CE 1.5 Contact Hours

Child Trafficking Victims in Pediatric Surgical Environments

Implications for Nursing Care and Advocacy

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Abstract: Human trafficking is a global human rights violation and emerging public health emergency. Child trafficking (CT), in particular, is both understudied and underreported. Despite the demonstrated need for skilled and knowledgeable health professional interventions, awareness across the continuum of care environments remains low. There is virtually no published scientific nursing literature exploring incidence and impact of CT specifically presenting in surgical settings, although survivor reports indicate an urgent and pressing need for it as victims may be hiding in plain sight within care environments. The purpose of this article is not to provide an exhaustive overview of the definitions, etiology, or means and purposes of CT but to draw attention of pediatric surgical nurses (PSNs) to consider how victims may be presenting for surgical care. PSNs need increased education, awareness, and tools to competently advocate for effective policy development and prioritized research efforts. PSNs should coordinate evidence-based, trauma-informed, and culturally responsive clinical actions in pediatric surgical care environments.

KEY WORDS: advocacy, child trafficking, labor trafficking, pediatric surgical care, sex trafficking

INTRODUCTION

Human trafficking (HT) is a global human rights violation (Greenbaum, 2018) and emerging public health emergency (Speck et al., 2018). Previously viewed primarily through a criminal justice lens, progress is being made toward a more holistic view of vulnerable populations through a public health framework. An ecological lens also provides context in understanding the complex, multilayered, and numerous interactions between victims; the complicated relationships encompassed within HT; and the environments that influence their health outcomes (Sanchez & Pacquiao, 2018). It is difficult to accurately estimate incidence and prevalence because of the illicit nature of criminal activity and hidden exploitation, lack of standard nomenclature and universal/centralized database, and underreporting of victims. Evidence of the widespread impact, however, is rapidly emerging as awareness increases (Greenbaum & Broderick, 2017).

Child trafficking (with the term "CT" encompassing both sex trafficking [ST] and labor trafficking [LT]), in particular, is both understudied and underreported. In a 2018 literature review of HT, a mere 9.7% of more than 22,000 articles specifically addressed CT (Sweileh, 2018). In addition, in 2018, the National Human Trafficking Hotline (NHTH) tracked 10,731 adult reports, 4,945 child reports (up from 2,762 the prior year), and 7,402 reports of HT with unknown victim age. Globally, the International Labour Organization (2018) estimates children comprise one in four of the 21 million victims of forced labor.

Risk factors for CT in the United States are numerous, with some overlapping potential exposure of vulnerable children to potential LT or ST. These risks include prior or current involvement with child protective services, foster care, or juvenile justice system (s); substance use/misuse and/or addiction (Polaris, 2018); intellectual disability (Reid, 2018); prior experience of physical, emotional, or sexual abuse; incarcerated family members; family or individual history of substance use and/or abuse (Sprang & Cole, 2018); identification as lesbian, gay, transgender, bisexual, queer, or questioning; untreated mental health disorders; homeless or runaway status; unaccompanied, undocumented, and/or recent migrant or refugee status; and family poverty, interfamilial violence, and/or forced migration (Greenbaum & Bodrick, 2017). The purpose of this article is not to provide an exhaustive overview of the etiology, means, and purposes of CT, nor is to give in-depth instruction on the clinical response. The purpose is to draw attention of pediatric surgical nurses (PSNs) to

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consider how CT victims may be presenting for surgical care and implement training and processes with which to enable appropriate response.

Background (CT)

The U.S. Department of Health and Human Services Office on Trafficking in Persons and the U.S. Department of Justice Office for Victims of Crime data estimate 31% of HT victims are exploited in ST, 65% in LT, and 3% in both ST and LT. Although ST has increased public awareness, data suggest LT is much more prevalent. For Fiscal Year 2018–2019, there was a 21% increase (n = 2,701) in cases of reported HT from the previous year (Devine, 2020). When looking specifically at child ST (CST), the National Child Abuse and Neglect Data System reports in 2018 that 89.1% of victims were girls and 10.4% of victims were boys (Kelly, 2020). Trafficker relationships to identified victims were identified as parents (16.1%), nonparents (34.5%), and unknown relationship (54.3%). The National Center for Missing and Exploited Children reports in 2019 data that the average age of CST victims reported missing is only 15 years (Reock, 2020). The NHTH identifies immigration status of victims of LT as foreign national (34.5%), U.S. citizen (8.2%), and unknown (57.4%). By contrast, immigration status of CST victims is identified as U.S. citizen (77.7%), foreign national (16.5%), and unknown (only 5.8% foreign). These data show the unrecognized vulnerability of U.S. teens to CST, despite the common misperception that it is mainly foreign nationals at risk. The top five types of HT reported to NHTH are (a) escort services, (b) residential commercial sex, (c) pornography, (d) outdoor solicitation, and (e) bars/clubs/cantinas followed by personal sexual servants (Cutter & Gerrior, 2020), whereas victims of LT are more likely to be exploited in involuntary domestic servitude, agriculture, construction, debt bondage, and hospitality industries (Peck et al., 2020).

The number 1 trafficker relationship to both victims of ST and LT is family members. The most commonly identified access point to help for victims of both LT and ST during exploitation is family members and/or friends. Health services is identified as Number 4 for ST and Number 8 for LT, likely indicating continued low levels of awareness. For ST victims, the second most common access to help is criminal justice, whereas the education system is ranked Number 2 for LT victims, indicating more potential for school involvement/awareness. The Child Welfare System ranks third for both groups of victims (Cutter & Gerrior, 2020).

These startling statistics position CT as a significant public health crisis with an urgent need for pediatric providers to further explore and implement effective prevention and intervention strategies (Greenbaum, 2017). Despite the demonstrated need for skilled and knowledgeable health professional interventions, awareness across the continuum of care environments remains low. Pediatric nurses have limited knowledge and resources to be equipped to facilitate safe exit of children from trafficking situations (Peck & Meadows-Oliver, 2019). Nurses, along with the general public, are susceptible to belief in trafficking myths often portrayed unintentionally by the media or other well-meaning but ill-informed activists, who fail to portray the complexities of trafficking and often view HT through a singular and distorted lens of ST (Gonzales-Pon et al., 2020). Nurses may be looking for media representations of chained female victims waiting for escape or rescue, missing identification of an adolescent in a clinical setting with a cell phone and the appearance of freedom. Healthcare professionals may be the first contact victims have once entering "the life" of trafficking, but failure to identify potential risk or exploitation results in missed opportunities to provide assistance (Scannell et al., 2018). Psychological manipulation and trauma bonding are invisible tethers entrapping victims (Relias Media, 2018). Considering the lack of standardized, scientific tools with established reliability and validity, it is imperative for health care provider to have adequate training and awareness to skillfully navigate clinical interactions with persons who are at risk for a trafficking experience or are being actively trafficked (Gonzalez-Pons, 2020). PSNs need increased education, awareness, and tools to competently advocate for effective policy development, prioritized research efforts, and coordinated evidence-based, trauma-informed, culturally responsive clinical actions in surgical care environments.

Problem (Potential Surgical Presentations of CT Victims)

There is virtually no published scientific nursing literature exploring incidence and impact of CT specifically presenting in surgical settings, although survivor reports indicate an urgent and pressing need for it as victims may be hiding in plain sight within care environments. Traffickers work to evade law enforcement presence and may intentionally select less prepared and less sophisticated healthcare systems, often paying in cash. Traffickers may seek surgical facilities accustomed to treating transient out-of-state patients. Two such reported cases include one trafficker seeking breast augmentation for his ST victim and another LT victim who experienced severe ingrown toenails and extreme delay of care, almost requiring amputation (Gomes,

2020). Victims do access ambulatory surgery centers and other surgical environments, but few healthcare personnel are adequately equipped to recognize and respond effectively (Relias Media, 2018). Lederer and Wetzel (2014) found 87.8% of victims they interviewed had some encounter with HCPs during their exploitation without being identified. Presentation environments included any type of clinic (57.1%), hospital or emergency room (63.3%), Planned Parenthood (29.6%), and urgent care (21.4%), among others. Similarly, Chisolm-Straker et al. (2016) found 68% of trafficking victims were seen by a healthcare provider while being trafficked. Victims presented to emergency/urgent care (56%), primary care providers (44.4%), dental care (26.5%), obstetrician/gynecologist (25.6%), and others. Dental care may be sought after complications of neglected oral health, mitigation of the effects of dental torture, or trauma from forced oral sex (Relias Media, 2018). Notably, most (55.1%) of the victims in this study began their trafficking experience before the age of 18 years, with a mean age of 16.5 years (Chisolm-Straker et al., 2016).

Physical Trauma Presentations

CT victims often experience physical trauma preceding presentation for care, with many complaints possibly creating need for surgical evaluation and/or intervention. Many of these children are beaten, punched, or kicked or endure other physical abuse requiring orthopedic surgical intervention for fractures and other injuries (Relias Media, 2018). Case studies report intentional severe physical injury of children including smashing the hand, beating the back with a fence post, and kicking in the hip with steel-toed boots for the purpose of acquiring narcotic pain medication to be used by the trafficker and not the injured victim (Bessell et al., 2017). Cases of victims jumping from a building or moving car requiring surgical intervention have also been reported (Relias Media, 2018). Other potential surgical presentations include organ trafficking, burn intervention, surgical abortion, gynecologic pathology requiring surgical intervention, and plastic surgery or esthetic services.

Organ Trafficking and Transplant Tourism

Organ trafficking and transplant tourism have been widely discussed internationally as a well-known and documented phenomenon with current coordinated mitigation efforts (Martin et al., 2019). Organ trafficking is illegal in the United States and widely condemned. Despite efforts to eliminate this practice, buying and selling of organs continues with estimates of up to 10% of all transplants occurring illegally. PSNs should be alert to questions asked about transplants. Currently, there is no universal data collection or reporting mechanism specific to concerns over organ trafficking, and development would require significant consideration of state and federal laws concerning confidential health information and mandatory reporting (Caulfield et al., 2016).

Burn Victim Presentations

Documented surgical burden of disease among individuals who are victims of ST in India continues to increase. A study of hospital admissions for burn injury (n = 222) found 43.9% experienced intentional burns with cigarettes, flames, and/or acid, largely inflicted by traffickers (Rahman et al., 2014). Cigarette burns and other kinds of burns found in victims in the United States are possible indicators of abuse inflicted by a trafficker, and HT should be considered in the differential paradigm (Office on Trafficking in Persons, 2020).

Reproductive Injury/Disorder Presentations

Another published survivor case report recounts the story of a young woman in Indonesia who, because of political instability and civil unrest, paid a recruitment agency to procure a hotel management position in Chicago. Upon arrival to the United States, she was immediately forced into a brothel and was repeatedly assaulted over several years before jumping from a second-story bathroom window to exit her trafficking situation. Before leaving Indonesia, she had had an intrauterine device placed, which was subsequently driven into the wall of her uterus after nearly continuous sexual assault during her trafficking experience. Without anesthesia or questioning about history of trauma or ST, physicians at a hospital in Queens tried unsuccessfully to remove the intrauterine device before referring her for gynecologic surgery where she continued to receive care in silence, with no questions asked by the healthcare providers she encountered (Gomes, 2020). Another case report details a female patient who had multiple presentations for care with reports of vaginal bleeding after injury and reported sexual assault with a foreign object. Although initially missing the signs indicating HT, the patient was eventually identified and received the care she needed (Scott-Tilley & Crites, 2016).

Genitourinary Presentations

The American College of Gynecologists issued a committee opinion voicing concern over lack of standards for cosmetic genital surgery as demand and performance of such procedures have increased. Labiaplasty rates alone increased more than 50% from 2014 to 2018. Incidence and prevalence of surgical intervention remain difficult to track because of the lack of standard nomenclature and published studies on the practice. There are also limited data to adequately inform women

on risks and benefits. Labiaplasty in female minors should only be considered in the case of significant congenital malformation or persistent severe symptoms related to labial anatomy. Cosmetic labiaplasty in girls younger than 18 years violates federal criminal law (Committee on Gynecologic Practice, 2020). Requests for such should raise concern for a possible trafficking situation, as should vaginal injuries acquired through intercourse (Bessell et al., 2017). Other potential gynecologic surgery considerations related to HT include female victims under the age of 18 years presenting with pregnancy who may require or request surgical delivery or surgical termination of pregnancy. Traffickers may use babies born to their victims as increased capability to manipulate the victim or may even traffic the baby illegally (Gomes, 2020).

Plastic, Reconstructive, Esthetic, or Cosmetic Procedure Requests

One case study published in the *Aesthetic Surgery Journal* detailed a White woman in her early 20s who was forcibly removed from her country and victimized by ST through a massage parlor. She presented for surgical care after previous breast augmentation and having injections of unknown substances into her buttocks administered by her trafficker. There are no published data on incidence of coerced cosmetic procedures, but there is sufficient concern among the surgical community to advocate awareness for plastic surgeons during primary esthetic consultations, including evaluation of complications from previous procedures and scar mitigation from previous injuries, burns, brandings, or tattoos (Izaddoost et al., 2019). Traffickers often use tattoos to mark their victims, causing psychologic distress and trauma bonding. Traffickers may seek removal of the tattoo of a former trafficker in favor of his or her own. In addition, former victims identifying as survivors may want cosmetic removal of tattoos and, as such, deserve trauma-informed care (TIC; National Association of Pediatric Nurse Practitioners [NAPNAP] Partners for Vulnerable Youth, 2018).

Trafficking by Surgical Providers

Trafficking has occurred within the surgical profession. Stereotypes of traffickers can present a barrier to prevent identification of traffickers, as many of us think of medical professionals as above reproach. In a horrifying story out of California, an oral surgeon was arrested in early 2020 for trying to purchase his office custodian's prepubescent daughters. Investigation has revealed allegations of hidden video cameras in his office and a cache of child pornography including video of himself sexually assaulting a minor (Gartreel, 2020). In another equally disturbing case, a plastic surgeon from Ohio was indicted and charged with ST by force, threats of force, fraud, and coercion and illegally distributing a controlled substance to victims (Dunn, 2020). As patients who require surgical intervention often need anesthesia, they are potentially more vulnerable to abuse by medical providers.

Medical/Surgical Consumables Produced by LT Victims

Another way in which PSNs may be impacted by trafficking is in using medical consumables produced by victims of LT. Two thirds of the world's surgical instruments are produced in Pakistan by approximately 50,000 workers, each working more than 80 hours per week for about two dollars per day. Approximately 5,000 of these workers are children as young as 7 years old, working to pay parental debt and not going to school. Manufacturers in Malaysia produce the highest number of surgical gloves, also with poorly paid persons working up to 13-hour workdays among reports of physical and sexual abuse. As surgical volume demand increases in the United States, demand for disposables is increasing, up to 47% in a 2-year period, with an average increase of 5% per year. In 2017, total surgical revenue was $38 billion in the United States, up from $28.3 billion in 2009. Although demand for elective surgical procedures is diminished related to COVID-19 restrictions, the demand for personal protective equipment has soared and will likely continue to do so as routine surgeries resume (Diamond, 2020). Labor exploitation for surgical supplies continues, although in violation of the International Labor Rights and Rights of the Child, which was ratified by 175 countries. In 2012, the National Health Service created a Labor Standards Assurance System and, in 2014, incorporated ethical procurement into a sustainable development strategy. Consumer demand has the power to improve working conditions and can be done strategically without incurring additional financial burden. Fair labor practices boost morale, improve quality, and promote worker retention. Buyers (including nurse buyers) of healthcare and surgical equipment can influence progressive, fair, and ethical changes. Many supply chain managers may be unaware of the unintentional use of products sourced from LT or their own ability to have voice in choosing which brands of supplies to purchase (Sandler et al., 2018).

Nursing is ranked annually as the most trusted profession by the American public. Nurses are skilled in therapeutic communication and face-to-face interactions and often encounter individuals in various scenarios of vulnerability, making them ideally equipped

and situated to leverage this skill set to address risk factors associated with CT in the surgical setting (Peck, 2020a).

Implications for PSNs

Individual Level

Many other professions outside healthcare are required to take HT education. The U.S. Department of Homeland Security began a training initiative called Blue Lightning for domestic airlines. This training has been adapted to other industry professionals including criminal justice, hospitality employees, train conductors, trucking associates, and other transportation industries including shared ride services. Many of these are mandated by company and/or state law ("Lessons Learned from Super Bowl Preparations," 2014); however, very few healthcare professionals are required to take such training. That tide seems to be turning with increased awareness. Some states, like Texas, are beginning to require mandatory training for healthcare providers, continuing to lag behind state legislation for other professions including cosmetology (Texas Health and Human Services, 2020). This process should meet stringent criteria for excellence, as well-intentioned but poorly executed education can be harmful to victims encountered. Considerations for continuing education, training, and lack of awareness are of primary concern for PSNs with intentions to enable the delivery of effective clinical interventions in scenarios of CT (Peck & Meadows-Oliver, 2019). On an individual level, all nursing HCPs should seek accredited, high-quality continuing education on HT that meets the following standards: evidence based, trauma informed, survivor informed, victim centered, and culturally responsive.

Few care providers have received adequate education and training to effectively identify and respond to potential victims in the clinical setting. In addition, PSNs should be trained to ask trauma-informed, culturally responsive, and open-ended questions consistent within their scope of practice to assess risk of potential trafficking (Peck, 2020a). Individual HCP interventional and therapeutic approach is the most effective victim identification tool to date. Passive judgment, bias, insensitive, dismissive, and other uninformed traumatic approaches are barriers to victims self-disclosing or even recognizing their own victimization (Albright et al., 2020). Some education provided to healthcare providers by well-meaning but ill-informed activist groups may contribute to continued bias and missed identification. Every effort should be given to strengthen the rigor of HT educational programs with standardized curricula to improve victim identification and facilitate connection to appropriate resources (Scannell et al., 2018; Texas Health and Human Services Commission, 2020).

Individual PSNs should be equipped and ready to respond appropriately should they encounter in the clinical setting children at risk for trafficking or children experiencing trafficking. PSNs must first provide a safe environment, then attend to pressing clinical needs, and, finally, connect children to appropriate services. It is not the role of the PSN to conduct a forensic interview if not properly trained to do so. It is also not the goal to force disclosure of victimization. Details on individual clinical response are beyond the scope of this article, and PSNs are highly encouraged to seek further detailed education and training to prevent unintentional additional harm to the child victim and to prevent vicarious trauma to the HCP (Peck et al., 2020). Table 1 provides a comprehensive list of resources available for further education.

Health Systems Level

On a health systems level, PSNs should advocate for standardized education and training to be provided to all personnel in the care environment, including ancillary staff, as part of onboarding as well as annual training (Peck, 2020b). Healthcare organizations should promote adoption of evidence-based, trauma-informed, survivor-informed, culturally responsive organizational protocols, policies, and governance related to surgical service provision to at-risk youth and those identified as victims of CT (Peck et al., 2020; Stoklosa et al., 2016). PSNs should also advocate for the adoption of formal policies and protocols in the clinical setting, no matter how large or small, as HT victims can present in any care environment. It is critical to work within interprofessional teams to create community collaborations with local law enforcement and other stakeholders and service providers (Peck et al., 2020). Collaboration of medicine, nursing, public health, law, and human rights fields in conjunction with community service providers, including victim advocates, contributes to an optimal care model (Richie-Zavalet et al., 2020). The Sexual Assault Response Team is a crisis intervention model with demonstrated improved outcomes through coalition building and interprofessional care for victims of sexual assault, which could be adapted for victims of HT. It facilitates collaborative responses among nurses (forensic), community and other advocates, law enforcement, and the criminal justice system (Vietor & Hountz, 2018). Another option explored to meet the needs of ST

Table 1: Resources for Individual HCPs, Health Systems, and Academic Institutions

Organization	Resource	Website
Alliance for Children in Trafficking (ACT), National Association of Pediatric Nurse Practitioners Partners for Vulnerable Youth	3-PARRT training (Providers Assessing Risk and Responding to Trafficking)	https://ce.napnap.org/3-PARRT
	ACT Advocates Train the Trainer program for healthcare professionals and speaker's bureau	https://www.napnappartners.org/act-advocates-program
	Provider & Public Resources	https://www.napnappartners.org/provider-public-resources
	Tattoos and human trafficking	https://www.napnappartners.org/tattoos-human-trafficking-victims
Dignity Health	Shared Learnings Manual	https://www.dignityhealth.org/hello-humankindness/human-trafficking
Dignity Health in partnership with HEAL Trafficking and Pacific Survivor Center	PEARR Tool (A Trauma-Informed Approach to Victim Assistance in Health Care Settings)	https://www.dignityhealth.org/hello-humankindness/human-trafficking/victim-centered-and-trauma-informed/using-the-pearr-tool
HEAL Trafficking	Protocol Toolkit for Developing a Response to Victims of Human Trafficking in Health Care Settings	https://healtrafficking.org/protocol-toolkit-for-developing-a-response-to-victims-of-human-trafficking-in-health-care-settings/
	Recent Publications and Reports	https://healtrafficking.org/publications-and-reports/
	Webinars	https://healtrafficking.org/webinars/
Missouri Department of Mental Health	Missouri Model for Trauma Informed Care	https://dmh.mo.gov/trauma
Polaris	National Human Trafficking Hotline	https://humantraffickinghotline.org/
Shared Hope International	State Report Cards for Sex Trafficking Laws	https://sharedhope.org/what-we-do/bring-justice/reportcards/2018-reportcards/
Stanford Social Innovation Review	A Trauma Lens for Systems Change (the Missouri Model)	https://ssir.org/articles/entry/a_trauma_lens_for_systems_change?fbclid = IwAR1cYcyPbUYJVwLROi5opF-yjWxrWa10ClfM3hSokxvN-mqp5nQUNalvQwk
U.S. Department of Health and Human Services; National Human Trafficking Training and Technical Assistance Center; Administration for Children and Families; Office on Trafficking in Persons; Office on Women's Health	SOAR (Stop, Observe, Act, Respond) to Health and Wellness Online Training Modules: Trauma-Informed Care; Culturally and Linguistically Appropriate Services; SOAR for: Behavioral Health, Public Health, Health Care, Social Services, School-Based Professionals, Native Communities	https://www.acf.hhs.gov/otip/training/soar-to-health-and-wellness-training/soar-online
U.S. Department of Homeland Security	Blue Campaign: a national public awareness campaign to educate the public, law enforcement, and other industry partners to recognize and respond to human trafficking	https://www.dhs.gov/blue-campaign

HCP = health care provider.

victims is the assessment, buy-in, case management, and diversion programming model, designed to recognize and close gaps between identification of health needs and provision of services (Murray & Smith, 2019).

Trauma-Informed Care

Implementing a TIC model and taking steps toward becoming a trauma-informed institution is critical for optimal health outcomes of CT victims (Leopardi et al., 2020). TIC should be approached as a way of being rather than an itemized checklist, with five core principles including (a) safety, (b) transparency and trustworthiness, (c) choice, (d) collaboration and mutuality, and (e) empowerment. The Missouri Trauma Initiative (see Table 1) as a model exemplar (Peck, 2020a) provides a developmental framework for TIC, avoiding the approach of a program with a checklist but considering a more holistic systems approach as a paradigm shift impacting knowledge, perspective, attitudes, and skills unfolding over time (Missouri Department of Mental Health, 2019). Facilitating a sense of autonomy and control is a core theme emerging from victims in recovery. Past traumas and absence of control require reclaiming exercise of agency and autonomy over health-related decisions to achieve optimal recovery

(Godoy et al., 2020). Pediatric nurses should be given adequate training to ask trauma-informed, culturally responsive, open-ended questions within their individual licensure and scope of practice limits to further assess risk when CT is suspected in the clinical environment. Health systems should be prepared to support HCPs who experience vicarious trauma when caring for victims (Peck, 2020a).

Research Agenda Priorities

Perhaps most pressing is the current need for scientific and rigorous generation of nursing and other health disciplines research (Stoklosa et al., 2016). Generation of peer-reviewed literature on CT has received inadequate attention and resources from HCPs, with literature and studies on prevention and early victim identification limited (Choi, 2015). Research agendas should address incidence, prevalence, risk and resiliency factors, physical and mental health effects of trafficking, and efficacy of clinical interventions and public health activities with a goal of prevention. With rising awareness among HCPs, screening tools and processes are much discussed, although limitations to applicability and practical use of such tools exist. There is wide variability between care environments and patient population demographics, limiting any type of one-size-fits-all approach (Leopardi et al., 2020a). On a health systems level, there is insufficient evidence to recommend universal adoption of a screening tool, but if developed for use in the clinical setting, institutions and individual HCPs should adhere to the strictest standards of scientific rigor in development (Peck, 2020a). Although new International Classification of Diseases, 10th Revision, Clinical Modification codes to identify HT victims were developed in the fall of 2018, insufficient evidence exists to recommend universal adoption or standardized use. Ongoing research should support exploration of this effort with consideration for privacy/confidentiality in reporting and efficacy of data collection in directing prevention and intervention efforts (Peck, 2020a).

Organizational Level

Only eight of 265 medical organizations have policies regarding HT. These organizations include the American Academy of Pediatrics, the American Association of Family Physicians, the American College of Emergency Physicians, the American College of Obstetrics and Gynecology, the American Medical Association, the American Medical Women's Association, the American Psychiatric Association, and the Christian Medical and Dental Association. Policies include combination variations of distinct policies for trafficking, recognition and intervention (the only universal element present), education, research, research, policymaking, prevention, and interprofessional collaboration (Fang et al., 2019). No such published analysis exists for nursing organizations, although several have made steps in this direction. The Association of Women's Health, Obstetric and Neonatal Nurses issued a position statement in 2016. The NAPNAP is leading nursing in the HT arena with the launch of a new 501(c)3 organization, NAPNAP Partners for Vulnerable Youth and the Alliance for Children in Trafficking (ACT; Peck, 2020a). ACT's accomplishments include developing high-quality, asynchronous continuing education; providing expert consultation to the United States House of Representatives and Senate on legislation impacting trafficking; serving the Office of Trafficking in Persons as appointed coauthor of core competencies for HCPs; and providing an expert speakers' bureau of trained grassroots experts in their ACT Advocates program (Peck & Meadows-Oliver, 2019). In 2018, the American Nurses Association issued a policy brief followed by a joint position statement issued by the Emergency Nurses Association in collaboration with the International Association of Forensic Nurses (Peck, 2020a). Opportunity exists to ensure professional nursing organizations have policies to direct meaningful change. No standards exist for integrating HT content into nursing curricula. Most providers have still not received evidence-based training. A commitment at the highest levels, including national nursing organizations, academic accreditation agencies, licensure regulatory bodies, and well-resourced health systems leaders, will be necessary to move forward with an effective response to epidemic of HT.

CONCLUSION

Children who are victims of HT and at risk of victimization are presenting in surgical care environments. Nursing has great potential to respond effectively and skillfully in a trauma-informed way, preserving the well-earned trust of the public.

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