Strategies for healthcare professionals to identify and assist migrant children at risk of labour exploitation or trafficking

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ABSTRACT
Increasingly large numbers of children and youth are migrating across international borders with many seeking employment in both formal and informal work sectors. These young people are at high risk of exploitation. Healthcare professionals need to be able to recognise vulnerable patients and advocate for their protection and safety, yet there is a paucity of literature that provides guidance on how to accomplish this. The goal of this paper is to provide guidance to clinicians on identifying and assisting migrant paediatric patients at risk of being exploited in the work sector, including conducting a risk assessment and making decisions about mandatory reporting. First, the best interest of the youth within their cultural context should be examined respecting their desires and goals, as well as immediate and longer-term physical health, mental health and safety issues. Second, clinicians should consider the best interest of the family, with attention to varying socioeconomic and psychosocial conditions including acculturation, immigration challenges, as well as cultural norms and values. Third, the situation must be evaluated within the legal framework of the host country regarding child labour, exploitation and trafficking. Cultural humility, open-mindedness, the active engagement of patients and families and an understanding of child labour within cultural contexts and legal statutes will empower healthcare professionals to identify and support patients at risk of exploitation in work settings. These recommendations serve to prioritise the best interests of vulnerable working migrant children and youth. The healthcare and migration systems of the USA will be used as a case for exploration.

INTRODUCTION
Millions of children and youth are forcibly displaced from their homes each year, and this includes large numbers who migrate to the USA. They flee from extreme poverty, war, community and family violence, persecution and other adversities. Rates of migration have increased substantially. During the initial 9 years of the US Unaccompanied Children Program, the Office of Refugee Resettlement served fewer than 8000 children each year. Since fiscal year (FY) 2012, this number has steadily and dramatically increased. The COVID-19 pandemic saw an unprecedented rise in referrals, with 15,381 referrals in FY 2020, spiking to 122,731 in FY 2021 and 128,904 in FY 2022.

As migrants, refugees or asylum-seekers, children and youth may travel alone, with family or with other individuals. While those arriving to the USA border come from a variety of countries, most originate from Latin America, especially Mexico, Guatemala, Honduras and El Salvador. They may work to pay living expenses, reduce family poverty or pay off debts. Social marginalisation, young age and lack of familiarity with host country labour laws, customs and language render them at increased risk for labour exploitation and trafficking. They may present for physical and mental healthcare for any number of concerns and healthcare professionals (HCPs) must be aware of their unique needs including the possibility of exploitation and trafficking.

Literature on identifying labour-exploited children in the healthcare setting is sparse and typically subsumes this topic under the more generalised subject of “child trafficking.” To date, we are not aware of any clinically validated screening tools to identify child labour trafficking/exploitation designed specifically for a high-volume healthcare setting. There is scant guidance for HCPs who must assess the safety and well-being of working children from a variety of cultural backgrounds. Moreover, these issues are poorly addressed in educational settings for HCPs. In this article therefore, we explore child labour among newcomer youth and those children born in the host country within families facing immigration issues, with the USA serving as a case setting. We identify factors associated with exploitation, discuss the related cultural issues that may complicate the assessment regarding possible labour exploitation and mandatory reporting, and provide guidance in working with families in which child work and child labour are of concern.
Factors associated with child labour exploitation in the USA

Many youths in the USA work in the private or public sector, within the bounds of state labour laws and the Fair Labor Standards Act of 1938. The Fair Labor Act was enacted to ensure that work is safe and does not jeopardise a youth’s health, well-being or educational opportunities. Important factors in identifying child work as ‘acceptable’ include an appropriate age of the child as defined by law, work hours that do not interfere with education, health, development and child well-being and the absence of exploitative and hazardous work conditions. ‘Child work’ is at one end of a spectrum which encompasses ‘child labor’ (work that may be hazardous to a child’s health and/or development, and may interfere with education), as well as ‘labor exploitation’ (when an employer benefits unfairly from a child’s work, either legally (eg, a legal ‘loophole’ such as exclusion of agriculture from multiple child labour restrictions related to age and hours) or illegally (eg, violating child labour statutes or engaging the child in illicit activities) and ‘trafficking’ (using force/fraud/coercion to involve a child younger than 18 years of age in involuntary servitude, peonage, debt bondage or slavery).

According to the US Department of Labor, there has been a steady increase in child labour violations since 2015. In 2022, 3,876 children were identified in these circumstances, 688 of whom were employed in violation of hazardous occupational work regulations. This is most likely a substantial underestimate of the true numbers given barriers to reporting, such as shame, the need to support self and family and fear of job termination, deportation or other retribution. The most common hazardous work violations involve operating motor vehicles, power-driven hoisting apparatus (eg, forklifts), power-driven food slicing machines and bakery machines, and power-driven paper-product machines. Violations are also common at slaughtering and meat packing plants. Child labour exploitation and trafficking may involve work in informal sectors (eg, forced criminality/begging, domestic work), or within formal economies and industries (eg, agriculture, construction, hospitality services).

Factors associated with child labour exploitation globally

Children and youth are generally at increased risk of labour exploitation and trafficking due to a host of factors at the individual, family, community and societal levels (see table 1). With respect to migrant youth, severe familial poverty in the home country, debt accumulated during the migration process and expectations that unaccompanied minors will provide financial support to their sponsors may drive migrant children to seek employment, and to accept and continue work, that is hazardous and/or exploitative. Their severe economic challenges render them vulnerable to labour trafficking. Children currently residing in the host country with caregivers of undocumented status may face similar vulnerabilities to exploitation due to poverty, limited access to resources and challenges associated with immigration issues affecting family members.

Research suggests that those participating in child labour, even in the absence of exploitation, are at elevated risk for a variety of physical and mental health adverse conditions. In 2020, 26 workers under 18 years of age died from work-related injuries in the USA; the incidence rate for non-fatal injuries among workers 16–19 years was 149.8 per 1000 full-time employees. Landrigan estimated that the risk of injury is nearly 10 times greater when a child is exposed to illegal work conditions. Injuries may involve burns, lacerations,
amputations, traumatic brain injury, fractures, exposures to toxins and other trauma. In a study of child labour in tobacco fields—in which 12-year-old can legally be hired for unlimited hours outside of school—approximately 75% of surveyed workers (ages 7–17) endorsed ‘nausea, vomiting, loss of appetite, headaches, dizziness, skin rash, difficulty breathing, and irritation to their eyes and mouth while working in the fields’. Child (and adult) labour trafficking has been associated with post-traumatic stress disorder, depression, problems with concentration and somatic dysregulation.

Cultural issues

HCPs may encounter migrant youth involved in work which may or not be exploitative as they may treat injured children at urgent care centers or emergency departments, provide primary care to youth at free and sliding scale clinics such as federally qualified health centers[28] or treat working youth at juvenile detention centers, medico-legal partnerships and/or social service agencies. HCPs need to remain culturally humble when discussing child labor and employment with patients and families. Cultures vary in their views of children’s rights to voice and choice with respect to employment, attitudes towards child labor, beliefs regarding a child’s role in supporting the family, what constitutes a child’s well-being, and definitions of character-building experiences.[29, 30] (NOTE: I accidentally deleted the text in this paragraph so had to cut/paste it back in. I hope the citation links are still active.)

Cultural factors as well as extreme socioeconomic vulnerabilities may play important roles in driving newcomer children and youth to seek employment.[29–33]

In some cultures, child work and child labour are socially acceptable, morally favoured and thought to improve the health and well-being of the child by socialising them and teaching them responsibilities and job skills, as well as preventing them from engaging in antisocial behaviours.[29, 30, 32] Work increases the individual’s competitiveness in a labour market, ensures continuation of the family business, offers an opportunity to pay school fees and continue education, supports the well-being of the family and has a positive impact on the community.[34, 35]

Cultural views on the rights of the child to participate in decisions regarding work may include unquestioning obedience to one’s elders and limited child voice.[29, 30]

Qualitative studies of children in a variety of countries and work environments demonstrate varied perspectives regarding work, with some children reporting satisfaction with work, a sense of pride and beliefs that work will help them further their goals and an internalisation of the normalised view of child labour.[35] Views regarding the benefits of formal education may also vary according to expectations and realities surrounding quality and accessibility.[29, 35] If education is not felt to improve a child’s prospects for future employment and family well-being, incentives to attend school may be low. Poor quality of educational experiences for migrant children in the host country may exacerbate the situation, especially for individuals attending schools with few resources and limited academic accommodations for those who do not speak the dominant language, do not understand the many nuances of the host culture or its education system and who are at risk for bullying.

Responsibilities of healthcare providers

Providers caring for working youth must navigate whether the patient’s work is interfering with and/or benefiting their health, well-being and education. The HCP should endeavour to understand the reasons the youth is working, the cultural views/practices of the youth and their family, the conditions of the work and the caregiver’s views on education and child development. It is important to speak with the youth and with the caregiver individually and privately to encourage openness and express understanding, being careful to review the limits of confidentiality before initiating the conversation. Sample questions regarding child work and labour, beginning with a question that elicits information about a typical weekday, are included in table 2. Box 1 provides more detailed questions to children and youth about possible exploitation including labour trafficking. The questions are derived from particularly effective questions used in other human trafficking screening tools[36, 37] the tenets of trauma-informed care[38] and the authors’ clinical practices with patients or clients who have experienced trafficking as children. Table 2 generally contains open-ended questions to create a trauma-informed environment that allows the clinician to establish a patient-centred therapeutic alliance, encourage open conversation and narrative and to build trust. These questions may be follow-up with more direct questions about specific exploitative conditions (box 1). The latter questions are not an exhaustive list because the goal of the HCP is not to make a legal determination of trafficking/exploitation, but to explore risk and provide resources.

In addition, youth perspectives regarding the school environment should be discussed, including issues of physical and emotional safety, availability of resources to facilitate learning and overall student well-being. These conversations require an open-minded and non-judgemental approach, with consideration of cultural norms regarding a child’s right to participate in decisions and voice opinions.

In addition, the HCP should communicate their own concerns in a non-blaming, non-threatening manner that minimises the negative influence of the inherent power differential between provider and patient/family.[39] The provider must consider their own views on child labour, child work, child rights related to work and the role of work in healthy child development. These views are influenced by national, community and family culture, legal provisions and an individual’s prior experiences among other factors. Healthcare workers should be aware of and question their own beliefs and biases, realising that
Table 2: Potential questions regarding child work/labour

<table>
<thead>
<tr>
<th>Questions to caregiver</th>
<th>Questions to youth</th>
</tr>
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<tbody>
<tr>
<td>Begin by explaining what is meant by ‘work’ or ‘job’ (eg, that is, anything that the child does that leads to payment, in money or other items they value or in exchange for things they need to survive, such as shelter or protection from harm). This can include working for family, paid/unpaid work that is inside/outside the home, and work that is formal (like a job in construction) or informal (like babysitting). ‘Can you describe a typical weekday for your child, when they are working?’</td>
<td>Begin by explaining what is meant by ‘work’ or ‘job’ (eg, that is, anything that the child does that leads to payment, in money or other items they value or in exchange for things they need to survive, such as shelter or protection from harm). This can include working for family, paid/unpaid work that is inside/outside the home, and work that is formal (like a job in construction) or informal (like babysitting). ‘Tell me all about your work/job.’</td>
</tr>
<tr>
<td>‘Tell me what you think would happen if your child did not work.’</td>
<td>‘What are the good and not-so-good things about having a job/working?’</td>
</tr>
<tr>
<td>‘Parents and caregivers have their children take jobs or work for the family for many reasons. What are some of the reasons you feel it is important for your child to work? What are the benefits? Are there any drawbacks? If so, can you describe them?’</td>
<td>‘What do you think would happen if you told your parent/caregiver you did not want to work?’</td>
</tr>
<tr>
<td>‘Children have special roles in a family and these roles can differ across cultures, and between families. What do you see is your child’s role in helping the family to thrive?’</td>
<td>‘Are you responsible for providing for your family here or back home? Tell me about that.’</td>
</tr>
<tr>
<td>‘Sometimes other people take advantage of children/teens and make them do things that are against the law, like stealing or selling drugs. This is also a form of ‘work’. Do you think anyone has ever tried to make your child do something like that?’</td>
<td>‘Sometimes other people make children/teens do things that are against the law, like stealing or selling drugs. This is also a form of ‘work’. Has anyone ever tried to make you do something like that?’</td>
</tr>
<tr>
<td>‘Has your child had other jobs or forms of work in the past? Can you tell me about them?’</td>
<td>‘We’ve talked about work you are doing now. Have you had a job, or done work for someone before this?’ (Repeat questions for each work experience).</td>
</tr>
</tbody>
</table>

Box 1: Direct questions about possible exploitation and labour trafficking include:

- In your current work, or your past work, did you ever have any of these experiences?
  - Felt unsafe at work?
  - Missed school because of work (did not attend some days/weeks, or were not enrolled in school).
  - Worked without getting the payment you thought you would get?
  - Worked a job that was different from what you were promised or told it would be?
  - Been physically or sexually assaulted by another employee or a supervisor/manager/boss?
  - Had your boss/ supervisor yell at you, insult you and/or make you feel bad?

Using the information gleaned from conversations with the child and caregiver, the HCP should therefore consider the situation from the following perspectives. First, the best interest of the youth within their cultural context should be examined respecting their desires and goals, as well as immediate and longer-term physical health, mental health and safety issues. Second, clinicians should consider the best interest of the family, with attention to varying socioeconomic and psychosocial conditions; acculturation; immigration challenges; as well as cultural norms and values. Third, the situation must be evaluated within the legal framework of the host country regarding child labour, exploitation and trafficking. When contemplating a report to authorities, HCPs should also consider the following questions; Does the situation fall under mandatory reporting laws? What ‘harm’ does the child face by working in their current situation? Which of these ‘harm’ are based on cultural views of child rights and roles in the family (and which may vary with the culture), and which are more globally identified as harmful to physical/mental/developmental health? If a report is made, how might potentially harmful consequences be mitigated (eg, a prompt referral to a pro bono immigration attorney to address deportation concerns, or referral to an organisation providing assistance to immigrants/refugees and asylees)? Finally, how can the clinician advocate for the rights of the child and family if they are undocumented or otherwise at risk of human rights violations?

Determining whether a child or adolescent is experiencing child labour exploitation versus labour trafficking is outside the domain of the HCP. In many cases, an exploited (but not trafficked) patient has the same need for services as does one whose exploitation is accompanied by force, fraud or coercion. The most important role of the clinician is to determine risk of harm.
related to child work/labour and to assess service needs, including referring to specialists who may determine the exact status of exploitation versus trafficking, as needed. This may involve a referral to a community immigrant/refugee-serving organisation or contact with the national referral agency for suspected human trafficking (in the USA, providers may contact the National Human Trafficking Resource Center at 1-888-373-7888, or refer to the Office of Trafficking in Persons by calling 202-205-4582 or visiting the website: https://www.acf.hhs.gov/otip/victim-assistance). A mandated referral to authorities (eg, a report to child protective services for suspected neglect) may or may not be indicated and the potential negative repercussions of a report must be considered and minimised.

Regardless of the decision to make a mandatory report, the HCP should actively engage the patient and caregiver (when safe to do so) in identifying harm reduction strategies that mitigate the risk for, and potential experience of child labour exploitation or trafficking. This includes helping the caregiver identify ways to improve the child’s well-being at work and minimise the impact of work on school involvement; identifying community services that ease current family stressors such as after-school childcare or food insecurity and providing the caregiver with resources on employee rights and local labour laws (for adults and minors). Referrals to local migrant-serving organisations that provide language instruction, individual academic tutoring and (in some cases) school supplies are helpful. Advocating for effective implementation of anti-bullying policies may increase school safety for migrant youth, as would advocacy for increased resources for schools to accommodate the special needs of newcomer children. At the same time, HCP’s can advocate for increased monitoring of businesses for unsafe and exploitative labour practices and strict implementation of punishments for labour violations.

If possible, the HCP should offer a ‘warm handoff’ to resources that help the family address factors making the patient vulnerable to child labour, trafficking or exploitation. This may involve the provider suggesting a referral to child protective services for assistance (as opposed to investigation), although immigration concerns may make this option less desirable to families who do not have a lawful presence in the host country and fear working with government officials. Referrals for services should be sought only with the informed consent of the guardian and permission of the patient and should involve active engagement of youth and caregivers. The HCP should be sure to ascertain beforehand that the family is eligible for these services and that referrals are accessible in the child’s or caretaker’s preferred language, and are free or available at a reasonable cost.

It may be emotionally taxing and highly stressful to confront issues of child work, and possible exploitation, especially when embedded in complex cultural dynamics that differ between patient/family and clinician. It is important to note that this can and should be a challenging process in unlearning stereotypes and biases. HCPs need to identify strategies for recognising and managing their own strong emotions and their underlying biases when working in these situations. It may be helpful to debrief with colleagues, reach out to community experts for more information and guidance on relevant cultural views regarding child work/labour, and identify resources in the community that can assist families in need, especially migrants, refugees and asylees. Clinicians may also access free and reputable online human trafficking training courses and resources for addressing associated cultural factors.

In conclusion, it is important for healthcare providers to be aware of the risk for child labour, exploitation and human trafficking among newcomers and children born in the host country within families facing immigration issues. Central to an appropriate healthcare response is the need to consider cultural beliefs and practices, as well as severe social and economic challenges faced by families. An open, non-judgemental and empathic approach will allow the practitioner to better understand the nuances of child work and labour within a given family and facilitate shared problem-solving and decision-making that prioritises the child/youth’s best interest within a cultural context. The process of developing cultural humility and responsiveness is a continuous one and requires thoughtful self-examination and intentional efforts to identify the beliefs, biases and practices of others. These methods should contribute to protecting the large and growing population of children at risk of exploitation in work settings.

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