned to bring multiple agencies together given that nodal departments for labour, beggary, destination crimes were all different. He wondered about the status of the existing Child Labour Act, Human Organ Act, and ITPA act once this legislation was passed– He wondered how India would recruit the huge police body that would look at prevention, protection prosecution. He expressed concern that in the new Act, pimping might become an unpunishable offence and brothel management unpunishable. He felt that the new thinking may have been influenced by international pressure groups as many western countries are legalising sex work and are decriminalising brothels.

Giving the example of bonded labour which vanished when the economy started being more inclusive and the poor had more options and opportunities, he regretted that the entire exercise appeared to be a myopic approach of crime and punishment to what was essentially a complex socio economic cultural issue

Expressing disappointment that the government had not called for any consultations, Dr. Patkar opined that before finalising, it was necessary to remove discrepancies and align the Act to existing legislations and align definitions. Within the current social cultural economic situation, he questioned the prudence of following a decriminalising model in total. While the women must not be punished, there needs to be a provision to penalize sex buyers.

Suggesting that there is a need to learn from best practices, Dr. Patkar gave the example of Mumbai’s special homes placed under joint management of the Government of Maharashtra and his NGO. Girls were not victimised, data was maintained through specially created software. Technology, victim registry systems, biometric systems, documentation were some of the suggestions that were put forward.

Following the session, the trailer of a film ‘Sold’ was shown to the participants. Based on true stories the film traces the travails of a girl who is trafficked
Mr. Joseph Wesley, World Vision, India provided an overview of World Vision's global presence and development work in India. Child protection is a cross cutting theme across all program work. This includes preventing child trafficking, working with street children, child labours, child slavery, combating female feticide. He shared the findings of a national level research conducted by World Vision in 119 districts across 19 states with 53,550 children and 71,400 caregivers. The study indicated that an average of 61.2 percent adolescents knew of services to report abuse, the perception of parents/caregivers is that community is a safe place for children average of 57.7 percent parents felt this. A significant number of adolescents knew of services available. World Vision intends to continue with its programs on capacity building, parenting skills training, personal safety education for children, community based child protection systems and research and advocacy. Mr Wesley emphasised on the need for programs on parenting skills.

Mr. Samrat from Childline shared details about Child helpline, 1098, which is India's first 24 hours toll free emergency outreach phone number. Any child or concerned individual can ring this number to report instances of child abuse. The 1098 number is integrated into the Integrated Child Protection Scheme of the Ministry of Women and Child Development. Child line has more than 700 partners across India covered 402 districts. The main focus is to provide emergency support to children. They conduct open house programmes where children come to participate in the preventive mode, Childline India Foundation organises awareness activities for children and all stakeholders and collaborate with child rights groups, local organizations, panchayats and child care institutes.

Mr. Samrat spoke of the special programme for children on railway platforms in collaboration with the Indian Railways. Child help desks are available in 20 railway stations where you can take a child or seek assistance – awareness campaign and provide emotional support to missing children.

Intervention is undertaken with the support of the local/district administration. Childline links with para legal groups to advocate on behalf of children.

Michelle Mendonca, focussed on the relevance of medical professionals in the legal system and their need to get involved. All trafficked children need to undergo verification of age and courts look towards the medical professionals to determine the age. She listed different age determination examinations that included dental examination, ossification method, and bone density. For proof of abuse, the physicians needed to identify the type of injuries. She reminded the group that as per current law it is not necessary for penetration to have happened. She stressed that rape is a legal conclusion and not a medical one and it was not the place of the medical professional conducting the examination to conclude definitely that rape had occurred. However, she cautioned that doctors stating that no injury had happened and therefore there was no rape may definitely influence the court. The identification of injuries and abuse testified by the
doctors could contribute to the compensation given to the victim. Ms. Mendonca reiterated the importance of documentation of injuries as very essential and helpful and recommended that doctors look past the hostile first responses and avoid using legal language while documenting their findings. She suggested that the doctors record their opinion and inference for conclusion, review their medical report a day before appearing in the court and deliver findings in a clear and concise manner.

Stressing on the importance of the role of doctors in the courtroom, Ms. Mendonca mentioned that doctors’ opinion were testified and they were privileged witnesses. The court looks to them for linkages with different systems.

Mr. Wesley shared the grassroots experience of World Vision while working in the communities. They had identified gaps in terms of capacity and coordination in the implementation of the ICPS scheme. The child protection committees need to be made aware of the scope of establishing the monitoring of vulnerable children based on specific listed criteria in the scheme. The capacity of police also needs to be built. Handling cases at the grassroots level, continues to be huge challenge for the person despite the existence of good policies. World Vision had found a lack of awareness even at the district level. On the issue of responding to sexual abuse in the community, the family members were reluctant to report incidents. Even if they did, interference from the community or political parties may prevent them from pursuing the matter.

Professor Taneja, spoke of the role of the medical professionals in prevention. She emphasised on the need for paediatricians to be advocates for children and the need to be vigilant in identifying bruises and marks on the body. The location of the injury should give the doctor an indication of abuse. The child’s body language may give a signal that something is wrong. While examining children, children who have been abused may react to touch. Unable to understand what has happened to them or name the proper body part, they may complain of stomach ache in cases of sexual abuse. Parents may try to avoid discussing the issue as they may not want to disrupt the family dynamics. There is a lack of parenting knowledge in India and the concept of sex education is completely absent in the country.

Ms. Rupa Kapoor, member NCPCR, invited to make observations, said that although the NCPCR was the nodal body for the protection of child rights, it needed the support of experts representing multiple disciplines. She said the extent of the instances of sex abuse was immense with 60 cases being reported daily in Delhi alone. The NCPCR and the State Commissions for Protection of Child Rights were trying to rope in volunteers to support them in their work. Ms. Kapoor recommended child friendly spaces in hospitals and that at least 2 doctors (of whom one should preferably be a female) be assigned to such cases. NCPCR is also in the process of trying to ensure that every school notebook has a page telling children about their rights and good and bad touch

The panel agreed that education and keeping children in schools was key to preventing trafficking

Open session:

Questions, discussions and recommendations centred on the difficulty for children to understand they had been sexually abused and subsequently report that instance. Adults may come across instances of sexual abuse but are unaware of the redressal mechanisms. Most parents do not want their children to be provided with information or sex education. The access of children to incorrect information online is a matter of concern. Manuals for parents and parent training was advised by many experts at the meeting

Concern was expressed on the lack of adherence to required procedures by doctors owing mainly to the lack of awareness on these. Frequently samples were not properly sealed, or transferred on time. Evidence went missing due to improper storage facilities. IAP was
requested to advocate for ensuring that senior doctors conduct medical examinations and that there be a one stop centre for children who have been abused.

Given the provision for crisis intervention centres and funds available in the ministry (Nirbhaya Scheme) participants suggested that lack of resources should not be an excuse for creating a separate room in hospitals for children to be comfortable in.

Participants recommended that there be more awareness created on the 1098 child helpline along the lines of the women’s helpline.

An issue that needed more discussion was the prevention aspect given the innate vulnerability of children and the need for consciousness to question whether children are being targeted because of their vulnerability or due to the prevalence of paedophilia.

Concluding the day’s deliberations, Dr. Rajeev Seth spoke of the need for ongoing consultations on the subject of human and child trafficking and the need for inter-disciplinary coordination to ensure optimum care and rehabilitation for trafficked and abused children and to ensure that they recover from the sustained trauma they have experienced. On behalf of ICANCL, he thanked all the speakers, moderators, participants and expressed appreciation for the support provided by the other partner organizations.

Ms. Razia Ismail welcomed the deliberations at the consultation and while appreciating the extremely stimulating interactions during the day’s proceedings, she also suggested constant engagement with the issue in order to make a difference in the lives of children who are trafficked. She requested participants to come together with a purpose and take the next step of sharing the current discussions outside of the current circle. Doctors, lawyers, police should all connect, and initiate a forum for continuous engagement on the issue.

**Conclusions and Summary of Observations and Recommendations**

The Consultation provided a platform for an inter-disciplinary conversation on the issue of Child Trafficking and Commercial Sexual Exploitation of Children. The participatory design of the programme ensured that the sessions were enriched by the contributions of many of the participants who themselves had significant experience in their field. A summary of observations and recommendations is provided below:

**Attitudinal Change:** All stakeholders must reflect on our attitudes towards children. This reflection must include how we implement policies and invest resources for children. The child must be seen as the index for respect of the village and every village must respect its children. The nation needs to invest abundantly and optimally on children’s survival, protection, development and participation.

**Defining Child Protection:** There exists very little understanding of what protection entails for children. The concept of child protection needs to be understood and redefined within the Indian context. Community awareness on the issue must be increased through sustained advocacy and communication measures.

**Increased attention to Prevention:** Interventions on trafficking need to begin with prevention. Providing safety nets in the form of community monitoring and support systems, keeping children in school, ensuring access to incentives and schemes by children in especially difficult situations. Identification of risks involved and ensuring protection for children during upheavals - natural disasters or community based violence is essential. Existing systems outlined in schemes like the Integrated Child Protection Scheme need to be strengthened and made functional at the grassroots.

**Trauma informed approach to assessments and interventions:** Children who are trafficked and have been sexually abused have lived for a considerable period in situations of extreme stress.
and fear. This must be recognised and inform all decisions while providing professional assistance. A multi-disciplinary approach is required to address the needs of children.

_No Health without Mental Health:_ Medical assessments and interventions should go beyond physical treatment of injuries to also include the mental health of victims of child sexual abuse. The psychosocial impact of prolonged bondage and subjugation needs to be acknowledged and addressed. Measures need to be taken to address the lack of trained professionals in this field.

_Invest in capacity building of health professionals:_ The current curriculum of medical training for doctors and other allied health services does not cover examination or treatment protocols involved in instances of child sexual abuse. Doctors also need to update their communication skills. At least two doctors need to be identified and trained in each healthcare institution at every level to work with children who have been abused.

_Ensure the implementation of existing policies, programmes and legislation:_ India has some strong legislation and good policies and programmes, however the challenge continues in the implementation of these. Concerted efforts must be made to involve various sectors to ensure that the benefits of these policies and programmes reach the most marginalised. Speedy trials and convictions will restore a sense of justice to the survivors of child sexual abuse.
About the Speakers

Ms Enakshi Ganguly
Enakshi Ganguly is the co-founder and co-director of HAQ: Centre for Child Rights. Over the years, Enakshi has been involved in Research, Advocacy and Training on wide-ranging socio-legal issues such as development induced displacement and those concerning women and children, including women in the unorganised sector, legal rights, reproductive health and children. She has several published works, which includes books, reports and articles. She has been awarded the Asoka Fellowship in recognition of HAQ’s work on children.

Dr. Jordan Greenbaum
Dr. Jordan Greenbaum is a child abuse physician from the United States who received her degree from Yale School of Medicine. She is the director of the Global Health and Wellbeing Initiative with the International Centre for Missing and Exploited Children. In addition, she works with victims of suspected physical/sexual abuse, neglect and sex trafficking at the Stephanie Blank Center for Safe and Healthy Children at Children’s Healthcare of Atlanta. Jordan provides trainings on all aspects of child maltreatment for medical and nonmedical professionals working with children. She gives trainings locally, nationally and internationally, working with child-serving professionals to prevent, identify and intervene in cases of suspected abuse and sex trafficking.

Dr. Rajesh Sagar
Dr. Rajesh Sagar is currently working as Professor in department of Psychiatry, AIIMS, New Delhi with special interest in Child & Adolescent Psychiatry. He is the Secretary to Central Mental Health Authority (Govt. of India) and Honorary Advisor on mental health, Dte. GHS, Ministry of Health & Family Welfare. He has been a core member of Delhi Commission of Protection of Child’s Rights (DCPCR), Govt. of NCT for development of Guidelines on Child Abuse... He has published more than 280 research papers/chapters and has presented several papers in national and international conferences. He is the editor of the Journal of Mental Health & Human Behaviour (JMHHB), the official journal of Indian Psychiatry Society.

Ms. Tannistha Datta
Ms. Tannistha Datta is a child protection specialist with UNICEF, India. She has been working for the last 15 years in the area of child rights and protection. Currently leading UNICEF India’s child protection programs, on juvenile justice, child protection systems and response service for children affected by violence, abuse and exploitation

Ms. Rupa Kapoor,
Ms Rupa Kapoor is a Member of the National Commission for Protection of Child Rights. She has done her Masters in Social Work from Shanti Niketan, West Bengal and has over 15 years of experience in working on reproductive health and community management of malnutrition .she has specialization in applying the positive deviance approach where community knowledge and resources are used to address community based problems

Dr. Pravin Patkar
Dr. Pravin Patkar has done his M.A. in Social Work at the Tata Institute for Social Sciences and his doctorate from the Sociology University of Mumbai. He is the co-founder and co-Director of Prema, India’s pioneering anti-trafficking and child protection civil society organization. He is a Fulbright Nehru Academic and Professional Excellence Fellow 2015-16 and has co-taught 4 courses in the Gender and Women Studies Program of the University of Rhode Island USA for one academic year 2015-16. He has initiated and managed several rural development projects and has several publications to his credit.

Peter Wesley
Joseph Wesley, presently the Strategic Lead for Child Protection in World Vision India has rich experience in implementing World Vision India's children-at-risk programs like, child slavery, urban child labour, street children and urban children-at-risk programs across the country. An advocate by
profession, in partnership with Boston and Tulane University, he has done extensive research among street children especially the violence experienced by them in different settings like families, communities, streets and care institutions. Joseph Wesley holds LLM (International Law) from University of Pune and Post Graduate Diploma in International Humanitarian Law (IHL) from NALSAR University of Law, Hyderabad.

Samrat
Samrat has received his Master degrees with specialization in Social Work and Rural Development from IGNOU, Central University, New Delhi He is also qualified in NGO Management. He is currently working as a Programme Coordinator with CHILDLINE India Foundation (CIF) which is a nodal agency for the Ministry of Women and Child Development, India for setting up and managing and monitoring the CHILDLINE 1098 service across the country. He has been catalyst in activating Child Protection Mechanism, effective implementation of Child related laws and responsible for Programme Planning, Support, Capacity Building, Advocacy & Evaluation. He has successful delivered training programmes for elected representatives, district administration, state government representatives and civil society organisations.

Michelle Mendonca
A merit-listed student, Michelle has an LLB. From Mumbai University and a Masters in Organizational Leadership from Eastern University, Pennsylvania. Michelle currently serves as Project Director for Counsel to Secure Justice, an agency that works with survivors of sexual abuse. Michelle also works on anti-trafficking projects. Her High Court advocacy led to increased protection for children and victim rights and multi-disciplinary support in court. She also provided expert advice to a Supreme Court Panel. A High-Court appointed trainer, Michelle trains at Judicial Academies in 4 States and has also trained at the National Judicial Academy. She sensitises judiciary and prosecutors on anti-trafficking and child sex abuse.

Dr Rajeev Seth
Dr Rajeev Seth is currently Director and Head, Department of Paediatrics, Rockland Hospital; Chairperson of Indian Child Abuse, Neglect & Child Labour (ICANCL) group; Executive Councillor, International Society for the Prevention of Child Abuse & Neglect (ISPCAN) & Managing Trustee and President of Bal Umang Drishya Sanstha (BUDS). Dr Seth work reaches out to the abused and neglected children, amongst urban poor and underprivileged rural children in India. Dr Seth is the editor of CANCL NEWS, co-author of a book on Child Abuse & Neglect: Challenges & Opportunities, besides has several scientific peer review publications to his credit.
About the Organisers

ICANCL
Indian Child Abuse, Neglect and Child Labour Group (ICANCL Group) is a nationally registered society (Registration number S-68745/2010). It was started in 1996 within the framework of Indian Academy of Pediatrics (IAP).
Recognising the impact of socioeconomic, cultural and environmental factors on child health, development and overall welfare, ICANCL Group specifically focuses on comprehensive child welfare, child rights, abuse, neglect, exploitation and rehabilitation.
The ICANCL Group addresses the problems of Child Abuse and Neglect (CAN) with a multidisciplinary approach with other agencies and community organizations interested in child welfare. The group has committed its efforts to reach out to the neglected, deprived and abused children for their comprehensive needs, which include health aspects, education, rehabilitation, protection and prevention. Membership of ICANCL group is open to people of all disciplines interested in protection of children. Advocacy, information and sensitization are the crucial issues. The Group has held a number of national and regional conferences and publishes a quarterly newsletter highlighting its work and informing on ICANCL issues.

The Indian Academy of Pediatrics
The Indian Academy of Pediatrics has closely linked with the development of the Pediatric Specialty in Delhi. In 1949, the leading pediatricians of Delhi met at the office of Dr K L Jain every Thursday afternoon. These pediatricians mostly were Members of the Association of Physicians of India. It was in that first meeting of pediatricians, that the idea of forming an Association of pediatricians of India was mooted. In 1954, the Association of pediatricians of India was christened and it established its Central office at Bombay. The Delhi State Branch came into being in 1964.
The first Department of Pediatrics was created at the Irwin (Now LNJP Hospital) Hospital and Dr P N Taneja joined as Head of Department in 1952. The Kalawati Saran Children's Hospital came up in 1956 and Dr Sheila Singh Paul was its Head of The department. The next Pediatric Department was established at the Safdarjung Hospital in 1957-59 with Dr A K Basu as its Head. The Pediatrics Department in AIIMS was started in 1958. Meetings in late fifties were mostly held in these hospitals. In 1996, IAP Delhi registered under Societies Act of 1986 and purchased its office premises at Ansari Road Dariyaganj, New Delhi. Currently the new office is at Flat # 113-114 First Floor, Bank House, Punjab & Sind Bank Bldg. 21 Rajendra Place, New Delhi 110 060

IACR
The India Alliance for Child Rights (IACR) is an advocacy 'platform' -- an initiative and forum operating since 2001. Popularly known as ‘IACR’, it has contributed to both governmental and non-governmental development of national positioning on human rights of children.
It has both a convening group and core volunteers, and a wide spread of NGOs and individual members collaborating under its banner. As at its start, the Alliance operates as an open and participatory platform, seeking and providing information and shared learning, and advocating child rights knowledge, commitment and promotion.
Its motto and credo is 'every right for every child.'

World Vision
World Vision is one of the world's leading child-focused humanitarian organizations. Through development, relief and advocacy, we pursue fullness of life for every child by serving the poor and oppressed regardless of religion, race, ethnicity or gender as a demonstration of God's unconditional love for all people.
With nearly 65 years of experience in India, World Vision works through long-term community development interventions in 191 districts impacting 26 lakh children and their families in over 6200 communities spread across 25 states and the National Capital Region (NCR) of India.
We work along with children, families and communities to address issues of Health, Nutrition, WASH, Education, Child Protection, Climate Change, Gender, Disability and Humanitarian Emergencies in partnership with governments, civil society, donors and corporates.
In all the above locations, child protection is an integral part of our work. World Vision India is also launching a 5-year global campaign to "End Violence against Children" by end of 2016.

BUDS

BUDS is a registered, non-profit organization formed with the objective of advancing the education, health, development and welfare of children in India without distinction of caste, class, gender, ethnicity, and religion, rural / urban, physical or mental disability. BUDS aims to serve the underserved children by preventing diseases, promoting health and providing access to education and vocational training to every child. The organization promotes equitable access to child rights and works as partners with Government, NGO’s and allied National and International organizations. We encourage voluntary participation of multi-disciplinary professionals such as doctors, nurses, teachers, lawyers, social scientists and child activists.
Annexure 1

Concept Note

Child Trafficking and Commercial Sexual Exploitation of Children: Medical & Psychosocial Services for the Victims

Child Trafficking and Commercial Sexual Exploitation of Children (CSEC) are major public health problems (1). These are serious violations of UN Child Rights Convention (UN CRC) and fundamental rights of children worldwide (2). The exact numbers of victims of child trafficking and commercial sexual exploitation are unknown, although estimates range into millions.

In developing countries, child rights, protection and sexual exploitation are intimately linked to poor socioeconomic conditions in a huge population base (3). The urban underprivileged, migrating population and rural communities are particularly affected. In large cities, there are serious problems of street children and child labourers. Children in difficult circumstances such as children affected by disasters, those in conflict zones, refugees, HIV/AIDS are also at risk of commercial sexual exploitation (4). The interaction of poverty and gender-based violence in developing countries heightens the risk of sex trafficking and CSEC. Prevention efforts should work to improve economic opportunities and security for impoverished children, educate communities regarding the tactics and identities of traffickers, as well as promote structural interventions to reduce sex trafficking (5).

Medical evaluation of CSEC and sex trafficking is an emerging area of research and practice and few healthcare settings have established screening practices, policies and protocols (6). Victims of CSEC rarely self-identify, due to fear and shame as well as concerns about loss of income for oneself and/or family. Although some victims have no risk factors or obvious indicators, children at risk for CSEC may have a history of running away from home, truancy, child maltreatment, involvement with child protection systems or the Juvenile Justice Act, multiple STIs, pregnancy, or substance use or emotional abuse issues (7).

There is limited information available to paediatricians and allied health professionals on how they may protect these trafficked and vulnerable children? Evaluations of CSEC victims may be challenging. Children are rarely forthcoming about their actual history and it requires patience and a secure environment to gain their trust. A comprehensive history related to injuries/abuse, reproductive issues, substance use, and mental health symptoms have to be obtained with a non-judgmental and open attitude. Knowledge of risk factors, recruitment practices, and common medical and mental health problems experienced by victims will help the paediatricians recognise potential victims and respond appropriately. In addition, all medical and multidisciplinary professionals must comply with child abuse mandatory reporting laws and existing legislation in their regions/country (8).

Aims & Objectives

1. The main aim of the proposed one day consultation is to create awareness and sensitise the paediatricians and allied professionals to prevent and respond to victims of “Child Trafficking and Commercial sexual exploitation of children”.

2. To educate paediatricians and allied professional to improve provision of direct medical care, anticipatory guidance and collaborative referrals to non-medical colleagues for complex health needs and psychosocial services to victims of CSEC.

3. The consultation also aims to provide useful information to paediatricians and allied health professionals regarding existing child protection systems available in the country.

Participants

Paediatricians, physicians, mental health professionals, academicians, psychologist, nurses, medical social workers, child rights activists, allied NGO’s, Government & International Agencies, members of media
References


# Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Schedule</th>
<th>Speakers</th>
<th>Moderators</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.30-10am</td>
<td>Registration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-11am</td>
<td>Overview of problem of Child Trafficking and Commercial Sexual Exploitation in India</td>
<td>Ms. Enakshi Ganguly, HAQ Center for Child Rights</td>
<td>Dr AK Shiva Kumar, Global Co Chair, Know Violence in Childhood &amp; Director</td>
</tr>
<tr>
<td>11am-12.30pm</td>
<td>Global Sex trafficking and Commercial Sexual Exploitation of Children: Medical Service for victims.</td>
<td>Guest Speaker Dr. Jordan Greenbaum, Child Abuse pediatrician, Atlanta USA &amp; Director of the Global Health and Wellbeing Initiative with the International Centre for Missing and Exploited Children.</td>
<td>Dr Sunil Mehra MAMTA &amp; Ms. Razia Ismail Convener IACR</td>
</tr>
<tr>
<td>12.30-1pm</td>
<td>Mental Health Services for victims</td>
<td>Dr. Professor Rajesh Sagar, Child Psychiatrist, Department of Psychiatry, AIIMS</td>
<td>Dr. D.N. Virmani, Past President IAP Delhi &amp; Dr. Kiran Modi, Udayan Care</td>
</tr>
<tr>
<td>1.00 -2.00pm</td>
<td>LUNCH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-3.30pm</td>
<td>Government Initiatives &amp; Draft Trafficking Bill</td>
<td>Special Guest Ms. Rupa Kapoor, Member, National Commission for Protection of Child Rights (NCPCR)</td>
<td>Ms. Tannistha Datta, Child Protection Specialist UNICEF &amp; Dr Rajeev Seth Chair ICANCL group</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Speaker Dr. Professor Pravin Patkar, Fulbright Nehru Academic &amp; Professional Excellence Fellow- 2015-16, Co- founder &amp; Director PRERNA Mumbai</td>
<td></td>
</tr>
<tr>
<td>3.30-4 pm</td>
<td>Tea/Coffee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4-5pm</td>
<td>Panel Discussions: Psychosocial Referrals, Resources, Innovative programs, Multidisciplinary interventions &amp; Way Forward recommendations</td>
<td>Panellists: Ms. Michelle Mendonca (Advocate), Dr. Samrat, (Dr. Taneja, BUDS)</td>
<td>Mr. Joseph Wesley World Vision India &amp; Razia Ismail Medical Resources, Child Line India (Child Protection systems)</td>
</tr>
</tbody>
</table>
### List of Participants

<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
<th>Institution/Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Ms. Sandhya Chowdhary</td>
<td>Institute of Home Economics</td>
</tr>
<tr>
<td>2.</td>
<td>Ms. Vaishali Gautam</td>
<td>Institute of Home Economics</td>
</tr>
<tr>
<td>3.</td>
<td>Mr. Joseph Wesley</td>
<td>World Vision</td>
</tr>
<tr>
<td>4.</td>
<td>Dr. Indra Taneja</td>
<td>BUDS</td>
</tr>
<tr>
<td>5.</td>
<td>Mr. Samrat</td>
<td>Childline India Foundation</td>
</tr>
<tr>
<td>6.</td>
<td>Mr. Subimol Goldsmith</td>
<td>World Vision</td>
</tr>
<tr>
<td>7.</td>
<td>Mr. Ajay Mahajan</td>
<td>World Vision</td>
</tr>
<tr>
<td>8.</td>
<td>Ms. Urvashi Tilak</td>
<td>CSI</td>
</tr>
<tr>
<td>9.</td>
<td>Mr. David Prabhudas</td>
<td>Mount Carmel School</td>
</tr>
<tr>
<td>10.</td>
<td>Ms. Renu + 4 students</td>
<td>Institute of Home Economics</td>
</tr>
<tr>
<td>11.</td>
<td>Mr. Jordan Greenbaum</td>
<td>ICHEC</td>
</tr>
<tr>
<td>12.</td>
<td>Ms. Lilly Vishwanathan</td>
<td>Consultant</td>
</tr>
<tr>
<td>13.</td>
<td>Ms. Michelle Mendonca</td>
<td>Counsel to Secure Justice</td>
</tr>
<tr>
<td>14.</td>
<td>Ms. Shreya Bhardwaj</td>
<td>Institute of Home Economics</td>
</tr>
<tr>
<td>15.</td>
<td>Mr. Mikhael</td>
<td>World Vision India</td>
</tr>
<tr>
<td>16.</td>
<td>Ms. Payal Saini</td>
<td>Institute of Home Economics</td>
</tr>
<tr>
<td>17.</td>
<td>Ms. Niki Chandila</td>
<td>Institute of Home Economics</td>
</tr>
<tr>
<td>18.</td>
<td>Ms. Vinodhini More</td>
<td>YWCA of India</td>
</tr>
<tr>
<td>19.</td>
<td>Ms. Twinkle Gupta</td>
<td>Institute of Home Economics</td>
</tr>
<tr>
<td>20.</td>
<td>Ms. Mary Thankappan</td>
<td>AIIMS</td>
</tr>
<tr>
<td>21.</td>
<td>Dr. Kiran Aggarwal</td>
<td>Past President, Indian Academy of Paediatrics</td>
</tr>
<tr>
<td>22.</td>
<td>Ms. Nirmala Pandey</td>
<td>Consultant MWCD</td>
</tr>
<tr>
<td>23.</td>
<td>Ms. Enakshi Ganguly</td>
<td>HAQ Centre for Child Rights</td>
</tr>
<tr>
<td>24.</td>
<td>Mr. Kishore</td>
<td>IACR</td>
</tr>
<tr>
<td>25.</td>
<td>Dr. Chander Kant</td>
<td>Ex MS, SRHC Hospital, Narela</td>
</tr>
<tr>
<td>26.</td>
<td>Ms. Jyoti</td>
<td>SGT University</td>
</tr>
<tr>
<td>27.</td>
<td>Ms. Kiran</td>
<td>SGT University</td>
</tr>
<tr>
<td>28.</td>
<td>Ms. Pinki</td>
<td>SGT University</td>
</tr>
<tr>
<td>29.</td>
<td>Mr. A K Shiv Kumar</td>
<td>Know Violence in Childhood</td>
</tr>
<tr>
<td>30.</td>
<td>Ms. Razia Ismail</td>
<td>IACR</td>
</tr>
<tr>
<td>31.</td>
<td>Ms. Ratna Saxena</td>
<td>MWCD</td>
</tr>
<tr>
<td>32.</td>
<td>Ms. Puja Negi</td>
<td>Justice and Care</td>
</tr>
<tr>
<td>33.</td>
<td>Mr. Aseem Paul</td>
<td>CANCL</td>
</tr>
<tr>
<td>34.</td>
<td>Ms. Shivangi Gupta</td>
<td>Institute of Home Economics</td>
</tr>
<tr>
<td></td>
<td>Name</td>
<td>Organization</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>37</td>
<td>Ms. Beena Raju</td>
<td>AIIMS</td>
</tr>
<tr>
<td>38</td>
<td>Ms. Usha Guthrie</td>
<td>AIIMS</td>
</tr>
<tr>
<td>39</td>
<td>Ms. Sanjivini</td>
<td>Institute of Home Economics</td>
</tr>
<tr>
<td>40</td>
<td>Ms. Kiran Modi</td>
<td>Udayan Care</td>
</tr>
<tr>
<td>41</td>
<td>Dr. Bharti Sharma</td>
<td>Child Rights Activist</td>
</tr>
<tr>
<td>42</td>
<td>Ruchika</td>
<td>Justice &amp; Care</td>
</tr>
<tr>
<td>43</td>
<td>Mr. Jayakumar</td>
<td>World Vision India</td>
</tr>
<tr>
<td>44</td>
<td>Mr. Dushyant Meher</td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>Dr. D N Virmani</td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>Ms. Neelam Singh</td>
<td>Consultant</td>
</tr>
<tr>
<td>47</td>
<td>Ms. Rupa Kapoor</td>
<td>Member, NCPCR</td>
</tr>
<tr>
<td>48</td>
<td>Dr. Manjula Chakravarty</td>
<td>Retired Government Official</td>
</tr>
<tr>
<td>49</td>
<td>Dr. Sunil Mehra</td>
<td>MAMTA</td>
</tr>
<tr>
<td>50</td>
<td>Ms. Deep Shikha</td>
<td>Childline India Foundation</td>
</tr>
<tr>
<td>51</td>
<td>Ms. Sasha</td>
<td>Institute of Home Economics</td>
</tr>
<tr>
<td>52</td>
<td>Ms. Tanya Sharma</td>
<td>Institute of Home Economics</td>
</tr>
<tr>
<td>53</td>
<td>Ms. Sulekha</td>
<td>Action India</td>
</tr>
<tr>
<td>54</td>
<td>Ms. Anjali</td>
<td>Action India</td>
</tr>
<tr>
<td>55</td>
<td>Dr. M Srivastava</td>
<td>AHA</td>
</tr>
<tr>
<td>56</td>
<td>Dr. Pravin Patkar</td>
<td>Prerna</td>
</tr>
<tr>
<td>57</td>
<td>Dr. Rajesh Sagar</td>
<td>AIIMS</td>
</tr>
<tr>
<td>58</td>
<td>Ms. Tannistha Datta</td>
<td>UNICEF</td>
</tr>
<tr>
<td>59</td>
<td>Ms. Prabha Kumar</td>
<td>RMNL</td>
</tr>
<tr>
<td>60</td>
<td>Ms. Rekha Anil Kumar</td>
<td>RMNL</td>
</tr>
<tr>
<td>61</td>
<td>Ms. Sonia Arora</td>
<td>RMNL</td>
</tr>
<tr>
<td>62</td>
<td>Ms. Bhavna Negi</td>
<td>Institute of Home Economics</td>
</tr>
<tr>
<td>63</td>
<td>Dr. Rajeev Seth</td>
<td>ICANCL</td>
</tr>
</tbody>
</table>
Annexure 4
Presentations and reading material
Global Sex Trafficking and Commercial Sexual Exploitation of Children: Medical Services for Victims

Jordan Greenbaum, MD
Objectives

• Recall scope of global human trafficking and risk factors involved

• Be familiar with trauma-informed approach to medical assessment

• Recall steps of medical evaluation
A word about the photos...
### What is Human Trafficking?

<table>
<thead>
<tr>
<th>Action</th>
<th>Means</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruits</td>
<td>Threat</td>
<td>Exploitation:</td>
</tr>
<tr>
<td>Transports</td>
<td>Force</td>
<td></td>
</tr>
<tr>
<td>Transfers</td>
<td>Abduction</td>
<td>Prostitution of others</td>
</tr>
<tr>
<td>Harbors or</td>
<td>Coercion</td>
<td>Other sexual exploitation</td>
</tr>
<tr>
<td>Receives</td>
<td>Fraud</td>
<td>Forced labor</td>
</tr>
<tr>
<td></td>
<td>Deception</td>
<td>Slavery</td>
</tr>
<tr>
<td></td>
<td>Abuse of power</td>
<td>Servitude</td>
</tr>
<tr>
<td></td>
<td>Give/receive</td>
<td>Removal of organs</td>
</tr>
<tr>
<td></td>
<td>payments for</td>
<td></td>
</tr>
<tr>
<td></td>
<td>consent</td>
<td></td>
</tr>
</tbody>
</table>

*United Nations protocol, 2000*
## Sex trafficking of minor

<table>
<thead>
<tr>
<th>Action</th>
<th>Means</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruits</td>
<td>Threat</td>
<td>Exploitation:</td>
</tr>
<tr>
<td>Transports</td>
<td>Force</td>
<td>Prostitution of others</td>
</tr>
<tr>
<td>Transfers</td>
<td>Abduction</td>
<td>Other sexual exploitation</td>
</tr>
<tr>
<td>Harbors or Receives</td>
<td>Coercion</td>
<td>Forced labor</td>
</tr>
<tr>
<td></td>
<td>Fraud</td>
<td>Slavery</td>
</tr>
<tr>
<td></td>
<td>Deception</td>
<td>Servitude</td>
</tr>
<tr>
<td></td>
<td>Abuse of power</td>
<td>Removal of organs</td>
</tr>
<tr>
<td></td>
<td>Give/receive payments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>for consent</td>
<td></td>
</tr>
</tbody>
</table>

**United Nations protocol, 2000**
Commercial Sexual Exploitation of Children (CSEC)

Occurs when a person induces a minor to engage in a sex act in exchange for remuneration in the form of money, food, shelter or other valued entity.

- Survival sex
- Trafficking child for commercial sex act (on account of which anything of value is given to or received by any person)
- Pornography
- Sex tourism
- Use of child in sexually oriented business

Does NOT require force, coercion, violence, etc
Human Trafficking Globally

Exact incidence and prevalence unknown

Thousands to millions

Victims from 152 countries, trafficked in 124 countries

Extremely profitable: low risk, high gains

Source: UNODC; ILO 2012
Global Demographics

Detected victims of trafficking in persons, by age and gender, 2011

Women: 49%

Africa and Middle East:
- Children: 62%
- Adults: 38%

Americas:
- Children: 31%
- Adults: 69%

South Asia, East Asia and the Pacific:
- Children: 36%
- Adults: 64%

Europe and Central Asia:
- Children: 18%
- Adults: 82%

MEN: 18%
BOYS: 12%
GIRLS: 21%
Youth at Risk

- Gender bias, violence
- Poverty
- Street children
- Family illness/death
- Drug/Alcohol abuse
- Child marriage
- Lack of education
- Abuse/Neglect
- Family Dysfunction
- Marginalized population
- Adult prostitution in home
- LGBTQ status
- Community violence, upheaval

Silverman, 2006
Do Victims Seek Medical Care?

Potentially severe adverse health effects for victims

Access varies
- May be ‘treated’ by trafficker
- Taken for care only when severe sx’s
- May have access via health clinics, NGOs

Healthcare professional has unique opportunity to intervene
Physical and Sexual Violence

STI, HIV, infertility

Substance abuse

PTSD

Suicidality

Exhaustion

Malnutrition

Pregnancy/
abortion

Chronic Pain

Ministry Health, India 2014; Rahman, 2014; Silverman, 2007; Zimmerman, 2006; Sarkar, 2008;
Sex Trafficking and HIV

High rates of HIV among trafficked women/girls
- Ages 15-17: 39.5% positive
- Ages < 15 yr: 60.6% positive

Factors associated with HIV positivity*
- Young age
- Trafficked to Mumbai (49.6% positive)
- Longer duration in prostitution
- Multiple brothels

Why rates increased in the very young?

HIV and other infections....

Silverman, 2007
So, how will I know a victim when I see one?
Challenges to Victim Identification

Victims don’t self-identify

Reluctant to disclose

Why?
Possible Indicators of Trafficking: First Impressions

Youth appears afraid of adult, or overly submissive, anxious

Youth gives false demographic information, inconsistent history

Delayed presentation of illness

Does not speak language
Possible Indicators of Trafficking

- Consider adverse health effects of trafficking...
  - Multiple STI’s
  - Pregnancies, abortions, or miscarriages
  - Illicit drug use
  - Suicide attempt
  - Current or past history of:
    - Sexual assault
    - Inflicted Injury

Visible signs of physical abuse
Medical Evaluation for Child Trafficking
What *is* trauma-informed care?
Trauma-Informed Care

- Trauma affects behavior, beliefs, attitudes
- Talking can trigger stress
- Minimize re-trauma
- Establish emotional and physical safety
- Encourage resilience
- Share decision-making
A Paradigm Shift

From

“What’s wrong with you?”

To

“What has happened to you?”
Trauma-Informed Approach

Treat victim with respect

- Explain what you want to do
- Ask permission
- Review limits of confidentiality early on
- Remain open, nonjudgmental
- Avoid blaming victim

Ministry of Health, India, 2014; Greenbaum, 2015; UN CRC, 1990
Trauma-Informed Approach

Sensitivity to victim’s reactions and to possible stress

Allow victim control when feasible

Offer resources

Have trained interpreter
What Questions Do I Ask?

Focus on information you need

- Guide exam and indicate referrals
- Address patient safety and well-being

Consider other sources of information

- NGO staff?
- Law enforcement?
- Other adult accompanying child?
Case 1

16 year old female brought to your clinic by NGO staff. Patient with history of pelvic pain and vaginal discharge x 2 weeks. History of trafficking from Nepal at age 14; drugged at village event, kidnapped, sold to brothel. Illiterate, no education. History of sexual abuse by uncle. In brothel, had 10-20 clients per night; No health care. Not allowed out of brothel. Housed in single room with 9 other women/girls.
What information do you need?

What do you ask?
Reproductive History

Current anogenital symptoms/signs

Condom use and other contraception

Prior STI’s, pregnancies, procedures

Prior anogenital injuries
Physical Assault/Injuries

Anyone ever hit, kick, slap, choke, beat you?

Can you tell me about what happened**

Any medical care?

Any long-term effects?
General Health

Chronic conditions?
Pain?
Access to food, adequate sleep conditions
Conditions of living
Safety Issues: Current and Past

**Home**
- Violence/abuse at home?
- Other danger in home?
- Ostracism if return?

**Trafficker**
- Who is trafficker?
- Fear of retribution?

**Stalking?**
Mental Health Screen

Screen for symptoms/signs
- Depression
- PTSD
- Anxiety, panic

Thoughts of hurting self, others?
Prior self-harm?
Make appropriate referrals
Exam and Diagnostic Evaluation

- Assess overall health, nutrition
- Assess and treat acute/chronic conditions
- Obtain sexual assault evidence kit (≤96 hours)
- Document injuries, genital/extra-genital
- Offer STI and pregnancy testing/prophylaxis
- Consider testing for endemic diseases of home country
- Offer drug testing
- +/- Age testing

Patient consent is critical!!

Ministry of Health, India, 2014; Greenbaum, 2015
Tips for the Exam

- Have a chaperone!
- Exclude suspected trafficker
- Monitor for signs of distress
- Explain each step before doing it
- Explain results
- Ask child if they have questions or concerns
Possible Inflicted Injuries

Often located in ordinarily protected areas

- Cheeks
- Neck
- Torso
- Genitals
- Inner thighs
- Upper arms

Restraint injuries
There may be no evidence of genital trauma.

WHY?
Healing of Hymenal Injuries

239 girls, 4 months to 18 years old

Accidental and inflicted injury

Left NO residual, except deep lacerations; no scar tissue seen

<table>
<thead>
<tr>
<th>Finding</th>
<th>Time to resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Petechiae</td>
<td>48-72 hours</td>
</tr>
<tr>
<td>Abrasions/mild bruising</td>
<td>~3-4 days</td>
</tr>
<tr>
<td>Marked bruising</td>
<td>May last ~11-15 days</td>
</tr>
<tr>
<td>Blood blister</td>
<td>May last &gt;30 days</td>
</tr>
</tbody>
</table>

McCann, Miyamoto, Boyle, & Rogers, 2007
Lab Testing

Baseline testing:
- HIV Ab, HBV, VDRL
- Gonorrhea, Chlamydia
- Trichomonas
- Urine pregnancy
- Urine/blood test for drugs/alcohol
- Consider tests for dz’s endemic to Nepal

CDC, 2015; India Ministry of Health, 2014
Treatment

Presumptive treatment if signs of STI; otherwise wait for test results
(*but consider likelihood of follow up and ability to contact patient with test results)

May give Hepatitis B Ig (up to 72 hours)

May start HIV prophylaxis (<72 hours, evaluate risk)

Offer pregnancy prophylaxis

Also need safety assessment and plan for discharge
Need for Ongoing Care

- Mental health assessment and treatment
- Substance abuse assessment and rehabilitation
- OB/GYN care
- Ongoing primary care
  - STI testing
  - Family planning
  - HPV vaccine
  - Health education
  - Immunizations
- Medical F/U:
  - 2 days
  - 3 and 6 weeks
Case 2

13 year old homosexual male is brought in by police after being found in apartment of local man. Child ran away from home and parents called police.

Child tells you he has no friends, is ostracized for his sexuality, and feels alienated from his parents. He ran away and met a man on the street who offered to let him stay at his apartment. He had sex with the man, stayed with him for 4 days and then the man began bringing other men home to have sex with patient. Police were called when neighbor became suspicious of all the activity.
What are the major issues?

Sexuality

Bullying, ostracism

Parents intolerant, unsupportive

Engaging in sexual activity

Exploitation
Could any of these issues influence the child’s behavior towards you?
Trauma-Informed Approach

Don’t take it personally!

Behavior may reflect reactions to trauma

Look beyond behavior, find its purpose

Remain nonjudgmental, calm, open

Work collaboratively

Set limits, give control when feasible
Before you start....

4 Actions to take:
- Explanations
- Confidentiality and privacy
- Safety
- Permission
What Questions Would You Ask About the Event?
He tells you that the last sexual event occurred earlier that morning. Two men came to the apartment and raped him, orally and anally. They beat him and choked him. While he is telling you this you notice he is no longer making eye contact and his voice has become soft and devoid of emotion.

What is happening?

What do you say and do?
What Questions Would You Ask...

About sexual/reproductive history?

Drug/alcohol use?
Mental Health Assessment

Critically important!
Assess need for emergency psychiatric evaluation
Help initiate referrals for full assessment, counseling
Trauma-focused therapy likely indicated

PTSD
Depression
Reports and Referrals

Authorities already involved
Trauma-focused behavioral health assessment and therapy
Resources for LGBTQ
Talk to parents about child’s sexuality (with consent of child)
Internet safety
Counsel on exploitation prevention
Crisis hotline
Human trafficking hotline if available
Follow up with child if possible
Conclusions

Trafficking victims experience many adverse health consequences

Medical evaluation needs to be trauma-informed, sensitive

Systematic evaluation with documentation is critical
THANK YOU.

Jordan Greenbaum, MD
International Centre for Missing and Exploited Children
Email: Jordan.greenbaum@choa.org

www.icmec.org
/ICMECOfficial
/ICMEC_Official
Child Trafficking and Commercial Sexual Exploitation of Children: Medical & Psychosocial Services for the Victims:

Mental Health Services for victims

Dr Rajesh Sagar
Professor
Department of Psychiatry
AIIMS, New Delhi
Introduction

• Victims of CSEC often go **unidentified** by healthcare providers
  • 28% of female victims are in contact with health services, but not identified

• In spite of more utilization of services, significant problems
  • Frequent healthcare contacts
  • Higher rates of delinquency
  • Higher rates of mental health problems

• Mental health professionals working in forensic, foster care settings more likely to come in contact with these children

• Interacting problems
  • CSEC itself
  • Difficult psychosocial histories
  • Significant mental health co-morbidities (? Cause ? Effect ?Unrelated)
Definition of Human Trafficking

“the recruitment, transportation, transfer, harbouring or receipt of persons, by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, or the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person for the purpose of exploitation.”

United Nations Palermo Protocol

- Exploitation includes sexual exploitation and trafficking for sex
- Broad definition, intends to cover a wide range of situations in which persons may be victimised
Definition of CSEC (Office of Juvenile Justice and Delinquency Prevention, USA)

• “crimes of a sexual nature committed against juvenile victims for financial or other economic reasons.”
  • Prostitution
  • Pornography
  • sex tourism
  • adolescent marriage (generally to older men)
  • performance in sexual venues such as strip clubs
  • survival sex (sex in exchange for shelter or basic necessities)
  • private parties
  • massage parlors
  • gang-based prostitution
  • Internet-based exploitation
  • ..also include youth who engage in sex for desirable items, perceived excitement, or social status
Scope of the Problem: Global

• Due to the illegal/clandestine nature of the act, numbers are not easy to come by

• For Human Trafficking (ESTIMATES ONLY, 2002)
  • ~2.5 million persons involved per annum
  • 43% for sexual exploitation
  • Children make up 40 – 50% of those trafficked (all cause)
Scope of the Problem: Indian Data

• Estimates suggest that ~10% of those trafficked annually are from South Asia (India, Pakistan, Nepal, Bangladesh, Bhutan, Sri Lanka)

• Variety of settings
  • May be culturally sanctioned and religious
  • More “modern” brothel-based prostitution involving minors—60% of commercial sex workers initiated between the ages of 12 and 15 (UNDP, 2005)
  • Child sex “tourism”

• Limited data on patterns
  • Push factors such as inequality, poverty, disempowerment
  • Pull factors related to demand for trafficked individuals
  • India is a source, destination and transit country for trafficked persons—from the rest of south Asia
    • Estimated 100,000 commercial sex workers from Nepal living and working in India

• One study by Deb and Sen of adult trafficked women (2005) found
  • Largely illiterate or semi-literate
  • From large families (>2 siblings)
  • Extreme poverty, rural backgrounds
Who is at risk?

• ANYBODY MAY BE AT RISK—A HIGH INDEX OF SUSPICION MUST BE MAINTAINED!!

• Children and adolescents in a child guidance clinic
  • Mental health co-morbidities are common—need to explore for exploitation/trafficking if suspected
  • Conditions affecting competence for consent may place the person at particular risk
    • Severe mental illness
    • Intellectual Disability
  • Relationship between CSA and CSEC is established

• Children/Adolescents in a pediatric setting
  • Medical illnesses that increase vulnerability
  • Medical illness as a consequence of exploitation/trafficking, eg STIs, HIV/AIDS

• Children in detention/other childcare institutions
  • May be referred for non-trafficking related offences

• Complex psychosocial histories
  • Abuse
  • Homelessness
  • Other sources of marginalization – belonging to a sexual minority,
SOCIAL AND LEGAL POLICIES
- Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children, 2000
- Trafficking Victims Protection Act, 2000
- Safe Harbor Law (Enacted by New York in 2008)

INSTITUTIONS AND SYSTEMS OF CARE
- Juvenile Delinquency System
- Child Welfare System
- Community Based Clinics
- Homeless Shelters
- Residential Facilities & Group Homes
- Emergency Rooms

NEIGHBORHOOD/COMMUNITY LIVING CONDITIONS
- Low Socioeconomic Status/Poverty
- High Crime/High Gang Density/Organized Crime
- Exploitation Normalized or Glamorized
- Transient Male Population
- Pre-Existing Adult Sex Industry in the Community

FAMILY FACTORS/DYNAMICS
- Familial Instability (violence, mental health problems, substance use, criminality)
- Decreased Parental Supervision
- Abandonment
- History of Intergenerational Exploitation

INDIVIDUAL RISK FACTORS
- Physical, sexual, emotional abuse and/or neglect
- Homelessness/Runaway
- Lesbian, Gay, Bisexual, Transgender, Queer Status
- Intellectual Disability and/or Learning Disorders
- Lack of Social or Family Supports
- Involvement with Juvenile Justice and/or Child Protective Services
- Substance Use Disorders
Psychological Impact of Trafficking on Children

1. Aggression / violence
2. Withdrawal from surrounding
3. Anti-social behavior
4. Over-sexualized behavior
5. Self-harm
6. Substance use

**Poor Psychological Well-being**
1. Feelings of Helplessness and Hopelessness
2. Fear and Horror
3. Hatred and Aggression
4. Disgust and Shame
5. Psychiatric Disorder (Depression, PTSD, Anxiety, Panic etc including emergencies like suicide and attempts to self-injury)

**Severe Behavioral Outcome**
1. Lack of trust on any adults
2. Difficulty in establishing intimate relations: bonding, attachment etc
3. Desire to punishing traffickers severely
4. Hatred towards all other adults
5. Difficulty in dealing with stigma, prejudice, discrimination

**Psychological Issues**

**Disrupted Social Relations**
1. Loss of Self-esteem; Low self-worth
2. Self-blame
3. Internalized aggression
4. Loss of self-respect
5. Loss of Self-efficacy

**Injury to Internal Self**
Characteristics of trafficked adults and children with severe mental illness: a historical cohort study.
Oram S¹, Khondoker M², Abas M³, Broadbent M⁴, Howard LM³.

Abstract

BACKGROUND: Evidence regarding the mental health needs of trafficked people is limited; however, prevalence of depression and post-traumatic stress disorder is high among trafficked people who are in contact with shelter services. We aimed to investigate the sociodemographic and clinical characteristics of trafficked people with severe mental illness.

METHODS: We did a historical cohort study of trafficked people in contact with secondary mental health services in South London, UK, between Jan 1, 2006, and July 31, 2012. We searched and retrieved comprehensive clinical electronic health records for over 200 000 patients from the Case Register Interactive Search database to identify trafficked patients. A matched cohort of non-trafficked adults was generated by simple computer-generated random selection of potential controls for each case within the parameters of matching criteria. We extracted data on sociodemographic and clinical characteristics and abuse history, and used multiple imputation to deal with missing data. We fitted logistic regression models to compare trafficked and non-trafficked patients.

FINDINGS: We identified 133 trafficked patients, including 37 children. 78 (81%) of 96 adults and 25 (68%) of 37 children were female. 19 (51%) of 37 children were trafficked for sexual exploitation. Among both adults and children, the most commonly recorded diagnoses were post-traumatic stress disorder, severe stress, or adjustment disorder (27 adults [28%] and ten children [27%]) and affective disorders (33 adults [34%] and ten children [27%]). Records documented childhood physical or sexual abuse among trafficked adults (41 [43%]) and children (28 [76%]), and adulthood abuse among trafficked adults (58 [60%]). Trafficked adults were more likely to be compulsorily admitted as a psychiatric inpatient than non-trafficked adults (adjusted odds ratio 7·61, 95% CI 2·16-26·60; p=0·002) and had longer admissions (1·48, 1·01-2·15; p=0·045). No association was found between trafficking status and either adverse pathway into care (adjusted odds ratio 0·91, 95% CI 0·40-2·05; p=0·82) or substance misuse problems (0·55, 0·27-1·17; p=0·12).

INTERPRETATION: Severe mental illness in trafficked people is associated with longer admissions and high levels of abuse before and after trafficking. Evidence is needed on the effectiveness of interventions to promote recovery for this vulnerable group.

FUNDING: Department of Health Policy Research Programme.
Aggression in sexually abused trafficked girls and efficacy of intervention.

Deb S¹, Mukherjee A, Mathews B.

Abstract
The broad objective of this study was to understand the incidence and severity of aggression among sexually abused girls who were trafficked and who were then further used for commercial sexual exploitation (referred to subsequently as sexually abused trafficked girls). In addition, the impact of counseling for minimizing aggression in these girls was investigated. A group of 120 sexually abused trafficked Indian girls and a group of 120 nonsexually abused Indian girls, aged 13 to 18, participated in the study. The sexually abused trafficked girls were purposively selected from four shelters located in and around Kolkata, India. The nonsexually abused girls were selected randomly from four schools situated near the shelters, and these girls were matched by age with the sexually abused trafficked girls. Data were collected using a Background Information Schedule and a standardized psychological test, that is, The Aggression Scale. Results revealed that 16.7% of the girls were first sexually abused between 6 and 9 years of age, 37.5% between 10 and 13 years of age, and 45.8% between 14 and 17 years of age. Findings further revealed that 4.2% of the sexually abused trafficked girls demonstrated saturated aggression, and 26.7% were highly aggressive, that is, extremely frustrated and rebellious. Across age groups, the sexually abused trafficked girls suffered from more aggression (p < .05), compared with the nonvictimazed girls. Psychological interventions, such as individual and group counseling, were found to have a positive impact on the sexually abused trafficked girls. These findings should motivate counselors to deal with sexually abused children. It is also hoped that authorities in welfare homes will understand the importance of counseling for sexually abused trafficked children, and will appoint more counselors for this purpose.
Identification

• Appearance and behavior
  • Youth is accompanied by an individual that appears controlling or does not want the youth to be interviewed alone
  • Youth displays a withdrawn, frightened, or guarded affect
  • Youth gives vague or changing demographic information
  • Youth appears intoxicated or impaired by substance use
  • Youth has evidence of branding or tattoos (including facial tattoos, gang-related tattoos)
  • Youth has evidence of physical injury (scars, burns, lacerations, fractures, traumatic brain injury)
  • Youth appears to be in poor physical health (evidence of skin infections, poor dentition, malnourishment)
  • Youth is carrying large amounts of money or expensive items that appear beyond the youth’s means

• Social history
  • Youth has a history of homelessness (includes running away, being abandoned, or forced to leave home)
  • Youth has an older boyfriend and/or history of multiple sexual partners
  • Youth has a history of juvenile justice system involvement
  • Youth has a history of involvement with child welfare services (including living in a group home/foster care home)
  • Youth does not attend school or is frequently truant

• Medical history
  • Youth has a history of pregnancy, abortion, ectopic pregnancies
  • Youth has a history of multiple sexually transmitted diseases, pelvic inflammatory disease
  • Youth has frequent emergency room visits (including for physical injuries, reproductive concerns, or sexually transmitted diseases)

• Mental health symptoms
  • Youth has symptoms of depression
  • Youth is suicidal
  • Youth has symptoms of posttraumatic stress disorder, traumatic stress, and/or anxiety symptoms
  • Youth has symptoms of a substance use disorder
  • Youth has problems with anger
  • Youth has self-harming behaviors
  • Having these signs does not mean that a child is being commercially sexually exploited, and lack of these signs does not rule out that a child is being commercially sexually exploited.

Patterns of mental health/other morbidity

• Abuse prevalence in CSEC victims—32 – 93%
  • Includes sexual, physical, emotional abuse
  • Abuse associated with lower age at being exploited

• Mental Health conditions associated
  • Post-traumatic Stress Disorder (PTSD) – up to 70%
  • Self-harm – up to 30% (moderate to severe)
  • Substance use – 50% in one study
  • others

• Higher rates for sexually exploited women as compared to those trafficked for other purposes
Mental Health Assessment

• Difficulties in getting an accurate history
  • Being from a marginalized/exploited background
  • Sequelae of recruitment, entrapment, enmeshment
    • Distrust of interviewer
    • Desire to protect trafficker
    • Shame and stigma

• Recommendations for interview
  • Interview alone
  • Development of an alliance that empowers the child
  • Assure safety, confidentiality
  • Must be sensitive to cultural background of the interviewee
Services

• Few systematic evaluation of interventions available
• Approaches mostly derived from treatment of other victimized groups
  • Sexual abuse, violence, torture
• General approach
  • Multi-disciplinary
  • Sensitive to experience of trauma
• Components of mental healthcare
  • Needs Assessment
  • Ensuring safety and confidentiality
  • Co-ordination of care
  • Trauma-informed psychological intervention
Indigenous Initiatives
Protection of Children from Sexual Offence (POCSO) 2012

- Under POCSO Act, 2012, any sexual activity with a child below 18 years, whether boy or girl, is a crime
- Definition of types of sexual abuse given in detail
- It promotes mandatory reporting
- Provisions for special courts for speedy justice
- Provision for various types and levels of punishment based on the intensity and type of sexual abuse committed
Child Sexual Abuse: Need for a Preventive Framework in Indian Context

Rajesh Sagar
Department of Psychiatry, All India Institute of Medical Sciences, New Delhi, India

As per WHO, Child Sexual abuse (CSA) is defined as ‘inappropriate sexual behaviour with a child, acts being committed by a person responsible for the care of a child (for example a baby-sitter, a parent, or a day care provider), or related to the child.”[1] Globally, CSA affects more than one out of five females and one in 10 males.[1] In the World Mental Health Surveys, in a representative multi-national sample of 51,945 persons, sexual abuse was reported by 1.6% (SE:0.1)

One of the first large-scale initiatives was taken by Ministry of Women and Child Development (soon after coming into existence in early 2006) in order to document the magnitude and dimensions of child abuse in various forms. The study “child abuse: India (2007)”[6] covered 13 states with a sample of more than 12,447 children aged 5–18 years, including children from a variety of settings like family, schools, streets, institutional care etc. The findings though cannot duty upon a person who has knowledge that a child has been sexually abused to report the offence; if he fails to do so, he may be punished with six months’ imprisonment and/or

Quick Response Code: 
Website: www.jmhhb.org

DOI: ***

Address for correspondence: Dr. Rajesh Sagar, Department of Psychiatry, All India Institute of Medical Sciences, New Delhi, India. E-Mail: drrajeshsagar@gmail.com
Guidelines for the Prevention of Child Abuse, 2013
Rationale Behind the Guidelines

• Though we have comprehensive acts and rules to describe detailed standard to be maintained, implementation is usually lacking. And it doesn’t incorporate preventive measures.

• Need for Preventive Guidelines was felt

• Multidisciplinary Preventive Guidelines have been proposed. It is supported by legal provisions under the Delhi Juvenile Justice Rules (2009) and POCSO (2013).
FRAMEWORK OF THE GUIDELINES

Institutional Responsibility

Community Involvement

Stakeholder Involvement

**CHAPTERS**

<table>
<thead>
<tr>
<th>PRELIMINARY &amp; DEFINITIONS</th>
<th>GUIDING PRINCIPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAPACITY BUILDING</td>
<td>CHILD PROTECTION SAFEGUARDS</td>
</tr>
<tr>
<td>COMMITTEES</td>
<td>AWARENESS AND EDUCATION</td>
</tr>
<tr>
<td>OUTDOOR ACTIVITIES</td>
<td>ONLINE SAFETY</td>
</tr>
<tr>
<td>FAMILY &amp; COMMUNITY</td>
<td>REVIEW &amp; REPORTING</td>
</tr>
<tr>
<td>RECRUITMENT PROCESSES</td>
<td>THERAPEUTIC INTERVENTION</td>
</tr>
<tr>
<td>TRANSPORT</td>
<td>RESIDENTIAL FACILITIES</td>
</tr>
<tr>
<td>MONITORING</td>
<td></td>
</tr>
</tbody>
</table>
Review of Psychological Trauma Intervention Used for CSA In Indian Context

Review Article

Review of Randomized Controlled Trials on Psychological Interventions in Child Sexual Abuse: Current Status and Emerging Needs in the Indian Context

Vandana Choudhary, Sujata Satapathy, Rajesh Sagar

ABSTRACT

Child sexual abuse (CSA) is a critical, psychologically traumatic and sometimes life-threatening incident often associated with sequel of adverse physical, behavioral, and mental health consequences. Factors such as developmental age of the child, severity of abuse, closeness to the perpetrator, availability of medical-legal-social support network and family care, gender stereotypes in the community complicate the psychological trauma. Although the research on the effects of CSA as well as psychological intervention to reduce the victimization and promote the mental health of the child is in its infancy stage in India, the global research in the past three decades has progressed much ahead. A search was performed using MEDLINE, PubMed, PsycINFO, and Google Scholar from 1994 to 2015 and only 17 randomized controlled trials (RCTs) out of 96 potentially relevant studies were included. While nonspecific therapies covering a wide variety of outcome variables were prominent till 1999s, the trend changed to specific and focused forms of trauma-focused therapies in next one and half decades. Novel approaches to psychological interventions have also been witnessed. One intervention (non-RCT) study on effects on general counseling has been reported from India.

Key words: Child sexual abuse, psychological intervention, randomized controlled trials, trauma

Indian Journal of Psychological Medicine
Therapy that has been found to be useful

• Cognitive Behavioral Therapy (CBT)
  • Mostly Trauma-focused, similar to that used in PTSD
  • Involves integration of thoughts, behaviors and emotions associated with trauma
  • Some modules make use of “mindfulness” ie measures relating to acceptance of unpleasant mental content

• Dialectical Behavioral Therapy (DBT)
  • Originally developed for self-harming subjects in the context of personality disorder
  • Has been found to be useful in the management of other traumatized individuals

• Therapy delivered by a trained psychotherapist—availability is a concern for a majority of victims
General Measures

• Coordination with other services
  • Shelter homes
  • Legal services
  • Social services
  • Physical and Sexual Health
• Psychological & Mental Health First Aid
• Counselling services
• Long-term rehabilitation and reintegration services
  • Dignity
  • Practical Assistance
  • Development of life-skills
  • Skill attainment and education
  • Dealing with Disempowerment and Displacement
  • Coping with stigma and alienation
  • Building Trust
Rescue, Recovery, Rehabilitation and Reintegration

- To facilitate the transition of the child back to the community/family
- Restoration of rights as a child
- Return to the life experience prior to sexual exploitation (as far as possible)
How? : STEPS to Reinstate Psychological Well-being

• Establishing a dependable safety network for victims to utilize and ensuring all their basic needs are met.
• Ensuring privacy and confidentiality to protect victims and their families and friends.
• Soliciting the support of medical experts, social workers, and psychologists who are trained in human trafficking and can provide trauma-specific therapy.
• Attending to victims’ physical well-being, as sometimes there are physical symptoms existing simultaneously with or indicative of underlying psychological disorders.
• Providing collaborative therapies that are culturally sensitive.
• Fostering an empowering environment in which victims actively participate as consumers of therapeutic and other services
• Assessing victims for **self-injurious** and **suicidal behavior**
• Screening for post-traumatic stress disorder (**PTSD**), substance abuse/dependence, depression, and anxiety – mental disorders that can develop as a result of being trafficked
• Providing **unconditional support**, especially amidst victims’ potential denial, distrust, reticence, shame, or anger
• Working towards **social** and **familial reintegration**
• **Rebuilding identity**
• **Reestablishing skill-sets**, self-esteem, and personal interests
Take Home Message

• Victims of CSEC and trafficking have high rates of psychological morbidity
• Morbidity may have complex interactions with the experience of sexual exploitation
  • As a risk factor
  • As a co-morbidity
  • As a consequence or coping mechanism
• Very little systematic evidence on psychological effects
  • Methodological issues related to reporting, identification of cases
Take Home Message - continued

• Mental Health Services of victims similar to that for other high-risk children
  • Suggestion that CBT/DBT may be effective
  • Specific treatments for a wide range of co-morbid conditions

• Current paradigms focus on integrated care with mental health services as one component

• Models that are most effective are:
  • Holistic
  • Long-term
  • Account for traumatic experience
  • Delivered in a culturally appropriate fashion
Let's make each child a happy child..!!

Thank You
World Vision Child protection work
Working in 99 countries. For Children. For Life.
119 Districts /projects

Ranchi PMO
Lucknow PMO
Bhopal PMO
Delhi PMO
Guwahati PMO
Kolkata PMO
Mumbai PMO
Hyderabad PMO
Chennai PMO
WV India’s child protection work

- **Child trafficking** (Jaipur, West Bengal)
- **Street Children** (Delhi, Mumbai, Kolkatta, Chennai, Kanpur, Vijayawada and Guwhathi)
- **Child labourers** (Jaipur, Meerut, Kanpur, Rajamundhry, Sivakasi, Vellore)
- **Child slavery** (Vellore)
- **Girl child** (North Karnataka)
- **Female feticide** (Tamil Nadu)
National level child protection baseline research ....

- 19 states (119 blocks/districts)
- Total child participants: 53,550 survey (450 in each district)
- Total caregivers participants: 71,400 (600 in each district)
Research findings:

- Adolescents know of services to report abuse: Average 61.20% (lowest 31.04%)
- Caregivers feel community safe place for Children: Average 57.77% (lowest 15.57%)
- Children able to express 3 personal safety methods & 3 sources of help: Average 63.18% (lowest 27.54%)
- Parents / Caregiver who would report child abuse: Average 74.21% (lowest 12.73%)
- Youth strong connection with caregiver: Average 49.68 (lowest 10.80%)
Our programs...

- Building the capacity of all agencies involved in responding to child abuse / trafficking
- Parenting skills training for parents
- Personal safety education for children
- Community based child protection mechanisms
- Research and local advocacy
End Violence Against Children

• Our upcoming global campaign for next 5 years;
• WV India’s theme: Child sexual abuse and exploitation
• Covering 19 states
• Would be collaborating with likeminded partners
What Is CHILDLINE?

CHILDLINE is India’s first 24–hour, free, emergency phone outreach service for children in need of care and protection. Any concerned adult, or a child in need of help can dial 1098, the toll free number to access our services. We not only respond to the emergency needs of children but also link them to services for their long-term care and rehabilitation.

1098 is not a mere number. 10 - 9 - 8 or CHILDLINE is a countdown to a better life for the street child. It stands for hope, acceptance and happiness. A friendly or sympathetic ‘didi’ or ‘bhaiya’ who is always there for them 24 hours of the day, 365 days of the year.

CHILDLINE is a integral part of the Integrated Child Protection Scheme of the Ministry of Women and Child Development, Government of India. CHILDLINE India Foundation is the national nodal resource organization for initiation and monitoring of the service throughout the country.

How CHILDLINE Works:

To effectively tackle child protection, CHILDLINE has adopted a three-pronged strategy:

1. It listens to the child before responding to his or her needs
2. It conducts sensitization programs with allied systems such as police/doctors/nurses
3. It advocates for child friendly systems at a national level

Children Who Call Us:

- Street children
- Child addicts
- Abused children
- Mentally ill children
- Child laborers
- HIV/AIDS infected children
- Differently-abled children
- Child victims of the flesh trade
- Children in institutions
- Child political refugees
- Children in conflict with the law
- Children whose families are in crisis
- Children affected by conflict and disaster
Children call CHILDLINE for:

- Medical assistance
- Shelter
- Missing children
- Repatriation
- Protection from Abuse
- Emotional support & guidance
- Death
- Information about CHILDLINE
- Silent calls and Chat calls

**Structure of CHILDLINE at the local level**

CHILDLINE functions through a network of NGOs, academic institutes the corporate sector and the allied systems. The focus of the service is to reach out to every marginalized child and hence programmes must be designed accordingly. The various structures in a city include:

- **CHILDLINE Advisory Board (CAB)** comprising senior level functionaries from the allied systems, NGOs concerned individuals, media etc. It is the policy making body for CHILDLINE at the city level and it undertakes periodic review of CHILDLINE.

- **The Nodal Organization**, essentially an academic institute/ resource and training organization to ensures coordination, training, research, documentation, awareness and advocacy;

- **The Collaborative Organization**, essentially a 24-hour service for children, responds to calls on 1098, provides emergency intervention, links children to services for ultimate rehabilitation, conducts awareness and outreach programmes, documents every call that comes into CHILDLINE

- **The Support Organization** responds to calls referred by the collaborative organization, conducts awareness and outreach programs.

- **Sub-centers**: In cases when the CHILDLINE is in a District Model with coverage in both rural and urban areas, subcentres ensure coverage of the service.

- **Resource Organizations**: These organizations act as referral centres for CHILDLINE. They also participate in outreach and awareness programs for CHILDLINE.

**CHILDLINE INDIA FOUNDATION**

**CHILDLINE believes in Partnership**

Initiated as an experimental project by the Tata Institute of Social Sciences in 1996, CHILDLINE is a unique partnership between the Government of India, Department of Telecommunications, Voluntary agencies, academic institutes, the corporate sector, children and the community:
- Government of India (GOI): ensures coordination, policy decision making and supports CHILDLINE with a partial grant,
- The NGO sector - About 750 NGO's working in the child protection sector across the country are CHILDLINE’s partners.
- Corporate Sector helps by giving expertise in their key areas, volunteers and funds.
- Academia helps translate the theories into issues, which can be addressed at the policy level,
- And most importantly the Child, the center of this web, plays a vital role in not only providing feedbacks of the service, but also gives opinions on key issues of the service.

Initiated as an experimental project in 1996, CHILDLINE currently consists of a growing network of across 402 cities in India. Like most non-profit organisations creating awareness, responding to every call, providing quality intervention and protection in the absence of sustainable funds is a great challenge. Today, it has taken over 24.5 million such calls and made a difference to the lives of hundreds of thousands of children all over the country. Still millions are left ...

In order to find more about us, do log on to: www.childlineindia.org.in

Or contact us at:

**Delhi Northern Regional Office:**
CHILDLINE INDIA FOUNDATION
North Regional Resource Center
SPWD Building, 5th Floor
14-A, Vishnu Digamber Marg
Rouse Avenue
New Delhi - 110002
Land Lines: 011-23218807/23218948

**Head office:**
CHILDLINE India Foundation
406, Sumer Kendra, 4th floor,
P. B. Marg, Worli,
Mumbai 400 018.
Tele-fax: 022-2490 3509.
Abstract

India is home to the largest child population in the world, with almost 41% of the total population under 18 y of age. The health and security of the country’s children is integral to any vision for its progress and development. Doctors and health care professionals are often the first point of contact for abused and neglected children. They play a key role in detecting child abuse and neglect, provide immediate and longer term care and support to children. Despite being important stakeholders, often physicians have a limited understanding on how to protect these vulnerable groups. There is an urgent need for systematic training for physicians to prevent, detect and respond to cases of child abuse and neglect in the clinical setting. The purpose of the present article is to provide an overview of child abuse and neglect from a medical assessment to a socio-legal perspective in India, in order to ensure a prompt and comprehensive multidisciplinary response to victims of child abuse and neglect. During their busy clinical practice, medical professionals can also use the telephone help line (CHILDLINE telephone 1098) to refer cases of child abuse, thus connecting them to socio-legal services. The physicians should be aware of the new legislation, Protection of Children from Sexual Offences (POCSO) Act, 2012, which requires mandatory reporting of cases of child sexual abuse, failing which they can be penalized. Moreover, doctors and allied medical professionals can help prevent child sexual abuse by delivering the message of personal space and privacy to their young patients and parents.

Keywords
Child abuse and neglect · Girl child · Child labour · Child sexual abuse prevention · Protection of Children from Sexual Offences (POCSO) act

Definition and Types of Child Abuse and Neglect

The World Health Organisation (WHO, 1999) has defined ‘Child Abuse’ as a violation of the basic human rights of a child. It includes all forms of physical, emotional ill treatment, sexual harm, neglect or negligent treatment, commercial or other exploitation, resulting in actual harm or potential harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power. ‘Child Neglect’ is defined as (a) inattention or omission by the caregiver to provide for the child: health, education, emotional development, nutrition, shelter and safe living conditions; (b) in the context of resources reasonably available to the family or caretakers; (c) and causes harm to the child’s health or physical, mental, spiritual, moral or social development. ‘Child Maltreatment’ sometimes referred to as child abuse and neglect, includes all forms of physical and emotional ill-treatment, sexual abuse, neglect, and exploitation that results in actual or potential harm to the child’s health, development or dignity [1].

Within the above broad definition of Child Abuse and Neglect, five subtypes can be distinguished—physical abuse; sexual abuse; neglect and negligent treatment; emotional abuse; and exploitation.

(a) Physical abuse of a child is that which results in actual or potential physical harm from an interaction, which is reasonably within the control of a parent or person in a
position of responsibility, power, or trust. There may be single or repeated incidents.

(b) **Child sexual abuse** is the involvement of a child in sexual activity that he or she does not fully comprehend, unable to give informed consent to, or for which the child is not developmentally prepared, or that violates the laws of the society. Child sexual abuse is evidenced by an activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power; the activity being intended to gratify or satisfy the needs of other person. This may include but is not limited to: the inducement or coercion of a child to engage in any unlawful sexual activity; the exploitative use of a child in prostitution or other unlawful sexual practices; and, the exploitative use of children in pornographic performances and materials.

c) **Emotional abuse** is the failure of a caregiver to provide an appropriate and supportive environment, and includes acts that have an adverse effect on the emotional health and development.

d) **Neglect** is the inattention or omission on the part of the caregiver to provide for the development of the child in all spheres: health, education, emotional development, nutrition, shelter and safe living conditions, in the context of resources reasonably available to the family or caretakers and causes, or has a high probability of causing harm to the child’s health or physical, mental, spiritual, moral or social development. This includes the failure to properly supervise and protect children from harm as much as is feasible.

e) **Exploitation** refers to commercial or other exploitation of child in work (child labour), or other activities for the benefit of others, such as child trafficking [2].

**Magnitude of the Problem**

Amongst all reported cases, the US National Child Abuse and Neglect system data (2009) revealed a prevalence of physical abuse 18 %, sexual abuse 10 %, emotional 8 % and rest as cases of child neglect [3, 4]. A Government of India, Ministry of Women and Child Development (2007) survey revealed that the prevalence of all forms of child abuse is extremely high [physical abuse (66 %), sexual abuse (50 %) and emotional abuse (50 %)] [5]. A more recent study by the National Commission for Protection of Child Rights (NCPCR), conducted amongst 6,632 children respondents, in seven states; revealed 99 % children face corporal punishment in schools [6].

In developing countries such as India, with adverse socio-economic situation and large population base, child neglect is a serious, widely prevalent public health problem. Poverty, illiteracy and poor access to health and family planning services, result in provision of very little care to the child during the early formative years. Even services that are freely available are poorly utilized. The urban underprivileged, migrating population (a very sizable number) and rural communities are particularly affected. In large cities, there are serious problems of street children (abandoned and often homeless) and child labourers, employed in menial work. Children in difficult circumstances such as children affected by disasters, those in conflict zones, refugees, HIV/AIDS, children with disabilities are a particular cause of concern [7]. The situation of the newborn and the periods of infancy and early childhood are particularly critical and the morbidity and mortality rates continue to remain very high. Maternal under-nutrition, unsafe deliveries, neglect of early development and education are major issues that need to be appropriately addressed. Child rearing practices reflect social norms and very often adverse traditions may be passed from one generation to the next, especially in illiterate and poorly informed communities. As guardians of health, the medical sector has to plan and manifest its efforts, to address child abuse and neglect in this scenario and tackle the many entrenched problems.

**Consequences of Child Abuse and Neglect**

Child Abuse & Neglect (CAN) exerts a multitude of short and long term effects on children. Short-term effects of sexual abuse may include regressive behaviors (such as a return to thumb-sucking or bed-wetting), sleep disturbances, eating problems, performance problems at school, sexualized behavior, externalizing symptoms like aggression or bullying and internalizing like social withdrawal or complaints of recurrent generalized aches and pains [2]. Physical health may also be affected with complaints of recurrent genital discharge, dysuria, abdominal pain and urinary tract infections. The short and long term consequence of children’s exposure to child maltreatment includes elevated levels of post-traumatic stress disorder, aggression, emotional and mental health concerns, such as anxiety and depression. According to the Adverse Childhood Experiences (ACE) Study [8], a major American research project examining the effects of adverse childhood experiences on adult health and well-being, a powerful relationship has been established between emotional experiences during childhood and physical and mental health during adulthood.

**UN Convention on the Rights of the Child (UNCRC) and Moral Imperative**

The UN Convention on the Rights of the Child (UNCRC) (1989) is the most widely endorsed child rights instrument
worldwide, which was ratified by India (1992) and defines children as all persons up to the age of 18 y [9]. Defining violence and children protection rights, the Article 19 of UNCRC declares, “States parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child” [9, 10].

Several developed countries of the world have well-developed child protection systems, primarily focused on mandatory reporting, identification and investigations of affected children, and often taking coercive action. The burden of high level of notifications and investigations is not only on the families, but also on the system, which has to increase its resources [11]. In these contexts, the problems of child abuse and neglect in India need serious and wider consideration, particularly among the underprivileged rural and urban communities, where child protection systems are not developed, or do not reach.

The term “protection” relates to protection from all forms of violence, abuse, and exploitation. Based on our understanding, the Indian Child Abuse, Neglect & Child Labour (ICANCL) group, Indian Academy of Pediatrics (IAP) has strongly propagated the view that in Indian perspective the term “child protection” must also include prevention from disease, poor nutrition and illiteracy in addition to action against abuse and exploitation [12]. This underlines the importance of anticipating and averting what might happen to damage and demean a child—not just response to hurt inflicted.

The 9th ISPCAN Asia Pacific Conference of Child Abuse & Neglect (APCCAN 2011) conference outcome document “Delhi Declaration” re-affirmed and pledged to stand against the neglect and abuse of children and to strive for achievement of child rights and the building of a caring community for every child, free of violence and discrimination. It urged and asserted the urgent need to integrate principles, standards and measures in national planning processes, to prevent and respond to violence against children [12, 13].

Cost Concerns

The financial costs for victims and society are substantial. A recent CDC study found the total lifetime estimated financial costs associated with just 1 y of confirmed cases of child maltreatment (physical abuse, sexual abuse, psychological abuse and neglect) is approximately $124 billion in the United States of America [14]. In India, the central budget allocation for child protection has never even reached 50 paisa (half a rupee) of every 100 rupees pledged for social development. This grave resource challenge calls for re-examination.

Clinical Manifestations of Child Abuse and Neglect

Injuries inflicted by a caregiver on a child can take many forms. Death in abused children is most often the consequence of a head injury or injury to the internal organs. Patterns of injury to the skin and skeletal manifestations of abuse may include multiple fractures at different stages of healing. There is evidence that about one-third of severely shaken infants die and that the majority of the survivors suffer long-term consequences such as mental retardation, cerebral palsy or blindness. Children who have been sexually abused exhibit symptoms of infection, genital injury, abdominal pain, constipation, chronic or recurrent urinary tract infections or behavioral problems. To be able to detect child sexual abuse requires a high index of suspicion and familiarity with the verbal, behavioral and physical indicators of abuse. Many children will disclose abuse to caregivers or others spontaneously, though there may also be indirect physical or behavioral signs. Emotional and psychological abuse has received less attention globally due to cultural variations in different countries. Moreover, corporal punishment of children i.e., in the form of slapping, punching, kicking or beating, is a significant phenomenon in schools and other institutions. Child neglect can manifest as failure to thrive, failure to seek basic health care, immunizations, deprivation of education and basic nutrition needs. A neglected child could be exposed to environmental hazards, substance abuse, inadequate supervision, poor hygiene and abandonment [15].

Specific Sub-groups at Risk of Child Abuse and Neglect

(a) The Girl Child

The Indian census data has revealed some shocking statistics: a high prevalence of female feticide (an act of aborting a fetus because it is female). The sex ratio of boys to girls in the 0–6 age group in India has risen from the normal 102.4 males per 100 females in 1961, to 104.1 in 1981, to 107.8 in 2001, to 108.8 in 2011 [16, 17]. Moreover, the child sex ratio is significantly higher in northwestern states such as Punjab (118) and Haryana (120). In these regions, female feticide can be seen through a cultural background, where male babies are preferred because they provide socio-economic advantages and success in the family lineage [18].

The rise in female feticide has been linked to the arrival of affordable ultrasound sex detection technologies, initially introduced in India’s urban regions in 1980s, and later widely adopted in rural village areas by 2000s [19, 20]. This has lead to a thriving business of “travelling ultrasonologists” in the villages of northern India. A study estimated that 100,000 abortions are performed every year in India solely because the fetus is female [21]. The Government of India has launched
multi-pronged strategies to curb female feticide, which include legislative measures such as Pre-Conception and Pre-natal Diagnostic Techniques (PCPNDT) Act in 2004, advocacy, awareness generation and programmes for socio-economic empowerment of women.

There is evidence that ‘Girl child’ is systemically neglected from before birth and right through her life cycle [22]. A study demonstrated significant differences in gender violence and access to food, healthcare, immunizations between male and female children. This leads to high infant and childhood mortality among girls, which causes changes in sex ratio [21]. Girls may lack formal recognition (e.g., birth registration), legal protection, and social networks; married early (child marriage), they are disproportionately burdened both at home with household chores and at outside home doing domestic labor, and are less likely to be in secondary education or in the formal paid workforce [23]. Box 1 shows example of an abused girl child.

Box 1 Case example of an abused girl child

Ruma*: Girl-child on the streets

Ruma’s family are illegal immigrants, who have joined a rag pickers colony in New Delhi, India, where thousands of rag picker families are clustered. Now 13 y of age, Ruma has a father, mother, three sisters and two brothers, all of who are engaged in rag picking or domestic work. The parents want Ruma to do domestic work, but Ruma wants to go to school, study and play with her friends. Due to her attitude, her parents beat her constantly; sometimes she is starved or thrown out of home. Since she has no place to go, she often sleeps on the street near her home. An unending downward spiral of verbal and sexual abuse continued to unfold, drowning Ruma into self pity, frustration and depression. Homeless and lonely, Ruma slept where she could, falling victim to sexual abuse repeatedly. Eventually, Ruma found work as a housemaid in the neighbourhood homes; where she was exploited sexually again by males in the households. Ruma was also sent with an escort on a 5 d trip to Nepal to get involved with sex work, but she escaped from that situation and visited our Drop in centre (DIC) in the city. The DIC offered her non-formal education, medical assistance, food and other services. What Ruma needed most was a place to live, but the Shelter Home accommodates only boys. After several weeks of inquiry, an organisation was able to find Ruma a shelter home for girls. Everyone thought that this will be a happy end to the story, but no. Ruma stayed at the shelter home for a couple of weeks, but then ran away. She is back on the streets, destiny unknown.

*Names have been changed

(c) “Child Labour”

It is a serious violation of fundamental rights of children. It deprives children of their childhood potential and their dignity, and that is harmful to their physical and mental development. It is essentially a socio-economic problem, inextricably linked to poverty and illiteracy. There is a consensus emerging that when a child is not in school, the child would perform be part of the labour pool. In linking child labour to education, the tasks of eliminating child labour and of universalizing education have become synonymous. There is an essential need in developing countries to develop a comprehensive plan to withdraw children from work and mainstream them into schools, in order to provide them basic right to education [28–30]. The Government should see this is as a working challenge in trying to access children in need—in institutions, in street groups, in work-places, on the move, or even in prisons. Linkage with NGOs connected to such kinds of settings may be considered as an outreach option. Box 2 shows example of a street child labourer.

Box 2 Case example of a street child labourer

Pintu*: Street Child, successfully integrated and supported

Pintu, an 18-y-old boy, from a village in Bihar, India lived with his parents, three brothers, uncle and grandmother. Like any other child, Pintu also wanted to be cared and loved, he had a deep desire to study. His poor, illiterate father pushed him to work for hours in the fields to look after the cattle. If he showed any reluctance, he was abused and beaten. He ended up getting into wrong company and undesirable pastimes like gambling. His father caught him and an ugly altercation ensued. Before he knew what happened, Pintu was pushed out of his home, when he was only ten. With no money or food, he ran for a long time and reached the nearest railway station and jumped into the first train he saw. After what seemed an eternity, the train reached Mumbai. A train companion took Pintu to one of his relatives. Scared and worried, Pintu sensed something fishy in the kindness showered on him. Sure enough, his instincts proved right: he discovered he was to be bonded into slavery! Pintu remembers that he ran again for more than an hour and reached the railway station. This time, he took another train to Old Delhi railway station. Luckily he was spotted by a peer educator of a non Government Organisation, Project Concern International (PCI) next morning. He was taken to the PCI Drop-in-Centre, counselled and then moved to its Shelter Home. The Shelter Home at Mewat, Haryana is a safe haven providing boys with shelter, nutrition, clothing, health care, psychological support, and access to formal and non-formal education in a supportive rural community. Located in five acres of sylvan land it can house 40 boys up to 18 y. Like a family, the older boys look after the younger ones and all take part in daily chores. The Home provides space for the boys to enjoy outdoor games and physical activities. Pintu was enrolled in local government school and has recently graduated his 12th school leaving board examinations with first division. He is now registered in bachelors in computer degree from a local University. Pintu is thankful for the support, but very few street children are so fortunate to live their dreams!

*Names have been changed

(b) Disabled Children

Several international studies have established that children with disabilities are at greater risk of child maltreatment [24–27]. Children with disabilities may comprise about up to 10 % of school going children and as such their needs are even more likely to be ignored in developing countries. Inadequacies in the school system fail to meet children’s special educational needs; leads to neglect, beyond parental control.
Approach to Protection of Children from Abuse and Neglect

Background Measurers and National Legislations

The Government of India has assigned focal responsibility for child rights and protection to the Ministry of Women and Child Development (MWCD) [31]. The National Commission for Protection of Child Rights, set up in 2007, enquires, investigates, and recommends action against perpetrators of child abuse and neglect. Government launched an Integrated Child Protection Scheme (ICPS) (2009), which is expected to significantly contribute to the creation of a system that will efficiently and effectively protect children. The guiding principles recognize that child protection is a primary responsibility of the family, supported by community, government and civil society [32]. A new ‘National Policy for Children (2013)’ has just replaced the 1974 policy [33]. It establishes 18 y as the ceiling age of childhood, and adds an affirmation of India’s acceptance of the UNCRC. The legislative framework for children’s rights is being strengthened with the formulations of new laws and amendments to existing laws [28].

The medical professionals must have basic understanding of the following two legislations meant to protect children:

(a) The Juvenile Justice (Care and Protection) Act 2000 (amended in 2006) is the primary legal framework for juvenile justice in India [34]. It establishes a framework for both children in need of care and protection (CNCP) and children in conflict of law (CCL). Child in need of care and protection (CNCP) and reports of child abuse are heard by Child Welfare Committee (CWC), which has a chairperson and four other members of whom at least one is a woman and at least one is expert in children’s issues. CCL are handled by Juvenile Justice Boards (JJBs), which have a Metropolitan or Judicial

---

**Fig. 1** Medical Assessment & Response in Indian settings [38].

CWC Child Welfare Committee; CHILDLINE /PHONE NUMBER 1098
magistrate and two social workers, where one of the workers must be a woman.

(b) The Protection of Children from Sexual Offences (POCSO) Act, 2012, specifically address the issue of sexual offences committed against children, which until now had been tried under laws that did not differentiate between adult and child victims. The POCSO Act requires mandatory reporting of cases of child sexual abuse by doctors and multidisciplinary professionals. As soon as a complaint is made to the Special Juvenile Police Unit (SJPU) or to the local police, the law provides for relief and rehabilitation of the child [35]. Moreover, the recent Criminal Law Amendment Act (CLA) 2013 has expanded the definition of rape to include all forms of sexual violence. CLA, 2013 and POCSCO Act, 2012 both recognize that any registered medical practitioner can carry out a medico legal examination and provide treatment and records of that health provider will stand in the court of law (164A CRPC) [36].

**CHILDLINE 1098**

This is an emergency telephonic help line, which helps link children in situations of abuse/neglect with rehabilitation services. CHILDLINE 1098 has become an exceptional model of public private partnership, operational in more than 200 cities/ districts across the country [37]. During their busy clinical practice, medical professionals should use this telephone help line to refer cases of child abuse to CHILDLINE, thus connecting them to socio-legal services.

**Medical Assessment and Response**

Physicians are often the first point of contact of a child, whenever abuse is suspected; the concerned doctor must try to gather a detailed medical history from the child, if possible, and the caretakers. Most cases of child abuse are committed by people known to the child, in secrecy and in homes. Therefore, the physicians must be sensitive to the child’s possible apprehensions and home situations. The history taking should be appropriate to the child’s developmental level and avoid any further trauma. The interviewer should maintain a professional, non judgmental approach and adhere to the best interest of the child, in accordance with the law of the land. Assessment is a continuing process. Interventions and services should be provided alongside the assessment. The health assessments should be comprehensive, multi-disciplinary, respond to developmental and psychosocial concerns. The IAP Child Rights and Protection program recommends appropriate and timely referrals, as illustrated in the flow chart (Fig. 1) [38].

**Medical Guidelines for Victims of Sexual Offence**

The Ministry of Health and Family welfare, Government of India [39] has recently framed guidelines for doctors who might be called upon to handle female victims of sexual abuse, assault / rape in the course of their duty whether in a government hospital or even a private one. Sexual assault victims cannot be denied treatment in either of these hospitals, when they approach them, as denial has lately been made a cognizable criminal offence punishable with appropriate jail terms or fines or both. All medico-legal examinations and procedures must respect the privacy and informed consent has to be taken. Every hospital must have a Standard Operating Procedure (SOP) for management of cases of sexual violence. The examination room should have adequate space, an examination table and equipment required for a thorough examination, and the sexual assault forensic evidence (SAFE) kit for collecting and preserving physical evidence following a sexual violence. Figure 2 provides an approach to respond to victims of sexual abuse/assault.

**Prevention**

Given the large child population, particularly among the underprivileged rural and urban communities in India, socioeconomic constraints and lack of well developed child protection systems, it is of utmost importance to take all possible
measures towards primary prevention of child abuse. The practice of pediatrics has to shift from a primary focus on the delivery of acute care to one which focuses increasingly on the provision of anticipatory guidance and preventive care to assure optimal growth and development. While we cannot “immunize” every child against possible child abuse, we can help prevent children from abuse. Pediatricians can prevent child sexual abuse by delivering messages on personal space/body safety at every annual health maintenance assessment, in a developmentally appropriate manner, from as early as 3 y onwards. There is not a parent who would not want to protect their child against a sexually abusive experience. Parents should explain (to children) that if anyone ever touches them in a way that is uncomfortable, or makes them touch someone else’s private parts, they need to tell two adults right away. It is a shared responsibility to protect all children. Children armed with information about personal safety are 6–7 times more likely to develop protective behaviors, enhance potential for disclosure and experience less self blame [40, 41].

Conflict of Interest  None.

Source of Funding  None.

References

40. Finkel MA. An ounce of prevention or two... providing anticipatory guidance regarding personal space and privacy. A commentary. Child Abuse Negl. 2013. Available at 10.1016/j.chiabu.2013.06.004.
Child Sex Trafficking and Commercial Sexual Exploitation: Health Care Needs of Victims

Jordan Greenbaum, MD, James E. Crawford-Jakubiak, MD, FAAP, COMMITTEE ON CHILD ABUSE AND NEGLECT

abstract

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

INTRODUCTION

Human trafficking is a major global health and human rights problem, with reported victims in at least 152 countries.1 The total number of victims is unknown, although estimates range into the millions.2 Women and children predominate: in 1 global study, up to 49% of the victims were women and 33% were children.3 Violence and psychological manipulation are common, and victims are at increased risk of injury, sexual assault, infectious diseases, substance misuse, untreated chronic medical conditions, malnutrition, post-traumatic stress disorder (PTSD), major depression and other mental health disorders, homicide, and suicide.4–9 Given the large number of children and youth involved and the numerous adverse effects on the victim's physical and mental health, medical providers are in a unique position to help potential victims.10
The United Nations’ “Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Especially Women and Children,” defines severe trafficking in persons as
the recruitment, transportation, transfer, harboring, or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power; or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude, and the removal of organs.

When children/youth (<18 years) are involved, force, deception, or other means need not be present. Commercial sexual exploitation of children (CSEC) is closely related to sex trafficking and involves “crimes of a sexual nature committed against juvenile victims for financial or other economic reasons.... These crimes include trafficking for sexual purposes, prostitution, sex tourism, mail-order-bride trade, early marriage, pornography, stripping, and performing in sexual venues such as peep shows or clubs.” Many also include “survival sex” in this definition (exchange of sexual activity for basic necessities such as shelter, food, or money), a practice commonly seen among homeless/runaway youth. When CSEC involves US citizens or legal residents victimized on US territory, this is termed domestic minor sex trafficking. Transnational trafficking involves victims transported across national boundaries for the purposes of commercial exploitation; in 2012, the majority of transnational victims identified in the United States originated from Mexico, Thailand, the Philippines, Honduras, Indonesia, and Guatemala. Research on human trafficking is limited by the lack of a common database, challenges in victim identification, differences in definitions of terms, small sample sizes, and mixed populations (women and adolescents; victims of labor versus sex trafficking). One of the main challenges to victim identification in many jurisdictions within the United States involves the misidentification of youth as criminals (eg, “prostitutes”) rather than as victims of child abuse and exploitation. In their 2008 evaluation of English language research-based publications on human trafficking, Gozdziak and Bump reported that only 16% of 218 journal articles were based on peer-reviewed empirical research. Only 8 of 218 articles were related to the medical field. Although research has continued and expanded in the ensuing years, the many challenges described herein continue to limit empirically based, peer-reviewed, quantitative studies of commercially sexually exploited children and youth, and research on male victims is especially sparse.

**RISK FACTORS FOR CSEC**

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

The proportion of female to male victims is unknown, because reliable estimates of the prevalence of human trafficking are unavailable. Much more attention has been paid to female victims, and this may be related to a number of factors, including higher proportions of females being identified as victims in large-scale studies, evidence to suggest that female victims are more likely than males to be controlled by pimps, public discomfort with the idea of males having sex with men, public misperception that males cannot be objectified or coerced, and a general lack of screening boys for possible CSEC activity. It is likely that the number of male victims is grossly underestimated, because males may be less likely to be seen as victims by themselves or others. Male and female victims of trafficking and CSEC may be recruited by peers, relatives, or strangers who groom...
children and seduce them with promises of love, money, attention, acceptance, jobs, acting/modeling opportunities, drugs, or other desirables. Recruitment may begin over the Internet using social media or may involve face-to-face encounters. The process may be abrupt or prolonged; it may be dominated by manipulation and deceit or by violence. Once recruited into trafficking and CSEC, many children experience repeated physical violence (eg, beating, choking, burning), sexual assault and gang rape, psychological abuse and manipulation, threats, and blackmail at the hands of the trafficker; facilitators in the trafficking trade, and buyers. Traffickers use these strategies to establish and maintain total control over a victim. Alternating acts of violence and cruelty with acts of kindness and “love” helps to build strong bonds between trafficker and victim, making it very difficult for the victim to leave. Indeed, the complex relationship between trafficking victim and exploiter has been compared with that between victim and perpetrator in some cases of intimate partner violence.

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

**VICTIM IDENTIFICATION AND EVALUATION**

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

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

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

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

---

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

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

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

In addition to the typical elements of a medical history, information may be sought regarding whether the youth has a regular source of medical care or a medical home and his or her immunization status, reproductive history (STIs, pregnancy/abortions, anogenital trauma, number and gender of sexual partners, age at first intercourse, condom use, etc), history of inflicted injuries related to CSEC, physical abuse or dating violence, substance use, and history of mental health signs/symptoms. Such information helps determine testing and referrals and opens the door for anticipatory guidance. Information regarding current housing and the youth’s feelings of safety in that housing is also helpful. A mental health assessment may be especially important, because many victims of
CSEC experience PTSD, major depression, anxiety, and signs/symptoms of other emotional disorders. The provider may ask about past thoughts/actions related to self-harm, current suicidal ideation, and current symptoms, such as intrusive thoughts, nightmares, dissociation, and panic attacks. An emergency psychiatric evaluation may be indicated in some cases.

The medical examination and diagnostic evaluation focus on

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

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

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

### TABLE 1 Potential Indicators of Commercial Sexual Exploitation of Children\(^{10,13,20,31,47}\)

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

The anogenital examination is best performed with the aid of a colposcope, digital camera, or camcorder. Complete visualization of the external genitalia and perianal area is necessary. For females, speculum examination may be indicated when pelvic inflammatory disease or internal injury is suspected and may also be helpful for evidence collection. Although visible injury and may also be helpful for evidence disease or internal injury is suspected indicated when pelvic in area is necessary. For females, camcorder. Complete visualization of performed with the aid of

The anogenital examination is best diagnostic imaging for possible internal injury may be indicated.

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

**REFERRALS, RESOURCES, AND MULTIDISCIPLINARY INTERVENTION**

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

Although laws and policies must be followed, providers should be aware of the potential issues related to reporting to authorities so that they can help minimize potential harm to the child. Depending on the services available to victims as well as the degree of understanding by CPS workers regarding the unique issues facing victims (which generally extend beyond those related to the home environment and caregiver behavior), making a report may not lead to positive intervention for the child, and the response to the report may be “uncertain and potentially ineffective or even harmful.” In addition, although federal antitrafficking laws clearly indicate that a child cannot “consent” to engage in commercial sex acts and must be considered a victim, many states view CSEC in terms of prostitution laws and treat minors engaging in these acts as criminals rather than as victims. Involvement in the juvenile justice system as an offender vastly decreases the likelihood that the child victim will receive critical services and protection and may lead to further trauma, including reentry into trafficking and involvement in other high-risk behaviors. A cogent discussion of the ethical issues related to CSEC reporting may be found in a report from the Institute of Medicine, and information regarding individual state laws regarding child trafficking and commercial sexual exploitation may prove helpful to pediatricians. To help minimize potential harm associated with reporting CSEC/sex trafficking, it is important for pediatricians to emphasize to authorities that the child is a victim of
exploitation who is in need of services rather than a juvenile offender in need of punishment. Describing a child’s limited ability to understand sophisticated psychological manipulation practiced by traffickers and the lack of brain maturation, which limits their ability to weigh risks and benefits of various behaviors, may help investigators understand the child’s victim status. Similarly, the pediatrician may stress the particular vulnerabilities identified in the youth which have made him or her susceptible to exploitation.

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

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

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

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

CONCLUSIONS AND GUIDANCE FOR PEDIATRICIANS

1. Male and female victims of sex trafficking and CSEC may present for medical care for a variety of reasons related to trauma, infection, reproductive issues, and mental health problems. They require a comprehensive evaluation and, often, numerous referrals. The pediatrician has the opportunity to work collaboratively as part of a team of professionals from a number of disciplines to address these needs.

2. Victims of CSEC rarely self-identify. Although some victims have no risk factors or obvious indicators, youth at risk for CSEC may have a history of running away from home, truancy, child maltreatment, involvement with CPS or the juvenile justice system, multiple STIs, pregnancy, or substance use or abuse.

3. Evaluations of CSEC victims may be challenging. A comprehensive history related to injuries/abuse, reproductive issues, substance use, and mental health symptomatology obtained with a nonjudgmental, open attitude may provide important revelations. However, this cannot be performed without attention to the youth’s safety and potential distress during the interview.

4. Medical evaluation of a CSEC victim involves addressing acute medical/surgical issues, evaluating possible chronic untreated conditions, documenting acute/remote injuries, testing and treating STIs, and often, obtaining a sexual assault evidence kit.

5. Providers may advocate for victims by educating child-serving professionals and families regarding CSEC and child trafficking and giving anticipatory guidance to parents and children regarding Internet safety as well as common recruitment scenarios. They may also advocate to change state laws so that minors involved in commercial sexual exploitation are treated as victims rather than as juvenile offenders.

6. Pediatricians are mandated reporters of suspected child abuse and neglect. In states where CSEC/sex trafficking is considered a form of abuse, the pediatrician must make a formal report of suspected exploitation to law enforcement and to CPS as well, if indicated.
RESOURCES

- National Human Trafficking Resource Center Hotline (1-888-3737-888);
- US Immigration and Customs Enforcement (1-866-872-4973);

LEAD AUTHORS

Jordan Greenbaum, MD
James E. Crawford-Jakubiak, MD, FAAP

COMMITTEE ON CHILD ABUSE AND NEGLECT, 2013–2014

Cindy W. Christian, MD, FAAP, Chairperson
James E. Crawford-Jakubiak, MD, FAAP
Emalee G. Flaherty, MD, FAAP
John M. Leventhal, MD, FAAP
James L. Lukefahr, MD, FAAP
Robert D. Sege MD, PhD, FAAP

LIAISONS

Harriet MacMillan, MD – American Academy of Child and Adolescent Psychiatry
Catherine M. Nolan, MSW, ACSW – Administration for Children, Youth, and Families
Linda Anne Valley, PhD – Centers for Disease Control and Prevention

STAFF

Tammie Piazza Hurley

REFERENCES

18. ECPAT USA. And boys too: An ECPAT-USA discussion paper about the lack of recognition of the commercial sexual exploitation of boys in the United States. Brooklyn, NY: ECPAT-USA; 2013. Available at: https://d1qkyo5p1l09bx.cloudfront.net/000288B180D4FCD-A991-2195275350AB/1b1295ef-1524-4f2c-b148-


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


Child Sex Trafficking and Commercial Sexual Exploitation: Health Care Needs of Victims
Jordan Greenbaum, James E. Crawford-Jakubiak and COMMITTEE ON CHILD ABUSE AND NEGLECT

*Pediatrics*; originally published online February 23, 2015;
DOI: 10.1542/peds.2014-4138

The online version of this article, along with updated information and services, is located on the World Wide Web at:

http://pediatrics.aappublications.org/content/early/2015/02/17/peds.2014-4138