Global Perspectives on the Health and Social Impacts of Child Trafficking

Carmelle Wallace, MD, MPH,[a] Jordan Greenbaum, MD,[b,c] Karen Albright, PhD[d,e]

abstract

BACKGROUND AND OBJECTIVES: Survivors of child sex trafficking (CST) experience many health and social sequelae as a result of stigma, discrimination, and barriers to health care. Our objective was to obtain a cross-cultural understanding of these barriers and to explore the relationship between stigmatization and health outcomes through application of the Health Stigma and Discrimination Framework (HSDF).

METHODS: In-depth, semistructured interviews were conducted with 45 recognized CST expert service providers. Interview data were analyzed using established content analysis procedures and applied to the HSDF.

RESULTS: Barriers to medical and mental health services span each socioecological level of the HSDF, indicating the various contexts in which stigmatization leads to adverse health and social outcomes. Stigmatization of CST survivors is a complex process whereby various factors drive and facilitate the marking of CST survivors as stigmatized. Intersecting stigmas multiply the burden, and manifest in stigma experiences of self-stigmatization, shame, family and community discrimination, and stigma practices of provider discrimination. These lead to reduced access to care, lack of funding, resources, and trained providers, and ultimately result in health and social disparities such as social isolation, difficulty reintegrating, and a myriad of physical health and mental health problems.

CONCLUSIONS: The HSDF is a highly applicable framework within which to evaluate stigmatization of CST survivors. This study suggests the utility of stigma-based public health interventions for CST and provides a global understanding of the influence and dynamics of stigmatization unique to CST survivors.

Full article can be found online at www.pediatrics.org/cgi/doi/10.1542/peds.2021-055840

[a]Department of Pediatrics, Kempe Center for the Prevention and Treatment of Child Abuse and Neglect, University of Colorado School of Medicine, and Children's Hospital Colorado, Denver, Colorado; [b]International Centre for Missing and Exploited Children, Alexandria, Virginia; [c]Children's Healthcare of Atlanta, Atlanta, Georgia; [d]Department of Medicine, Division of General Internal Medicine, University of Colorado School of Medicine, Denver, Colorado; and [e]Denver-Seattle Center of Innovation for Veteran-Centered and Value-Driven Care, Department of Veterans Affairs, Washington, District of Columbia

Dr Wallace conducted analysis and interpretation of the data, drafted the initial manuscript, and revised and reviewed the manuscript; Dr Greenbaum conceptualized and designed the study, conducted data acquisition, and revised and reviewed the manuscript; Dr Albright conceptualized and designed the study, supervised and conducted analysis and interpretation of the data, and revised and reviewed the manuscript; and all authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

DOI: https://doi.org/10.1542/peds.2021-055840

Accepted for publication Jul 21, 2022

Address correspondence to Carmelle Wallace, MD, MPH, Child Protection Team, Kempe Center for the Prevention and Treatment of Child Abuse and Neglect, 13123 E 16th Ave, B-138, Aurora, CO 80045. E-mail: carmelle.wallace@childrenscolorado.org

WHAT'S KNOWN ON THIS SUBJECT: Survivors of child trafficking experience health and social impacts, including barriers to health care and social stigma and discrimination. Less is known about the complex socioecological interplay of these factors and how they may be addressed to improve survivor care.

WHAT THIS STUDY ADDS: We explore in-depth the multiplicity of stigma and discrimination experienced by survivors and provide a concrete framework for understanding the health and social impacts. This framework provides a basis for physicians, service providers, policymakers, and others who work with survivors.

To cite: Wallace C, Greenbaum J, Albright K. Global Perspectives on the Health and Social Impacts of Child Trafficking. *Pediatrics.* 2022;150(4):e2021055840

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Child sex trafficking (CST) is a global health crisis. The United Nations defines CST as “the recruitment, transportation, transfer, harboring, or receipt of a child (<18 years) for the purposes of a commercial sex act.”[1] There are ~1 million CST survivors annually.[2,3]

Marginalized children are particularly vulnerable. Risk factors include poverty; housing insecurity; previous abuse; substance misuse; and lesbian, gay, bisexual, transgender, queer (LGBTQ+) identity.[4] Societal issues such as gender bias, systemic violence, and corruption further exacerbate vulnerability.[4] Survivors experience health consequences, including injury, infections, substance misuse, anxiety, depression, and posttraumatic stress disorder (PTSD).[5–9] They also experience significant barriers to health care,[10,11] including fear of arrest, deportation, and trafficker retaliation; discrimination; confidentiality concerns; difficulty navigating the system; social instability; and resource constraints.[12] These health care barriers exist across the socioecological spectrum from individual, interpersonal, organization, community to policy levels and are the context within which CST survivors experience stigma.

Stigma was first described as an “attribute that is deeply discrediting,” resulting in “disqualification from full social acceptance.”[13] Research has further elaborated stigmatization as a social process enabled by cultural, economic, and structural influences that label, stereotype, and exclude the affected person or group. The result is discrimination or unfair and unjust treatment on the basis of an attribute or status.

Global research demonstrates a significant connection between stigma and poor health outcomes.[14] Understanding stigma, therefore, is pivotal in mitigating the health outcomes of marginalized populations. Previous stigma research exists on HIV, obesity, and mental illness.[15–20] However, stigma research on trafficking is limited. Research has described stigmatization in adult trafficking survivors in a single geographical location, but none evaluate stigma in CST survivors globally.[10,11,21–23]

We designed a qualitative study to obtain an in-depth, cross-cultural, and global understanding of the barriers to health care experienced by CST survivors, and to explore the process of stigmatization and its effect on health. We did so through the application of the Health Stigma and Discrimination Framework (HSDF). The HSDF is well suited to this purpose for several reasons. It was derived by a globally recognized consortium of diverse stigma research experts including United Nations, international, and nongovernmental organization (NGO) affiliates.[24] It was then rigorously tested through a multicenter study that demonstrated reduction in HIV-associated stigma.[25] Although not validated in CST survivors, patients with HIV have similar vulnerabilities, and these populations often overlap. Finally, in contrast to previous stigma frameworks that focus on individual and interpersonal interactions, the HSDF evaluates stigma as a socioecological process that is influenced by organizational, community, and public policy factors. This makes the framework constructive for planning public health interventions the recommended approach to addressing trafficking.[26] A public health approach removes the focus on the individual who is the victim, shifting the weight onto the socioecological forces at play.

A detailed explanation of the HSDF has been published elsewhere.[27] Briefly, the HSDF categorizes the causes of stigma into stigma drivers, which are inherently negative perceptions that drive stigmatization, and stigma facilitators, which are positive or negative external influences such as policies and social norms (Fig 1). Drivers and facilitators determine whether stigma marking occurs, wherein negative attributes are applied to the individual or group. Intersecting stigmas refer to additional coinciding stigmas that may be applied. Marking manifests in stigma experiences, defined as the stigma and discrimination experienced by the person, and stigma practices, which describe societal stereotypes, prejudices, stigmatizing behavior, and discriminatory attitudes. The HSDF surmises that these manifestations influence outcomes within the population and institutions interacting with them, ultimately leading to health and social impacts.

METHODS

Participants

In-depth interviews were conducted with global CST experts and service providers working directly with survivors. Interviewees were initially recruited through professional networks, then referred and enrolled purposively to seek variance in the populations served and representation from all World Health Organization (WHO) regions and World Bank country income classifications. All participants were English-speaking.

Data Collection

A semistructured interview guide was used covering several domains, including health care needs, services, and barriers to care. Interviews were conducted through a secure Skype call, lasted 45 to 60 minutes, and

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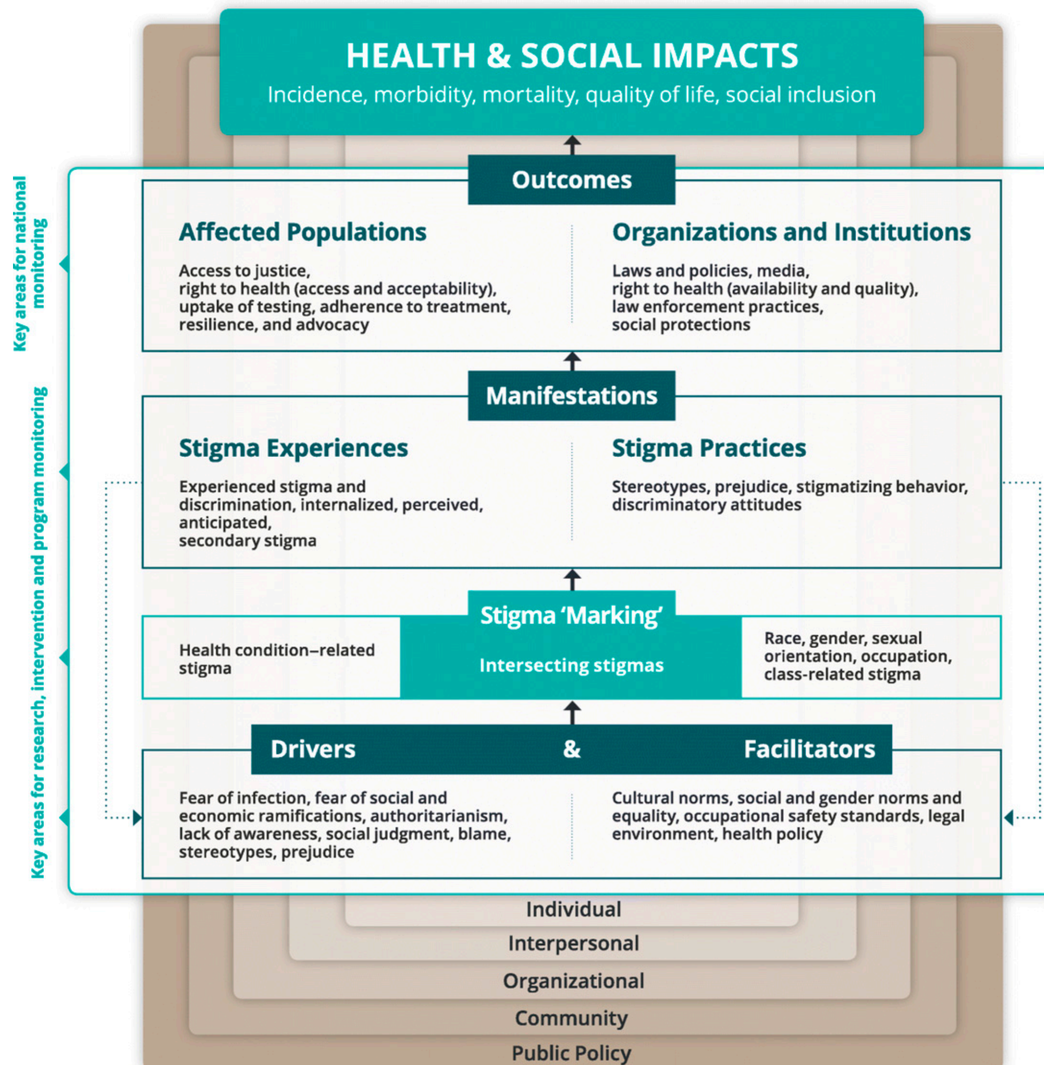

FIGURE 1
The Health Stigma and Discrimination Framework.[1] Used with permission. [1]Stangl AL, Earnshaw VA, Logie CH, et al. The Health Stigma and Discrimination Framework: A global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. *BMC Medicine*. 2019;17(1):18-23.

were audio recorded then transcribed. Children's Health Care of Atlanta institutional review board approved the protocol.

Data Analysis

Analysis occurred in an iterative process using established content analysis procedures and reflexive team analysis.[28,29] Transcripts were independently read multiple times by 2 analysts to achieve immersion. Codes were then inductively derived and independently applied by each analyst to 10% of the transcripts. Intercoder reliability was assessed and disagreements resolved through consensus. The remaining transcripts were coded using the final coding schema.[30] Axial coding was also employed to group codes and elucidate trends. Throughout the analysis, team members met regularly to discuss emergent themes.[31] ATLAS.ti v8.3.1 software was used.

RESULTS

Forty-five experts were interviewed, representing all WHO regions and World Bank classifications.[32,33] Interviewees included direct service providers such as physicians, psychologists, and social workers as well as researchers and NGO leaders (Table 1). Themes were synthesized by using the HSDF and are presented in Fig 2.[27] Each aspect of the stigma schema was explored in-depth and is presented below (subject number denoted S#, World Bank classifications denoted L= low, LM = lower middle, UM = upper middle, H = high).

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TABLE 1 Participant Demographics

	Participants		
Total participants (*n*)	45		
Geographical representation by WHO region[a]		World Bank Classification[b]	
African region % (*n*)	13.3 (6)	Low income %	15.6 (7)
Region of the Americas		Lower middle income %	35.6 (16)
North America % (*n*)	8.9 (4)	Upper middle income %	26.7 (12)
South America % (*n*)	11.1 (5)	High income %	22.2 (10)
South-East Asia region % (*n*)	22.2 (10)		
European region % (*n*)	22.2 (10)		
Eastern Mediterranean region % (*n*)	4.4 (2)		
Western Pacific region % (*n*)	17.8 (8)		
Roles[c]			
Researcher % (*n*)	22.2 (10)	Psychologist % (*n*)	17.8 (8)
NGO director % (*n*)	31.1 (14)	Social worker % (*n*)	6.7 (3)
NGO program coordinator % (*n*)	15.6 (7)	Counselor % (*n*)	2.2 (1)
Physician % (*n*)	20.0 (9)	Special educator % (*n*)	2.2 (1)
Nurse practitioner % (n)	4.4 (2)	Consultant % (*n*)	2.2 (1)
Client or patient population (all minors <18 y)			
Male %	11.1 (5)	Rural %	4.4 (2)
Female	28.9% (13)	Urban %	46.7 (21)
Both or unspecified[d]	60.0% (27)	Both %	48.9 (22)
Organization setting[e]			
Advocacy program	11.1% (5)		
Community resource program	84.4% (38)		
Government response program	8.9% (4)		
Hospital or clinic	20.0% (9)		

[a] https://www.who.int/healthinfo/global_burden_disease/definition_regions/en/.
[b] https://databank.worldbank.org/home.aspx.
[c] Several participants had 2 roles.
[d] Participants did not specifically denote if their primary clients or patients identified as LGBTQ+ but several alluded to working with the LGBTQ+ population, and thus are implicitly included.
[e] Several participants have worked with organizations with multiple programs or have worked with multiple organizations.

Health and Social Impacts

Participants reported that CST survivors experience a litany of health and social impacts. They reported social isolation, difficulty reintegrating into the community, sexually transmitted infections, reproductive health issues, seizures, malnutrition, untreated injuries, depression, anxiety, PTSD, eating disorders, and substance misuse (Fig 2).

Barriers to Services as Stigma Drivers and Facilitators, Stigma Manifestations, and Stigma Outcomes

Themes describing barriers to services spanned each socioecological level of the HSDF, providing rich descriptions of the individual, interpersonal, organizational, community, and policy contexts in which stigmatization occurs (Table 2). Most barriers were described in countries from all income levels. They were reflected in the model as stigma drivers, facilitators and manifestations, as well as outcomes leading to health and social impacts. Overlapping themes spanning multiple components of the model are italicized to emphasize pervasiveness (Fig 2).

Stigma Drivers: Victim Blaming

Participants frequently described victim blaming. One interviewee (S5, LM) shared how a survivor was told: "You went away. You migrated for work. This is what happened to you. It is your fault." Another shared:

> *"It is the girl's fault ... She was the one who got pregnant. She shouldn't have been wearing that slutty outfit, or flirting with those boys. She basically got pregnant because she was acting like she wanted it." (S9, LM)*

Similarly, subject 26 (UM) described how the societal opinion was that survivors "just got into this stuff because they are trouble anyway."

Intersecting Stigmas: Stigma Associated With CST

Many reported that trafficking itself was stigmatizing. They described a loss of position in society, calling CST "highly stigmatizing, highly disempowering" (S28, UM). Subject 26 (UM) described it as "it's like you are dirty," whereas subject 2 (LM) shared that it was "like these girls [were] branded." Another described CST as "the worst thing" (S8, LM).

Intersecting Stigmas: Gender

Gender-based stigmatization was frequently discussed. Many described a prevailing bias against female survivors, especially those in patriarchal cultures:

> *"Girls are like a piece of cloth. Once it is soiled, it is spoiled forever.*

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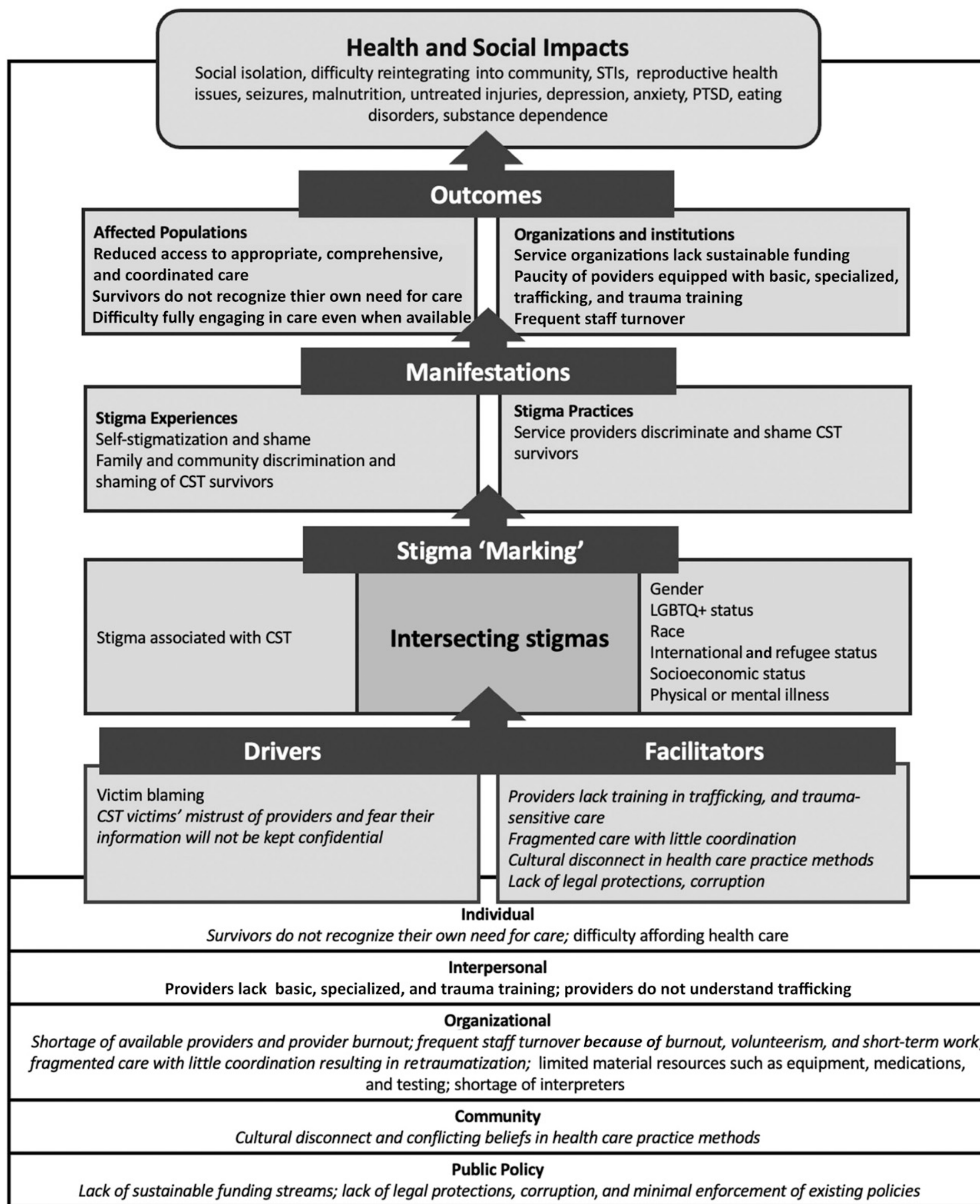

FIGURE 2
Interview themes organized within the Health Stigma and Discrimination Framework. Overlapping themes are italicized for emphasis on the intersectionality.

A boy is like a piece of gold. If you just wash it clean it's fine again." (S25, LM)

Participants also felt patriarchal attitudes contributed to stigma against males. Subject 25 (LM) explained that boys were not allowed to reveal weaknesses, "because they need to just brush

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TABLE 2 Barriers to Medical and Mental Health Care Presented Within Socio-Ecological Levels per HSDF With Notable Country Income Level Trends

Theme	Illustrative Quotes	Mental Health Care	Medical Care	Country Income Levels
	Individual			
Survivors do not recognize their own need for care	They just don't recognize it [mental health problems]. They would rather say I have Malaria or I have fever, but they do not recognize it. (S6, L) A lot of times just survival mode. Like it is ... you know ... I guess for them it is more like well, as long as I have food on my plate then I'm fine. (S5, LM)	Yes	No	All income levels
Mistrust of providers and fear their information will not be kept confidential	For the most part, [I observe] just absolute numbness. Just a lack of feeling and trust. They are not going to trust anybody. (S11, H) That is very true. They are very afraid because they don't understand confidentiality. They are afraid that people will find out. That people will know. (S8, LM)	Yes	Yes	All income levels
Difficulty affording health care	Not so much when they are in the shelter, but the before and afterward is the associated cost and the fact that most families get into debt. And most of the debt is health associated. (S1, LM) There are psychiatrists and behavioral health specialists, but those are really for paying patients. And there are people who are really good. But they work in private hospitals and the basic person, the immigrant, your average exploited person, doesn't have access to that. (S4, UM) But when something happens in the country and things become destabilized, they drop off therapy to look for basic needs again. (S44, LM)	Yes	Yes	Low- and middle-income
	Interpersonal			
Providers lack basic training	I gave a Grand Rounds on basic child abuse: sexual abuse and physical abuse. Because even that foundational understanding was lacking. It was very hard to build on. It was very hard to teach them about trafficking ... and how to look for and how to treat it and so forth, without them having a basic understanding of how to work up sexual assaults. (S9, LM) But those who work directly with the children, are mostly public workers in need of a job. And the NGOs give them a job. And more absolutely have gathered whatever experience they have, over a small period of time without any professional training. (S12, LM)	Yes	Yes	All income levels
Providers lack specialized training	Even with our caseworkers ... they were the ones providing the informal support, informal counseling, because they just weren't, you know, enough psychiatrists or psychologists available. (S27, UM) One ... I feel that if possible, if proper doctors especially, pediatricians, if they could be on hand for the children, it would be very nice. (S21, L) But then there is that level of understanding. But there, you often have lay people who are volunteering their time, or they don't get paid very much and they don't have any kind of	Yes	Yes	Low- and middle-income

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TABLE 2 Continued

Theme	Illustrative Quotes	Mental Health Care	Medical Care	Country Income Levels
	mental health understanding or awareness. (S2, LM)			
Providers do not understand trauma-sensitive principles	Trauma informed care … [is] really a foreign concept. (S9, LM) I think in general, most of them did not have training. So they are not up on trauma and child rights. That is not what they are thinking about. It doesn't mean they don't think about them with respect, but it is not something they are very well skilled in. (S33, H) I think there [are] huge barriers in the health care field regarding a lack of sensitivity. A lack of understanding of the nuances of trauma. (S4, LM)	Yes	Yes	All income levels
Providers do not understand trafficking	They have no trained officials in the health facilities that can easily handle young people who have been sexually exploited or for sex trafficking purposes. Because the way you handle the general cases, is different from how you handle a victim of trafficking. And with no trainings for health services in that area, it is quite difficult for them to also detect who is the trafficked victim and what kind of care and handling they need. (S6, L)	Yes	Yes	All income levels
	Organizational			
Shortage of available providers and resultant provider burnout	[The doctors are] indifferent. Yeah. That's a good term to describe it. Because it was … I mean they just had so many people that needed care and they were so understaffed. (S9, LM) The demand is huge and there is not … enough people … And as we say, she is crying at my shoulder and I am crying at her shoulder. (S10, UM) Sometimes they do not have a good attitude. And you can't blame them so much because of that doctor/patient ratio which is very high. And they [are] having to see the next patient. (S20, LM)	Yes	Yes	All income levels for mental health providers; low- and middle-income levels for physical health providers
Frequent staff turnover because of burnout, volunteerism, and short-term work	A lot of this is done by volunteers. Often, in some cases, foreign volunteers. So very, very transient type of support. And certainly when you talk to the children, you can see that they sort of feel left hanging. (S13, UM) But now the problem with that is we don't have doctors going out to the municipalities to become doctors there. They do it only for a short while and then they leave. (S19, LM) Staff turnover here is so great … Because the people can only handle a tiny bit of stress. And in our work there is a lot of stress. Because you are dealing with children who are raped all the time and so, it is our staff … max 2 or 3 years and they are gone. (S30, LM) There is a huge challenge in terms of retaining counselors in organizations. Most of them are, I would say, interns who come in for internship for a short duration of time. And then they are immediately sought after they have the experience, they leave the NGO. That is breaking that entire process of continuity	Yes	No	Low- and middle-income

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TABLE 2 Continued

Theme	Illustrative Quotes	Mental Health Care	Medical Care	Country Income Levels
	of care for the child. And the child is extremely left out in the changeover. (S12, LM)			
Fragmented care with little coordination resulting in retraumatization	That panel [of service providers] is very seldom together. You know, sometimes there are a lot of pieces that are missing in that panel. And it really usually comes down to check boxes as opposed to really providing holistic support. (S3, LM) But one of the things that children complain about is that they are moved from one group to the next. And one specialist to the next and they have to retell their story. And case management is definitely a weakness there, and information is not shared. So that is what's leading me to say, I think in general, cooperation between different support services is not always very strong. (S13, UM)	Yes	Yes	All income levels
Limited material resources such as equipment, medications, and testing	And once they get to the health facilities, and there are no drugs, it is very difficult for them to keep coming every day. And then no drugs [medications], no drugs, no drugs. (S6, L) In fact, we had a few patients there in the little emergency department for sexual assault but they had no evidence collection kit. They did a basic exam. If there was an injury they would document that injury. There was no photo documentation and no colposcopy. (S9, LM) You go to the hospital and you are asked to do a laboratory test and the hospital does not have the equipment to test. So you have to go to another private person to do the laboratory test. And they keep rotating. You just move from one place to another. Move from one place to another. And that is also ... it is also expensive. (S20, LM)	Yes	Yes	Low- and middle-income
Shortage of interpreters	And it gets very difficult for translations. So we rely on a person who may know the language. Or a person that is able to speak that particular language. They do not have specific translators. (S6, L)	No	Yes	Low- and middle-income
	Community			
Cultural disconnect and conflicting beliefs in health care practice methods	Like, for example, they do a lot of Cognitive Behavioral Therapy in America ... but it is not very effective in traumatized patients anyway. And definitely not in an Asian context where they just don't talk ... But the thing is, a lot of medicine that is being practiced there is just based on Western philosophy. (S4, LM) There is such a cultural connotation of witchcraft in Kenya, I have to be really careful when using an approach like EMDR to make sure that the person doesn't feel like I'm doing some sort of voodoo. (S44, LM) Honestly, it is interesting because the Monks and the Healers, the Witch Doctors, they all kind of ... just do a bit of everything ... There was a doctor who came visiting for a while ago and she went into a shelter and she saw that a girl had a great big cut and she couldn't work out what was in the cut ... and they said, "Oh you know, she had that great big	Yes	Yes	Low- and middle-income

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TABLE 2 Continued

Theme	Illustrative Quotes	Mental Health Care	Medical Care	Country Income Levels
	cut," so what they do is they sliced up garlic and put garlic in it. (S1, LM)			
	Public Policy			
Lack of sustainable funding streams	They are like NGOs who are so dependent on funding, that sometimes they function and sometimes they don't. It is not like a reliable stream really. (S25, LM) I think the government needs to commit to a Victim's Support Fund that pays for support activities that has to do with sex trafficking. For victims. Because I mean you cannot get into hospital or health center unless I am a victim and I am provided the medical care, but I do not have the money to maybe . . . the victim may be ill but not have money to buy the medication. (S6, L) Money from the government . . . and that is for the best, 2 y or one year, that has been lacking. You know? We were building this up for at best 5 y, 10 y. And now 1 to 2 y, because of the change of government. And we are having problems again. (S10, UM)	Yes	Yes	All income levels for mental health care; low- and middle-income levels for physical health care
Lack of legal protections, corruption and minimal enforcement of existing policies	Sadly, because the political system and the legal system moves so slowly, that these kids, you know, there will be horrible stories that you hear of human trafficking that they want to prosecute and it just takes too long for the kids to get through the system. Or they age out. (S26, UM) Oh . . . the police. When most of them are found . . . going to be little. When the police catch them. The police sometimes do physical abuse to them. And verbal abuse like his parents. (S38, UM) And the government wasn't supporting with the legal systems. When they went in to present into court, the defense attorney was very rude to them and actually triggered the secondary trauma. And triggered the experiences they had gone through. So this person felt like she really did not want to live anymore and her life was not helped by the system. (S6, L) There is so much corruption . . . You know? That traffickers, they can bankroll these girl's cases here or pay people off whatever and so these girls end up being prisoners again of the rescue shelter. (S2, LM) Because the barrier also is that if you are illegal, they are afraid they will be found out. Or deported. (S4, UM)	Yes	Yes	Low- and middle-income

Subject number denoted S#, World Bank classifications denoted L = low, LM = lower middle, UM = upper middle, H = high

themselves down and pick themselves up and get on with life."

The dichotomy of being a male survivor, and therefore perceived as weak, was at odds with the cultural view that boys should be strong.

"They will be seen as less of a man. Many of those cases go unreported. But it is because of the culture. The mind sets, their attitude is more, 'it is the weak ones that should go and get medicine.'" (S6, L)

The stigmatization of male CST survivors also presented significant challenges because of providers believing that "a boy cannot be raped," resulting in "massive, massive shame issues" (S1, LM). Another shared:

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"The boys we work with need care and love and compassion. And they don't get that at the hospital because they are seen as rough around the edges and homeless youth. As delinquents." (S31, UM)

Intersecting Stigmas: LGBTQ+ Status

Several indicated that CST survivors identifying as LGBTQ+ suffered additional stigmatization. The underpinnings of this stigma were structural and cultural. One subject shared that "it is illegal" to identify as LGBTQ+ (S44, LM). Another explained how their language reflected bias against minoritized sexual orientations:

"There is a strong stigma against being perceived as gay ... or 'obla.' Literally there is no word for 'straight' in Tagalog. The word for straight translates 'real man.'" (S3, LM)

LGBTQ+ survivors were described as ostracized, and even survivors who did not identify as LGBTQ+ had "fear about does this mean I'm gay," because they did not want to be additionally stigmatized (S21, L).

Intersecting Stigmas: International or Refugee Status, Race and Ethnicity, and Socioeconomic Status

Other intersecting stigmas were because of international or refugee status, race and ethnicity, and socioeconomic status. For example:

"They would be treated differently just because they are not welcomed as a citizen ... There is the perception of, like migrants come in and they steal all of this from us." (S5, LM)

Ethnic minorities were also shamed:

"There is discrimination ... if the child is Serbian, or from Albania, Croatia or Hungary ... They will say something like they deserve to live like that. Or they want to live like that. Or ... they are like gypsy. They are not even like the Roma population." (S17, UM)

"There are ethnic Vietnamese girls that have been trafficked and gone through the system. And yes, they are treated very differently. They are very much looked down on." (S1, LM)

Several also shared that socioeconomic status contributed to the multiplicity of stigma: "Trafficking is a crime that preys on the weak and the most poor and impoverished communities." (S2, LM)

Intersecting Stigmas: Physical illness

Stigma because of the physical sequalae of exploitation was also highlighted. Subjects described trafficking-related disabilities, sexual and reproductive issues, and gastrointestinal issues as sources of shame. Subject 24 (L) stated, "imagine the child has these issues [STIs], people laugh at her or him." Another participant described the stigmatization due to the fecal incontinence a survivor was experiencing as "another whole layer of shame" (S25, LM).

Intersecting Stigmas: Mental illness

When describing stigma associated with mental illness, interviewees elucidated cultural underpinnings. Many revealed that words for mental illness carried negative connotations. Across multiple cultures, survivors with mental illness were considered "crazy."

"[Mental health] is not something that we appreciate in our culture ... actually, if you went into the mental hospital, they will think you are mad. Because people who are just mad or crazy, they are there." (S6, L)

Others described those with mental illness as "weak in their eyes," (S16, UM). In honor-shame–based cultures in which "saving face" (S31, UM) was a priority, those with mental illness were described as "the underdog. They will look down on you, and hurt you physically" (S38, UM). Stigmatization was also embedded in religious or spiritual associations:

"In Hinduism there is a belief that whatever condition you have is the result of whatever you did wrong in a past life ... If you have any infirmity of any kind, it is because you richly deserved it and earned it in a past life." (S14, L)

"A lot of times [mental illness] is seen as [demon] possession." (S44, LM)

Stigma Manifestations: Stigma Experiences: Self-Stigmatization and Shame

Data also revealed that many survivors internalized these sociocultural beliefs, leading to self-stigmatization. Subject 38 (UM) described, "most of them have a self-stigma. They tell themselves I am bad, bad. I cannot be like this." Participants described how survivors felt worthless and experienced difficulty accepting that they were exploited. They struggled to access services and remained in exploitation.

Stigma Manifestations: Stigma Experiences: Family and Community Discrimination and Shaming

Subjects noted that cultural stigma manifested in shaming from the family and community.

"The family. Most of their parents speak to them like you are bad. You are not proper to birth in this world. Or you are worthless." (S38, LM)

Many participants described community rejection and difficulty reintegrating, either from the shame of trafficking itself or from time spent in aftercare facilities: "The community stigmatized them and said 'you are the kids who went to live with the foreigners.'" (S30, LM). The degree of discrimination varied from shunning to violence, and

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many described how the community "will blame you and treat you badly" (S38, UM).

Stigma Manifestations: Stigma Practices: Service Providers Discriminate

There were many egregious accounts of discrimination by service providers.

> *"There were many boys in prostitution ... The police basically said there was not an issue about the boys. Even though they knew." (S24, L)*

Others described the health care system as "the first place [survivors] experience stigma and discrimination," (S13, UM) and as a place in which survivors were "not welcome ... a death sentence" (S25, LM). Many also observed inappropriate care:

> *"This boy has been raped. He is bleeding ... And all the doctor basically didn't do an exam ... then wrote on the report, this boy has not been sexually abused." (S30, LM)*

Interviewees felt that provider discrimination prevented survivors from accessing services: "There are people who don't want to go because of the discrimination that they will face. (S4, UM)

DISCUSSION

This unique data set provides an in-depth yet global view of CST survivor health inequities through the lens of stigmatization. Current work has explored stigmatization of survivors generally, but few studies address how the stigmatization process weaves its way from individual-level interactions to system-level outcomes, directly affecting health and social well-being.[21,22,34–36]

Our themes reveal how stigma drivers like victim blaming and survivor mistrust of providers propel external stigmatization and self-stigmatization. Although self-stigmatization has been described, our study articulates its interaction with external factors and victim blaming in CST survivors with more depth.[37] We also identified several key barriers to care that are stigma facilitators, including providers who lack training in trauma-sensitive techniques and specialized care of survivors, fragmented care, lack of legal protections, and systemic corruption and inequities. Although these barriers have been previously reported, the HSDF sheds light on the influence of stigma on these barriers.[12] Importantly, these barriers are opportunities for destigmatizing interventions, which could include increasing trauma-sensitive and trafficking-specific training for providers, implementation of policies that support bolstering the workforce of providers qualified to work with CST populations, and educating professionals at large on the social and cultural factors that influence stigmatization.

Our participants described an alarming number of intersecting stigmas, including gender bias, LGBTQ+ status, race, refugee or international status, socioeconomic status, and physical and mental illness. Many of these stigmas have been described previously and individually, but separately from their interaction with CST.[37,38] This suggests interventions should also address these additional stigmas.

Our data support the HSDF's assertion that stigma experiences and practices are linked to outcomes affecting survivor well-being. Participants broadly described reduced access to care and paucities of funding, resources, training, and qualified providers. Intuitively, these are directly linked to health and social outcomes, which our participants described as social isolation, difficulty with reintegrating into community, as well as a plethora of physical and mental health problems.

Understanding CST survivor stigmatization via the HSDF makes a very complex social phenomenon concrete. It also highlights how pediatricians, mental health professionals, policymakers, advocates, and other stakeholders may participate in a global public health response. Stigma drivers, facilitators, marking, and manifestations present opportunities for intervention, including avoiding the use of harmful rhetoric, increasing public awareness regarding the intersection of CST and stigma, expanding research on stigma, increasing trafficking-specific and trauma-sensitive training opportunities, supporting funding and polices that are inclusive, and employing culturally sensitive and innovative approaches to empowering CST survivors. The HSDF Outcomes also suggest ways to monitor targeted interventions such as measuring availability and accessibility of services, amount of specific funding, and presence of policies that foster an informed workforce that protects the rights of CST survivors. Ultimately, longitudinal studies that quantify the health and social impacts of stigma reduction interventions would provide strong evidence for addressing CST. Table 3 provides a summary.

LIMITATIONS

Although this qualitative study is in-depth, it is impossible to ascertain generalizability. Though we gathered information from a broad and diverse environment, the sample size was limited and all participants were English-speaking. Representation from a given country varied from 1 to 5 subjects. However, the remarkable thematic

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TABLE 3 Health Stigma and Discrimination Framework-Driven Interventions and Recommendations

Framework Component	Recommendations
Stigma drivers	To minimize the stigma drivers of victim blaming and decrease stigmatization of CST survivors as "prostitutes," and other harmful rhetoric, consider policy-level approaches that treat CST survivors as victims rather than offenders, recognizing the unique vulnerabilities to exploitation associated with age and developmental capacities.
	Increase public awareness that child involvement in commercial sex stems from a place of extreme vulnerability, rather than desire and truly free choice. Children are exploited, and as such, deserve support and assistance rather than punishment.
	Educate health professionals and other child-serving professionals on human trafficking dynamics, harmful effects of stigma and bias, the Health, Stigma and Discrimination framework, and the rights-based approach to patient or client care
	Expand research on the multilayered interactions of stigma related to human trafficking and its measurement. Identify ways to measure stigma to design effective prevention strategies.
Stigma facilitators	Increase trauma-informed and trafficking-specific training for providers to increase access to optimal health care by trafficked children.
	Implement policies that support further training of medical and mental health care providers, and prioritize a focus on retaining experts in their home countries.
	Improve coordinated, holistic care for trafficked children by enacting public policy that facilitates multidisciplinary community collaboration and promotes involvement by health care facilities
	Educate health professionals on cultural factors affecting views on human trafficking, mental and medical health, and health care.
Stigma marking	Normalize mental health problems and mental health care through public health education efforts and community-based efforts to affect cultural norms. This should start at an early age and can be done in schools, community centers, clinics, and other key community sites.
	Support inclusive policies that provide rights and protections for all people regardless of gender, sexual orientation, race, refugee status, or socioeconomic status. These policies should be reflected on all levels of government, from local to international, and within health facilities.
	Create an organizational culture that does not tolerate bias and discrimination toward patients, and implement a system that allows anonymous patient or staff reporting of such behavior.
Manifestations	Employ innovative, culturally-sensitive approaches to help build resilience and empowerment among CST survivors. This may include novel strategies such as group therapy, dance therapy, art and music therapy, and a blend of cultural practices.
	Prioritize funding to research culturally relevant and safe ways to provide comprehensive care for survivors and their families.
	Educate health professionals on rights-based and trauma-informed care and the health effects of stigma, bias and discrimination
	Support community-level educational messaging to change the victim-blaming rhetoric around survivors and to understand CST and how to prevent it.
Outcomes	Monitor the availability and accessibility of centralized trauma-sensitive services to improve care coordination.
	Monitor sustainable and reliable funding streams from both the private and public sector.
	Monitor the creation and existence of policies that foster an environment of wellness, provide opportunities for staff to practice self-care, and that support the mental health needs of service providers to help decrease turnover.
	Monitor the longevity of service providers
	Monitor for equitable pay and benefits for service providers to decrease reliance on short-term assignments and volunteerism.
	Monitor support for policies that call for specific protections for survivors to help decrease inequities. All states should consider adopting the United Nations Convention on the Rights of the Child and should actuate the protections called for in the Optional Protocol to the Convention on the sale of children, child prostitution, and child pornography. Further, States should monitor national efforts to effectively protect these protected rights.
Health and Social Impacts	Conduct longitudinal studies to evaluate the health and social outcomes before and after multilevel stigma reduction interventions. For example, mental illness and physical health diagnoses, accessible and appropriate care, disability and quality-adjusted life years, life expectancy, employability, education attainment, quality of life, family and social community relationships, etc.

consistency suggests that we were able to identify critical dynamics of stigma in CST survivors globally.

Several barriers to health and mental health care were identified by participants in low- and middle-income countries only, despite abundant anecdotal evidence of their prevalence in high-income countries. This may be because of insufficient sampling or differences in perceived priorities among experts.

Although this study reflects the perspectives of experts, we recognize that these are not the perspectives of survivors. Because of the global nature of the study, we had ethical concerns about the ability to uniformly verify and

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monitor the capacities of each locale to support a vulnerable child being interviewed about a traumatizing subject in a resource-limited setting. Nonetheless, the perspectives of experts uniquely include the collective experience of the myriads of children they have served, providing valuable guidance on trends, issues, and priorities.

Finally, the use of the HSDF as a basis for intervention should be accompanied by appropriate cultural contextualization, as exploration of the nuances of each regional-specific culture was beyond the scope of the study.

CONCLUSIONS

Survivors of CST experience many health and social consequences as a result of stigma, discrimination, and barriers to health care. Stigmatization of survivors is complex and interacts with barriers to care across all socioecological levels. Evaluating the stigmatization process within the HSDF framework helps to prioritize how barriers should be addressed within interventions along each step of the stigmatization process, and how to monitor for change. Next steps should include further exploration of intersecting stigmas and testing of stigma-based interventions by measuring stigma reduction and psychosocial, mental, and physical wellbeing.

ABBREVIATIONS

CST: child sex trafficking
HSDF: Health Stigma and Discrimination Framework
LGBTQ+: lesbian, gay, bisexual transgender, queer
NGO: nongovernmental organization
PTSD: posttraumatic stress disorder
WHO: World Health Organization

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

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FUNDING: This study was supported by the International Centre for Missing and Exploited Children.

CONFLICT OF INTEREST DISCLOSURES: Dr Greenbaum is employed by the International Centre for Missing and Exploited Children (ICMEC). The other authors have no conflicts of interest to disclose.

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